Public Document Pack

NEWCASTLE UNDER LYME BOROUGH COUNCIL

Civic Offices
Merrial Street
Newcastle-under-Lyme
Staffordshire
ST5 2AG

Date of meeting **Wednesday, 11th April, 2018**

Time **7.00 pm**

Venue **Committee Room 1, Civic Offices, Merrial Street, Newcastle-under-Lyme, Staffordshire, ST5 2AG**

Contact Jayne Briscoe 2250

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 PREVIOUS MEETING **(Pages 5 - 8)**

To consider the minutes of the meeting held on 10 January 2018

4 MINUTES FROM THE HEALTHY STAFFORDSHIRE SELECT COMMITTEE - 7 March 2018 **(Pages 9 - 10)**

5 PRESENTATION BY Dr EMMA SUTTON AND Dr BARRY EDWARDS - NEW MODELS OF CARE FOR THE ELDERLY **(Pages 11 - 26)**

6 DEMENTIA FRIENDLY TOWN CENTRE - HOW WE ENGAGE WITH THE BID

To receive a verbal update.

7 DEMENTIA FRIENDLY SWIMMING

To receive a verbal update from the Head of Leisure and Cultural Services.

8 DEMENTIA AWARENESS TRAINING **(Pages 27 - 30)**

9 RESPONSE FROM CHIEF EXECUTIVE ROYAL STOKE UNIVERSITY HOSPITAL (Pages 31 - 36)

A verbal update will be given by the Chair

10 PRESENTATION FROM QUEENS NURSE CHARLOTTE HARPER - CARE NAVIGATION

11 DESIGNING YOUR FUTURE LOCAL HEALTH SERVICES (Pages 37 - 50)

12 RESPONSE OF THE SECRETARY OF STATE - BRADWELL HOSPITAL REFERRAL (Pages 51 - 66)

13 WORK PROGRAMME (Pages 67 - 70)

14 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.

15 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 Bloor, Miss J Cooper, Dillon, Gardner, L Hailstones, Jones, Loades (Vice-Chair), Naylon, Wilkes, G Williams and Wright (Chair)

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.

NOTE: THERE ARE NO FIRE DRILLS PLANNED FOR THIS EVENING SO IF THE FIRE ALARM DOES SOUND, PLEASE LEAVE THE BUILDING IMMEDIATELY FOLLOWING THE FIRE EXIT SIGNS. PLEASE **DO NOT** USE THE LIFTS.

COUNCIL CHAMBER: FIRE EXITS ARE AT THE REAR OF THE CHAMBER AT BOTH SIDES AND THIS IS THE SAME FOR OCCUPANTS OF THE PUBLIC GALLERY.

COMMITTEE ROOMS: EXIT VIA THE WAY YOU ARRIVED AT THE MEETING OR AT THE FAR END OF THE COUNCIL CHAMBER.

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HEALTH AND WELLBEING SCRUTINY COMMITTEE

Wednesday, 10th January, 2018
Time of Commencement: 7.00 pm

Present:-	Councillor Ruth Wright – in the Chair
Councillors	Bloor, Miss J Cooper, Dillon, Gardner, Jones, Wilkes and G Williams
Officers	Jayne Briscoe - Democratic Services Officer and Robin Wiles (Partnerships Locality Officer)
Also in Attendance	Anna Collins (Head of Communications and Engagement – North staffs Clinical Commissioning Group)

1. **APOLOGIES**

An apology was received from Councillor L Hailstones and Councillor J Waring (Portfolio Holder for Community Safety and Wellbeing).

2. **DECLARATIONS OF INTEREST**

There were no declarations of interest stated.

3. **MINUTES OF PREVIOUS MEETING**

Agreed: That the minutes of the meeting held on 19 October 2017 be accepted as a correct record.

Matters arising

Care Navigation Programme.

Members discussed the Care Navigation Programme with Anna Collins (Head of Communications and Engagement at the North Staffordshire Clinical Commissioning Group and Stoke on Trent Clinical Commissioning Group). Anna Collins explained how the programme was a non-optional part of Governments national 5 year Forward View and it aimed to ensure that the patient saw the appropriate medical professional quicker. Success relied upon trained reception staff and the willingness of the patient to disclose information relating to their medical condition. A future evaluation of the scheme with Healthwatch was anticipated.

Members sought assurances regarding the level of training which the receptionist received and issues relating to the importance of maintaining confidentiality. The Programme did not replace the need to continue to recruit doctors.

Members spoke about the historical notion of “dragons on reception”. Anna Collins mentioned mental health referrals to the charity and voluntary sector

which led to a discussion on the need to refer patients with mental health needs appropriately to ensure correct diagnosis and treatment.

Anna Collins suggested that Charlotte Harper, Queens Nurse, who was responsible for the introduction of the Care Navigation project, be invited to attend the next meeting of the Scrutiny Committee.

4. **MINUTES FROM THE HEALTHY STAFFORDSHIRE SELECT COMMITTEE**

Agreed: That the summary of business transacted at the meeting of the Healthy Staffordshire Select Committee held on 1 December2017 be noted.

5. **RESPONSE FROM UHNM TO QUESTIONS FROM MEMBERS - 19 OCTOBER**

Members considered a written response to a request from this Committee (19/10/2017) for a representative from the Royal Stoke University Hospital (RSUH) to attend a meeting of the Committee to discuss certain issues:-

Is the Royal Stoke Hospital achieving timely discharge for residents of Newcastle under Lyme?

If there are delays what is the cause?

Do the residents of Newcastle under Lyme experience any delays in relation to operation waiting times?

Members of the Committee expressed deep concern at the absence of a representative from the hospital and at the lack of an explanation of measures that were being undertaken to address the difficulties being experienced at the hospital.

Agreed: That a letter be sent to the Chief Executive of the Royal Stoke Hospital, with a copy to the Chair of the Healthy Staffordshire Select Committee, expressing the deep concerns of this Scrutiny Committee in relation to the absence of a representative in attendance at the meeting and also the poor quality of the information given by the hospital, particularly the lack of any information on how the situation in relation to the timeliness of discharge and waiting times for residents of Newcastle under Lyme was being addressed.

6. **DEMENTIA SERVICES DATABASE**

Following a request from members at the Joint Meeting of the Health and Wellbeing Scrutiny Committee and the Active and Cohesive Scrutiny Committee (5/7/2017), the Partnerships Locality Officer presented a data base of dementia friendly activities in the area of the Borough, compiled with the assistance of the CEO of Approach, with the emphasis on partnership activities and projects.

The report was welcomed by members who wished to see the document kept up to date and maintained in a paper format in addition to a digital presence and available to the public. Members also asked whether the Borough could help to support other organisations to contribute to the list and the Partnerships Officer invited members to email with information in respect to any gaps that they identified.

Agreed: That the report be noted

7. **WORK PLAN**

Agreed: That the Project Manager for the Care Navigation Project and Primary Care Nurse Facilitator, Charlotte Harper, Queens Nurse be invited to attend the 11 April meeting.

8. **PUBLIC QUESTION TIME**

There were no members of the public present at the meeting.

9. **URGENT BUSINESS**

Invitation to be involved in designing future local health services in North Staffordshire and Stoke on Trent.

The Scrutiny Officer highlighted an invitation received from the North Staffordshire Clinical Commissioning Group and Stoke on Trent Clinical Commissioning Group for members to attend a 2 day Options Development and Appraisals event on 23 January and 14 February at the Bridge Centre, Birches Head.

10. **DATE OF NEXT MEETING**

The next meeting will be held on 11 April 2018.

COUNCILLOR RUTH WRIGHT
Chair

Meeting concluded at 8.20 pm

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Healthy Staffordshire Select Committee – 7 March 2018
District/Borough Digest

Under the Health Scrutiny Code of Joint Working with District and Borough Councils, Authorities have undertaken to keep relevant Partners informed of their consideration of health matters having regard to the general working principle of co-operation and the need to ensure a co-ordinated Staffordshire approach.

Therefore, the following is a summary of the business transacted at the meeting of the Healthy Staffordshire Select Committee held on 7 March 20178 - link to Agenda and reports pack:-

http://moderngov.staffordshire.gov.uk/ieListDocuments.aspx?CId=871&MId=8513&Ver=4

Agenda Item	District(s)/Borough(s)
All Age Disability Strategy The considered a report of the Deputy Leader and Cabinet Member for Health, Care and Wellbeing on the development of an All Age Disability Strategy for Staffordshire. Building on the previous "Living My Life My Way" initiative and taking into account the many recent changes in Local Government, the Strategy will set out the Authority's vision for disabled people from 2018 onwards. During the meeting, the Committee participated in workshops aimed at refining the draft document giving their comments and views, as appropriate. They emphasised the need for the Authority to (i) 'do the right thing' ensuring that the strategy was fit for purpose; (ii) have clear vision regarding outcomes; (iii) treat people as individuals focusing on their abilities and not disabilities and; work with stakeholders to reduce need. Their contributions are to be incorporated (where possible) into the final draft version of the Strategy to be published in April 2018 for consultation and public engagement during the spring – summer 2018.	All to note

Their next meeting will be held on Monday 11 June 2018.

ELDERLY CARE MODEL FOR NEWCASTLE-UNDER-LYME: PROGRESS ONE YEAR ON

Our Vision

Our vision is to deliver a single, coherent and consistent approach to elderly care in Newcastle. This work involves the 20 practices of the three localities of Newcastle under Lyme, covering a population of 130,000+. Practices met initially in January 2017 to agree this approach and this document represents an update 12 months on.

As local clinicians, we know that care of the elderly can be fragmented and services do not always work together effectively. High numbers are admitted to hospital, often with long lengths of stay.

We feel that a single whole population approach will allow us to proactively identify issues and work with patients and carers to improve experience.

The underpinning work has been two-fold. As practices, we worked together to have a single approach to the new contractual requirements around frailty. We also shared local innovation that had occurred in the South of Newcastle around an 'elderly care facilitator' model to proactively assess this population and identify needs. The ECF model consider some elements of health and social care but also factors such as isolation and loneliness and links strongly back into our local communities and voluntary sector offers. A single delivery of this model will occur across our patch from April 2018.

We have also taken learning from the vanguards and are very grateful to Trish Hamilton in the New Models of Care Team and Ashley Moore and Jason Flannigan-Salmon in Fylde Coast: they have supported us to develop their 'extensivist' concept to our cohort of highest needs/most complex elderly.

To this end, we are developing a team to deliver a community-based multidimensional, multidisciplinary assessment on a cohort of highest needs elderly to allow the development of individualised, holistic plans. We have been supported by NHS Horizons in an accelerated design event to develop this concept and have now brought different elements of this team together from a range of partners and will implement our 'extensivist' approach in April 2018.

We feel that this approach will improve functional outcomes; rationalise use of the health and social care system and enable the local system to have a more effective urgent care response to individual's need. Most importantly, perhaps, will be the ability to empower patients and carers to better understand their care needs and improve their level of activation/engagement and ability to self-manage. This will improve patient satisfaction and allow them to utilise the local health and care systems more effectively.

Overall, our strategy aims to deliver a consistent, community offer to the elderly living in Newcastle-under-Lyme, meeting different levels of care need by using a stratified approach. We will achieve this by working collaboratively as a group of practices and in partnership with other providers and our communities.

Aims

To have a clearly articulated, consistent approach to the community management of elderly care across the population of Newcastle-under-Lyme, framed around the four levels of need described in the MCP care model.

To integrate this approach with other health and social care community providers including third and voluntary sector

To describe person- centred outcomes to ensure that service re-design starts with the patient. These can be described using the 'I' statements:

'I want to stay at home'
'I want one person to call and I want to know who they are'
'I want to be able to access services when I need them'
'I want to be treated as a whole person not a list of conditions'
'I want to tell my story once'
'I want to be involved in the decisions'

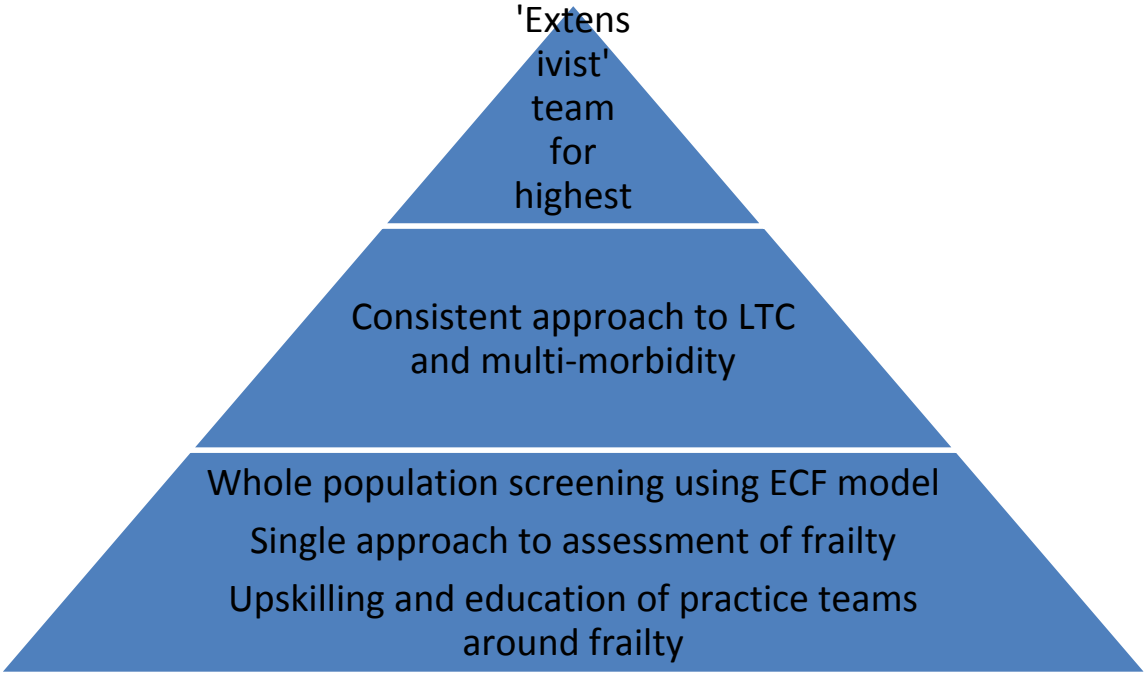
Identification of the Population

Within the three Newcastle localities there are 25,202 patients over the age of 65 with 3244 patients over the age of 85 (January 2017). There are many ways of risk stratifying this group however the CCGs favoured tool is Aristotle. This stratifies patients with respect to their use of acute and non-acute services as well as their co-morbidities. For clarity, the GP contract work on frailty considers the population aged 65 and over and our work streams will consider patients aged 75 and above.

Patients can be divided into high (>80%), medium (30-80%) and low risk (<30%). The three tiers can be equated with the suggested interventions that are being planned:

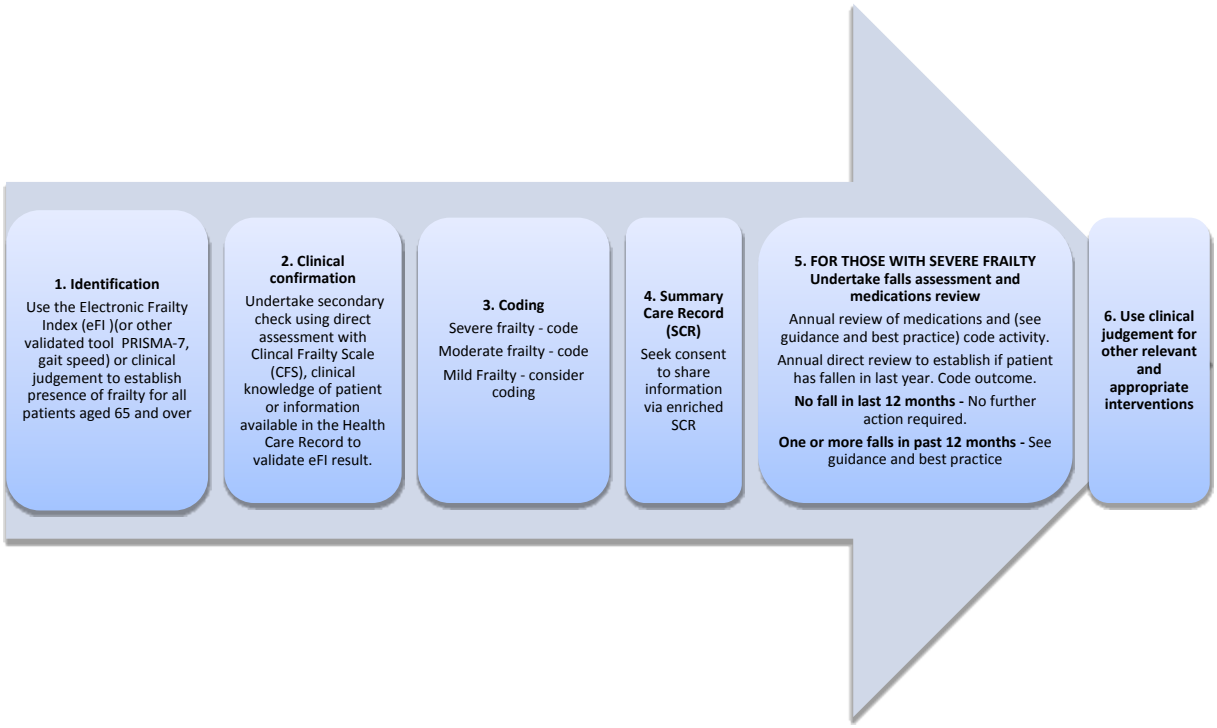
- Highest risk will be offered an extensivist intervention if appropriate (highest needs in the MCP model with some elements of urgent care needs)

- Most of the medium risk and low risk would receive the ECF and practice based intervention (whole population and ongoing care needs of the MCP model)


'Extens
ivist'
team
for
highest
Consistent approach to LTC
and multi-morbidity
Whole population screening using ECF model
Single approach to assessment of frailty
Upskilling and education of practice teams
around frailty

Frailty

As part of the new GP contract changes from April 2017, a six step process for the coding of frailty was introduced:



Over the last 12 months:

- All practices have used the eFI frailty tool to calculate the level of frailty within the group. This showed that there were significantly higher levels of frailty than expected. Further work was carried out with Dawn Moody as national lead for frailty. The guidance for frailty was amended to ensure that a clinical sense check was made rather than the eFI being the sole tool used to code frailty

- We have developed a common and consistent approach to the process of coding (see appendix 1)

- We have developed a template to help code and manage patients in line with the contract (see appendix 1)

- Secured funding from the CCG to undertake an educational event in April 2018 to support the work.

Over the next 12 months our aims are:

- Continue to use the template to code all patients over the 65 with their frailty assessment and manage accordingly

- Have monthly reports generated by the DQF to help understand how quickly the cohort are being identified

- Undertake an educational event in April 2018 to help practices understand the key concepts in frailty and how to manage this group of patients.

- Develop a single care plan for primary and secondary care based on the frailty passport developed in secondary care

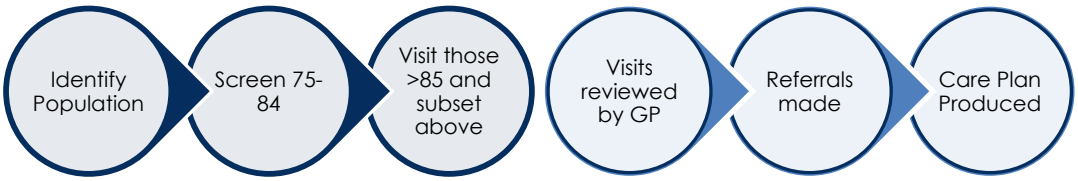
Elderly Care Facilitator (ECF) intervention

The ECF model forms the backbone of a whole population approach to elderly care.

It combines a **proactive**, early identification approach, helping us identify frailty and other issues earlier with a **care co-ordination** function that spots issues early and reacts and responds in an agile way.

ECF delivers whole population screening of patients aged 75 above and ensure that current social capital is understood and built upon. This service is strongly community and social care based.

There are six main steps:



The information will be documented on the GP IT system which will help to support the frailty work. There will be weekly GP and nurse time will be put in place to:

- Review patients to discuss needs and actions identified and ensure appropriate interventions and referrals, which may be completed within the practice or involve other members of the wider Primary Health Care Team referral or voluntary services.
- Determine frequency of future reviews to the level of risk identified at the time of assessment.

18/20 practices within Newcastle are developing their ECFs or already have ECFs working within their practice. Of the two remaining practices, one practice will have the ECF service delivered by a neighbouring practice.

Over the last 12 months we have:

- Undertaken an educational event in November 2017 where all practices sent along the staff who would be undertaking the ECF role. A small group of ECFs met to develop and agenda and lead the event. Patients were also present to give a patient perspective.

- A small group have updated the ECF template and this has been shared with practices

- A WhatsApp group has been set up between the ECFs to share best practice

Over the next 12 months our aims are:

- Develop a directory of services to be a resources for the ECF and all staff on the services that patients can be signposted to in their area

- Support the initial ECF work with a further educational event in October to share best practice amongst the ECFs

- Develop a single care plan for primary and secondary care based on the frailty passport developed in secondary care

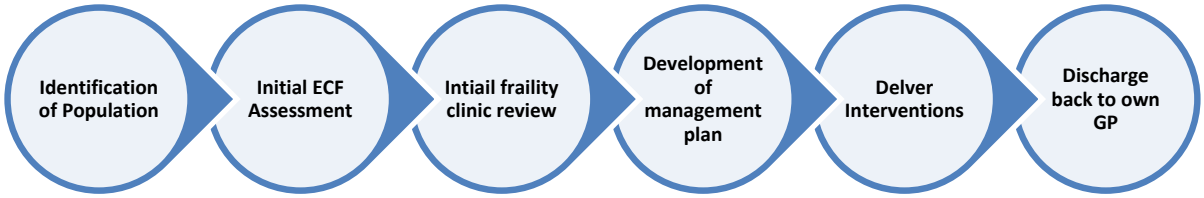
- To link with the Staffordshire Fire Service and local voluntary sector organisations to embed ECF into a wider community resilience offer, reduce duplication and enhance collaborative working across our populations

- To develop a single Newcastle application for CCG LIS 2018-19 to reflect our collegiate approach

Extensivist intervention

The most challenging element of the work has been around the extensivist model. We have brought together different elements of the health economy to both support and fund the service. Appendix 2 gives a detailed summary of the service to date.

A summary of the service is shown below :



There will be six main steps

- Identification of the patient group within primary care
- Holistic assessment of the patient in their own home by the practice-linked ECF
- Assessment of the medical and functional needs of the patient via clinicians in a community clinic- at this step patients will be identified as appropriate for management within this service or will be discharged back to primary care
- Developed of a management plan by an integrated MDT using both information sources above.
- Intervention team
- When pathway over, discharge back to primary care with appropriate care plan completed

Over the last 12 months we have:

- Held two workshops to develop and agree the concept- the latter being a nationally facilitated accelerated design event
- Reviewed the cohort at practice level and with community providers
- Liaised with the vanguard team in Fylde and presented to the CCG, Northern Alliance Board, STP and to Simon Stevens and the national team.
- Secured innovation funding for a GP fellow role to lead this service, agreement on hosting an honorary contract via SSOTP and support to advertise and recruit to this role from the federation (GPF)
- Identified other team members as resource in kind from partner organisations- this includes a coordinator, matron, therapist, voluntary sector and CPN support
- Secured evaluation support via CSU and IT solutions supported by the GPF

Over the next 12 months our aims are:

- To appoint a GP fellow as clinical lead for the service
- To agree a community location and work with the new 'team' to start implementing the service from April 2018
- To ensure this service dovetails into primary care and works for us and our patients, to improve patient experience and outcomes whilst also helping with GP workload and retain the flexibility and agility to adapt to local needs
- To ensure that this is a true 'bottom up' service that meets local needs
- To effectively evaluate the service to determine scope for expansion

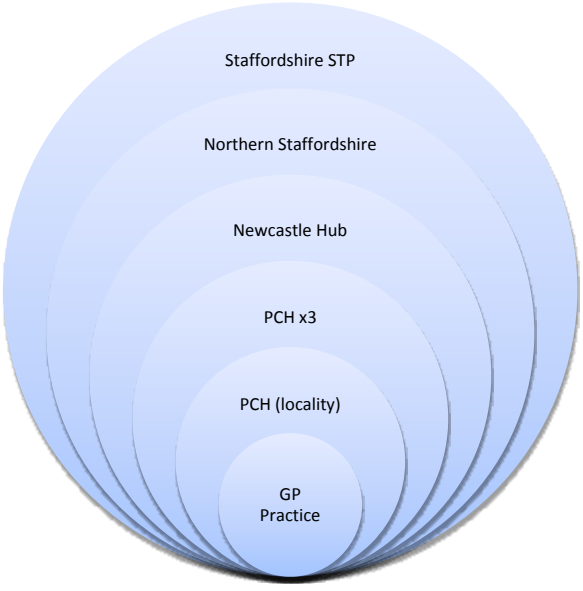
Primary Care Home

We have been accepted onto the PCH community of practice and been supported in an initial launch event in January 2018. We identified some key themes around:

- Communication
- Building trusted relationships
- Developing teams

We will work with MiDOS to facilitate the understanding of our wider teams and continue the work started by the practice managers and SSOTP to keep regular lines of communication open.

As individual PCH sites, the localities have agreed to consider areas to develop alongside the pan Newcastle Elderly Care work.



Community Hospitals

A piece of work is taking place to consider the future of the community hospitals within our health economy and there has been debate on where there will be preservation and investment in the five community hospitals and their future rules.

There is real opportunity for our local hospital, Bradwell to become a **super community hospital** and deliver a range of functions including health promotion, social prescribing, tier 3 clinics, phlebotomy etc. There is potential for it to become our GP extended access hub to cover weekends and bank holidays.

This model could have genuine **GP managed step-up beds** supported by physio and occupational therapy, which would link back into our Newcastle Elderly Care work. There is also potential to become one of 2 proposed **dementia centres of excellence** which links strongly with our previous innovation around community dementia services, the higher than average diagnostic rates within Newcastle and into our wider agenda around elderly care.

For this vision to come to fruition, it will need significant push and support from Newcastle practices.

Closing Comments

The last 12 months has been an exciting and frustrating time for Newcastle practices. We have managed to bring together a group of practices on a regular basis around a single area of working. Practices are meeting and sharing ideas.

The work underpinning this been met with enthusiasm from the provider arm but there has been a lack of clear structure and resource to allow us to deliver change. Towards the end of 2017 funding was finally released for the GP fellow aspect of the work and the educational event however the process was lengthy and disjointed.

A single admission of a frail elderly patient can lead to significant costs to the health economy and significant distress to the patient and their family. If a coherent approach described here can be supported with funding from the CCG significant costs can be saved for the CCG but more importantly a better service for our elderly population achieved.

Appendix 1: Frailty Identification and Assessment

1. Identification: eFI tool

- Clinician review of the list generated by the DQFs on the system /EMIS prompt
- Directly code a proportion of the moderately and severely frail cohort based on local knowledge. Add as a new problem, active indefinitely.

2. Clinical Correlation

If further assessment is needed to confirm frailty carry out when patient well using most appropriate tool:

- Assess the patient using the PRISMA-7 tool

1] Are you more than 85 years?
2] Male?
3] In general do you have any health problems that require you to limit your activities
4] Do you need someone to help you on a regular basis?
5] In general do you have any health problems that require you to stay at home?
6] In case of need can you count on someone close to you?
7] Do you regularly use a stick, walker or wheelchair to get about?
PRISMA-7: If score >3 consider frailty

- Assess gait speed: ***taking more than 5 seconds to cover 4 meters is a positive test***
- TUGT (timed up-and-go test): ***taking more than 10 seconds to get up, walk 3 metres, turn around and then sit down again is a positive test***
- Code results of these assessments
- ***Any mobility assessment will be affected by co-morbidities e.g. OA hip***

3. Coding Degree of Frailty

- Use the pictorial clinical frailty scale to assess ***degree*** of frailty –see overleaf
- Code those patients with moderate or severe frailty (new problem, active indefinitely)

4. Review patient with severe frailty

- Seek consent to share information via enriched care record
- Use embedded frailty template to code
  - Medication Review
  - Falls Review
- Further assessment and referral dependent on above

Clinical Frailty Scale

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9 Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise evidently frail.

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

Appendix 2: The Extensivist Approach

Newcastle has high numbers of A+ E attendances and non-elective admissions (NEL) in the population aged 75 and above and many have prolonged length of stay. We know that this causes deconditioning in patients with potentially poor outcomes compared to care in the community. In addition, we know that many of these patients have multi-morbidity and frailty and can be seen by a range of professionals without a single co-ordinated plan. This means that patients and their carers' are often unclear about their health and care needs and options on who to contact during a period of deterioration.

As a local health economy, admissions and long length of stay have a negative impact both economically and on flow in the acute care settings. Poor flow results in acute portals becoming 'blocked' which further drives A+E attendances and costs.

We also know that patient and carer experience can be suboptimal and that this cohort of patients utilise large amounts of primary care and community resource.

Intervention: applying an 'extensivist' type approach
Performing a community-based multidimensional, interdisciplinary assessment on a cohort of highest needs elderly will allow the planning and implementation of individualised, holistic plans for treatment, intervention, support and follow up. There is evidence that such an approach will improve functional outcomes and has the potential to avoid significant changes in life such as admission to a care home or hospitalisation.

There is also potential to rationalise current utilisation of the health and social care system, manage multi morbidly and polypharmacy and enable the local system to have a more effective urgent care response to individual's needs, including reducing bed days in the case of required admission. Empowering patients and carers to better understand their care needs is likely to improve their level of activation/engagement and their ability to self-manage- this is turn improves patient satisfaction and allows them to utilise the local health and care systems more effectively.

Cohort
Patients age 75 and over with an Aristotle risk score of 80% and above, excluding care home patients and End of Life care. This cohort is likely to also have multi morbidity and frailty. The proposal is to use this cohort initially but adapt this based on initial assessment feedback.

Pathway

a. Extensivist co-ordinator runs Aristotle risk stratification tool and identifies patients. This is cross- referenced with the D2A and High-Intensity User teams. If there is duplication, a decision is made about which service is best placed to meet patient needs. Of the remaining list, patients with increasing scores are sent to the practices for review and exclusion of patients who are unsuitable. This is then shared back with the co-ordinator. This occurs once a quarter.

b. Co-ordinator links with nominated ECF in practice to arrange initial home assessment: this mirrors the agreed practice ECF holistic assessment and would be completed using the agreed EMIS template. The ECF describes the extensivist service to the patient/carer and gains consent: this is then communicated back to the co-ordinator. If consent is not gained, the patient leaves the pathway at this point.

c. Co-ordinator arranges an appointment at the extensivist clinic- this is community based in Newcastle and uses EMIS web as the IT system of choice. Co-ordinator also contacts UHNM to gain information about existing and future planned activity.

d. Patient and carer attend the community assessment and have a functional assessment (physio/nurse/OT skills) plus a medical assessment (GP fellow) with access to both EMIS web, docman and information about current health service utilisation. These assessments would include an understanding of patient and carer ideas, concerns and expectations and their current level of activation.

e. Multi-disciplinary team discussion to understand a multidimensional assessment (physical, MH, functional level, social support network, living environment, level of participation and individual concerns, compensatory mechanism and resourcefulness that the individual uses). This will allow the team to:
    - understand necessary interventions and implement these
    - rationalise polypharmacy
    - rationalise out-patient activity- includes professional conversation with clinical colleagues
    - develop agreed care plan/ frailty passport and share- ability to enter/ share to existing EMIS record plus share with secondary care.
    - ensure patient/ carer understanding of health and social care needs and advance plans for deterioration/ acute intervention
    - consider advanced care planning
    - consider links with community resources/ voluntary sector to maximise activation

f. Patient will be reviewed in the community clinic and either:
    - Have all needs managed adequately and have no additional need from the service > discharge with care plan.
    - Require interventions- this would then be managed by the most appropriate practitioner from within the team.

Requirements for delivery

a. Engagement from practices and community providers. Support from commissioners and UHNM. Public and patient engagement.

b. **Location:** community based setting in Newcastle area with good accessibility and ability to use GP IT systems. It is proposed to use a GP premises for this pilot period.

c. **IT solution**: North Staffs GP Federation Hub system is used as the Clinical Record base for the Extensivist Service. This will need a new DSA and EMIS activation. Alison Yates, via GP

federation is supporting this work. For the 2 system one practices, a GP record viewer will be needed.

d. Team members:

Existing resources will be provided:

- GP practice – Elderly Care Facilitator
- SSOTP – Therapists/ Nurse with training in frailty/ social work, Co-ordinator (part time, band 3). Also matron to act as link with community nursing teams.
- NSCHT – Mental Health Worker/ Community Psychiatric Nurse- commitment gained but some issues with existing staffing numbers due to need to support care home service.
- UHNM – Geriatrician mentorship and support to GP fellow.
- Voluntary sector (Staffordshire Housing and VAST)

All will be utilised as 'resource in kind' with agreement via Alliance Board.

New resources:

- GP fellow (1 day per week) – SSOTP will hold an honorary contract for this role.

e. Wrap-around and links with other parts of the acute care system: this scheme will only deliver during specific hours and therefore needs to strongly link with other parts of the system to allow a more effective urgent care response. This may be via the realigned community nursing teams that now include matrons and links with Home First or D2A resource.

f. Governance

Clinical responsibility will remain with the registered practice during the time in the service, though the patient/carer would be given the extensivist co-ordinator contact details as a first point of contact. It is envisaged that the practice ECF would be a key contact point in the practice itself.

DAA

Staffordshire & Stoke-on-Trent Dementia Action Alliance

Working to become Dementia Friendly 2017-2018

MEMBER UPDATES – QUARTER 2 – TO BE REPORTED MARCH 2018
COVERING: DECEMBER 2017 / JANUARY 2018 / FEBRUARY 2018

CONTACT NAME: Robin Wiles **NAME OF ORGANISATION:** Newcastle-u-Lyme Borough Council

Please complete this form by adding the progress that your organisation has made in the last quarter against each of the priority areas agreed below, and email a completed version back to Claire Reader – claire.reader@stoke.gov.uk :

ARTS, CULTURE, LEISURE ORGANISATIONS AND RECREATION
(e.g. Theatres, Cinemas, Museums, Art Galleries, Libraries, Football Clubs, Golf Clubs, Rugby Clubs, Leisure Centres, Garden Centres, and any other leisure activity)

Weekly Dementia Friendly swimming sessions being provided at Jubilee 2, in partnership with Approach and the Amateur Swimming Association.

RNW has delivered 3 Dementia Awareness sessions to 15 staff at Newcastle Library and is due to deliver a session to staff and volunteers at the Borough Museum.

BUSINESSES AND SHOPS
(e.g. Shops, Banks, Supermarkets, Markets, Post Offices, Dementia Friendly High Streets / Villages

CHILDREN, YOUNG PEOPLE AND STUDENTS
(e.g. Schools [Primary and Secondary], Sixth Form Colleges, Colleges, Universities

HEALTH AND SOCIAL CARE
(e.g. GP Surgeries, Hospital Settings, Pharmacies, Dental Practices, Clinical Commissioning Group, Stoke City Council)

COMMUNITY, VOLUNTARY, FAITH GROUPS AND ORGANISATIONS
(e.g. Parish Councils, voluntary organisations, voluntary groups, churches, BME communities)

RNW is supporting Dementia Friendly Community projects in Audley (approved), Loggerheads (just started) and Wolstanton (approval awaited). DFC projects also in Madeley, Kidsgrove & Talke.

Statistics for 2017 show:-

Postcode	Area	Sessions completed	Friends reported	Digital Friends	DFs by orgs	Converted Champions
ST5	Newcastle	114	1512	481	47	16
ST7	Audley/Kidsgrove	48	528	312	14	9
CW3	Madeley	15	84	36	N/A	2
TF9	Loggerheads	22	293	134	4	4
TOTAL		**232**	**2970**	**1254**		**42**

FIRE AND POLICE
(e.g. Fire Service, Police Authority, Special/Community Police)

HOUSING
(e.g. Sheltered Accommodation, Extra Care Facilities, Housing Sector organisations)

- A number of Aspire Housing staff are accredited to deliver Dementia Awareness sessions.
- The Newcastle Belong Village is due to open on Monday 9th April 2018.

TRANSPORT
(e.g. Taxi Services, Bus Services, railways stations, Civil Enforcement Team)

LOCAL AUTHORITIES / PUBLIC SECTOR
(e.g. local authorities across the geographical DAA area, other public sector organisations not referred to elsewhere in the action plan, private sector and VCSE organisations contracted by local authorities and other public sector organisations)

- *(Weekly Dementia Friendly swimming sessions being provided at Jubilee 2, in partnership with Approach and the Amateur Swimming Association – see also Section 1).*
- Dementia Awareness sessions to be provided as part of the Council's Corporate Induction.
- Assessment of Council buildings on hold until (delayed) move to Castle House.
- A directory of Dementia services to be produced.

INVOLVEMENT OF PEOPLE LIVING WITH DEMENTIA AND CARERS

- Two people living with dementia are members of the Staffordshire & Stoke-on-Trent DAA, one of whom has a blog – please see https://fizzyhammers.com/

MEDIA
e.g. Local Press, Local Radio Stations, BBC Midlands Today, Central News, Local Authority Media and Communications Teams

NHS
University Hospitals of North Midlands
NHS Trust

Royal Stoke University Hospital
Executive Suite
Newcastle Road
Stoke-on-Trent
Staffordshire
ST4 6QG

Tel: 01782 676610
Email: paula.clark@uhnm.nhs.uk

Our ref: PC/JD

13 February 2018

Councillor Ruth Wright
Civic Offices
Merrial Street
Newcastle-under-Lyme
Staffordshire
ST5 2AG

Dear Councillor Wright

Thank you for your letter of 5 February 2018.

We fully appreciate the importance of the role of the Newcastle-under-Lyme Health and Wellbeing Scrutiny Committee and respect the position of your members. We are, therefore, sorry that your members were disappointed that we did not send a representative to the meeting on 10 January 2018. However, the request to us was that we send a representative or, if not possible, a report. Given the severity of the pressures that the entire NHS was experiencing in January I am sure you can appreciate that we were focusing all of our efforts into resolving the very operational issues that your members were asking about. This is why we sent a report on this particular occasion. I do think organisations would find it helpful if the Committee could be clear if their attendance is required as this will prevent such misunderstandings occurring which are frustrating for both parties.

In normal circumstances we would be very pleased to send a representative to the Committee and, in terms of specific meetings, we will send the most appropriate colleague to discuss the chosen topic. For more general contact, my colleague Naomi Duggan, Director of Communications, would be very happy to meet with you to discuss how we can best work with your Committee in the future. Naomi can be contacted on 01782 676620.

I can appreciate that the report that was sent to you was too literal in answering the specific questions asked, rather than giving members the broader context around delays, although again the Committee may wish to note that the requirement was not particularly clear. I attach a fuller, more up to date, report which should provide more helpful context. You may still find it worthwhile to share this with your members for information as timely discharges need to be viewed as a whole system year-round responsibility, and to a lesser extent so do cancelled operations.

I am sure that we can work together more productively in the future and look forward to doing so.

Thank you again for taking the trouble to write to me.

Yours sincerely

PAULA CLARK
CHIEF EXECUTIVE

Enc

cc Naomi Duggan, Director of Communications

Report for Newcastle Borough Health and Wellbeing Scrutiny Committee in response to questions raised by Members

Is the Royal Stoke achieving timely discharges for residents of Newcastle under Lyme?

Achieving timely discharges for the residents of Newcastle under Lyme is dependent on a wide variety of factors, and is the responsibility of the whole health and care economy.

Effecting discharges to the community or to people's homes from Royal Stoke has been a significant challenge for a number of months. The bed capacity in the system wide winter plan was based on assumptions about demand (numbers of people needing care) which were exceeded during the autumn and the type of illness more acute than expected. Disappointingly a number of out of hospital schemes, that should have come on stream by autumn 2017 have not operated to the levels expected by commissioners and this left University Hospital North Midlands with more medically fit patients in our beds than we should have to enable efficient flow and timely discharges.

There are regularly 150-200 people who are medically fit for discharge (MFFD) occupying beds at Royal Stoke. This means that they no longer need acute care, but they may need on-going support at home or within a community setting such as a nursing home. A more acceptable figure for a hospital would be 100. As these patients are still occupying beds this contributes to long waiting times in A&E.

Complex discharges, where patients need more intensive support, remain the biggest problem as these are not occurring in sufficient numbers, leaving medically fit for discharge patients stranded in acute beds.

Many independent commentators, including NHS Improvement and the Care Quality Commission have commented on the compassionate care we provide to patients despite our pressures, so once people are admitted they can expect to receive high quality care. Indeed our latest Care Quality Commission report rated us as outstanding for caring.

However it is well documented that acute hospitals are not the best place for many people, especially the frail elderly, to receive care once they no longer need medical intervention. Extended lengths of stay in hospital can lead to de-conditioning with patients losing muscle mass and becoming confused. This then reduces their chances of remaining independent and in control once they do leave hospital. Extended lengths of stay are also unnecessarily expensive, as acute hospitals are the most costly part of the health system.

If there are delays what is the cause?

There are a number of historic and current issues that have contributed to the lack of timely discharges:

Demand

The demand for services this winter throughout the NHS has been higher and more acute than anticipated leading patients to occupy beds for longer than usual. Committee members will not doubt have seen the national media coverage in relation to this.

Lack of Acute Beds

Royal Stoke University Hospital is too small to fully meet the evolving needs of both the local population and those from a wider catchment. This is why despite our challenges we have invested £2m to create 45 new beds on the site. At the moment we have a net gain of 41 beds, with more to follow in the coming weeks.

We have developed a proposal for additional beds in the Trent Building but this would be a longer term initiative and is dependent on funding from NHS Improvement.

Closure of Community Beds

The Stoke-on-Trent and North Staffordshire Clinical Commissioning Group has closed significant numbers of beds at Bradwell, Cheadle, Longton and Leek Community Hospitals in recent years.

Whilst UHNM supports the principle of providing care as close to home as possible, we believe that some of these closures occurred prematurely as they were based on assumptions of demand that were too low, and predicated on out of hospital initiatives which did not come on line as quickly as expected. Bradwell Hospital temporarily re-opened in December 2017 to help absorb some of the winter pressures and is being used to care for patients who are medically for discharge from RSUH.

Other additional community capacity has recently been put in place at Haywood Hospital, Brighton House and Milford House.

The CCG are carrying out a consultation on the long term future use of the community hospitals.

Care Home Provision

The community care home sector is very congested and whilst there is some private nursing home provision there have been some quality issues and providers closing for financial or other reasons. These homes will often not take patients with complex needs, so whilst on paper there may be beds available, in practice these often do not correlate to the needs of patients waiting to be discharged leaving the patients in an acute bed.

Another issue we are facing is that homes are sending frail older people into hospital even though they could be better cared for in situ or by primary care. The Clinical Commissioning Group have been very clear that patients should not sent to hospital without a GP referral, and we are working with the West Midlands Ambulance Service to ensure that patients are not brought to Royal Stoke unless they have such a referral.

Domiciliary Care

In recent months there has been an increase in the number of care packages within people's homes, but the local domiciliary care offer still isn't strong enough to sustain a healthy flow throughout our hospitals.

Discharge to Assess

This is nationally recognised best practice which provides patients with an assessment in the community or their home and gives them up to six weeks of enablement support once they leave hospital. This is seen by the CCGs as the solution to issues with hospital flow. However Discharge to Assess can only work if there is capacity in the community.

Over Cautious Approach to Discharges by Clinicians

Whilst accepting all the challenges relating to a lack of sufficient appropriate community capacity, the national view is that UHNM has unnecessarily long lengths of stay for some patients and that we could do more ourselves to achieve discharges. In recent weeks John Oxtoby, our Medical Director, has written to our consultant body asking them to review their threshold for discharge in relation to every patient, so that we achieve more timely discharges. We are not asking anyone to compromise their integrity, but we are asking everyone to ensure their decision making is appropriate in the circumstances we currently face.

Multi Agency Discharge Event

We recently held a week long Multi Agency Discharge Event (MADE) involving all health and care system partners which focused on working together to reduce the queues and waiting times in our hospitals, and identifying and removing the barriers to discharges. All stranded patients (those with long stays as outlined above) have been reviewed as part of this exercise. We will be using the learning from this week to improve processes throughout the whole health economy so that more patients can get back home or to the most appropriate care setting as quickly as possible. Discharging patients in a timely way will help free up beds, reduce waiting times and improve patient experience.

As part of this event we have had the support of nationally respected experts including Dr Ian Sturgess and Liz Sergeant OBE, and are committed to taking advice and best practice on board.

Do the residents of Newcastle under Lyme experience any delays in relation to operation waiting times?

Much of the Trust's income is reliant upon the income received for performing operations, so it is in our interest as well as that of our patients that we do everything we can to prevent cancellation of operations.

There are many reasons for delays in operation waiting times some of which are associated with system pressures, or in-hospital issues such as staff sickness. However some do not take place because of patient cancellations or failure to attend appointments.

Cancer and urgent operations are our priority, and even when we are pressurised we do everything we can to minimise any cancellations. Our biggest challenge has been a lack of critical care capacity, as we cannot perform major operations without having the appropriate skilled aftercare in place. Flu has had an effect on this capacity throughout January as have the number of other acutely unwell patients coming through our doors.

Some elective surgery was cancelled in the autumn, and we have moved more routine surgery down to County Hospital to help prevent such cancellations in future. We paused non-urgent elective surgery during January 2018 in line with the national directive to do so in order to deal with winter pressures but are aiming to get back on track this month.

UHNM February 2018

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North Staffordshire Clinical Commissioning Group
Stoke-on-Trent Clinical Commissioning Group

Designing Your Future Local Health Services in Stoke-on-Trent and North Staffordshire

How you have been helping us to shape the solutions

North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCGs) are in the process of gathering the views of local people in the design of high quality, accessible and affordable local health services that meet your needs in and around the Community Hospitals.

This is a much broader picture than just the hospital buildings at Bradwell, Cheadle, Haywood , Longton Cottage and Leek Moorlands as it is about making sure the right services are in the right place at the right time, whether these services are provided from the hospital location, GP Practices or other health service providers.

We are in the process of working with local stakeholders to develop a pre-consultation business case with viable scenarios for each location on which we will formally consult later in the year.

Background

Over recent years we have been talking to you about the proposed model of care of providing care closer to home. Since October 2018, we have been on a journey, gathering your view on how we could deliver the best services to all patients to meet their changing health needs. We have also commissioned the Consultation Institute to help us to make sure we get this right and use best practice in the way we do this.

We have been working with local people, stakeholders and clinicians to understand the information and data we have about local health needs and the services that should be provided to meet those needs. We want to take an opportunity to let you know what we have been told so far, how we are listening to your views and what we will do next. .

What has been happening over the past few months?

The information and ideas you provided in a public survey and feedback from the Listening Events we held from October to December was independently analysed by the Centre for Health and Development.

We used this information, along with a lot of information about the services currently provided at the Community Hospitals and analysis of local health needs at an Options Development Event on 23rd January.

The event was attended by over 70 people, including representatives from provider organisations, Local Authorities and GP Localities, as well as patient representatives and the voluntary sector.

Working in groups, people reviewed the information about each location and reduced the long list to a shorter list and considered the criteria against which the list will be evaluated.

What we did

From the perspective of each location and a whole population perspective

Local Health Needs

Based on the data available to us from a variety of different sources, we produced data packs for each location which told us about the local population's health needs, the use of current services, travel and equality data.

Based on this information, we asked participants to provide their opinions of which services should be provided at each Community Hospital.

The core set of services to emerge were:-

- Walk in Centre / Minor Injuries Unit / Urgent Treatment Centre
- Out of Hours Services
- Outpatients – Current provision plus tailored services based on local needs
- Beds – slightly differing provision by site
- Diagnostics eg X-ray, ultrasound ,ECG
- Mental Health –crisis care, counselling , day care, clinics
- Dementia Services – ranging from memory clinic to a Centre of Excellence
- Phlebotomy – based on required demand in each locality.
- Hub - wellbeing - voluntary sector - social prescribing - Care navigators
- GP Services – Differing provision by site

At a second event held on 14th February, we presented this information back and used exercises to understand the preferences and choices that people would make given the scenario that we cannot provide everything from every location and that we will have to make difficult choices about the best place to locate the services to meet local needs. The aim of the event was to understand the choices local people make with regards to how far they would travel for community hospital services and to understand the choices they make for each service offer. The services they considered included community hubs, beds, urgent treatment centres, diagnostics such as x-ray and ultra sound and dementia services.

What you told us

The most common services for each site are listed at Appendix 1. Feedback from the conversations and exercises around choice revealed 5 top themes for consideration:-

- Need to recognise rurality as well as urban locations
- Transport links need to be carefully considered
- Recognition that not everything can be provided everywhere
- More accurate data is required to inform thinking
- There are too many interdependencies between sites to consider them individually

Criteria

When we assess the ideas that you have put forward, we will need a way to assess each suggestion. These are the criteria which we asked participants to discuss and describe to us:-

Must Haves - determined by external factors

- Affordability
- Quality care
- Fit with national and local strategy

Assessment Criteria

- Clinically sustainable
- Meets need
- Accessible

We asked people what these phrases meant to them and turned it into a word cloud. The larger the word in the picture below, the more often it was said:-

Next steps

During April, we will discuss what you have told us with clinicians and commissioners to see how viable each of the solutions might be. Some of the services suggested are not commissioned by Clinical Commissioning Groups and so we will have to discuss these with providers, partners and the wider NHS, Public Health and Local Authorities. We will hold reference groups to provide feedback on these discussions and will present a view as a whole health economy with some proposals for further consideration.

Once the scenarios have been developed further, they will be included as part of our Pre-Consultation Business Case, Which we will submit to NHS England for their consideration and to go through their assurance process to make sure that we have considered everything that we need to and that our proposals meet their tests. This process is likely to take a couple of months.

Only when that process has been completed will we be able to formally consult on the proposals and no decisions will be made until this process is complete.

We will keep you updated as we work through the process. We will be open and transparent throughout and will publish all of the information you need here:-
https://www.stokeccg.nhs.uk/stoke-get-involved/consultation-engagement/designing-your-local-health-services

and

www.northstaffsccg.nhs.uk/get-involved/consultation-engagement/designing-your-local-health-services

Appendix 1: Suggested Services by Location

Leek
Urgent and Diagnostic: Stakeholder Suggestions
• GPs under one roof • Need an urgent care offer in Leek • Current services need to be integrated – Minor Injury Unit etc. • Moorlands fragmented - no local access point for GP Out of Hours in Leek or Biddulph, have to go to Campbell Road, some referred to A&E – a lot of travel required if got transport • Minor Injury Unit do not cater for patients under 5 years old so quite varied on what can be prescribed etc. • Need to improve urgent care offer in Leek – need think differently / need to tweak what is already there - Minor Injury Unit closes at 8pm in Leek – travel to Stoke – no public transport, 45 minutes travel time – concern for elderly which is the nature of the population in Leek • Need prescribing ANPs in Leek • Diagnostics to be available to match the Minor Incident Unit 8am-8pm seven days a week • Phlebotomy services needed e.g. 6 days in Leek • X-ray and ultrasound • Baby ultrasound • Medical presence daily (including weekends) (GP) • Up to date scanning and X-ray facilities – extended opening times • Extra care facilities
Community: Stakeholder Suggestions
• Respiratory offer including chest therapy / MDT approach / mental health offer / dementia • Integrated team Hub – Leek – counselling, pharmacy, small number of palliative beds • Physio • Podiatry • COPD • Asthma • CHD • Diabetes • Stroke • Care Navigator – Health and Social Care • Previous Public Health services – smoking sensation, sexual health, • Well persons clinics to promote good health • Hub base for the integrated, community team • Primary Care led - GPs, District Nurses, Health Visitors, social care, voluntary sector
Mental Health: Stakeholder Suggestions
• Need a help hub to offer support, but not inpatient care cost • Dementia Centres needed in Leek • Value in having NHS dementia hub • Crisis Centre / mental health patients • EMI

Planned Care Stakeholder Suggestions
• Specialist outpatient clinics in more remote locations • Smarter access to outpatient appointments e.g. one stop shop • Same services that there is now with proper IT
Beds Stakeholder Suggestions
• Step Up facilities • Short term step up facilities • Rehabilitation and step up beds • Beds need provide various uses step up, rehabilitation, end of life

Bradwell
Urgent and Diagnostic: Stakeholder Suggestions
• Look at priorities for Bradwell, may not require a full diagnostic service and maybe off-set against other priorities such as physio and OT to support frail/elderly. • Surgery offer some diagnostic services • Consideration for other services in the area • Walk in Centre • Surgery – offer some diagnostic services • X-ray services in Newcastle • Expert faculties into community hospitals to strengthen Hubs e.g. CT scans • MIU / Walk In Centre • Hub • X-Ray • Phlebotomy • ECGs • GPs under one roof • EOL – bolt into localities – more consistent approach • Pharmacy
Community: Stakeholder Suggestions
• Sexual health clinic • Combine Lymebrook for specialist care and GP extended access for weekends • Wellbeing Hub • extended GP access at weekends • Care Navigation – Social Prescribing + carer support (including LTC) • GP Hub – out of hours and weekends (Extended Access to Primary Care) • Prevention services Hub (alcohol, smoking) + related f/o services – linked back to Public Health indicators • Wider community Hub – integrated Voluntary / Community Sector (bereavement services) + local assets (Schools etc.) / wider carer support (including respite) – addressing key determinants of health. • Asthma • COPD • Diabetes • Lifestyle services i.e. co-located with maternity / stop smoking ke • Chronic disease outreach • Keep all outpatient clinics
Mental Health: Stakeholder Suggestions
• Physio First, Pharmacy First + Mental Health First • Mental health services (shouldn't be bed-based) • Mental health (integrated model) (including LTC) • Dementia services

Planned Care: Stakeholder Suggestions
• Investment in integrated + Intermediate Care • Chronic disease • Outpatient clinics in place currently remain including phlebotomy • Primary care Hub • Multi-disciplinary teams in community
Beds: Stakeholder Suggestions
• Palliative Care • Respite - potential support by the third sector such as respite • Step up beds • Step down • Rehab • Reablement

Haywood

Urgent and Diagnostic: Stakeholder Suggestions

- Minor Injury Unit / ailments / GP offer
- X-Ray
- Phlebotomy
- UTC, enhanced diagnostics
- Walk-In wait see GP supported by ANP / Pharmacy
- GP onsite / prescribing ANP
- GP practice
- Complete Walk –in centre – fracture clinic – needs to be really good – hours open – X-ray, Phlebotomy
- GP service here, Primary Care Centre e.g. referred Hanley Walk-in Centre
- ECG

Community: Stakeholder Suggestions

- COPD
- Diabetes
- Respiratory / COPD / LTC clinics 'the pathway'
- Podiatry
- Physiotherapy
- VCS Hub (prevention + education)
- Drug and alcohol services
- Community nursing services / Health Visitors
- Health and Wellbeing Centre v's hospital – community medical facility
- Voluntary Groups
- District Nurses

Mental Health: Stakeholder Suggestions

- Memory Clinic
- Mental Health Services
- Mental Health officer – EMI – dementia
- Cognitive Behavioural Therapy to much higher need
- Dementia – more community based
- Centre of excellence

Planned Care: Stakeholder Suggestions

- Rheumatology and MSK physio
- Offer outpatient services at Community Hubs – need to ensure utilised fully
- Chronic disease clinic
- One stop shop – prevention / education – UCC – managing LTCs
- Other Out Patient Department services – bring the consultants out e.g. Gynaecologists more local specialists pharmacy for public
- Wheelchair service

Beds: Stakeholder Suggestions
• Specialist beds • Beds assessment and rehab • Palliative beds • GP led start (Step Up)

Cheadle

Urgent and Diagnostics: Stakeholder Suggestions

- Primary Care Access Hubs – Hub and spoke model. Extended GP Access
- Minor Injury Unit / ailments / GP offer
- Fracture clinic
- X-Ray Unit / Scan
- Out of Hours service
- Phlebotomy
- GP offer
- Basic diagnostics
- GP practices into onsite potentially
- GP under one roof / GP Care Hub
- Minor Injury Unit / X-Ray – GP provided Urgent Care – longer hours
- Pharmacy location at Cheadle – central location and impact on general practice

Community: Stakeholder Suggestions

- Hub for day to day / LTCs, frailty (over 60s)
- District Nurse
- Day care facilities
- CHD
- Diabetes
- Stroke
- Asthma
- Epilepsy
- Physiotherapy
- Wellbeing clinic
- Care Navigator – Health and Social Care
- GP practices / chronic disease management / working together
- Smoking
- Breastfeeding
- Audiology
- Cancer screening
- Counselling
- Maternity services
- Paediatric services
- Eye
- Family planning
- Age fitness support
- Dental
- Drug rehab
- Smear testing
- Voluntary Sector Hub – partnership

Mental Health: Stakeholder Suggestions
• Memory clinic • Specialist dementia services = critical services need to retain local for this vulnerable group of • Bed based facilities plays a part in Dementia Services e.g. Northfield • Need to consider mental health in general also, for Leek as a location • Group felt that clinical services are required in Cheadle for this vulnerable group • Different service offer for the patient and their family • Bed base facilities • Mental Health crisis services
Planned Care: Stakeholder Suggestions
• Specialist outpatient clinics in more remote locations
Beds: Stakeholder Suggestions
• Limited number of step up beds • Care home beds in Cheadle is limited

Longton

Urgent and Diagnostics: Stakeholder Suggestions

- Minor Injury Unit / ailments / GP offer
- X-Ray
- MIU / Walk In Centre
- Phlebotomy
- ECGs
- Same day access for a GP (local GP)
- Practices collaborate
- Extension of core GP services
- Pharmacy provision to on site – good local provision around LCN currently – use it in the right way

Community: Stakeholder Suggestions

- LTC offer
- Social prescribing
- Children's services
- Education
- Dietetics
- Exercise
- Counselling
- CHD
- Diabetes
- Hypertension
- GPs under one roof
- Care Navigator – Health and Social Care
- Audiology
- Physiotherapy
- Podiatry
- Drugs and alcohol
- Diabetes, Respiratory, Cardiac – 3rd sector – education / self-care
- Community rooms for groups 'VCS Hub' - open drop in e.g. loneliness
- Multi-disciplinary team at Longton. District nurse community nurses physio and podiatry, phlebotomy, social worker and wellbeing
- GP led
- A social Hub that develops what are very deprived communities
- Voluntary sector – lifestyle/a lot of services what is the contribution
- Café
- Counselling and support groups – massively deprived area (Blurton, Fenton, Normacot Bentlee etc)

Mental Health: Stakeholder Suggestions

- Access to CPNs
- Mental health and perinatal – for patients / families – local holistic care / include 3rd Sector – including education – opportunities through Longton development
- Need to be dementia friendly
- Memory clinic – dementia café's care or awareness

- Resource centre
- Carer support
- Early stage dementia
- Counselling, support groups

Planned Care: Stakeholder Suggestions

- Dependent on patient demographics in Longton
- Priorities on volume - Look at patient flows for high volume outpatient areas for the local area and then apply that
- One stop shop

Beds: Stakeholder Suggestions

- GP beds in the community
- Short term (Length of Stay 2-3 days) GP led Step up capacity
- Sub-acute with a view to growing community services to support (stepped change)
- Community beds – until D2A working properly
- Discharge to residential beds more than community hospital bed and care better in community hospital
- Beds – we would like beds that support ongoing rehabilitation (e.g. supported by intensive physio / OT). Share GP practices, sign-up/ respite beds
- Respite for carers if people are being cared for by families

IRP

6th Floor
157 – 197 Buckingham Palace Road
London
SW1W 9SP

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Richmond House
79 Whitehall
London SW1A 2NS

18 October 2017

Dear Secretary of State

REFERRAL TO SECRETARY OF STATE FOR HEALTH
Consultation on the *'My Care My Way - Home First'* proposals
Stoke-on-Trent City Council on behalf of the Adults and Neighbourhoods Overview and Scrutiny Committee

Thank you for forwarding copies of the referral letter and supporting documentation from Cllr Dave Conway, Leader, Stoke-on-Trent City Council on behalf of the Adults and Neighbourhoods Overview and Scrutiny Committee. NHS England provided initial assessment information. A list of all the documents received is at Appendix One.

The IRP has undertaken an initial assessment, in accordance with our agreed protocol for handling contested proposals for the reconfiguration of NHS services. In considering any proposal for a substantial development or variation to health services, the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 require NHS bodies and local authorities to fulfil certain requirements before a report to the Secretary of State for Health may be made. The IRP provides the advice below on the basis that the Department of Health is satisfied the referral meets the requirements of the regulations.

The Panel considers each referral on its merits and concludes that **this referral is not suitable for full review because further action by the NHS with the Committee and Council can address the issues raised.**

Background
Stoke-on-Trent, together with the neighbouring town of Newcastle-under-Lyme and the more rural Staffordshire Moorlands to the north and east lie in North Staffordshire with a combined population of around 470,000. The area is largely coterminous with the responsibilities of two NHS clinical commissioning groups (CCG) – North Staffordshire and Stoke-on-Trent CCGs – which have a combined budget of around £670m to commission health services. Most of the acute and specialist hospital services for the population are provided at the Royal Stoke University Hospital (RSUH), part of the University Hospitals of North Midlands NHS Trust (UHNM). A range of NHS services, including inpatient beds,

day care and outpatients, are also provided from community hospitals across the area at Bradwell, Longton, Haywood, Cheadle and Leek Moorlands.

Historically, services in North Staffordshire have been based around beds with too many patients admitted into hospital when they could stay at home and be treated within the community. Clinical evidence suggested that there were better ways to provide care and deliver better outcomes for many people currently admitted to hospital and, as a result, from 2013 the CCGs invested some £12m over two years in a range of out of hospital services such as district nurses, intermediate care teams and specialist nursing teams.

In 2014, the CCGs developed and proposed a new model of care, *My Care My Way – Home First*. Under the model, RSUH would be responsible for a patient from the moment they are admitted to hospital through to their final assessment and discharge, including their recovery at home or, if necessary, in a community hospital bed. The plans involved RSUH taking on the management of the beds at Bradwell and Cheadle Hospitals and having the ability to discharge people home with community-based care and support in place, thus reducing the number of days a patient will need to stay in hospital. In addition, GPs would become more involved in co-ordinating care for their patients at home, working closely with district nurses and specialists to plan care for people who are frail or vulnerable. Further increasing the provision of more intensive care within people's homes would ensure that patients who can be treated within the community without the need for a hospital admission would be able to access high quality and timely care when required.

A first phase of engagement commenced in December 2014 and involved the sharing of a briefing, developed with support from Healthwatch, to targeted individuals including MPs, general practice, local authorities, voluntary and patient groups. An online survey and paper questionnaire were also available. A number of positive themes emerged from the feedback including that patients benefit from and prefer to be at home and that there was support in principle for the new model. However, respondents also sought assurance about capacity in community services, the future of community hospitals, support for carers, patient follow up in the community, careful implementation and the investment to support the changes to the model of care.

In response to the feedback, the CCGs continued to develop plans for capacity and workforce requirements to implement the new model. A communication and engagement group was formed to ensure access to the networks of a wide range of voluntary organisations, key stakeholders, providers and staff and to help to shape proposals in the second phase of the engagement process. From June 2015, engagement activities continued, including communicating a plan to conduct a three month consultation in the autumn of 2015.

On 9 July 2015, at a meeting of the Adult and Neighbourhoods Overview and Scrutiny Committee of Stoke-on-Trent City Council (the Committee), the CCGs provided briefing in response to concerns raised with committee members by the public, patients and carers. The

concerns related to bed closures at Longton Cottage Hospital, the lack of consultation and that the proposed 'step up step down' model of care was undeliverable. Although not opposed to the model in principle, the Committee agreed that:

- it did not consider there was sufficient reason to close Longton Cottage Hospital in August 2015 and was concerned that there was insufficient capacity within the community to address the shortfall in beds
- the new model of care was a substantial variation and that a three month public, staff and patient consultation should be carried out when there was sufficient detail to make the consultation meaningful and that there should be no reduction in community beds before that happened
- the CCG should come back to the Committee in September 2015 with more detail on the model and its consequences

On 9 September 2015, the Committee was informed by the CCGs that, after full implementation of *My Care My Way – Home First*, 110 beds would be required at Bradwell and Cheadle hospitals, and 113 at Leek and Haywood hospitals. 30 intermediate care beds previously commissioned at Hilltop Nursing Home would not be recommissioned and 37 beds at Longton Cottage Hospital would no longer be required. The latter would be the subject of a formal three month consultation commencing 14 September 2015. Responses would be reviewed by the CCGs before publication of the outputs by March 2016. At the same meeting, the Committee considered the impact of the new model of care on adult social care. It asked for a fuller assessment of the impact and agreed that it would be fully involved in, and respond to, the CCGs' consultation whilst disagreeing with the closure of beds at Longton Cottage Hospital prior to consultation, and expressing serious concerns about the decision making process.

On 14 October 2015, the Committee was informed by the CCGs that the consultation would be focussed on *My Care My Way – Home First* as a new model of care with three key questions:

- *"Is there anything further we should be considering with regards to the My Care My Way model of care?*
- *Are there further mitigations we should put in place/consider in proposing this change?*
- *Are there any question/issues that individuals would like to raise as part of this process?"*

The CCGs informed the Committee that they had been advised by NHS England that they could not consult on the closure of beds and so the future of the 37 beds at Longton Cottage Hospital had been removed. The beds at Longton Cottage Hospital would remain closed and all community beds would be considered as part of the wider *Staffordshire Provider Transformation* work to be carried out across Staffordshire once the current consultation had concluded.

On 1 December 2015, in line with part of the proposed new model of care, a 'step down' contract between the CCGs and UHNM was implemented through which the latter took responsibility for use of community beds at Bradwell and Cheadle hospitals.

The Committee responded to the consultation which ended on 17 January 2016. The NHS has confirmed to the IRP that no formal evaluation report of the responses to the consultation or outputs from it have been considered by the CCGs' governing bodies to inform their decisions about the new model of care.

On 29 July 2016, UHNM formally served three months' notice with regard to the 'step down' contract with the CCGs. They were unable to accept the CCGs' contract offer which resulted in the Cheadle bed base funding being withdrawn with effect from 1 October 2016. Without the proviso that all existing beds at Bradwell and Cheadle hospitals remained in the contract, UHNM said they had no option but to agree and accept the Commissioners proposal of a 3 month termination notice period. In response, the CCGs sought alternative providers and conducted an options appraisal.

In August 2016, a clinical audit was undertaken to identify whether the patients in the community hospital beds needed to be in hospital. This study, carried out across the adult intermediate and rehabilitation (AIRS) beds open across the five community hospitals, showed that the overwhelming majority of patients were receiving assessments or care that could be carried out at home or a care home or were waiting for another service. The AIRS beds existed to provide bed based intermediate care and, by exception, assessment where there was an ongoing medical or nursing need. However, only nine per cent of patients across the AIRS beds on the day of the audit met the criteria, with the other patients waiting to go home with a social care service, intermediate care or overnight service, waiting for a care home bed or undergoing an assessment.

On 4 October 2016, the CCG's Joint Governing Board considered a report that noted all patients at Cheadle Hospital had been discharged by 30 September 2016 and the beds closed to admissions. Work was ongoing to achieve a similar position at Bradwell Hospital by the end of October. Presented with four options, the Joint Governing Body decided to close Bradwell Hospital's 63 adult AIRS beds to admissions and commission alternative services elsewhere on the basis that this was the most cost effective option and would deliver better outcomes for patients.

On 11 October 2016, the CCGs attended the Committee's meeting to provide an update on the implementation of *My Care My Way – Home First*. The CCGs informed the Committee that, since they had last met, the proposals had been assured by NHS England, the Joint CCGs' Board had considered the proposals, public engagement was under way and would end on 9 December 2016 with a report of findings in January 2017 and full consultation on the future of community hospitals to be launched in February 2017. The Committee agreed that NHS England be invited to a future meeting of the Committee to discuss the *My Care*

My Way - Home First consultation and that the CCG be invited to a future meeting to provide details of phase 2 of the consultation.

On 1 November 2016, the Accounting Officer's report to the CCGs' Joint Governing Body confirmed the temporary closure to new admissions of the community beds at Cheadle Hospital, Bradwell Hospital and on Jackfield ward at Haywood Hospital. It proposed a further one month period of patient and public involvement commencing November 2016 and a plan to undertake further consultation on the future of community hospital beds and services, commencing in February 2017.

The CCGs engaged with local people via an online survey and community events between 1 November and 21 December 2016.

On 22 November 2015, the Chair of the Committee wrote to the CCGs advising them that whilst supporting in principle the new model of care, they had serious concerns about the perceived lack of capacity in the community to support people to recover at home, following discharge from acute services and the lack of proper consultation on the closure of community beds. Consequently, at a meeting on 20 October 2016, the City Council had made the following recommendations:

- "*This City Council notes the proposed closure of Community Beds at Longton Cottage, Cheadle and Bradwell Hospitals and the devastating effect this will have on the most vulnerable residents in this City.*
- *We call on the CCG to put a hold on these plans until meaningful consultation has taken place and a full impact assessment has been carried out."*

The Chair further advised that the Committee proposed to make a decision at its meeting on 30 November 2016 on whether to recommend that the *My Care My Way - Home First* consultation proposals be referred to the Secretary of State for Health.

On 30 November 2016, at the invitation of the Committee, representatives of the CCGs and NHS England attended to give a further update on the implementation of *My Care My Way – Home First.* NHS England advised that '*a comprehensive robust consultation exercise had been undertaken by the CCG last year*' and '*the decision taken to re-provide the service was the right decision for patients and a robust process had been followed*'. With regard to lack of consultation to date about community beds and hospitals, NHS England said '*the CCG had commissioned alternative services and, as this was not a significant change to care, they were not required to go out to consultation*'. The Committee agreed to refer the matter to the Secretary of State for Health. A letter of referral and supporting documentation was sent on 26 January 2017.

In January 2017, in parallel with the Committee's referral, an independently prepared report on the findings from the latest engagement was completed. Overall, it concluded that there was public support for the *My Care My Way - Home First* model of care, but expressed doubts about the model's deliverability and successful implementation raising concerns about safe and good health outcomes for patients.

On 7 February 2017, the CCGs decided to pause the planned consultation on the future of community hospitals until after the local elections in May 2017.

On the 8 February 2017, the CCGs wrote to the leader of Stoke-on-Trent City Council responding to the content of the referral to the Secretary of State.

In March 2017, the CCGs approached the West Midlands Clinical Senate for independent clinical advice. Representatives from the CCGs provided a presentation on the case for change to the Senate in May 2017 with the intention of obtaining early advice and support prior to a North Midlands NHS England Strategic Sense Check, due to take place in July 2017.

In June 2017, the Senate Council concluded that it supported the CCGs' proposals for a reduction in community hospital beds replaced by an increase in place based care. It identified areas where it believed further information and development work was needed to strengthen the plans:

- Further detail outlining the workforce that will deliver the new clinical model should be worked up in conjunction with Health Education England West Midlands
- Any further closure of beds should be staged to manage any risk and unforeseen consequences, mindful of seasonal variation and demand
- Plans for engaging with the public, staff and primary care colleagues should be clearly set out and implemented to support change. A clear vision should be articulated emphasising the benefit to the local health economy and fit with overall system changes and STPs. This should include:
    - The rationale why certain sites have been selected for closure and why others would remain open
    - Clarification about how the remaining community hospital beds will be used
    - Clarification about how the community hospital estate will be used post-closure
    - How GPs link into placed based care, any impact upon them clinically or otherwise and any unintended consequences need to be considered
    - The connections with and the provision of social care needs should be described in more detail and take into account any planned council reductions in care packages
    - A review of residential and nursing home bed capacity and utilisation should be considered
    - Consideration should be given to ensuring clinical responsibility is effectively managed for on-going prescribing for patients by prescribers within the model, rather than relying on community GPs. The original proposal risks obfuscating and undermining effective and clear lines of clinical responsibility, and resolving this was important

On 28 July 2017, as part of its assurance process for service change, NHS England undertook a strategic sense check of the CCGs proposals for community beds in North Staffordshire. In its letter of 14 August 2017, NHS England identified areas for further work

before a pre-consultation business case was complete, concluding that the four tests had been partially met so far.

In parallel with NHS England's assurance process, one ward at Leek Moorlands closed due to inadequate staffing levels in August 2017 and the remaining ward has closed to new admissions to achieve full closure by the end of October 2017.

Basis for referral
Stoke-on-Trent's letter of 26th January 2017 states:

"At a special meeting of the Adults and Neighbourhoods Overview and Scrutiny Committee held on 30 November 2016, the committee recommended to City Council that:

'After being consulted by a relevant NHS body on a proposed substantial development or variation to the provision of health service within Stoke-on-Trent, the Adults and Neighbourhoods Overview and Scrutiny Committee recommends to City Council that it:

1. ***refers the My care My Way: Home First proposal ("the proposal") as a new model of care provision within Stoke-on-Trent to the Secretary of State for Health for the following reasons:***

i) it is not satisfied that the consultation conducted on the proposal has been adequate in relation to the content. The consultation lacked any information about the closure of community beds which forms part of the new model of care or the impact such closures will have on the health service in Stoke-on-Trent;

ii) it is not satisfied that the reasons given for the lack of consultation on the closure of community beds ie. a directive from NHS England not to consult, is adequate.

iii) the closure of the community beds would not be in the best interests of the health service, given that capacity in the community is not there, there is a lack of GPs in the area, the instability of the domiciliary care market in the area is of concern and there is a significant backlog of people waiting for adaptations to their homes'

Consequently at the meeting of City Council on 26 January 2017, the following recommendation was approved:
'That, pursuant to Regulation 23(9) of the Local Authority (Public Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, the City Council refers the My Care My Way: Home First consultation proposals to the Secretary of state for Health'*".*

IRP view
With regard to the referral by the Stoke-on Trent City Council, the Panel notes that:

- *My Care My Way - Home First* continues to attract support in principle
- Nearly three years after proposing the new model, the NHS has not yet demonstrated the case for change

- The NHS has failed so far to show the capabilities required properly to implement *My Care My Way - Home First*
- The NHS has to date undertaken periodic engagement activity, consulted with health scrutiny but not consulted with the public about the future of local services
- Although there has been extra investment in out-of-hospital services, the closure of community beds to date is associated with cost cutting rather than the implementation of better services with improved outcomes for patients
- The future of community beds in North Staffordshire is now the subject of NHS England's assurance process

Advice

The IRP offers its advice on a case-by-case basis taking account of the specific circumstances and issues of each referral. **The Panel does not consider that a full review would add any value. Further action by the NHS with the Committee and Council can address the issues raised.**

From the feedback to the initial engagement in late 2014 through to the review by the West Midlands Clinical Senate in June 2017, the broad proposition that it is better for services to be organised and delivered in a way that keeps patients out of hospital where appropriate has been positively received. In the context of North Staffordshire's health services, this proposition implies a need for change from the historical over-reliance on hospital bed based services to more services being provided in patients' homes. Since the main recipients of such care are likely to be older people, the proposition is of integral interest to carers, adult social care and a wide variety of voluntary groups. All have expressed their support in principle, as have the elected representatives of local residents in the form of the City Council.

Identifying an outdated pattern of care and garnering support in principle for a modern alternative from stakeholders are necessary steps but not sufficient to make the case for change. A case for change must also demonstrate how the proposition will be made to work, why the approach taken is the best one, what part will be played by organisations and individuals in delivering change, how risks during transition will be mitigated, and how progress will be measured and used to inform further implementation leading to evaluation of the change against its objectives.

Throughout all the work done so far - from the first engagement exercise through the subsequent interactions with the Committee and the current NHS England assurance process - legitimately interested parties have sought assurance about how the CCGs would make *My Care My Way - Home First* work in practice. The Panel considers that this consistent and reasonable holding to account has at no point yet been met with a proper and adequate response from the NHS.

Without a solid case for change, the NHS has not established a robust programme for change and experienced a number of false starts. The bed modelling presented to the

Committee in September 2015, has proved entirely incorrect and misleading. Many of the beds described as being used to deliver the fully implemented model have subsequently been closed and the contract with UHNM for 'step down' services was abandoned within 12 months as consequence of disagreement about the continued funding of bed capacity. The pattern demonstrated is that the CCGs present plans that they simply do not carry through and make decisions that do not turn out as intended. They seem to have been overtaken by events and demonstrated a lack of both capacity and capability to implement major change with their partners.

In contrast to the clarity of the Committee's referral, the NHS appears to have tied itself in knots about engagement and consultation. The initial engagement activity in late 2014 produced some clear themes and the CCG identified the need to do more with stakeholders to shape the future of services and address issues raised, including the future of community beds and hospitals. Since that point, the NHS has not delivered against its stated intentions. It has been confused about the differences between engagement activity and true engagement, between engagement and consultation and between consultation with scrutiny and wider consultation. As a consequence, it has undertaken what appears to be a series of reactive, incomplete and ill-focused activities. When approached, the Committee was clear that it considered the matter to be a substantial variation and wished to be consulted. The 2013 regulations do not define what constitutes a substantial development of variation. Well established good practice through protocols agreed locally between scrutiny committees and the NHS can help in this respect. While determining whether or not a proposal or action is substantial is a matter for joint agreement it is worth reflecting on the fact that, ultimately, it is local authorities that have been given the power of scrutiny. The IRP considers that the logical conclusion of this is that the local authority's view should prevail.

The circumstances of the NHS's original decision not to consult about the closure of the Longton Hospital beds are unclear. Advice from NHS England was cited by the CCGs and is recorded in the minutes of the Committee meeting on 14 October 2015. However, when asked by the IRP to supply details of that advice NHS England responded that "*unfortunately we do not have any other documentary evidence to support this statement due to changes in personnel"*. The Panel agrees with the Committee that such a directive is not an adequate reason under the regulations for not consulting with the Committee and has found no other reason that would meet the requirement of the regulations.

The CCGs decided to proceed with a consultation about *My Care My Way - Home First* that did not include any meaningful reference to the impact on community beds and hospitals. NHS England later told the Committee that it had provided assurance of a robust consultation. The evidence provided to the Panel only contradicts this statement. The "Case for Change" document, which the CCGs advised was the consultation document, contained little relevant content. At the time, the CCGs explicitly said implementation would continue during consultation. Further, the CCGs have been unable to evidence that they evaluated responses to consultation before deciding how to proceed. Given this evidence, the IRP does

not consider that true consultation took place in line with good practice and Gunning[1] principles. The Panel agrees with the Committee's concerns at the time that the consultation '*has not been carried out in a meaningful and transparent way. The new model of care has already been introduced which calls into question the validity of the consultation and the questions being asked are not about the new way of working, only mitigation. The Overview and Scrutiny Committee do not expect consultation to be carried out in this way*'.

The Committee and City Council demonstrated great patience with the NHS's changes of direction and confusion about engagement and consultation until their concerns about the future of community beds and hospitals were brought to a head by further closures. Because the CCGs have not responded effectively to the issues raised with them, have not made the case for change, and have not consulted about changes to services, those holding them to account, in particular NHS England, are open to criticism. The NHS has described the closures as 'temporary', repeatedly promising but not delivering consultation before final decisions are taken. This has continued since the Committee's referral last January, most recently with the closure of beds at Leek Moorlands Hospital reported this month. The myth of temporary closures is reinforced by the NHS confirming that they have no plans to reopen the beds and that their financial plans for the last two years rely on almost £10m of savings from the closures.

Three years after the CCGs gained widespread support in principle for *My Care My Way - Home First* and after investing significant resources in new out of hospital services, NHS England's own assurance process, as described in its letter to the CCGs of 14 August 2017, demonstrates that what is required to achieve successful change is not yet in place. The Panel agrees with the content of that letter and with the Clinical Senate's detailed recommendations in its report of June 2017. Regrettably for those patients and staff affected, many of the issues were identified early in the process and not acted upon.

The CCGs and NHS England must assure themselves and the Council that bed capacity and function are aligned to meet all the needs of local people, lessons are learned from the mistakes made and the capability put in place to move forward successfully. This must include:

- engaging properly the public and patients in the co-production of future services
- consulting in an open and meaningful way with the public and scrutiny
- in the context of the Better Care Fund, establishing the partnerships with providers and adult social care that are essential to deliver the proposed model of care
- identifying and supporting the clinical leadership that is needed to effect changes in care on the ground
- demonstrating how the new model will work and that it is delivering the better services, reduced use of hospital beds and better outcomes for patients and their carers that were promised
- applying explicitly the new patient care test for hospital bed closures

[1] http://www.nhsinvolvement.co.uk/connect-and-create/consultations/the-gunning-principles

This advice sets out the failures that have occurred in the past and what is required going forward. As work from now on proceeds, the lessons learned must be acted upon to ensure that previous errors are not repeated and that effective service change is implemented in the interests of local people.

Yours sincerely

Lord Ribeiro CBE
IRP Chair

APPENDIX ONE

LIST OF DOCUMENTS RECEIVED

Stoke-on-Trent City Council

1 Letter to Secretary of State for Health from Cllr Dave Conway, Council Leader, 26 January 2017
Attachments:
2 Briefing for Stoke on Trent City Council Adults Overview and Scrutiny Committee, 9 September 2015
3 Briefing for Stoke on Trent City Council Adults Overview and Scrutiny Committee, undated
4 Open report, Adults and Neighbourhoods Overview and Scrutiny Committee, 14 October 2015
5 My care My way – CCG consultation – Questions from the CCG website
6 Letter to North Staffordshire CCG from Chair of the Adults and Neighbourhoods Overview and Scrutiny Committee, 22 November 2016
7 Letter to Stoke-on-Trent City Council from Department of Health, 1 March 2017
8 Letter to Department of Health from Stoke-on-Trent City Council, 13 April 2017
9 Adults and Neighbourhoods Overview and Scrutiny Committee minutes of meeting, 9 July 2015
10 Adults and Neighbourhoods Overview and Scrutiny Committee minutes of meeting, 14 October 2015
11 Adults and Neighbourhoods Overview and Scrutiny Committee minutes of meeting, 11 October 2016
12 Adults and Neighbourhoods Overview and Scrutiny Committee minutes of meeting, 30 November 2016

NHS

1 IRP template for providing initial assessment information
Attachments:
2 Bed based capacity
3 Delivery Board update, 23 January 2017
4 Evidence base for step up step down, January 2016
5 Communications plan, March 2016
6 CCG engagement and consultation document, 15 September 2015
7 New model of care Phase 2 Engagement Working Group Terms of Reference
8 Ethnic minorities needs assessment for Stoke, January 2015
9 Profile of North Staffordshire CCG by the nine protected characteristics, January 2016
10 CCG paper for Health and Wellbeing Scrutiny meeting, July 2015
11 Briefing for Stoke on Trent City Council Adults Overview and Scrutiny Committee, 9 September 2015
12 My care My way – CCG consultation – Questions from the CCG website
13 New models of care: consultation response – Age UK North Staffordshire
14 Healthwatch frail and elderly discharge consultation response, March 2015

15 Pensioners' convention feedback, 12 February 2016
16 CCGs Phase 1 feedback, March 2016
17 Meeting with pensioners convention and retired unison members, 9 March 2016
18 Save Longton Cottage Hospital, 18 August 2015
19 CCG General Update to Staffordshire Moorlands Health Overview and Scrutiny Panel meeting, 9 March 2016
20 CCG Case for Change
21 CCG My Care My Way – Home First, Public Engagement Report, January 2017
22 CCG My Care My Way – Home First Implementation, engagement briefing
23 CCG Joint finance recovery group meeting, 27 September 2016
24 Staffordshire system resilience group meeting, 26 February 2015
25 Staffordshire system resilience group meeting, 10 December 2015
26 CCG Accountable Officers report to Governing Body, 4 October 2016
27 CCG Patient and public involvement report to Governing Body, 6 December 2016
28 CCG Chief Operating Officer report to Joint Governing Board, 1 November 2016
29 CCG Accountable Officer report to Joint Governing Board, 7 February 2017
30 CCG Accountable Officer report to Joint Governing Board, 4 October 2016
31 CCG Chief Operating Officer report to Joint Governing Board, 1 November 2016
32 West Staffordshire A&E Delivery Board meeting papers, 24 November 2016
33 Discharge to assess paper, 23 June 2016
34 Discharge to assess report to Staffordshire system resilience group, 23 June 2016
35 Letter to Stoke on Trent CCG from UHNM NHS Trust, 29 July 2016
36 Equality impact and risk assessment Stage 1 screening tool, 28 October 2016
37 List of stakeholder events, May 2015 – February 2017
38 CCG presentation on Step Up Step Down new model of care, July 2015
39 CCG presentation to Stoke Scrutiny, 9 September 2015
40 CCG presentation to Newcastle under Lyme Scrutiny, 30 September 2015
41 CCG presentation to Stoke Scrutiny, 14 October 2015
42 CCG General Update to Staffordshire Moorlands Health Overview and Scrutiny Panel meeting, 9 March 2016
43 My Care My Way phase 1 summary
44 My Care My Way presentation to Stoke Scrutiny
45 My Care My Way implementation engagement overview
46 My Care My Way evidence base
47 CCG meeting with Newcastle under Lyme Scrutiny, 8 July 2015
48 My care My way – CCG consultation – Questions from the CCG website
49 New models of care consultation response, Age UK North Staffordshire
50 Healthwatch frail and elderly discharge consultation response, March 2015
51 Pensioner convention feedback
52 Meeting with pensioners convention and retired unison members, 9 March 2016
53 My Care My Way first consultation event #5
54 Bentilee Neighbourhood Centre feedback
55 Cheadle Guild Hall feedback
56 Fenton Manor feedback

57 Moorlands District Council feedback
58 Longton CoRE feedback
59 Tunstall Market feedback
60 Community Hospitals outpatients – current delivery activity, October
61 CH utilisation
62 Newcastle under Lyme Stronger Safer Strategy
63 CQC community health inpatient services quality report, 19 March 2015
64 Clinical Senate feedback
65 Bradwell and Cheadle quality impact assessment, 6 April 2017
66 Longton Cottage quality impact assessment
67 CCG presentation to Stoke Scrutiny, May 2017
68 Discharge to assess, June 2017
69 Letter to Stoke-on-Trent City Council from CCGs, 8 February 2017
70 Letter to CCGs from NHS England, Strategic Sense Check, 14 August 2017
71 Supplementary information requested by IRP from NHS
72 Stoke Scrutiny minutes of meeting, 14 October 2016
73 Community reconfiguration question
74 Communications and engagement document
75 My Care My Way – Home first: additional questions and answers
76 CCG Public response to the new model of care proposals: provisional findings

Lindop, Jonathan (S,G&C)

Subject: FW: Your correspondence of 9 January

From: Department of Health and Social Care [mailto:donotreply@dh.gsi.gov.uk]
Sent: 07 February 2018 14:32
To: Gould, Tina (S,G&C)
Subject: Your correspondence of 9 January

Our ref: DE-1117702

Dear Ms Gould,

Thank you for your correspondence of 9 January about Bradwell Hospital, following Staffordshire County Council's referral to the Secretary of State of 11 January 2017. I have been asked to reply and I apologise for the delay in doing so.

As you are aware, the Department has previously indicated that the Council's referral was under consideration. However, Departmental officials have decided not to officially refer this case to the Independent Reconfiguration Panel (IRP), as the issue of the closure of wards at Bradwell Hospital was covered in another IRP referral.

The IRP published its advice on that referral on 19 December, and it is available by clicking on the following link:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669539/IRP_Stoke-on-Trent_referral_advice_18.10.17.doc

I hope this reply is helpful.

Yours sincerely,

Daniel Belmore
Ministerial Correspondence and Public Enquiries
Department of Health and Social Care

Please do not reply to this email. To contact the Department of Health and Social Care, please visit the Contact DH section on Gov.uk

To receive news about DH: sign up to our monthly newsletter

Members: Bloor, Julie Cooper, Dillon, Gardner, L. Hailstones, Jones, Loades, Naylon, Wilkes, Wright

HEALTH AND WELLBEING SCRUTINY COMMITTEE

NEWCASTLE UNDER LYME BOROUGH COUNCIL

Chair: Councillor Wright
Vice Chair: Councillor D Loades

Portfolio Holder(s) covering the Committee's remit:
Councillor Jill Waring (Community Safety and Wellbeing)
Councillor Mark Holland (Leisure, Culture)

This document sets out the work programme of the Health and Wellbeing Scrutiny Committee 2017/18
The Health and Wellbeing Scrutiny Committee may wish to scrutinize the following topic areas which fall under the remit of the Committee:

- 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

We review the work programme from time to time. Sometimes we change it if something comes up during the year we should investigate as a priority. **Councillor Ruth Wright, Chair, Health and Wellbeing Scrutiny Committee.**

If you would like to know more about our work programme please get in touch with Jayne Briscoe, Democratic Services Officer on
01782 742250 or jayne.briscoe@newcastle-staffs.gov.uk

HEALTH AND WELLBEING SCRUTINY COMMITTEE

Date of Meeting	Item	Background/Objectives
5th July 2017 (agenda dispatch 27th June 2017) Members of Active & Cohesive Scrutiny Committee invited to attend for presentation on Dementia	Presentation by Will Boyce, Joint working on Dementia Care and provision of services in the Borough	A Corporate Priority – A healthy and active community
	Minutes from the Healthy Staffordshire Select Committee	To receive the minutes of the March meeting
	Work Plan	To discuss the work plan and potential topics that Committee members would like to scrutinise over the forthcoming year
19th October 2017 (agenda dispatch 11th October 2017)	Evaluation of the Space Programme Young Carers	
	Work Plan	To discuss the work plan and potential topics that Committee members would like to scrutinise over the forthcoming year
10th January 2018 (agenda dispatch 2nd January 2018)	Annual Work Plan Review Response to questions asked by members at previous meeting (19/10/2017)	To evaluate and review the work undertaken during 2016/17

Date of Meeting	Item	Background/Objectives
11th April 2018 (agenda dispatch 3rd April 2018)	Review of Space Scheme – access by young carers and ways to monitor this – **evaluation abandoned due to lack of data.**	
	Presentation by Charlotte Harper, Queens Nurse – Care Navigation Project	Exploring this topic further following 10 January meeting
	Examination of how the Borough engages with the BID in terms of dementia friendly activities	Developing the dementia friendly topic
Suggestions for Potential Future Items:	• How do we support Autism awareness • Review of the effectiveness of the GP referral programme	