Minutes of the Health Overview and Scrutiny Committee

County Hall, Worcester

Thursday, 7 December 2023, 10.00 am

Present:

Cllr Brandon Clayton (Chairman), Cllr Christine Wild (Vice Chairman), Cllr Salman Akbar, Cllr Lynn Denham, Cllr Paul Harrison, Cllr Bakul Kumar, Cllr Emma Marshall, Cllr Jo Monk, Cllr Chris Rogers and Cllr Kit Taylor

Also attended:

Cllr Karen May, Cabinet Member with Responsibility for Health and Wellbeing
Cllr Adrian Hardman, Cabinet Member with Responsibility for Adult Social Care
Stephen Collman, Managing Director, Worcestershire Acute Hospitals NHS Trust
Clare Bush, Divisional Director of Nursing, Urgent and Emergency Care, Worcestershire Acute Hospitals NHS Trust
Wendy Joberns-Harris, Director of Operations (Urgent Care) Worcestershire Acute Hospitals NHS Trust
Rob Cunningham, Director of Intermediate & Urgent Care, Herefordshire and Worcestershire Health and Care NHS Trust
Chris Cashmore, Urgent Care Lead, NHS Herefordshire and Worcestershire Integrated Care Board
Nathan Hudson, Director of Performance and Improvement, West Midlands Ambulance Service University NHS Foundation Trust
Jo Ringshall, Chair, Healthwatch Worcestershire
Simon Adams, Managing Director, Healthwatch Worcestershire

Mark Fitton, Strategic Director for People
Lisa McNally, Director of Public Health
Kate Griffiths, Interim Democratic Governance and Scrutiny Manager
Emma James, Overview and Scrutiny Officer

Available Papers

The members had before them:

A. The Agenda papers (previously circulated).

(A copy of document A will be attached to the signed Minutes).

1169 Apologies and Welcome

The Chairman welcomed everyone to the meeting and advised that this meeting was not being webcast.

Apologies were received from HOSC members Peter Griffiths, Adrian Kriss, Antony Hartley and Tom Wells.

1170 Declarations of Interest and of any Party Whip

None.

1171 Public Participation

None.

1172 In Hospital Update on Improving Patient Flow and the Emergency Department

The Chairman invited initial comments from the organisational representatives present.

The new Managing Director (MD) of Worcestershire Acute Hospitals NHS Trust (WAHT) introduced himself to the Health Overview and Scrutiny Committee (HOSC). He reminded the HOSC that his role was MD of WAHT, since WAHT had joined the Foundation Group Partnership of NHS Trusts, of which Glen Burley was Chief Executive and Russell Hardy was Chairman. WAHT had retained its own Board and the MD saw the move as a real opportunity.

Nonetheless, the MD was under no illusions about the challenges for WAHT. He apologised to residents that recent experiences at Worcestershire Royal Hospital (WRH) and the Alexandra Hospital (the Alex) were not acceptable, which needed to improve at pace.

The majority of those attending the hospitals were older people, and frailty was a big issue, therefore there were plans to rebalance the hospitals by increasing geriatric and frailty teams, and the bed base, with help from social care colleagues and inpatient beds within Herefordshire and Worcestershire Health and Care Trust (HWHCT). 'Home First' was a big campaign.

WAHT was financially challenged, but £4.5m had been identified to address winter schemes, for example, from 18 December two wards would be used (one at each hospital) as general medicine wards, to give increased flexibility to enable the Same Day Emergency Care Ward to provide support.

The Executive Team's focus was to try to simplify things, including governance, in order to have more pace and hopefully, deliver improvements.

The Divisional Director of Nursing, Urgent and Emergency Care explained that the whole scope of the new project was to co-locate the Emergency Department (ED) with acute medicine and Same Day Emergency Care

(SDEC), which would cater for the biggest numbers of emergency patients coming into WRH. There was a separate paediatric emergency department, as well as a GP, diagnostics, CT scanning and X-ray facilities to hand. The new environment was much more seamless and efficient and benefitted staff as well as patients and overall feedback was fantastic.

The Director of Operations (Urgent Care) added that the improved environment had a much larger major area and there were future opportunities for frailty using the first floor and being able to move patients between the two floors was really flexible. There were other pockets which helped prevent people staying too long in the ED, for example co-location of mental health partners, and the team continued to review opportunities for the new area and there was massive potential to work on pathways, including work with partners within the Foundation Group.

The concept of frailty was explained, which resulted from more people living longer with comorbities. The critical key issue was to identify very quickly those people coming into the ED who did not have any particular acute needs, and with the help of HWHCT colleagues, to be able to turn them around within hours, rather than days, to avoid unnecessary time in a hospital bed which was not good for their health – and to reduce pressure on emergency care.

The Integrated Care Board (ICB) Urgent Care Lead added that a key milestone was in December when some of the winter initiatives come on board in terms of the additional bedding capacity. He reflected on the patient perspective of being in the ED in December the previous year under the same sort of pressures, and how the new ED was very much the right thing for patients and staff. Once the winter schemes were more in place, there would be more scope to tackle the pressures, and the number one priority was to reduce ambulance hospital handovers. Having worked within the system for many years, he did not recall a more positive position for opportunities.

The Director of Performance and Improvement from West Midlands Ambulance Service (WMAS) University NHS Foundation Trust advised that they worked closely with WAHT, as one of six ICS areas, and there were other areas also with extreme pressures.

The ICB representative added that there had never been closer working with WMAS, and he acknowledged WMAS' hard work on admission avoidance.

The HWHCT Director of Intermediate and Urgent Care referred to the sense of dread brought by the prospect of the winter period, but he agreed that there had never been such strong joint working. Many of the community pathway elements would be included in a further report to the HOSC in January, including urgent community response and virtual wards. The HWHCT had recently gone live with a care navigation hub, bringing together various disparate teams across the county into a single location, to co-ordinate service to ensure patients coming from acute care got to the right place, swiftly.

An example of real change from integrated working was the newly live Single Point of Access (SPA) set up by the HWHCT, as a result of regional and

national requests, for key stakeholders and partners in health and social care. Experienced clinicians and call handlers sat alongside HWHCT teams to triage calls, particularly from Primary Care, NHS111 and the Ambulance Service, with the aim of getting the patient to the right place and avoiding unnecessary ED attendance. Since Monday, that service had received around 189 calls from GP's and 74% of those patients were redirected away from the ED front door.

The Chairman invited questions and the following main points were raised:

- When asked to clarify the difference between the Acute Medical Unit and the Medical Same Day Emergency Care (SDEC) Unit, it was explained that in simple terms, SDEC was within the ED to treat patients within a few hours, whereas there were speciality wards for those who may need a few days in hospital, for example for a serious heart attack.
- A member praised the new ED unit and staff enthusiasm, but recalled many new approaches over the years he had been a HOSC member, and asked what was different about the current position. The WAHT MD acknowledged a turnaround would take time and that it would be important to be clear where results would first be evidenced, to give confidence. It was also important not to have too many areas of focus, and stripping things back would hopefully bring improvements in elective care, therefore reducing pressure across the hospitals. He felt lack of beds could be strongly evidenced, with many bed days being lost due to the issue of frailty. The aim over the next 12-18 months was to focus on having a much better frailty service which would give both hospitals greater flexibility and focus time. The MD would be happy to provide further updates to the HOSC.
- The Council's Strategic Director for People referred to the incredibly challenged local and national NHS, which he saw as a very complex eco system. The previous day's announcement of further Junior Doctor strikes would significantly impact on the plans laid out. He referred to the collective view amongst partners present that each organisation had a part to play, however for the first time there was a joint commitment to tackle the problem (of patient flow).
- The Vice-Chairman sought assurance that obstacles on the patient journey, culminating in obtaining medication, were being investigated, since she was aware that health services were the main topic within her community with many worried about access to their GP, getting ill and needing to go to A&E. The WAHT MD acknowledged that the discharge experience was not as good as it should be due to current pressures and a focus on many different aspects. He referred to the areas of work discussed, in particular lack of frailty specialists meant that discharge and medication planning often took place at a congested stage in the process, rather than as patients were admitted.
- The Vice-Chairman sought clarification on when hospital pharmacy started prescribing for discharge patients, which the WAHT representatives agreed to provide. It was acknowledged there was work to do on making sure medication or transport did not delay a patient being discharged, especially checking at an earlier point whether a

patient's medication had actually changed – and the Vice-Chairman was pleased that the issue was being looked at.

- The HWHCT representative highlighted that the WAHT could not improve discharge performance on its own, and there was a necessary role to be played by his and other organisations represented such as the Council. The nature of community-based services worked in days and weeks, and this needed to shift to accommodate the rhythm of A&E, which was hours and minutes.
- When asked about the environments where patients waited to leave the hospital, the WAHT representatives advised there were discharge lounges at both hospitals, which were expanding, and that staff collected patients from 8am, unless it was not a suitable environment for them. Use of the lounge areas was monitored and was being expanded to accommodate patients with more complex needs.
- The ICB representative highlighted the improved trajectory in discharging patients by midday, which had increased from 19% in November 2022 to 23.5% this November. The national target in terms of best practice was 33%, nonetheless discharges before midday had never been as consistently high as over the previous 4-5 weeks – future reports would communicate early discharge data more clearly and the HOSC Chairman was pleased to acknowledge this clarification.
- A HOSC member who was familiar with changing pathways from experience of working in the NHS, asked for a strategic overview of what would change for the patient journey with the new ways of working. The WAHT representatives acknowledged that pathways changed, as treatments and ways of working changed and it was important for pathways to be clear. The SDEC would pull everything together and give clarity to GPs on who they needed to contact, which would impact patients as GPs were their first point of contact. This provision was already working well in other places, which it was important to learn from, and it was brilliant to hear the recognition from partners about the importance of a culture based on hours and minutes.
- In terms of the level of experienced nursing staff on the frontline, for example to know if patients did not fit a clear pathway, it was explained that lately Worcestershire benchmarked well for triage nurses, with 2 on the major side and 2-3 on the ambulance side, plus 1 on the children's side, all trained in the Manchester triage method - the workforce was mapped to the number of patients arriving each hour.
- The WAHT representatives advised that harm review processes were strong, with a very experienced governance team and with weekly governance meetings to investigate any concerns.
- Regarding the graph (page 4) it was clarified that this showed numbers of patients waiting on ambulances, which had not changed especially over the graph period, as well as also showing average waits on ambulances (the yellow line), which was reducing so that in November there were just over 150 people waiting over 30 minutes - however future reports would include clearer data and enable greater comparison.
- In response to a question from Cabinet Member with Responsibility for Health and Wellbeing, further information would be provided on how Worcestershire compared to other areas for ambulance waits. The

WMAS representative advised that Worcestershire was one of the most challenged systems and that October had been challenging but with mitigating circumstances, however he felt by the new ED and new ways of working and importantly, the Service was working tirelessly with WAHT to bring improvement.

- When asked how the rest of the system could effect a shift in the pace of work to support the minutes and hours rhythm of A&E, the HWHCT representative explained that the nature of work for different services was very different, however the Single Point of Access would be important. Discussions were underway to improve communication about bed management with acute colleagues and the HWHCT was due to introduce a new IT system which would enable better forecasting and earlier discharge planning.
- The Council's Director of Public Health agreed that numbers of ambulance handover delays were moving in the right direction, which was very positive, nonetheless figures were still far too high and it was important to track incidences of harm occurring as a result. Acknowledging partners' determination, she felt that WAHT was being let down by the rest of the system, by factors such as performance around frailty and access to a GP, which led to them going to A&E. Data from a GP survey showed that only 50% of people found it easy to get through to a GP, which was a considerable increase from 75% after the pandemic. It was important for the system to consider how to support the new leadership at WAHT.
- In response, the ICB representative did not feel that WAHT was being let down by the wider system, and while he acknowledged that some patients went straight to the ED and that the patient experience was important, he highlighted the fact that GP appointments per population was the highest ratio in the region and one of the best in the country, at 0.67.
- Regarding issues around frailty, the ICB representative was pleased to advise that the Frailty Strategy had just been signed off, and would be made available to HOSC members.
- The Chairman reminded everyone that access to Primary care would be discussed at the 19 February meeting.
- A member suggested there was a disconnect between the design of the health system and patient experiences, and the WAHT representatives clarified that the report to the Committee was to set out system changes and was aimed at an audience with varied understanding, rather than patients.
- The HOSC was advised that around 20% of calls to NHS111 may result in visits to the ED or a call for an ambulance, which was not ridiculously high but did need to reduce. The SPA was a tool for GPs rather than patients.
- The representatives acknowledged some frustrations around additional funds allocated for winter planning arriving too late for this winter, but a benefit was that temporary funding could be used to trial new things – it would be important to evaluate what had worked well, however finances remained extremely tight.

- It was clarified that the increased beds would be staffed by temporary nursing staff, using regular bank staff. The HWHCT also had surge bed capacity for period of extreme pressure.
- A HOSC member asked about recruitment of A&E Consultants, which the Committee was aware had been an issue, and was advised that there were some vacancies, which in the interim were being filled by very experienced locum staff who were known to the Trust. A&E nursing recruitment was good and consultant interviews were scheduled for the following week; the new Unit was attracting staff.
- It would be important to model bed use over a period of time.
- Comment was invited from the Healthwatch Worcestershire representative present, who referred the HOSC to Healthwatch's 2022 review of A&E walk-ins, during which 350 people were spoken to, which found that 70% had been referred from other parts of the NHS - they were not necessarily walking in unprompted and frailty was not found to be a major issue. The review demonstrated that walk-ins was something the sector needed to look at and he believed that Minor Injuries Units (MIUs) needed to be able to deliver at scale.
- The ICB representative advised that a review was starting on MIU functionality, for example adding the presence of a GP to increase activity, and he emphasised the review sought to extend and not reduce their use.
- The Chairman invited comment from the Director of Public Health about A&E walk-ins, and she repeated the importance of supporting the Acute Trust to achieve and the need to match the primary care narrative with the figures. The findings around GP access were quite stark and it was important to consider this involved older people who were not necessarily digitally aware.
- The ICB representative would provide more information about primary care in the report being considered by the HOSC in February, and highlighted that all stakeholders wanted in-hospital patient flow to improve and he had never known the degree of support provided to the Acute Trust over the previous 12-18 months.
- The Director of Public Health sought clarification on investment from the ICB to support the frailty strategy, which the ICB representative would arrange.
- A HOSC member sought the new WAHT MD's view on the Trust's financial situation, and he confirmed there remained a significant deficit, with much to do to return to a sustainable point.
- Regarding virtual wards, the HOSC was advised that the pilot in Wyre Forest had recently been evaluated as successful and recruitment was underway for Evesham, Pershore and Malvern. A blended medical model was being looked at and further detail would be provided to the HOSC in January.
- The HWHCT representative would report back the comment that it would be useful for First Responders, and maybe staff in other services, to have access to the Single Point of Access.

The Chairman thanked everyone for their contribution and advised that a further update would be scheduled when appropriate.

The WAHT Managing Director made the offer for HOSC members to get in touch if they had any particular questions.

1173 Overview from West Midlands Ambulance Service

The Director of Performance and Improvement of West Midlands Ambulance Service (WMAS), who was also still a paramedic, gave a brief summary of the slides included in the Agenda, which provided an overview of the Service.

He reminded the HOSC that WMAS had a paramedic on each ambulance, of which there were around 45-50 a day in Worcestershire. 15 Hubs received around 6000 calls a day with 3000 incidents.

WMAS was the only ambulance service rated as outstanding. The Service covered 6 different ICS areas and had an ICS lead. WMAS had no financial deficit.

While WMAS really valued face to face contact with patients, the Service recognised that an ambulance response was not necessarily what was needed for all patients and a pressurised healthcare system required different ways of working, therefore more people were redirected. The Director highlighted that WMAS rates for 'Hear and Treat' had risen from 4% (in 2019) to 20%. Rates for 'See and Convey' showed that only 50% were now transported to A&E. The Service was really pleased with performance on non-call answering which was exceptional compared to other services.

However, WMAS recognised that performance standards to patients at the current time were not acceptable, which led to some patients making their own way to Emergency Departments, and performance was lower compared to the previous year - this was due to a number of factors which had been discussed during the previous Agenda item on patient flow.

WMAS did not provide patient transport services from hospitals in Worcestershire, but this worked well in other very challenged areas. New use of technology was also referred to, including use of drones.

Importantly, sickness absence was being managed and mandatory training was being maintained; staff wellbeing was very important to WMAS as an organisation.

The Chairman invited discussion and the following main points were raised:

- It was explained that the 6000 calls in relation to 3000 incidents included repeat calls from patients due to the current pressure on the Service.
- Hear and Treat rates in Worcestershire were good which resulted in less patients being seen in person, and WMAS could also access GP appointments across the region where appropriate.
- The Redditch Borough Council HOSC representative asked whether the reconfiguration of maternity and paediatric services had resulted in any

increase in ambulance activity to Worcestershire Royal Hospital and was advised that activity had remained fairly static.

- Common themes from complaints were delays in getting to patients due to current pressures, since the public perception was around a prompt response. Productivity in terms of calls responded to per shift had dropped dramatically.
- When asked about resuscitation of patients on ambulances, the Director advised that paramedics had completed a 3 year degree level programme and were therefore trained in resuscitation. Staff at WRH were very good and would make room for any patient waiting on an ambulance with critical needs.
- A HOSC member sought the Director's strategic insight from other areas serviced by WMAS about pressures in Worcestershire and from his experience working with WAHT, the Director felt there were some great working practices in place. It was important for all organisations within the ICS to be clear in acknowledging their part in the problem as well as the solution. There was a danger that NHS organisations could stagnate because of the pressures and it was important to continue to look at how things could be done differently, for example how Artificial Intelligence could be used in clinical decision making.
- When asked about the recent change in Police practice in responding to mental health incidences, the Director advised that the Government had allocated £7.3m to improve services and WMAS had chosen to have mental health paramedics working within the region. Pathways had been set up within West Mercia which was exciting but would need investment to meet demand since mental health was an epidemic. There were some concerns about the impact on staff from incidences heightened by drugs or violent behaviour and ambulance staff now had cameras.
- When asked about contact with community hospitals, the Director pointed out that it could create confusion, however newly trained staff were more aware of community services and the Directory of Services.
- Regarding sickness and staff turnover, sickness rates were the best in the country however stress was a factor, and unhappy patients affected morale – on the whole this was managed but was monitored. Regarding staff attrition, feedback from clinicians showed paramedics wanted to do more for patients and in a more clinical setting – there was a need to sell this to the ICS and add value. Different generations viewed things differently and there was less appetite for 24/7 shift work and a preference for more flexible working.
- The Chairman asked about whistleblowing and was advised that Freedom to Speak Up advocates had been increased, with more staff coming forward. There were very good HR policies and the organisation tried to encourage people to speak up in relation to policies rather than anonymously. The National Guardian Policy for NHS staff was also available for any concerns.

The Chairman thanked the Director for his attendance.

1174 Work Programme

The Chairman asked members to prepare questions for the 9 January meeting, the main focus of which was services to avoid people requiring acute hospital stays. In relation to this report, the Chairman reminded members that the Committee's request for further information and data about access to GP care had been picked up by the ICB representative present at the meeting today.

In relation to the work programme, the following suggestions were made, which would be scheduled as part of agenda planning with the Chairman:

- Dementia Care – new
- Routine Immunisation
- Screening (and whether prostrate screening could be included)

A member who was also on the Children and Families Overview and Scrutiny Panel referred to a request for Scrutiny to consider aspects of West Mercia Youth Justice Service, and the Scrutiny Officers would check arrangements.

The meeting ended at 12.45 pm

Chairman …….