

Public Document Pack

Date of meeting	Wednesday, 18th November, 2015
Time	7.00 pm
Venue	Committee Room 1, Civic Offices, Merrial Street, Newcastle-under-Lyme, Staffordshire, ST5 2AG
Contact	Justine Tait

Health and Wellbeing Scrutiny Committee

AGENDA

PART 1 – OPEN AGENDA

- 1 Apologies**
- 2 DECLARATIONS OF INTEREST**
To receive declarations of interest from Members on items included on this agenda.
- 3 MINUTES OF THE PREVIOUS MEETING (Pages 3 - 8)**
To consider the minutes of the meeting held on Wednesday 30th September 2015
- 4 Minutes from the Healthy Staffordshire Select Committee (Pages 9 - 28)**
- 5 HEALTHWATCH, STAFFORDSHIRE**
Healthwatch, Staffordshire Engagement Manager will be in attendance. Update to follow
- 6 DEMENTIA SERVICES WITHIN NEWCASTLE-UNDER-LYME (Pages 29 - 38)**
In attendance will be the Commissioning Manager for Dementia, District Commissioning Lead for Newcastle and the Commissioning Manager for North Staffordshire Clinical Commissioning Group
- 7 BETTER CARE FUND (Pages 39 - 44)**
In attendance will be the Head of Housing and Regeneration Services to present the report
- 8 PORTFOLIO HOLDER QUESTION TIME (Pages 45 - 72)**
Portfolio Holder for Leisure, Culture and Localism will be in attendance.

The Head of Leisure and Cultural Services will carry out two presentations; Physical Activity for Older People followed by Physical Activity in Deprived Communities.
- 9 PUBLIC QUESTION TIME**

Any member of the public wishing to submit a question must serve two clear days' notice, in writing, of any such question to the Borough Council.

10 URGENT BUSINESS

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

11 WORK PLAN

(Pages 73 - 78)

To discuss and update the work plan to reflect current scrutiny topics

12 DATE AND TIME OF NEXT MEETING

Wednesday 6th January 2016, 7.00pm in Committee Room 1

Members: Councillors Allport, Bailey, Eastwood (Chair), Frankish, Hailstones, Johnson (Vice-Chair), Loades, Northcott, Wilkes, Winfield and Woolley

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.

FIELD_TITLE

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

HEALTH AND WELLBEING SCRUTINY COMMITTEE

Wednesday, 30th September, 2015

Present:- Councillor Colin Eastwood – in the Chair

Councillors Allport, Bailey, Frankish, Hailstones, Loades, Northcott, Wilkes and Woolley

1. **APOLOGIES**

Apologies were received from Councillors Mrs Johnson and Mrs Winfield.

2. **DECLARATIONS OF INTEREST**

Councillor Mrs Hailstones declared an interest as she is employed by Staffordshire and Stoke-on-Trent Partnership NHS Trust as a district nurse.

Councillor Loades declared an interest on item 5, Healthwatch.

3. **MINUTES OF PREVIOUS MEETINGS HELD ON THE 8TH JULY 2015 AND THE 27TH JULY 2015**

Resolved:

That the minutes of the meetings held on Wednesday 8th July 2015 and Monday 27th July 2015 was agreed as a correct record.

4. **MINUTES OF THE HEALTHY STAFFORDSHIRE SELECT COMMITTEES HELD ON THE 5TH AUGUST 2015 AND 10TH AUGUST 2015**

Resolved:-

Committee received the summary of the Healthy Staffordshire Select Committee meetings held on the 5th August 2015 and the 10th August 2015.

5. **NORTH STAFFORDSHIRE CLINICAL COMMISSIONING GROUP - A NEW MODEL OF CARE IN NORTHERN STAFFORDSHIRE**

The Chair welcomed the Interim Accountable Officer from North Staffordshire Clinical Commissioning Group and the Clinical Lead from Stoke-on-Trent Clinical Commissioning Group to the meeting.

The name “New Model of Care” had been changed to “My Care My Way – Home First”. A Member raised concern over the renaming, as those who worked within the NHS still recognised it as Step Up and Step Down and asked how was the CCG going to roll it out to individual people?

The Interim Accountable Officer advised the title “Step Up Step Down” was a nationally accepted term. The Step Down model of care, saw the patient’s journey from the point of admission to discharge, supporting less transfers of care between

multiple organisations which would result in a reduction in delays. As part of the wider system reconfiguration the model Step Up was developed, which saw a diagnostic and assessment centre introduced within the community and a continued increase in easily accessible home based services within the community, improving the quality of care for all patients.

The stakeholder group working with the CCGs suggested My Care My Way – Home First, as it was felt that this name better described the service in northern Staffordshire, giving it a unique identity rather than the generic term Step Up Step Down.

The following questions were raised by Members and response provided:-

- Q1: What was the cost to the CCG of implementing this service?
A1: CCGs pay for a Spell (the length of time in days from admission date to discharge date) and HRG (a means of aggregating health data into groups of interventions that are of a similar cost and of a similar nature and complexity). When patients are discharged within the trim point (Spell) they often move into a community service and a similar payment is made to the community trust, this is known as a complex discharge. In effect, the CCG pays twice for each complex discharge. My Care My Way will save money as more people will be discharged home rather than into another service.
- Q2: What would be the savings and were there plans to reinvest into the community care?
A2: There would be a saving of c£15m for the full year. This was a combination of savings of patients returning home rather than into a community bed and admissions avoided.
- Q3: This would affect a vast amount of people, had there been sufficient communication with the patients?
A3: All patients and their families are routinely communicated with regarding their ongoing care. Specific communications about My Care My Way have been issued via the CCGs' websites, briefings, public meetings and public facing documents and advice leaflets.
- Q4: What impact had there been on the staff?
A4: Redeployment and retraining of staff was being considered. There had been an increase of 30% more staff.
- Q5: The consultation document advises that 37 beds at Longton would be lost. Are we going to be looking at more closure of beds in the community hospitals?
A5: As a commissioner the CCG buys services. The CCGs do not own or operate the community hospitals, SSOTP does, My Care My Way will see more people receive their care at home rather than in a community bed. As such, the use of the community beds will be reviewed, as will the role of the five community hospitals.
- Q6: North Staffordshire had invested £190,000 into the dementia service. How had the funds been allocated?
A6: The funding had been invested into memory clinics. As a consequence of My Care My Way a range of commissioned services had received additional investment over the last two and a half years.

- Q7: The carer would be their partner and it is important they receive adequate support.
- A7: General Practitioners were trying to diagnose dementia in its early stages and were now diagnosing more patients than was the case a few years ago.
- Q8: Patients remain on medication longer than they should.
- A8: This was being investigated to perceive if patients still required the drugs. Patients were regularly reviewed to ensure they still required their medicines or if they need changing.
- Q9: How do you envisage improving access to psychology services? How many staff was qualified and was those posts met?
- A9: The North Staffs IAPT service is performing well and achieving national standards. Across all community services, we are confident that the staff was in place to deliver My Care My Way. We are also confident that there was the appropriate balance between qualified and non-qualified staff to deliver safe patient care.
- Q10: How many qualified staff was there in district nursing?
- A10: The CCG agreed to supply the number of qualified staff following the meeting.

Resolved:-

- (a) Interim Accountable Officer to provide Committee with the number of qualified staff investing in district nursing.

6. SWIMMING IN THE NATIONAL CURRICULUM FOR KEY STAGE 2 PRIMARY SCHOOLS

The Chair welcomed suggestions on how the Committee could progress the analysis of how many Key Stage 2 school children can swim 25 metres within the Borough and why are not all the schools in the borough delivering a swimming programme.

Resolved:-

- (a) As a Committee, to engage with all primary schools.
- (b) To request from Entrust the number and names of schools who have/have not signed up to a swimming programme.

7. HEALTHWATCH, STAFFORDSHIRE

The Committee received the July and August updates.

Resolved:-

That Healthwatch provide specific information regarding the following areas:-

Residential Care

How many visits are being carried out in Newcastle and Staffs Moorlands.

Disabled People Accessing Services and Continuous Care

- Disabled people are having difficulty in accessing health care services and difficulty in waiting times.
- Disabled people arriving for appointments and being turned away because they live on boundaries of the ward that the funding coding has changed and then being told to report back to their GP. In some cases there had been no warning via letter or telephone.
- People accessing mental health care services, child and adolescent.

8. EXCLUSION RESOLUTION

9. WORK PLAN

Resolved:-

That the following items be added to the work plan:-

Wednesday 18th November 2015

Better Care Fund

The Head of Housing and Regeneration Services be invited to present the future direction of the Better Care Fund process. What role should districts/boroughs play?, What should the Council be offering in relation to the wider health and wellbeing agenda, particularly in terms of the services it delivers? Has the Partnership focussed on the 'right' areas in terms of needs, priorities and outcomes?

Dementia Services within Newcastle-under-Lyme

The Commissioning Manager, Dementia and District Commissioning Lead for Newcastle be invited to present a report covering:-

- What is dementia?
- What causes dementia and how can it be prevented?
- What is the dementia pathway in North Staffordshire from memory services to end of life?
- Work that was happening in health and social care

Wednesday 6th January 2016

Swimming as part of the National Curriculum for Key Stage 2 Children

A report to be presented into the findings carried out by Committee.

The Midway Walk In Centre

A review to be presented by Officer(s) from North Staffordshire and Stoke on Trent Clinical Commissioning Groups on the outcome of a programme of work and the level of patient engagement undertaken to establish a suitable service.

10. PUBLIC QUESTION TIME

No questions had been received from the public.

11. URGENT BUSINESS

There was no urgent business.

12. DATE AND TIME OF NEXT MEETING

Wednesday 18th November 2015, 7.00pm in Committee Room 1.

COUNCILLOR COLIN EASTWOOD
Chair

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Minutes of the Healthy Staffordshire Select Committee Meeting held on 21 September 2015

Present: Kath Perry (Chairman)

Attendance

Michael Greatorex (Vice-Chairman)	David Smith
Charlotte Atkins	Conor Wileman
Chris Cooke	Ann Edgeller
Philip Jones	Brian Gamble
Ian Lawson	Barbara Hughes
David Loades	Janet Johnson
Shelagh McKiernan	David Leytham
Christine Mitchell	Stephen Smith
Trish Rowlands	

PART ONE

103. Apologies

Apologies were received from Councillors Colin Eastwood, Andrew James and Dianne Todd.

104. Declarations of Interest

There were none received.

105. Minutes of the last meetings

Resolved: That the minutes of the meetings held on the 5 August 2015 and the 10 August 2015 be signed by the Chair.

106. Minor Injuries Unit at Sir Robert Peel Hospital, Tamworth and Samuel Johnson Hospital, Lichfield

Andrew Donald, Accountable Officer South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group (CCG) introduced Dr James Ward, Locality Clinical Director and Ruth Paulin, Head of Strategic Projects, South East Staffordshire and Seisdon Peninsula CCG.

Dr Ward reminded the Committee that the NHS was in the middle of a ten year programme of unprecedented financial challenge, at a time where patients were getting older, there was population growth both locally and nationally and medical care was becoming increasingly complex and expensive. Health service inflation ran above the normal rate of inflation and health service spend had been increased by just over

inflation for the last five years. The majority of savings over the last five years had been achieved by controlling staff pay and staff costs but something different was required and the rate and scale of change would be significant. The CCG had a statutory duty to make a balanced budget but had a £16 million overspend last year. There was a recovery plan to address this but over £6.5 million of savings had to be delivered this financial year which equated to approximately three percent of the CCG's budget, with NHS productivity running at about one and half percent. The massive scale of change was emphasised and that inefficient care needed to be eliminated. The prescribing budget in the area was around £20 million per year and the running costs of the two Minor Injuries around £2.5 million per year. Minor Injuries Unit attendance cost on average around £58 which was similar to an Accident and Emergency Department attendance.

The CCGs proposals were around the urgent care system with the principle objective being to encourage more self-care. Dr James highlighted that there was a need to help people with urgent care needs to get the right advice, in the right place, first time. Unfortunately this did not always happen. There was a need to provide highly responsive urgent care services outside of hospital so people no longer chose to queue in A&E and that those with more serious or life threatening emergency needs received treatment in centres with the right facilities and with the expertise to maximise chances of survival and a good recovery. The urgent care system was complex and there was a long list of providers of urgent medical and social care, with overlap of provision. Practice members and patients had been consulted on the proposals and support had been received from all the GP practices in Burntwood, Lichfield and Tamworth. The proposals had also been discussed with the Patient Council. There had been wider engagement with patients regarding the issues that they thought were important for the CCG to focus on. Key patient messages included good communication which had been the number one priority as patients felt isolated and frustrated as they had moved between services. Patients had wanted better co-ordination of care and to look after themselves. Patients who understood their condition did much better than those patients who did not. Patients disapproved of waste in public services particularly when they could see the pressure on frontline staff.

It was explained that the Choose Well Campaign was trying to help people identify where to go when they needed help. The NHS 111 service was intended to prevent people attending an A&E department inappropriately and use much better and more efficient services. NHS 111 was a triage service to help signpost people to the most appropriate care. The main activity at Minor Injuries Units took place during the day and reduced significantly after 9pm. The x-ray facility was not available consistently and was restricted to office hours at the Lichfield and Tamworth sites which limited the number of people that could be treated first time at the Units. In addition the Units did not have access to the diagnostics that would be considered standard in a modern practice, for example there was no way blood test results could be fed back quickly. Detailed analysis of patients who presented at the Minor Injuries Units had showed that over half of patients presented when there was no x-ray facility available. Fifty percent of attendances did not require any diagnostic investigation or treatment and patients were seen by a nurse, had a wound dressing and had not required any follow up care. Sixty percent of attendances were suitable for General Practice and primary care, for example, wound dressings or minor illness, nineteen percent of attendance were for follow up treatment and twenty five percent of people seen at night had moved onto an

alternative service provider which meant that there was double the expenditure and the patient did not get the appropriate treatment immediately.

The CCG was proposing that the Units opening hours should change to 8am – 9pm. The proposals had been based on a strategy which diverted the patient and encouraged them to seek help before attending. The out of hours service had been delivered on the same site as the Minor Injuries Units. The main justification was that the proposed changes would reduce waste. On average nurses had been seeing one patient every two hours at the sites which was not efficient care. The proposal was clinically sound, there were low volumes of patients and the proposals would not put people at risk. The proposal would not affect outcomes for patients with more serious conditions.

The public consultation would start over the next four weeks and Members comments were invited. The case for change would be presented to all scrutiny bodies and decision would be made on how the CCG should proceed.

A Member sought a copy of the consultation material and queried why the Committee had not had sight of it before the meeting. Ruth Paulin confirmed that the consultation had begun that day and the information would be available on the CCG's website and a copy provided to Members after the meeting. Approval was sought for a four week consultation. It was commented that the case for change document had been previously shared with the Committee in confidence and a document that had been devised with the Patient Council would now be much more widely available. On further questioning Ruth Paulin confirmed that the document included a description of the available services, including the GP out of hours service, community hospitals and other services and at the end of the consultation process, if it was decided to make changes, the CCG would be actively promoting any changes made and publicising the alternatives.

Andrew Donald referred to the work required to make sure that people knew about the alternatives to the Minor Injuries Units. In relation to GPs there was work to be undertaken to consider what needed to be done differently. It was acknowledged that access to GPs was one issue that was often raised. Getting a GP appointment could be difficult. Changes to the Minor Injuries Unit in Cannock had resulted in one thousand more GP appointments being made available in the area. The CCG was working with GPs to consider how they could manage extra demand, for example wound dressings, so that they could do this work.

A Member commented that the need for change was obvious but it was important that the primary care service was in place and understood before any changes were made. Andrew Donald acknowledged that this was important and that this would be part of the work being undertaken.

Dr Ward referred to wound dressing clinics that had been set up by the community provider and that all GP practices were aware that they would need to take referrals from Minor Injuries Units. GPs from Tamworth and Lichfield attended the Units to review patients and close working arrangements were already in place. Absorbing the five or six patients per night that used the Sir Robert Peel Minor Injuries Unit would not be too difficult but the CCG did not want to be complacent about this.

It was queried why the consultation period would be for only four weeks as it would be significant change to local service delivery. Andrew Donald referred to the verbal advice received by the Scrutiny and Support Manager. The changes proposed were significantly less than the proposals relating to the Cannock Minor Injuries.

It was queried how the CCG would be engaging with patients and patient groups when there had been no questions circulated to the Committee and how patients and primary care services would know about the alternatives on offer.

Ruth Paulin explained that if, at the end of the consultation period, a decision was made to change provision, there would be an implementation phase separate to the proposed four week consultation period which would be focussed on educating patients on any changes to be made. For the consultation phase there were a number of public events planned in the localities, an online survey and a questionnaire to be distributed. Some engagement work had already taken place with District Councillors and patient groups. If the requirement was to extend the consultation then this would be undertaken. There would be a significant period of engagement subsequent to the decision as well as during the consultation. A number of events would be publicised.

Andrew Donald emphasised that significant pre-consultation had been undertaken. There had been a series of events entitled 'Lets talk about health' which had asked about general CCG challenges. There had been work in the Districts and the Patient Council.

Concerns were raised by Members that the outcome of the consultation had already been decided as the implementation period indicated the outcome was known.

Andrew Donald explained that as part of the consultation process community groups would be used to access patients. Two local MPs had been informed about the developments and Burton Hospitals would be used to gather information from patient groups that used the services. The numbers who used the services were very small. It was important to share the alternatives. The pre-consultation period had resulted in questions about what alternatives were available at night if the Minor Injuries Unit was not available and a list has been put together. A report would be put together for the Governing Body which would include all the information gathered for the Body to make a final decision on whether it supported the proposals for the reduction of opening hours overnight. The CCG reached into groups and connected with others which was a model for other CCGs. Andrew Donald had confidence that information had already been gathered from the public and further information was being collated. He stated that it was important to manage the resources the CCG had whilst also retaining clinical services. This was the least worst option in trying to manage a minus £17.994 million budget. It was one of the ways of making the most of the money that the CCG had and to bring the budget back into balance. MPs had questioned the proposals and made alternative suggestions.

It was commented by a Member that the CCG was running a business and queried why the Committee was only now being asked about closing a service that people had not used between 9pm and the early hours of the morning. The average cost per visit at night when people were not attending was highlighted. Concerns were raised that if people were to access services elsewhere the cost would move to another budget. It

was suggested that as there was another major service locally, provision could come together and operate more efficiently. It was commented that the questionnaire on the proposals should ask about the service rather than people's personal details.

Andrew Donald explained that healthcare costs had increased by four percent each year and that the NHS budget had not kept up with this. The NHS was keeping more people alive for longer but not healthier for longer. Infrastructure issues had not been addressed previously. Difficult decisions now had to be made. When services were taken away, members of the public were disappointed, but best patient care had to be provided within the resources available. In relation to integration four things could be done to manage the NHS better. These included stopping doing things which were controversial, substituting one thing for another which was better clinically, running faster to save money which was not sustainable going forward and integrating services. Many services and organisations operated in silos and did not connect together. The challenge for commissioners was to get services more connected and get organisations to work across boundaries for the benefit of patients, centred on patient's needs.

Ruth Paulin referred to the questionnaire. She explained that it was very simple, was one element of the consultation plan and had just four questions. The language had to be patient facing and it had been developed with the Patient Council. It would provide the information required but was not intrusive. It was confirmed that the questionnaire would be available following the meeting subject to the agreement of the Committee.

Members queried the impact on A&E services. It was commented by a Member that the number of Cannock Chase GP appointments had been increased temporarily until March but to her knowledge this was not a permanent arrangement.

Dr Ward explained that work was required with local providers to ensure that there was not a significant impact, however he reiterated that numbers of patients were low and one in four were already been diverted to an alternative service. The NHS share of spend for Primary Care services had reduced year on year and was now below six and half percent, a reduction from approximately ten percent five years ago. NHS England co-ordinated primary care services. There was a lot of work to be done to integrate services locally. The number of practices in Lichfield had reduced from eleven to eight and numbers could continue to decline. This created options for dealing with urgent care more effectively in the future. Each GP Practice received lots of calls for patients between 8am and 8:30am and if this was centralised for example, with a more direct booking service, there would be better outcomes for patients. The proposal put forward was a small part of the urgent care strategy. There was no variation between the number of patients attending the Minor Injuries Units during weekdays and the weekend which suggested there was a cohort of patients that were just using the Minor Injuries Units rather than GPs which was not necessarily a good thing as they would be receiving nurse appointments rather than GP appointments and could have missed out on health promotion and screening programmes offered by the GP.

Ruth Paulin referred to the more radical options considered by the CCG. The numbers of patients attending at night was very low and if a person needed to see a doctor the out of hours patient service was located at both of the hospitals where the Minor Injuries Units were based. If a person rang the out of hours service they would still be able to see a doctor at either of those hospitals if required.

Andrew Donald referred to the importance of doing more work in primary care to avoid people going elsewhere and to ensure that more money could support prevention. GPs could do more with populations that needed it, for example the elderly may require more than a ten minute appointment. The issue was how GPs in Tamworth and Lichfield could work differently together to create the space and time to do what Cannock GPs were doing in keeping people away from hospital. It was important to discuss how GP services could be provided in the future. An options appraisal had been requested to consider how the two hospitals could be used most effectively in the future. This was to ensure a proper debate about how the facilities could be used rather than just stopping or increasing parts of the service.

It was queried by a Member if centres of excellence would lead to fewer units.

It was clarified by Andrew Donald that it could not be presumed that if one CCG took a decision others would follow, however there was a national strategy around urgent care and a document produced by Sir Bruce Keogh suggested that there should be specialist hospitals, a next level down to A&E and primary care urgent care which linked back to general practice. Nationally there was a wide range of services as every time the NHS had had a problem in the past another access point was opened. This had created confusion over where patients should go. Services needed to be streamlined. This could be the start of this process but there was more work to be undertaken.

It was reported by a Committee Member that Tamworth Borough Health Scrutiny Committee had received a presentation on the matter. The issues concerning the Tamworth Committee had been raised by the Healthy Staffordshire Select Committee also. The Chairman of the Tamworth Committee was not at the meeting but it was reported that the Tamworth Committee would be calling a special meeting to consider its formal response to the consultation. Concern had been expressed by Tamworth Members about communication and the suggestion of an options appraisal was welcomed by the Member in attendance. In terms of Members understanding of the position, it was remarked that there had been no indication of the savings that could be made if the decision was taken. Members had also queried if other services would go from the community hospitals and raised concerns about the long term future of the hospitals. It was commented that the outcome from the engagement with the Patient Council had not been shared and more information was requested regarding the engagement events and the documentation in support of the proposals.

Andrew Donald referred to the savings that could be made and explained that the CCG paid for Minor Injuries Unit attendances so the logic was that if patients did not go to the Units, savings would be made, however there was no guarantee that patients would not go to Units elsewhere. Burton Hospitals NHS Foundation Trust which ran the Units would potentially make savings to their infrastructure costs if the changes were agreed. Discussions with the Trust to date indicated that the CCG would also get some benefit. The amount of benefit overall was however very small. The big issue was about changing provision when provision was already available. Information from the Patient Council would be shared with the Committee. Nine events called 'Let's talk about patient health', had been held and had discussed the challenges that the CCG faced and the types of changes that had to be made in the future. Representatives of the public, voluntary agencies and statutory agencies had been involved. The events going forward

would be focussed solely on the consultation. The CCG needed to be credible in the information that it shared. Even if the CCG did not make savings and Burton NHS Foundation Trust did, then this would be a saving to the health economy and the system needed to work as a whole rather than in individual parts.

Ruth Paulin added that the AGM would take place on the 29 September and drop in events would take place across Lichfield and Tamworth. At the end of the period of consultation all information would be collated and presented to the Select Committee and the Governing Body. The Committee would have the opportunity to say whether the consultation has been adequate.

A Member suggested more engagement was required. Concerns were raised that some people would still need to be seen during the night locally and that they would end up seeing a doctor which would cost more money than if they had seen a nurse or health visitor.

Andrew Donald explained that an out of hours and 111 contract was already in place so there would be no extra cost as these services would undertake the work they are required to do. The hospital would remain open and the out of hours service should cover the individual patients.

Dr Ward explained that it could be counter productive to go to Minor Injuries Units when quick triage was required and appropriate care could be assessed quickly through consulting with 111 or using the out of hours doctor service.

Andrew Donald confirmed that the contract for the out of hours service meant that no matter how many patients were seen the price would remain the same. The CCG was going to use the existing services available and there had to be education on what was available and what to do.

A Member referred to the need for Tamworth residents to travel to hospitals outside of the area and use of the Minor Injuries Unit. It was commented that the frontline was being cut and reducing the footfall to the local hospitals would make the hospitals not viable and people had concerns they would therefore be shut down. It was queried if GPs and hospital A&Es would receive payment for the additional patients seen who would have previously gone to a Minor Injuries Units.

Andrew Donald referred to the different views on Community Hospitals and suggested that what was required was a proper options appraisal, with Burton Hospitals NHS Foundation Trust on what should be done with the hospitals, subject to a discussion across the GP membership and the Governing Body about where the hospitals were going in the future. This was about streamlining the system. It reflected the national picture where there were multiple services and a lack of clarity on what was available. When the County Hospital A&E closed, people self-managed and did not access services elsewhere. People made intelligent decisions about how they used services if they have the right information. If there were appropriate care plans in place for children for example, it was not the case that they would need to be admitted overnight to hospital. GPs had general medical services contracts, within this they must see patients and patient slots had to be used and maximised. GPs would be asked to do work not within the contract and this has to be funded from elsewhere but this would be a very

small amount. Six patients was not a large amount of additional people to be seen by GPs. There could not be duplication of services as this wasted money.

A Member made reference to the small change that the proposals would bring considering the scale of the changes required and asked if budgets were just been moved about. It was queried if in five years' time small cuts would still be brought to the Committee for consideration.

Andrew Donald explained that in 2010 the new Government implemented the Health and Social Care Act. CCGs in Staffordshire had been in place since 2013 and now had significant deficits. It was the job of CCGs and GPs to make changes to reduce costs and maintain sustainability. The system was consuming too much of the things that were not required and this had to be stopped. Although the proposal was a small change it was very symbolic as the public needed to understand that the CCG was trying to make best use of the resources that it had. Money could not be spent on duplicating services where there was no money. South East Staffordshire and Seisdon CCG needed to achieve a minus £18 million deficit. This deficit was not sustainable in the long term. Clinicians had to explain why they were making changes to the things that people valued. South East Staffordshire and Seisdon CCG was a level one CCG and therefore did not have a primary care budget but it was working with GPs to achieve co-commissioning which would give access to the primary care budget to make changes.

RESOLVED:

- That a copy of the consultation document be shared with the Committee.
- That details of the feedback from patient groups and the Patient Council be shared with the Committee
- That the Committee recommend a 6 week consultation period be adopted.
- That the Committee further consider the matter once the consultation concludes.

107. Hearing aid commissioning policy for the South Staffordshire Clinical Commissioning Groups

Andrew Donald, in his capacity as Chief Officer, Stafford and Surround CCG, introduced Dr. Marianne Holmes, Clinical Lead, Stafford and Surrounds CCG and Jane Chapman, CCG Engagement Lead, Stafford and Surrounds CCG.

The Chair reminded the Committee that new proposals were put forward to the Committee and that concerns had been shared with the Committee regarding the proposals.

Dr Holmes explained that there was a similar group under Primary Care Trusts to the Clinical Priorities Advisory Group (CPAG). These Groups looked at services and treatments to see if they were best use of NHS money and whether new services were right to introduce locally. There were two prioritisation groups in Staffordshire one in the North and one in the South, with close working between them. Approximately seven years ago a joint policy was developed between the two groups to enable them both to use one another's scores. The South Group's process had been taken from the North Group's process and a modified Portsmouth score was used. There were individual scoring programmes in the North and South however scoring outcomes had been very

similar. The North Group had looked at hearing aids for mild, moderate and severe hearing loss and the South Group had accepted the North Group's scores and also looked at the provision. The scoring system took multiple things into account, including if evidence was robust, for example whether it took information from randomised trials or case studies. It looked at the health impact on the person, the cost impact and for example whether one group was affected more than another. The different areas were not weighted differently. There were different scores in relation to hearing aids dependent on whether hearing loss was mild, moderate or severe due to the impact that this would have on a person's life.

Jane Chapman explained that the CPAG had established that the service currently provided did not meet the threshold for commissioning. Normally this would have resulted in the decommissioning of a service, however the CCG knew from the engagement undertaken by North Staffordshire CCG that this had attracted strong negative feedback from stakeholder and specialist groups. The CCG therefore did not want to ask whether to decommission hearing aids for mild to moderate hearing loss as this would result in a similar response and cause unnecessary distress. The CCG was however looking to build on the engagement undertaken in North Staffordshire and consult on what it would mean if Stafford and Surrounds CCG implemented the thresholds that had been approved in North Staffordshire. The introduction of an eligibility criteria for mild to moderate hearing loss would impact on a small number of patients currently eligible, which was estimated to be around fifteen percent of patients. Stoke CCG were following a similar process and had asked that the timescales for consultation were aligned*. The consultation was planned to start on the 27 September and finish on the 20 December 2015. This would be a twelve week process following advice from the Committee. Questions were being refined so that the same questions could be asked by all CCGs as hearing aids were commissioned jointly and this would reduce duplication and support working across CCGs. Once the CCG consultation programme was completed it would be shared with the Committee. The consultation process would involve local meetings open to the public, including hearing providers and Action on Hearing Loss and other local specialists.

Andrew Donald reiterated that North Staffordshire CCG's process had collected evidence that the CCG would use but a further three month consultation across South Staffordshire and Stoke was being proposed to gather more information. The proposal was to change the thresholds by which someone could access a hearing aid and not to decommission a service. This would allow individuals, where they felt they had a special case, to put a claim through their consultants to be considered even if routinely they would not have access. Changing the threshold was a more appropriate way of managing this process rather than decommissioning.

A Member referred to the lack of consultation by North Staffordshire CCG and the flawed engagement exercise. The CCGs plans to properly consult were queried. Given the number of people possibly affected in South Staffordshire compared to the numbers in the North of the County, it was queried how the CCG would ensure that the proposals would be designed to meet the needs of those in the population that the CCG served, and not those in the North of the County.

Jane Chapman referred to the different ways of working in the South of the County compared to in the North. The consultation would ask about the South Staffordshire

commissioning policy. The work to date showed a small proportion of people with mild to moderate hearing loss that would be affected, approximately fifteen percent. The way hearing loss was assessed was dependent on the impact it had on a person's life rather than just the measurable hearing loss.

A Member asked if fifteen percent of those with mild hearing loss would not qualify for hearing aids compared to those that presently had one and how people could prove the impact of hearing loss on their lives.

Dr Holmes explained that the scoring system was universal and that the CCG had used a threshold of a score of one hundred on whether or not to commission hearing aids. The score of the provision of hearing aids for mild and moderate was under a score of one hundred. The evidence did not support the commissioning of hearing aids for mild and moderate hearing loss, but clinicians would take into account the impact on life.

Andrew Donald explained that it was a commissioning policy and not decommissioning. Routinely people with mild to moderate hearing loss would not be able to access a hearing aid but there were some safeguards in place so that people who had other circumstances, which meant that it might be reasonable for them to have access to a hearing aid, could do so. The same framework was being used as in North Staffordshire but it was being applied differently in South Staffordshire.

A Member sought clarification that if someone had mild to moderate hearing loss then they would not get a hearing aid unless they could articulate that it would impact on their everyday life using the questionnaire in the paperwork. How it would be proved that the questions had been answered truthfully was queried and how clinicians could be sure that the questionnaire reflected everyday life, as people with a disability underestimated the impact of the disability on their everyday life or could be having a good day when they filled in the questionnaire, was questioned.

Andrew Donald explained that clinicians needed to be trusted to make a proper judgement as they worked with patients.

Dr Holmes explained that the audiologist would do the scoring and that the default was to believe what the patient was saying. This approach was used a lot for example in sleep apnoea. It was not about proving or disproving what the person was saying. Hearing aids impacted on sound generally and a lot of people with mild hearing loss did not tolerate them. In mild hearing loss a person could hear conversation but hearing aids increased background noise which made it difficult for those with mild hearing loss to hear so they stopped wearing the hearing aids and only started wearing them again when hearing loss got worse.

It was queried what the chances were that someone with severe hearing loss would adapt to using a hearing aid if they had never used one previously.

Dr Holmes clarified that from an evidence point of view this was not known but that people typically started using hearing aids when they were experiencing moderate hearing loss.

Andrew Donald explained that sometimes a line had to be drawn and evidence available had to be used to make decisions.

Dr Holmes explained that the scoring considered if people were able to hear speech so people still had time to adapt.

It was commented that reference to investment in the report was curious as people had paid their taxes and should feel worthy of investment. It was stated that hearing aids were an investment and could transform people's lives. The cost difference between an NHS and private hearing aid was raised.

Andrew Donald explained that there was not the money available to provide everything that everyone wanted. In reality mild to moderate hearing loss did not meet the threshold. It was challenging for commissioners to provide what everyone wanted and this could not always be done.

A Member asked what would happen across Staffordshire regarding the provision of hearing aids. It was suggested that a professional should explain to the Committee about hearing loss as the Committee needed to understand the effects of hearing loss. Concerns were raised whether the right decision was being taken.

A workshop with the Select Committee was suggested to bring in clinical advice. North Staffordshire information was being used but it was important to talk to and consult the CCG's own population.

A Member sought clarification on whether or not hearing aid provision in Staffordshire would be provided individually by hospitals in the County or if the service would be eventually centralised.

Andrew Donald explained that the Staffordshire Transformation Programme had to ensure services were clinically and financially sustainable. Virtually all organisations in Staffordshire were in deficit so there was pressure to address this. Debate on a far larger scale was required about the provision of healthcare to ensure a clinically and financially sustainable situation.

A Member referred to the poor consultation undertaken by North Staffordshire CCG. It was queried what the CPAG score was and if it had gone to the CPAG group on more than one occasion.

Dr Holmes did not have this information available but explained that it had been scored by the North CPAG but not by the South CPAG. Both CPAGs had however used each others scores as both scored the same issues similarly.

A Member sought clarification if hearing aid provision had been considered at the CPAG twice. It was commented that the evidence could not have been strong as there had been no evidence available from this country. It was suggested that the Committee should find out more and listen to campaigners to get a better understanding.

Andrew Donald explained that clinical evidence changed all the time, and commissioners tried to use the most up to date information as possible. A judgement

had to be made on what money should be spent on and there had to be a way of giving people what they clinically needed within the resources available. The challenge was how to do more with the money that the CCG had.

A Member asked what the position was in East Staffordshire.

Andrew Donald confirmed that the Accountable Officer for East Staffordshire CCG had confirmed that the CCG wanted to be part of the process. It was commented that Stafford and Surrounds CCG had appointed a lay member from Action on Hearing Loss to ensure full debate.

A Member suggested that the Committee see the Portsmouth Score and how it had been arrived at and a comparison with scoring on other areas. It was queried if there was any evidence for treating mild to moderate hearing loss with hearing aids.

Dr Holmes explained that there was no evidence from within the UK and evidence from overseas had therefore been considered. An example of the scoring could be shared at the workshop. The score took into account several factors and if little evidence was available the score would be low. Finance accounted for two of the nine questions. East Staffordshire CCG had nominated doctors onto the CPAG. An example was provided of plurax catheters, used at the end stage of cancer treatment to prevent the fluid build-up in the stomach. This scored highly even though it was expensive, as it benefitted the patient and family by stopping them having to go into hospital. Diabetes education also scored highly.

A Member suggested that people should be asked about the impact of hearing aids on their lives. The report should consider what people were asking for rather than what the CCG was able to provide. It was highlighted that hearing aids cost the NHS approximately £90 per pair but if the NHS reduced its service and buying power the price could go up. It was commented that commercial alternatives were not always suitable. Withdrawing services would mean people would have to access services through the open market. It was commented that the questionnaire within the report was very patronising.

Andrew Donald thanked the Committee Member for the helpful points and explained that a debate with the public regarding what was wanted and needed was required. People consumed healthcare because they wanted it but not because they always needed it. An Any Qualified Provider Contract awarded contracts to numerous organisations, and optometrists offered hearing tests. The NHS was not allowed to offer co-payment. During the consultation the debate needed to be turned around to get different evidence about what the public was saying. The public would make intelligent choices. The point about patronising comments was taken on board and it was acknowledged that it was important to make sure that the document was not presented like that.

A Member asked why there was no age factor considered on the priorities as this appeared to go against the Age Well priority. Concerns were raised regarding loneliness and the effects that hearing loss had on people. It was suggested that the CCG ask Shropshire CCG what they were doing.

Andrew Donald explained that for clear commissioning decisions, people had to be involved in the design, implementation and evaluation. The question of age may be something to be taken significant account of. The whole issue was about how the resources available could be used to best effect for the population's benefit. £31 million more was being spent than the CCGs were allocated and there had to be a way found to manage the resources more effectively. The three month consultation was key.

A Member questioned why the CCG could not wait until an impact assessment on the changes made in North Staffordshire had been completed before putting the proposals forward. It was commented that the wording of the patient functional test had made it appear that it was directed towards the elderly and it was not clear if younger people affected by hearing loss could undertake the test. The Member reminded the Committee that the CCGs spent £185 million on prescribing in Staffordshire, this had increased more than the rate of inflation. The indication was that £40-50 million more than it should be was being spent on prescribing and that this imperilled health and social care.

Andrew Donald explained that following a twelve week consultation any proposals the CCG wished to implement would not be put in place until April 2016. The CCG would be doing its own impact assessment. The CCGs were tackling prescribing and the QIPP plans were clear that prescribing costs should be reduced. There were issues however as patients needed to understand for example when they did not need antibiotics.

In response to further questions referring to the NICE paper on prescribing, Dr Holmes referred to the GP Members Board discussions on the issue. Pharmacists had discussed with GPs how they could reduce prescribing. She suggested that the public also needed to take on some responsibility. Prescribing costs had increased as there was more medicine available and new drugs were more expensive.

A Member referred to the Business Case and asked what savings were estimated. The prematurity of the proposals was remarked on as the North Staffordshire scheme did not start until 1 October 2015. It was also commented that South Staffordshire had an older population than in North Staffordshire and this should be considered.

Jane Chapman explained that possible savings equated to approximately £30-40,000 per year but this has not been the primary driver of the proposals. The difference in populations was recognised and each CCG would have to go through an independent process and each CCG Governing Board would need to make a local decision on any proposals put forward.

Andrew Donald clarified that by the time the consultation had finished there would be six months of evidence from North Staffordshire and this would be taken account of.

The Chair thanked Members for their questions and for the responses received. It was agreed that a workshop would be undertaken to incorporate professionals, action groups and interested parties views. A Member suggested that this workshop session should be held in public due to the public interest in the issue. This would enable people to engage in the debate which was important as the proposals may be copied in other parts of the country.

It was confirmed by the Chair that the workshop meeting would be webcast.

**Note from Clerk – Following the meeting it was confirmed that Stoke on Trent CCG did not wish to introduce the eligibility criteria.*

Resolved;

- That a public workshop be held to consider the views of professionals, action groups and interested parties and to enable the Committee to make valid comment back to the CCG on the proposals.

108. Proposed changes to the provision of specialist inpatient haematology services at the County Hospital

Jonathan Belcher, Director of Strategy. Cannock and Staffordshire CCGs introduced the item. He explained that the proposal was about permanent change to the haematology services at County hospital and was in addition to the TSA work. The proposal before the Committee was for inpatient haematology services provided at County Hospital to be moved to the speciality haematology wards at the Royal Stoke University Hospital and New Cross Hospital, Wolverhampton. The proposal was considered to be the only technically viable option. The recommendations of the TSA had had a consequential impact on County Hospital but there had been no specific TSA recommendation regarding inpatient haematology so consultation needed to take place. The consultation was focussed on specialist inpatient haematology, this affected a small number of beds, eight in total at the County Hospital site. The impact at a patient level had been mapped and presented to the Committee.

Total inpatient activity at the County Hospital over a twelve month period equated to one hundred and eighteen cases or eighty three patients that had been through an inpatient ward. There was no changes proposed to outpatient or day case activity. It was important to recognise that as a result of the TSA model, patient flow had started to change and approximately forty percent of activity that would have previously gone to County Hospital had now moved towards Cannock Hospital and New Cross Hospitals. National evidence had been considered and additional expertise sought. The CCG had sought advice from specialists including Professor Charles Craddock, Director of the Blood and Marrow Transplant Unit at the Queen Elizabeth Hospital, Birmingham and Professor of Haemato-oncology at the University of Birmingham, and the West Midlands Haematology Network to consider other options. They had concurred that the proposal would be the most appropriate move for services. The current provision, how this has been assessed and the proposed future reconfiguration of services had been included in the Committee papers.

University Hospitals of North Midlands NHS Trust services at the County Hospital site were provided at level 2b service, with eight inpatient beds on two floors divided by gastroenterology. These beds were not fit for purpose given the future arrangements for haematology and the infrastructure required around it. The proposal was for the inpatient beds to move which would leave a 2a service at the County Hospital site, enabling outpatient and day care services to remain. There would also be two step down beds put onto the wards to allow repatriation of patients back to County Hospital. At Royal Stoke University Hospital there would be an additional five beds to match the reduction at County Hospital and to maintain the level 3 status of the hospital. The Cannock Hospital provided no services but through the redevelopment of the site there

would be a chemotherapy suite of twenty day case chairs, confirmation was awaited on when the suite would open, putting 2a service in place. An additional three beds would be provided at New Cross Hospital keeping the service at a level 2b. Level 2b and 3 services were the same except for the ability to provide bone marrow transplantation. In the North this would be provided by Royal Stoke University Hospital and in the South by University Hospitals Birmingham.

In undertaking the consultation a Health Equality Impact Assessment was completed under the TSA process however this was not sufficient for the haematology proposals so an additional Health Equality Impact Assessment was being undertaken. A clear timeline of events, as part of the previously agreed six week consultation process, was presented within the Committee papers. There were two options, to do nothing or to move services. Using the TSA evaluation criteria, the self assessment had added to the reason and rationale for the scoring of the two options. The TSA required the model to be clinically and financially sustainable and reasonable in terms of access and deliverability. The current provision was reasonable but not clinically sustainable and not financially sustainable as it was supported by in excess of £660,000 per year to keep the staffing base in place. The model was deliverable until 7 September 2015 when there was a decision by the Sustaining Services Board that for clinical and safety reasons the provision would not remain at the County Hospital site and a temporary service transfer was put in place. The questions being asked in the consultation included what other options could be considered, and whether the TSA evaluation principles had been applied appropriately. The communication and engagement plan and the technical aspects for change were also included in the Committee papers.

Dr. Gavin Russell, Associate Medical Director, University Hospitals North Midlands NHS Trust, commented that the proposals related to a small number of very sick patients. For those involved in the TSA model it was already understood that specialist services would move from County Hospital. This was not however under the framework of haematology. Cancer services were not removed from the County Hospital site. There was £3 million investment in a new chemotherapy unit at County Hospital and there was investment at Cannock Hospital for local patients to access chemotherapy. The proposal was in relation to patients who were extremely unwell, for example a young person with acute leukaemia undergoing treatment who was extremely at risk. The patient was prone to sepsis and therefore needed to be in the right environment to access facilities such as pressure rooms, ITU facilities and acute renal failure facilities. These facilities were not available at County Hospital. To treat very sick patients, effective numbers of consultants and middle grade doctors were required. There had been four consultants at County Hospital however, one had left and one had retired, so there was only two substantive posts at County Hospital. Recruitment to the County Hospital site was not successful as consultants wished to be part of a haematology team of eight to ten people in specialist centres. There were plans to develop more specialist haematology outpatient services at the County Hospital site as some patients had had to travel to Stoke anyway to access treatment.

A Member queried how seven day working could be managed and clarity was sought on why recruitment to the specialism had not been prioritised and whether reputational problems had impacted on this. Whether rotas could be shared and networking could take place between hospital sites was questioned.

Dr Russell explained that the number of haematology patients at County Hospital was small and the recruitment of nurses and a consultant haematologist could not therefore take place, unless they were part of a wider haematology team. Two rotas could not run at the same time or for such a small number of patients. People wanted to work at large centres as they needed to be part of a wider team and required colleagues for peer review. The County Hospital Consultants going to work at the Royal Stoke University Hospital would be part of the rota and would continue to work locally. Day surgery was continuing to increase at County Hospital and more outpatient and care of long term conditions was taking place.

In response to issues regarding seven day working it was confirmed that there was recruitment at the Royal Stoke University Hospital and there was no problems in envisaged in recruitment going forward.

A Member referred to the move of renal treatment to the Royal Stoke University Hospital. It was clarified by Dr Russell that a £3 million satellite renal facility was being built at Stafford which would have twelve stations. There were eighteen stations at Leighton Hospital and at the Royal Stoke University Hospital there were approximately fifty stations.

It was queried what the need of an inpatient was. Dr Russell referred to patients that received chemotherapy and were very prone to infection or getting infections and becoming very sick. Some of the lines used for putting in chemotherapy had to be done by imaging, which required an interventionist Radiologist of which there were few at County Hospital. At the Royal Stoke University Hospital the line could be put in very quickly. The facilities at the Royal Stoke University Hospital managed very unwell patients. For patients with less severe illness there may be opportunities for step down at County Hospital and day case treatment for patients at County Hospital would be evolved.

It was suggested that the consultation questionnaire should not ask personal questions and only ask questions relative to the proposal.

Jonathan Belcher confirmed that there was a duty under the Equality Act to ask such questions and an exercise had been undertaken to reduce the number of questions asked. It was confirmed that information provided in relation to the consultation would be considered even if not all of the questions had been answered.

Dr Russell stated that it was important to get the views of patients and their relatives and ask what could be done to make things better for them if services were moved. For example how they could be helped and supported through illness, had to be considered.

A Member referred to families' needs and what could be done to help people.

Jonathan Belcher explained that there was a two step process. The Trust would confirm overnight parking exceptions and through the Trust there would be engagement with patients to find out what else could be done to support them. An open day at both Units if the move was supported had been suggested.

The Chair thanked all for the questions and responses received.

Resolved:

- That the Committee agree the rationale supporting the recommendation that inpatient haematology services currently provided at the County Hospital be moved into the specialist wards at the Royal Stoke University Hospital and New Cross Hospital.

109. 'Living My Life My Way' - Strategy for Disabled People

Resolved:

- That this item be deferred to a future Committee meeting to ensure appropriate time for scrutiny of the item.
- That the Cabinet Member be asked to consider re-writing the report in response to feedback from Members at the meeting.

110. District and Borough Scrutiny Report Updates

It was commented that the Committee Chairman and Officers supporting the District and Borough Select Committees be contacted regarding the content of the report as in some cases the information submitted was too limited.

Resolved:

- That the Scrutiny and Support Manager contact the relevant Officers for more details regarding the work of the District and Borough Committees for inclusion in future updates to the Committee.

111. Healthy Staffordshire Select Committee Work Programme September 2015

The Chair of the Committee confirmed that following the Committee's discussions at the meeting, a workshop would be programmed to consider South Staffordshire Clinical Commissioning Groups proposals regarding hearing aid policy and consultation, in more detail. In addition agenda Item 7, 'Living My Life My Way' – Strategy for Disabled People would be brought to a future Committee meeting.

A Member referred to the item under 'Special meetings to be arranged' on the Work Programme, on the distressed health economy. It was suggested that as the conversation at the meeting had referred to the difficult financial position that CCGs faced, a session should take place on the outcome of the KPMG report which was over a year old. It was commented that the Committee needed to know what the outcome of joint working was and required more information about the deficits of the Staffordshire CCGs and NHS Trusts. The Committee requested more information on which organisations were successfully working within their budgets, what the common issues were across organisations, including over-prescribing for example, more information on issues such as joint working and on the County Council's financial position. This meeting needed to take place promptly as this information underpinned all of the Committee's current work.

A Member requested that the update from Healthwatch Staffordshire should be provided to the Committee as a priority.

Resolved:

- That a workshop for the Committee to consider the proposed hearing aid policy and consultation for the South Staffordshire Clinical Commissioning Groups be arranged.
- That the deferred item on 'Living My Life My Way' – Strategy for Disabled People be included on the Committee Work Programme.
- That the item on the work programme on the Distressed Health Economy be programmed to come to the Committee as a priority.
- That the update from Healthwatch Staffordshire be timetabled to come to a Committee meeting as a priority.

Chairman

**Summary of the main agenda items from the
Healthy Staffordshire Select Committee meeting –Wednesday 14 October 2015**
<http://moderngov.staffordshire.gov.uk/ieListDocuments.aspx?CId=871&MId=6211&Ver=4>

Agenda Item	Of particular interest to ...
<p>On Wednesday 14 October 2015 the Healthy Staffordshire Select Committee held an Accountability Session with the North Staffordshire Combined Healthcare Trust who delivered a report which highlighted that the Trust was achieving financial balance and performing well against national performance bench marks and metrics.</p> <p>Members of the Healthy Staffordshire Select Committee together with members of District and Borough Health Scrutiny Committees and the public had the opportunity to ask questions and raised issues in relation to the Trusts workforce including staffing shortages ,agency staff, recruitment and staff engagement. Mental health issues around young people, the capacity and process for persons taken into police custody, patient safety in relation to falls and how the data was presented was also discussed. The committee also asked the trust about the evidence and information provided by Healthwatch.</p> <p>A number of outcomes and areas to follow up were highlighted which the trust agreed to respond.</p>	All
<p>Report of the Scrutiny and Support Manager :- Members received District and Borough Scrutiny Report updates</p>	All

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

Report to the Newcastle Health and Wellbeing Scrutiny Committee

Wednesday 18th November 2015

Dementia Care across North Staffordshire



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Introduction

The purpose of this report is to provide an overview of the work that is taking place within both health and social care, for people living with dementia, including their families/carers, living in Newcastle under Lyme and Staffordshire Moorlands. The report includes some background information in terms of what dementia is, the pathway of care that people should experience and the work that we are doing across Staffordshire County Council and North Staffordshire Clinical Commissioning Group in order to improve outcomes across the population.

Background

The commissioning managers at Staffordshire County Council and North Staffordshire Clinical Commissioning Group work closely together in order to deliver the dementia strategy, with support from a dedicated clinical lead. In order to ensure equity across Northern Staffordshire there is close partnership working with colleagues from Stoke on Trent CCG and the Council. . A joint health and social care strategy for Dementia was produced in 2012 which came to an end in March 2015, therefore commissioners are now in the process of developing a new plan for Dementia Services in North Staffordshire. Engagement with provider organisations, people living with dementia and carers began in September this year and will continue until the end of November, in order to help commissioners identify priorities for the next 4 years.

In terms of prevalence, we believe there to be over 2,800 people living with some form of dementia across North Staffordshire (excluding Stoke on Trent), and currently, roughly 71% of those have a formal diagnosis. The majority of people living with dementia are over the age of 65 and prevalence increases with age, however numbers of people with young onset dementia are also increasing, and

services need to be commissioned to be tailored and personalised for people because everyone's experience of dementia is individual.

Questions to be Addressed

How would the scrutiny committee wish to input into and support the engagement process and development of the new dementia plan for North Staffordshire?

Is there any additional information that the committee would wish to receive in terms of commissioning for dementia services or delivery of the dementia pathway?

What priorities does the committee identify for supporting people to live well with dementia?

Would the scrutiny committee be interested in supporting Newcastle Borough Council to become a member of the Dementia Action Alliance, and attend a dementia friends session?

Outcomes

Much of the work over the last 12 months has been to raise awareness amongst professionals and increase dementia diagnosis rates in line with the Prime Ministers National ambition. The CCG has to report on this nationally and diagnosis rates have increased from 40% to 71% in the last 12 months.

It has been proposed that another health and social care national indicator to measure and monitor that people with dementia are supported to live well will be developed for 2016/17.

There is a great deal of work taking place towards the dementia agenda from commissioners at the county council as well as the clinical commissioning group, as part of the wider dementia strategy. The overall aim is to support people living with dementia and their families, to achieve positive outcomes and have the information they need at the right time, in order to live well at home for as long as they wish to.

Supporting Information

The Alzheimer's Society describes the word dementia as *"a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. A person with dementia may also experience changes in their mood or behaviour."*

Dementia is caused when the brain is damaged by diseases, such as Alzheimer's disease or a series of strokes. Alzheimer's disease is the most common cause of dementia but not all dementia is due to Alzheimer's. The specific symptoms that someone with dementia experiences will depend on the parts of the brain that are damaged and the disease that is causing the dementia.

The Dementia UK report (2007) which was recently updated in 2012, predicts that roughly two thirds of people living with dementia are living at home, with the remaining one third residing in some form of long term care such as a residential or nursing home. The report also predicts that roughly 80% of those people residing in a care or nursing home setting, will have some form of dementia either diagnosed or undiagnosed.

The dementia pathway for North Staffordshire typically consists of the following steps/stages:

- GP input (pre assessment) and potential onward referral to the memory assessment and diagnostic service
- The memory services (which are provided by North Staffordshire Combined healthcare Trust) which is made up of community psychiatric nurses, supported by a consultant psychiatrist, carry out in depth assessments and tests in order to determine a diagnosis
- If a person is diagnosed with some form of dementia, then they may possibly be prescribed medication and will then have the chance to be referred onto the Dementia Advisory Service
- The Dementia advisory service is provided by Approach Staffordshire which is a local voluntary sector organisations based in Stoke on Trent. A person would be assigned with a dementia advisor who would then offer to visit the person/family at home in order to discuss what information or support is needed, and help them to access this.
- Alongside this, North Staffordshire Combined Healthcare Trust provide a range of other community services which help people with dementia to remain at home, including the community mental health team and community outreach teams.
- In order to support people with social care needs as well as health needs, Staffordshire and Stoke on Trent Partnership Trust provide support for people in the community via Integrated Local Care Teams, including social workers and social care assessors.
- Other commissioned services include the Approach Carer Cafes which provide peer support and a social environment for carers of people living with dementia; and a specialist dementia advocacy service provided by the Beth Johnson Foundation.
- The county council also commissions specialist day opportunities for people with dementia and other complex conditions, which are also provided by Approach. Additional social care support for people living with dementia includes domiciliary care, and respite beds for people with high level needs.
- There are also a number of other non-commissioned services provided by local voluntary sector organisations such as singing for the brain provided by the Alzheimer's Society and carer groups provided by North Staffs Carers Association, to name a few.

University Hospital North Midlands also has a dementia steering group which includes a number of stakeholders, led by Dr Marilyn Brown, in order to review and improve upon the pathway of care and patient experience for people living with dementia that access Royal Stoke Hospital. Examples include providing training for their staff, having dementia champions and implementing the 'butterfly scheme' in order to improve awareness and recognition of dementia, whilst also providing personalised care.

Work is ongoing to support professionals to have increased awareness and knowledge of dementia, whilst also considering the need to ensure that our local communities are set up to support their residents which may be living with dementia. Both Staffordshire County Council and Stoke City Council lead an initiative called 'Dementia friendly communities' which is a national initiative driven by the Dementia Action Alliance in association with the Alzheimer's Society.

A Staffordshire wide action alliance has been established which meets on a regular basis and involves all organisations across the county that have signed up to become dementia friendly. Across the county we also have a large number of dementia champions and dementia friends. A dementia friend is someone that has attended a dementia friends session which is delivered by a trained champion, and helps to raise people's awareness and inform them of what dementia is and how it can affect people. Anyone can become a dementia friend and at the end of the free session, they are given a small pin badge which features the 'forgot me not' blue flower as a recognisable symbol.

Work is beginning in Audley to create a dementia friendly community including Newcastle Borough Council and others associated with the Local Action Partnership.

In terms of governance for the work being carried out on Dementia, we have a joint North Staffs and Stoke on Trent Dementia Steering Group which meets every couple of months and is attended by representatives from across the health economy including commissioners, providers, voluntary sector organisations and clinicians. Previously we also had representatives for people living with dementia and carers, however due to personal circumstances they have been unable to be part of the group and so we are looking into other ways that we can ensure ongoing engagement with people as part of the work that we do.

From a commissioning point of view, we also have an Older People's Mental Health Service Delivery Group established which looks at operational delivery of dementia services. We also have a dementia commissioners meeting, both meetings take place on a monthly basis and act as a forum for discussing important issues, agreeing actions and monitoring progress.

Invited Partners/Stakeholders/Residents

- Mark Hewitt, District Commissioning Lead (Newcastle), Staffordshire County Council
- Nicola Bucknall, Commissioning Manager, North Staffordshire Clinical Commissioning Group

Constraints

Within Staffordshire County Council, funding for dementia specific services comes from a central care budget however this fund is very limited and all current funding is tied up in existing contracts for voluntary sector run services. North Staffordshire Clinical Commissioning Group fund the majority of current services through a block contract with North Staffordshire Combined Healthcare Trust and the voluntary sector.

Conclusions

To summarise, there is dedicated resource in terms of officer time across health and social care in order to create, improve upon and sustain a suitable pathway of care for people with dementia. We recognise that whilst services have improved over years, there is still a great deal more that needs to be done and ongoing discussions with people living with dementia confirms this to be true. Our approach is very much one of working together and of partnership with those organisations that deliver care to people, and we will continue to do the best with the resource that we have and plan for the future, in order to improve outcomes for the people of North Staffordshire.

Relevant Portfolio Holder(s)

Councillor Colin Eastwood

Local Ward Member (if applicable)

All

Background Materials

Draft North Staffordshire Dementia Plan – Executive summary which is currently out to consultation

Appendices

NA

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North Staffordshire Dementia Plan (2015-19) – Executive Summary

Staffordshire health and social care see dementia as everybody's issue and one that deserves attention and effort in order to help people with dementia to live well. The NHS and social care have come together across Staffordshire in order to declare our commitment to improving the lives of people with dementia, as well as their families.

We want to develop a new plan of action which tells people what we will do as a whole health economy in order to achieve our vision for people with dementia.

Our vision is "that the people of North Staffordshire living with dementia have access to an integrated, holistic care pathway which meets people's own individual outcomes and needs"

What is Dementia?

Dementia is a term used to describe the symptoms that occur when the brain is affected by certain diseases or conditions. There are many different types of dementia although some are far more common than others. They are often named according to the condition that has caused the dementia. Around 60% of people with dementia have Alzheimer's disease, which is the most common type of dementia, around 20 per cent have vascular dementia, which results from problems with the blood supply to the brain and many people have a mixture of the two. There are other less common forms of dementia, for example dementia with Lewy bodies and frontotemporal dementia.

What's important to people living with dementia?

People with dementia have told us what is important to them. They want a society where they are able to say:

- I have personal choice and control over the decisions that affect me.
- I know that services are designed around me, my needs and my carer's needs.
- I have support that helps me live my life.
- I have the knowledge to get what I need.
- I live in a helpful and supportive environment where I feel valued and understood.
- I have a sense of belonging and of being a valued part of family and community life.
- I am confident my end of life wishes will be respected. I can expect a good death.

*Dementia Action Alliance is a national organisation which seeks to support organisations to become dementia friendly. Staffordshire and Stoke on Trent also have their own action alliance.

- I know that there is research going on which will deliver a better life for people with dementia, and I know how I can contribute to it.

What do services look like now?

Some good practice from individuals, but a disjointed pathway which can be confusing, with duplication and not enough information and guidance for people

How do we want service to look in the future?

We want to create a clear pathway of care which is joined up and easy for people to follow, with professionals who have the right awareness of dementia and people having access to the right information and advice.

What are our priorities?

Across North Staffordshire we shall prioritise:

- **Supporting people to have access to accurate and timely diagnosis** – ensuring that good quality services are closer to home, enabling people to be able to plan for the future
- **Enable people to Live Well with Dementia**- by having access to high quality, personalised support for both the person with dementia and their carers;
- **Creating dementia friendly communities** that help to improve the quality of life for people with a diagnosis of dementia and their carers;
- **Spreading the message of ‘living well’** – by improving professional and public awareness of dementia, whilst also making sure that people with dementia and carers have access to the right information, advice and guidance

How are we going to do this?

1. By making memory services more accessible, and closer to home in order to ensure that people know where to go to get a diagnosis
2. By working with local provider organisations in order to promote personal, family and community resilience in order to help people stay as independent as possible
3. By focusing on the delivery of integrated community services in order to avoid admissions to hospital but also support people when they leave hospital

*Dementia Action Alliance is a national organisation which seeks to support organisations to become dementia friendly. Staffordshire and Stoke on Trent also have their own action alliance.

4. Review our community dementia services in order to ensure that they are fit for purpose and achieve positive outcomes for people
5. Support the development of a flexible and responsive care market for health and social care that is able to meet the needs and aspirations of people living with dementia and their families, at a high quality standard.
6. Be part of the Staffordshire and Stoke on Trent Dementia Action Alliance* in order to create dementia friendly communities

How can you give feedback?

If you would like to tell us what you think about our plans for Dementia in North Staffordshire, we invite you to complete the a feedback form which can be found by accessing the North Staffordshire Clinical Commissioning Group website at <http://www.northstaffscg.nhs.uk/dementia-strategy> or phone 0300 404 2999 Ext 8168 and a member of staff will post a copy out to you, along with a freepost envelope.

*Dementia Action Alliance is a national organisation which seeks to support organisations to become dementia friendly. Staffordshire and Stoke on Trent also have their own action alliance.

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Report to the *Economic Development and Enterprise Overview and Scrutiny Committee*

18th November 2015

Better Care Fund



Report Author: Joanne Halliday
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Introduction

This report has assimilated information from public reports and information provided by the Lead Manager to provide an overview of the Better Care Fund.

Background and Supporting Information

The Staffordshire Health and Social Care Economy is one of the eleven areas nationally identified as being challenged and with a need to focus on frail elderly.

The Better Care Fund (BCF) is a mandatory national programme, which requires every Health & Wellbeing Board area to establish a pooled budget, in order to reduce non-emergency hospital admissions and protect Adult Social Care.

The Better Care Plan was designed to focus on three target groups:

- Frail elderly,
- People with a long term condition (particularly those with dementia)
- and Carers.

Staffordshire's elderly population is due to grow much faster than the England average, whereas the number of working people will reduce.

The current and predicted costs relating to this population are shown in the table below:

	2012/13	2019/20	Growth
	(000s)	(000s)	(000s)
Social Care - Adults Aged 65 and over ¹	£158,731	£188,138	£29,407 (19%)
NHS – adults aged 65 or over	£688,362	£833,874	£145,512 (21%)

It sees closer working between health and social care as key to addressing the challenges faced by acute providers and encourages integrated approaches to preventing and managing demand.

What outcomes is the BCF seeking?

The BCF Plan seeks to achieve the national conditions:

- a. A reduction in non-elective admissions
- b. Protection of social care services to ensure that in a context of shifting towards prevention, essential social care services are protected
- c. Achievement of 7 day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- d. Data sharing between health and social care systems
- e. A common approach to the risk stratification of frail elderly populations and effective case management of those at high risk

The BCF Plan is consistent with the Health and Wellbeing Board Joint Health and Wellbeing Strategy. To support that strategy, the BCF has six priorities:

- a. Focussing on frail elderly pathways, as the core element of our quality and sustainability challenge. There is now a single agreed Frail Elderly Pathway across Staffordshire and Stoke-on-Trent across Health and Social Care as shown below
- b. Focus on those individuals who are already in the health and care system (e.g. in hospital, or receiving long-term care).
- c. Prioritising early intervention with people who are struggling to maintain their independence.
- d. Integrating commissioning – bringing together our combined commissioning activities and funding for care in community settings in a phased way.
- e. Integrating provision – reducing fragmentation, duplication, and hand-offs between professionals.
- f. Developing the concept of locality-based commissioning, with District and Borough councils playing key roles.

Investment areas

Scheme 1: Integrated Access to Care - Maximising Independence and Self-Help

BCF investment - £0

Promoting low level prevention, and self- and early help through joint effective marketing and communication campaigns building on foundations developed through public health.

Scheme 2: Integrated Local Community Teams - Managing Dependency on Services

BCF investment - £16.96m

To ensure that individuals within the community whose needs have increased receive integrated personalised care tailored to their needs and aspirations, to return them to ongoing stability without the need for acute intervention.

Scheme 3: Integrated Local Community Teams - Managing Safe Return to Steady State

BCF investment - £19.168m

Health and social care will work together to support individuals who have been admitted to the acute system in order to return them to the greatest level of independence within the community by ensuring that individuals are appropriately discharged following an escalated hospital need back to their place of residency, with care plans and receiving ongoing in-community support.

Schemes 4: Enabling Schemes

BCF investment - £9.556m

- 4.1: Disabled Facilities Grant - Providing home adaptations so that people with disabilities can remain living safely at home within their communities.
- 4.2: Adult Social Care Capital Grant - Providing capital funding to support development of personalisation, reform and efficiency.
- 4.3: Technology Enabled Care Services (TECS) and Assistive Technology - Providing Technology Enabled Care Services and Assistive Technologies so that people living in Staffordshire are supported to manage and improve their health and well-being.

4.4: Integrated Community Equipment Service (ICES) - Providing aids and equipment so that people with disabilities or recovering from healthcare interventions can remain safely at home within their communities.

Scheme 5: Continuing Healthcare (CHC)

BCF investment - £56.007m

Providing support to those patients requiring long term high cost care in their home (own, residential or nursing).

Scheme 6: End of Life

BCF investment - £1.516m

There are currently a number of services which provide end of life care to the registered population of South East Staffordshire & Seisdon Peninsula CCG. These services are subject to a review and will be considered as part of the overall model of care for the CCG.

Scheme 7: Carers (Inc. Carers Breaks, Mental Health Carers Support and Information for Carers) (Includes Dementia Carer Cafes)

BCF investment - £0.792m

Jointly commissioning improved outcomes for carers through a Whole Carers System Redesign, which includes the re-commissioning of Carers Breaks and wider universal carers support.

Scheme 8: Care Act Implementation Funding

BCF investment - £0.738m

A formal change programme to ensure robust and effective implementation of the Care Act. Work is under way to support all partners to understand their responsibilities within the Care Act and the changes which will need to be implemented.

Protection of Adult Social Care

The Better Care Plan identifies that an additional saving of £16.9m is required to have been secured across the system as a whole in 2015/16 to ensure that the costs of the Care Act are covered and the protection of Social Care is demonstrated.

The SCC and the CCGs considered the savings requirement over a three year period (2015/16 - 2017/18) and have agreed:-

- a. That CCGs commit a resource of £6.9m in real cash in 2015/16 (comprising £1.9m for Care Act Revenue implementation and £5m to protect social care)
- b. That both parties commit to identify and deliver savings over a three year period to protect social care and support CCG financial recovery, to be shared on a 50/50 basis with CCGs

Partners continue to explore options to improve performance in other areas to generate the remaining savings needed in order to protect adult social care. An example of these options is given below:

- Assistive Technology – there is potential to harness opportunities, particularly in telehealth, to improve outcomes for people and generate savings for the BCF partners.
- Risk Stratification - there is potential to achieve a more in depth understanding of the needs of our population which will lead to more appropriate services and more effective use of resources.
- Community Risk Intervention Teams – by involving the Fire & Rescue Service and other agencies in the response to falls there is the opportunity to reduce emergency admissions to hospital.

- Community Nursing Task Force – by using community nursing specifically to address the issue of Urinary Tract Infections in nursing home residents there is the potential to significantly reduce non-elective hospital admissions.

It is worth noting that these options still require considerable additional work to explore and confirm their potential to generate savings for the partners. Alongside the development of outlines for these opportunities, further discussions with the Pan-Staffordshire Transformation Programme will be required to agree how this work should be delivered.

Governance and Performance Reporting

The Health and Well Being Board is responsible for the overarching accountability for the delivery of the integrated commissioning programme.

Partnership Board

- The Partnership Board will report to and obtain input and approval from the Health and Wellbeing Board where it is required to do so in respect of the delivery of the Better Care Fund Plan and Individual Schemes.
- Consider business cases put forward by the Delivery Group and Task and Finish Groups in order to take decisions on new Individual Schemes and changes to existing Individual Schemes.
- Attendance of the partnership board consists of at least one Council representative and each CCG's representative.

Delivery group

- The objective of the Delivery Group is to ensure the delivery of current existing schemes and to lead on the development and implementation of new Individual Schemes, including the preparation of business cases for submission to the Project Board and any other requirements as set out by the Project Board from time to time to enable the Project Board to meet the Outcomes.
- Attendance of the delivery group consists of at least one Council representative and one representative of each CCG

The BCF Support Team required that all BCF areas review and revise, if necessary, their targets for reduction in non-elective admissions. As a result of changes in CCG operating plans made after the submission and approval of the BCF Plan, Staffordshire's reduction in non-elective admissions target has been reduced from 3.5% to 1.2%. It is worth noting that Staffordshire are not unique in making such an adjustment.

How are partners involved

In addition, below the HWB, the Joint Transformation Board which represents SCC, CCGs, Stoke-on-Trent City Council, District and Borough Councils and providers will provide a forum for all partners to jointly oversee the delivery of the BCF work in Staffordshire.

Furthermore we recognise that District and Borough Council's will have an important role to play in the delivery of the BCF Plan and our wider work around integrated commissioning. Local commissioning boards have been established to ensure a strong connection to the powerful local knowledge and impact of District and Borough Councils.

Locality commissioning boards (LCBs) follow a district footprint and are generally hosted by the district/borough council. Through the Locality Commissioning Boards there aims to be alignment of outcomes and resources in the form of locality commissioning prospectuses. This alignment includes public health commissioners, the police and crime commissioner, other county council commissioners, CCG commissioners and district council commissioners.

The LCBs are focussing on commissioning and influencing activity that improves wellbeing in their local population. Older people are a target population in all localities and improvement in wellbeing in this group will support them to 1) connect – thus reducing social isolation, 2) be active – thus improving physical health particularly risk of falls, 3) keep learning – with a focus on self-care, 4) take notice – with a focus on noticing those in their community who need support and 5) give – thus developing community assets to address need.

Over the last couple of months a Staffordshire wide sub group reviewed 40 schemes across Staffordshire which we believed could prevent older people being admitted to hospital using a RAG rating, this rating considered deliverability and costs amongst other things. From this we highlighted 4 potential schemes where we felt there was potential to rollout across Staffordshire. The projects/services we evaluated, and how we considered they supported a range of priorities, for example supporting the local Staffordshire Living Well strategy, as well as their potential to support what older people want as referenced in national research.

The schemes that were evaluated crossed the spectrum of prevention and early intervention but were focused on the core BCF purpose of preventing older people from being admitted to hospital. From this we were then going to present a proposal to the BCF working group of the options that could be expanded Staffordshire wide.

The schemes that were chosen:

1. Warmer homes - reducing/preventing ill-health which occurs/is exacerbated as a result of cold homes and results in excess winter deaths, higher admissions to A&E, and other usages of health and care urgent services and institutional care
2. Risk stratification for example by SAFER (Tamworth and S Staffs) and in Stafford Healthy Homes – where data is gathered to target those at risk; people are then visited and offered a series of support/interventions to keep them independent.
3. Developing services and support systems for dementia , including Dementia Friendly communities and specific services for those who have dementia to stay well at home, for example in partnership with the Alzheimer's Society – a Dementia Support Service – which provides one-to-one support to people with dementia, carers and family members
4. Being active / active ageing for example through local Walking Programmes - Volunteer walk leaders, recruitment, support and development.

There was also discussion at the meeting about the potential benefits of effectively utilising Home improvement agencies and handypersons and the importance of DFG's. The next steps were for the shortlisted schemes to be presented to the Strategic Locality Leads Group and then to the BCF working group.

There is also the opportunity for residents to get involved

- Engaging Communities Staffordshire has been asked to develop the engagement around the new Better Care Fund.
- Because so much of the Better Care Fund is focused on the development of greater integration we consider it a vital piece of work.
- We will be supporting the people of Staffordshire to ensure they can have their voice heard via focus groups, public surveys and case studies. The feedback that we collect can be used to influence the upcoming implementation of the Better Care Fund.
- We will soon be rolling out our online public survey, this survey will enable you to have your say on the Better Care Fund in Staffordshire. You can also get involved in the conversation by joining us on Twitter @HWStaffordshire and using the hashtag #BetterCareStaffordshire.

Next steps for the Staffordshire BCF

The Collaborative Commissioning Congress meeting, which took place in August, considered the BCF in the context of the wider system change being planned for the Staffordshire Health Economy. It concluded that the scope of the BCF falls within that of the Pan-Staffordshire Transformation Programme and should be migrated to that programme, and should not be treated separately.

Specifically, the BCF falls within two of the three Pan-Staffordshire Transformation Programme workstreams; “High Risk and Independent” and “Receiving Care”. Officers from Staffordshire County Council, Stoke-on-Trent City Council and the Staffordshire CCGs are working together to scope these workstreams and to ensure that the BCF is appropriately planned within this programme.

Questions to be Addressed

Members may wish to consider the information provided in this report with a view to developing a range of questions to be directed to the BCF lead.

Outcomes

Members may wish to consider if Newcastle residents are receiving their share of the BCF.

Financial Constraints

The County Council entered into a pooled budget arrangement for the Better Care Fund, with £105m in the 2015/16 budget. Contributions are received from CCG partners primarily including £16.234m of S.256 funding previously transferred from the NHS to support Social Care activities.

The Council continues to receive Disabled Facilities Grant funding through the BCF which is vital to the delivery of mandatory grants to help the most vulnerable live in their own home.

Invited Partners/Stakeholders/Residents

This report has been written as an introductory item to enable Scrutiny members to consider the basic issues with a view to more in depth questions being developed to be directed to the BCF leads.

Relevant Portfolio Holder

Safer Communities

Appendices

None

Physical Activity for Older People

Health and Wellbeing Scrutiny
Committee

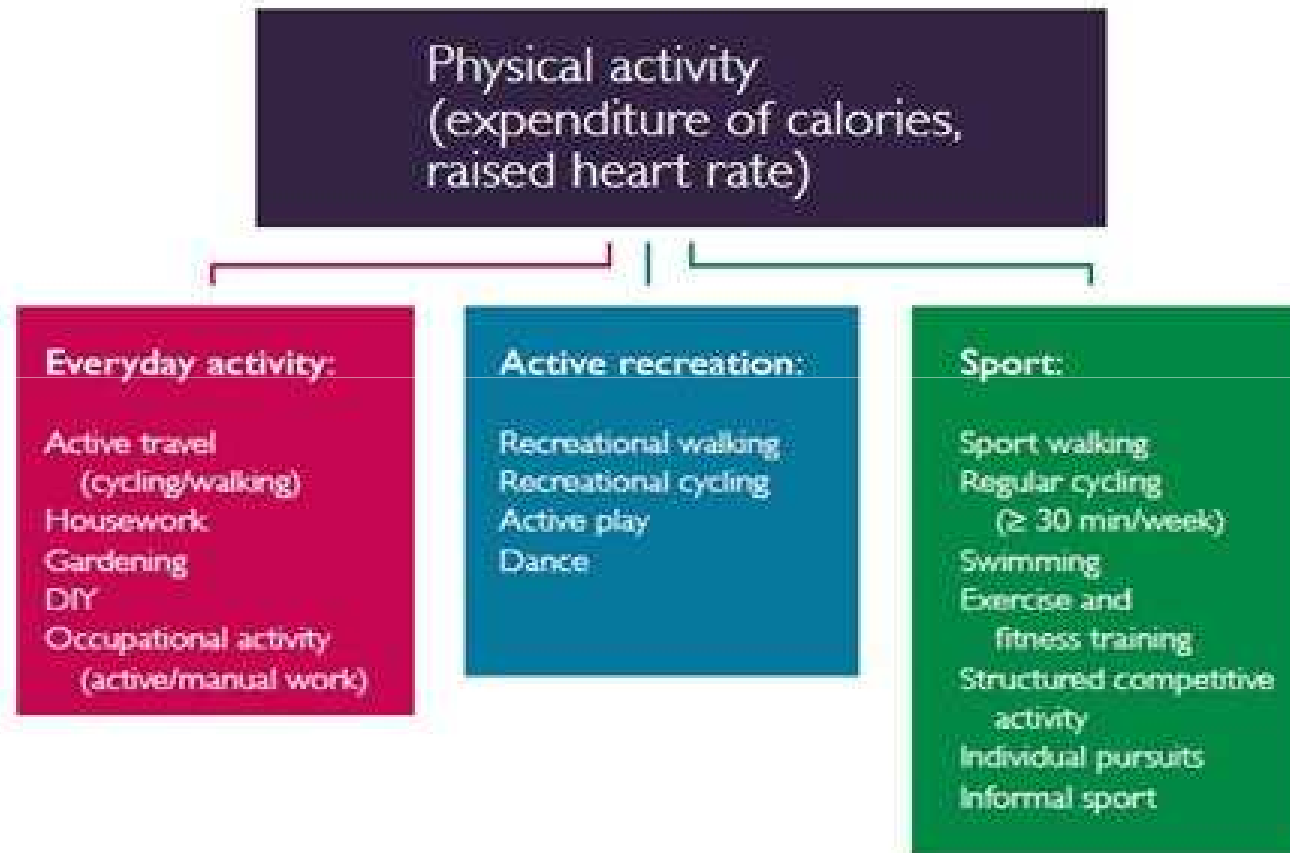
18 November 2015



Summary

- What is Physical Activity?
- Why is it a Priority for Older People?
- The effect of Physical Activity on the Aging Process
- Our Services
- Outcomes
- Recommendations
- Evaluation

What is Physical Activity?



Why a Local Priority?

Of the 24 wards in Newcastle, 18 have high proportions of older people aged 65 and over than the England average.

	65 -74	75+	Total
Newcastle-under-Lyme	12,000 (9.6%)	10,800 (8.7%)	124,500 (100.0%)
Staffordshire	86,000 (10.3%)	69,000 (8.3%)	831,300 (100%)
West Midlands	9.1%	8.1%	5,455,200
England	8.6%	7.9%	52,234,000

The Aging Process

- Decrease in maximum cardiac output
- Reduction in lung performance
- Loss of skeletal muscle mass
- Decrease in myoglobin in muscle cells
- Reduced insulin sensitivity
- Reduction in bone marrow and loss of minerals
- Decline in short term memory
- Changes in hormonal regulation
- Diminished capacity in immune system

Our Services

Our Facilities

- J2 and Kidsgrove SC

Our Fitness Team

- Cardiac Rehabilitation, GP Referral, Personal Training, Group Exercise, Disability

Our Programme

- All abilities – eldest user 88 (cardiac care)

Lyme Card

- 602 Members over 65 + 837 registered Lyme Card Holders

Outcomes

- Allocate exercise into member schedules
- Promote quicker healing
- Individual Physical Activity Programmes
- Functional Independence
- Reduce co-morbid conditions
- Promote Self Care
- Reduce Health Care Costs (Health Wider Economic Value £43.6m)
- Leisure Time (£21.2m GVA participation)

Recommendations

- Exercise participation at least twice a week for aging individuals
- Moderate exercise duration of more than 30 minutes
- Strength training, resistance training, and flexibility exercises, performed in conjunction with aerobic conditioning (This is capable of producing significant strength, endurance and functioning in the elderly population)

Recommendations contd.

- Warm-up and cool down phases of 5-10 minutes duration including flexibility and aerobic exercises (Important due to the risks of hypertension and musculoskeletal complication)
- Aerobic training should be initiated gradually at light intensity levels with progression to moderate intensity. (This assists in injury prevention by increasing the elasticity of the muscle and connective tissue)

Recommendations Contd.

- Participation in group physical activity provides social support and improve frequency of participation

Evaluation

Certified Health Professionals needed to assess:

Patients health status, including living conditions, depression or life satisfaction scales, mental examination, physical assessment and physical fitness

Long Term Measurements

Decreased mortality rates, increased life expectancy, reduction in prevalence of chronic diseases

Further Information

Fitness Trainers

Cardiac Rehab: Andrea.Turner@newcastle-staffs.gov.uk

GP Referral: Lynne.Dixon@newcastle-staffs.gov.uk

Personal Training: Mark.Morgan@newcastle-staffs.gov.uk

Group Exercise Hayley.Hal@newcastle-staffs.gov.uk

Health and Fitness Officer

Disability: Nicky0.Robinson@newcastle-staffs.gov.uk

Health and Fitness Manager

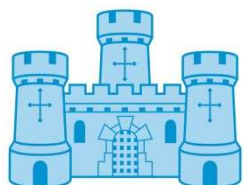
Membership: Andrew.Murfin@newcastle-staffs.gov.uk

Sport and Active Lifestyles Manager

Andrew.Arnott@newcastle-staffs.gov.uk

Head of Leisure and Cultural Services

Robert.Foster@newcastle-staffs.gov.uk



Physical Activity in Deprived Areas

Health and Wellbeing Scrutiny
Committee

18 November 2015



Summary

- Where is the Deprivation and how many people does it affect?
- Physical Activity and Health
- Physical Activity and Crime
- Physical Activity, Young People and Education
- Physical Activity and Regeneration / Environment
- Physical Activity and Volunteering
- Physical Activity and Ethnic Minorities

Indices of Deprivation 2010

38 Indicators

- Income (22.5%)
- Employment (22.5%)
- Health and disability (13.5%)
- Education, skills and training (13.5%)
- Barriers to housing and services (9.3%)
- Crime and disorder (9.3%)
- Living environment (9.3%)

IMD Contd./

- Newcastle has an overall average weighted deprivation score of 18.9 and is ranked as being 150th most deprived district of 326 local authorities.
- There are 12 lower super output areas (LSOAs) in Newcastle that fall within the most deprived fifth of areas in England making up 14% of our population.

12 lower super output areas (LSOAs)

	IMD score	Nat.Rank	Pop
Cross Heath	54.4	1,479	1,200
Knutton and Silverdale	51.4	1,944	1,300
Chesterton	47.1	2,750	1,400
Butt Lane	40.4	4,461	1,200
Kidsgrove	39.2	4,819	1,400
Chesterton	38.8	4,946	1,500
Silverdale and Parksite	37.7	5,301	1,800
Town	37.2	5,449	1,600
Holditch	37.2	5,462	1,600
Cross Heath	36.2	5,811	1,500
Thistleberry	35.1	6,180	1,600
Holditch	34.8	6,292	1,600

Physical Activity and Health

- Frequency of activity required to achieve health benefits is difficult for many to achieve.
- Appropriate and convenient local facilities
- Promotion of a more active lifestyle
- Lower participation by men than women (except on referral)

Physical Activity and Crime

- Short-term funding means that projects do not last long enough to achieve any meaningful impact
- Traditional facility-based programmes have a limited impact.
- Most effective when combined with programmes addressing wider personal and social development.

Physical Activity Young People and Education

- There is a causal relationship with academic performance
- There are mutually beneficial opportunities to involve professional sports clubs in the development of integrated sport/education programmes, particularly in attracting under achievers.

Physical Activity Regeneration / Environment

- Facilities make an important contribution to the physical infrastructure of communities, providing a social focus and affecting people's perception of their neighbourhood.
- The maintenance of under-used community facilities and wider environmental recreation related improvements have a significant role to play

Physical Activity and Volunteering

- Short-term funding means that developing volunteers is a priority for many initiatives
- Barriers to volunteering
- There is a need for a systematic approach to the recruitment, training and support of volunteers,

Physical Activity and Ethnic Minorities

- Specific issues relating to cultural/religious beliefs and perceived racist attitudes
- Several factors reduce opportunities for casual participation, reduce variety of sports which can be accessed and limit facility access for clubs at premium times.

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Jubilee2

The services and courses at Jubilee2 continue to expand:

Climbing

We have our own skills and safety awards to work towards, with certificates for each course highlighting progress at each level. The highest award being the National Indoor Climbing Award Scheme (NICAS) courses

The Lyme Card

The Lyme Card is both a membership card, discount card the loyalty card, offering card holders get great deals at many town centre businesses.

Swimming Lessons

Our classes are based on the Amateur Swimming Association's (ASA) National Plan for Teaching Swimming (NPTS) which is an all-inclusive programme that takes non-swimmers from their first splash to developing confidence and competence in the water.

Fitness

The 95 station gym has cutting edge "Technogym" equipment. This gives our staff valuable information on customers exercise programmes and exercise habits.

The "Wellness" key system controls access to the gym and also acts as a workout card and holds a memory chip which guides users through their exercise programme.

The key stores, downloads and displays workout data such as the number of workouts completed, workout duration, calories accumulated / burned off and the weight lifted. It also enables customers to take part in challenges.

Swimtag

Swimtag is wearable technology that allows members to keep a record of their swims and review their training progress. It records personal bests, provides interactive training plans, competition with other users, challenges and is enabled for customers to share results on social media.

Group Exercise Classes

Jubilee2 has over 60 group exercise classes a week that caters for a range of ages, abilities and class tastes with some of the most popular classes in the UK

Table Tennis

Table tennis is now included in membership and available on a pay and play basis also.

Sports Massage

Sports massage is the latest activity to be added.

Kidsgrove Sports Centre

Progress with the replacement pool for Kidsgrove was reported to Cabinet on 11 November. Agreement has been reached with the County and Kier regarding the undertaking of the feasibility study.

Partners are committed to extending the current joint use agreement until the new facilities are available.

The Borough Council is looking to enter into a dual use agreement with the school for community use of the school sports facilities that will not be under the control of the county council.

Sports Development

Castle Sport – the new advisory sports council for the borough held its first AGM on 19 October 2015 and is now in a position to advise the grants panel on sports grants and work through its constitution on improving opportunities for sport and active recreation locally.

The Council's Football Development Officer has left to join Port Vale Football Club as their Community Development Manager and is to be replaced with a generic Sports Development Officer. The emphasis on our directly provided activities will become multisport and have a wider appeal.

The Council is working in partnership with local Archery Clubs and the sports governing body to increase access to the sport.

Sportivate funding is being applied for to engage young people under 25 in sports activities.

This Girl Can and Active2 Memberships

Newcastle partnership is providing part funding for women and young people from the Boroughs deprived wards to access the above membership schemes.

Museum update

Exhibitions

The B(u)y Me for Christmas exhibition opens on November 14 – 10 Jan. The exhibition showcases the work of makers – including ceramics, jewellery, glass and textiles.

The B(u)y Me craft fair held at the museum on October 31 was successful.

Father Christmas will be visiting the museum on December 12 and 19.

Education

A new Roman Newcastle session has been launched focusing on the local Roman sites and the lives of people who lived in this area 2000 years ago.

Collections

The 2016 Museum Calendar will be available next week ready for Christmas. The calendar uses images from the museum's collections.

A new Collections volunteer has been inducted and is assisting the collections officer. The museum now has 17 volunteers in its team

Building

The exterior of the museum building is currently being painted and should be completed before the end of the month and the winter sets in.

Projects

The museum is a founding member of the Astley Committee. The committee is a partnership between the Borough, Staffordshire University, Keele University, the New Vic Theatre, Newcastle Library, Newcastle BID, Staffordshire Film Archive and a local, professional circus practitioner. The committee exist to deliver a project to celebrate the life and contribution of Phillip Astley, the inventor of the modern circus, who was born in Newcastle in 1742. The groups are preparing a Stage 1 HLF bid to deliver a series of activities leading up to and including 2018.

West Midlands Museum Development Programme Small Scale Capital Grant Scheme

After submitting an expression of interest application for the above grant the Museum has now been invited to submit a formal application. The purpose of the grant is to improve museum/gallery facilities and environment to enable smaller institutions to host/loan objects from national collections. There is a hope that in 2018 as part of the Astley project the museum will loan items from the V&A and having tighter security measures in place will assist with this process. The grant applied for will be in the region of £11k and will cover items such as high specification cases, CCTV improvements, environmental controls, security screws and a security shutter.

HLF Projects

The museum is involved with both the successful HLF projects at both the Maxim's site and St Giles' Church. The museum will be assisting the CLS group with site interpretation and reminiscence. The St Giles' includes a permanent display at the museum and a possible temporary exhibition dependant on the result of the excavations.



Members: Bailey, Allport, Mrs Winfield,
Loades, Northcott, Mrs Hailstones, Miss
Frankish, Miss Walklate and Woolley

HEALTH AND WELLBEING SCRUTINY COMMITTEE WORK PLAN

Chair: Councillor Eastwood
Vice Chair: Councillor Mrs Johnson

Portfolio Holder(s) covering the Committee's remit:
Councillor Tony Kearon (Safer Communities)
Councillor Amelia Rout (Leisure, Culture and Localism)

Work Plan correct as at: Friday 6th November 2015

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
8th July 2015 (agenda dispatch 26th June 2015)	North Staffordshire Clinical Commissioning Group – Promoting independence, choice and dignity: a new model of care in Northern Staffordshire	The Clinical Commissioning Groups aim is to integrate care services to connect people with the care they need, when they need it. Officers from both North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups are invited to attend to answer any concerns raised by Members
	Health and Wellbeing Strategy	The Health and Wellbeing Strategy seeks to identify and prioritise the key determinants of health in Newcastle under Lyme, develop a shared approach to addressing health inequalities and ensure that our residents are well placed to benefit from current health reforms
	Minutes from the Healthy Staffordshire Select Committee	To receive the minutes of the meeting held on the 8 th June 2015
	Local Government Association Peer Review of Decision Making Arrangements	To advise Members on the recommendations of the LGA Peer Review and to request feedback on the recommendations
	Healthwatch, Staffordshire	Update on North Staffordshire activity June 2015
	Work Plan	To discuss the work plan and potential topics that Committee members would like to scrutinise over the forthcoming year

Date of Meeting	Item	Reason for Undertaking
30th September 2015 (agenda dispatch 18th September 2015)	Healthwatch, Staffordshire	July/August summary updates to be provided by Healthwatch, Staffordshire
	Minutes from the Healthy Staffordshire Select Committee	To receive the minutes of meetings held on the 5 th August 2015 and the 10 th August 2015.
	North Staffordshire Clinical Commissioning Group – Promoting independence, choice and dignity: a new model of care in Northern Staffordshire	Officers from both North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups are invited to attend to present Members with the new proposals of the model of care which would come to effect October 2015
	Swimming in the National Curriculum for Key Stage 2 Primary Schools	Ben Adams, Cabinet Member for Learning and Skills, Staffordshire County Council to be invited to attend to provide an account of swimming provision for Key Stage 2 primary school children within the Borough
	Work Plan	To discuss the work plan and potential topics that Committee members would like to scrutinise over the forthcoming year
18th November 2015 (agenda dispatch 6th November 2015)	Healthwatch, Staffordshire	Sue Baknak from Healthwatch, Staffordshire attending to provide a summary update
	Minutes from the Healthy Staffordshire Select Committee	To receive the minutes of the meeting held on the 21 st September 2015 and Digest of the 14 th October 2015
	Portfolio Holder(s) Question Time – Cabinet Portfolio Holder for Leisure, Culture and Localism will be in attendance	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
	Better Care Fund	The Head of Housing and Regeneration Services be invited to present the future direction of the Better Care Fund process. What role should districts/boroughs play?, What should the Council be offering in relation to the wider health and wellbeing agenda, particularly in terms of the services it delivers? Has the Partnership focussed on the ‘right’ areas in terms of needs, priorities and outcomes?

Date of Meeting	Item	Reason for Undertaking
18th November 2015 (agenda dispatch 6th November 2015) Cont'd ...	Dementia Services within Newcastle-under-Lyme	The Commissioning Manager, Dementia and District Commissioning Lead for Newcastle be invited to present a report covering:- <ul style="list-style-type: none"> • What is dementia? • What causes dementia and how can it be prevented? • What is the dementia pathway in North Staffordshire from memory services to end of life? • Work that is happening in health and social care
	Work Plan	To discuss the work plan and potential topics that Committee members would like to scrutinise over the forthcoming year
6th January 2016 (agenda dispatch 24th December 2015)	Minutes from the Healthy Staffordshire Select Committee	To receive the minutes of meetings held on the 9 th November 2015 and the 4 th December 2015
	Healthwatch, Staffordshire	Summary update to be provided by Healthwatch, Staffordshire
	Swimming as part of the National Curriculum for Key Stage 2 Children	A report to be presented into the findings carried out by Committee
	The Midway Walk In Centre	A review to be presented by Officer(s) from North Staffordshire and Stoke on Trent Clinical Commissioning Groups on the outcome of a programme of work and the level of patient engagement undertaken to establish a suitable service
	Work Plan	To discuss the work plan and potential topics that Committee members would like to scrutinise over the forthcoming year

Date of Meeting	Item	Reason for Undertaking
6th April 2016 (agenda dispatch 27th May 2016)	Minutes from the Healthy Staffordshire Select Committee	To receive the minutes of meetings held on the 2 nd February 2016 and 22 nd March 2016
	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:	<ul style="list-style-type: none"> • 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. • Health and Wellbeing within the Public Health Function. District Public Health Development Officer - Newcastle under Lyme to be invited.

DATES AND TIMES OF CABINET MEETINGS:	Wednesday 10 th June 2015, 7.00pm, Committee Room 1
	Wednesday 22 nd July 2015, 7.00pm, Committee Room 1
	Wednesday 16 th September 2015, 7.00pm, Committee Room 1
	Wednesday 14 th October 2015, 7.00pm, Committee Room 1
	Wednesday 11 th November 2015, 7.00pm, Committee Room 1
	Wednesday 9 th December 2015, 7.00pm, Committee Room 1
	Wednesday 20 th January 2016, 7.00pm, Committee Room 1
	Wednesday 10 th February 2016, 7.00pm, Committee Room 1
	Wednesday 23 rd March 2016, 7.00pm, Committee Room 1
	Wednesday 8 th June 2016, 7.00pm, Committee Room 1

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