HEALTH SCRUTINY COMMITTEE

Wednesday, 13th February, 2013

Present:- Councillor Colin Eastwood – in the Chair

Councillors D Becket and Loades

1. APOLOGIES

Apologies were received from Cllr Mrs Cornes, Cllr Mrs Hailstones, Cllr Mrs Johnson and Cllr J. Taylor.

2. DECLARATIONS OF INTEREST

Councillor Loades declared an interest in the agenda items referring to his involvement with Healthwatch, Staffordshire LINk and the UHNS Supervisors Board.

3. MINUTES OF PREVIOUS MEETING

RESOLVED: That the minutes of the meeting of the Committee held on 9 January 2013 be agreed as a correct record.

4. PRESENTATION BY LESLEY RUSSELL OUTLINING HER ROLE AS CHIEF DIETICIAN IN SUPPORTING NUTRITION AT UHNS

The Committee received a presentation from Lesley Russell, outlining her role as Chief Dietician in supporting nutrition at the University Hospital of North Staffordshire (UHNS). The Chair explained that Members had concerns regarding feedback and complaints that had been received about food at the hospital, and requested a general overview.

Dieticians were employed at UHNS according to their different specialities and the hospital had a nutrition policy with three key elements. The first was nutrition screening, where the risk of malnutrition was documented and the progress of patients could be tracked. Some patients were malnourished when they entered the hospital, with 30% of patients at risk when admitted. The second element was ensuring the food provided was of the right nature and the correct menus were provided. Since the trust had become a Private Finance Initiative (PFI) Trust with PFI caterers more attention had been paid to the catering service. Sodexo managed the contract, with their food manufacturing business Tillery Valley provided the catering service. The third element of the nutrition policy dealt with food not being suitable for some patients, e.g. for patients who required tube feeding. A lot of work had been undertaken by the hospital in tasting food etc. There had been problems initially, for example when the mashed potato provided was different from that given at tastings. However, there had been a lot of hard work over the years to improve the situation.

The dieticians had a lot of input into the menus at the hospital, which was important. The dietician's biggest triumph was to introduce a hot choice for both lunch and dinner, with an increase in the range of menus. There had been three different systems before, which had been difficult to manage. All meals were cook/freeze now which was better for storage, and there were a la carte menus. Members questioned whether meals could be freshly cooked on site if required. They could be if

requested, but large numbers of meals were not prepared on site due to the large volumes of patients. The screening process for nutrition was questioned and whether this was dependent upon the information provided by patients. It was objective and would depend upon BMI, the acute disease score, whether there had been recent weight loss etc. Screening would not be provided for palliative patients or for patients who refused to be subject to screening. Patients with multiple allergies would be monitored by an alert system, which would be communicated to the caterers by hospital staff if they were aware of a patient having allergies. The hospital also had an allergy menu. Wards could refer patients if they were having difficulties with a patient not eating, there were guidelines to follow and food assessment charts. A ward should pick up if there were problems with a patient's eating habits.

Members of the Committee were interested in food waste at the hospital; the percentage of food that was supplied and not eaten and whether any food was recycled. The catering department would hold the information relating to this, but it was likely that care would have to be taken with regard to any aspects relating to food recycling in a hospital environment, due to bugs etc. The Chief Dietician would pass the query to the relevant department to provide an answer.

With regard to chronic illness, the point a dietician became involved would be dependent upon the nature of the illness and the dieticians spent a lot of time with renal patients, diabetics etc. The dieticians tended to see patients who had been referred by consultants and patients would be referred if there was a problem. Members questioned the initial checks patients received, how often further checks were undertaken and whether patients should be at a healthy level when they were discharged. Within the hospital's policy, stable patients would be screened every week and high risk patients every two to three days. Sunday had been designated as 'weigh day' as it was generally quieter and the aim was to get into a weekly routine. Patients would also be supported with dietary supplements when they were discharged if required. It was questioned what was being done through the policy to promote the prevention of dietary problems. This was not contained in the policy as such, as the policy was intended for patients who were being treated in hospital, and the UHNS did not have any health promotion dieticians. What was necessary was to make every contact count, e.g. with smoking, and diet was next on the agenda.

Members questioned how the Trust dealt with elderly dementia patients who refused to eat. In recent years a lot more had been learnt about dementia and a member of staff had been seconded from Combined Healthcare. Easy to eat foods were available to patients who required them, which could be purees and easy chew foods. There was also a finger food menu for buffet style eating and there had been an attempt to get more feeding volunteers in recent years.

Members often heard the negative aspect of hospital catering and there was concern about patient's feedback. The Patient Advice and Liaison Service provided a report regarding performance monitoring and following feedback received from patients, there had been culls of dishes on the menu.

Members questioned whether UHNS linked up with outside agencies to support patients e.g. carers/agencies looking after the elderly at home. This was considered highly desirable; there was a service level agreement with Combined Healthcare but not for care homes, which would be great to have. There were areas around the country that did liaise with outside agencies and it was acknowledged that there was a gap in service with regard to this. Members felt that this was something the Committee should look into.

It was advised that there were thirty dieticians in the Trust, of which 26 were full time staff which included provided services to South Cheshire and Stafford renal units. Two dieticians looked after GP work and there was a small paediatric team. Members questioned whether there would be a need to increase the size of the dietician team in the future. There would need to be an increase as a public health remit was needed to tackle such problems as malnutrition in the community.

The Committee thanked the Chief Dietician for her attendance at the meeting.

RESOLVED: That the information be received.

5. **PRESENTATION BY DR M SHAPLEY (CLINICAL CHAIR) AND/OR DR D HUGHES (CLINICAL ACCOUNTABLE OFFICER) ON THE ROLE OF THE NORTH STAFFS CLINICAL COMMISSIONING GROUP.**

The Committee received Dr M. Shapley (Clinical Chair) and Dr D. Hughes (Clinical Accountable Officer) to discuss the role of the North Staffordshire Clinical Commissioning Group (CCG). The Chair emphasised that the Committee would like to see closer links with the CCG and to work together rather than focusing on financial aspects. Newcastle Borough Council had their own initiatives, but were very keen to see preventative measures.

In April 2011 the CCG was delegated an authority and would be designated an authority in April 2013. The upcoming months were very important and there would be public meetings of the board. The CCG was poised to get through 2013 well, with 80% of services commissioning and were also in a good position as they had come from a single Primary Care Trust (PCT), and had retained good staff and skills. The PCT had 158 full time staff; the CCG had 38 and was much smaller. This had been mitigated to some extent by PCT staff working in the commissioning support unit, e.g. in HR. The CCG aimed to be lean and nimble, but there was quite a challenge ahead. The Doctors felt the CCG was significantly leaner and working very hard.

Members questioned what services were being commissioned by the CCG as a commissioning body. The system had changed dramatically in 2012, with the Director of Public Health having accountability and the CCG taking responsibility for meeting targets. The CCG did not commission areas coming under general practice, such as sexual health, but were able to purchase some aspects of preventative care and could commission certain services if required. However, the primary accountability was with Public Health. With regard to community services provided by the hospital, Members felt an understanding of the health requirements of North Staffordshire was needed. Through the Joint Strategic Needs Assessment, there was a good idea of what was happening in different areas and this would influence what services it was felt needed to be commissioned.

The responsibility for walk-in centres was questioned by Members. As the NHS had changed dramatically, Members felt a road map of how the NHS worked was required. The CCG had inherited the walk-in centres and it was advised that there was an on-going review. The Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP) were responsible for the Haywood walk-in centre, which was an important centre and worked well with A and E. Some walk-in centres were the responsibility of the CCG, and there were CCG staff employed at the Haywood

centre. This was not considered positively by Members. Members noted that the purpose of the walk-in centres was to see patients who would have otherwise gone to A and E, and had personally experienced visiting Morston House and not being able to see a doctor as it was necessary to be registered at the centre. A few years ago an appointment could be obtained within one hour, but it appeared that the centre was now operating more like a GP surgery. The CCG had no control over this and it had been inherited from the NHS Commissioning Board, which had commissioned the service.

Members questioned if the Doctors envisaged there being any problems from April. They also noted that the public may ask which body was delivering what service and ask what the CCG would be giving to patients. It was acknowledged that there had been a problem for many years with discharge information. For around eighteen months there had been a communication group between Stoke-on-Trent and the CCG, which discussed such areas as electronic discharge of patients and making improvements through this. The Doctors felt this was a useful group and were aware of the problem. The changes which were taking place would give patients and the public a greater voice and Members felt that what was being set up by the CCG would be an improvement, but that this needed to be communicated to the public. It was advised that patients would be members of the CCG, there would be a partnership with the public and there was also the Patient Congress. Members felt the changes were a big opportunity, but were concerned about how they would be communicated to the public and questioned how information from the Patient Congress was communicated back to the public. The CCG worked very closely with communications and there was a flow of information. It was questioned whether there were difficulties in getting a wide range of people to participate in patient groups, e.g. a cross section of different age groups. This was acknowledged as a problem that the CCG were trying to address, as people did not want to give up their time.

The CCG covered both Staffordshire Moorlands and Newcastle, as per the old primary care trust, but worked closely with Stoke e.g. with joint executive committees. Members felt that the predominant problem was there were too many people going to hospital when they did not need to. Some of the problems were caused by the flow of patients through the hospital and the Doctors considered that there could be admission avoidance as they did not think patients wanted to go to hospital if they could be cared for at home. The contract for the West Midlands Ambulance Service was held by the CCG and it was necessary to make sure that ambulances were not taking people to hospital who did not need specialist care. There were tools available, such as a flow and capacity hub, to identify services that were not necessarily for A and E and replace the transport to the hospital. There would also be advanced long term condition management. The CCG had a responsibility to promote quality and GPs were managing the patients going to A and E. Members felt that one reason for high patient numbers could be that the UHNS was more easily accessible by public transport than other hospitals, and people would go there for that reason meaning walk-in centres such as the Haywood were not utilised to their full potential.

The buildings and contents of GP surgeries would not be transferred to the CCG and Members questioned how they could be sure they would remain open. This aspect was currently in development and the NHS Commissioning Board had a duty to ensure they would remain. It was questioned that if there was an increase in usage of a surgery and more doctors were required, how this would be proved. This would be taken back to the NHS Commissioning Board. It was a very important issue and the model of care was to keep patients as close to home as possible. There was a

district nursing review and it would be necessary to ensure that there was community infrastructure going forward.

Members asked if GP practices could have extended opening hours to help prevent the public from going to A and E. It was the responsibility of GPs to work with CCGs to reduce the pressures on A and E and it would be wrong for the CCG to dictate to GPs. There was however a national contract with specified hours and it would be sensible to be flexible. There would also be a new GP out of hours service in April and a new 111 number was to be introduced to replace NHS Direct. The Doctors also noted that when the new UHNS A and E opened there was an increase in patient figures, which could reflect people going there to see the new department.

It was questioned how local authorities could assist more. The Executive Director, Operational Services advised that whilst for example the Borough Council had a statutory responsibility with regard to community safety, Staffordshire County Council held statutory responsibility for public health. Public health underpinned so many of the things that the Borough Council did, but the Council did not have the statutory responsibility for it. What the Council could do was to include any awareness campaigns in the Borough newspaper, The Reporter. There were other initiatives within the Council and the Chair considered that the Council needed to work more closely with health agencies. There was also the Let's Work Together initiative, which had been initiated by the Fire Service. Let's Work Together would see the agencies who go into the public's homes looking for problems aside from the service they were providing. Members felt that health agencies could also be involved in the initiative, but understood that they were not yet on board. Members would like to see Council Officers and members of the CCG sit down and discuss where they could work together. The Doctors advised that clinical directors and associates would have a role in engagement and concurred that it made absolute sense for the Council and the CCG to work together where they could. The CCG were not unwilling to engage and urged the Committee to inform them when things were not working.

Members questioned what the CCG point of view was with regard to Health and Well Being Boards providing assistance to them. Everything was very new, but there were clear links with the CCG and Health and Well Being Board. The Joint Strategic Needs Assessment and the Health and Well Being Strategy would give an idea of what was required and it would be necessary to learn how to bring all the different strands together. There were real challenges facing the CCG and they would have to do things differently, which might not be popular with the public and the Doctors felt that Member support would help with this. Members felt education was important and conveying information to the public about GP practices, walk-in centres etc.

The Chair emphasised that the Committee were not being critical of the CCG, but were being their critical friend and the more the Council and the CCG worked together the better. The Doctors concurred that it had been a good exercise for them to attend the meeting. The Chair considered that it would be helpful if the CCG could attend a future Full Council meeting to talk to Councillors about the public health changes and explain the structure of the NHS.

The Chair thanked the Doctors for their attendance at the meeting.

RESOLVED: (a) That the information be received.

(b) That the CCG attend a future Full Council meeting to discuss the changes in public health and explain the structure of the NHS.

6. **VERBAL UPDATE ON PROPOSED VISIT TO ACCIDENT AND EMERGENCY DEPARTMENT AT UHNS.**

The Chair advised the Committee that the visit to the Accident and Emergency department at UHNS would take place on Tuesday 5 March 2013 between 1pm and 4pm. Further relevant information would be communicated before the visit.

RESOLVED: That the information be received.

7. **WORK PLAN**

The Committee considered and discussed their work plan. It was questioned whether there had been any communication about the financial position of Combined Healthcare, which there had not been. This would be chased up the next working day by the Chair and Scrutiny Officer.

There was a request that the parking problems being experienced at UHNS be added to the work programme. Members felt that parking was becoming a big issue and that people were parking in the town ward due to the parking problems. The Committee would like to know what was being done to address the problem. The Interim Chief Executive for UHNS would be invited to the next meeting of the Committee in April. Members did feel that it would be beneficial to invite UHNS officers with specific knowledge of the areas the Committee were concerned with.

There was discussion of the Mid-Stafford Report and the thirty pages concerned with the activities of the Borough and Staffordshire County Council Overview and Scrutiny Committees. The County Council had made significant improvements with such things as the accountability sessions, but had come out badly in the report as not providing officer support and that health knowledge and officer time were not provided. Members felt that this section of the report should be studied and thought given as to whether Newcastle Borough Council would have been in the same position as the County Council. It was agreed that a review of the report would be included in the work plan, with the Committee then providing a report for consideration to Cabinet, EMT and the Co-ordinating Committee. The Committee felt that they should work out where Newcastle would have been deficient if the situation had happened here. Councillor Loades would take this away as part of his LINk work and bring back what objectives other people were looking at to the next meeting.

With regard to the accountability sessions, the Committee noted that they needed to give thought to the questions asked at these sessions to ensure the right questions were asked and to ensure they spoke to each other well in advance of the sessions to discuss what they wanted to ask. Members concurred that they needed to be more prepared and demanding and if a sufficient answer was not provided they would not let it lie. Members questioned whether there was a pre-meeting for the accountability session. The Portfolio Holder for Stronger and Active Neighbourhoods advised that difficulty may arise from the fact that the Committee was a sub-committee of the county Health Scrutiny Committee. It might be necessary to negotiate with the County Council to attend, but that as Newcastle Borough was on the doorstep of UHNS, the Borough Council would be well placed to attend. It was noted that the Council did not have a solely dedicated resource for the issue, although there were a number of officers in public health roles. It was also noted that the County Council had reduced officer support, and so were pushing work out.

RESOLVED: (a) That UHNS officers be invited to the next Committee meeting in April to discuss the parking problems at UHNS.

(b) The consideration of the Mid-Stafford report be added to the work plan.

8. **URGENT BUSINESS**

There was no urgent business considered.

COUNCILLOR COLIN EASTWOOD
Chair