MIDDLESBROUGH COUNCIL

AGENDA ITEM 7

OVERVIEW & SCRUTINY BOARD

30 APRIL 2013

DRAFT

HEALTH SCRUTINY PANEL FINAL REPORT – WINTER PRESSURES IN THE SOUTH TEES HEALTH & SOCIAL CARE ECONOMY

PURPOSE OF THE REPORT

1. To outline the findings of the Health Scrutiny Panel, in relation to its consideration of the winter pressures facing the South Tees Health & Social Care Economy. The Overview & Scrutiny Board is asked to consider and endorse the final report.

Consideration

2. The topic of Winter Pressures on the local health and social care economy, has been a subject of interest to the Health Scrutiny function for a number of years. Winter pressures, when coupled with a rising demand for healthcare from an ageing population, has been an issue of significant political and academic interest in recent years, together with how exactly these challenges can be met. The challenge posed by these issues are undoubtedly exacerbated by a national economic climate that makes significant additional funding very unlikely for the next few years, at least.

3. Whilst this is a national matter, it is also a local matter and it follows that these issues have to be tackled in Middlesbrough. The Health Scrutiny Panel was conscious that over the 2012/13 winter period, a number of items had been in the local media about demand pressures at Accident & Emergency at James Cook University Hospital, as well as delays in Ambulances being able to 'hand-over' patients to hospital based services.

4. During the winter of 2012/13, the Panel saw these issues raised in the local media and was keen to explore them further. The Panel, however, was keen to not add to pressures faced by relevant services, at the peak of winter demands. As such, a meeting to discuss those

pressures, with all relevant organisations, was arranged for 19 March 2013.

5. In attendance at the meeting were senior representatives from North East Ambulance Services, South Tees Hospitals NHS Foundation Trust, South Tees Clinical Commissioning Group, Middlesbrough Council Social Care and the NHS Local Area Team. To guide the discussion, the Panel drafted a number key questions, which are outlined below. All agencies attending the discussion had adequate notice of these questions and were asked to attend ready to speak about them.

5.1 It is clear that A&E at JCUH has experienced significant pressures over the winter period, with demand presenting a major challenge to the capacity of the service. To what extent is this an exceptional winter to be dealt with, or does it represent a new 'normal' winter period, given the context of an ageing population with increasing levels of illness?

5.2 To what extent do the pressures faced by A&E at JCUH highlight a service simply lacking the necessary capacity to meet local demand, or are those pressures symptomatic of wider systemic issues, which leave people felling that they have no other viable choice when unwell, other than accessing such services at JCUH?

5.3 The Panel has noted the local media stories regarding ambulances having to wait a considerable period to 'hand-over' patients. What would be a 'normal' hand-over time and what has been the average over winter 2012/13? Has this caused a situation where the area has been at risk, or exposed, to having too few operational ambulances? Is this a risk that can be managed?

5.4 For future winter periods, how do we prevent this scenario from taking place again? Is the answer additional investment at JCUH, or providing more facilities in the community (and adequate information about their appropriate use) for those seeking medical assistance?

6. The discussion was started with the South Tees FT outlining some key pressures facing James Cook University Hospital, which are heavily connected to demographic pressures. The Panel was advised of data relating to NEAS ambulance arrivals at the JCUH from April 2010 to the present time.

7. The data shows that over the period there has been a rise from around 300 ambulance arrivals per week in 2010 to around 500 per week in winter 2012/13 (a 66% rise). It was confirmed that this peaked at 577 ambulance arrivals in week commencing 30 Dec 2012. In reference to the first question set by the Panel, it was stated that, in STHFT's view, this sort of scenario is the new "normal". It was pointed out that in addition to NEAS arrivals, JCUH also takes arrivals from Yorkshire Ambulance Services and from helicopter deliveries.

8. The Panel was shown data which detailed the growth in A&E attendances over the past 8 years, together with the parallel rise in the number of patients admitted through A&E. It was stated that the A&E department at JCUH was originally scoped for 75,000 attendances per annum. Over the past 8 years this figure has been continually exceeded. Predictions for 2012-13 indicate an expected outturn in the order of 105,000 attendances.

9. In addition, the Panel heard that there is clear evidence that in the winter months, patients are staying longer than in the summer months. It was suggested that this is consistent with the profile being reported clinically, of older and sicker patients being admitted to the hospital during the winter months. The Panel was advised that Trust analysis suggests that many of these are respiratory patients requiring around 40 more beds during the peak winter months, compared with the remaining 9 months a year.

10. The Panel heard that, in the view of the South Tees FT, the pattern seen over the past 8 years will continue and demand is likely to increase as the population ages. Whilst the South Tees FT is working with colleagues across the system on admission avoidance schemes in primary care and community based services, it is believed this will slow the trend in referrals but demographic demand will continue to rise.

11. On the point of demographic pressures and the profile of those attending JCUH, the Panel heard that, according to research done by South Tees FT, the vast majority of patients attending the JCUH by ambulance are sick and in need of admission.

12. The Panel was interested to learn from a South Tees FT perspective, the key issue over the winter has been the capacity in the health and social care economy, to absorb patients from acute hospital beds. The Panel was advised that work undertaken in 2011 identified that across the JCUH and FHN hospitals combined, approximately 200 patients at any one time did not need to be in an acute hospital bed. It was reported that appropriate alternatives might include: intermediate care services, such as community hospital beds, domiciliary support (professional rehabilitation and therapy, social care, voluntary sector), nursing or residential home care.

13. It was reported to the Panel that in January 2013, the number of such patients at the JCUH peaked at c112 on a bed base of 700 (16%). The Panel heard that this, more than anything else, prevented smooth flow of patients in to and out of the A&E department. It was pointed out to the panel that if beds are unavailable in the main hospital, it is not possible to move patients in a timely manner out of A&E to a suitable ward, thus creating capacity in the A&E department for the next arrival. It was confirmed to the Panel that the most significant build up in patients who could be discharged to alternative accommodation, was over the Christmas period when a number of agencies were running reduced services. There is also a tendency for beds to fill over

weekend periods as most agencies (including STHFT) are running 5 day services.

14. The Panel was keen to explore the suggestion that Social Care services were struggling to cope with the demand, emanating from James Cook University Hospital, at the height of winter pressures. Further, there seemed to be a clear suggestion to the Panel from the South Tees FT that a major impediment to the hospitals efficient handling of patients and associated bed demand, was due to a lack of capacity in Social Care.

15. It was broadly accepted by the Department of Social Care that the extent of the pressures faced during winter 2012/13 had asked significant questions of Social Care's capacity to respond, although the Department had been successful in securing some *winter pressures* additional funding to recruit additional seasonal social workers. It was said, however, by all around the table that there is not a single reason as to why discharges were delayed, but it was certainly a pressing concern for the system.

16. The Panel also had the benefit of senior clinical expertise at the meeting, based in A&E at JCUH. The Panel heard that it was clear that the demographic change was now quite visible within units, to the extent that clinicians were seeing a patient group, growing in number, which is increasingly old, increasingly frail, with multiple illnesses. Whilst it was a fairly clear decision as to whether or not someone needed to occupy an acute hospital bed any longer, it was far from clear what sort of home environment the patient would be discharged to and whether they could cope. As such, some services could also be forgiven for erring on the side of caution and keeping someone in hospital, until social care services could enable their safe discharge. Whilst that approach was entirely understandable and even desirable, in the here and now, the Panel heard that it did not dilute or lessen the need for the local health and social care system to develop a better model of caring for a older, more frail and more populous cohort.

17. In a sense, the Panel heard that the policy drive to allow people to stay supported, in their homes for as long as possible, had become a 'victim of its own success'. It allowed people to stay in their homes to the latest possible point, but a return to home following a period of hospitalisation and probable weakening, was often not possible.

18. In discussing where else in the system that this expanding group of older and more frail people could be supported, attention turned to other aspects of the Health and social care economy, such as Nursing & Residential Homes and Out of Hours service providers.

19. The Panel heard that whilst there were undoubtedly more older people, who are very poorly, there is also an element of a 'transfer of risk' taking place, which allows people to move patients into the acute setting, who arguably do not need to be there. Evidence from the CCG indicated a feeling amongst General Practice that care homes had

lowered their threshold as to when they would seek to move/transfer someone into JCUH.

20. The Panel heard that this, to an extent, is an understandable situation to arise in care homes. The sector is prone to paying low wages to relatively low skilled staff and it is entirely understandable, if not predictable, that such staff will want to move someone to a hospital environment and 'transfer risk'. It could even be argued that such a 'safety first' approach is desirable.

21. The Panel also heard, however, of a view that the current Out of Hours service provider was also quite swift to call Ambulances and seek the hospitalisation of someone, without having physically examined them.

22. The Panel was advised, that in the view of the CCG, the contract awarded to the Out of Hours provider did not invest sufficient resources into ensuring that there were sufficient visits by Out of Hours GPs. As such, there was a default setting in many circumstances that an Ambulance would be called in absence of a patient being assessed by a doctor. The Panel heard this was exacerbated by the fact that the Out of Hours service did not have experience with patients in the way that General Practice does and that the Out of Hours provider does not have access to the patient's medical records.

23. Whether it be due to a culture of risk aversion or not, the Panel was less accepting of the suggestion that the Out of Hours service also seeks assistance from Ambulances to transfer risk, as opposed to making proper assessments of a patient's need. The suggestion that Out of Hours services sought to utilise Ambulances for such means, or as a means of transport was a concern. The evidence presented on the day, suggested to the Panel that there had been significant underestimates in the commissioning process for Out of Hours services and the view coming from the CCG would suggest that the service was not delivering as it should, as a result.

24. On the subject of ambulances being called and the appropriateness of those calls on ambulance services, the Panel was keen to seek the views of the Ambulance Trust, on responding to calls for its assistance. The Panel heard that should a call for assistance received from a member of the public, or a care home, there are a few options open to the Ambulance Trust. Firstly, the Ambulance Trust may be able to provide sufficient assistance under the 'hear and treat' scheme, where clinical advice or an appropriate referral to an alternative service (such as a walk in centre or general practice) be given. NEAS confirmed that it is able to successfully and safely 'hear and treat' in around 5% of its calls.

25. Secondly, the Ambulance Trust may be able to 'see and treat'. In this scenario, a paramedic would attend a call out and be able to assess the patient, to take a view as to whether it was necessary for someone to be taken to hospital, or whether sufficient treatment could be administered at the in situ, to deal with the matter. NEAS reported that

around 30% of its activity is dealt with under the 'see and treat' initiative.

26. Then there is the other most obvious scenario where someone is regarded as sufficiently ill to be taken to hospital, but the Panel was pleased to see that the Ambulance Trust was increasingly becoming involved in demand management schemes such as this, utilising the advanced skills that paramedics posses.

27. It should be noted, however, that if a Doctor calls for an ambulance to take someone into hospital, an Ambulance Trust is not permitted to question the Doctor's judgement on the matter and it must simply transport the person to hospital. This point, specifically in relation to Out of Hours work, led the Panel to wonder if it was a little 'too easy' for the Out of Hours model to suggest an ambulance and hospitalisation, as a transfer of risk. The Panel questioned whether this was appropriate for a Doctor led Out of Hours service to be doing and whether, the Ambulance service was seen in this scenario as a transport provider, as opposed to a provider of advanced healthcare. This point remains largely unanswered, although remains a concern for the Health Scrutiny Panel.

28. The Panel was keen to discuss the wider pressures on the local health and social care economy posed by an ageing society, which are exacerbated by winter pressures.

29. The Panel heard that whilst very useful and valuable schemes could be developed and introduced around hospital avoidance or demand management schemes, it should be noted that the entire system faces hugely significant pressures. It was reported to the Panel that it is difficult to overstate the challenges being posed by a patient cohort that is increasingly old and frail. On this point, the Panel was advised by the South Tees FT that growth in demand had exceeded projections and demographic pressures were reaching a tipping point, where some significant action would need to be taken.

30. The Panel was advised that the South Tees FT is already looking at the physical capacity of the A&E section and specifically investigating the expansion of the resuscitation area.

31. It was said that the local health and social care economy needed better data about the local population, predicted morbidity and projections on possible/probable need.

32. It was widely accepted around the table that whatever steps were taken about physical capacity at JCUH, much more work was required to increase the system's ability to respond to need in primary care and community services. Further, more work was needed as a matter or urgent to improve the process and the speed of the process, in discharge.

33. It was also said that the ideal percentage for bed occupancy at JCUH would be around 85%, which then ensures that the hospital has sufficient capacity to deal with pressures. The concern was, the Panel heard, that during winter 2012/13 that figure was quite often running at 95%, which provides the Trust with very little room to manoeuvre.

34. The Panel enquired as to whether this was a problem that was largely impacting upon James Cook University Hospital, or whether it was affecting other facilities. The Panel heard that local community hospitals had similar pressures and acute hospitals were unable to rely on the concept of mutual aid, as neighbouring hospitals were facing similar pressures.

35. The Panel was keen to hear the views of those present as to whether similar pressures could manifest themselves again, and the extent to which there was confidence that sufficient experience had been gained to ensure it did not happen again.

36. The Panel heard that from one perspective, NEAS would have reservations about the system's ability to cope in future winter periods, particularly if there were aggravating factors such as especially severe weather or outbreaks. That the Ambulance Trust, such a crucial component in a healthcare system's resilience, had this view caused the Panel concern.

37. In response, the Panel heard that the South Tees FT feels as though it has a plan in place to address some of the issues that had been experienced during 2012/13 winter period and it was cautiously optimistic. South Tees FT did, however, sound a note of caution in relation to the demographic pressures facing services. All representatives around the table agreed that the system does not know fully yet, whether it is now in a suitable configuration to deal with the changing demographics, or whether those demographics will exert pressures, that have not as yet, being brought to bear on the system. This was an issue where only time would tell, the Panel heard. It was, however, also said that the local health and social care economy would benefit from improved data about the local population and specific data on age profiles and likely morbidity.

38. The Panel was advised that in one sense, it could be perceived as positive that the 2012/3 winter had been so challenging for services. It had acted as a catalyst for organisations to realise that without significant work, services would not be able to cope with future pressures and demand.

39. The Panel heard that whilst the debate about managing demand, developing community facilities and related endeavours are all very worthy, at some point acute hospital capacity would required expansion, as the demands emanating from the population are simply

too great to be adequately managed within the existing service configurations. The Panel was advised by the South Tees FT that consideration is currently being given to the physical expansion of facilities at JCUH, with specific thought being paid to more resuscitation capability and acute medical ward capacity.

40. The Panel was keen to ascertain what the next steps will be for the local health and social care economy. It was reported that a seminar would be held between all relevant organisations, in May 2013, to crystallise what the organisation had learned from Winter 2012/3 and what should be applied to Winter 2013/14.

Conclusions

41. It is clear that the local health and social care economy faces significant pressures from an ageing population, which is increasingly sick, and creating significant extra demand on services. It is less clear as to whether we have reached the 'high water mark' of that demand, or whether it is a trend that will continue to gather pace, exerting more and more pressure on services. That the local health and social care economy does not know this with any certainty raises questions about the quality of data that it has access to, relating to its local population and associated projections. It would be prudent, however, to expect this demand to rise for the foreseeable future. As such, high demand, allied with advanced levels of sickness and a larger very old patient group represents the new normal, which will only be exacerbated in the winter months.

42. On the strength of the evidence presented to the Panel in this piece of work and others, the local health and social care economy's current service configuration is unable to cope with the demands that are currently being placed on it during winter, and the greater demands that will come in time. It would appear, that the area of service that seems least able to cope with demand, is the social care function specific to hospital admissions and discharge. The Panel has heard evidence from the South Tees FT, that one of the major impediments in assisting with the efficient discharge of patients is the relative slow response from Social Care. The Panel was struck by the observation from the South Tees FT that whilst the admitting of patients and the use of beds at JCUH is a 24/7 task, the social care element is a five day operation. The Panel wonders if this mismatch with services' operational hours creates an inevitable bottleneck.

43. The Panel considers that the overriding danger of such a scenario not being adequately dealt with, or these pressures not being effectively managed, is a hospital environment that becomes more and more under strain and could potentially become so pressured it becomes unsafe. It should be emphasised that there is no evidence that services at JCUH are currently unsafe, but there must be a risk of services

becoming so, if no action is taken, due to the pressures outlined in this report.

44. On the strength of the evidence presented to the Panel, there is substantial dissatisfaction in the General Practice community about the current Out of Hours service and the extent to which it manages patients' conditions out of hours. The Panel is left with the impression that the CCG feels as though the Out of Hours provider is too eager to call ambulances for people to be taken to hospital, thereby 'transferring risk'. If this is accurate, the Panel finds this very concerning as this is precisely the outcome that having a doctor led out of hours service is intended to eliminate, or at least restrict.

Recommendations

45. That the local health and social care economy, led by the Health & Wellbeing Board, develops and implements a strategy to ensure that the local health and social care economy is more able to deal with winter pressures. The strategy should have a specific and explicit focus on the following areas of priority;

45.1 How Social Care provision, specifically that based at JCUH, will be developed to ensure it can efficiently and safely meet the demand for services associated with assessment and discharge of patients, which presents itself through the winter months. The detail of how this is to be done, whilst largely a management function, should pay appropriate attention as to whether current operating hours are sufficient, as well as whether staff numbers are sufficient.

45.2 How the local health and social care economy will develop a better and more robust range of service options based in the community, which will allow people to be safely discharged out of acute hospital, who may still require some recovery period. The strategy should be explicit about how this will be funded and what is needed to make it happen. An important aspect of that will be the management of the 'local market', to ensure that provision is in harmony with need and demand.

45.3 How the local health and social care economy will seek to utilise the skills and expertise of NEAS staff more, particularly around the concept of paramedics being able to 'see and treat'. The suggestion, that the Panel has heard from more than one source, that General Practices seeks to utilise NEAS primarily as a mode of transport to hospital, to transfer risk, should also be urgently investigated and challenged, by the competent body, if necessary. There should be clear protocols published, which provide directions for paramedic staff to be able to question the appropriateness an ambulance transporting someone to hospital.

45.4 How the local health and social care economy will ensure that the Out of Hours service provider does not, or will not in the future, seek to

adopt an approach where it abdicates risk and transfer that risk to the hospital environment. This should involve an urgent review to ensure that the current Out of Hours contract is being complied with.

46. To support the development and formation of a strategy, the Health and Wellbeing Board should commission work to identify include detailed projections on population and morbidity data, which attempts to identify where, when and how service pressures will come to bear. The suggestion that the health and social care economy doesn't have this level of data available to it and doesn't really know what future pressures are coming, struck the Panel and should be remedied.

47. The Panel would be keen to see the local health and social care economy hold a conversation about whether it would support the idea of there being greater inpatient winter capacity at JCUH, which perhaps would be closed throughout the warmer parts of the year. The Panel is conscious that this would create a degree of inefficiency at JCUH, but would be interested to learn whether that small amount of unused capacity laying dormant throughout most of the year, would be supported if it could be relied upon during winter.

48. That the South Tees Hospitals NHS Foundation Trust expedites its work to investigate the feasibility of expanding the physical capacity at JCUH, particularly around the resuscitation facilities. The Panel would like to know the outcome of this work.

49. That the South Tees Hospitals NHS Foundation Trust, reassures itself and the wider health and social care economy, that the development of a major trauma unit at JCUH, and the associated additional patients, does not detract from the facility's ability to carry out its District General Hospital duties, particularly in winter.

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Chair, Health Scrutiny Panel

BACKGROUND PAPERS

50. Please see Health Scrutiny Panel papers from meeting on 19 March 2013.

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