Public Document Pack

Date of meeting	**Wednesday, 19th November, 2014**
Time	**7.00 pm**
Venue	**Committee Room 1, Civic Offices, Merrial Street, Newcastle-under-Lyme, Staffordshire, ST5 2AG**
Contact	Julia Cleary, Ext: 2227

Health and Wellbeing Scrutiny Committee

AGENDA

PART 1 – OPEN AGENDA

1 Apologies

2 Minutes of the Previous Meeting - Tuesday 21st October 2014 **(Pages 3 - 6)**

3 Declarations of Interest

4 HEALTHWATCH, STAFFORDSHIRE

A verbal update will be provided by the Community Engagement Lead for North Staffordshire

5 North Staffordshire Combined Healthcare NHS Trust - Adult Acute Outreach **(Pages 7 - 8)**

6 Digest from the Healthy Staffordshire Select Committee (10th November 2014) **(Pages 9 - 18)**

7 Presentation from the Community Safety Officer - Alcohol Lead and the Partnerships Manager (Newcastle Borough Council) **(Pages 19 - 28)**

8 NORTH STAFFORDSHIRE COMBINED HEALTHCARE NHS TRUST - ALCOHOL USE AND MISUSE **(Pages 29 - 56)**

A copy of the presentation is to follow

9 ONE RECOVERY **(Pages 57 - 68)**

A presentation will be carried out by One Recovery North Staffordshire Service Manager regarding the various services available to service users

10 WORK PLAN **(Pages 69 - 74)**

To discuss and update the Work Plan to reflect current scrutiny topics

11 URGENT BUSINESS

To consider any business which is urgent within the meaning of Section 100 B(4) of the Local Government Act 1972.

Members: Councillors Allport, Mrs Astle, Bailey, Becket, Eagles, Eastwood (Chair), Mrs Hailstones, Mrs Johnson (Vice-Chair), Loades, Northcott and Owen

PLEASE NOTE: The Council Chamber and Committee Room 1 are fitted with a loop system. In addition, there is a volume button on the base of the microphones. A portable loop system is available for all other rooms. Should you require this service, please contact Member Services during the afternoon prior to the meeting.

Members of the Council: If you identify any personal training/development requirements from any of the items included in this agenda or through issues raised during the meeting, please bring them to the attention of the Democratic Services Officer at the close of the meeting.

Meeting Quorums :- 16+= 5 Members; 10-15=4 Members; 5-9=3 Members; 5 or less = 2 Members.

Officers will be in attendance prior to the meeting for informal discussions on agenda items.

HEALTH AND WELLBEING SCRUTINY COMMITTEE

Tuesday, 21st October, 2014

Present:- Councillor Colin Eastwood – in the Chair

Councillors Allport, Mrs Astle, Bailey, Eagles, Mrs Hailstones, Mrs Johnson, Loades, Northcott and Owen

1. **APOLOGIES**

2. **DECLARATIONS OF INTEREST**

3. **FRANCIS REPORT**

The Committee received a report relating to the public inquiry into the Mid-Staffordshire NHS Foundation Trust and allegations of poor care and higher than average mortality rates at Stafford Hospital.

The Francis Report included a range of references to the role played by local authority scrutiny committees between January 2005 and March 2009.

Page 9 of the agenda listed a set of questions to be addressed and the Chair requested that the Committee consider these questions in detail.

The first and most vital question to be addressed in the first instance was:

1. Should this area of scrutiny (of hospitals) be undertaken solely by Staffordshire CC (or Stoke on Trent CC) or should there be a division of responsibilities (in the case of Staffordshire) or joint working (in the case of Stoke on Trent) with the relevant district/borough council(s)?

Members considered that this Council should be carrying out scrutiny of hospitals. Some concerns were raised regarding guidance in relation to what should be looked at and it was suggested that better use of organisations such as Healthwatch would enable the Committee to focus on specific areas of importance.

It was stated that scrutiny needed to be both proactive in a preventative sense and reactive in response to constituent feedback. Scrutiny was an important safeguard to the people of the Borough in relation to the health services they received.

The Committee agreed that the Committee should deal with areas that lay within the Borough boundary and that care had to be taken to avoid any duplication of work.

Members raised the importance of having set objectives when carrying out a piece of scrutiny and that it was important to have clear lines of communication with the County Council to ensure that outcomes were reported back and information shared.

Members of the Committee also suggested that in order to carry out effective scrutiny, training was required in relation to areas such as the health framework and who actually does what.

2. Where does the NULBC Health and Wellbeing Scrutiny Committee get its information from in relation to UHNS and other hospitals?

Members considered that there was a need to approach a variety of forums and networks outside of the normal UHNS partners and that information should also be sought from a patient perspective. Specific information was required rather than a broad overview and the Committee needed to be clear in what it was asking of partner organisation that attended meetings. A set of actions needed to be produced after each meeting that required feedback and monitoring. The suggestion was also made that groups such as PALS and Healthwatch attend the meetings of the Committee to discuss their findings and outcomes and that the PCT should attend meetings to provide feedback on alcohol related admissions.

Members considered that the current remit of the Committee should be looked at as it was deemed inadequate and needed to reflect exactly what the Committee were doing. Tightening up on the remit would also help members to decide what areas of scrutiny the Borough would not be undertaking and avoid duplication with the County and City Councils. The Committee agreed that a member led working group be set up to consider the remits of the scrutiny committees.

3. Are the existing resources dedicated to the NULBC Health and Wellbeing Committee adequate both in terms of committee/scrutiny support and also the provision of expert advice (other than that from UHNS)?

Officers considered that some additional training would help to make the current resources more effective and efficient.

4. Are the existing methods of recording meetings adequate?

Members considered that the current way of recording meetings allowed for challenge and was therefore adequate.

5. Is there sufficient clarity in terms of the respective roles of the SCC Healthy Staffordshire Select Committee and the NULBC Health and Wellbeing Committee?

Members considered that there was clarity and that they were clear in their role as representing the Borough of Newcastle under Lyme and its residents.

6. Do Members feel they receive sufficient training to undertake this role?

Members considered that additional training was required.

7. Is information form the public both sought and responded to?

Members considered that more could be done in relation to this including using the Reporter Newsletter and the website to publicise.

8. What role does the public play at meetings of the NULBC Health and Wellbeing Committee?

A public question time had now been introduced but more could be done to publicise this through the website and the Reporter magazine.

4. **URGENT BUSINESS**

The Chair welcomed Elizabeth Jarrett from Healthwatch to the meeting. Mrs Jarrett gave a brief overview of the work currently being undertaken by Healthwatch and drew members attention to three public events that would be taking place in November in relation to the UHNS transition of services.

With regards to the GP access project Mrs Jarrett stated that this had been planned for August and September but due to a large amount of interest from NHS England the project had been expanded to include other local authority areas such as Shropshire and Telford and Wrekin. Three GP practices would be chosen per CCG.

A question was raised regarding the criteria for choosing GP practices for the Healthwatch project. Mrs Jarrett stated that she would find out this information and email a response.

The Committee thanked Mrs Jarrett for the update.

COUNCILLOR COLIN EASTWOOD
Chair

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North Staffordshire Combined Healthcare NHS Trust

Briefing Paper to: Stoke Overview and Scrutiny Committee.
3 September 2014

Report name
Enhancement of Community Older people's Mental Health Outreach Team

Author of Report
Andy Rogers, Director of Operations, North Staffordshire Combined Healthcare NHS Trust

Background
A community outreach team was established in 2012. This was part of a planned service redesign based on experience from elsewhere with the aim of reducing reliance on inpatient beds. The service was designed:

- To support and enable the safe and appropriate discharge of service users into the community when they do not need to be treated within a hospital.
- To support service users in their home abode, to prevent the necessity for inappropriate admission to an acute hospital.

Over the 2013/14 the workload of the unit has been almost equally split between the two roles.

The budget of the service includes just over 11 Whole Time Equivalent (WTE) staff (two thirds nursing, one third support workers/admin).

Proposed Change:
It is anticipated that demand for older people's services will rise significantly over the next few years. The Trust's Business Plan shows that demographic change will mean that within our catchment population the number of people aged over 65 years will increase by 7.8% between 2012 and 2017 and by 12.7% for people over the age of 80.

The enhanced outreach team will continue the core role of supporting patients in their own homes as an alternative to hospital admission and in supporting discharge. However, this will be extended to support more complex patients – which could be people in residential or nursing homes.

The team size will significantly increase in staffing to address:

- The anticipated increase in caseloads
- The increase in complexity of casemix
- The current levels of overstretch.

The establishment of the service has facilitated a decrease in occupied bed days in older people's wards in recent years, with the result that on average of 17 or more beds are vacant on these wards on any given day.

The enhancement will be achieved by supporting the cohort of patients with one less 15 bedded ward, allowing for staff from this area to be redeployed into the community team.

This allows for the vacant ward to be developed, to support a cohort of patients who currently require out-of-area placements. This patient group will be supported in the redeveloped ward, thus enhancing access to locally-provided services.

Rationale and evidence
Delivery of high quality, safe care within people's own homes and within community settings maximises support for independent living and for maintaining relationships and support networks within the community. The transition to this from hospital based care, which can be more institutional is key to delivering this goal

Local commissioners are also clear that they wish to see as many people as possible cared for within community settings and avoid unnecessary hospital admissions. Similarly, commissioners of social care services have also signalled their intent that locally too often the outcome for many older people who have care needs is admission to long term placement in either Residential or Nursing Homes.

Both Stoke on Trent and Staffordshire local authorities are concerned that rate of admission to care homes is higher than the national average and are developing strategies to reduce this.

The aspiration of both the Department of Health and local commissioners is supported by evidence from across the country that providers are increasingly able to reduce their reliance on hospital based inpatient services if they make the appropriate investment in community outreach services.

Day Hospitals were originally designed as an alternate to in-patient admission but research evidence in the UK suggests that replacing day hospitals with intensive community outreach teams could have a greater impact in reducing the use of hospital beds, (*Royal College of Psychiatry 2008*) citing examples of these changes from Merseyside, London and Yorkshire. Further examples can be found in Suffolk [*Dibben et al 2008*] and Sussex [*Sussex PCT 2009*].

Impact on Constituents
The Trust believes this proposal is a quality improvement providing care closer to home and using limited resources in a way that reduces inappropriate admissions to hospital and cares for people in a familiar environment, wherever possible.

It will allow older people with mental health issues to be better supported for longer in their own homes.

Harplands Hospital wards will, in the short term, maintain the capability to support similar cohorts of patients. In the longer term, they will also provide greater variety of services, by way of enhancing rehabilitation services.

Contact for further information:
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Classification: NULBC **UNCLASSIFIED**

Minutes of the Healthy Staffordshire Select Committee Meeting held on 7 October 2014

Present: Kath Perry (Chairman)

Attendance	
David Loades (Vice-Chairman)	
Charlotte Atkins	
Bob Fraser	
Sheree Peaple	
Trish Rowlands	
Mike Worthington	
Andrew James	Tamworth Borough Council
Thomas Marshall	Lichfield District Council
Stephen Smith	East Staffordshire Borough Council
Amyas Stafford Northcote	Stafford Borough Council
Chris Baron	Stafford Borough Council
Maureen Bowen	Stafford Borough Council
Ann Edgeller	Stafford Borough Council
Maureen Freeman	Cannock Chase District Council
Mike Hampson	South Staffordshire District Council
Hyra Sutton	Cannock Chase District Council
Ann Bernard	Cannock Chase District Council

Apologies: Philip Jones, Shelagh McKiernan, David Smith, Elaine Baddeley (Staffordshire Moorlands District Council), Val Chapman (South Staffordshire District Council) and Colin Eastwood (Newcastle Borough Council)

PART ONE

37. Declarations of Interest

There were no declarations of interest.

38. Mid Staffordshire NHS Foundation Trust

Maggie Oldham, Chief Executive advised the Committee that her intention with the support of her colleagues was to update the members on past performance and of the agenda going forward. She explained that the report following the recent Care Quality Commission was imminent and early feedback indicated that the services were considered to be safe but fragile, recruitment remained a challenge with 100 nurse and 30 consultant vacancies at the Trust, and that the fragility in services had been reflected in the Trusts Self-Assessment Report. In relation to Inpatient beds had been reduced to a level that could be safely managed by the level of staffing available.

Suzanne Banks, Director of Nursing informed the members that following the Care Quality Commission (CQC) responsive review report, the Trust had set up a Learning from Experience Group (LEG).The group through an integrated governance approach had taken the lead role on behalf of the Quality Committee to identify lessons learned from Serious Incidents(SI), Complaints, Patient Experience and Claims and that the outcome was the provision of a forum to enable the Trust to review serious incident reports on investigations and that the Divisional Performance Review Group would ensure and timely action. Members were informed that the Trust continued to contribute to the Safety Thermometer on the middle Wednesday of each month, an important audit to provide an overview of “harm free care. The principal type of harm was outlined, pressure ulcers, falls, VTE and catheter associated urinary tract infections (UTI). The improvement of “harm free” performance in certain areas in particular the incidence grade 2, 3 hospital acquired ulcers and the apparent inconsistencies in other areas was described. She provided an overview of the work and progress ongoing in relation to falls and reported good level of performance against National Patient Safety indicators.

She acknowledged that Clostridium Difficile (C.Diff) remained a challenge, 5 incidents had been recorded in July with no outbreaks and fortunately they had a different Ribotype making the risk of transmission unlikely. She informed of work in progress with Clinical Commissioning Group to address this issue. In relation to the “Patient Experience” inconsistencies in performance in relation to complaints, the method of Net Promoter Scoring, evaluation of Friends and Family Test and the monthly Patient Surveys was explained to members. In respect of the Hospital Standardised Mortality Ratio (HSMR) Suzanne Banks reported that it was lower than expected and that the Trust continued to perform well when measured against peers.

In respect of operational performance Mark Partington, Director of Transition/Chief Operating Officer reported on a number of improvement achievements that included;

- 18 weeks Referral for Treatment (RTT).
- Cancer access targets
- Diagnostic 6 week waits
- Stroke

In relation to these areas of operational performance he advised members the criteria and targets were being achieved.

He reported that in relation to A&E that the 4 hour access target was a challenge due to fragility of service and staffing shortages. The Trust was 10% below the National Standard of 95%. The focus was on the provision of a safe service and a determined effort to improve access. He informed members of challenges in the area of daily discharges due to the high number of agency nurses and locum doctors. He advised of 11 delayed discharges and of work with the Emergency Care Intensive Care Support Team to address the issue (this is the lowest figure for some time often at 25 plus).

Jeff Crawshaw, Deputy Chief Executive, advised the members that despite the difficulties in recruitment and retention of permanent staff. manadatory training and appraisal rates remained strong and compare well against other NHS Trusts. He acknowledged the difficulty in recruitment and the need to reduce the dependency on agency and bank staff. These staff played a vital role in assisting the Trust to meet peaks in demand. Ultimately that, with the restoration of the Trusts reputation, recruitment would cease to be a problem in the future.

John Doyle, Director of Finance gave members an overview of income and expenditure. The Trust had a planned deficit of £20.5m which would increase with the investment necessary to increase clinical staffing levels. In relation to the Cost Improvement Programme (CIP) he advised that it was £0.2m ahead of plan saving £0.54m.It was expected that the Trust would £2.6m CIP against the annual requirement of £7.49m.Detail of capital expenditure was explained and that the Trusts Capital Plan for 2014/15 had been approved by Monitor and the Department for Health. He advised of expenditure on schemes to improve fire safety, patient environment, new equipment and the investment of £6m for a new Endoscopy Unit to be opened during October 2014.

A member of the public asked if the Trust could clarify safeguarding measures in the contract or contractual obligations on Wolverhampton Hospital to ensure the longevity and future of the Minor Injuries Unit (MIU) at Cannock Hospital.

Jeff Crawshaw responded, he advised that the MIU was a service of the Trust, located at Cannock Hospital. It was probable that the commissioner of services for the Unit was paying rent to the Clinical Commissioning Group. His view was that the Trust would hand over the whole site to Wolverhampton Hospital with the existing tenants in situ. Ultimately it would be the decision of the CCG and Wolverhampton Hospital on the location of the Unit and whether it would remain in its present form or replaced by other services. Dr Diarmuid Mulherin, Deputy Medical Director added that the main risk to the MIU would be from the CCG but in respect of the contractual issues there would presumably be a Lease in existence and that it was a matter to be taken up with the David Loughton Chief Executive of the Royal Wolverhampton NHS Trust.

In response to the question from a member in advance of the meeting the Committee were informed that the question had been answered. The member referred to recent attendance at a Board meeting of the University Hospital of North Staffordshire and made the comment that as the A&E service was in crisis at the Stoke and Stafford sites due to finance and staffing issues asked why the proposed consultant led GP service programmed for April 2015 and why wasn't it a 24/7 service.

Maggie Oldham responded advising that the eleven beds referred to was a vast improvement on previous numbers that had be as high as 30. As the usual ward bed

configuration was 21-28 the figures were significant and that was an area that the Committee should focus when assessing future performance and that the provision of social care was critical to the success of the process. The ongoing work to create a GP model and of plans for GPs in A&E to triage patients was outlined. Members were informed that the greatest challenge was training and the selection to ensure the right mix of skills and ability and that the 40% shortfall of GPs in Stoke-on-Trent did not help recruitment.

A member asked when risk assessments would be carried out at the receiving hospitals in accord with the recommendations. Figures up to 3 September indicated that throughout the region there was a shortage of beds with obvious patient safety implications. A break down for the region up to that date and the implications was outlined. The comment that persons did not wish to work at Stafford for reputational reasons was challenged. It was more likely that people were leaving for the fear of job loss. Finally in the interest patient safety when would the Chairs and Chief Executives listen to the voice of the people?

Maggie Oldham responded that it was not for the MSFT to instruct or organisations to carry out risk assessments In respect of other organisations she was not privy to their assessments and it might be a matter to be referred to the UHNS.

Prof. Hugo Mascie-Taylor, Trust Special Administrator responded that in relation to patient safety that it was primarily the responsibility of the Board of the Trust. That there was already a considerable number of safety measures in place outlined in the TSA Report, additional safeguarding as the CCGs had responsibility to ensure compliance. Additionally the Development Authority and CQC had responsibility to monitor the Trust. He explained that before transfer of services the Trust would undergo inspection by an external Medical Director and Chief Nurse. In relation to capacity he advised that it was not in the gift of the Trust.

Jeff Crawshaw acknowledged that staff turnover was too high but despite this the work force had been remarkably stable given the circumstances. The trust had experienced a continued but small decrease in nursing staff. He advised of a challenge to get people in the NHS to work at Stafford Hospital. He explained that from a local perspective for junior doctors Stafford Hospital was a good place to work. In respect of recruiting reputation was a problem that could be expected to continue until the Trust became part of another organisation and staffing problems was not exclusive to Stafford but was a national problem.

A member referred to Healthwatch Staffordshire and Stoke-on-Trent and the Interim Transition Group/Advisory group commissioned by UHNS. At a recent meeting of the group it had been the decision that there was a dire need for an Impact Assessment and that one would be carried out over the next 2 months. In respect of the statements made that Stafford was not a good place to work they were unhelpful.

A member referred to the issue of complaints and expressed concern that the two principal areas were in communication and attitude, and asked if there was a correlation between agency temporary or permanent staff.

Members were advised that the principal complaints nationally were communication, attitude and the delivery of bad news. These were issues that had been recognised and were being addressed by the LEG across the wards. There was no obvious correlation between permanent, agency and permanent staff but it was important that the worth of the temporary worker should not be overlooked, without them the hospital would have ground to a halt. Temporary staff worked to the highest level but there was a reporting mechanism in place back to the agencies if necessary.

Jeff Crawshaw and outlined the key points, and advised that it was the last presentation of the MSFT leadership before the hand over to UHNS and RWT .He explained of past failings, the improvement of patient safety, the Trust was still financially unsustainable and although safe at the moment it remained fragile due to problems of recruitment and finance. Members were advised that on 1 November Cannock Hospital would transfer to RWT and Stafford Hospital to UHNS. That the TSA had prepared a detailed transition, disaggregation and that as far as possible it would be “business as usual”. The legacy, challenges and the makeup of the new management teams was explained.

A member referred to Maternity Services and asked what they would look going forward at Stafford Hospital as there was still a wish locally for a full obstetrics service. In respect of the CQC as it appeared to that the report was delayed further would be advantageous if the Committee wrote to the CQC, the delay was creating uncertainty and preventing the progress at Stafford hospital. The member referred to the detail of use of locums and agency staff at A&E and asked for information concerning their employment in other specific areas, what measures had been put in place to address the issue and had any effects been noted as a result of the measures.

Hugo Mascie-Taylor endorsed the comment of the member in relation to the delay in publication of the repot of the CQC. He was of the view that it would be out in the public domain next two or three weeks.

Jeff Crawshaw referred to the staffing issues and explained that the shortages were across the acute emergency pathways notably acute medicine and elderly care He also advised of shortages in Radiology, Pathological and Acute Surgery and explained of the difficulties in recruitment. Due largely to a national shortage resulting in fierce competition for a finite resource number, staffing implications of a safe 24/7 service was outlined to members.

In respect of the apparent lack of critical beds following a recent event when a patient had to be taken to an hospital outside of the area. A member asked how many beds were there locally.

Prof. Hugo Mascie-Taylor responded that he did not know the exact number but that the TSA had reported that there were two issues, the absolute need and distribution. He added that the UHNS were creating a number of additional beds and that transport could not be overlooked as delivery from the smaller hospitals to larger organisation made a significant difference to patient survival rates and that going forward would be challenges for t Commissioners of service.

A member asked when the local hospital boards would take responsibility or the lead in the event cross border problems. This because that there appeared to be a lack of

responsibility and it was incumbent on the board to have a mechanism to get answers for the general public.

Prof. Hugo Mascie -Taylor responded that as a public servant he shared the frustration and that the problem was that the health service was designed by politicians. In the past there had not been the will to make the fundamental changes now necessary. The focus had been on a change to the middle tiers of management but ultimately it was about the re-organisation but a change in the provision of healthcare services.

A member asked for clarification in relation to the response to an earlier question concerning delayed discharge and asked if the problem was a lack of Social Workers, Social Services or a lack of agencies able to provide care in the home setting and had the deficiencies led to patients being discharged to care or nursing homes to relieve bed blocking.

Mark Partington, Director of Transition, Chief Operating Officer acknowledged that all of the circumstances outlined were present and that recently the Community Patient Trust had struggled with capacity. He explained that the biggest single reason for delay was the when the person going home had complex needs and they were unable to put the complex plan together.

In relation to Infection Control, a member noted the figures for C.Diff and asked what had been the Trusts performance in respect of MRSA .Members were advised that all trusts had an annual trajectory for C.Diff but that in the case of MRSA there was a zero tolerance. In 2013/14 The Trust had reported two cases that related to the same patient who was particularly unwell As with all cases a root cause analysis was carried out and Public Health NHS England and the Commissioners had been satisfied with the outcome. The period April 2014 to date there had been no cases of MRSA and that it was worthy of note that the two reported cases in 2013 /14 were the first for several years.

A member referred to the issue of complaints and commented in this category that there was no means of measurement and asked how they compared with other trusts locally and nationally. Maggie Oldham advised members that there was no mechanism to capture that information, the complaints process and the definition of a serious indent was explained to the Committee.

Maggie Oldham thanked the Committee for the positive contributions and the constructive challenge. She urged the Committee to remain as a critical friend to Cannock and Stafford Hospitals and that the support given to MSFT would invaluable to RWT and UHNS. She acknowledged that it would be the start of a new era but that challenges still had to be met.

The Chair thanked Maggie Oldham and her team for the open and honest presentations t this and all previous meetings. She asked for the Committees thanks to be conveyed to all staff for their efforts through very trying times. She acknowledged that there was still a long way to go but that the Committee would remain focused to ensure the best Healthcare for the people of Staffordshire.

RESOLVED:- that the Committee note the Final Report of the Trust

Chairman

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Summary of the main agenda items from the
Healthy Staffordshire Select Committee meeting –Monday 10 November 2014

http://moderngov.staffordshire.gov.uk/ieListDocuments.aspx?CId=871&MId=5130&Ver=4

Agenda Item	Of particular interest to …
The Healthy Staffordshire Select Committee met on Monday 10 November 2014 when the agenda included the **Better Care Fund,** an update on the **Drugs and Alcohol Strategy** and the final draft of the **Emotional Wellbeing and Mental Health of Children and Young People Strategy** Members considered the items and asked questions concerning the outcomes and achievability of the Better Care Fund, in particular the financial implications and concerning the implementation of the drugs and alcohol strategy they were particularly interested in the outcomes being seen and expected within the local area. In relation to the Emotional Wellbeing and Mental Health of Children and Young People Strategy, members discussed the strategy in depth and agreed to form a **working group** to support the implementation. Members were also advised of the outcomes of the proposals for the **Minor Injuries Unit at Cannock**, which it had been agreed would move to a reduce hours service, and the provision of **Hearing Aids** by **North Staffordshire CCG**, which had not being agreed and had been referred back by the Board for further development.	All
Report of the Scrutiny and Support Manager :- Members received District and Borough Scrutiny Report updates	All

Agenda Item		Of particular interest to …
Trust updates.	None on this occasion	

Health and Wellbeing Scrutiny Committee

Briefing Note for Members

Purpose of the meeting

As you may be aware Combined Health has asked to attend the next Health and Wellbeing Overview and Scrutiny Committee meeting. Their objective in attending this meeting is to seek support for a proposal to change the Enhancement of Community Older people's Mental Health Outreach Team.

However this is an excellent opportunity for Members to scrutinise the work Combined Health are doing specifically around alcohol (prevention, education and treatment) such as the Edward Myers Unit. It also allows Members to tease out and identify any potential opportunities for further preventative work around alcohol, working in partnership with Newcastle Borough Council and other partners.

Regarding possible questions to ask Combined Health the following questions have been suggested;

- How do people get referred to Combined Health?
- How does Combined Health assist people with alcohol issues?
- What is provided as part of any aftercare provision?
- What does Combined Health do to prevent people from experiencing alcohol issues?
- How much do these services cost?
- What more is needed in the County to prevent escalation?
- How can partners contribute?

There is a clear opportunity for Members to examine what Combined Health is doing /not doing and whether lessons can be learnt around, especially, prevention and/or early intervention.

We would also like to remind the Committee about the proposal we put together several years ago on using Let's Work Together to identify alcohol related issues. This proposal was discussed with Tony Bullock from Public Health – please see the document attached for more details.

Prior to the presentation from Combined Health there will be a presentation from Trevor Smith (Community Safety Officer – Alcohol Lead) and Sarah Moore (Partnerships Manager) on what work we undertake as a partnership around preventing and dealing with alcohol related issues in the Borough, the needs of the Borough in relation to alcohol, the strategic process the partnership goes through to identify key actions around these needs, what projects are in place to prevent alcohol misuse, what the success rates, the role of the

Partnership HUB and groups such as the Responsible Bodies Group and Reducing The Strength.

There will also be a presentation from One Recovery who provides a comprehensive array of prevention and treatment services across the County will also be attending to take questions from the Committee on their services and referral processes.

Classification: NULBC **UNCLASSIFIED** Organisational

BRIEFING NOTE – ALCOHOL PROJECT

- The need to focus on alcohol as a key area of health policy relating to other issues was identified as part of the "Health Round Table" meeting on 30th January 2013

- This decision is supported by the developing Newcastle-under-Lyme Health and Well-Being Strategy which focuses on growing obesity levels as a major population trend and further identifies alcohol as a significant risk factor leading to a number of clinical symptoms and conditions

- This position is supported by the Newcastle-under-Lyme Stronger and Safer Communities Strategy, which identifies alcohol as a major factor in issues such as domestic violence and anti-social behaviour

- The overall aim – in terms of outcomes – of these strategic positions is to reduce treatment costs; ensure better mental and physical health; and – from a crime perspective – seek to reduce levels of offending and fear of crime

- Related to the local strategic position described above, there is a stated aim nationally for public health issues to be dealt with in partnership and for work to be based on issues set out in the JSNA for the area and focused on areas like alcohol as a key issue relating to health improvement. The alcohol project referred to here is a partnership-based piece of work involving the Borough/County Councils and Public Health – it would be beneficial for the CCG to be involved as well for the reasons set out below

- Statistics show that, as part of this wider concern about alcohol, around 18,000 of the 16+ population in the Borough (17.3%) of the population are classed as being involved in "increasing risk drinking", and 6,000 in "higher risk drinking" (5.9% of the population). Both these percentage figures are higher than both the West Midlands and English averages

- In addition to these figures, alcohol-related admissions in Newcastle have increased by 42% between 2008/9 and 2011/12 – a rise which is 8% greater than the national average. Newcastle has the second highest rate of alcohol-related hospital admissions in the county of Staffordshire

- A range of services are in place which seek to deal with these issues – these include brief advice and extended brief interventions; hospital liaison and inpatient detoxification

- In addition, a number of community programmes are up and running including the 'Strengthening Families' Programme and social norming activities carried out around alcohol use and misuse

- The cost of treatment are vastly more than prevention and the latest commissioning plan from the Staffordshire Alcohol and Drug Executive Board supports this. Despite an explicit desire to focus more on prevention and early intervention, these two areas make up only 3.7% of the total commissioning budget for the county in 2013/14. This compares to 96.3% spent on treatment (from a budget of £11m)

- Based on the figures set out above, it is the contention of the project commissioned on 30th January (see above) that there are a number of people in the Borough who are

engaged in increasing risk drinking and higher risk drinking but who are not presenting themselves to a GP or health professional and so are not benefiting from any of the early/brief intervention services described above. The result of this situation is that these individuals are only seen for the first time by the health service when they are admitted to hospital as an acute case (usually via A & E).

- On the basis of this position, the cost of treatment to these people is much higher than it otherwise would have been had they been picked up earlier in the course of their alcohol use/misuse

- The suggestion coming through this work is that there requires some form of early detection or identification of these individuals in order to refer them to the appropriate organisation/practitioner

- The suggested pathway for this referral process is the ongoing "Let's Work Together" project in Newcastle. LWT is a piece of work which is taking place across Staffordshire, having been piloted in Lichfield. The aim of LWT is to train home visitors and other professionals who come into contact with people in their own homes or communities to be aware of certain risk factors – it is clear that alcohol is one of these risk factors

- The training delivered to home visitors via LWT is in the form of a series of training and awareness sessions, sometimes involving forms of e-learning and the training is delivered from a range of professionals with varying organisational backgrounds

- In terms of the CCG's role, it is clear that treatment – for the moment – needs to be resourced and that any changes in funding or commissioning patterns will take some time to feed through the system. From an LWT perspective, however, support from the CCG would be a welcome step forward and would assist in implementing the emerging findings from the alcohol work.

- This support could come in a variety of ways, including funding (LWT requires constant support and needs work to continue to develop it); staff time (people will be needed to lead on training sessions focused on alcohol); information (despite some statistical information as presented here, the project is short of information at the sub-borough level, whether it be LAP based or ward based); services (do additional services need to be provided to address the issues outlined here)

- The partnership between the CCG, Public Health, SCC, Police and NBC which could be brought together under the LWT banner would be a significant development not just for Newcastle but for the whole of Staffordshire and would offer a focus on alcohol which has not been seen elsewhere

- As referred to earlier, discussions on the project have already taken place with Sally Parkin on this issue and a project team comprising Mark Bailey (NBC), Denise Vittorino (Public Health) and Mark Hewitt (Staffs CC) is already in place and has been working on this area since the initial meeting in January 2013

- The project team sees LWT as a key piece of work which can be supported by different organisations acting in partnership, as well as being delivered by them. It is a Staffordshire-wide initiative and offers the potential to assist in this area of work.

The needs of Newcastle Borough in relation to alcohol

Trevor Smith

19th November 2014

NEWCASTLE UNDER LYME BOROUGH COUNCIL

Needs

Population of 125,000

The number of jobs in the Borough has decreased by 1,000 over the last decade

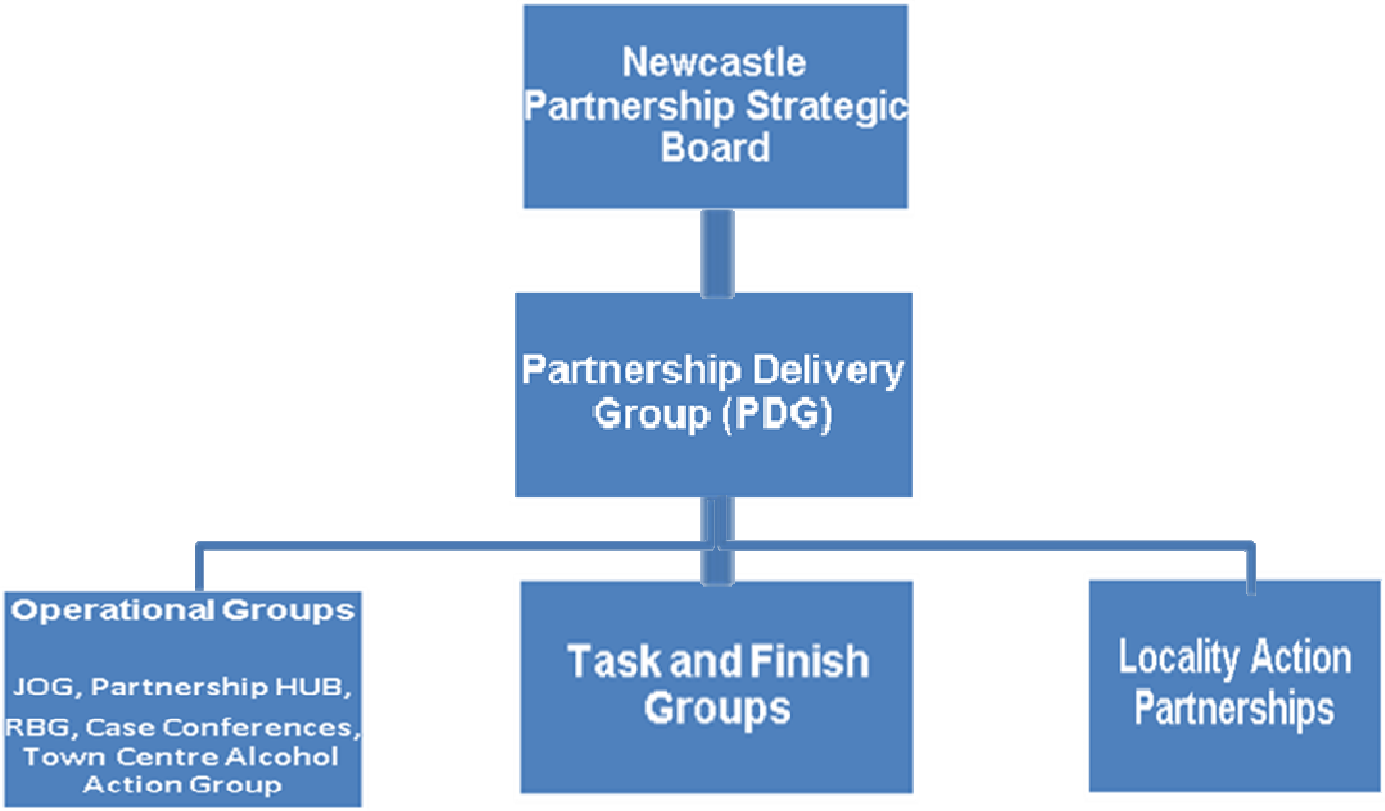
Alcohol related admissions (per 100,000 persons) to hospital in Newcastle were higher than England in 2012/13. This equates to around 3,200 admissions in Newcastle

Youth unemployment is a particular issue in a number of hotspots

The rate of crime per 1,000 residents in Newcastle Borough is higher than the County average

NEWCASTLE UNDER LYME BOROUGH COUNCIL

Partnerships



Alcohol Projects

- Purple Flag
- Reducing The Strength
- First Aid Triage & Street Chaplains
- Dependent Drinkers/Social Inclusion Case Conference
- I'll be Des
- Alcohol Education in Schools Project

NEWCASTLE UNDER LYME BOROUGH COUNCIL

Opportunities

- **Partnership Working**
- **Collaboration on alcohol and health related projects**
- **Develop the alcohol, Drugs and Mental Health agenda**

NEWCASTLE UNDER LYME BOROUGH COUNCIL

Questions?

NEWCASTLE UNDER LYME BOROUGH COUNCIL

North Staffordshire Combined Healthcare NHS Trust

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exceeding expectations

your values

Substance Misuse Services

Dr Derrett Watts, Clinical Director for the Substance Misuse Directorate,

Health and Wellbeing Scrutiny Committee Newcastle Borough Council
Wednesday, 19th November, 2014
7.00 pm

About the Service

- To answer the question ‘What does Combined Healthcare do to assist people with alcohol issues?’

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Strapline and Vision Statement for Substance Misuse Services

- **Compassionate Care,**
- **Real Recovery,**
- **Stigma Stopped**

To provide caring, trusting environments which enable service users to feel accepted and achieve their goals, and their families and carers listened to and supported.

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Focus on…..Substance Misuse – locations are expanding …. 1st July 2014

New Locations for 2014

- Stoke Heath Prison
- Stafford
- Cannock
- Tamworth
- Burton

DRR (Longton)

Range of Locations used in NORTH STAFFS for Addiction Services for CHC

Morston House, Newcastle

Edward Myers OPD & INPATIENT UNIT (inc IOU)

Cheadle Hospital

UHNS Maternity Clinic – Pregnant Drug Use

Leek Health Centre

GPs Surgeries

Client's Homes

Drunks to be kept off A&E in new 'drying out' unit

This is Staffordshire Follow

Saturday, March 24, 2012

DRUNKEN patients are being plucked from A&E and transferred to a new-style 'drying out unit' in a different hospital.

Around 30 people have been helped in the first five weeks of the initiative, being piloted for three months in North Staffordshire.

Referral routes

- To answer the question ‘How do people get referred to NSCHT’

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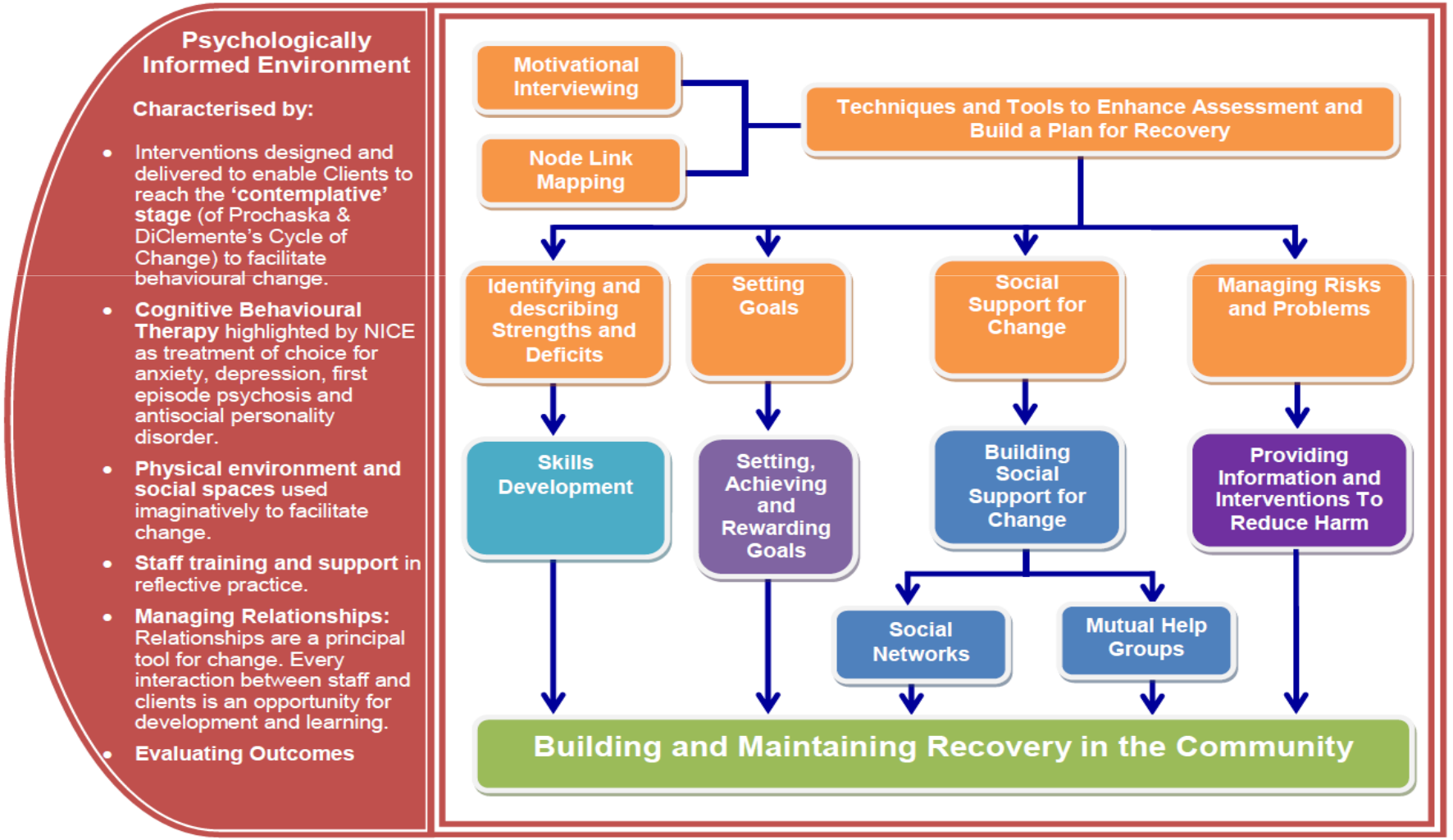
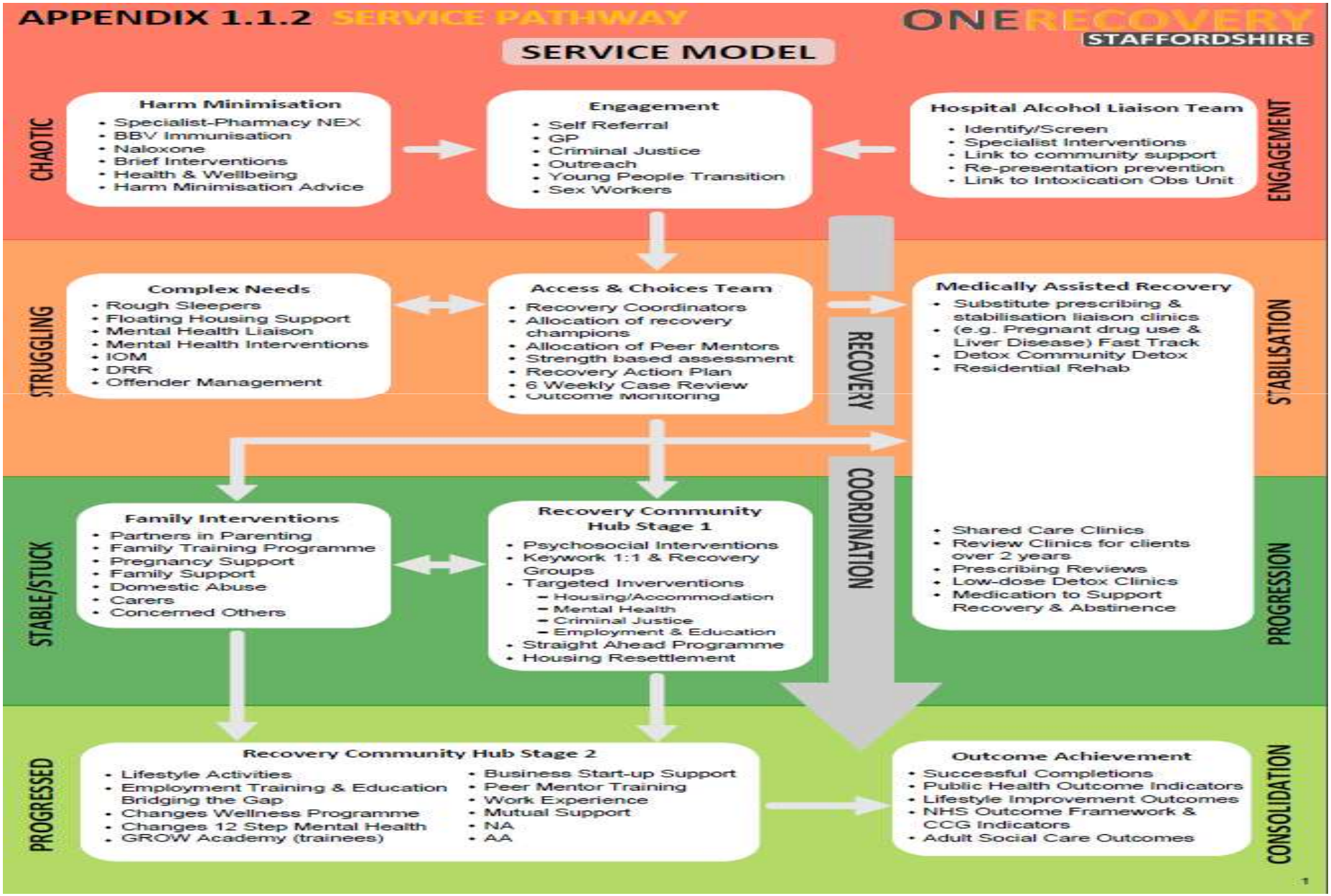
INTEGRATED SERVICES
(across health and social care):

APPENDIX 1.1.1 MODEL OF BEHAVIOUR CHANGE

ONERECOVERY STAFFORDSHIRE



Referral Route - One Recovery



Referral Route; EMU In-Patients

- Referral meeting held once a week to receive referrals from Community Services
- Separate meetings for Stoke-on-Trent and County patients
- Also one bed on the Unit is used for transfers from UHNS
- Have some referrals from Out of County

Aftercare

- To answer the question ‘What is provided as part of any aftercare provision’

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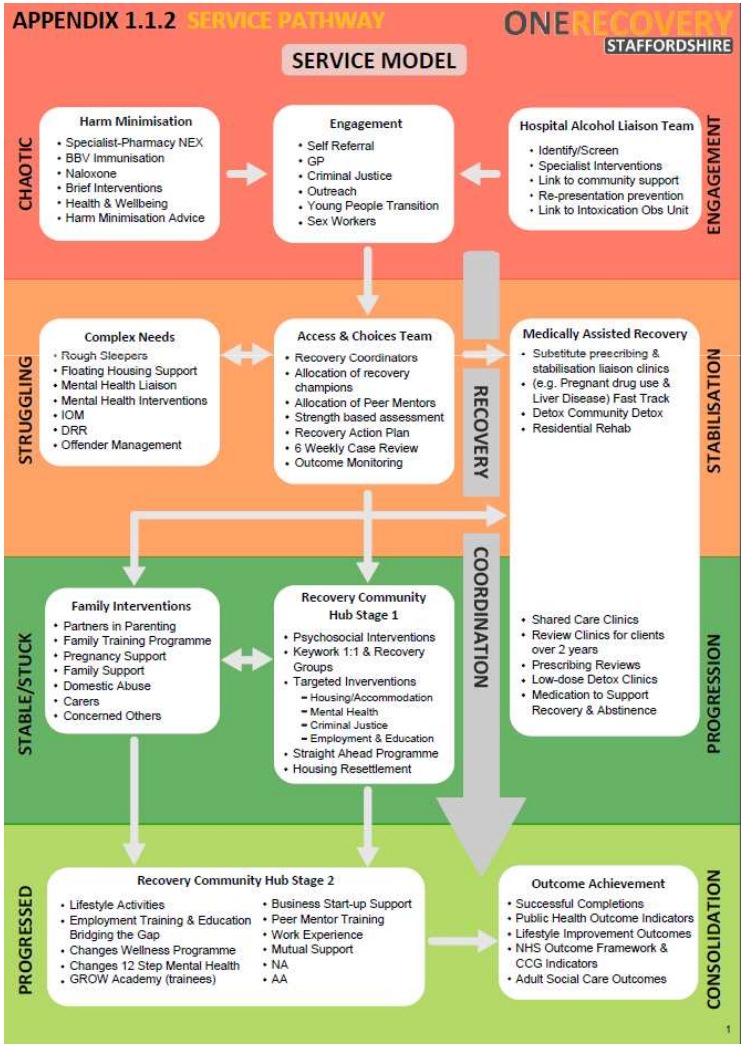
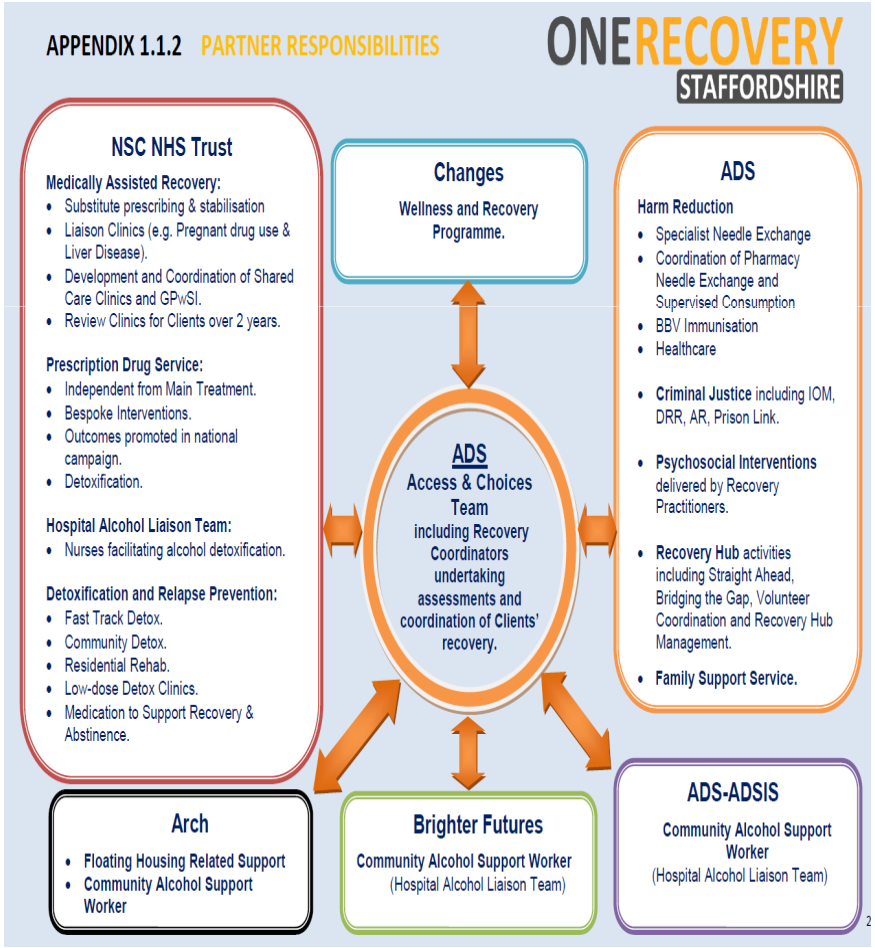
After-care Implicit to the Service Model of One Recovery Staffordshire

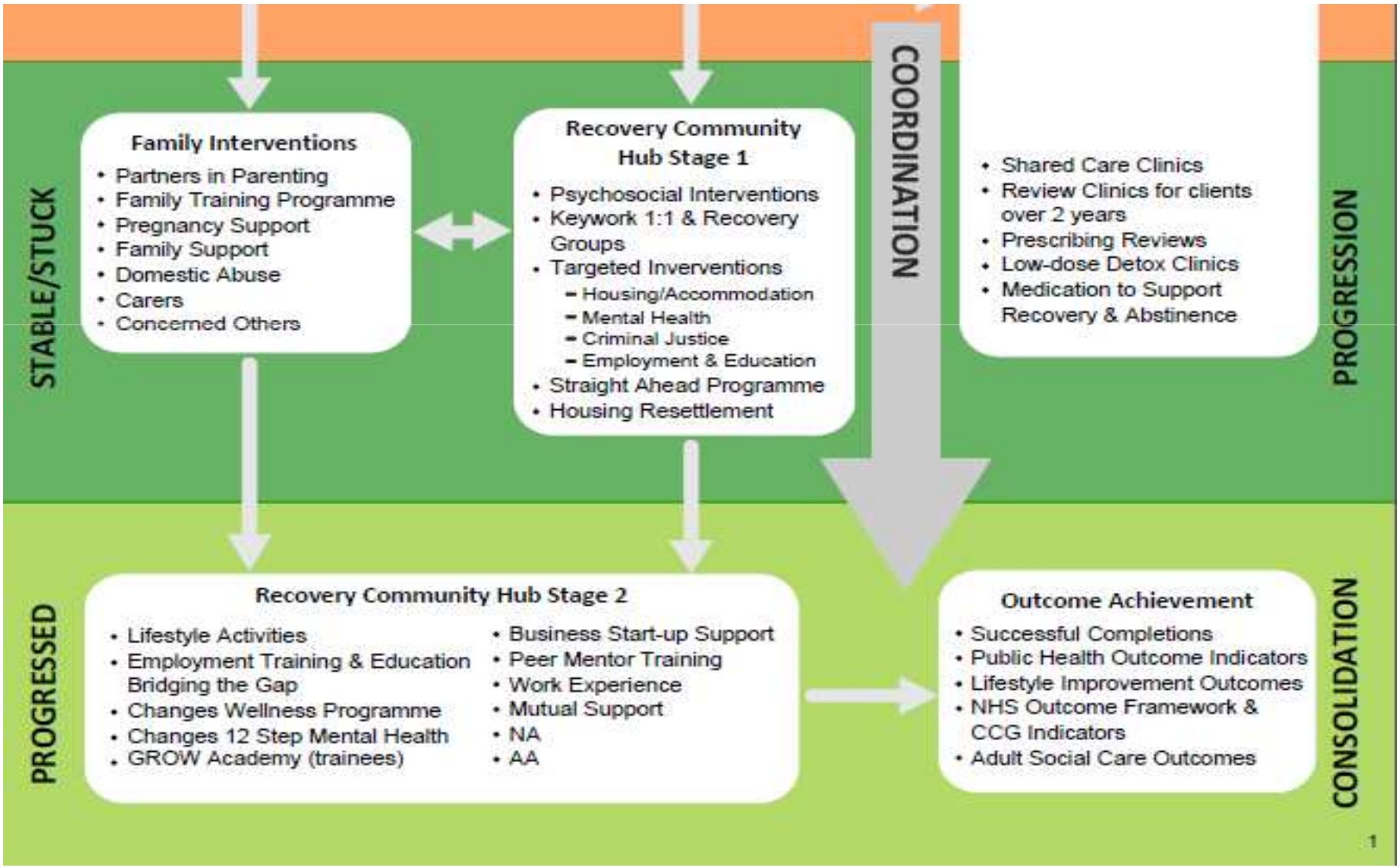
Person Centred Need Identification



Developing Integrated Partnership



After-care Implicit to the Service Model of One Recovery Staffordshire



After-care implicit to workings of EMU Inpatient Unit

North Staffordshire Combined Healthcare NHS
NHS Trust

EMU AFTER-CARE PLAN

Developing a care plan to follow admission to the Edward Myers In-Patient Unit

Dear .....,

Welcome to the Unit. This booklet is designed to help you develop plans for your continuing recovery when your stay at the Edward Myers Unit has finished. Although it may seem difficult to think about these plans straight away, you have been given this soon after coming in as we feel it is important to use as much time as we can to develop these plans with you.

You don't have to fill all of it today - the idea is that we can complete this during your stay. Some of the groups on the ward should help identify needs and know more about what help is available. There may be some differences depending on where you live but we will explain this to you.

We want this to be filled in jointly by yourself and the ward team. We hope that you will receive help from all the staff for this, but in particular from me as your named nurse. I am happy to help with reading and writing if this is needed. You can choose to keep the plan yourself or ask me to keep it for you.

I look forward to helping you in this.

Staff Nurse: ... ... **Date Given** ....

---

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Finances

- To answer the question ‘How much do these services cost?’

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Nationally Not Enough Spent!

- 2011 No Health without Mental Health, set out plans to improve people's mental health and wellbeing in England.

-> the concept of need for parity between services for physical and mental health.

- In the first instance we need to aim to have **parity between services for Substance Misuse and Mental Health.**

Finances

1. **We are primarily commissioned by Public Health as opposed to CCGs**

2. **We have just gone through tenders for Staffs (hence One Recovery) and will have similar process for Stoke**

3. **Inpatient services will shortly go to tender ..... THEREFORE DIFFICULT TO TALK ABOUT COSTINGS PUBLICLY**

Education

- To answer the question ‘What does Combined Health do to prevent people from experiencing alcohol issues’

NSCHT & Prevention

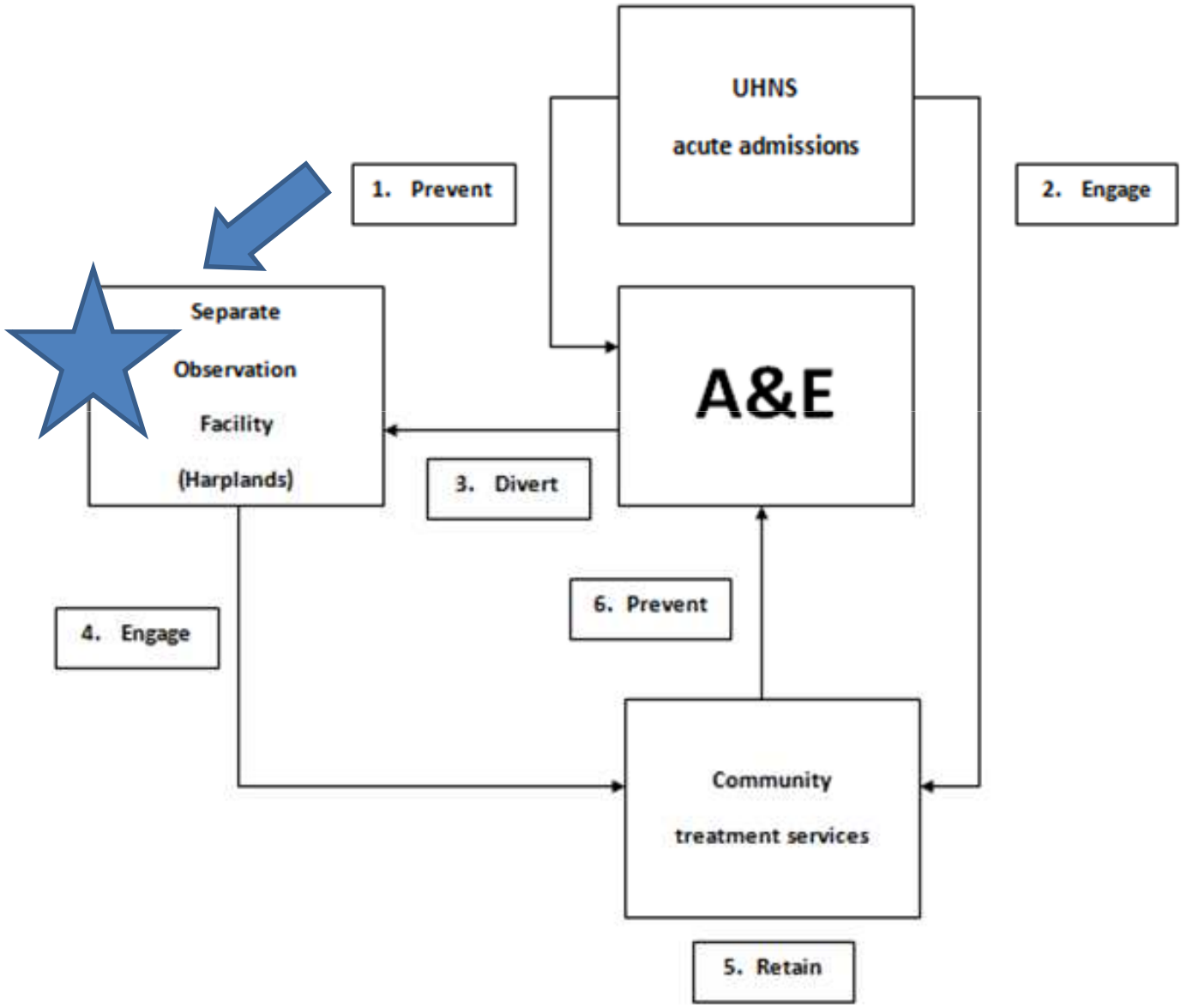
- Hospital Liaison Work/IOU

- Helps **PREVENT**;
- Short-term;
  - Attendances at A&E
  - Admissions to UHNS (& shorten length of stay)
- Medium-term;
  - Use of WMAS
- Longer-term;
  - Complications of Hepatitis

- Quality treatment;

- High quality treatment will help **PREVENT** by;
  - Facilitating travel on the recovery journey for some individuals
  - Encourage patients & staff to see Recovery as possible & desirable
  - Provide hope for families and carers

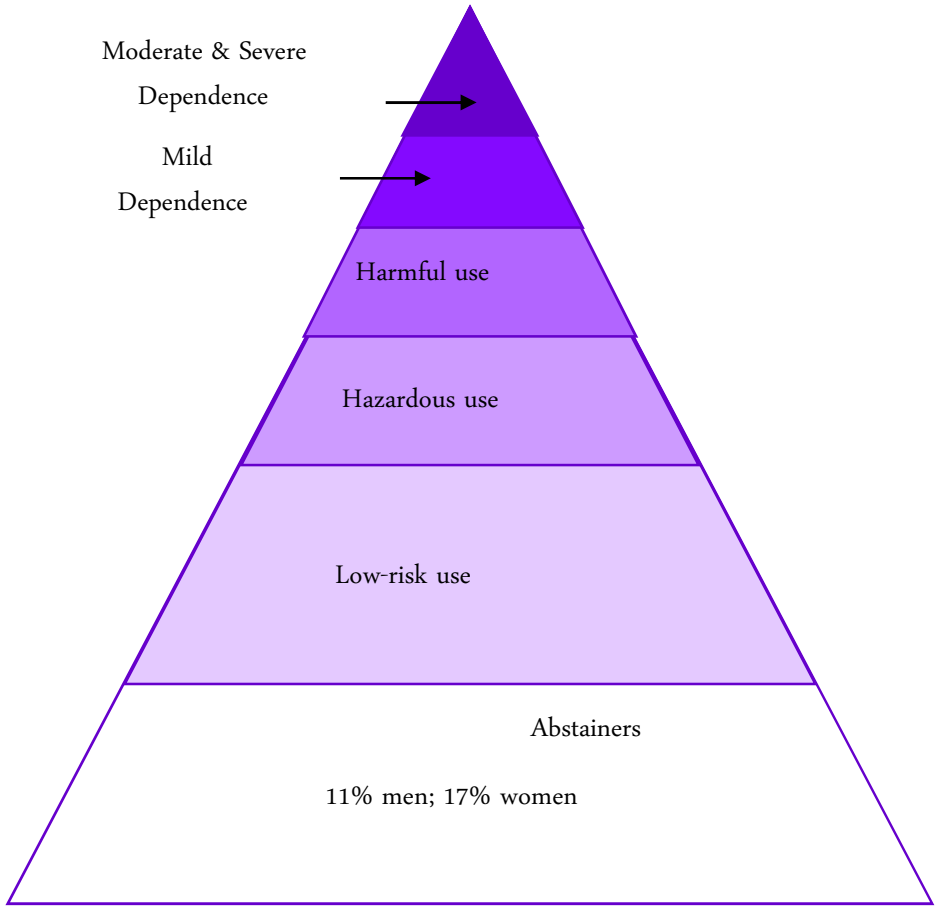
IOU Pathway – within other projects



Size of Problem Alcohol (2)

UK Alcohol Use

- AUD = Alcohol use disorder = using alcohol in either a hazardous, harmful or dependent fashion
- **33% men & 16% women with AUD = 24% overall**
- **11.5% men & 2.8% women dependent = 7.2% overall**
- **0.7% men & 0.1% women moderate or severe dependent = 0.5% overall**
- Figures from;
  - Adults Psychiatric Morbidity Survey 2007; The NHS information Centre
  - General Household Survey 2006
  - Figures are for England



AUDIT (Alcohol Use Disorders Identification Test)

This questionnaire was developed by the World Health Organisation to identify persons whose alcohol consumption has become hazardous or harmful to their health.

FOR EACH QUESTION SELECT YOUR ANSWER AND FILL IN THE SCORE GIVEN IN BRACKETS [ ] IN THE BOX

One unit of alcohol is: ½ pint average strength beer/lager OR one glass of wine OR one single measure of spirits. Note: a can of high strength beer or lager may contain 3-4 units. *(See our Ready Reckoner fact sheet for more information about units of alcohol.))*

1. How often do you have a drink containing alcohol?

[0] Never **[1]** Monthly or less **[2]** 2-4 times a month
[3] 2-3 times a week **[4]** 4 or more times a week

2. How many units of alcohol do you drink on a typical day when you are drinking?

[0] 1 or 2 **[1]** 3 or 4 **[2]** 5 or 6 **[3]** 7, 8 or 9
[4] 10 or more

3. How often do you have six or more units of alcohol on one occasion?

[0] Never **[1]** Less than monthly **[2]** Monthly
[3] Weekly **[4]** Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

[0] Never **[1]** Less than monthly **[2]** Monthly
[3] Weekly **[4]** Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

[0] Never **[1]** Less than monthly **[2]** Monthly
[3] Weekly **[4]** Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

[0] Never **[1]** Less than monthly **[2]** Monthly
[3] Weekly **[4]** Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

[0] Never **[1]** Less than monthly **[2]** Monthly
[3] Weekly **[4]** Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

[0] Never **[1]** Less than monthly **[2]** Monthly
[3] Weekly **[4]** Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

[0] No **[2]** Yes but not in the last year
[4] Yes, during the last year

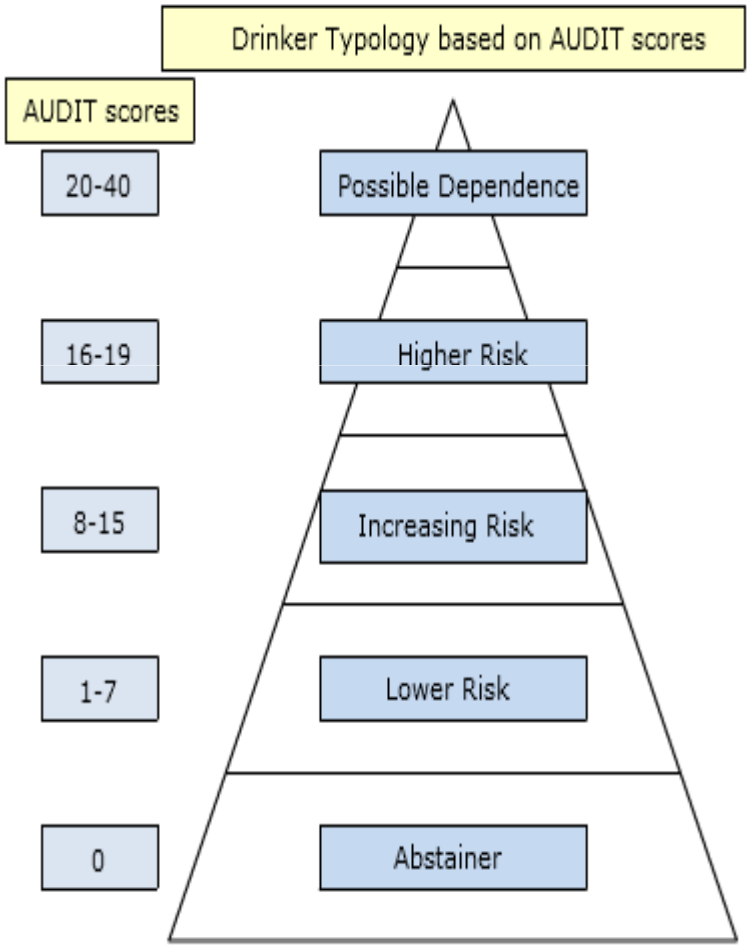
10. Has a relative or friend or doctor or another health worker been concerned about your drinking or suggested you cut down?

[0] No **[2]** Yes but not in the last year
[4] Yes, during the last year

Record total of specific items here

If total over 8, alcohol use disorder very likely

Full Audit Scores



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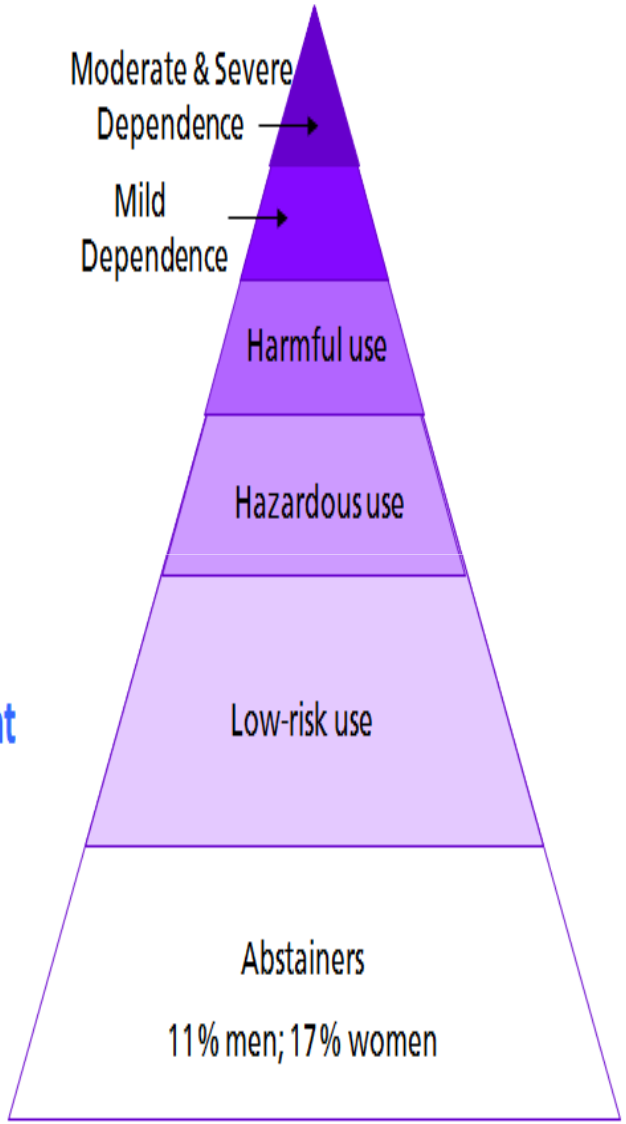

Partnership working

- To answer the questions ‘What more is needed in the County to prevent escalation’ and ‘How can partners contribute? ‘

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Enabling the Vision for Substance Misuse- PARTNERSHIP

Collaboration is Fundamental

- **Collaboration is central to the future of services and will vary according to different areas of work.**
- **Significant amounts of this are on-going and follow the principles outlined previously for integration .**
- **It enables;**
  - **unnecessary retelling of a service users journey to be avoided**
  - **maximising the therapeutic content of contact and not just assessment;**

Examples of Partnerships

- **3rd Sector; One Recovery, RAPt** (Rehabilitation of Addicted Prisoners Trust)
- **UHNS;,** "frequent attenders", IOU and transfers from UHNS
- **GPs** ; Shared Care and GPWSI roles
- **Local (and further away) Commissioners** – for increased use of inpatient facility
- **Other Service Lines within NSCHT;** "interdependencies"
- **Service Users/Carers**; New Beginnings Service User Group

GAPS / EFFICIENCIES / CHANGES TO SERVICE MODEL REQUIRED TO DELIVER SERVICES

- **Within the whole local health economy a joined-up approach;**
  - ***DOES IT MATTER WHOSE SAVINGS THEY ARE?***
  - ***NO CLOSED DOORS***

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Are we further than this?

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ADS Addiction Dependency Solutions

arch REGISTERED CHARITY

ONERECOVERY STAFFORDSHIRE

DEBBIE MOORES – SERVICE MANAGER

North Staffordshire Combined Healthcare NHS Trust

brighter futures creative support, housing and employment

Changes Health & Wellbeing

ONERECOVERY STAFFORDSHIRE

BACKGROUND

Previous commissioning model –

Multiple service providers

Mixture of statutory and voluntary agencies

Drugs an alcohol commissioned separately

Current commissioning

- Integrated drugs and alcohol service
- ADS lead provider working with North Staffordshire combined healthcare

- Sub contractors –
- Changes mental health services
- Brighter Futures housing support
- Arch housing support

ONERECOVERY STAFFORDSHIRE

Interventions

- Substitute prescribing for opiate users
- Psychosocial interventions
- Access to mutual aid
- Concerned others peer support
- Access to help with housing, education, training, volunteering opportunities
- Hospital alcohol liaison team

Specialisms

- Family worker
- Needle syringe programme co-ordinator
- Education, training and employment worker
- Outreach and engagement worker
- Volunteer co ordinator

Access and choices hubs

ONERECOVERY STAFFORDSHIRE

- Accept referrals from partner agencies
- Service users can self refer and be assessed straight away
- Refer to partner agencies
- Needle exchanges
- Alcohol reduction programmes or medical detoxification
- Help with new and emerging drugs and over the counter medicines

ONERECOVERY STAFFORDSHIRE

Recovery Hubs

Centre's of Excellence for

learning Integrating Developing Recovering

Independent Living	Healthy Cooking	IT Suites
Diversion Activities	Skills Courses	Sports
Literacy/Numeracy	Womens Groups	Volunteering

ONERECOVERY STAFFORDSHIRE

Locality need

- Work with local initiatives to meet local need
- Rough sleepers
- Work with IOM units to target offenders
- Deliver criminal justice programmes for substance misusers
- Complex needs / multiple needs

ONERECOVERY STAFFORDSHIRE

Client journey

- Achieve stability
- Set goals for the future
- Improve physical and emotional well being
- Improved social awareness / functioning
- Prepare for employment
- Help others to achieve the same

ONERECOVERY STAFFORDSHIRE

One Recovery will…..

- Provide accessible, integrated service to deal with complex needs
- Improve the health and wellbeing of our service users *and* their families
- Reduce crime associated with drugs and alcohol
- Raise aspirations of our client group
- Support, care and empower
- Be responsive to new challenges

Questions??

ONERECOVERY STAFFORDSHIRE

Find us at Units 2 and 7 Fellgate Court

Froghall, Newcastle

ST5 2AU

01782 662585 / 637545

debbie.moores@onerecovery.org.uk

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Members: Reginald Bailey, Kyle Robinson, Margaret Astle, Anthony Eagles, David Loades, Paul Northcott, Linda Hailstones, David Becket and Ken Owen

HEALTH AND WELLBEING SCRUTINY COMMITTEE WORK PLAN

Chair: Councillor Colin Eastwood
Vice Chair: Councillor Hilda Johnson

<u>Portfolio Holder(s) covering the Committee's remit</u>:
Councillor John Williams (Planning and Assets)
Councillor Tony Kearon (Safer Communities)
Councillor Trevor Hambleton (Leisure, Culture and Localism)

Work Plan correct as at: Friday 7th November 2014

Remit:
Health and Well Being Scrutiny Committee is responsible for:

- Commissioning of and provision of health care services, whether acute or preventative/early intervention affecting residents of the Borough of Newcastle-under-Lyme
- Staffordshire Health and Wellbeing Board and associated committees, sub committees and operational/commissioning groups
- North Staffordshire Clinical Commissioning Group (CCG)
- Staffordshire County Council Public Health
- University Hospital North Staffordshire (UHNS)
- Combined Healthcare and Stoke and Staffordshire NHS Partnership
- Health organisations within the Borough area such as GP surgeries
- NuLBC Health and Wellbeing Strategy and Staffordshire Health and Wellbeing Board Strategy 'Living Well in Staffordshire 2013-2018'

- Health improvement (including but not exclusively) diet, nutrition, smoking, physical activity, poverty (including poverty and licensing policy)
- Specific health issues for older people
- Alcohol and drug issues
- Formal consultations
- Local partnerships
- Matters referred direct from Staffordshire County Council
- Referring matters to Staffordshire County Council for consideration where a problem has been identified within the Borough of Newcastle-under-Lyme

Date of Meeting	Item	Reason for Undertaking
9 July 2014 (agenda dispatch 27 June 2014)	Minutes of the Health and Well Being Task and Finish Group	To provide an update of the meeting held with Healthwatch, Staffordshire on Wednesday 4 June 2014
	Representatives from Stoke-on-Trent and North Staffordshire Clinical Commissioning Groups	Presentation to be carried out by Marcus Warnes (Chief Operating Officer) North Staffordshire CCG relating to Urgent Care and Emergency Care Primary Care
	The Enter and View GP Project	To present the findings of a research study that was commissioned by Healthwatch, Staffordshire to try and understand GP service concerns around A&E and confusion as to what other services are in place
	Health and Well Being Strategy	A verbal update to be provided by the Head of Leisure and Cultural Services
	Minutes from the Healthy Staffordshire Select Committee	To receive the minutes of the meeting held on Wednesday 2 July 2014
	Report on the Francis Enquiry	To discuss the role of the local authority Health Scrutiny Committee: Lessons from the Francis Inquiry Report
	Work Plan	To discuss the work plan and potential topics that Committee members would like to scrutinise over the forthcoming year
24 September 2014 (agenda dispatch 12 September 2014)	CCG Urgent Care Strategy	Dr Andrew Bartlam, Clinical Accountable Body (North Staffordshire CCG) to be invited to attend to present the Strategy, it is to be sent for approval by the end of August 2014. Marcus Warnes to also contribute to this
	Hearing Aid Consultation	Marcus Warned from North Staffordshire CCG will be attending to discuss the Hearing Aid Consultation
	Minutes from the Healthy Staffordshire Select Committee	To receive the minutes of the meeting held on Monday 11 August 2014

Date of Meeting	Item	Reason for Undertaking
	Work Plan	To discuss the work plan and potential topics that Committee members would like to scrutinise over the forthcoming year
21 October 2014 (agenda dispatch 10.10.14)	Health and Well Being Strategy	The Head of Leisure and Cultural Services to provide an update on the implementation of the Borough's Health and Well Being Strategy
	Report on the Francis Enquiry	To discuss the role of the local authority Health Scrutiny Committee: Lessons from the Francis Inquiry Report
	Healthwatch, Staffordshire	
19 November 2014 (agenda dispatch 07.11.14)	North Staffs Combined Healthcare Trust (accountability session on 10th September 2014, Stafford)	Vice Chair to provide some questions/background
	Healthwatch, Staffordshire	Summary update to be provided by Healthwatch, Staffordshire
	Minutes from the Healthy Staffordshire Select Committee	To receive the minutes of the meeting held on Tuesday 7th October 2014
	North Staffordshire Combined Healthcare NHS Trust – Alcohol Use and Misuse	An update to be provided by the Partnerships Team (Newcastle Borough Council) on the work they undertake around preventing and dealing with alcohol related issues within the Borough
	North Staffordshire Combined Healthcare NHS Trust – Adult Acute Outreach	A briefing note to be presented by Combined Health surrounding enhancement of community older people's mental health outreach team
	One Recovery	One Recovery North Staffordshire Service Manager will carry out a presentation. This will provide an opportunity for Members to raise questions on the various services available to service users.
	Work Plan	To discuss the work plan and potential topics that Committee members would like to scrutinise over the forthcoming year
7 January 2015 (agenda dispatch 24.12.14)	Joint Code of Working	Implementation of recommendations, at a District level, to be monitored – Staffordshire County Council are revising their Code of Joint Working, which the Health Scrutiny Committee will receive in draft form for their comments

Date of Meeting	Item	Reason for Undertaking
	Portfolio Holder Question Time	An opportunity for the Committee to question the Portfolio Holder(s) on their priorities and work objectives for the next six months and an opportunity to address any issues or concerns that they may wish to raise
	Healthwatch, Staffordshire	Summary update to be provided by Healthwatch, Staffordshire
	Work Plan	To discuss the work plan and potential topics that Committee members would like to scrutinise over the forthcoming year
29 April 2015 (agenda dispatch 17.05.15)		
	Healthwatch, Staffordshire	Summary update to be provided by Healthwatch, Staffordshire
	Annual Work Plan Review	To evaluate and review the work undertaken during 2014/2015

Task and Finish Groups:	
Future Task and Finish Groups:	
Suggestions for Potential Future Items:	• Partnership Working between Newcastle Borough Council and other organisations in the area of health 'prevention' work • Issues relating to Children and Adolescent Mental Health • Supporting People Funding. To look at what implications of withdrawing this funding could cause for some organisations that are supporting vulnerable residents

DATES AND TIMES OF FUTURE MEETINGS:	Wednesday 9 July 2014, 7.00pm, Committee Room 1
	Wednesday 24 September 2014, 7.00pm, Committee Room 1
	Tuesday 21 October 2014, 7.00pm, Committee Room 1
	Wednesday 19 November 2014, 7.00pm, Committee Room 1
	Wednesday 7 January 2015, 7.00pm, Committee Room 1
	Wednesday 29 April 2015, 7.00pm, Committee Room 1

DATES AND TIMES OF CABINET MEETINGS:	Wednesday 18 June 2014, 7.00pm, Committee Room 1
	Wednesday 23 July 2014, 7.00pm, Committee Room 1
	Wednesday 10 September 2014, 7.00pm, Committee Room 1
	Wednesday 15 October 2014, 7.00pm, Committee Room 1
	Wednesday 12 November 2014, 7.00pm, Committee Room 1
	Wednesday 10 December 2014, 7.00pm, Committee Room 1
	Wednesday 14 January 2015, 7.00pm, Committee Room 1
	Wednesday 4 February 2015, 7.00pm, Committee Room 1 (BUDGET)
	Wednesday 25 March 2015, 7.00pm, Committee Room 1
	Wednesday 24 June 2015, 7.00pm, Committee Room 1

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