Minutes of the Health Overview and Scrutiny Committee

County Hall, Worcester

Wednesday, 2 November 2022, 10.00 am

Present:

Cllr Brandon Clayton (Chairman), Cllr Lynn Denham, Cllr David Chambers, Cllr Adrian Kriss, Cllr Jo Monk, Cllr Chris Rogers, Cllr Kit Taylor, Cllr Tom Wells, Cllr Mike Chalk, Cllr Calne Edginton-White, Cllr John Gallagher and Cllr Frances Smith (Vice Chairman)

Also attended:

Cllr Karen May, Cabinet Member with Responsibility for Health and Wellbeing
David Mehaffey, NHS Herefordshire and Worcestershire Integrated Care Board
Alison Roberts, NHS Herefordshire and Worcestershire Integrated Care Board
Tom Grove, NHS Herefordshire and Worcestershire
Sue Harris, Herefordshire and Worcestershire Health and Care NHS Trust
Simon Challand, Herefordshire and Worcestershire Health and Care Trust
Jan Austin, Herefordshire and Worcestershire Health and Care NHS Trust
Simon Adams, Healthwatch Worcestershire

Liz Altay, Interim Director of Public Health
Samantha Morris, Overview and Scrutiny Manager
Emma James, Overview and Scrutiny Officer

Available Papers

The members had before them:

A. The Agenda papers (previously circulated);

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

1092 Apologies and Welcome

The Chairman welcomed everyone to the meeting. Apologies were received from Councillors Salman Akbar, Sue Baxter and Kit Taylor.

1093 Declarations of Interest and of any Party Whip

Cllr Lynn Denham declared an interest in respect of Agenda item 4 (Integrated Care System Development and Development of the Draft Integrated Strategy) as a district council member of the Health and Well-Being Board.

During Agenda item 5 (The Role of Community Hospitals) Cllr Frances Smith declared an interest as the Chairman of Friends of Evesham Community Hospital.

During Agenda item 5, Simon Adams, Managing Director of Healthwatch Worcestershire declared an interest in that years ago in his previous role at the County Council he had chaired meetings which discussed the future of community hospitals.

1094 Public Participation

None.

1095 Integrated Care System Development and Development of the Draft Integrated Care Strategy

A summary of the Agenda report was provided by the Associate Director for System Development and Strategy for Herefordshire and Worcestershire Integrated Care System (ICS) and the Executive Director of Strategy and Integration.

It was emphasised that the ICS was not one organisation, and included all of the representatives present, as well as the voluntary and community sector. The Agenda report focused predominantly on the ICS, the Integrated Care Partnership (ICP) and more specifically, the Integrated Care Strategy.

Since the last report to the HOSC in January, some significant legislative changes had taken place, including implementation of the Health and Care Act 2022, which put ICSs on a statutory footing. Essentially, the Act meant that all providers and partners involved in the ICP had responsibility to improve the health of the local population, including the wider determinants of health and wellbeing.

Other important factors were:

- the ICP would be co-chaired by the two Health and Wellbeing Chairs, reflecting the joint working approach
- the important role of public health
- the timeline for production of the Strategy which included three phases of engagement including ICP representatives and wider engagement with people who lived and worked in the ICS area
- the Strategy would be published in April 2023.

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

- In terms of the membership of the ICB and how it would work in practice, it was explained that the aim had been to create an equal

partnership between the three statutory organisations, which would encompass public health and the Health and Wellbeing Board (HWBB), and organisations had been asked to nominate representatives – however ICP meetings took place within a much wider forum.

- No cap had been given for membership of the ICP which had more than 50 partners, as it was a platform for development and it was pointed out that Bristol and Somerset ICP had 200.
- Regarding appointments to the ICB, Board members were all highly experienced, and recruitment had involved advertising in medical journals and the wider press, use of an agency to search nationally, and appointments panels involving Council Cabinet Members.
- Regarding the key requirements to include in the IC Strategy, a HOSC member suggested that 'population health and prevention' should top the list and stressed that interventions such as NHS health checks were far too late to influence and promote the importance of healthy lifestyles, which should start at school age. The Director of Public Health completely agreed with the importance of this message, which would be included in plans for a whole prevention agenda and wider public health work set out in the Health and Wellbeing Strategy – she clarified that the health check programme for those aged 40-70 was to screen for specific markers.
- The Cabinet Member with Responsibility (CMR) for Health and Wellbeing agreed that prevention was key.
- In terms of monitoring expenditure of the considerable budgets involved, it was explained that this would be largely the responsibility of the relevant organisation's Board and auditing mechanisms, whereas the ICB oversaw the strategic allocation and requirements.
- A major change from the ICB would be the ability to move finance around the system, whilst also shifting away from the current very monetary based system to one which focused on outcomes and flexibility - and this would have a positive impact on communities.
- It was clarified that the three phases of development concerned the development of the ICB and its Strategy, and not the development of services.
- A recent example of a positive difference was the ability of Herefordshire and Worcestershire Health and Care Trust (HWHCT) to respond more quickly and directly to challenges in areas of mental health services by making use of the voluntary sector – this type of response had been used during the Covid pandemic and was now being really strengthened.
- The CMR highlighted the challenge of integrating services across Herefordshire and Worcestershire which were very rural.
- In terms of whether responsibility for outcomes sat with the ICB or the individual organisation (contracted for the service), the relationship was described as being one family but with very clear accountabilities. The individual organisation would likely look at any specific issues for example relating to a specific staff member, whereas the ICB would consider wider issues.
- Collective decisions would be easier since the ICB included Chief Executives from organisations responsible for health and social care.

- The Committee was assured that the collaborative (rather than competitive) approach to allocating resources would still be subject to all the necessary checks.
- The Executive Director of Strategy and Integration believed the major benefits of the integrated system would be collaboration, less restriction, focus on outcomes, removal of competition when procuring services, and information sharing about patients to health and social care professionals.
- Some selective outsourcing may be used to improve specific outcomes.
- The IC Strategy would plug any gaps required by national guidance that were not already covered in the HWBB strategies.
- Regarding wider engagement, the Director of Communications and Engagement for the ICB explained that the current desktop exercise involved working through the huge input received during the pandemic so that it was not lost. Thought was being given to the subsequent phases of engagement around the Strategy, which would include harder to reach communities – a focus on outcomes rather than the processes of the ICS would likely be of more interest to the public.
- The CMR highlighted the benefit of incorporating wider determinants of health, for example active travel which had such a significant impact on health and wellbeing
- The Director of Public Health agreed the ICS was an exciting development as the public health budget and staff team were small and public health would now be the responsibility of the whole system.
- A Committee member agreed the potential of the new system was fantastic, but asked about the risks and challenges, and the representatives highlighted workforce shortages as by far the biggest concern, plus vacancy numbers putting a strain on existing staff.
- When asked about capacity for example for GP appointments to meet the needs of more people coming forwards following the pandemic, the representatives pointed out that capacity in Worcestershire was one of the best in the country, however demand was 18% higher than before the pandemic and in September, GPs had seen 420,000 people. Nonetheless, problems in getting GP appointments were recognised and being acted on. Demand from the level of people coming forwards with complex health needs was also concerning.
- Despite the challenges from workforce pressures and increased demand, the representatives all felt the integrated care system was the best way to meet demand collectively and move forwards.
- Regarding differences in appointment systems across GP practices, the ICS Executive Director explained that this was because they were individual businesses. The ICS was working to support practices and share learning through primary care networks and members wishing to see practice terms of reference were encouraged to contact the individual practice to discuss.
- When asked whether a resident should direct concerns from their community about services to the ICB or to the organisation concerned, the representatives advised they would be happy to be contacted.
- The CMR stressed the importance of everyone supporting the ICS, which as a system was safe, aimed for the best outcomes and focused on wider health; it had to succeed.

- A member queried how and where any particular district area concerns should be raised under the ICS, and the CMR referred to the place-based approach which she believed was effective, and urged members to contact their district council representative, who would then feed into the HWBB and the overall Worcestershire system.
- A member referred to the ambitions of the plan and asked whether there was sufficient budget available, how it would be prioritised, and how expectations would be managed, and the CMR responded that the key components were very much evolving, however funds would be aligned to outcomes, and the Strategy would be aspirational for every resident. The representatives also pointed out that irrespective of funding, workforce was the significant risk.
- A member asked whether the ICB would have a role in looking at patient flow, which was being monitored by the HOSC as an ongoing concern and was reassured that this was absolutely the case; the Strategy would focus on a longer-term view and sustainability of services, whilst also tackling current issues such as patient flow.
- The CMR highlighted that the County Council was very much involved with the ICS, and encouraged a solutions-focused approach to scrutiny about areas such as patient flow, being mindful of the importance of promoting the benefits of Worcestershire as a place to come and work.

It was agreed that a further update would be scheduled before the Integrated Care Strategy was finalised.

1096 The Role of Community Hospitals

The Director of Strategy and Partnerships at Herefordshire and Worcestershire Health and Care Trust (the Trust) welcomed the opportunity for a dedicated discussion about community hospitals following the briefing notes circulated to Committee members during the Covid pandemic. Community Hospitals were also clearly a very important part of integrated care, urgent care and therefore patient flow.

The Trust's Associate Director for Countywide Community Services and responsible for all community hospitals and other community services introduced the Report, which gave an overview of community hospitals and site by site services, with the caveat that these may change where changes to staff teams or pathways were necessary.

The seven community hospitals ranged from state of the art, to post war, prefabricated buildings and hosted three distinct clinical areas: inpatient services (across all seven sites), outpatient services (across four sites) and minor injury units (MIUs) across four sites. Ordinarily there were 233 inpatient beds available however on most days this figure was exceeded and that day there were 245 beds which incorporated additional 'surge' capacity for when the whole system was under pressure.

Additional points made included:

- MIUs were technically a sub-contract of the A&E contract, so while the Trust was sub-contracted to run the MIUs, the activity belonged to Worcestershire Acute Hospitals Trust (the Acute Trust) and some aspects such as X-Ray services were provided by the Acute Trust.
- Where historically there had been situations of multiple of contracts for clinics, this was being streamlined and Outpatient Services would be predominantly provided by staff from Worcestershire Acute Hospitals Trust, at community hospital sites.
- Community Hospital sites were also the work base for a range of community health services such as neighbourhood teams at Tenbury, which benefitted patient flow as staff from one team could speak with another more easily.
- Bromsgrove MIU hours had recently been increased to include Saturdays and Sunday mornings since while the Trust tried to offer a consistent timeframe across all MIUs, Bromsgrove had been an anomaly in not having weekend provision, and it was by far the busiest MIU.
- Staffing shortages sometimes meant services had needed to close temporarily, since even the most expensive recruitment agencies could not provide the specialist staff – an example was Tenbury MIU which was by far the least used.
- The number of people requiring stroke rehabilitation had increased significantly and at times, every bed allocated to this pathway was occupied and there were people waiting.
- Over the past 18 months the Trust had demonstrated success with a newly commissioned 21 bed pathway at Worcester City Inpatient Unit for intensive assessment and reablement of people who previously would have moved from acute care to a residential care home.
- A recent development programme looking at the role and remit of community hospitals had identified the clinical medical model as an area of focus, leading to a move away from a situation of multiple contracts with GP practices to provide care and intervention on an individual basis, to develop an advanced clinical practice model, where advanced nurse practitioners managed the majority of clinical work in community hospitals, whilst still being very much supported by primary Care. This way of working was demonstrating considerable benefits.
- Pressures within the system and patient flow impacted significantly on community hospitals, so that bed occupancy was 93% and while this would seem to indicate that 7% of beds were empty, each would already be allocated to new patients and best practice recommended occupancy of around 85%.
- Admissions per month had remained fairly consistent even during the pandemic, at around 245, however length of stay had increased a great deal, now averaging 24 days, although during the pandemic this had averaged 12 days.
- Patients delayed in hospital was a symptom of overall system pressures and on most days there were 40-50 patients delayed for a range of reasons, with 87 delayed on some recent days.

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

- Comment was invited from Simon Adams, the Healthwatch Worcestershire representative present. The Representative asked whether the Trust had capacity to be flexible with bed numbers, for example to meet the growing demand for stroke rehabilitation, since flexibility had been highlighted as a key benefit of integrated care during the previous Agenda item discussion (Integrated Care System Development). The Trust representatives confirmed that they did have flexibility within the context of the total bed base – for example the previous day there had been 36 stroke rehabilitation patients which was above the number of beds commissioned (32), however stroke care was challenging as it was very defined with a higher staff ratio.
- The Healthwatch representative also asked how the Integrated Care Board could assist with capacity and delayed discharges, and the Associate Director responded that a step-down facility which catered for the more complex needs would be helpful.
- It was suggested that some delays in discharge from hospital related to funding issues, for example whether a patient was entitled to continuing healthcare and should not be happening in a one system approach.
- The Trust's representatives clarified that there was no plan for all community hospitals to provide the same offer, due to the different facilities and environments.
- When asked why services had been extended at Bromsgrove MIU when there was no X-Ray facility at Tenbury MIU despite funding offers from Tenbury Hospital League of Friends, it was explained that the extended offer at Bromsgrove was to build on this facility's considerable footfall and staff team; in comparison pre-Covid attendance at Tenbury MIU averaged 3.5 a day and was now even less.
- Despite low footfall at Tenbury MIU, it was explained that the hospital was a very well used Worcestershire facility with 22 beds plus surge space and that its location did not matter to families if their relative could be provided for.
- The Trust's representatives gave their absolute commitment to the future of all the community hospitals as long as they could be sustained and wanted by the public and explained that the most recent engagement exercise had been well attended by the public and stakeholders.
- When asked about asked about the reasons for the delay of the 87 patients being discharged, the Associate Director referred to challenges around brokerage, Continuing Health Care, homelessness and arranging packages of care.
- HOSC members were keen to know aspirations and plans for each of the hospitals, which they felt was lacking in the report and the Trust's representatives reiterated their commitment to community hospitals and believed there was an opportunity to tailor services to meet population health need, tackle inequalities, integration of primary care networks - work was re-starting following the Covid pandemic and councillors' support in promoting the commitment to community hospitals would be very helpful.
- Regarding the future vision, the Trust's Consultant in Palliative Medicine and Associate Medical Director for Community Care Services, highlighted the increasing role of community hospitals' care for older,

frail people with multiple problems. The relatively new concept of frailty would need to be considered by the ICS in view of the area's local population, as there was a need to develop dedicated practitioners to make care more proactive and effective.

- Regarding increased demand for stroke care (based at Evesham) when overall bed numbers at Evesham had been reduced over the years, the Associate Director explained the context of many more patients returning home more quickly with packages of care and the significant evidence that people responded much better to treatment and rehabilitation in a homely environment, compared to a hospital bed – Worcestershire had far more beds available than other similar counties, nonetheless Worcestershire's higher than average older population meant that a balancing act was needed.
- When asked whether the ICB had the ability to increase bed space and staff at Evesham hospital for stroke care, the Director of Strategy and Partnerships confirmed the ICB's desire to make the system more agile to meet local need and that bed numbers had been re-profiled and were flexed but staffing remained an issue. If pressures on stroke care were sustained then the Stroke Programme Board may recommend permanent increases.
- Stroke rehabilitation was based at one site because this greatly helped consultant cover which made for a much more robust model.
- Staff vacancies averaged 15% overall but there were significantly higher rates in some areas.
- In terms of services managed by the Trust in Kidderminster, it was clarified that the Trust managed a 16 bedded ward based at the site of Kidderminster Hospital and Treatment Centre (a step-down facility, mainly for older people requiring rehabilitation after acute care), and some mental health services – the remainder of the site was for acute care.
- When asked why MIU facilities could not be consistent so that the public was confident facilities like X-Rays would be available and would not instead go to A&E, it was explained that there had been differences due to historical contracts, however the offer was now consistent, with facilities all open 12 hours a day 8am – 8pm (apart from Tenbury due to staffing). MIU attendance averaged 800 patients a week and was strongly linked to daylight hours, therefore seasonal. Bromsgrove was very much the busiest facility followed by Malvern, with Evesham less attended and Tenbury very much less.
- It as acknowledged that more needed to be done around educating the public in use of MIUs, which was challenging at local and national level – for instances of minor injury, the Trust's representatives' advice was to contact NHS111 who would advise which facility to use.
- A member asked about support for medical staff moving from overseas which was understood to be a complex process and was advised there was collaboration across the ICB to recruit international nurses using a specialist agency at significant cost and with checks to ensure transfers did not deplete staff from other countries – this had been successful with around 24 nurses gained. There was a programme of induction and examination before nurses could be registered and qualified and help

was given especially around affordable accommodation to provide a support network.

- The Trust had not experienced any problems caused by staff not wanting Covid vaccinations because the rules had changed and the very small number of nurses who had declined were moved into alternative roles.
- It was explained that beds left empty at any given point was not usually for very long, for example a couple of hours, sometimes longer than planned, very rarely for 12 hours. Bed use was monitored by the Acute Trust so that in the lead up to a patient leaving a community hospital bed, the next occupant would already be known.
- Staffing across services and social care was what kept the representatives awake at night, and several services were not as robust as the Trust would like, although roles could be re-worked.
- Parkinson's Disease was an example of a service with staffing pressures, where the voluntary and community sector was helping with capacity, mainly helping with phone calls which saved a lot of time, however this sector was also challenged.
- It was confirmed that the Trust worked with the VCS wherever possible and the example given related to community mental health services. The Trust's representatives said there were some very practical examples where the voluntary sector attended staff meetings – there was certainly an appetite to use the increased flexibility brought by the ICS for specific areas of challenge.
- Where there were delays in patients moving from hospital to residential care homes, this was for a variety of reasons such as patient/family choice, availability and need – social workers were very much integrated at this stage and were on site to advise.
- The Chairman raised members' concerns about lack of X-Ray services at Tenbury MIU, however the Associate Director reported that she was aware of the perspective of the Acute Trust's Chief executive as she had attended a public meeting with him and the local MP where the Chief Executive had said that the numbers attending Tenbury MIU did not justify X-Ray provision within his responsibility for allocating resources – although clearly a disappointment to the local population, facilities were available at Kidderminster.

1097 Work Programme

The HOSC agreed the following in respect of the Work programme:

- A development session for HOSC members to aid members understanding on the role of health scrutiny of the Integrated Care System would be arranged
- The information from Centre for Public Scrutiny about scrutiny of the Integrated Care Systems would be circulated to the Committee
- Screening (Cervical/antenatal/newborn/diabetic/Eye/abdominal aortic aneurysm/AAA/breast/bowel) would be scheduled in early 2023
- A further update on the ICS would be scheduled for February/March 2023.

The meeting ended at 12.50 pm

Chairman …….