HEALTH SCRUTINY COMMITTEE

Minutes of a meeting of the Health Scrutiny Committee held on Thursday 12 December 2024 at 2.00 pm in Council Chamber, Third Floor, Southwater One, Telford, TF3 4JG

Present: Councillors D R W White (Chair), F Doran (Vice-Chair), P Davis, S Handley, R Sahota and P Thomas.
Co-optees: H Knight, S Fogell and D Saunders

Also Present: Councillor P Watling (Cabinet Member: Adult Social Care & Health Systems)

In Attendance: I Bett (Chief Delivery Officer for Shropshire, Telford and Wrekin Integrated Care Board), M Bennett (Hospital & Discharge and Better Care Fund Service Delivery Manager), S Froud (Director: Adult Social Care), S Hardwick (Lead Lawyer: Litigation & Regulatory), H Onions (Interim Director: Health & Wellbeing) and P Starkey (Senior Democracy Officer (Scrutiny))

Apologies: Councillors M Boylan, N A Dugmore and J Urey

HAC-9 Declarations of Interest

None.

HAC-10 Minutes of the Previous Meeting

RESOLVED – that the minutes of the meeting held on 10 October 2024 be confirmed and signed by the Chair.

HAC-11 Update from the JHOSC

The Telford & Wrekin Co-Chair of the Joint Health & Overview Scrutiny Committee (JHOSC) provided Members with an update on the work recently completed by the JHOSC. The Committee were due to meet publicly on Monday 16 December with a main focus still remaining on the CQC report published in May 2024 on hospital performance, the Channel 4 Dispatches programme and winter planning. The Co-Chair advised that a new management structure had been put in place at the Shrewsbury and Telford Hospital Trust (SaTH) and that the Committee had challenged the timely issuance of reports.

HAC-12 Update from the Health & Wellbeing Board

The Interim Director: Health & Wellbeing provided Members with an update on the recent work of the Health and Wellbeing Board. The Board held its first meeting of the municipal year on 28 November 2024 following a change in

meeting timetables as a result of the General Election earlier that year. The Board were provided an update on the progress of the Health and Wellbeing Strategy over the past 12 months and also received the Healthwatch GP Access Survey which included an update of the work undertaken by Healthwatch in relation to primary care networks.

Members asked a number of questions following the update:-

Recent reports indicate growing difficulties related to lifestyle, suggesting an increase in bowel cancer among young people due to factors like lack of exercise. Is there anything the Health and Wellbeing Board can do locally to try and change this situation?

The Interim Director: Health & Wellbeing advised that primary prevention was a crucial for local authorities and the Council were due to extend their stop smoking services from April 2024 and implement a new healthy weight strategy.

There are significant pressures on the NHS, particularly around admission into hospital and accessing primary care. How much pressure is this putting on council services?

The Interim Director: Health & Wellbeing confirmed that the Council had established prevention pathways and that the NHS has several prevention programmes, including those focused on tobacco. Specific programmes were in place to support pregnant women and inpatients who smoke. Additionally, the Council also provides a community stop smoking service.

HAC-13 <u>Hospital Discharge</u>

The Chief Delivery Officer for Shropshire, Telford and Wrekin Integrated Care Board (ICB) and the Service Delivery Manager for Hospital & Discharge and Better Care Fund, Telford & Wrekin Council presented Members with an update on hospital discharge rates and intermediate care provision.

Members heard that the ICB had implemented a system-wide approach aimed at enhancing the quality and efficiency of urgent and emergency care services. The System UEC Improvement Programme 2024/25 aimed to integrate services across the healthcare system to improve patient outcomes.

The Programme consisted of 5 distinct workstreams, each focused on various aspects of urgent and emergency care improvement:-

- Alternatives to Emergency Department (ED) – providing safe timely coordination of alternative pathways to emergency department visits with support from the Emergency Care Intensive Support Team (ECIST).

- Frailty – providing a system-wide integrated pathway to manage frail patients including early identification and intervention to prevent

deterioration and admission avoidance supported by the Getting it Right First Time programme (GIRFT).

- 4hr Performance – aimed to improve the efficiency of emergency departments to meet the 4 hour target for patient treatment and discharge with support from Tier 1 resources.

- Acute Medicine & Integrated Pathway Support (IPS) – providing initiatives to improve ward processes, referral response and speciality engagement to ensure effective treatment for patients with acute medical conditions.

- Discharge – supported by Newton Europe to streamline discharge processes, ensuring that patients are discharged in a timely and safe manner. This involved identifying and eliminating bottlenecks in the discharge pathway, commencing discharge planning as soon as the patient arrives rather than waiting until they are medically fit and the development of the Care Transfer Hub.

Each workstream was supported by a Senior Responsible Officer (SRO) to ensure collaboration across different healthcare providers and an overall unified approach to patient care. Each workstream also spanned the entire patient care pathway, from initial contact to discharge to ensure comprehensive care delivery.

It was noted that the programme was also closely related to other strategic plans delivered by the Shrewsbury and Telford Hospital Trust (SaTH) including Emergency Care Transformation, Medicine Transformation and the Care Quality Commission (CQC) Dispatches Action Plan.

Members heard that one key function that had made a significant difference to discharge rates was the introduction and development of a transfer hub. Shropshire, Telford and Wrekin were one of three areas to receive additional funding from the Better Care Fund (BCF) to deliver a new discharge model following national pressures for healthcare providers to develop a more integrated function and create additional discharge teams.

In October 2024, the Care Transfer Hub was launched following extensive engagement with ward staff and medical professionals including therapists and pharmacists. The aim of the Hub was to provide a dedicated service to facilitate the safe and timely discharge of patients from hospitals to their homes or community care settings and played a crucial role in coordinating care and support to aid in recovery and admission avoidance. The Hub had brought together a multidisciplinary team of professionals from the NHS, local council and voluntary and community sector organisations to ensure that patients receive comprehensive support tailored to their individual needs.

Members heard that the introduction of the Hub had reduced the number of patients waiting in hospital beds for discharge and thus shortened the average waiting times, improving patient outcomes through supporting

physical and emotional well-being and supported with winter preparedness, helping to address challenges of higher escalation in hospitals due to winter illness.

Members also received an update on how the Acute Hospital Transformation Programme had supported improvements in discharge planning specifically in relation to simple and complex discharges. Members heard that simple discharges were related to patients who were discharged from hospital after receiving the necessary acute medical care and required minimal or no additional care after discharge. Complex discharges related to patients who had received necessary care but required additional support to recover and manage their health conditions after discharge to prevent readmission to a hospital setting. The ICB had focused extensively on reducing the length of hospital stays for simple discharges with an aim to make discharges timelier.

Graphs presented to the Committee during the meeting illustrated that the length of stay for simple discharges had steadily decreased however further improvements were to be made. Many patients experienced delays with discharge as a result of waiting for medication or paperwork. To address some of the issues surrounding discharge waiting times, a Discharge Lounge was introduced at hospital settings to provide an area for patients to be moved to away from the ward to free up beds for new admissions.

It was noted that additional focus was given around patients with complex discharges who needed some level of care of therapy and part of the metrics for ascertaining this involved looking at patients who no longer needed to be in a hospital setting or had no criteria to reside (NCTR). From the graphs presented to Committee, it was reported that the percentage of patients with NCTR between July and December 2023 was at 21.26% and had reduced to 14.58% with an increase in patients being discharged on pathway 0 by 0.5%. There had been a reduction in pathway 1 by 1% and pathways 2 and 3 had seen a 4% increase in the number of patients discharged each month before 5pm. The average days for complex discharges with NCTR was averaging at 3.1 days at the time of the meeting against a base line of 4.6 days and a target of 2.0 days by March 2025.

Members heard that the ICB had reviewed how patients had left hospital and a recent external review conducted by Professor John Bolton of the Institute of Public Care found that 50% of complex discharges involved patients going into either sector of community hospitals. Recognising the additional cost implications as a result of this, the review assisted with the setting of pathway targets with 70% of patients discharged and referred to pathway 0 as patients who would not need additional support, 25% of patients discharged and referred to pathway 2 as patients who would need short-term recovery in a community hospital and 5% of patients discharged and referred to pathway 3 as patients who would need long-tern care. It was noted that following the monitoring of pathway profiles, only 50% of patients were discharged and referred to pathway 0, with more patients being discharged and referred to pathway 2.

Following the presentation, Members asked several questions:-

On 31st October, SaTH had 208 patients who did not meet the criteria to reside. Out of these, 92 patients were discharged and 116 patients remained in hospital. How does this compare to other Hospital Trusts and can you explain why so many patients continue to stay in hospital?

The Service Delivery Manager for Hospital & Discharge and Better Care Fund confirmed that each Trust maintains a list of all patients who are medically fit for discharge. It was noted that some patients may have been waiting for completion of documents such as transfer of care documentation which can sometimes be delayed due to identifying suitable beds, discussions with carers or the need for additional assessments.

Members asked several questions around impacts following the reduction in community nursing and care plans, the difference in discharge figures at different times of the day, if discharge figures included both discharges to community beds and discharges from wards. Members also asked if information relating to readmission rates could be provided and if metrics were in place to measure when discharge planning should commence following admission and how many patients had been impacted by the discharge planning process following admission.

The Service Delivery Manager for Hospital & Discharge and Better Care Fund advised that detailed readmission rates were not available to be presented but would be followed up outside of the meeting. However there was a priority around a 'Home First' approach and the need to understand the number of readmissions including how quickly they occur. Members were informed that there is significant pressure for discharges on a Monday but that discharges ease off towards the end of the week with an increase in discharges over the weekend.

In light of representatives being unable to attend the meeting, the Director: Adult Social Care advised the Committee that questions raised would be referred back to colleagues in the Hospital Trust and the Shropshire Community Health NHS Trust to ensure that more detailed responses are provided.

What proportion of patients that are considered fit for discharge end up being readmitted to hospital and what is the criteria for discharge? Many patients end up being medically fit for discharge but have to wait around 12 to 14 hours. Is this model one which is used in other Trusts or is it a model that has only been implemented for Shropshire, Telford and Wrekin?

The Chief Delivery Officer for Shropshire, Telford and Wrekin Integrated Care Board (ICB) advised that the Trust incorporate best practice from hospitals across the country including the Care Transition Hub model.

Members commented on the effects of step down wards on Hospital Trusts over the last two years including what had worked well and if step down

wards were being used more frequently. Members also commented on the pressures around adult social care and GP practices.

The Service Delivery Manager for Hospital & Discharge and Better Care Fund informed Members that some aspects of the complex discharge process had been working well, however the complexity of the pathway profile remained a challenge with more patients being admitted to beds. Whilst there had been improvements in preventing hospital admissions, there was still significant work to be done to manage the patient flow through hospital doors. It was also recognised that there had been an increase in the number of frail and complex patients with many older patients being admitted and provided addition la care at home following discharge.

Can you explain what virtual wards are and their effects on services?

The Chief Delivery Officer for Shropshire, Telford and Wrekin Integrated Care Board (ICB) advised that the virtual ward service had been running for a couple of years and usage of the service had increased significantly. At the time of the meeting, the service was operating at 75% occupancy with 100 to 125 patients at any given time. It was noted that there were still some service improvements to be made.

The Cabinet Member: Adult Social Care & Health Systems advised that the council had invested additional funding into Adult Social Care over the last eight years and were currently focusing on areas such as enablement to allow patients to live at home following discharge. The primary focus for the Council had been around patient outcomes and prevention, specifically the need to reduce hospital admissions as a result of a fall.

HAC-14 Work Programme

The Senior Democracy Officer (Scrutiny) presented the updated work programme to the Committee. The next formal meeting was scheduled to take place in March and would include an update on the actions following the recent CQC assessment of Adult Social Care and results of the Healthwatch GP Access survey. It was noted that Mental Health was also a topic of interest for the Committee and work on this item was due to commence in the new year in the form of a workshop.

HAC-15 Chair's Update

None.

The meeting ended at 3.35 pm

Chairman: --

Date: Thursday 6 March 2025