Public Document Pack

Date of meeting	**Wednesday, 21st November, 2012**
Time	**7.00 pm**
Venue	**Civic Offices, Merrial Street, Newcastle-under-Lyme, Staffs ST5 2AG**
Contact	Julia Cleary 01782 742227

Health Scrutiny Committee

AGENDA

PART 1– OPEN AGENDA

1 Apologies

2 Minutes of Previous Meeting **(Pages 1 - 4)**

3 MINUTES FROM THE COUNTY HEALTH SELECT COMMITTEE MEETING HELD ON MONDAY 5TH NOVEMBER 2012

Minutes will be circulated once published.

4 Minutes from the Health Accountability Session held on 22nd October 2012 **(Pages 5 - 16)**

5 INFANT MORTALITY

Mr John Harvey, Public Health Consultant will be in attendance to discuss infant mortality.

6 Model of Care Phase Two Fortnightly Update **(Pages 17 - 22)**

7 NUTRITION

Awaiting confirmation regarding attendance at the meeting by the North Staffs Team Leader for Nutrition.

8 HEALTH SCRUTINY MEMBERS VISIT TO A&E

To be arranged by Newcastle under Lyme and to invite Members of the County Council Health Select Committee. Possible dates will be provided closer to the date of the meeting.

9 VISIT TO BRADWELL HOSPITAL - NEW DATES

22nd November from 10am to 3pm
27th November all day
28th November all day

10 Declarations of Interest

11 URGENT BUSINESS

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

Members: Councillors D Becket, Mrs Cornes, Eastwood (Chair), Mrs Hailstones, Mrs Johnson, Loades, Taylor.J and Williams

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

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

HEALTH SCRUTINY COMMITTEE

Wednesday, 24th October, 2012

Present:- Councillor Colin Eastwood – in the Chair

Councillors D Becket, Mrs Cornes, Mrs Johnson, Loades and Taylor.J

1. **APOLOGIES**

Apologies were received from Cllr Mrs Hailstones.

2. **DECLARATIONS OF INTEREST**

Cllr Mrs Johnson stated that she worked for an organisation that covered Combined Health Services.

3. **MINUTES OF PREVIOUS MEETING**

That the minutes of the meeting held on 15th August 2012 be agreed as a correct record.

4. **MINUTES FROM THE COUNTY HEALTH SELECT COMMITTEE ON 1ST OCTOBER 2012**

Resolved: That the minutes be received.

5. **QUESTION AND ANSWER SESSION WITH REPRESENTATIVES FROM THE CCG**

The Chair stated that unfortunately the representatives from the CCG were unable to attend the meeting. It was however also confirmed that a meeting was due to be organised by the County Council Health Select Committee to which the CCGs, County Council representatives and Borough Council Representatives would be invited. It was hoped that the meeting would be held towards the end of November. The Chair confirmed that he would be attending a Board meeting of the North Staffordshire CCG on 7th November along with Cllr Becket, Cllr Loades confirmed that he would also like to attend the meeting which would be held at the Hartshill medical Institute at 2pm.

Members requested that it be highlighted to the CCG that the Borough Council were still keen to meet with their representatives.

6. **UPDATE REGARDING PHASE 1 OF THE ADULT MENTAL HEALTH CONSULTATION INCLUDING THE MOVE OF ELDERLY PEOPLE TO HARPLANDS HOSPITAL**

Members welcomed Kath Clark, Service Line Manager for Older People's Services and Jacqui Wilshaw, Modern Matron for Older People's Services.

The Assessment Ward (Ward 4) had dealt with people aged over 65 with dementia or suspected dementia; often these patients were admitted following deterioration in their mental health treatment of which could be intensive.

In order to cater for this a complex needs purpose built ward had been installed which used the surrounding environment to help treat patients. The move of Ward 4 was to be completed in 2 phases with completion scheduled for February 2013. The move of Ward 6 which dealt with complex needs had already been completed on April 2012.

Members requested information regarding the beds in the wards and it was confirmed that there were 20 beds in Ward 4 and that 17 were currently being used, a 60 day turn for beds around was considered average. There were 10 beds in Ward 6 which were all occupied and there would be 15 once the move was completed.

Members discussed the involvement of Carers in the care process and it was confirmed that carers were a vital part of the care package especially prior to a patient returning home as staff had to be sure that facilities were in place for domiciliary home care and that a care package had been agreed. Members requested that at a future meeting an exercise be carried out to show in details the care pathway that was followed.

Members queried how support was offered to patients once they had returned home and it was confirmed that each case was dealt with on an individual basis. A model of care was available to carers in order to help them make an informed decision as to whether they were able to care for the patient at home or whether additional help was required. It was thought that at present a larger percentage of patients went into care rather that back home but that this could change in the future due to the National Dementia Strategy which could lead to more early diagnoses.

Members raised concern regarding the funding that was available for patients and carers once they left hospital and the availability of services in the community to support them. It was confirmed that training sessions were organised for Carers by Mrs Wilshaw that that training formed a part of the role of staff on the wards. Community Mental Health Nurses were also available to help.

The question was raised as to where GPs fitted into the picture and it was confirmed that master classes were being held with GPs and more referrals were being made on the basis of these.

Overall members were please with the progress that had been made and that continued to be made regarding the move of facilities and thanked Mrs Clark and Mrs Wilshaw for attending the meeting.

7. **UPDATE ON INFANT MORTALITY FROM THE COUNCIL'S PARTNERSHIPS MANAGER.**

The Committee received a briefing note from the Council's Partnerships Manager regarding Infant Mortality in Newcastle under Lyme.

Members raised concerns regarding where Health Visitors fitted into the process and it as confirmed that at present there was no Health Visitor Representative on the Infant Mortality Commissioners Group.

Concerns were also raised regarding the apparent slow progress of the scrutiny topic and that the Commissioners Group still appeared to be in the scoping phase. The issue had first been identified in spring 2011 at which point the County Council Health Scrutiny Committee had requested Newcastle to carry out a scrutiny exercise on the topic.

The Partnerships Manager stated that it looked as of the figures were dropping but that further clarification was required and that no ward in the Borough appeared to be worse affected than any other. Members stated that if the figures were improving then the reasons for this needed to be identified to ensure that there was no relapse in the future.

A request was made that a representative form the Commissioners group attend a future meeting of the Scrutiny Committee and provide more up to date figures regarding Infant Mortality in the Borough including clarification as to what was classed as infant mortality.

Resolved: That the information be received, that further more up to date information be requested for the next meeting and that if possible a representative of the Commissioners Group be invited to attend a future meeting.

8. **NEWCASTLE HEALTH SCRUTINY COMMITTEE VISIT TO BRADWELL HOSPITAL - COUNTY CMHT/MEMORY CLINIC**

Resolved: That the visit be arranged for 1st November after 4pm.

9. **URGENT BUSINESS**

There was no urgent business.

COUNCILLOR COLIN EASTWOOD
Chair

This page is intentionally left blank

Minutes of the Health Select Committee Meeting held on 22 October 2012

Present: Kath Perry (Chairman)

Attendance	
Dylis Cornes	
Michael Oates (Vice-Chairman)	
Elaine Baddeley	Staffordshire Moorlands District Council
Colin Eastwood	Newcastle Borough Council
Stephen Smith	East Staffordshire Borough Council
David Becket	Newcastle-under-Lyme Borough Council
Hilda Johnson	Newcastle-under-Lyme Borough Council
David Loades	Newcastle-under-Lyme Borough Council
John Taylor	Newcastle-under-Lyme Borough Council
John Williams	Newcastle Borough Council
Mahfooz Ahmad	Staffordshire Moorlands District Council
Hilda Sheldon	Staffordshire Moorlands District Council
Patricia Rowlands	Stafford Borough Council

Also in attendance:

Apologies: Gill Heath, Brian Gamble (Cannock Chase District Council), Andrew James (Tamworth Borough Council), Janet Johnson (South Staffordshire District Council Representative) (South Staffordshire District Council), Amyas Stafford Northcote (Stafford Borough Council Representative) (Stafford Borough Council), Frank Hopley (Staffordshire Moorlands District Council) and Christina Jebb (Staffordshire Moorlands District Council)

PART ONE

63. Declarations of Interest

There were no declarations of interest.

64. Minutes of the Accountability Session held on 10th November 2011

RESOLVED – That the minutes of the Accountability Session held on 10 November 2011 be confirmed and signed by the Chairman.

65. Minutes of the Accountability Session - Mid Staffordshire NHS Foundation Trust held on 27th September 2012

RESOLVED – That the minutes of the Accountability Session for MidStaffordshire NHS Foundation Trust held on 27 September 2012 be confirmed and signed by the Chairman.

66. Minutes of the Health Select Committee meeting held on 1st October 2012

RESOLVED – That the minutes of the Health Select Committee held on 1 October 2012 be confirmed and signed by the Chairman.

67. University Hospital of North Staffordshire NHS Trust

The Chairman welcomed everyone with, the Scrutiny and Support Manager explained the arrangements for the meeting.

Trust Introduction

The Trust was represented by the Chief Executive Julia Bridgewater, Chairman John MacDonald and Chief Nurse Elizabeth Rix.

Julia Bridgewater gave a presentation in respect of the self assessment report of the Trust during which she advised that there would be a focus on nutrition and hydration ensuring patients are fed and watered at the appropriate times at the appropriate level during the actual presentation.

She advised that the presentation would focus on key targets and update in respect of performance over the previous year. She felt that overall the self assessment report was positive and that they could be proud of the quality of care that was being provided.

She pointed out that the 18 weeks from referral to treatment percentage was 96.63% of outpatients seen for the period compared with the 95.4% last year. 89.19% inpatients seen in 18 weeks compared with 88.48% of the previous year. All cancer targets have been achieved, two week wait referral to first outpatient appointment all cancers was 96.3% compared with 94.3% last year.

Overall she felt that they could be very positive about the care being administered at the hospital. She advised that there had been an increase in the number of cancelled operations from 810 last to 860 this year she felt that this issue would be addressed with the introduction of the new operating theatres, when up and running to their optimum.

On a positive note she was able to advise that the number of operations rearranged within 28 days was reduced to 61 compared to 95 last year. The A & E four hour wait was performing well against the national target of 95% being achieved at 92.51%. The infection control incidents of MRSA was 6 recorded when compared with 22 last year and C Diff 69 recorded when compared with the 274 last year. These were positive results.

In relation to clinical care, she advised that the VTE (venous thromboembolism) assessment was exceeding the national target of 90% achieving a figure of 95%. She advised that they were hitting all access targets and the death rate was 82 as at June 2012 which was a favourable figure taking into account the type of patient expected. This was a key indicator which when taking into the account the SHIMI(summary hospital level mortality indicator) score of 10.4 and a banding of 2 meant that the levels of mortality are within the expected limits or better than expected for the case mix seen.

Julia Bridgewater advised that the elimination of pressure ulcers was on track with an aim to eliminate totally all avoidable pressure ulcers by December 2012. In respect of safety express 97.38 of patients were on harm free in July and that 100% of patients were surveyed once a month.

The committee were advised, a recent visit of the Care Quality Commission(CQC) who made unannounced visit to the A and E and assessment wards and elderly care and surgical wards. They were compliant with key standards and no areas of concern.

The West Midlands Quality Review Service, Mental Health and Learning Disabilities inspection where the assessors had found that there was no need for immediate concern, but there was support required around adults safety, dementia disability services and persons with learning difficulties attending A&E and urgent care.

She chose to focus on four clinical service highlights, the move to the single site, the second stroke services, major trauma centre and the vascular services, she felt that these were success stories worthy of further comment.

In respect of the move to the single site she advised that this took place in November 2011 to March 2012 and that the first patient had moved in on the 4th November. The A&E facilities are considered to be one of the best of Europe. With all the space that was needed to treat patients, a children's hospital within the hospital and the intensive care unit with 40 beds, state of the art facility. The retained estate, in particular the Trent and Lyme buildings have had a £50m refurbishment and are valuable amenity of the hospital.

Julia Bridgewater gave a very favourable report in respect of stroke services saying that it was one of the best services in the country and that 96% of stroke patients admitted to the stoke unit compared to 88% nationally. Patients spent an average of 6 days on ward compared with 10 nationally and 4% of transfers to residential care homes for the

first time compared with 10% nationally, 17% patients received thromboembolism compared with 5% nationally this is the most effective form of early treatment.

Julia Bridgewater provided an informative description of the telemedicine facility for stroke services the first in the West Midlands. It gave a faster access to treatment and that patients who present at their local hospital with symptoms of a stroke received treatment rapidly at any time of the day or night. She said that stroke physicians could be contacted out of hours for advice and when necessary would return to the hospital to administer treatment. Overall the outcomes for stroke victims at the University Hospital of North Staffordshire are better then most in the remainder of the country.

She advised that the major trauma centre had been live since the 26th March 2012 serving a population of 2.25m and that they received major trauma from the surrounding hospitals. The unit covered Staffordshire, Cheshire, Shropshire, Derbyshire and North Wales and was aligned with the North Staffs Rehabilitation Service and the Haywood Hospital. The facility had now secured a very high calibre of staff and she was able to advise that from one consultant it had now increased to 15 consultants since the unit had come into being.

The committee were informed of the importance of a Major Trauma Unit saying that it had saved 60 lives in the West Midlands and 12 locally, exposes people to expertise only available at larger centres, specialist services and it helps to secure future training of staff.

Vascular services, Julie Bridgewater advised that during the last year the UHNS vascular surgeons have worked in partnership with Mid Staffordshire Mid Cheshire Hospitals to centralise major vascular services at the Trust.

It was explained that the collaboration had resulted in a dedicated emergency on call vascular rota giving access to high level expertise on a 24/7 basis including vascular and interventional radiology. The local clinics would continue to deal with matters of a less complex nature.

She expanded on the vascular services describing the AAA screening programme, (abdominal aortic aneurism) stating that 8 of people who suffer an AAA usually die, it is a silent killer but is treatable if discovered on time.

A screening programme was launched in April involving a simple ultrasound test for men over 65 who fit the criteria of being at risk. This was a condition that usually affected men and that since launch 2000 men had been screened, 30 were discovered to have small aneurisms and 3 significant aneurisms. Screening is a life saving opportunity, a procedure that saves lives and therefore every effort should be made to promote and expand the process.

The focus for the year ahead was explained, the completion of the hospital move was a major feature and they would continue with the fight against infections. She informed that in the first quarter the target for infection control had not been achieved but in the second quarter it had.

She advised that it is unlikely that the target would be met in the third quarter as there had been a challenging four weeks and she was aware that they had not met the targets for the final two weeks of the period. On a positive note she was able to advise the session that there had not been an outbreak of MRSA at the University Hospital of North Staffordshire for 236 days.

The Strategic Development Plan was explained and that the integrated Business plan (IBP) would be developed by the quarter four of this year. It was important to take into account the major service reconfiguration including the implications of the review of the Mid Staffordshire FT. Major Service configuration required to be financially viable and that the changes needed to be clinically led and driven by safety. She added that the long term financial model must be financially viable and in addition to the UHNS would include mental health and the clinical commissioning groups.

Carbon had been included in the presentation as the Trust were one of the largest carbon produces in the county and that their carbon management plan set a target of reducing the CO2 omissions by 10% by 2015. There had been a reduction in water consumption and there was a recycling process on site to assist with the reductions.

Julia Bridgewater outlined the policy for ensuring that patients are well nourished after admission to the hospital. She stated that it was important that different patients had different dietary needs for instance oncology would require a different diet than surgical as would children and people with other dietary requirements.

It was important that protective mealtimes were recognised and that the right ambiance was provided at mealtimes for the patients. Timeliness is of importance, and snacks should be available in the event of meals being missed and that the location of dieticians on site was particularly critical to the success of the process.

The Chairman thanked the Trust for an in-depth and informative presentation.

Questions from the public

There were no questions from the public

Questions from the Members

A member commented that he did not feel that the Trust's answers to supplementary question 5 actually answered the question. He felt that they had missed the point and were making reference to issues that he did not feel were part of the problem. In particular the name was a piazza or plaza and that the issue of people smoking outside of the hospital entrance which was not part of the original question.

He reiterated the point contained in the original question being what he considered to be a poor design resulting in patients being exposed to inclement weather when visiting the hospital. Also the disabled parking was positioned too far away from the entrance.

He offered a number of suggestions to rectify the issues as he saw them and asked if there were any plans to turn the plaza into car parking for the disabled and to provide

protected walkways thus offering protection to people having parked their cars that were walking back to the entrance across the exposed area of the plaza.

Julia Bridgewater responded that she was sorry that the design of the plaza was not to his liking but that there were no immediate plans to make major modifications. She did however point out that the disabled parking had been passed by various bodies as suitable and would not have been put into place had it not been so.

She conceded that there was an opportunity for a roundabout at the plaza and the provision for more drop off points. She agreed that there were long walks from some of the disabled parking spaces but pointed out that it was not feasible to accommodate all blue badge holders in the immediate vicinity of the entrance. She concluded by saying that they were looking at innovative ways of addressing the issue of parking spaces at the front of the hospital entrance, and that there was a covered walkway into the atrium already in place.

Another member commented that she was pleased that they were looking a modified turning circle for vehicles at the front of the entrance and in particular the ambulances as there were a number of junctions which she considered to be dangerous.

Julie Bridgewater responded saying that they were looking at signposting across the site as it was now near completion as some of the signs related to the site as it was being developed therefore needed to be revised on completion. She added that they were looking at other innovative ways of addressing traffic flows etc.

Another member recounted her recent experience in respect of the 10 minute drop off time at the front of the hospital as it gave very little time having taking someone into the hospital to return to your vehicle before taking it to a parking area on the site.

Another member expressed concern in respect of the announced reduction of beds that had been based on a number of planning assumptions. She asked that had the anticipated large influx of population into the Newcastle, Stoke and Moorlands area been taken into account when these figures were being arrived at.

Julia Bridgewater responded that population growth was one of the assumptions that had been taken into account but reiterated that the other planning assumptions in particular develop of community services, primary care and the improvement of the efficiency of the Acute and Community Trust would support the planning assumptions.

She said that the modern ethos was that people should be returned home as soon as possible as it was now accepted that they recovered quickly with the correct support in the home environment.

She advised that there was flexibility in the system as in August of this year it has been necessary to open 300 additional patient beds which was 300 more of the same period in 2011. Also of the community strategy work with Primary Care and the Trust and those schemes have worked but not kept up with other areas of admission avoidance, work was in progress between the Primary and Community Trust.

The same member then asked if any enquires were made in other areas in respect of these issues. John MacDonald replied that they had and there were a number of serious of pieces of work ongoing to address these issues.

A member commented that there was no mention of A&E figures in the Trust response to supplementary questions.

She commented from the A&E figures they had a big impact, they had not anticipated the stepped increase at the old hospital prior to transfer. Similarly the new hospital had had an effect in respect of increased referrals. She advised that an increase of 10 to 15% of A&E referrals will have an effect on the admission percentage of inpatients.

She reiterated that it would be necessary to open up an additional 300 beds during August, the average number of referrals to the A&E was between 280 and 340 per day but on some days it could be between 390 and 400. These figures had serious implications in respect of the staffing model which must be reflected over the 24 hour period. It makes this type of model expensive but it is important that the same level of service is available at whatever time of the day the patient comes in.

That it was particularly important to have the correct staffing levels over the 24 hour period in respect of the trauma centre, and there was some debate for the National Health Service in respect of the service provided and that an area response rather than a local determines level of staffing and therefore provides greater flexibility than a local model.

She commented that she felt that the issue of screening had an effect on the 4 hour wait in A&E as it was felt that people were reluctant to go to their GP or elsewhere as it was often more convenient to go to the A&E department she felt that it was not a symptom of population growth but that of an attitude of people over the past 10 years.

A member commented that it had been mentioned in the report that the renal unit was moving and that there was an increase in beds she asked when this would take place.

Julia Bridgewater replied that they intended to move in December and it was necessary to have more beds as people were living longer and that they would be in a position to provide more renal stations within the hospital.

A member commented that the answers to question 9 and 11 did not make sense

Julia Bridgewater agreed that question 9 did not make sense and that the cost was £600,000. She conceded that question 11 had not been answered as it did not contain the management of chronic heart and asthmatic conditions.

The Chairman then advised that at the meeting of accountability Session for Mid Staffs a need had been identified to raise and highlight a real need for the public and committees to understand this issue. She commented that there would be a public event in December of this year for this purpose.

A member making reference to the mortality figures asked if they included elderly people who died later having left the hospital for instance at the Douglas Macmillan

Hospice, Elizabeth Rix responded saying that these figures included anyone who died 30 days after treatment, in or out of the hospital.

Julia Bridgewater offered her services for the forthcoming workshop saying that she would be more than happy to contribute. She commented that the figures do not vary whether person died in the hospital or at a hospice. She then went on to explain that there were coding measures in effect to compare like hospitals when coming to the figures for mortality and that they were adjusted in accordance and to take account of the death mix.

A member asked if it was accepted that there was a need to educate the public in the use of A&E as the walk in centres which were intended to advise and reduce the throughput of A&E were not as effective as initially anticipated. Julia Bridgewater replied that it was a good question and it was an ongoing agenda item and that there had been campaigns in the past with limited results. There was an obvious need to work with patient groups and GP's to raise awareness in this area.

Elizabeth Rix commented that there was need to work with partners, GP's and CCG's in this area and that there was a case for education. In particular schools, where children could be advised from an early age the appropriate pathway to follow for medical support.

John Macdonald commented, why do the members of the public choose A&E was it confidence, convenience, treatment or the perceived need of an x-ray. There was no evidence of the last 10 years that the walk in centres had any effect on the number of persons attending A&E.

General conversation then followed during which it was the consensus of the meeting that there was a need for the public to be educated in respect of their use and attendance of the A&E and the effects of misuse on the wellbeing and service provided by the hospital.

Julia Bridgewater summed up saying there was a need to build up confidence, to determine how that confidence was to be achieved bearing in mind there was a financial cost and that people also visit A&E during the day. It was important that there was partnership work, commissioners, walk in centres and that there should be the right amount of support for nursing homes and similar establishments in an attempt to avoid admission to the hospital.

A member asked if there were any plans to bring transplant surgery back to North Staffordshire. He was advised by Julie Bridgewater that there were no plans. It was acknowledged that the specialist skills held centrally resulted in better outcomes for patients. There was work through the CCG's to ensure that people have access to this service.

A member raised the issue of the statistics relating to infections in the hospital asking that did the figures relate to one specific infection or multiples of infections. Elizabeth Rix replied that each infection was recorded as a single entity, if there was more than one individually they were recorded in accordance with where and when they occurred.

The member asked if the Trust had a plan in place to raise the confidence of the public in respect of infections in the hospital John Macdonald responded saying that it was ongoing work but confidence would be raised if the public could see that there was a noticeable decrease in the infection rate within the hospital.

Julia Bridgewater advised that there were prevention measures in place, screening and that the issue of infection was an agenda item, there was a downward trend in MRSA and C Diff and that is an indicator that other infections are also following the same trend.

Elizabeth Rix commented that they were looking to provide harm free care not just in the area of infections but from other areas of clinical delivery, that there was a proactive programme in place to achieve this.

A member commented from the financial charts the costs were way ahead of the planned cost that was programmed. How would this overspend be addressed without an effect in the quality of care.

Julia Bridgewater commented they do not want to lose what they had gained it is a massive hospital and there were ways of finding savings, citing a quick turn around of patients without detriment to a level of care as an obvious means. She advised that the single site must be considered to more efficient in terms of rotas in the intensive care unit and less duplication.

She pointed out that the staff was still working in a new place and that efforts were being made on their own initiative to achieve internal efficiencies and in consequence savings. There had been an increase in costs through agency work and locums but she was looking of ways of generating income with the CCG's but adamant that no scheme would reduce care quality and that there was a financial challenge going forward .

The Chair asked if there was any issues regarding appointments being missed Julia Bridgewater said it was inevitable in a new building of such size when often the staff were new also and that people may often be waiting in the wrong areas to be called through for their appointments. They were looking at ways of addressing this issue and in particular felt that there were lessons to be learnt from other areas.

A member asked if the PFI payments would inhibit further development of the Trust. Julia Bridgewater explained that part of the financial model meant that the payment to the PFI took first priority .If the hospital is to increase its proficiency performance by 4-5% annually minus that part of budget fixed to meet the payment it puts pressure on the remainder when trying to achieve these figures.

A member commented on the signage within the hospital, saying that they on a recent visit they had difficulty in finding a way out. Julia Bridgewater commented that they were looking at the signage within the establishment internally and externally as most of it was put into place before completion of the buildings and outlining areas and therefore was worthy of revision.

A member asked if there was any evidence of a healthy lifestyle choice, diet and exercise having an effect on the overall budget, better health would require less medical support. John Macdonald commented that there was no specific information in relation

to this but there was statistics' to confirm that a smoker giving up for 18 months reduced the risk of heart attach dramatically.

A member asked if A&E closures at Mid Staffs Hospital had a noticeable impact on the UNHS she was interested where services were being accessed. Had the patients accessed UNHS and if this had an effect on the viability of the financial model. Could it reach a point when the hospital would not achieve its 4- 5% annual efficiency savings.

Julia Bridgewater responded that UHNS were managing the flow of patients from Stafford but further work was being undertaken to understand the flow of patients not just at night but also in the day time.

Julia Bridgewater highlighted that UHNS would not be financially viable going forward unless there were local health economy solutions working with partner organisations in an innovative way to provide for the needs of an increasing ageing population.

A member asked if there was a need to increase turnover to meet overheads, would it affect the financial balance, the facilities and the treatments provided in particular queuing.

Julia Bridgewater responded saying queuing was not acceptable, the high spec of equipment and building need less in terms of financial support as payment for maintenance it is met though the PFI, and this would be an issue had they have not followed the PFI route.

The old three site hospital was not a cheap option and finances would not stack up in respect of the refurbishment of the old three site hospital route and they have not gone down the PFI route.

A member commented from the statistics there had been an increase in staff's sickness since August was there a reason for this and was there support in place to reduce it.

Julia Bridgewater accepted there was a need to handle sickness as it was part of the efficiency savings and that were sickness was genuine that it should be managed in a sensitive manner. At the same time robust systems must be in place to ensure that there was not a misuse of the system.

A member asked if the Trust had a Bradford Score system in place for managing attendance and work, sickness. Julia Bridgewater advised that they had.

Summary and way forward

The Chairman thanked the Trust representatives for attending and answering the member's questions.

RESOLVED;

(a) That University Hospital of North Staffordshire NHS Trust be asked to provide further information in response to member questions 9 and 11.

(b) That members note the further work the Trust in undertaking in relation to the Plaza roundabout area.
(c) That the Trust be encouraged to follow up the points made in the debate concerning the appropriate use of the accident emergency services.
(d) That members note that the Trust accept the need to review the numbers of beds required in conjunction with the primary care leads and the primary trust and request that the Trust keep members informed of the outcomes.
(e) That the Trust be asked to confirm the numbers of stations and the expected opening date for the new renal unit.
(f) That members welcome the offer by the Trust to participate in the planned mortality workshop
(g) That the Trust be encouraged to raise the profile of infection control
(h) That the Trust undertake to review of the new signage now that the new site is occupied. That the Trust be asked to provide the impact of the temporary closure of the accident and emergency services at Stafford Hosptial.

Chairman

North Staffordshire Combined Healthcare NHS Trust

Update on changes

Issue 2

Friday October 19, 2012

A fortnightly-update on the implementation of plans to improve mental health services across Stoke on Trent and North Staffordshire

Issued on behalf of

North Staffordshire Combined Healthcare NHS Trust

For further information, please speak to the

Communications and Membership Team on 0800 032 8728

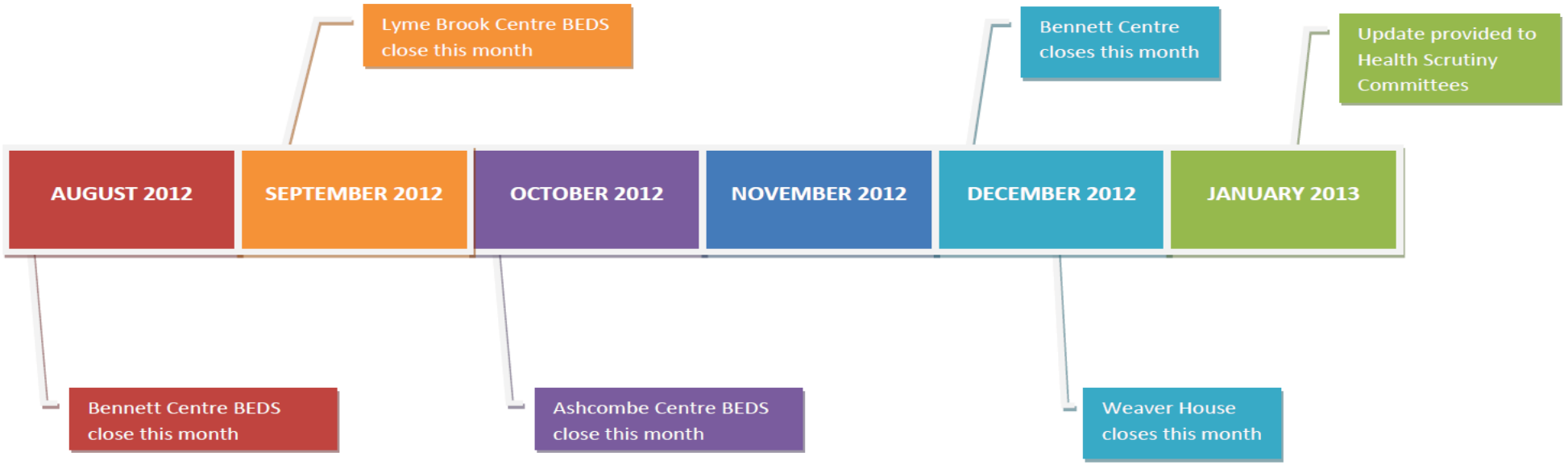
Contents

Timeline

The following is a high-level timeline which shows the periods when changes will take place.

Key Messages:

- Changes will take place between the first day and last day of the month, dependant on the needs of service users. The changes will only take place **if clinically safe and appropriate to do so**.
- All changes to appointment locations will be advised to service users and patients by the Care Coordinator, involving carers wherever possible and appropriate
- Changes are planned and coordinated in advance. However, there are circumstances when plans may be brought forward or slip as a result of unforeseen circumstances (staff sickness, high-level care requirements, etc). We plan to manage this wherever possible and have in place contingency plans and risk logs as a matter of course.



Progress Report

Action	When	Affecting
Bennett Centre inpatient bedded area closed	September 1, 2012	NSCHT staff Service users Partners
Lyme Brook Centre inpatient bedded area closed	October 1, 2012	NSCHT staff Service users Partners
Ashcombe Centre inpatient bedded area closed to new referrals with aim to close bedded area by the beginning of November once clinically safe to do so.	Beginning of November 2012	NSCHT staff Service users Partners

UPDATE

Weaver House

Below are progress updates from both North Staffordshire Combined Healthcare NHS Trust (NSCHT) and Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP) relating to the planned closure of Weaver House.

NSCHT

Of the original 63 people attending Weaver House, 48 have been appropriately discharged or have moved to alternative more suitable care locations. 15 patients will continue to attend Abbots Day Hospital in the absence of an alternative provider. Difficulties with alternate providers have been due to lack of assurance they can support people with dementia, lack of capacity and the cost implication from carers to accept need to pay for a service.

Other options for day care elsewhere in the area are also being explored.

The Trust is on schedule for closure of Weaver House by early December 2012. However, this work is due to be discussed by commissioners and the Trust in terms of the Phase 2 implementation process. Service Leads will be working closely with Commissioners to provide assurance that all service users have been assessed appropriately and had their service re-provided in a safe and suitable manner.

SSOTP

Moorlands District Social Care Team has a system in place in order to monitor the progress of assessments. An action plan has also been developed which maps out next steps and current activity against a timeline. Activity includes:

- Team Managers to attend meetings at Weaver House to collate service user information and compile a spreadsheet
- Liaison with Weaver house staff to ensure that everyone is aware of the assessment process, timescales and alternative provision
- Weaver house and social care to provide clear information to service users about the timeframe for closure and the process to be undertaken, including financial assessment, Continuing Health Care (CHC) eligibility or alternatives.
- All cases to be allocated to named workers
- Social care team to meet with assessors in order to clarify the assessment process and timescales and generate action plan for staff.
- To inform workers on other teams who have service users attending Weaver House of the need to find an alternative provision and to provide guidance where necessary.
- To commence assessments
- To prioritise assessments to complete those with higher needs first and identify where service users have no alternative resource.
- To inform relevant commissioning bodies of any challenges to reprovision
- Weekly meetings to be held and progressed to be tracked progress in order to ensure completion by the end of November

Community Mental Health Resource Centres

The inpatient bedded areas at the Bennett Centre and Lyme Brook Centre are now closed and the Ashcombe Centre bedded area is closed to new referrals, with the aim of closing the bedded unit by the beginning of November.

As with previous inpatient unit closures, staff will be redeployed from the Ashcombe Centre to support other clinical areas within the Trust. All staff will receive an induction to unfamiliar clinical areas.

All CMHRCs remain open. Staff from the Adult Mental Health Services Division have met with some key groups, including North Staffs Users Group and Active Carers Group, to ensure service users and carers are able to influence the way in which changes are progressing.

As a result of these discussions, services hours have been extended to provide additional access to each of the areas' community teams.

Community Team support will be available 8am to 8pm Monday to Friday and 9am – 5pm over the weekend and Bank Holidays.

During core hours (9am-5pm) service users will have access to their usual CMHRC staff and during the extended hours support will be provided on a team area basis from:

- Newcastle Team – Lyme Brook Centre
- Moorlands Team – Ashcombe Centre or Brandon Centre
- City Team – Greenfields Centre or Sutherland

Service users will continue to call their preferred Centre and support will be provided by a clinical member of staff where needed from the area's team.

Other than the closure of the bedded areas, there have been no changes made to the delivery of adult mental health services from the CMHRCs. Until the Management of Change (MoC) process is complete, staff will continue in their existing roles. Care plans will not be affected.

Following the MoC process, care coordinators will inform their clients of changes (if any) in the best way for individual service users. Many service users will not be affected at all by these changes.