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Health Overview and Scrutiny Committee
Wednesday, 5 November 2014, County Hall - 1.30 pm

Minutes

Present:

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

Mr M J Hart

Also attended:

Frances Martin, Integrated Commissioning Unit
Jenny Dalloway, Worcestershire County Council
Simon Hairsnape, Redditch and Bromsgrove Clinical Commissioning Group / Wyre Forest Clinical Commissioning Group
Simon Trickett, South Worcestershire Clinical Commissioning Group

Worcestershire Health and Care NHS Trust - Sue Harris, Stephen Collman and Dr William Creaney,

Bulman, Worcestershire Health and Care Trust Patient Representative
Mr P Pinfield, Worcestershire Healthwatch
Simon Adams, Healthwatch Worcestershire

University Hospitals Birmingham NHS Foundation Trust - Dame Julie Moore, Rt Hon Jacqui Smith, Andrew McKirgan and Viv Tsesmelis

Worcestershire Acute Hospitals NHS Trust - Harry Turner, Chris Tidman and Mark Wake

Cllr Susan Barnett, Birmingham Health Overview and Scrutiny Committee

Suzanne O'Leary (Overview and Scrutiny Manager) and Emma James (Overview and Scrutiny Officer)

Available papers

A. Agenda papers

B. Presentation handouts for items 4 and 5

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

Date of Issue: 26 November 2014

711 Apologies and Welcome

Apologies had been received from Committee members Mike Johnson and Frances Smith. Apologies had also been received from Richard Keble, Head of the Council's Integrated Commissioning Executive Unit, in relation to Agenda item 4.

The Chairman welcomed everyone to the meeting.

712 Declarations of Interest and of any Party Whip

During Agenda item 5 (Acute Hospital Services), Cllrs Fran Oborski and Pat Witherspoon declared an interest as members of the Patient Public and Stakeholder Advisory Group for the Worcestershire Acute Services Review.

713 Public Participation

None.

714 Mental Health Liaison

Attending for this item were:

Commissioners:
Integrated Commissioning Executive Unit – Frances Martin (Director) and Jenny Dalloway (Interim Lead Commissioner for Mental Health and Dementia)

Simon Trickett, Chief Operating Officer of South Worcestershire Clinical Commissioning Group (CCG) and Simon Hairsnape, Chief Officer of Redditch and Bromsgrove CCG and Wyre Forest CCG

Providers:
Worcestershire Health and Care NHS Trust (WHCT) – Sue Harris (Director of Strategy and Business Development) and Stephen Collman (Director of Operations)
Dr William Creaney – Medical Director at Worcestershire Health and Care NHS Trust

Feedback of Experiences:
Jim Bulman – Patient Representative
Peter Pinfield – Chairman of Worcestershire Healthwatch
Simon Adams – Chief Operating Officer of Worcestershire Healthwatch

The Chairman explained the context for the discussion, which followed the Health Overview and Scrutiny Committee's (HOSC) consideration of the Well Connected Programme, which comprised a number of projects, including mental health liaison. The HOSC was aware that additions had been made to the service in 2012, as part of a pilot exercise.

Earlier this year the Integrated Commissioning Executive Unit (ICEU) decided not to recurrently commission the pilot service following feedback from an independent evaluation and review, which found little or no evidence of impact on admission numbers, length of patient stay, or savings and efficiencies.

The Director of the Integrated Commissioning Unit and the Interim Lead Commissioner for Mental Health and Dementia delivered a presentation which provided an update on the current Mental Health Liaison Service, including service development, A&E and ward activity from April to August 2014, an overview of who accesses the service and next steps.

There had been a number of service changes over several years, most recently in April this year. Work was ongoing to improve outcomes for patients, as part of commissioners' overall strategic aims. To take this forward, there was a need for greater understanding of the detail and pressures involved.

A&E and Ward activity April to August 2014

In relation to A&E activity, from April to August 2014 64,446 people had attended A&E, of which 367 presented with mental health issues. 134 of the 367 breached the 4 hour A&E target (approximately the same numbers breached the target during daytime hours as night-time hours (10pm – 8am).

This did not include figures for patients with mental health issues presenting after 10pm, which would be addressed by a different pathway and community based team (crisis team).

Liaison activity was currently provided to the wards where the patient had been admitted with self-harm or overdose. One of the changes from the recent review was that previously the liaison service had provided support for older mental health needs including older adults with dementia.

Who accesses the service?

Those accessing mental health liaison could be divided into four groups: those in crisis, those in mental distress, physical health admission with mental health needs, and physical health admission with dementia.

There was no change in service for those in crisis (16 during the stated period), who would be assessed under the Mental Health Act. The Service was meeting its

contractual requirements and although the 4 hour A&E target would always be breached, this was because of the specialist nature of the assessment – this was an example of where targets did not align.

The 4 hour target commenced from the point of arrival at A&E until a referral to the wards. Clinically, many mental health patients would need longer to have a specialist assessment and this was dependent on their illness.

More work was needed to understand the needs of the second group (patients with a high level of mental distress), especially after 10pm. This group would not need Mental Health Act assessment and would be seen by the liaison service. If arriving at A&E after 10pm, they could wait, accept a follow-up appointment (59% offered this), or may leave. 9% of these patients declined service or discharged themselves.

It was explained that those requiring Mental Health Assessment within 24 hours may be people with long standing mental health problems, which may have deteriorated, leading to a primary physical health issue such as self-harm or overdose. They would be admitted to an acute bed or discharged with a follow-up appointment. For patients admitted with self-harm, the liaison service would assess within 24 hours.

In relation to dementia care on the wards, two Liaison Nurses were available to provide service to patients with a dementia diagnosis. Previously the Mental Health Liaison Service had provided support to these older adult patients.

It was acknowledged that a growing number of younger people suffered dementia and the Medical Director confirmed that the Dementia Service was ageless.

<u>What next?</u>
The main areas of work with a local focus, led by commissioners focused on dementia care for inpatients and the urgent care pathway. There were a number of Department of Health strategies and clearer expectations around mental health, and a crisis concordat, involving multi-agency support, including West Mercia, was looking at improving outcomes for patients at local and regional level.

Training was another area of work, as well as looking at getting the right level of support for patients, and understanding why people present at A&E.

In conclusion, the ICEU Director wanted to reassure HOSC members that statutory requirements continued to be met for the huge numbers of people. It was unfortunate that the pilot had not delivered its original aims, but the service had come a long way from its 2008/09 provision, which spanned 5 days a week, 9am-5pm and commissioners had no areas of significant concern.

Service provider perspective

The WHCT's Director of Strategy and Business Development acknowledged the work in hand, which it was hoped would address the Trust's on-going concerns relating to:

- dementia care (ideally where patients would be supported within the setting most appropriate for their physical needs)
- access to services after 10pm for those who have self-harmed (accepting that A&E was not the best patient route, access to support from a specialist consultant should be available for those presenting there)
- the crisis care pathway
- achieving parity of esteem for mental and physical health and holistic care for the patient

Dr William Creaney, Medical Director explained that post 10pm, a screening tool was used to identify patient needs. Mental Health Act assessment for those in crisis took considerable time and involved more than one doctor with appropriate experience and a social worker. If the patient was not detained, assessment would be followed up the next day.

Feedback of experiences

Jim Bulman, a patient representative, pointed out the simplicity of hospital access for someone with a physical injury, such as a broken leg, compared to a mental health problem, which was less obvious, especially over a 24 hour period. He highlighted the difficulty for carers of patients many of whom would be elderly parents, caring for people in their 30s or 40s, who could be faced with the fear of a family member self-harming and there being no one available to go to. What do you do?

Worcestershire Healthwatch representatives (Peter Pinfield, Chairman and Simon Adams, Chief Operating Officer) set out the role of Healthwatch as an independent body which gathers patient experiences. Mental health liaison was a complex service area,

although it was only one small part of a very wide service. Healthwatch did not have any data on mental health liaison specifically, and whilst the lack of comparable data on outcomes for mental health liaison hampered analysis, it was clear that those around the table all wanted improvements. It was clear that providers and commissioners were now moving forwards together and it would be important to continue to maintain communications and consultation with service users. Healthwatch would be having input to the Care Quality Commission's inspection of Mental Health Services in the New Year, and the inspection may answer some of the issues being raised by HOSC.

Mental Health Services in Primary Care was a business priority for Healthwatch, particularly services for those with a mental health crisis. This was based on experiences from patients and carers during the organisation's first year of operation, which continued and which had been corroborated with the county's GPs. The main issues were:

- availability of talking therapies
- re-accessing services once discharged
- out of hours crisis support
- suitable places of safety for children and young people
- capacity

Healthwatch action to date included talking to a range of people within the relevant organisations and mapping the existing services and pathways in an understandable way. This work had included comparison of services with guidelines from the National Institute for Health and Care Excellence (NICE) guidelines and setting up a task and finish group. Initial observations, which would be fed into the CQC inspection, included a lack of information and guidance, the closure of local support groups and whether NHS111 plugged the gap in providing a 24/7 helpline.

The Redditch District Council HOSC member pointed out that she was aware of five mental health action groups within the area.

HOSC members welcomed the issues highlighted by Healthwatch, which provided a focus of scrutiny beyond NHS reports, and would reflect on the most appropriate opportunities to assist and engage.

Main Discussion points

- It was acknowledged that the different patient

pathways for mental health services, including mental health liaison, presented a complex picture;

- Members asked whether there had been an evaluation of the impact of the changes to mental health liaison. Because of changes in the data collected, it was not possible to make direct comparison between the current and past service provision, but it was reiterated that all statutory responsibilities were met;
- Concern was expressed about young adults presenting at A&E with mental health needs, who may be assessed as an adult, but would benefit from a service tailored to children. It was confirmed that amongst the 367 people presenting at A&E, some may be under 17 years of age, however the Health and Care Trust's Director of Operations reassured members that the Mental Health Liaison Service did not differentiate between the age of a patient;
- There was a single point of assessment, which included children and young people;
- Patients with potential to self-harm, who presented at Minor Injuries Units would be directed to A&E or the crisis team
- 59% of those in high level distress were offered follow-up appointments and members queried whether the system was robust enough to ensure people did not slip through the gap? This was an area the HOSC would want to monitor. The Lead Commissioner agreed this was always a major concern. The objective was to have a single care plan where people would be followed up. Through analysis of case studies, commissioners could learn lessons and try to avoid patients turning up at A&E;
- From a provider perspective, administrative systems were felt to be 'pretty slick' and a key difference with mental health liaison was that people did not need to be directed back through their GP;
- Cllr Griffiths, who had previously been a member of the Community Health Council subcommittee dealing with mental health services, felt disappointed that services appeared to her relatively unchanged since 1999
- Cllr Gretton queried the figures for patients presenting at A&E with mental health issues amounting to around one a day, including older people with dementia – but was advised that these were the number of patients where mental health was the primary cause of admission to A&E, others with dementia or mental health needs would have physical health needs as their primary cause of admission;
- Members expressed concern about the 10pm cut off point and commissioners explained that the rationale

behind this was because evaluation during the pilot (when provision was 24hour), indicated that the vast majority of patients accessed services between 8am and 10pm;

- It was clarified that mental health liaison was hospital based, did not go out into the community, and operated from 8am to 10pm. Outside of those hours the crisis team would respond;
- It was clarified that people being treated within the community were unlikely to go to A&E unless there were particular changes in circumstances, such as self-harm, although they may be treated at an alternative mental health facility;
- The WHCT's Director of Operations confirmed that the dedicated assessment team was available 24hours, 7 days a week and worked with the police force. He felt there had been significant changes during his 20 years' experience and the service area being discussed today was only a small part of this.

In particular HOSC members welcomed the experience of the patient representative and the issues highlighted by Healthwatch, which provided a focus of scrutiny beyond NHS reports, and would reflect on the most appropriate opportunities to assist and engage.

The ICEU Director was given the opportunity for closing comments and thanked the Committee and service users for the discussion. The purpose of today's update had been to look at mental health liaison in acute hospitals and not the whole range of mental health services. Everyone was committed towards achieving parity of esteem for both physical and mental health.

715 Acute Hospital Services

(a) University Hospitals Birmingham (UHB) Temporary Embargo

Attending for this part of the agenda discussion were:

University Hospitals Birmingham NHS Foundation Trust
Rt Hon Jacqui Smith (Chair), Dame Julie Moore (Chief Executive), Andrew McKirgan and Viv Tsesmelis (Directors of Partnerships)

Worcestershire Clinical Commissioning Groups (CCGs)
Simon Hairsnape (Chief Officer of Wyre Forest CCG and Redditch and Bromsgrove CCG)
Simon Trickett (Chief Operating Officer of South Worcestershire CCG)

Simon Hairsnape, Chief Officer of Redditch and Bromsgrove (R&B) CCG and Wyre Forest (WF) CCG set

out the background to the discussion, following the Committee's invitation to representatives from University Hospitals Birmingham NHS Foundation Trust (UHB). Worcestershire's CCGs commissioned services from a variety of providers, based on their judgement of capacity and demand. Towards the end of August UHB colleagues had notified Worcestershire CCGs that they were unable to accept referrals initially for three specialty services, but there were now seven affected; tertiary referrals were unaffected.

To date this had affected 61 patients who would have wanted to go to the Queen Elizabeth Hospital (QE) - 47 from Redditch and Bromsgrove, 7 from Wyre Forest and 7 from South Worcestershire. For some patients in Redditch and Bromsgrove, the QE was closer than Redditch's Alexandra Hospital (the Alex). Whilst understanding the basis for the decision, it was not one which the CCGs fully agreed with and this complex area was being worked through in dialogue with UHB.

Responding to members' concerns about the impact on patient choice, particularly for those whose circumstances made it far easier to access the QE, Dame Julie Moore, UHB's Chief Executive denied any breach of the NHS constitution, which stated that patients needed to be given a choice of four different places to be treated. These could be anywhere in the country and it was the responsibility of commissioners to ensure that choice was available.

UHB's Chief Executive explained that the Trust had seen a steady increase in demand over recent years, with bed numbers rising from 1100 in 2010 to 1500 and the Trust being forced to fully re-open the former QE, which was supposed to have closed after the new site was opened. UHB had reduced lengths of stay and increased efficiency, but demand was still outstripping supply. Whilst popularity was good, it had reached disproportionate levels and demand from Worcestershire residents had increased vastly by 56% over recent years. She felt that this was partially the result of ongoing uncertainty surrounding services at The Alex, which had been going on for far too long. In her view The Alex needed to be a vibrant hospital. The Chief Executive was sorry to have to have taken this step and that the decision would be reviewed at the end of November.

Acknowledging the popularity and excellence of the QE, Rt Hon Jacqui Smith, UHB Chair explained that one of the difficulties of capacity was that current levels were

putting at risk provision of the tertiary services which were only available at the QE; it was necessary to control demand to enable the Trust to deliver those services for which there was no alternative for the public – for example treatment of children with heart problems.

Main discussion points

- The UHB representatives were very pleased to be invited to this meeting and have the opportunity to discuss the situation;
- The temporary embargo would be reviewed at the end of November, but it was important that the QE's tertiary services could be delivered;
- UHB's Chief Executive reiterated that the NHS constitution specified that patients had to be offered a range of providers and this was the responsibility of commissioners; the Trust had sought legal advice, which had reached the same conclusion;
- Cllr Vickery, a regular attendee at R&B CCG's board meetings asked if things could have been done differently, to have not taken people by surprise – the UHB Chief Executive hoped the situation would not arise again, but pointed out that the Trust had communicated the potential situation to stakeholders over a long period of time; it had not taken anyone by surprise;
- When asked about opportunities to collaborate with others regarding services in demand, the Chief Executive advised that this already took place, with over 60 various providers at the last count. If the Trust was a commercial business, it would open a new branch;
- The UHB Chair spoke about the Trust's consistent steps since 2010/11 to address capacity, which had not been taken behind closed doors – including 170 extra beds in the last two years and £4m capital investment; however the point had been reached where decisions had had to be made to protect tertiary services;
- In response, Redditch and Bromsgrove CCG's Chief Officer said that there were 'two sides to the story', and differences in opinion about responsibilities. He explained the process for setting contracts each year, which included a degree of flexibility and allowance for patient choice. The UHB situation may have resulted in part from efforts over recent months to encourage patients to visit hospitals with shorter waiting lists, including the QE, in order to ease pressure points;
- HOSC members were reassured that although patient choice had been affected, the additional demand was being dealt with and there would be no clinical consequence for patients who would have

normally gone to the QE, who would be referred elsewhere;

- The R&B CCG Chief Officer confirmed that capacity, workforce needs and training were closely monitored with stakeholders, although they did not always get things right, and everyone was doing their best to work through the current situation. He was confident of a long-term solution and would want Birmingham based hospitals to continue as a provider for Worcestershire residents, as for many this concerned their local hospital;
- The South Worcestershire CCG Chief Operating Officer explained how CCGs tried to plan service provision for patients, and how this would include future expected demand for example from new housing;
- A HOSC member was keen to stress the excellence of Worcestershire's own hospitals;
- HOSC members agreed that the on-going uncertainty around services at The Alex were hard for staff and also worrying for the public;
- It was confirmed that the situation affected patients living in the other boundary areas, not just Worcestershire, and that there were pressures on the QE from outside Worcestershire also;
- A concern around access to breast screening clinics at the Princess of Wales Community Hospital for Alvechurch GP surgery patients would be picked up by the CCG Chief Officer, and was not related to the UHB situation;
- The UHB representatives said that the Trust had been looking at possibilities of boosting capacity, although this was more complex as a Foundation Trust. Whilst it was right to look to provide more care in the community, it was a false hope that this would reduce acute care needs – people were living for longer but at some point would still need hospital care.

In finalising this part of the discussion, the HOSC Chairman felt that that although the temporary embargo may not have started off as a substantial change for Worcestershire residents, it had gradually become one. He pointed out the need for good communications going forward. The UHB Chair and Chief Executive reiterated that they were more than happy to attend any future HOSC discussion.

(b) Future of Acute Hospital Services in Worcestershire

Attending for this part of the agenda discussion were:

Cllr Susan Barnett, Chair of Birmingham City Council Health and Social Care Scrutiny Committee

Worcestershire CCGs
Simon Hairsnape (Chief Officer of Wyre Forest CCG and Redditch and Bromsgrove (R&B) CCG)
Simon Trickett (Chief operating Officer of South Worcestershire CCG)

Worcestershire Acute Hospitals NHS Trust
Harry Turner (Chairman)
Chris Tidman (Deputy Chief Executive)
Mark Wake (Medical Director)

Simon Hairsnape, Chief Officer of R&B CCG and WF CCG summarised the current situation, whereby the Future of Acute Hospital Services Programme Board was continuing to work through the assurance process. The proposals were now being considered by the West Midlands Clinical Senate, and a small number of outstanding actions were being addressed. The Clinical Senate's work would take some months and would not report back until February 2015, with the result that it was unlikely to be possible to initiate public consultation before the May 2015 general election. However, pre-consultation engagement had started, and the HOSC had been supplied with a copy of the presentation, which aimed to communicate some complex messages in an accessible way.

As a consequence of the delayed timescale, the Programme Board was working closely with partners to monitor service demands.

The Chairman asked the Overview and Scrutiny Manager to update the Committee on engagement with other HOSCs regarding a potential Joint HOSC, since it was possible that discussions at today's meeting may have influence. It was explained that a Joint HOSC would be required if a service change affecting neighbouring local authorities was deemed a substantial change for its residents. Birmingham's HOSC had expressed a desire for involvement in Worcestershire HOSC's discussions, however, scrutiny colleagues in the other boundary areas had confirmed they did not view the proposals as a substantial change and therefore there was no envisaged need for a Joint HOSC at this stage.

Cllr Oborski pointed out that someone from Warwickshire had attended the Patient Public and Stakeholder Advisory Group for the Worcestershire Acute Services

Review, of which she was a member, and queried whether Warwickshire's scrutiny function should therefore also be involved?

The Scrutiny manager advised that Warwickshire had confirmed it did not view the changes as substantial. The WF CCG Chief Officer explained that the boundary area CCGs had opted to be consultees, rather than to consult their residents; if they were consulting alongside Worcestershire's CCGs, then they would need to be part of a Joint HOSC.

Cllr Barnett, Chair of Birmingham City Council's Health and Social Care Scrutiny Committee advised that a few months ago she had become aware that the proposals for The Alex may affect Birmingham patients, particularly should it close, and was aware of residents who went there because it was quicker to reach.

At this point Worcestershire Acute Hospitals NHS Trust's Deputy Chief Executive was keen to stress that there was no suggestion of The Alex closing and that the proposals protected the vast majority of services there, with A&E services actually being enhanced. Worcestershire hospitals were experiencing similar pressures in demand as Birmingham, with referrals up by 8% in the last year.

The Chief Officer of R&B and WF CCGs advised that the Chief Executives of the relevant hospital trusts and CCGs had been written to, and all had confirmed within the last month that the changes did not look significant for them.

Main discussion points

- Regarding the HOSC's dialogue with other area HOSCs, the Chairman referred to Birmingham's concerns, as expressed by Cllr Barnett, which would need to be reflected on and considered alongside the guidance;
- The HOSC Vice-Chairman was concerned about the number of stages of review the proposals were being subject to and referred back to the fairly strong assurances previously given to the HOSC about timescales - in response Chief Officer of RB and WF CCGs acknowledged that the delay allowing for regional level consideration was frustrating, however advised that the local NHS England area team had been hugely supportive;
- HOSC members asked what assurances could be given about patient safety and sustaining services,

and Mark Wake, Medical Director from Worcestershire Acute Hospitals NHS Trust (WAHT) explained that this would be reviewed on an on-going basis to identify any implications arising from the unfortunate delay. Whilst WAHT was concerned, the Board had a clear review process, which would remain at the top of its priorities, including feedback from the patient experience committee and a suite of measures to monitor safety. WAHT would take any necessary measures to correct any issues, in dialogue with commissioners and stakeholders;

- Harry Turner, WAHT Chairman stressed that the Trust's Board meetings were public, as it was important to have transparency around safety and sustainability of services, even if on occasion this led to controversial media coverage;
  Cllr Vickery suggested that a Joint HOSC could assess the potentially negative changes for Redditch and some Birmingham residents; if, as voiced today, UHB may have the capacity to expand, and Worcestershire did not, why were commissioners not collaborating with neighbouring Trusts? The Chief Officer of RB CCG confirmed that the Trusts did already work together;
- Another HOSC member, whilst acknowledging the disappointing delay, praised the WAHT Board for its clear focus on quality, safety and patients.
- Plans for consultation would be brought to HOSC at an appropriate time and commissioners were keen to hear about any groups who may benefit from seeing it. HOSC members praised the new public presentation for being clear and understandable.

716 Health Overview and Scrutiny Round-up

In Redditch the local disability action group had some concerns about new arrangements for reviewing people's return to work in relation to welfare. The Overview and Scrutiny Manager would refer this issue to the Adult Care and Well-being Scrutiny Panel. As this service involved GPs, the HOSC Chairman would also raise the issue with the CCGs.

In relation to Cllr Rayner's enquiry into how the 80 or so domiciliary care providers in the county were monitored, the Chair advised that this area was part of the remit of the Adult Care and Well-being Scrutiny Panel, and that he had attended a recent panel briefing on this topic.

The Overview and Scrutiny Manager advised that

information about a consultation on changes to Tenbury Minor Injuries Unit was expected in the New Year.

Cllr Oborski referred to a Parliamentary report on children's mental health, which she would be bringing to the attention of the Children and Young People's Scrutiny Panel, and which may also have relevance to the HOSC.

The discussion about Healthwatch England's report on complaints would be deferred to a future meeting.

Regarding the future work programme, the following suggestions were put forward:

- GP opening times and availability of appointments
- GP surgeries in areas bordering other CCGs, for example Alvechurch
- Availability of services at Minor Injuries Units
- Mental Health (Issues raised at the meeting by Healthwatch)

The meeting ended at 4.20 pm

Chairman ……..