Worcestershire County Council

Agenda

Health Overview and Scrutiny Committee

Tuesday, 15 July 2014, 1.30 pm
County Hall, Worcester

All County Councillors are invited to attend and participate

This document can be made available in other formats (large print, audio tape, computer disk and Braille) on request from Democratic Services on telephone number 01905 728713 or by emailing democraticservices@worcestershire.gov.uk

If you can not understand the contents of this document and do not have access to anyone who can translate it for you, please contact 01905 765765 for help.

বাংলা। আপনি যদি এই দলিলের বিষয়বস্তু বুঝতে না পারেন এবং আপনার জন্য অনুবাদ করার মত পরিচিত কেউ না থাকলে,অনুগ্রহ করে সাহায্যের জন্য 01905 765765 নম্বরে যোগাযোগ করুন। *(Bengali)*

廣東話。如果您對本文檔內容有任何不解之處並且沒有人能夠對此問題做出解釋，請撥打 01905 765765 尋求幫助。*(Cantonese)*

普通话。如果您对本文件内容有任何不解之处并且没有人能够对此问题做出解释，请拨打 01905 765765 寻求帮助。*(Mandarin)*

Polski eżeli nie rozumieją Państwo treści tego dokumentu i nie znają nikogo, kto mógłby go dla Państwa przetłumaczyć, proszę zadzwonić pod numer 01905 765765 w celu uzyskania pomocy. *(Polish)*

Português. Se não conseguir compreender o conteúdo deste documento e não conhecer ninguém que lho possa traduzir, contacte o 01905 765765 para obter assistência. *(Portuguese)*

Español. Si no comprende el contenido de este documento ni conoce a nadie que pueda traducírselo, puede solicitar ayuda llamando al teléfono 01905 765765. *(Spanish)*

Türkçe. Bu dokümanın içeriğini anlayamazsanız veya dokümanı sizin için tercüme edebilecek birisine ulaşamıyorsanız, lütfen yardım için 01905 765765 numaralı telefonu arayınız. *(Turkish)*

اردو. اگر آپ اس دستاویز کی مشمولات کو سمجھنے سے قاصر ہیں اور کسی ایسے شخص تک آپ کی رسائی نہیں ہے جو آپ کے لئے اس کا ترجمہ کرسکے تو، براہ کرم مدد کے لئے 01905 765765 پر رابطہ کریں. *(Urdu)*

کوردی سۆرانی. ئەگەر ناتوانی تێبگەی لە ناوەرۆکی ئەم بەڵگەیە و دەستت بە هیچ کەس ناگات کە وەیگێڕێتەوە بۆت، تکایە تەلەفۆن بکە بۆ ژمارەی 01905 765765 و داوای ڕێنوێنی بکە. *(Kurdish)*

ਪੰਜਾਬੀ। ਜੇ ਤੁਸੀਂ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਮਜ਼ਮੂਨ ਸਮਝ ਨਹੀਂ ਸਕਦੇ ਅਤੇ ਕਿਸੇ ਅਜਿਹੇ ਵਿਅਕਤੀ ਤੱਕ ਪਹੁੰਚ ਨਹੀਂ ਹੈ, ਜੋ ਇਸਦਾ ਤੁਹਾਡੇ ਲਈ ਅਨੁਵਾਦ ਕਰ ਸਕੇ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਮਦਦ ਲਈ 01905 765765 'ਤੇ ਫ਼ੋਨ ਕਰੋ। *(Punjabi)*

Find out more online:
www.worcestershire.gov.uk

worcestershire county council

DISCLOSING INTERESTS

There are now 2 types of interests:
'Disclosable pecuniary interests' and 'other disclosable interests'

WHAT IS A 'DISCLOSABLE PECUNIARY INTEREST' (DPI)?

- Any **employment**, office, trade or vocation carried on for profit or gain
- **Sponsorship** by a 3rd party of your member or election expenses
- Any **contract** for goods, services or works between the Council and you, a firm where you are a partner/director, or company in which you hold shares
- Interests in **land** in Worcestershire (including licence to occupy for a month or longer)
- **Shares** etc (with either a total nominal value above £25,000 or 1% of the total issued share capital) in companies with a place of business or land in Worcestershire.

NB Your DPIs include the interests of your spouse/partner as well as you

WHAT MUST I DO WITH A DPI?

- **Register** it within 28 days and
- **Declare** it where you have a DPI in a matter at a particular meeting
  - you must **not participate** and you **must withdraw**.

NB It is a criminal offence to participate in matters in which you have a DPI

WHAT ABOUT 'OTHER DISCLOSABLE INTERESTS'?

- No need to register them but
- You must **declare** them at a particular meeting where:
  You/your family/person or body with whom you are associated have a **pecuniary interest** in or **close connection** with the matter under discussion.

WHAT ABOUT MEMBERSHIP OF ANOTHER AUTHORITY OR PUBLIC BODY?

You will not normally even need to declare this as an interest. The only exception is where the conflict of interest is so significant it is seen as likely to prejudice your judgement of the public interest.

DO I HAVE TO WITHDRAW IF I HAVE A DISCLOSABLE INTEREST WHICH ISN'T A DPI?

Not normally. You must withdraw only if it:

- affects your **pecuniary interests OR**
  relates to a **planning or regulatory** matter
- **AND** it is seen as likely to **prejudice your judgement** of the public interest.

DON'T FORGET

- If you have a disclosable interest at a meeting you must **disclose both its existence and nature** – 'as noted/recorded' is insufficient
- **Declarations must relate to specific business** on the agenda
  - General scattergun declarations are not needed and achieve little
- Breaches of most of the **DPI provisions** are now **criminal offences** which may be referred to the police which can on conviction by a court lead to fines up to £5,000 and disqualification up to 5 years
- Formal **dispensation** in respect of interests can be sought in appropriate cases.

Simon Mallinson Head of Legal and Democratic Services July 2012 WCC/SPM summary/f

worcestershire
countycouncil

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

Membership

Councillors:

Mr A C Roberts (Chairman), Ms J Marriott (Vice Chairman), Mr W P Gretton, Mr P Grove, Mrs J L M A Griffiths, Ms P A Hill, Mr A P Miller, Mrs F M Oborski, Ms M A Rayner, Prof J W Raine, Mr G J Vickery, Dr B T Cooper, Mrs F S Smith, Mrs P Witherspoon and Vacancy

Agenda

Item No	Subject	Page No
1	**Apologies and Welcome**	
2	**Declarations of Interest and of any Party Whip**	
3	**Public Participation** Members of the public wishing to take part should notify the Director of Resources in writing or by email indicating the nature and content of their proposed participation no later than 9.00am on the working day before the meeting (in this case 14 July 2014). Enquiries can be made through the telephone number/email address below.	
4	**Confirmation of the Minutes of the Previous Meeting** (to follow)	
5	**Winter Pressures**	1 - 66
6	**Future of Acute Hospital Services in Worcestershire**	67 - 70
7	**Pilot Project Introducing a System of Clinical Navigation at the Alexandra Hospital**	71 - 76
8	**Health Overview and Scrutiny Round-up**	77 - 78

Agenda produced and published by the Director of Resources, County Hall, Spetchley Road, Worcester WR5 2NP

To obtain further information or hard copies of this agenda, please contact Emma James/Jo Weston telephone: Worcester (01905) 76 6627, Kidderminster (01562) 822511 or minicom: Worcester (01905) 76 6399 email: scrutiny@worcestershire.gov.uk

All the above reports and supporting information can be accessed via the Council's website at http://www.worcestershire.gov.uk/cms/democratic-services/minutes-and-agenda.aspx

Date of Issue: Friday, 4 July 2014

This page is intentionally left blank

worcestershire countycouncil

Health Overview and Scrutiny Committee
15 July 2014
Item No. 5

WINTER PRESSURES

Summary

1. The Health Overview and Scrutiny Committee (HOSC) is invited to consider local NHS organisations' preparedness for winter 2014/15 and how it coped with winter 2013/14.

2. Representatives of the Clinical Commissioning Groups, Acute Trust, Health & care trust and Adult & Social Care have been invited to the meeting.

Background

3. Weather conditions over winter bring additional pressures and challenges for health providers, many of which have been referred to during the HOSC's discussions with local NHS organisations.

4. Some current HOSC members will have been involved in the Committee's previous scrutiny review of the Winter 2008/09, which was carried out over the course of 2010. The review was prompted by the challenges presented by exceptional weather conditions, as well as outbreaks of Norovirus, and a potential swine flu pandemic. HOSC members praised the desire among all partners to work together, and acknowledged that partnership working extended to the broader local economy, for example the Council's role to play in co-ordinating emergency planning and in maintaining transport routes and schooling so that health and care staff could continue to work.

5. HOSC members will be well aware of national pressures on Accident and Emergency services, and of the resultant work underway within Worcestershire, including the Urgent Care Strategy, which has been discussed at HOSC meetings this year.

Lessons learnt from 2013/14

Emergency Care Intensive Support Team (ECIST) Evaluation of Winter schemes delivered in 2013/14:

6. The aim of most of the schemes was to reduce emergency admissions through and/or attendances at local accident departments. Some schemes were aimed at improving patient flow and safety in hospitals and the community.

7. ECIST carried out a one-day observational visit during January, when a number of schemes were visited and discussions held with clinicians and managers responsible for their delivery.

8. In April, a meeting was held where scheme participants and managers had an opportunity to discuss their successes, challenges and learning from the schemes.

9. The evidence base for hospital admission avoidance schemes is notoriously flimsy. Measurement of impact is very difficult due to the confounding effects of overlapping schemes, environmental factors and normal variation.

10. In Worcestershire, the good quality of primary and community health care services means that much of the 'low hanging fruit' outside of hospitals has been picked, so admission avoidance and 'demand management' is less likely to have a dramatic effect.

11. Conclusions from the data:-

- The data suggest that the 2013/14 winter schemes have not led to a significant reduction in emergency admissions or A&E attendances across the patch.

- The reduction in type 1 A&E attendances this year seems to be part of a local longer-term trend. Nationally, type 1 A&E attendances in 2013/14 were lower than in the previous year.

- The A&E conversion rate has been steadily increasing over the years, partly driven by the fall in A&E attendances. However, as with elsewhere in England, it seems that increased admissions are predominantly driven by a reduced admission threshold and the aging population.

12. Conclusions:

- In most cases, the effectiveness of the various schemes could only be assessed on the basis of their activity. As overall, there is little evidence that the schemes collectively reduced admissions or A&E attendances.

- Cost effectiveness was not generally considered by scheme leaders.

- Some schemes were relatively small scale and unlikely to have a measurable impact. Given the effort required to stand these schemes up, the opportunity costs may have outweighed any benefits.

- Several of the hospital based schemes were late starting and relied on recruitment.

- Most of the winter schemes added some capacity to existing processes but the processes themselves remained largely untouched.

13. Recommendations from the Evaluation:

- Patient flow through the acute Trust needs to be improved.

- New processes, including ambulatory emergency care, assertive management of frailty pathways and a relentless focus on eliminating internal delays need to be developed to improve flow.

- The local reliance on community hospitals as a preferred discharge destination needs to be questioned.

- Discharge to assess must replace assess then discharge.

- Processes to lessen the number of frail older people being admitted to hospital need 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.

- This will need whole system action and collaboration and the avoidance of the temptation to blame others for system failures.

Resilience and Capacity Planning 14/15

14. Background:

- New guidance was published on the 13th June having been jointly prepared by NHS England, the NHS TDA, Monitor and ADASS. This guidance is available in full on the NHS England website at http://www.england.nhs.uk/wp-content/uploads/2014/06/op-res-cap-plan-1415.pdf The publication of the guidance was accompanied by each CCG receiving a non-recurrent funding allocation to support delivery during 2014/15.

- These allocations have been made to individual CCGs but across Worcestershire total just over £3 million. It is proposed that these are pooled at Worcestershire level to deliver the maximum system-wide benefit in terms of resilience and delivery.

- There is already a proportion of the 2014/15 Better Care Fund winter planning allocation that is devolved down to CCGs and it is clear that the success criteria for the wider system resilience work and use of this new national non-recurrent funding will very much be at a Worcestershire-wide level.

- In addition to this NHS England will be distributing funding to support the delivery of RTT at Area Team level so Worcestershire can expect an additional non-recurrent allocation that will be confirmed in the coming weeks.

- The guidance includes a very clear steer that Urgent

Care Working Groups now need to 'evolve' into System Resilience Groups, with a broadened remit that includes urgent care but also covers elective activity.

- The most important initial task for the System Resilience Group is to develop a local operational resilience and capacity plan. This plan needs to be collaboratively developed involving all local partners and is required to be submitted to NHS England Area Team before 30th July.

- All plans must build on existing work but must also include detail of how they will meet a series of 'Good practice' requirements

- The plan must also be accompanied by a letter co-signed by all of the organisations who are members of the System Resilience Group.

Planning Process

15. The Best Practice Urgent Care Patient Flow Committee – is the operational group responsible for implementation of the Urgent Care Strategy, which includes Winter Planning. This group met on the 28th April to agree the key priorities to support Winter 14 /15, based on recommendations from ECIST following the evaluation of winter schemes in 13/14. It was agreed that the sustainability fund would be prioritised against 'big ticket' items rather than a number of smaller projects and would focus on the Frail Elderly pathway and patient flow at the back door of the Acute Trust. The agreed priorities also reflect some of the key priorities that have been identified for delivery in 14/15 of the Urgent Care Strategy.

Key Priorities

1. **Frailty Unit**. The aim is to provide a Multidisciplinary acute frailty and elderly assessment ('silver') unit within the current AMU location at Worcester Royal Hospital to provide early and comprehensive geriatric assessment to frail elderly people admitted as medical emergencies. Length of stay is up to 72 hours, and care will be supported by an integrated care pathway that is outcome-based, supports nurse/therapy-led discharge (once the patient has been deemed Clinically Stable for transfer), and has clear 24, 48 and 72 hour milestones.

2. **Discharge home to assess – Pathway 1** This pathway will require patients to be discharged home once they are stabilised, and the assessment for their on-going care (health and social care) and rehabilitation needs to be completed at home rather than in an acute hospital. There has been a tendency to focus on transferring patients into base wards or community units whilst these assessments are carried out so this will be a significant cultural shift for the LHE

3. **Discharge to assess – Pathway 3 for patients who require assessment of their long term care needs,**

including. The service entails the block provision of nursing home beds in the community in order to enable the speedy discharge of patients from the acute hospitals, who require assessment of their long term care needs in a more appropriate community setting.

4. **Discharge to assess – Pathway 3 for patients with severe dementia, who require assessment of their long term care needs.** The service entails the block provision of care home beds in the community in order to enable the speedy discharge of patients with moderate to higher level dementia / delirium from the acute hospitals.

5. **Patient Flow centre** As part of the Well Connected Improving Patient Flow programme within Worcestershire it has been agreed to commission an integrated patient flow centre to reduce the complexity of achieving the right care in the right place at the right time across the health and social care system. This function aims to provide a link between the organisations and to provide managed and systematic processes for capacity and demand.

6. **Enhanced access to Primary Care**: Good practice standards suggest this should include seven day access to primary care, proactive care and avoiding unplanned admissions. Plans should demonstrate comprehensive flu planning.

Clinical Reference Group

16. To ensure that the identified priorities and the pathways developed are clinically sound a number of senior clinicians from across the LHE met on 1st July to discuss the business cases and provide clinical recommendations to the System Resilience Group.
The priorities were clinically endorsed with a recognition that the Health & Care Trust needs to work in partnership with the Acute Trust to deliver the transformation within Community Hospitals in the South, to ensure timely access and transfer to Community hospitals..

Purpose of the Meeting

17. The HOSC is invited to consider and comment on the review of last year's winter plans and lessons learned for winter planning in the future.

Supporting Information

Appendix 1 (pages 7-66): Worcestershire Winter Schemes Evaluation – a hard copy has been circulated to HOSC members and paper copies will be available at the meeting.

Contact Points

County Council Contact Points
Worcester (01905) 763763, Kidderminster (01562) 822511
Or Minicom: Worcester (01905) 766399

Specific Contact Points for this Report
Emma James / Jo Weston, Overview and Scrutiny Officers, Resources Directorate (Ext 6627);

Email: scrutiny@worcestershire.gov.uk

Background Papers

In the opinion of the proper officer (in this case the Director of Resources) the following are the background papers relating to the subject matter of this report:

- HOSC Scrutiny Report 'Winter Pressures – Preparedness of Local NHS Organisations' (May 2010)
- HOSC discussion of Urgent Care Strategy (26 February and 30 April 2014

Interim Management and Support

Evaluation of Winter Schemes in Worcestershire 2013/14

Did they make a difference?

NHS Emergency Care Intensive Support Team 2014

Contents

Introduction

This paper examines the impact of the 2013/14 'winter schemes' across Worcestershire.

The aim of most of the schemes was to reduce emergency admissions through and/or attendances at local accident departments. Some schemes were aimed at improving patient flow and safety in hospitals and the community.

ECIST carried out a one-day observational visit during January, when a number of schemes were visited and discussions held with clinicians and managers responsible for their delivery. In April, a meeting was held where scheme participants and managers had an opportunity to discuss their successes, challenges and learning from the schemes.

The evidence base for hospital admission avoidance schemes is notoriously flimsy. Measurement of impact is very difficult due to the confounding effects of overlapping schemes, environmental factors and normal variation. In Worcestershire, the good quality of primary and community health care services means that much of the 'low hanging fruit' outside of hospitals has been picked, so admission avoidance and 'demand management' is less likely to have a dramatic effect.

This evaluation, while using data, observation and the views of experienced emergency care experts must be seen as a contribution to inform discussion rather than a definitive judgement on whether the schemes 'worked' or not. Having said that, it is our view that the winter schemes generally did not have a significant impact on admissions, A&E attendances or patient flow. This is not to blame primary and community care for poor demand management, nor the Trust for failing to manage flow. Rather it is a restatement of the fact that managing emergency and urgent care demand is complex and may be refractive to short term injections of cash.

Comments by ECIST from our observational visit January 2014

- **Local plans appear overly optimistic about the likely impact of the schemes. Previous methodologies for evaluating winter schemes seemed to us to be flawed and this may have contributed to the over-optimism.**

- **The local schemes that we visited were of good quality and being delivered enthusiastically. However, without whole pathway improvement and a strategic approach, such schemes can only have a limited effect that will be lost in the 'noise' of local crises and activity variation.**

- **We felt that the local system's reliance on community beds may be causing pressure rather than relieving it.**

- **There was a misunderstanding about 'discharge to assess' – successful schemes discharge a high proportion of people to their normal place of residence, not to designated bedded destinations.**

- **There is a need for an integrated pathway for frail older people that incorporates a discharge to success model**

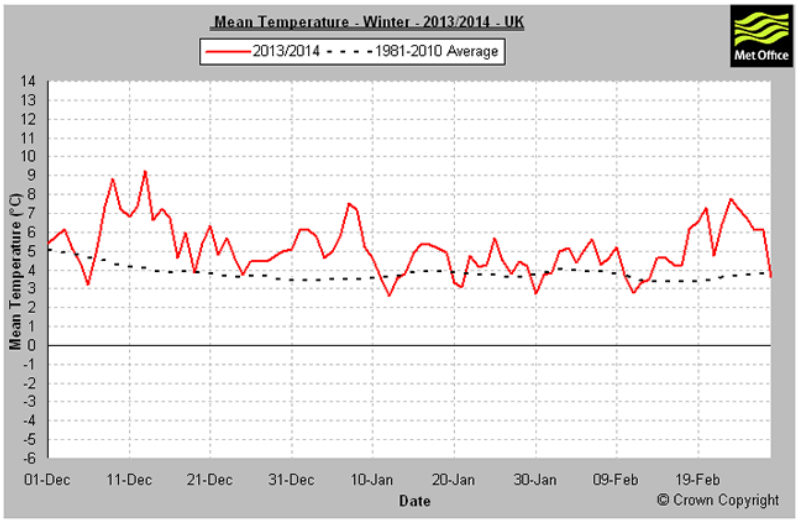
- **Relationships at a senior level were not felt to be good by most of the people we met. Some senior partners appeared to be too willing to blame each other for perceived failures. This may be obstructing collaborative improvement activity. A hallmark of successful local health communities is the strong, respectful relationships that prevail.**

What do the data tell us?

There have been very favourable winter conditions, locally and nationally

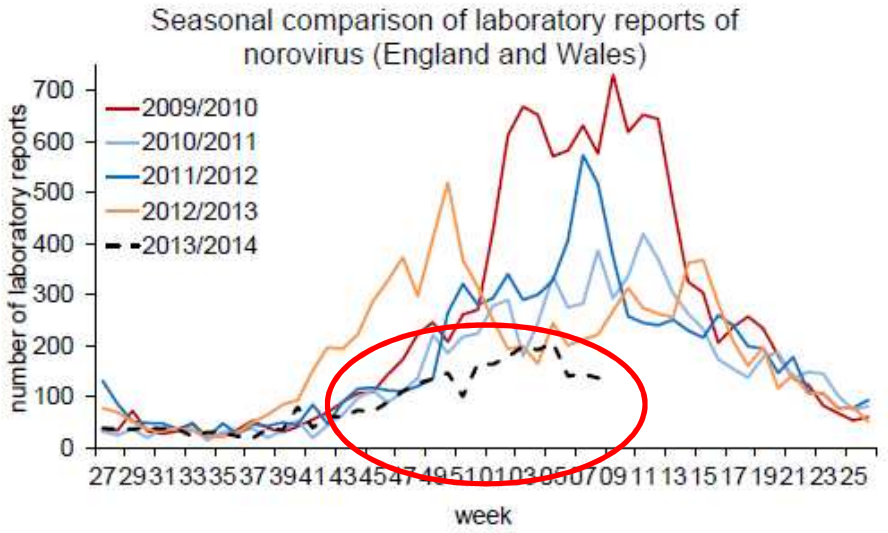
The environment - national picture

Warm winter

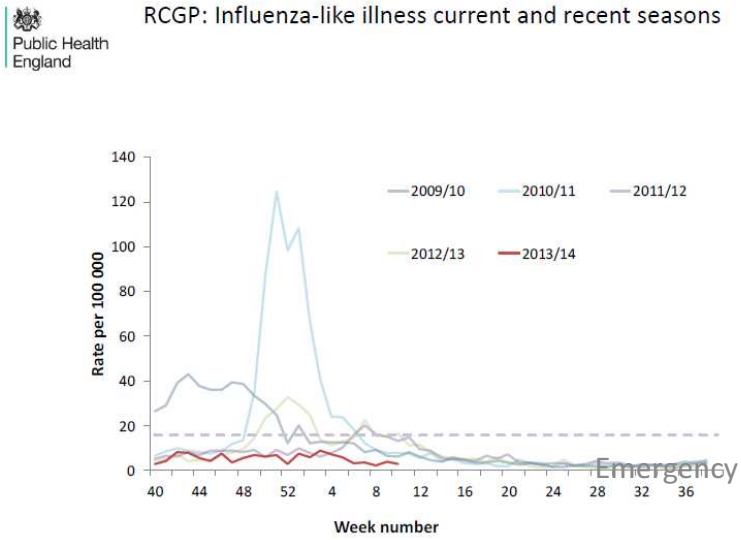


Low rates of Norovirus

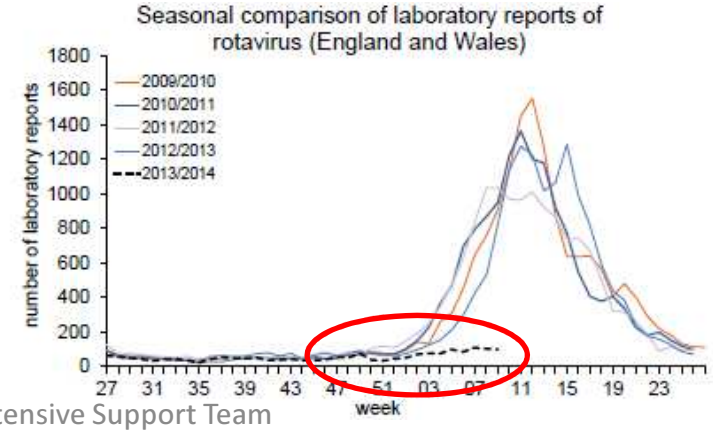
Interim Management and Support



Low incidence of flu



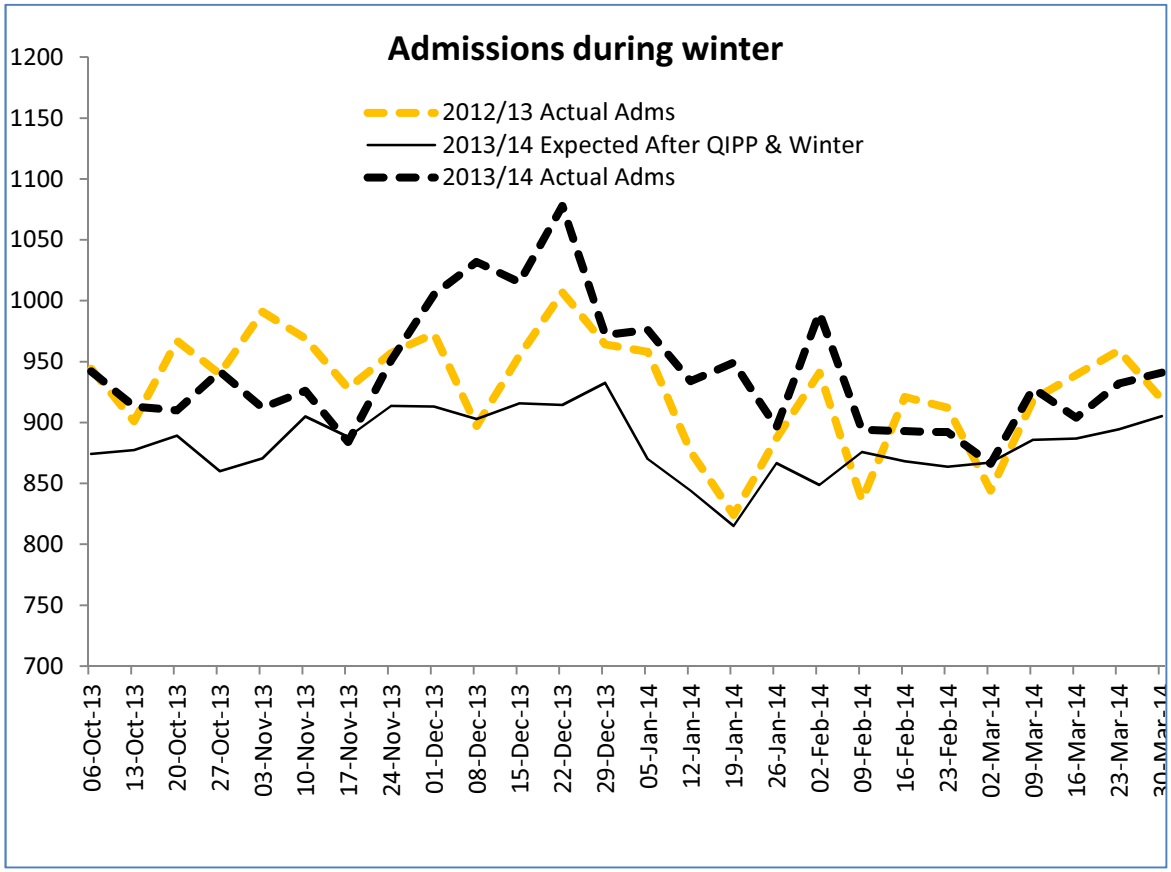
Rotavirus outbreaks greatly reduced following immunisation programme

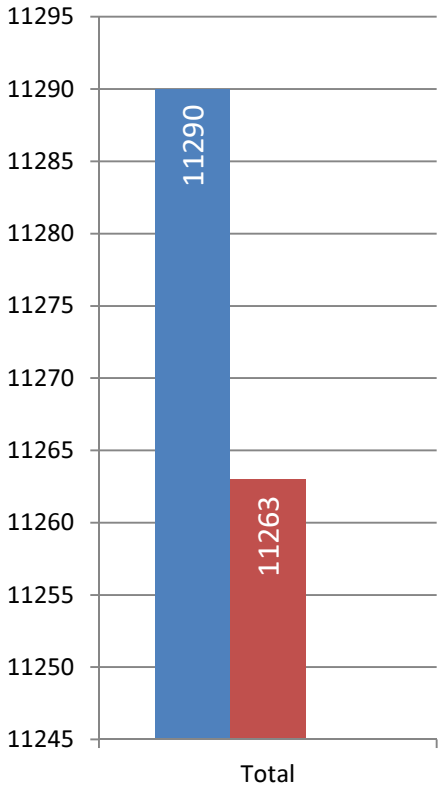


- **Nationally, environmental conditions were favourable during the winter of 2013/14, with mild weather conditions and low rates of flu.**
- **Locally, norovirus outbreaks were limited and this meant that many more inpatient beds were operationally available for admission than during the previous winter.**
- **Outbreaks in nursing homes locally were also low.**
- **Nationally, all-cause mortality was below expected rates, reflecting both the mild winter of 2013/14 and the more severe previous winter.**
- **A local factor that should be considered is the impact of flooding. This made transport of patients and staff to and from health care facilities more difficult. An assessment of how this may have affected services is beyond the scope of the of paper.**

Overall, the evidence suggests that the local health community was not exposed to the adverse pressures that could have been expected had the weather been less favourable and norovirus more widespread. This created a potentially favourable backdrop to the delivery of health services during the winter.

Winter admissions were broadly similar to last year's

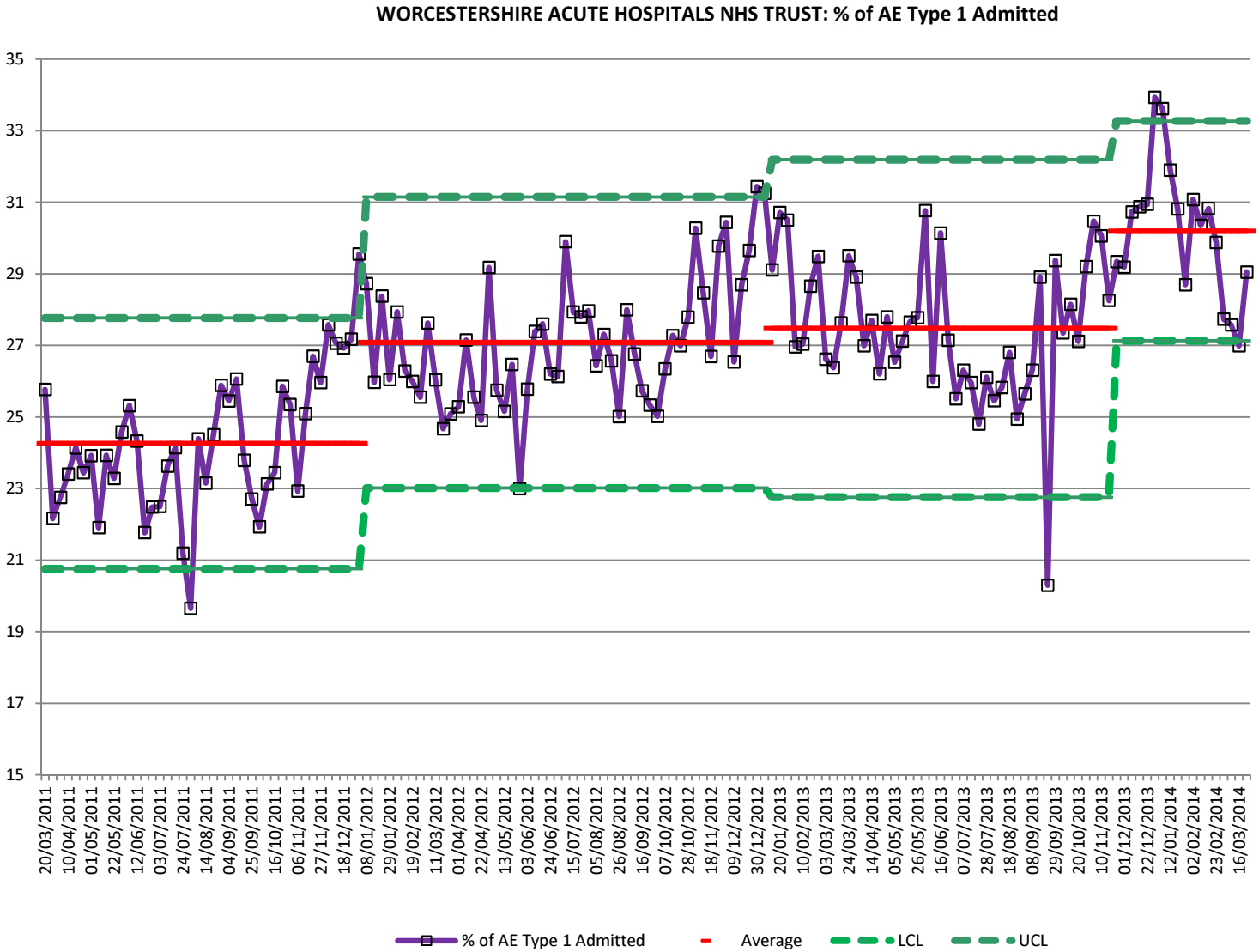




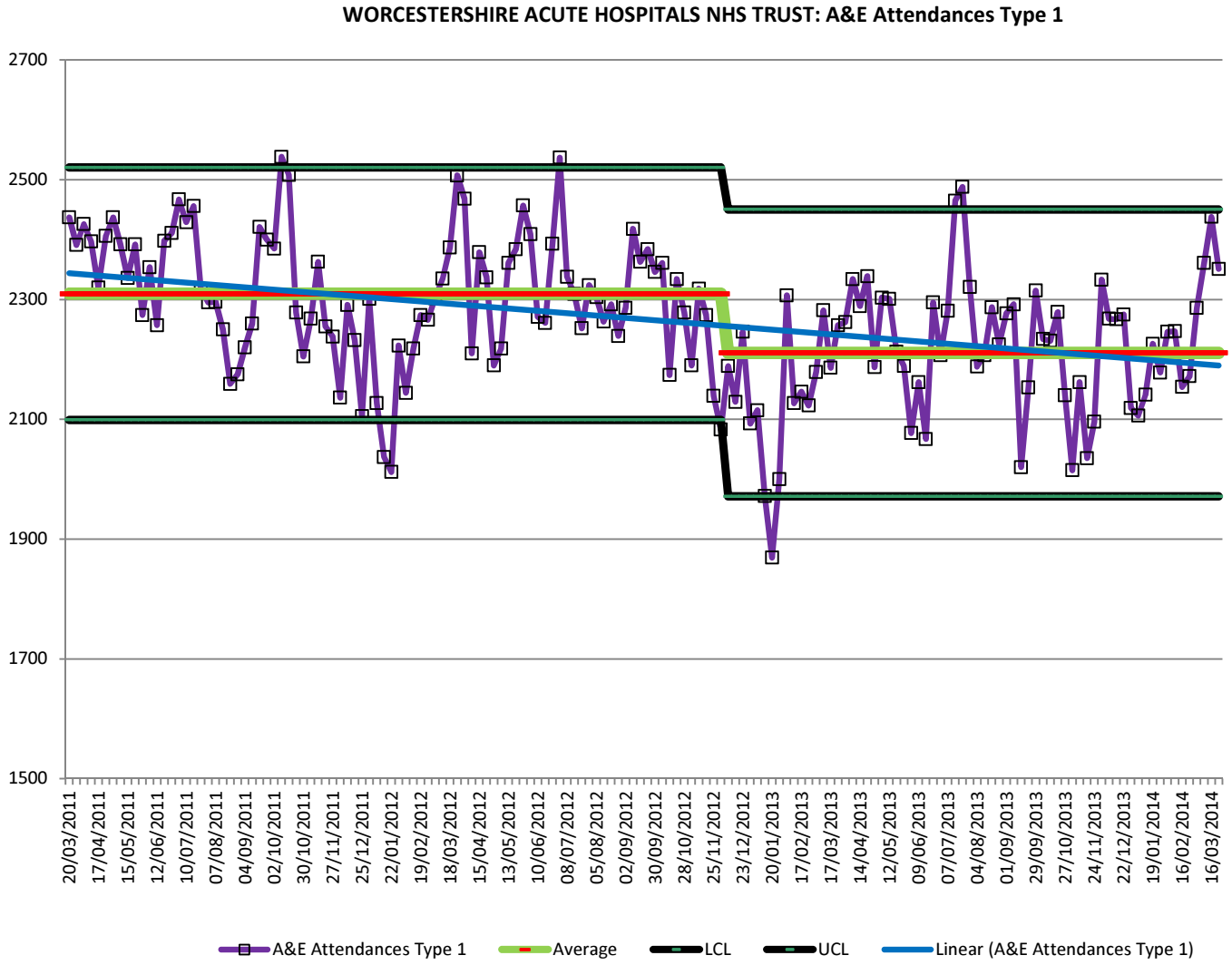
13/14 12/13

Note: gap is 27. Scale exaggerates difference

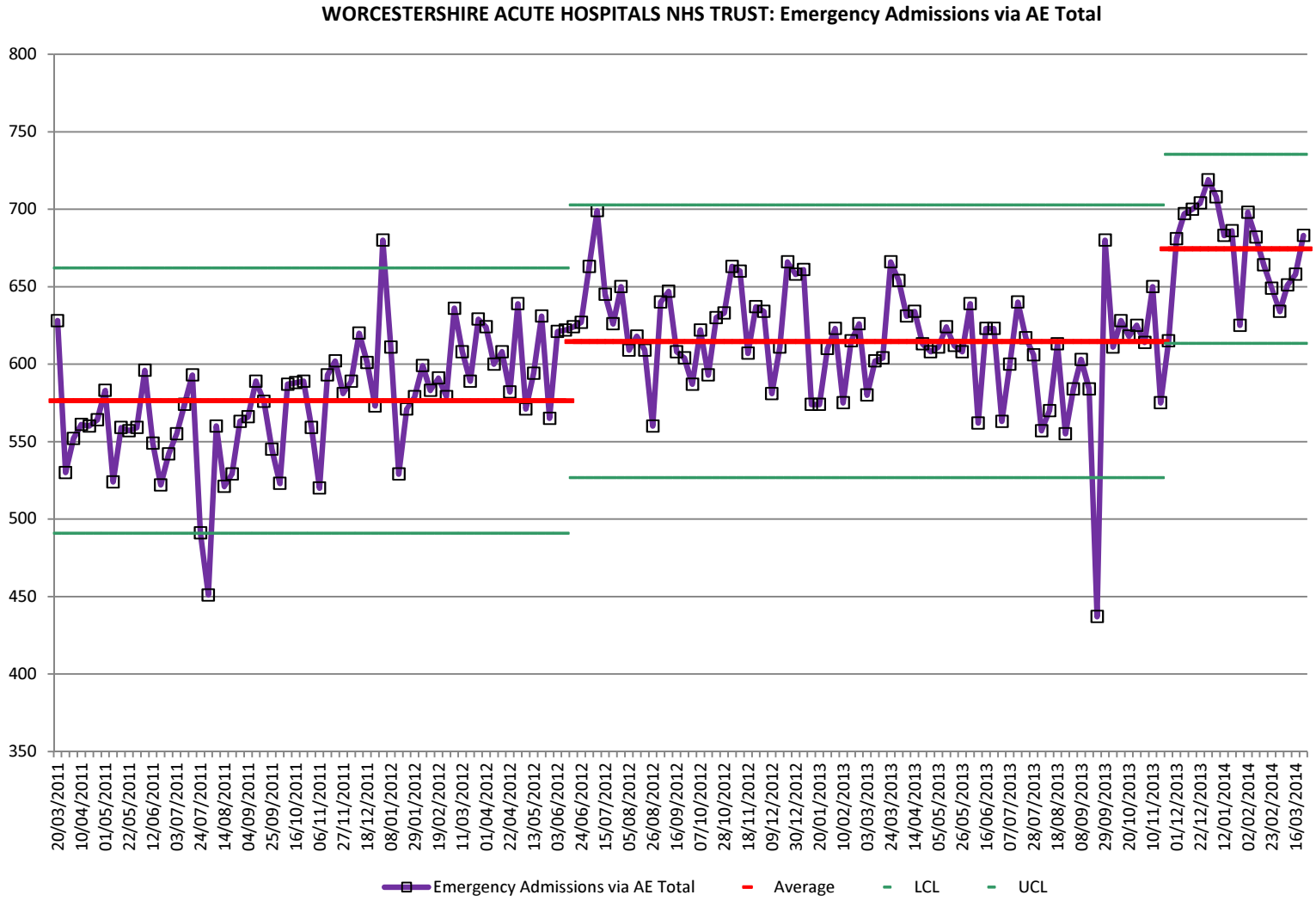
The conversion rate has been steadily increasing over the last 3 years



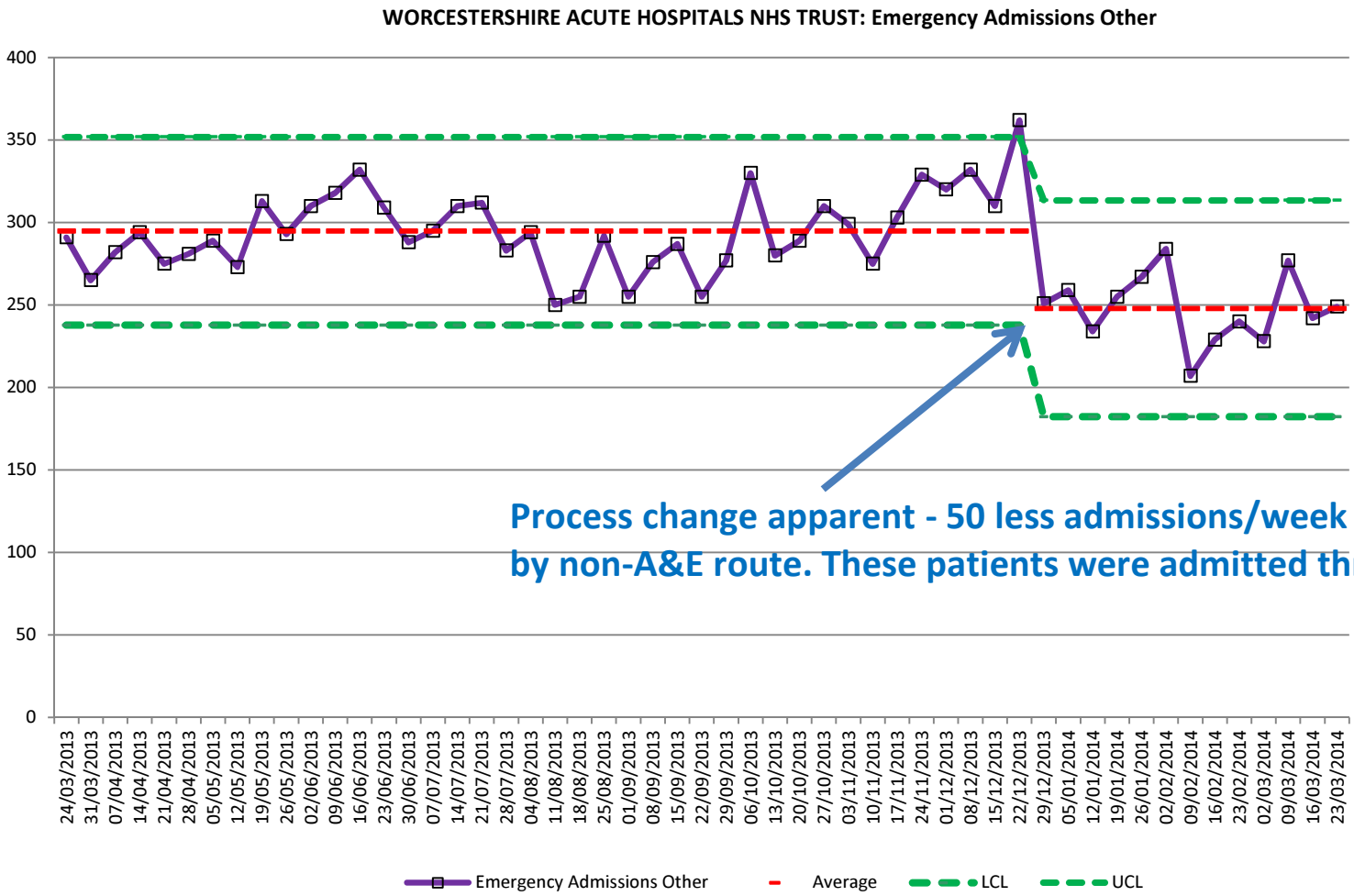
Type 1 A&E attendances have been falling, with typical seasonality. This has affected the conversion rate, but does not fully explain its increase.



The *number* of A&E *admissions* has been slowly increasing (the jump this winter is a data artefact caused by a fall in non-A&E admissions)

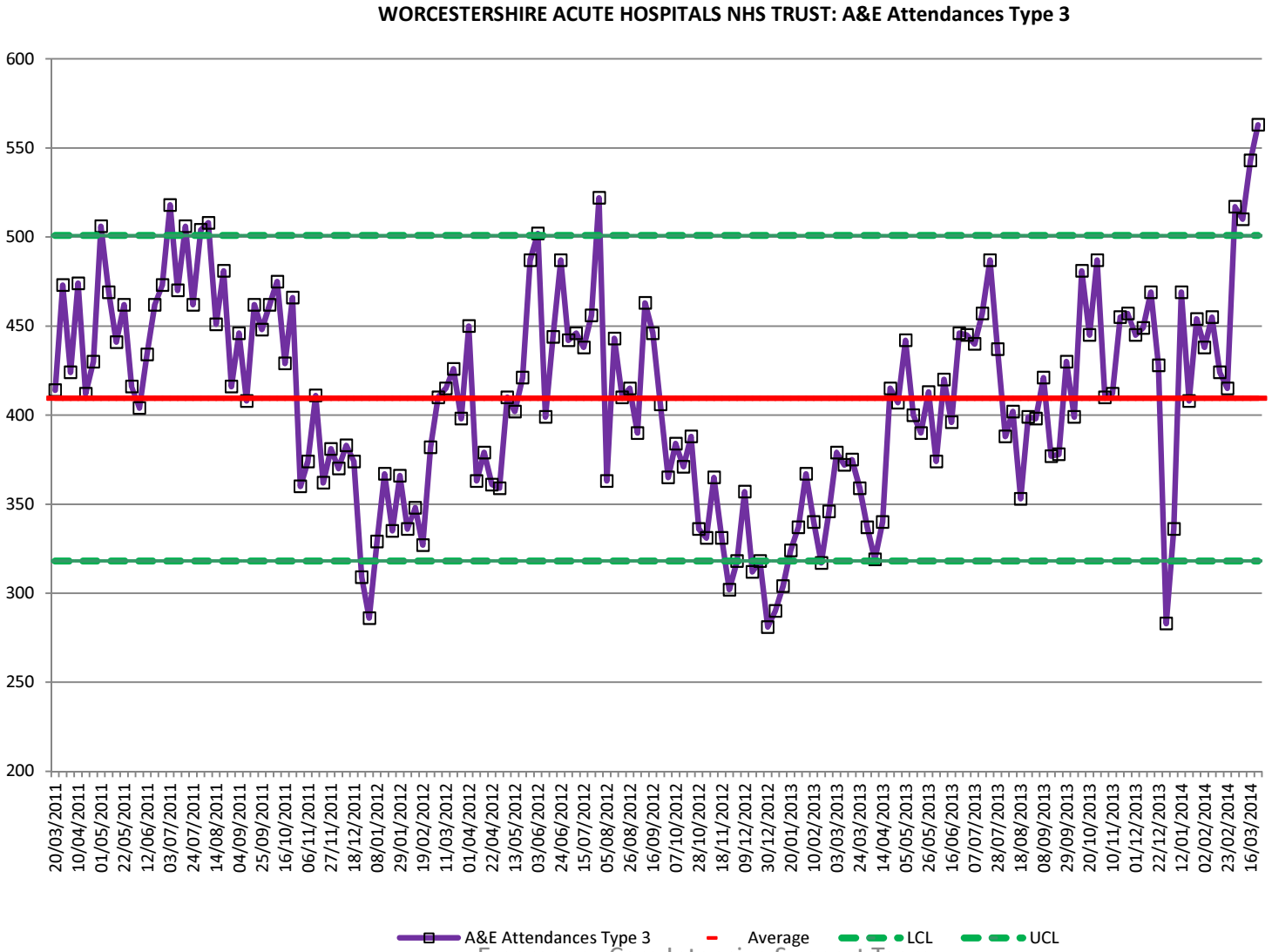


Non-A&E admissions fell by 50 a week at beginning of January, suggesting a policy change. This will have led to more crowding in A&E.

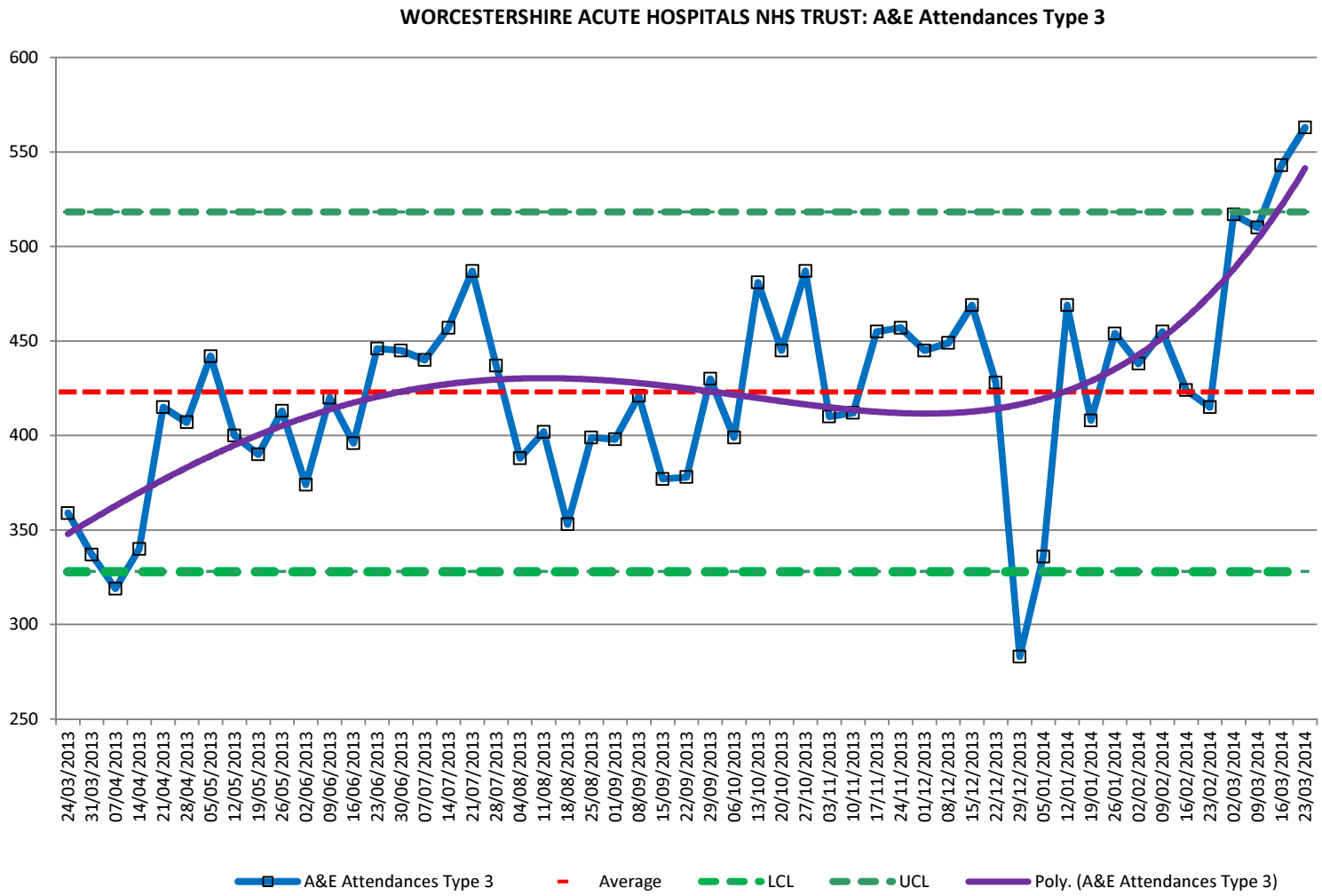


Process change apparent - 50 less admissions/week by non-A&E route. These patients were admitted through A&E

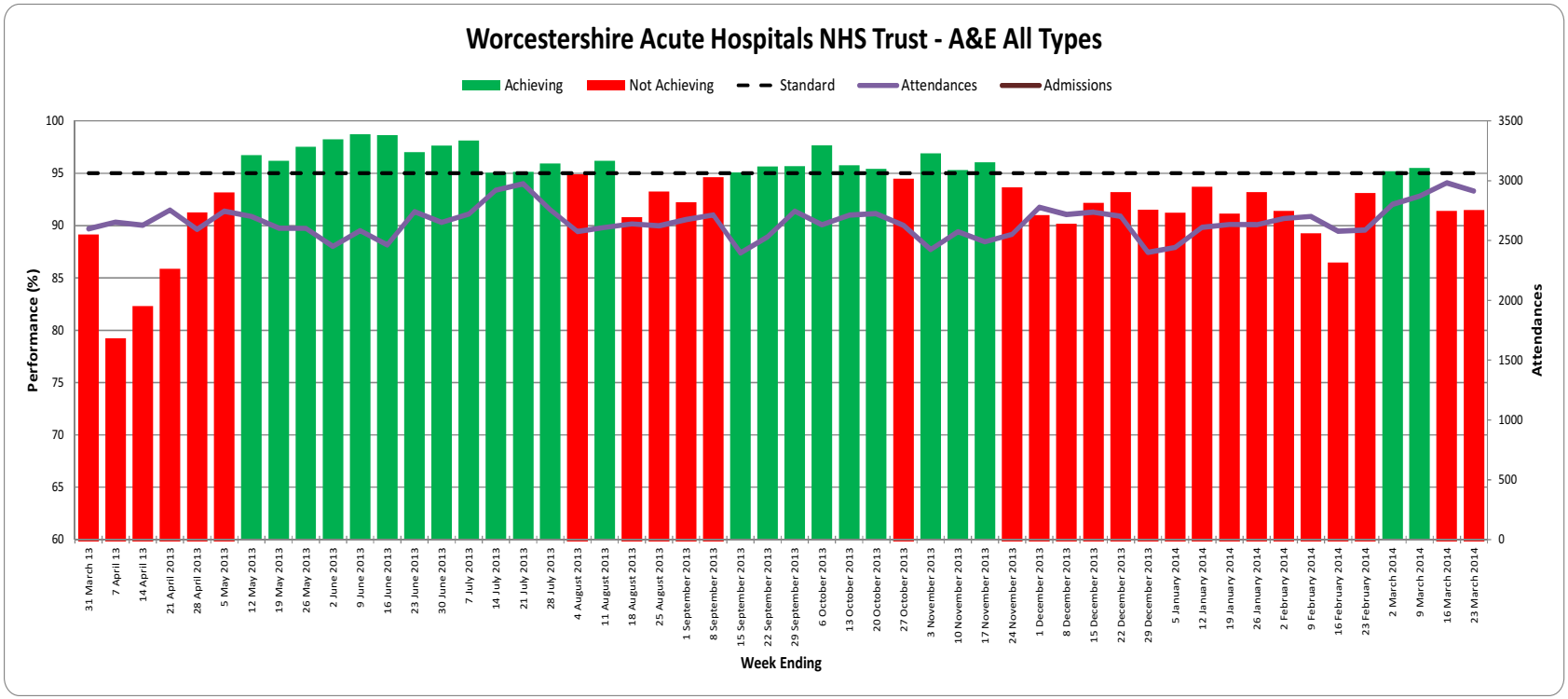
Type 3 activity is erratic, with no overall growth and distinct seasonality. However, winter 2013 activity and the jump in March is counter-trend.



Type 3 activity jumped in March 2013



There is little to suggest that attendances independently affect 4-hour performance



Summer 2013 **Autumn 2013** **Winter 2013/14**

Conclusions from the data

- The data suggest that the 2013/14 winter schemes have not led to a significant reduction in emergency admissions or A&E attendances across the patch.
- The reduction in type 1 A&E attendances this year seems to be part of a local longer-term trend. Nationally, type 1 A&E attendances in 2013/14 were lower than in the previous year.
- The A&E conversion rate has been steadily increasing over the years, partly driven by the fall in A&E attendances. However, as with elsewhere in England, it seems that increased admissions are predominantly driven by a reduced admission threshold and the aging population.
- Type 3 attendances have not exhibited the sustained growth seen elsewhere in England. However, of note is the fact that the typical winter 'lull' in attendances seems to have been absent locally in 2013/14, with a big jump in March. This seems worthy of further investigation.
- The number of A&E attendances does not appear significantly to affect weekly 4-hour performance.

A look at some of the schemes

During April, we held a meeting with scheme leaders to consider what worked well, what could have worked better and whether overall the scheme was effective. The slides presented by scheme leaders are provided as an appendix and provide a rich source of learning.

Overall, a number of conclusions can be drawn:

1. **In most cases, the effectiveness of the various schemes could only be assessed on the basis of their activity. This could create a misleading impression of the impact of some schemes, with activity being causally linked to outcomes when at best there was a correlation. As overall, there is little evidence that the schemes collectively reduced admissions or A&E attendances, great caution should be exercised when considering the effectiveness of any of the individual schemes.**
2. **Cost effectiveness was not generally considered by scheme leaders. Where there was an attempt to evaluate cost savings, this was very crude and based on untested assumptions. It is probably overly optimistic to expect managers who are not trained economists to evaluate the cost effectiveness of this type of scheme.**
3. **Some schemes were relatively small scale and unlikely to have a measurable impact. Given the effort required to stand these schemes up, the opportunity costs may have outweighed any benefits.**
4. **Several of the hospital based schemes were late starting and relied on recruitment. The wisdom of allowing these schemes to go ahead should be questioned.**
5. **In many cases, useful learning came from implementing some of the schemes. This is outlined below.**

Selected learning points

1. Communication initiatives

The communications team used its winter money on a range of initiates aimed at 'messaging' the public on the appropriate use of health services during the winter. Research suggests that general messaging is not effective in changing behaviours and the team was concerned that this was the case locally. We **recommend** that before any further communications initiatives are made, a better understanding is developed of the way that different groups use urgent and emergency care services. This will enable messages to be better targeted and services to be more effectively 'marketed'. The Nuffield Trust has useful resource available that may be a helpful point of departure: http://www.slideshare.net/NuffieldTrust/michaela-firth-social-marketing-in-the-nhs

2. GP with WMAS

This scheme involves a GP being based at ambulance stations to support crews and manage patients referred by them. Half of the schemes funding comes from 'winter' money. The data indicate that 64% of activity is at the weekend, with 36% covering the rest of the week. Weekday productivity is low, with an average of less than four calls a day. It seems likely that the current model is not cost effective. We **recommend** reviewing the model. It may be that a single GP supporting NHS 111 and the ambulance control room on weekdays at peak periods, with a team covering the patch at weekends, may be worth considering.

3. South Worcestershire enhanced intermediate care schemes (including community hospital beds)

The local evaluation of these schemes seemed to us to be reasonable. Nationally, there is under-capacity in intermediate care schemes that makes admission avoidance more difficult. Enhancing the service locally seems to have been effective. Schemes that involved additional beds appear to have been less effective. There needs to be a much greater emphasis on getting patients home from hospital, rather than just getting them out of hospital. We have **recommended** that there is a need for well-thought through frailty pathways in the county and enhancing intermediate care and reviewing the use of community hospitals should be part of this work.

Selected learning points

4. Infection control

Good quality, evidence based and well resourced approaches to the control of infection both in hospitals and the wider community are essential to patient safety. The local enhancements should be mainstreamed and further developed as 'business as usual'. The catastrophic consequences of bed closures in the acute hospital and care homes should be enough to make the case.

5. Acute schemes

The schemes described in the feedback session are mainstream services in many parts of the country and should not rely on temporary winter funding. Adequate consultant staffing in A&E (most EDs stretch cover to 22.00 hrs or midnight), an effective frailty service, greater depth of medical staffing at weekends and ambulatory emergency care should all be in place throughout the year. The absence of such services (and the more general implementation of good practice) will adversely affect patient flow and lead to bed crises. Schemes that are inherently complex and require planning should not receive late-arriving and temporary winter funding or be staffed by locums (e.g. the 'front door geriatrician').

6. 20-minute access to a GP (Wyre Forest)

Wyre Forest set up a scheme to guarantee access to a GP within 20 minutes in the expectation that this would be of help to clinical decision making in A&E. The service was not used. While the principle is sound that clinician to clinician conversations are important to patient care, in practice twenty minutes may seem too long to wait. It would be better if a process was crafted that would allow much faster access, in both directions. Such processes have been established elsewhere and can often involved experienced nurses, supported by doctors. We recommend that failure of this initiative is used to stimulate the development of a process that will work well for all concerned.

Conclusion

If you do what you've always done, you'll get what you've always got.

This quote may sum up the lessons that should properly be drawn from the winter of 2013/14. Most of the winter schemes added some capacity to existing processes but the processes themselves remained largely untouched. A more radical approach is needed.

Patient flow through the acute Trust needs to be improved. New processes, including ambulatory emergency care, assertive management of frailty pathways and a relentless focus on eliminating internal delays need to be developed to improve flow. The local reliance on community hospitals as a preferred discharge destination needs to be questioned. Discharge to assess must replace assess then discharge. Processes to lessen the number of frail older people being admitted to hospital need 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.

This will need whole system action and collaboration and the avoidance of the temptation to blame others for system failures.

ECIST 2014

Appendix

Slides presented at April feedback session

What worked well ?

The campaign messages were very clear and easy to understand:

68.9% Public & Patients.

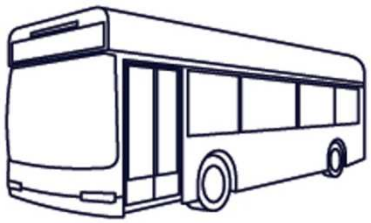
85% Clinical & Non Clinical staff.

The overall integrated campaign was a success:

91% Public & Patients had seen, heard or read about the campaign.

81% Clinical & Non Clinical staff had seen, heard or read about the campaign.

Targeted bus advertising campaign



52% Public & patients had seen the advert on the buses.

44% Clinical & Non Clinical staff had seen the bus adverts.

Guide to Local Health Services

62% Public & patients said that they found the leaflet really useful and would use it again.

Mobile phone app

42% Public & Patients said that they have used the app.

83% said the app was useful and they would use it again.

Working in partnership

Communications colleagues in the local health and social care economy worked together to ensure a coordinated communication approach.

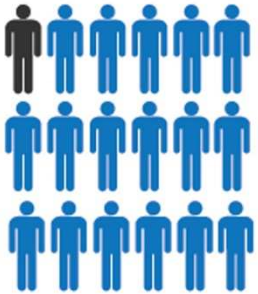
What could have worked better ?

Visibility of messages in GP Practices

10%
People surveyed had seen the messages in GP Practices.

Promotion via screens in GP practices

7%
People surveyed had seen the campaign on a screen in a surgery.



Promoting messages through radio advertising:

21%
People surveyed had heard the campaign via the radio.

Awareness of Minor Injury Units

Before 32%

After 40%

There was only a slight increase in people awareness of local MIUs before and after the campaign.

Is there any proof it made a difference ?

Public awareness and support for the 'Is A&E for me?' campaign

Who has seen, heard or read about the campaign?

Feedback from stakeholders

91% Public & Patients

81% Clinical & Non Clinical staff

Public awareness and understanding of the NHS services in their local area

Media Coverage

22 Radio Interviews

35 Articles

Hits to on-line information e.g. Is A&E for me webpagess and social media sites

Website Hits

12,000 Hits

Twitter

160	301	30	56	124,208
Tweets	Followers	Mentions	Re-Tweets	Potential Reach

Mobile Phone App Downloads

801 app downloads

42% of people questioned had downloaded the app.

83% of the 42% questioned found the app useful and would definitely use it again.

GP with WMAS

Winter Evaluation
13/14

Initiative

- 2 GPs 7 days / week 12- 8pm and 3rd GP on Sat, Sun and BH - 8am -10pm.
- Covering population of 580,000.
- GPs based in ambulance station with access to the CAD.
- Calls from paramedics who have assessed the patient.
- GP provides a face to face assessment or telephone advice.
- GPs able to respond to everything except: life threatening emergencies, major trauma, confirmed AMI and FAST ve+.
- Top 5 calls: Generally ill , Breathing difficulties, Falls , Chest pain and Abdo pain

What's working well

- Positive feedback from ambulance clinicians
- Rapid access to GP advice and visit.
- Safety netting and increased risk tolerance.
- Increased clinician confidence in decision making
- Partnership working – breaking down barriers between GPs and paramedics, enhanced understanding of each others skills.
- Reduced conveyance rate
- Freeing up crews to respond to the next 999 call
- Increased use of patient's own GP when appropriate.

Could have worked better

- More paramedics are aware of and understand the service.
- Paramedics call is more consistent – 'Think GP' for everything that's not 'Big sick'
- Provide direct access to community teams , care homes and MIUs – rapid access to GP assessment and advice.
- More to do :

➢ To reduce inappropriate conveyance

➢ Integration between Primary care and pre- hospital providers

➢ Reduce delays in requests for GP services from ambulance services.

Impact

Total contacts with GP in ambulance over time period Oct 13 - Mar 14

Day of week	Number of call outs	Number of days in time period	Average number of calls on day
Monday	82	26	3.2
Tuesday	82	26	3.2
Wednesday	97	26	3.7
Thursday	97	26	3.7
Friday	80	26	3.1
Saturday	399	26	15.3
Sunday	384	26	14.8
Grand Total	1221	182	6.7

GP in the Ambulance contacts by type of response and % conveyed to hospital over time period Oct 13-Mar 14

	Not transported		Transported	
Response Type	Number	%	Number	%
Face to Face	609	88.52%	79	11.48%
Telephone	358	67.17%	175	32.83%
Grand Total	967	79.20%	254	20.80%

Impact

Conveyance rates for specified chief complaints over time period Oct 13-Mar 14

	Not transported		Transported	
Complaint Group	Number	%	Number	%
Abdominal Pain	59	75.64%	19	24.36%
Breathing Difficulties	138	80.70%	33	19.30%
Chest Pain	71	79.78%	18	20.22%
Falls	113	77.40%	33	22.60%
Generally Ill	158	77.83%	45	22.17%
Grand Total	539	78.46%	148	21.54%

NHS
South Worcestershire
Clinical Commissioning Group

South Worcestershire Winter Schemes

Schemes

- Additional capacity
  - Timberdine – 6 beds
  - Tenbury – up to 3 beds
- D2A beds at Pershore Community Hospital
  - 8 beds
- Enhanced Medical Cover
  - Additional GP support
  - Additional consultant support

What worked well?

- Additional capacity - ***beds***
  - Patient experience is positive
  - occupancy regularly over 95%
  - DTOC minimised, where delays experienced the length of the delay was short

- Additional capacity – ***Integrated Community teams***
  - Dramatic increase in referrals for rapid response admission prevention service
  - Increased flexibility to increase in-reach activity at times of increased pressure
  - Reduced acute admissions for >65s, specific range of HRGs
  - Reduced acute admissions from care homes

- D2A beds at Pershore Community Hospital
  - Patient experience & outcomes improved
  - Hospital occupancy improved, average of 6 beds used
  - Dedicated medical support – GP & Consultant

- Additional medical cover
  - Reduced delays for community hospital beds, pathway smoother
  - Regular patient reviews (weekly or biweekly)
  - Time to have difficult conversations with patient/family eg re Advance Care Planning
  - engagement with the teams (ward & ECT)
  - medical leadership in the MDT

What could have worked better?

- Additional capacity - ***beds***
  - Greater focus on “home first”, rather than beds
  - Tenbury – low use, poor location, complaints from patients & families
  - Timberdine – ? unable to accommodate peaks in stroke demand

- Additional capacity – ***Integrated Community teams***
  - Improved pathway with A&E/AMU – awareness, communication
  - Increased use of GP with WMAS scheme to access medical support for deteriorating patients
  - Timing! 600 staff through change management, needed time to embed

- D2A beds at Pershore Community Hospital
  - Pathway - ?D2A……high numbers of Friday afternoon admissions??
  - Co-ordination – barchester, care homes, PCH all treated differentlyanticipated reduction in care home use not delivered
  - SW and CHC support, extended LOS

- Additional medical cover
  - Clear & functioning referral pathway from GPs - at PH only
  - Better communication between consultant & GPs eg face to face or by phone
  - GP presence in MDT to facilitate planning & implementation

Is there any proof it made a difference?

- ??????

- Formal evaluations still being completed
- Improved quality of care provided
- ? Improved flow
- Reduced emergency admissions >65s

- ?? Failed to deliver the reduction in admissions we had planned

NHS
South Worcestershire
Clinical Commissioning Group

Infection Prevention and Control
Evaluation of Winter Plan 2013-14

Initiatives

- Improved communication in local health economy daily bulletins – PHE, Acute Trust, Health & Care Trust, Pathology laboratory, Capacity team, West Midlands Ambulance, Director on call, Harmoni out of hours and across County sharing of information.
- Increased understanding of community outbreaks, epidemiology and admissions.
- Able to target /track admissions & discharges that may pose a risk of infection in receiving units.
- Prompt repatriation of patients to care homes.
- Assist bed managers to place discharges that may have been delayed due to infection risk.
- Practical support and advice offered to all care homes throughout the outbreak (visits, posters, fluid balance charts – able to offer emergency contact for out of hours – courtesy service)
- Education program and documentation packs to increase awareness and knowledge of outbreak management and importance of hydration.
- Patient experience and care home visits has increased understanding of how outbreaks are managed and what advice is realistic , practical and in the residents best interest.
- Identified homes that require increased quality assurance monitoring and support.

Can do better…

- Post community outbreak reviews to identify areas of best practice and areas where improvements are needed.
- Residents admitted without medical review - route cause of individual admissions would identify if they could have been avoided and if so what systems are needed.
- Clear communication process to ensure homes and ward informed promptly of admissions occurring from the affected area in the 72 hours prior to onset of outbreak.
- Increased communication and links with PHE to avoid duplication of work for both organisations and care homes.
- Increase the education campaign – pre November with on line access.
- Outbreak packs to be revised to include hydration assessment tool and packs to be available to down load from web site.
- Out of hours support – review what is achievable in a small team.
- Enhanced public campaign to ensure better understanding of the problem and clear advise what they can do to help manage the problem.

Impact

- 33 Outbreaks in 31 homes – each were contacted and offered support within 24 hours of reporting increase in incidence to PHE.
- 12 admissions (4 for dehydration) – promptly alerted to acute trust by WMAS / Care Home / CCG.
- Admission avoidance – unable to confirm, anecdotal evidence suggests that admissions were avoided.
- Improved and timely communication relating to outbreaks within the HE and with neighbouring counties .
- Timely repatriation of residents to and from outbreak areas, health economy liaison to ensure risks were minimised whilst recognising environmental constants and bed pressures.
- Reduced risk of cross infection from community outbreaks – positive feedback from acute.
- Education sessions for care staff – 128 staff educated with excellent evaluation.
- Care staff gained enhanced awareness and understanding of risks, priorities and infection prevention and control strategies from daily calls.
- Care home staff – acknowledged support, appreciated individual point of contact and were able to pose questions and concerns and seek advice in a timely way.
- Patient experience and impact of outbreak on a residential and a nursing home presented to CCG public boards – increased understanding of the problem.

Worcestershire NHS
Acute Hospitals NHS Trust

Winter 2013/14 Review

What worked well….

- Capacity hub – building relationships
- Additional ED Consultant – support weekends / evenings
- Front Door geriatrician
- Increased weekend doctor cover
- Ambulatory Emergency Care
- Structured response - internal

Worcestershire NHS
Acute Hospitals NHS Trust

Winter 2013/14 Review

What could have worked better…

- Timeliness of money being made available
- Use of permanent staff rather than locum to support
- Demand management
- ED pressures
- Levels of escalation – economy response

Worcestershire NHS
Acute Hospitals NHS Trust

Winter 2013/14 Review

Did it make a difference

- Really difficult to measure.....

What worked Well: Wyre Forest

- Additional capacity approved in APT
- Wanted to implement 7 day CM cover but couldn't appoint.
    - 1 Band 6 rapid response nurse (Jan 14), 2 band 4s at 0.8wte (1 Dec 13, 1 Jan 14) , 1 band 4 technical instructor for UPPs beds(Nov 2013) Band 2 admin support at weekends (Jan 2013). 3 Band 3s doing part time hours (Nov 2013)
- GP to support ADT and WMAS
- Improved access to GPs

- Worked well
  - The additional Band 4 rehab assistant worked well, also in-reached to The Grange to keep flow going.
  - The GP for late day calls for some practices (under utilised by some)
  - Made changes in structure in time so senior grades could be more responsive by utilising band 3s. Thereby increasing capacity when needed.
  - The dependency has increased as utilised HCAs more
  - Rapid response has made it more responsive.
  - Additional HCA to do maintenance/therapeutic visits, and supporting senior staff in monitoring. Therefore freed up CM time.
  - Occasionally 10 referrals in 2 hour period and 'more bodies on ground to respond. '(most was 13 referrals in 1.5 hours).
  - Response time maintained irrespective of increased demand.
  - In-reach as required
  - Supported discharge
  - GP with WMAS

What could have worked better: Wyre Forest

- The 20 min access to GPs: there was an anticipated need but not utilised ? What would have been utilised instead?
- The momentum for the GP in APT took a while to embed, but became more established.
- The appointment i.e. interviewing etc took a lot of time out of team leaders day ? This may have offset the additional staff time.
- The band 4 role not utilised well, as a new post took a while to grow.
- Getting staff in post sooner, the selection process so time consuming.
- Risk stratification

Is there any proof it made a difference: Wyre Forest

- APT have reported an increase in activity both referrals and dependency.
- Patients in UPPS beds have a shortened length of stay: the purchasing plan next time could reflect this.
- Emergency admissions have remained the same, no significant increase during winter.
- Capacity in GP surgery's increased, therefore more responsive.
- An average caseload increased from a potential 20 to 35.

- NB: still collating data

WMAS 2013/2014 PTS Winter Pressures.

What worked well?

- The extra resource provided enhanced discharge cover over the winter period .
- It offered increased scope during the prolonged flooding.
- We were able to “lock” discharge crews into the hospitals.
- The Acute Hospitals were able to prioritise discharges according to their demand.
- The extra resource enabled us to improve our discharge reaction times.

WMAS 2013/2014 PTS Winter Pressures.

What could have worked better?

- The funding of a PTS ”HALO”. This member of staff could have been based with in the WRH HUB making it easier for PTS to understand the “live” pressures on site. The PTS HALO could then offer up to date sit reps as requested and help coordinate discharges.
- Better use of “Surge “ crews at the weekend (more bookings).
- Better coordination of “Boundary” discharges to reduce unnecessary repetitive journeys to the same destination/ Area.

WMAS 2013/2014 PTS Winter Pressures.

Did it make a difference?

- YES

Urgent Care Scheme

Winter Pressures 2014

Full years activity and high level outcomes

Interim Care - All Events | **All Worcestershire** | **01 April 2013** to **31 March 2014**

Situation After Three Weeks

Latest Uniq Uniq

Count	Step Down	UUP	POP	Grand Total
Residential/nursing care	184	144	48	376
Deceased	16	53	10	79
No current WCC res/nursing service	18	313	84	415
Time line not reached	4	21	10	35
Grand Total	**222**	**531**	**152**	**905**

Situation After Seven Weeks

Latest Uniq Uniq

Count	Step Down	UUP	POP	Grand Total
Deceased	32	90	12	134
Residential/nursing care	72	87	20	179
No current WCC res/nursing service	101	292	92	485
Time line not reached	17	62	28	107
Grand Total	**222**	**531**	**152**	**905**

Situation After Three Months Weeks

Latest Uniq Uniq

Count	Step Down	UUP	POP	Grand Total
Deceased	49	117	17	183
Residential/nursing care	57	80	18	155
No current WCC res/nursing service	71	216	75	362
Time line not reached	45	118	42	205
Grand Total	**222**	**531**	**152**	**905**

Situation After Six Months

Latest Uniq Uniq

Count	Step Down	UUP	POP	Grand Total
Deceased	60	151	22	233
Time line not reached	84	206	69	359
No current WCC res/nursing service	39	117	48	204
Residential/nursing care	39	57	13	109
Grand Total	**222**	**531**	**152**	**905**

October to March activity by CCG

Interim Care - Summarised By Care Comissioning Group 01 October 2013 to 31 March 2014

Situation After Three Weeks

Latest Uniq Uniq

Count	UUP	POP	Step Down	Grand Total
(blank)	5	4	4	13
South Worcestershire C C G	138	32	38	208
Deceased	6	2		8
No current WCC res/nursing service	88	15	3	106
Residential/nursing care	34	13	34	81
Time line not reached	10	2	1	13
Wyre Forest C C G	67	20	21	108
Deceased	9	1	3	13
No current WCC res/nursing service	32	12	1	45
Residential/nursing care	19	6	17	42
Time line not reached	7	1		8
Redditch and Bromsgrove C C G	44	20	44	108
Deceased	4	1	3	8
No current WCC res/nursing service	27	8	2	37
Residential/nursing care	9	5	37	51
Time line not reached	4	6	2	12
Grand Total	**254**	**76**	**107**	**437**

Situation After Seven Weeks

Latest Uniq Uniq

Count	UUP	POP	Step Down	Grand Total
(blank)	5	4	4	13
South Worcestershire C C G	138	32	38	208
No current WCC res/nursing service	71	18	19	108
Residential/nursing care	16	1	11	28
Time line not reached	34	10	5	49
Deceased	17	3	3	23
Wyre Forest C C G	67	20	21	108
No current WCC res/nursing service	29	12	7	48
Residential/nursing care	9	2	5	16
Time line not reached	19	5	3	27
Deceased	10	1	6	17
Redditch and Bromsgrove C C G	44	20	44	108
No current WCC res/nursing service	26	7	21	54
Residential/nursing care	3	1	8	12
Time line not reached	9	11	7	27
Deceased	6	1	8	15
Grand Total	**254**	**76**	**107**	**437**

Situation After Three Months Weeks

Latest Uniq Uniq

Count	UUP	POP	Step Down	Grand Total
(blank)	5	4	4	13
South Worcestershire C C G	138	32	38	208
No current WCC res/nursing service	47	9	12	68
Residential/nursing care	12	2	9	23
Time line not reached	61	17	11	89
Deceased	18	4	6	28
Wyre Forest C C G	67	20	21	108
No current WCC res/nursing service	15	9	3	27
Residential/nursing care	4	1	2	7
Time line not reached	34	9	10	53
Deceased	14	1	6	21
Redditch and Bromsgrove C C G	44	20	44	108
No current WCC res/nursing service	11	7	6	24
Residential/nursing care	4		6	10
Time line not reached	21	12	22	55
Deceased	8	1	10	19
Grand Total	**254**	**76**	**107**	**437**

Situation After Six Months

Latest Uniq Uniq

Count	UUP	POP	Step Down	Grand Total
(blank)	5	4	4	13
South Worcestershire C C G	138	32	38	208
Time line not reached	115	28	32	175
Deceased	23	4	6	33
Wyre Forest C C G	67	20	21	108
Time line not reached	53	18	15	86
Deceased	14	2	6	22
Redditch and Bromsgrove C C G	44	20	44	108
Time line not reached	36	19	33	88
Deceased	8	1	11	20
Grand Total	**254**	**76**	**107**	**437**

Total cost for the year (accumulative)

Costs		
POP	UUP	Step Down
£ 36,441.86	£ 60,907.80	£ 63,211.64
£ 70,402.71	£113,727.59	£109,586.50
£107,453.71	£165,291.87	£152,394.93
£148,702.00	£223,124.16	£221,538.93
£188,304.71	£253,442.59	£287,585.64
£233,447.07	£280,113.66	£324,364.79
£274,440.43	£321,313.02	£380,283.00
£309,480.64	£355,037.74	£437,994.93
£342,875.64	£393,253.74	£477,104.78
£381,548.00	£448,619.24	£543,107.78
£429,882.28	£496,587.10	£586,500.36
£451,870.43	£522,062.45	£603,423.78

Total Winter Costs (Oct – March)

Costs		
POP	UUP	Step Down
£ 40,993.36	£ 41,199.36	£ 55,918.21
£ 76,033.57	£ 74,924.08	£113,630.14
£109,428.57	£113,140.08	£152,740.00
£148,100.93	£168,505.58	£218,743.00
£196,435.21	£216,473.44	£262,135.57
£218,423.36	£241,948.79	£279,059.00

Rough estimate on the savings to the NHS over the year

- UUP x 531 x £250 per night x 7 = £1,753,717
- Saving = £1,231,655 (does not include community care support costs)
- DTA x 222 x £250 per night x 21 = £1,165,500
- Savings = £562,077
- PoP x 152 x £250 per night x 28 = £1,064,000
- Savings = £612,130
- Estimated savings over the year **£2,405,862**

Ashtley Hall block October to March

- Only 10 placements made
- Total of 292 days occupation
- Cost of block £44,320
- Unit cost per placement £4779:50
- Spot purchase (£79 per night) - £2,306.80 per placement

What worked well

- cost,
- care closer to home,
- more homely environment,
- less risk of infection,
- Managed by local care team,
- Capacity management,
- Closer partnership working with providers,

What didn't work so well

- Out area placements,
- Temporary GP registration,
- Little choice over care home and location,
- More than one move,
- Care team may not have all the required skills,
- lack of continuity of care
- Reduced direct access to care home,

What could have worked better?

- Clearer contracting with the home
- 7 day access to care homes
- Consistent CHC/Step down nurse cover
- Block contracting?
- Better information given to patients/relatives/carers on transfer
- Earlier in the day transfers

This page is intentionally left blank

FUTURE OF ACUTE HOSPITAL SERVICES IN WORCESTERSHIRE

Summary

1. The Health Overview and Scrutiny Committee (HOSC) is to consider the progress of the review of the Future of Acute Hospital Services in Worcestershire.

2. Representatives from the three Clinical Commissioning Groups (CCGs) within Worcestershire and Worcestershire Acute Hospitals NHS Trust have been invited to the meeting.

Review process so far

3. To re-cap, during its meeting on 22 January 2014, the NHS England area team for Arden, Herefordshire and Worcestershire reported to HOSC on the outcome of the Independent Clinical Review Panel, which had been established in September 2013 as the main component of the next phase of work. The role of the Panel was to review the work resulting from the two options for delivering a particular model of services that were proposed as part of the previous Joint Services Review (which ran from January 2012 to March 2013).

4. The preferred clinical model determined by the 2012-13 Joint Services Review was to centralise consultant-led maternity services, overnight children's services and full A&E services on the Worcestershire Royal Hospital site. The two possible options to deliver this model, which were progressed jointly by Worcestershire Acute Hospitals NHS Trust and the three CCGs, were:

- Option 1 (delivering care across three sites) to refine and update the proposals
- Option 2 (seeking a new provider for services at the Alexandra Hospital)

5. In determining the way forward, the Independent Clinical Review Panel was guided by the following principles:

- Clinical teams needed to maintain and improve their skills
- Recognition of the difficulty faced by patients and the public accessing services
- Provision of safe and sustainable health services requiring safe and sustainable organisations
- Balance between access to local services and improving the quality of those services
- Support proposed changes where in the best interest of the whole population of Worcestershire.

6. In January 2014 the Independent Review Panel concluded its review and recommended:

- Creation of a networked 'Emergency Centre' at the Alexandra Hospital. Hospital based services across Worcestershire will be networked and led by consultants with an 'Emergency Centre' at the Alexandra Hospital and a 'Major Emergency Centre' at the Worcestershire Royal Hospital.
- Consultant led maternity services should be centralised at Worcestershire Royal Hospital but Redditch and Bromsgrove CCG should consider commissioning a stand-alone midwife-led birth centre in North Worcestershire.
- Paediatric inpatients should be centralised in Worcester but a day-time consultant-led paediatric assessment unit at the Alex would accept referrals from GPs and other professionals.
- The Clinical Commissioning Groups and Worcestershire County Council should review transport links between North Worcestershire and the Worcestershire Royal Hospital.

7. The Independent Review Panel has informed the HOSC about the overall recommendations and implications for Paediatrics, Obstetrics, Accident and Emergency (A&E), medicine, surgery and specialised services.

8. Throughout the review, the HOSC has had a number of discussions with NHS colleagues, which have included the conclusions from the JSR and how they were being progressed, and also governance processes for the review.

Update

9. The HOSC will be updated on progress since the report from the Independent Clinical Review Panel. The Review Panel's recommendations were accepted by the Boards of the three CCGs and the Acute Hospitals Trust and since then, extensive modelling work has been underway to work through areas such as finance and transport. The three clinical sub groups – women's and children's, emergency care and planned care have completed their modelling work and have produced specifications which are now subject to financial scrutiny to ensure they are affordable to the health community in Worcestershire.

Consultation Plans

10. Public consultation is likely to run for 12 weeks and plans are being overseen by a Patient, Public and Stakeholder Advisory Group. The three clinical commissioning groups in Worcestershire are working with neighbouring CCGs in South Warwickshire, Herefordshire, Solihull and Birmingham to ensure that their patients are included in the planned public consultation.

Joint HOSC

11. HOSC members will be aware that plans are also in hand

to establish a Joint HOSC with these neighbouring councils to respond to the consultation.

Purpose of the Meeting

12. Members are invited to consider progress of the development of acute hospital services. Issues which members may wish to cover include:

- Consultation plans
- How the Acute Trust is ensuring safe services during this period of uncertainty
- Issues raised during recent HOSC discussions, including finance, transport, impact on ambulance services, the potential limits of midwife-led birthing units and the role of Kidderminster Hospital and Treatment Centre

Supporting Information

Presentation handouts will be available at the meeting.

Contact Points

County Council Contact Points
Worcester (01905) 763763, Kidderminster (01562) 822511
Or Minicom: Worcester (01905) 766399

Specific Contact Points for this Report
Emma James/Jo Weston, Overview and Scrutiny Officers, Resources Directorate (Ext 6627);
Email: scrutiny@worcestershire.gov.uk

Background Papers

In the opinion of the proper officer (in this case the Director of Resources) the following are the background papers relating to the subject matter of this report:

Health Overview and Scrutiny Committee agenda and minutes of 4 July 2012, 6 November 2012, 24 January, 25 June and 8 October 2013, 22 January 2014.

All of which are available on the Council's website at:
http://www.worcestershire.gov.uk/cms/democratic-services/minutes-and-agendas.aspx

Clinical Commissioning Groups Press Releases, June 2014 – Future of Acute Hospital Services in Worcestershire programme is on track for public consultation this Autumn

Neonatal care at the Alexandra Hospital
http://www.redditchandbromsgroveccg.nhs.uk/news/

Future of Acute Hospital Services in Worcestershire Programme Stakeholder Brief, June 2014 – Future of Acute Hospital Services

http://www.worcsfuturehospitals.co.uk/

This page is intentionally left blank

PILOT PROJECT INTRODUCING A SYSTEM OF 'CLINICAL NAVIGATION' AT THE ALEXANDRA HOSPITAL

Summary

1. The Health Overview and Scrutiny Committee (HOSC) is to consider a pilot project to introduce a system of clinical navigation at the Alexandra Hospital in Redditch.

2. Representatives from NHS Redditch and Bromsgrove Clinical Commissioning Group have been invited to the meeting.

Introduction

3. For 2014/15, NHS Redditch and Bromsgrove Clinical Commissioning Group (NHS RBCCG) has a key strategic priority for Urgent Care and a number of initiatives will contribute towards the transformation of Urgent Care services locally.

4. One of the main areas of NHS RBCCG service transformation is to introduce a pilot for a system of 'Clinical Navigation' at the Front Door of the Emergency Department at the Alexandra Hospital. By introducing a system of 'Clinical Navigation', patients will receive a rapid and robust assessment which directs them to the correct clinical area.

5. In terms of overarching benefits, the following is anticipated as a result of the changes:

- patients will be seen by the right clinician at the right time;
- enhanced patient experience will 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.

6. It should be noted that the 'Clinical Navigation' pilot is an NHS RBCCG strategic priority to improve and enhance current systems within the Emergency Department (ED).

Background

7. Emergency Departments provide a convenient access point for patients and has created a demand as a result of this. The importance of appropriately managing this demand is nationally recognised and is one of the key aims of the 'Clinical Navigation' pilot – by introducing rapid clinical assessment and re-direction to other local services, where appropriate.

8. A number of national examples of 'Clinical Navigation' systems have been considered to inform the NHS RBCCG

pilot plans and in the development of a comprehensive service specification. 'Clinical Navigation' systems suggest an average achievable reduction of circa 30% of unnecessary ED attendances and improved patient experience in terms of accessing the right service, at the right time.

9. Currently, Care UK provides the Out of Hours (OOHs) service to the patients of Worcestershire. The OOHs service operates separately to the ED Department elsewhere within the Alexandra Hospital currently. Patients accessing the ED Department are currently triaged by an Emergency Nurse Practitioner (ENP) and then managed in the ED Department.

10. Care UK has agreed to extend current OOHs arrangements in order to deliver the requirements within the 'Clinical Navigation' Service Specification as agreed with NHS RBCCG and NHS Worcestershire Acute Hospital Trust (NHS WAHT).

11. Care UK has demonstrable experience in terms of establishing successful 'Clinical Navigation' systems and a track record of successfully mobilising a pilot within a 6 – 8 week timescale. The aim is to introduce the 'Clinical Navigation' pilot at the Alexandra Hospital from 1st September 2014.

12. The pilot period will also allow for the re-integration of OOHs into the Front Door of ED, which will secure a 24/7 'Clinical Navigation' solution.

13. Task and Finish' project governance arrangements have been agreed and are progressing with key stakeholders in order to move the pilot project forward at pace and introduce the service within ambitious timescales.

Key Issues for Consideration

'Clinical Navigation' Pilot
Aims and Scope:
14. To effectively facilitate introduce 'Clinical Navigation' and integrate into the local healthcare community, 'Clinical Navigation' will ensure that the majority of clinical hours are fulfilled by locally practicing clinicians who have sound local knowledge and the ability to support and educate patients as to the range of available local services.

Reception Plan:
15. Patients will access the 'Clinical Navigation' system via a single reception point. The clinical systems will be populated as necessary and the 'Clinical Navigation' system will not result in an additional booking-in process for the patient.

Clinical Navigation:
16. Clinical Navigation' will be delivered by experienced Advanced Nurse Practitioners (ANPs). ANPs will be supported by GPs at all times should more senior clinical

decision and support be required. The aim of the service will be to initially review all ambulatory (walk-in) patients attending the Emergency Department (ED) and, through rapid robust assessment, direct patients to the correct clinical stream. The 'Clinical Navigation' system will ensure that patients are seen by the most appropriate clinician, in a timely manner. Patients arriving via ambulance will also be introduced to the 'Clinical Navigation' system at the earliest possible time. Clearly communicated protocols and exclusions will underpin the 'Clinical Navigation' system.

Primary Care 'Hotline':

17. West Midlands Ambulance Service (WMAS) will have access to a Primary Care 'hotline' to support clinical decision making and to ensure that patients access the most appropriate service, by the most appropriate clinician. The ANP or GP will be able to advise WMAS if a patient could be managed via the 'Clinical Navigation' system or where there is a requirement to bypass directly into ED.

Patient Education and Self Care:

18. The service will play a key role in patient education and in particular self-care advice and appropriately accessing acute healthcare thus actively supporting the 'Choose Well' ethos widely recognised. By also educating about the use of NHS 111, the 'Clinical Navigation' pilot will encourage patients to 'Talk before you Walk' which will help standardise the assessment of patients wherever they access healthcare.

Following Initial Assessment:

19. After rapid initial assessment (15 minutes for children and 20 minutes for adults) there will be a group of patients who will be appropriate for immediate advice or treatment. Other patients will be:

- Safely re-directed to other community primary care services including patients' registered GPs by active and facilitated re-direction
  or
- Treated by Primary Care 'see and treat' stream (within ED) but with robust patient education
  or
- Passed through to the Emergency Department

4 Hour Target/Governance

20. The 'Clinical Navigation' process will have a key responsibility not to cause delays to the 4 hour performance target. From a governance perspective, patients managed via the 'Clinical Navigation' system will be the responsibility of Care UK. Only when patients are handed over to ED following clinical navigation via the Patient First system (NHS WAHT IT system) do they become the responsibility of NHS WAHT. Joint systems and processes underpinning necessary governance arrangements have been agreed between Care UK, NHS WAHT and NHS RBCCG.

21. The Local GP Lead within the 'Clinical Navigation' pilot will assume day to day management responsibility for all Care UK-employed clinicians. Doctors and ANPs will be professionally accountable to the GP Lead and Nurse Lead, respectively.

Patient Care Pathways

22. Potential groups for the management via 'Clinical Navigation':

- Minor illnesses;
- Other illnesses requiring same day treatment e.g. chronic disease exacerbations/concerns;
- Low end minor injuries (e.g. abrasions which would be seen in everyday Primary Care).

23. The 'Clinical Navigation' pilot will establish an integrated approach to the delivery of high quality unscheduled Primary Care and will focus on:

- Directing patients to their own GP practices where safe and appropriate;
- Rapid navigation and direction for patients;
- Management of the 'Front Door' of the ED Department to ensure controlled and appropriate access;
- Improved access to urgent and unscheduled care while ensuring that ongoing healthcare needs are met in the most appropriate setting;
- Not replicating existing services or providing a further access point for routine NHS care;
- Reducing unnecessary diagnostic tests;
- Alignment with NHS 111;
- Robust reporting for commissioners and GP practices;
- Patient education and communication;
- Supporting admission avoidance;
- Maximising the use and potential of other community services;
- Identifying current community-bases services (Virtual Ward, POWCH, District Nurses etc.), creating strong links in order to manage patients upstream and downstream to both avoid admission and facilitate discharge.

Patient Information

24. Care UK will have the opportunity to access Primary Care GP records where the patient consents. This will facilitate seamless treatment and provides a significant opportunity for improvements in patient care.

Evaluation

25. Review and evaluation points will be agreed as part of the project governance.

Purpose of Meeting

26. Members are invited to:

- consider and comment on the plans for the pilot

- determine whether any further action is required.

Supporting Information

Presentation Slides will be circulated at the meeting.

Contact Points

County Council Contact Points
Emma James and Jo Weston
Worcester (01905) 766627, Kidderminster (01562) 822511
Or Minicom: Worcester (01905) 766399
Scrutiny@worcestershire.gov.uk

Specific Contact Points for this Report
NHS Redditch and Bromsgrove Clinical Commissioning Group:-
Dr Marion Radcliffe, Urgent Care Lead
Andrea Guest, Head of Business Development and Operations
Andrea.Guest@worcestershire.nhs.uk

Background Papers

In the opinion of the proper officer (in this case the Director of Resources) the following are the background papers relating to the subject matter of this report:

These are all available on the Council's website at:
http://www.worcestershire.gov.uk/cms/democratic-services/minutes-and-agendas.aspx

This page is intentionally left blank

HEALTH OVERVIEW AND SCRUTINY COMMITTEE ROUND-UP

Summary

1. To receive a round-up of information on:
   - County Council activities in relation to health;
   - District Council activities in relation to health;
   - NHS Board Meetings;
   - Consultations in Worcestershire;
   - Urgent health issues in Worcestershire; and
   - Items for future meetings of the Scrutiny Committee.

Background

2. In order to ensure that Members of the Scrutiny Committee are fully informed about issues relating to health scrutiny in Worcestershire, communication will be essential. To assist in this, an item will be placed on the agenda for each meeting of the Scrutiny Committee to consider consultations, County Council activities, District Council activities, urgent health issues arising in Worcestershire and future agenda items.

3. Regard for the Council's statutory requirements in relation to access to information will be critical.

County Council Activities in Relation to Health

4. A range of County Council services can impact upon and also be impacted upon by health services. Recognising that the health-related work of the County Council will be of interest to the District Councillors on the Health Overview and Scrutiny Committee, an oral update on such activities, and on other matters the Chairman has been involved in, will be provided at each meeting by the Committee Chairman at each meeting of the Scrutiny Committee.

District Council Activities in Relation to Health

5. The statutory power of health scrutiny, including the power to require an officer of a local NHS body to attend before the Council, rests with the County Council. However, it is recognised that a number of District Councils within Worcestershire are undertaking work in relation to local health issues, under their duty to promote the economic, social or environmental well-being of their area.

6. Recognising that the work of the District Councils will be of value and interest to the wider Health Overview and Scrutiny Committee, an oral update will be provided on such activities by District Councillors at each meeting of the Scrutiny Committee.

NHS Board Meetings

7. To help the Scrutiny Committee Members to keep up-to-date and maintain their knowledge of health issues around the County, it was agreed that a 'Lead Member' would be identified for each of the local NHS bodies to attend their Board Meetings and then provide an oral update at each meeting of the Scrutiny Committee.

Consultations in Worcestershire

8. The Health Overview and Scrutiny Committee has a duty to respond to local Health Trusts' consultations on any proposed substantial changes to local health services.

Urgent Health Issues in Worcestershire

9. Worcestershire County Council's constitution makes provision for urgent items to be considered. Standing Order 12.2 specifies that the Chairman of the Scrutiny Committee "may bring before the meeting and cause to be considered an item of business not specified in the summons or agenda where the Chairman is of the opinion, by reason of special circumstances (which shall be specified in the minutes) that the item should be considered at the meeting as a matter of urgency".

10. Additionally, Standing Order 9.4.2 allows for the Chairman of the Scrutiny Committee at any time to call a special meeting of the Scrutiny Committee. Standing Order 9.4.3 allows for at least one quarter of the members of the Scrutiny Committee to requisition a special meeting of the Scrutiny Committee. Such a requisition must be in writing, be signed by each of the Councillors concerned, identify the business to be considered and be delivered to the Director of Resources. In accordance with Access to Information Rules, the Council must give five clear days' notice of any meeting.

Items for Future Meetings

11. It is necessary that the Scrutiny Committee's ability to react to emerging health issues in a timely manner and the public's expectation of this is balanced against Worcestershire County Council's statutory duty to ensure that meetings and issues to be considered are open and transparent and meet legislative requirements. This agenda item must not be used to raise non-urgent issues. Any such issues should be raised with Democratic Services Unit at least two weeks in advance of a scheduled meeting of the Scrutiny Committee.

Contact Points

County Council Contact Points
Worcester (01905) 763763, Kidderminster (01562) 822511
Or Minicom: Worcester (01905) 766399

Specific Contact Points for this Report
Emma James/Jo Weston, Overview and Scrutiny Officers, Resources Directorate (Ext 6627);
Email: scrutiny@worcestershire.gov.uk

Background Papers

In the opinion of the proper officer (in this case the Director of Resources) the following are the background papers relating to the subject matter of this report:

- Worcestershire County Council Procedural Standing Orders and Access to Information Rules, September 2012