Health Scrutiny Committee

Thursday 26th March, 2015, at 6.00pm
In Committee Room 2 at the Council House, Priory Road, Dudley

Agenda - Public Session
(Meeting open to the public and press)

1. Apologies for absence.

2. To report the appointment of any substitute Members for this meeting of the Committee.

3. To receive any declarations of interest under the Members' Code of Conduct.

4. To confirm and sign the minutes of the meetings held on 22nd January and 16th February, 2015 as correct records.

5. Public Forum – To receive questions from members of the public:-

   The Public are reminded that it is inappropriate to raise personal cases, individual details or circumstances at this meeting, and that an alternative mechanism for dealing with such issues is available.

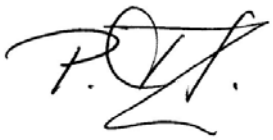
   Please note that a time limit of 30 minutes will apply to the asking of questions by members of the public. Each speaker will be limited to a maximum of 5 minutes within the 30 minutes.

6. Mental Health Quality and Performance Review

7. Update on Transfer of the 0-5 Years Public Health Commissioning to Local Authorities

8. Responses to Questions

9. To consider any questions from Members to the Chair where two clear days notice has been given to the Director of Corporate Resources (Council Procedure Rule 11.8).



Strategic Director (Resources and Transformation)
Dated: 18th March, 2015

Distribution:

Members of the Health Scrutiny Committee:
Councillor C Hale (Chair)
Councillor N Barlow, (Vice-Chair)
Councillors C Elcock, M Hanif, D Hemingsley, S Henley, K Jordan, M Roberts, E Taylor, K Shakespeare and K Turner
Ms Pam Bradbury – Co-opted Member

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- Information about the Council and our meetings can be viewed on the website **www.dudley.gov.uk**

- Elected Members can submit apologies by contacting the officer named below. The appointment of any Substitute Member(s) should be notified to Democratic Services at least one hour before the meeting starts.

- The Democratic Services contact officer for this meeting is Manjit Johal, Telephone 01384 815267 or E-mail manjit.johal@dudley.gov.uk

Minutes of the Health Scrutiny Committee

Thursday 22nd January, 2014 at 6.00 p.m.
in Committee Room 2 at the Council House, Dudley

Present:-

Councillor C Hale (Chair)
Councillor N Barlow (Vice-Chair)
Councillors M Hanif, D Hemingsley, S Henley, K Jordan, P Miller, K Shakespeare, E Taylor and D Tyler

Officers

M Farooq ((Assistant Director – Law and Governance (Lead Officer to the Committee), K Jackson (Interim Director of Public Health) and M Johal (Democratic Services Officer – Directorate of Resources and Transformation).

Also in Attendance

Ms Paula Clark – Chief Executive, Dudley Group NHS Foundation Trust
Ms Liz Abbis – Dudley Group NHS Foundation Trust
Dr David Hegarty – Dudley Clinical Commissioning Group
Ms Laura Broster – Dudley Clinical Commissioning Group
Mr Jason Evans – Dudley Clinical Commissioning Group
Mr Neill Bucktin – Dudley Clinical Commissioning Group

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33 **Apologies for Absence**

Apologies for absence from the meeting were submitted on behalf of Councillors C Elcock, M Roberts and K Turner and P Bradbury.

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34 **Appointment of Substitute Members**

It was reported that Councillors P Miller and D Tyler had been appointed to serve in place of Councillors C Elcock and M Roberts for the meeting of this Committee only.

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35 **Declarations of Interest**

In accordance with the Members' Code of Conduct, a non-pecuniary interest was declared by Councillor E Taylor in respect of any reference made to Russells Hall Hospital in view of the fact that her daughter works at the hospital as a staff nurse.

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36 **Minutes**

Resolved

That the minutes of the meeting of the Health Scrutiny Committee held on 20th November, 2014 be approved as a correct record.

37 **Public Forum**

No issues were raised under this agenda item.

38 **Care Quality Commission Inspection Outcomes**

A report of the Chief Executive, Dudley Group NHS Foundation Trust, was submitted on the outcomes of the Care Quality Commission hospital inspection of the Dudley Group NHS Foundation Trust, and on the plans the Trust had in place to address the report.

Arising from the presentation of the report the following queries and comments were made by Members and responses were given as indicated:-

- With regard to ophthalmology clinic provision a Member stated that service pressures and problems had been known for a number of years and it was queried why it had taken so long to address the issues. Reference was also made to skilled employees being recruited from abroad and it was queried why problems were being experienced in recruiting medical staff that had been trained in the United Kingdom (UK).

  Problems relating to staff shortages was a national issue and there were additional pressures because of increased demand due to the aging population. In relation to problems in recruiting skilled people in the UK this was due to national training being reduced. However, issues were being addressed and it was reported that the Trust were currently in discussions with Wolverhampton University with a view to compiling a course and training specifically for medical staff at a reduced cost to encourage more students to join. It was also reported that an ophthalmology consultant had recently been recruited and was due to commence employment in March 2015.

  In response to further questions relating to demand it was reported that there was an increase in the number of elderly patients seen at the ophthalmology clinic particularly with conditions relating to glaucoma and cataracts.

- In response to a query about Ambulatory Emergency Care (AEC) it was explained that this scheme gave some patients a faster and better service as the less sick patients were targeted with a view to being diagnosed, stabilised and treated quickly so that they could go home which also eased the pressure on beds.

- Staff that were recruited from abroad had to undertake tests to ascertain their written and spoken English and dialect sessions were also held. It was reported that the Trust had very high quality nursing staff that had been recruited from abroad and there had been no language barrier problems. Staff turnover was approximately 8% per year and efforts were continuously made to fill vacancies by holding open days.

- With regard to maternity services it was queried how births were restricted and the reason for the restriction.

  It was explained that historically there were capacity issues and a plan had been agreed with the Clinical Commissioning Group (CCG) with a view to addressing and managing the problem. Capacity problems at Russells Hall Hospital had arisen because of the high quality maternity service offered at the hospital which meant that patients chose that hospital over other hospitals. There were problems recruiting midwives and a tool used to ascertain the ratio of midwives to patients determined that the ratio should be 1/34 however the hospital were at 1/40 births. Plans were put into place to manage the situation which entailed limiting births at the hospital to 4,900 and this was achieved by allocating those patients living further away to other hospitals.

- In relation to calling on the services of "bank staff" it was explained that the Trust had their own internal "bank" of staff comprising of a mixture of existing and retired employees, and, occasionally where certain shifts could not be filled or specialised training skills were required, external agencies were used. It was further reported that the Trust offered a novice training programme to people with little or no experience as the Trust supported a "grow your own" approach.

- Reference was made to plans to reduce staff and posts particularly at Russells Hall Hospital and it was queried whether this would impact on the quality of services and whether targets would still be met, given the significant reduction.

  It was reported that certain staff and nurses were exempt from the process and redundancy schemes would not apply to them given the problems encountered in recruiting for these posts. However, the Trust were currently overspending and would be £7m in deficit at the end of this financial year and measures had to be put into place to address the issue. It was acknowledged that existing staff were concerned and worried about their positions and it was stated that the Trust were doing everything in their power to ensure that the process was completed as quickly as possible. It was explained that there was a good redeployment system in place and assistance would also be given to staff with a view to them finding alternative employment.

- With regard to an increase in the demand for blood tests it was reported that there were plans to introduce an additional phlebotomy service at the Guest Hospital. It was acknowledged that there was a need to offer other services at the other hospitals as they were underutilised.

Resolved

That the information contained in the report and Appendix to the report submitted on the outcomes of the Care Quality Commission hospital inspection of the Dudley Group NHS Foundation Trust and on the plans the Trust has in place to address the report, be noted.

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39 **Winter Pressures**

A joint report of the Head of Commissioning (Dudley Clinical Commissioning Group) and the Chief Executive (Dudley Group NHS Foundation Trust) was submitted on plans that had been put into place to deal with demand in the health and social care system and on performance during the winter period.

Arising from the presentation of the report the following queries and comments were made by Members and responses were given as indicated:-

- The Head of Commissioning undertook to circulate to the Chair the cost associated with the number of excess bed days arising from patients remaining in hospital once they were medically fit for discharge during recent months.

- Reference was made to delays in social workers being allocated to patients.

- It was queried whether information was available on the effectiveness of the flu vaccination, if there were figures available on how many people had received the vaccination and whether information was collated on patients that were admitted to hospitals to ascertain whether they had been vaccinated.

  It was reported that there had been an increase in patients through the winter due to a virus which was not flu related and flu vaccinations would not have had an impact. However, it was acknowledged that the uptake of flu vaccinations in Dudley was low and there was the need to promote the service.

  The Interim Director of Public Health reported that information was received from General Practitioners (GP's) and from pharmacies on uptakes of flu vaccinations and figures were currently being monitored. Work was also underway with elderly groups and the Local Authority with a view to promoting and increasing uptake.

Resolved

That the information contained in the report and Appendices to the report submitted on plans that had been put into place to deal with demand in the health and social care system and on performance during the winter period, be noted.

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40 **NHS Health Check Implementation**

A report of the Interim Director of Public Health was submitted on an overview of the implementation of the national NHS health checks programme in Dudley.

Arising from the presentation of the report and in responding to Members' queries the Interim Director of Public Health explained about services offered by the Council to their staff, such as programmes relating to stopping smoking and good health initiatives. She also reported on methods used to promote services and undertook to provide information on how services were promoted, where they were promoted and figures on successes and uptake.

Arising from further discussions, the Interim Director of Public Health undertook to circulate information and leaflets to Members with a view to promoting services offered. A Member also stated that Community Forums could also be used with a view to making a presentation to promote the service.

Resolved

That the information contained in the report and Appendix to the report submitted on performance and constraints relating to the NHS Health Check Implementation, be noted and action taken to increase uptake, be supported.

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41 **The Better Care Fund**

A report of the Chief Executive, Dudley Clinical Commissioning Group was submitted on the Better Care Fund (BCF).

Resolved

(1) That the revised financial plan for the Better Care Fund be noted.

(2) That the proposed arrangements for the Section 75 Agreement and pooled budget be noted.

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42 **Update on Urgent Care Centre Development**

A verbal report was given by the Chief Executive (Chief Executive, Dudley Group NHS Foundation Trust).on progress made towards the opening of the new Urgent Care Centre (UCC) in Dudley.

In presenting the oral report the Chief Executive, Dudley Group NHS Foundation Trust stated that since the previous meeting the Trust had continued to work with the CCG and Malling Health with a view to opening the urgent care centre on an interim plan from April, 2015. The interim plans included operating the centre from the existing phlebotomy and outpatient 3 areas and consideration was being given to rehouse some of the phlebotomy services. Malling Health had been on site since December, 2014 with a view to trialling plans and addressing issues that may arise on implementation.

Resolved

That the information contained in the verbal report on progress made towards the opening of the new Urgent Care Centre in Dudley, be noted.

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43 **Responses to Questions**

A report of the Lead Officer to the Committee was submitted on updates and responses arising from the previous meeting.

Arising from the presentation of the report a Member referred to the Dudley Walsall Mental Health Trust and the query relating to the eating disorder service and stated that the number of specialists allocated to this service had been queried but not answered.

In responding the Chair indicated that a report relating to the Trust's accounts was being considered at the next meeting and reference could be made to the issue at that time.

Resolved

That the information contained in the report and Appendix to the report submitted on updates and responses from previous meetings, be noted.

The meeting ended at 8.10 p.m.

CHAIR

Minutes of the Health Scrutiny Committee

Monday 16th February, 2015 at 6.00 p.m.
in Committee Room 2 at the Council House, Dudley

Present:-

Councillor C Hale (Chair)
Councillor N Barlow (Vice-Chair)
Councillors M Hanif, D Hemingsley, S Henley, C Perks, M Roberts, K Shakespeare, E Taylor, K Turner and Ms P Bradbury

Officers

M Farooq ((Assistant Director – Law and Governance (Lead Officer to the Committee), D Harkins (Chief Officer, Health and Well Being), K Jackson (Interim Director of Public Health), A Sangian (Scrutiny Officer – Directorate of People Services) and M Johal (Democratic Services Officer – Directorate of Resources and Transformation).

Also in Attendance

Ms Marsha Ingram – Dudley and Walsall Mental Health Partnership Trust
Ms Rosie Musson – Dudley and Walsall Mental Health Partnership Trust
Mr Derek Eaves – Dudley Group NHS Foundation Trust (DGNHSFT)
Mr Nick Henry – West Midlands Ambulance Service
Dr Rathore – Dudley Clinical Commissioning Group
Mr Daniel King – Dudley Clinical Commissioning Group

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44 **Apologies for Absence**

Apologies for absence from the meeting were submitted on behalf of Councillors C Elcock and K Jordan.

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45 **Appointment of Substitute Member**

It was reported that Councillor C Perks had been appointed to serve in place of Councillor K Jordan for the meeting of this Committee only.

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46 **Declarations of Interest**

No Member declared an interest in any matter to be considered at this meeting.

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47 **Public Forum**

No issues were raised under this agenda item.

48 **National Health Service (NHS) Quality Accounts**

Quality account summary reports were submitted from the Dudley Group NHS Foundation Trust and the Dudley and Walsall Mental Health Partnership NHS Trust. The quality account update report from the West Midlands Ambulance Service NHS Foundation Trust had been circulated separately to the agenda.

The Dudley Group NHS Foundation Trust

Arising from the presentation of the report Members made comments and raised questions as follows and responses were given as indicated:-

- Reference was made to surveys that were undertaken to determine scores and it was queried whether vulnerable groups were included to ascertain their opinions and the methods used to communicate with them.

  In responding it was stated that the person responsible for collating information from patients for the survey did not have any input from nurses and patients were chosen randomly. It was commented that there were problems in gathering feedback from various vulnerable groups particularly where communication was a barrier and consideration was being given to addressing the matter. However, one of the methods currently used to obtain information from patients with learning disabilities was by setting up a specific Forum tailored to that individual's needs whereby the patient attended with their carer and questions were asked about their care plans and how improvements could be made.

  There was also a "red tray system" which included those people that needed assistance with feeding and regular surveys were undertaken of these patients with a view to compiling information for audit purposes.

- With regard to call bells clarification was sought on what was considered to be a reasonable time to respond to the bell. It was considered that a time should be specified particularly for vulnerable patients as they needed reassurance and if they knew that they would be seen within a certain time, for example within 10 minutes, they may be less anxious and agitated.

  It was stated that it was difficult to allocate a specific time that could be considered as being "reasonable", particularly as people's perceptions and definitions of a "reasonable time" varied. It had therefore been agreed that it would be better to ask patients if calls had been answered within a reasonable time.

Following on from further discussion, Mr Eaves (DGNHSFT) undertook to feedback comments made in that there should be a benchmark or mechanism in place to clarify response times. It was considered that a specific response time could be allocated and the patient then asked if they had been responded to within that time.

- A Member commended the hospital on the service he had received following his recent experience on being admitted and further commented that there were some people that did not need to use the call bells as their needs were being met and addressed.

  Mr Eaves concurred with the comment made and explained about "intentional rounding" which was a process currently in place whereby nurses approached patients every hour with a view to offering assistance with care needs such as helping them to the toilet, which reduced the need to use the call button. When conducting their hourly rounds, nurses had specific questions that patients were asked and all documentation was recorded with a view to analysing data and continuous improvements being made.

- The steady decline in pressure ulcer incidents and the work undertaken to achieve this was welcomed. However, details relating to those cases that had experienced delays in equipment being provided by the relevant organisation was queried, specifically how long individuals had been waiting and whether there were any alternate providers of the service.

  The meeting were informed that the Clinical Commissioning Group paid for the services of the provider of the equipment and discussions were being held with them with a view to improvements being made. There was no alternative provider for the equipment and the reasons for the delay or timeframes of the delays were not known.

  Mr Eaves undertook to ascertain the reason for the delays, the length of time patients had been waiting for the delivery of equipment and also to feedback concerns on there being only one provider of that service.

  In responding to a further query about specific details relating to the single stage 4 ulcer, it was reported that usually stage 4 ulcers had broken skin and a deep wound. However, in this particular case skin had grown over the wound and the stage of the ulcer was only revealed following operational investigations. Procedures had now been put into place to prevent this from happening again and Mr Eaves undertook to circulate to the Committee details of the extent of the investigations that now took place.

- With regard to targets relating to MRSA and Clostridium difficile it was stated that these were set by the Government and calculated by using a specific formula that was based on the hospital's performance and its size.

- Reference was made to the targets measured by the Nursing Care Indicator process relating to nutrition and hydration which consisted of 10 records on every ward being audited each month and it was commented that 100% should be achieved given the small numbers being measured.

  It was stated that there were 10 sets of records collated from 25 wards each month which equated to 750 records each quarter. Senior Nurses scanned these records and it was not considered that records should be inspected rigorously by these staff as they should be undertaking their other duties. However, it was acknowledged that there should be an expectancy to achieve 100%.

- Comments made about the quality of the food at the hospital were acknowledged and it was stated that this was an ongoing issue. Currently the hospital were in the midst of trialling a new menu on certain Wards which involved patients being asked their choice of food on the day which was then electronically submitted directly to the kitchen. Food scores had improved on these Wards and it was considered that this was partly due to reintroducing food, such as chips. However, for nutritional reasons, there needed to be a balance against these types of foods.

- With regard to results from the annual survey and community targets it was requested that further information be provided on the target groups, the questions asked and who was responsible for setting the targets.

  Mr Eaves stated that the annual survey had not as yet concluded but he undertook to provide details contained in the final annual survey together with further information as requested above.

- The Chair referred to comments made at the previous meeting whereby the Committee had acknowledged the importance of acting swiftly to tackle overspend issues. However, concerns were expressed about proposed efficiencies involving the transfer of constituent higher care worker roles to nurses given they were already subject to staffing shortfalls. It was queried whether progress had been made relating to safeguards being put into place to ensure the safe and sustainable transition of responsibilities for patients and staff alike.

  Mr Eaves indicated that he was unaware of the issue but undertook to ascertain the position and to report back. The Scrutiny Officer also undertook to write to the Dudley Group of Hospitals NHS Foundation Trust with a view to obtaining a response.

<u>Dudley and Walsall Mental Health Partnership NHS Trust</u>

Arising from the presentation of the report Members made comments and raised questions as follows and responses were given as indicated:-

- In response to a query about managing training for staff given constant changes and staff turnover and how care plans were managed given the extensive workloads it was reported that it was an ongoing challenge. However, efforts were made to engage and work with carers with a view to ensuring a quality service was provided. Nurses were aware of embedded practices together with expectations and all nurses had a card with the priorities listed as a constant reminder.

  In response to a query Ms Ingram undertook to provide specific details of the content of the basic skilled-based training that was provided to all inpatient nursing staff together with details of staff competency to show the gaps and strengths of individuals.

- Regarding patients that were discharged and what procedures were in place to ensure they were not discharged prematurely, it was explained that the Trust had key performance indicators in place with a view to monitoring effective discharges, which included a seven day follow up to ascertain any risks. A discharge checklist was also used. It was further pointed out that the Trust did not have a shortage of beds which alleviated the pressure of discharging patients quickly, and where possible, appropriate care and pathway arrangements were usually made prior to their discharge.

  In response to a query Ms Ingram undertook to circulate to the Committee details on their bed occupancy.

- It was considered that there had been an increase in people with mental health needs, particularly in younger people. Although there were no inpatient services for young people work was ongoing with schools and the Dudley Safeguarding Board with a view to early intervention and detection.

  In response to a query Ms Ingram undertook to circulate to the Committee a breakdown on the number of mental health patients to show those that were from the black minority ethnic groups.

- Reference was made to progress against Priority 2 and it was requested that background documentation and details relating to roles and responsibilities training that had been delivered to clinical staff, the joint working protocol between Adult Mental Health Services and Child and Adolescent Mental Health Services and the Policy for dealing with Domestic Abuse be provided to the Committee.

- Given the national concerns about sexual abuse particularly those involving vulnerable people it was queried whether consideration had been given to introducing additional measures to prevent such instances and to protect patient safety.

  It was explained that a safeguarding hub had been set up and considerable investments had been made in this regard. There were several policies relating to safeguarding and an annual report on the safeguarding process was available and could be circulated to Members, if required.

West Midlands Ambulance Service NHS Foundation Trust

Arising from the presentation of the report Members made comments and raised questions as follows and responses were given as indicated:-

- With regard to coping in the event of a major incident and maintaining the service for other incidents, Mr Henry reassured Members that he was very confident that the service would cope given the significant amount of investment that had been made on equipment and training. He gave examples of incidents that had occurred in the past and explained that they were able to flex and pool resources regionally so that normal service standards could be maintained.

- Reference was made to recent ambulance turnaround delays and given the number of ambulances that were queuing at the hospital it was queried how the service was maintained.

  It was stated that there were protocols in place to manage the situation and the service was mainly maintained by prioritising patients and making appropriate judgements depending on the situation at the time.

  In response to a further query it was stated that work was ongoing with a view to making improvements to ambulance services. An Action Plan had been drafted to improve ambulance flow and work was also ongoing in conjunction with the CCG with a view to streaming patients.

- Although percentages were given in the report, specific numbers relating to the number of patients that had called and been assessed and numbers of those patients that had been waiting to the nationally agreed target of thirty minutes was requested.

  Mr Henry stated that he was not aware of the specific numbers but he assured the Committee that they had a safe process in place. This included offering a ring back service whereby if an ambulance could not immediately be deployed the patient would receive a call from a Senior Nurse or Paramedic with a view to being reassessed and categorised accordingly. However, he undertook to provide further information in respect of the various categories to include a breakdown of the calls relating to the percentages.

  In response to a further query it was stated that some targets were not being achieved as priority was given to red calls and vehicles were diverted which impacted on other category targets.

- The significant difference in percentage data given for the Black Country and other data with regard to the ambulance quality indicators relating to Stroke FAST patients transported to Hyper Acute Centre within sixty minutes was queried.

  Mr Henry undertook to clarify the figures as data for the Black Country had included the FAST care bundle.

- Arising from further discussion the West Midlands Ambulance representative stated that every call was assessed and resources allocated accordingly. Based on assumptions a timeframe was given for completion of the job but this was not always adhered to as the crew encountered varying obstacles which caused delays and impacted on other jobs. A major problem encountered by the crew was where it was considered patients did not require the emergency service it was difficult to access other community services as they only operated during certain hours and staff ended up having to transport the patient to the hospital instead. It was difficult to capture and present information on exact details of delays as they were not recorded. However, there were plans to choose three random days with a view to recording information for audit purposes, and when available this could be submitted to the Committee, if required.

A Member referred to a booklet on "jargon busters" and requested that the document be recirculated for the benefit of newer Members of the Committee.

Resolved

That the information contained in the reports, submitted on the Quality Accounts relating to the Dudley Group NHS Foundation Trust, Walsall Mental Health Partnership NHS Trust and the West Midlands Ambulance Service NHS Foundation Trust, be noted.

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49 **Delivery Against Committee Review Action Plans : Tobacco Control Review 2013/14**

A report of the Interim Director of Public Health was submitted on progress made on the action plan agreed by the Overview and Scrutiny Management Board following the Committee's scrutiny of tobacco control.

Arising from the presentation of the report and in responding to Members' queries and comments the Interim Director of Public Health commented that prevalence of smoking in young people had reduced. However, it was confirmed that there was an increase in children smoking when transferring to secondary education and that there had also been an increase in younger females smoking. Members were informed that Trading Standards worked together with retailers and conducted spot checks with a view to prosecuting if shops were found to be selling cigarettes to the under aged.

Resolved

That the information contained in the report and Appendix to the report submitted on progress made on the action plan following the Committee's Tobacco Control Review 2013/14, be noted.

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50 **NHS England Co-Commissioning and Primary Care Intentions – Dudley Commissioning Group – Delegated Responsibility for the Commissioning of General Medical Services (General Practitioner (GP) Services)**

A report of the Head of Membership Development was submitted on the Clinical Commissioning Groups (CCGs) submission to NHS England to take on delegated responsibility for the commissioning of GP services.

Arising from the presentation of the report a Member referred to the Urgent Care Centre (UCC) and the delays in constructing the proposed extension to the Accident and Emergency section and it was queried whether the interim planned structure would operate effectively. It was considered that a high number of patients attended the Walk in Centre and it was queried whether any analysis of patients had been made, specifically, the number of patients attending from each practice; patient attendance at home practice of surgeries with high usage of the centre; the number of doctors that had registered their intention to terminate contracts at the Walk in Centre due to current and proposed amendments to practices; and an assurance was sought on the future of services.

In responding to the above queries Dr Rathore stated that GP practices held records on patient numbers and indicated that certain information was available. It was pointed out that most Doctors that worked at the Walk in Centre were not local GP's and were used from a pooled source. Malling Health had advertised with a view to recruiting high quality Doctors and all GP's would be given the opportunity to apply for these positions. Insofar as the construction of the UCC it was acknowledged that there were delays and an interim measure had to be put into place to enable the centre to be opened in April of this year.

During the ensuing debate a Member was of the view that a further detailed report should be presented to the Committee containing information on the proposals, an analysis on the improvements that would be made in comparison to the existing and new structures, the benefits and the impact on GP services. It was also queried how patients and the public were informed about the proposlas, particularly as five GP practices did not have Patient Groups.

In responding to the above issues Dr Rathore stated that a key benefit for the CCG taking on delegated responsibility for the commissioning of GP services was that new arrangements would enable practices to open all day.

The Head of Membership Development undertook to circulate the strategy and further detailed information behind the submission to all Members of the Committee. The Chair requested that following receipt of the document that Members submit any further questions directly to him.

Resolved

(1) That the Head of Membership Development be requested to submit further information and the strategy on the submission to NHS England to all Members of the Committee and that any further questions be submitted direct to the Chair.

(2) That the information contained in the report and appendices to the report submitted on the Clinical Commissioning Groups (CCGs) submission to NHS England to take on delegated responsibility for the commissioning of GP services, be noted.

(3) That the submission to NHS England providing full assurance that the CCG has taken action to ensure that any potential conflicts of interest have been addressed, be noted.

(4) That the process in place to ensure a managed transition of functions from NHS England into the Clinical Commissioning Group, be noted.

The meeting ended at 9.00 p.m.

CHAIR

Agenda Item No. 6

Health Overview and Scrutiny Committee – 26th March 2015

Report of the Head of Commissioning – Dudley CCG

Mental Health Quality and Performance Review

Purpose of Report

1. To advise the Committee of the arrangements in place for the commissioning of mental health services.

Background

2. Dudley CCG spends c £29m on mental health services. This report sets out the portfolio of services commissioned and the arrangements in place for managing the associated contracts and holding the relevant providers to account.

3. The CCG commissions services from 6 providers. The providers and contract values are illustrated below:-

4.

	£
Dudley and Walsall Mental Health Partnership NHS Trust -	26,193,021
Birmingham and Solihull Mental Health Foundation Trust -	277,965
Black Country Partnership NHS Foundation Trust -	924,759
South Staffordshire and Shropshire NHS Foundation Trust -	500,846
Worcestershire Health and Care NHS Trust -	135,764
Individual Placements (figure shown is forecast spend for 2014/15) -	935,020
Total	28,967,375

5. Clearly, Dudley and Walsall Mental Health Partnership NHS Trust is the CCG's main service provider. The other contracts mainly exist to provide services for patients who may reside outside Dudley but are registered with Dudley GPs. The contract with South Staffordshire and Shropshire NHS Foundation Trust includes the provision of a specialist dementia nursing service, commissioned specifically from this organisation.

6. In addition to these contracts, the CCG commissions specific individual placements, some of which are outside Dudley, for patients. This occurs due to the specialist nature of the care to be provided and the challenging nature of the patients involved. At the time of writing this report, placements are commissioned for 17 patients, some of these are joint funded with the Council.

7. This report deals specifically with the arrangements which exist for Dudley and Walsall Mental Health Partnership NHS Trust from which the CCG commissions a full range of mental health services.

8. The contract with the Trust is managed through a set of three meetings:-

- a contract review meeting focussing on contractual performance in relation to finance and activity;
- a clinical quality review meeting focussing on service quality and patient safety;
- a service development meeting overseeing implementation of an agreed "Service Development Improvement Plan (SDIP)".

9. These meetings take place on a monthly basis and report into the CCG's governance structure.

10. The contract is managed against a set of key performance indicators. These indicators and the performance as at month 10 is shown at Appendix 1.

11. The NHS planning guidance for 2015/16 sets out some specific issues to be addressed in contracts including:-

- new access and waiting time standards, including for people experiencing their first episode of psychosis;
- the provision of psychiatric liaison services for patients with mental health needs in acute hospitals;
- provision of "crisis" services;
- child and adolescent mental health services (camhs) and eating disorder services for children.

12. These will feature in the 2015/16 SDIP (see above).

13. The Committee has previously expressed an interest in camhs. Camhs are often described in terms of the following tiers:-

- Tier 1 – non-specialist primary care workers such as school nurses and health visitors dealing with common childhood problems;
- Tier 2 – specialised primary mental health workers offering support to other professionals;
- Tier 3 – specialist multi-disciplinary teams;
- Tier 4 – specialist day and inpatient units.

14. Tiers 1 and 2 are largely provided by Black Country Partnerships NHS Trust and commissioned by the NHS England (health visiting) and the Council (school health advice). Tier 3 is commissioned by the CCG from DWMHPT.
Tier 4 is commissioned by NHS England from a range of NHS and independent sector providers. Waiting times for tier 3 services meet national standards. The main challenge for camhs has been the ability to access specialist tier 4 services.

15. This issue is being addressed by:-

- NHS England looking to commission new capacity;
- the potential development of a "tier 3 plus" service as an alternative to tier 4, which is being reviewed by Black Country commissioners.

Recommendation

That the position in relation to the quality and performance of mental health services be noted.

Neill Bucktin
Head of Commissioning – Dudley CCG

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Contractual and Quality KPIs, month 10

	Target	Loc	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	YTD	RAG
1. New cases accepted to EI - Cumulative	Trust - 89	YTD %	8%	18%	31%	43%	48%	55%	69%	74%	91%	97%	97%	
		Actual	7	16	28	38	43	49	61	66	81	86	86	
	Dudley - 43	% YTD	12%	21%	30%	40%	47%	53%	63%	70%	91%	93%	93%	
		Actual	5	9	13	17	20	23	27	30	39	40	40	
	Walsall - 46	% YTD	4%	15%	33%	46%	50%	57%	74%	78%	91%	100%	100%	
		Actual	2	7	15	21	23	26	34	36	42	46	46	
2. Gate-keeping of inpatient admission *	95%	Trust	100% (67/67)	100% (76/76)	100% (65/65)	100% (90/90)	100% (71/71)	100% (81/81)	100% (92/92)	100% (63/63)	100% (84/84)	100% (88/88)	100%	
	95%	Dudley	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	95%	Walsall	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
3. 7 day follow up on Inpatient discharge *	95%	Trust	96% (89/92)	95% (99/104)	97% (82/84)	96% (102/106)	97% (92/94)	100% (100/100)	97% (113/116)	97% (71/73)	96% (115/119)	97% (112/116)	97%	
	95%	Dudley	95%	95%	98%	96%	96%	100%	95%	95%	97%	96%	96%	
	95%	Walsall	100%	95%	97%	97%	100%	100%	100%	100%	98%	98%	98%	
4. DToCs (All reasons)	<7.5%	Trust	0.7% (30/4510)	0.0% (1/4701)	0.9% (42/4447)	2.0% (101/4937)	1.7% (79/4709)	2.0% (90/4563)	1.9% (94/4983)	2.7% (136/5047)	1.6% (82/5050)	1.6% (76/4645)	1.5%	
	<7.5%	Dudley	0.0%	0.0%	0.6%	2.9%	1.8%	1.8%	3.2%	4.7%	2.3%	2.4%	2.0%	
	<7.5%	Walsall	1.5%	0.04%	1.3%	1.0%	1.5%	2.2%	0.4%	0.2%	0.7%	0.7%	0.9%	
5. Average length of stay *	<64 days	Trust	40	45	52	36	62	39	50	42	57	59	47	
	<64 days	Dudley	39	37	39	37	52	32	40	42	64	45	43	
	<64 days	Walsall	41	58	71	35	76	48	61	42	47	56	54	
6. Users with a copy of their care plans *	95%	Trust	95%	95.4%	96.2%	95.8%	95.4%	95.1%	92.1%	92.2%	95.4%	96.6%	96.6%	
	95%	Dudley	95%	95.4%	96.2%	95.8%	95.4%	95.1%	92.1%	92.2%	95.4%	96.6%	96.6%	
	95%	Walsall	95%	95.4%	96.2%	95.8%	95.4%	95.1%	92.1%	92.2%	95.4%	96.6%	96.6%	

Contractual and Quality KPIs, month 10

KPI	Target	Loc	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	YTD Actual	RAG
7. CRHT HT episodes *	1187 (100/mth)	Trust	132	131	123	128	132	138	164	161	148	139	1396	
	579 (49/mth)	Dudley	78	70	64	73	70	73	89	79	77	74	747	
	608 (51/mth)	Walsall	54	61	59	55	62	65	75	82	71	65	649	
8. Inappropriate admissions of under 18s to an adult ward*	0	Trust	0	0	0	0	0	0	0	0	0	0	0	
	0	Dudley	0	0	0	0	0	0	0	0	0	0	0	
	0	Walsall	0	0	0	0	0	0	0	0	0	0	0	
8a. Appropriate admissions of Under 18s to Adult Ward	No target	Trust	0	0	1	1	0	0	1	0	0	2	5	
9. % of patients seen in 18 weeks Complete / incomplete	95%/ 92%	Trust	98% 98%	100% 97%	97% 95%	100% 93%	100% 96%	100% 93%	98% 94%	97% 97%	100% 95%	100% 98%	99% 95%	
	95% /92%	Dudley	98% 99%	100% 96%	96% 94%	100% 89%	100% 97%	100% 94%	98% 95%	96% 97%	100% 97%	100% 98%	99% 95%	
	95%/ 92%	Walsall	100% 97%	100% 98%	100% 97%	100% 95%	100% 95%	100% 92%	100% 93%	100% 100%	100% 92%	100% 97%	100% 95%	
10. Physical health checks for inpatients more than 12 months	100%	Trust	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	100%	Dudley	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
	100%	Walsall	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
11. Completion of NHS number on MHMDS	99%	Trust	99.5% (8463/8502)	99.6% (8848/8880)	99.6% (9072/9108)	99.7% (9065/9094)	99.7% (8963/8993)	99.4% (9098/9153)	99.4% (9328/9386)	99.6% (9009/9041)	99.5% (9011/9050)	99.4% (9027/9075	99.4%	
	99%	Dudley	99.5%	99.6%	99.6%	99.7%	99.7%	99.4%	99.4%	99.6%	99.5%	99.4%	99.4%	
	99%	Walsall	99.5%	99.6%	99.6%	99.7%	99.7%	99.4%	99.4%	99.6%	99.5%	99.4%	99.4%	
12. Completion of ethnicity code on MHMDS	90%	Trust	81.9% (6959/85	90.1% (8078/88	91.3% (8321/91	92% (8370/90	92.7% (8335/89	91.9% (8416/91	90.7% (8510/93	92.3% (8346/90	92.2% (8345/90	91.2% (8279/90	91.2%	
	90%	Dudley	81.9%	90.1%	91.3%	92%	92.7%	91.9%	90.7%	92.3%	92.2%	91.2%	91.2%	
	90%	Walsall	81.9%	90.1%	91.3%	92%	92.7%	91.9%	90.7%	92.3%	92.2%	91.2%	91.2%	

Contractual and Quality KPIs, month 10

KPI	Target	Loc	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	YTD Actual	RAG
13. IAPT - number of people who receive psychological therapies - attending one session only	10585 (882/mth)	Trust	1003	925	1055	847	797	1094	1057	1120	944	1080	9922	
	4825 (402/mth)	Dudley	425	418	488	424	379	474	501	577	458	471	4615	
	5760 (480/mth)	Walsall	578	507	567	423	418	620	556	543	486	609	5307	
14. IAPT - People who have successfully completed treatment	50.5%	Dudley	50.8%	34.6%	50.8%	53.6%	43.3%	37.5%	52.5%	56.3%	60.3%	56.4%	50.3%	
	50.5%	Walsall	62.8%	59.2%	61.0%	53.3%	52.0%	51.9%	51.0%	52.6%	47.1%	50.8%	54.2%	
15. IAPT - completion of outcome data PHQ9 and GAD7	90%	Trust	99.1% (334/337)	99.1% (341/344)	99.1% (328/331)	98.0% (343/350)	98.6% (276/280)	96.0% (291/303)	94.8% (343/362)	93.0% (334/359)	97.5% (318/326)	97.5% (319/327)	97.3%	
	90%	Dudley	100%	99%	99%	97.0%	97.7%	93.8%	93.3%	90.0%	96.4%	96.6%	96.4%	
	90%	Walsall	98.3%	98.9%	98.9%	98.9%	99.3%	97.7%	96.0%	96.2%	98.4%	98.3%	98.1%	

Agenda Item No: 7

Office of Public Health

Report to the Health Scrutiny Committee

Update on Transfer of the 0-5 years Public Health Commissioning to Local Authorities

1.0 Purpose

The purpose of this report is to update the committee on the local authorities' new commissioning responsibilities for 0-5year olds.

2.0 Background

Health Visitor Service

The Health Visiting Service is a workforce of specialist community public health nurses who provide expert advice, support and interventions to families with children in the first years of life, and help empower parents to make decisions that affect their family's future health and wellbeing. This service is led by health visitors and supported by a skill mix team. The service is central to delivering public health outcomes for children.

The start of life is a crucial time for children and parents. Good, well resourced health visiting services can help ensure that families have a positive start, working in partnership with GPs, maternity and other health services, Sure Start Children's Centres and other early years services.

The **Health Visitor Implementation Plan 2011-2015** set out a call to action to expand and strengthen health visiting services**.** As well as bringing in new recruits, the programme would offer existing health visitors the opportunity to refresh and develop their skills.

The period up to 2015 saw:

- more health visitors in training and returning to practice
- growing numbers of health visitors in post
- a more comprehensive health visiting service locally.

An extra 4,200 health visitors were recruited following the national ‘Call to Action’ and locally numbers increased to 72 Health Visitors across the Dudley Borough.

National specification

In December 2013 NHS England published a National Health Visiting Core Service Specification for 2013/14. This document set out what all families can expect from their local Health Visiting service. This included:

- **Four service levels**

- Community offer
- Universal offer
- Universal partnership offer
- Universal partnership plus offer

- **Mandated elements of the Healthy Child Programme**

- Antenatal health promoting review (new)
- New baby review
- 6-8 week assessment (separate to GP assessment)
- One year assessment
- 2 to 2.5 year review

- **Six priorities for demonstrating success and building sustainable services post 2015:**

- Transition to parenthood and the early weeks
- Maternal mental health (PND)
- Breast feeding (initiation and duration)
- Obesity to include nutrition and physical activity
- Health and wellbeing at 2 (development of the child two year old review (integrated review) and support to be ‘ready for school’
- Managing minor illness and reducing accidents (reducing hospital attendance/admissions)

FNP

The Family Nurse Partnership programme (FNP) is an intensive and structured preventative programme for first time mothers. It offers intensive home visits, delivered by specially trained nurses, from early pregnancy until the child is two years old. The programme aims to improve pregnancy outcome, child development and breaks and cycle of poverty.

The FNP programme have been evaluated through a high quality research in the USA and the UK and has been found to have the following benefits:

- Improved prenatal health
- Fewer childhood injuries
- Fewer subsequent pregnancies and greater intervals between births
- Increased maternal employment
- Improved school
- Improved emotional and behavioural development

The FNP programme began in England in 2007 as a pilot in 10 sites. There are now over 50 sites across England offering places to over 6,500 families.

The NHS operating framework 2012/13 states that the delivery of FNP should continue and the programme is to double its capacity by April 2015 to improve outcomes for the most vulnerable first time teenage mothers and their children.

Dudley Borough has a range of 140-193 under 19 first time pregnancies per year with ninety percent of under 18 conceptions occurring in the three most deprived areas.

3.0 Progress to Date

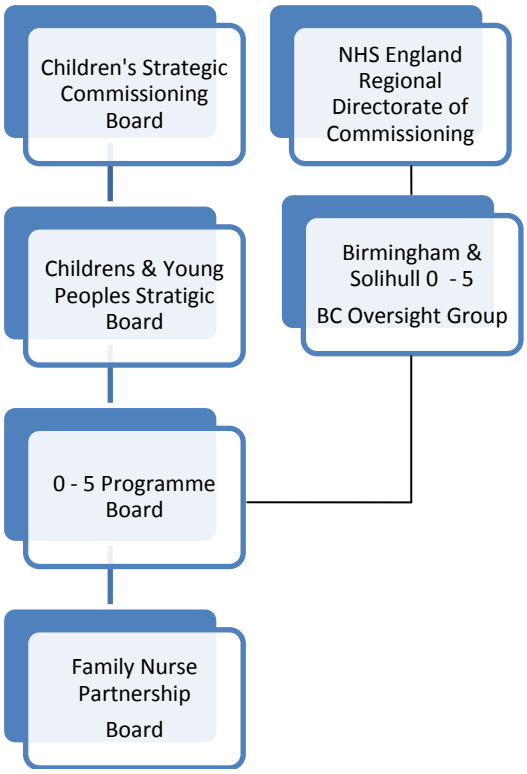
Commissioning provision

Currently the Health Visitor service in Dudley is provided by the **Black Country Partnership NHS Foundation Trust**. This contract is monitored quarterly against a set of national and local quality requirements. It is the intention to continue and to build upon this working relationship to minimise the need for changes to contract, in the first instance, and to ensure stability of services.

Co-commissioning and other commissioning partnerships and networks between Dudley Council, Dudley Clinical Commissioning Group, Local Area Teams, NHS England and other early years and children's commissioners have been established. These networks offer further assurance of a safe and robust transfer.

Governance

Governance arrangements are in place to support a partnership approach to the transfer of Health Visiting commissioning responsibilities to the Local Authority from October 2015.



In September 2014 Dudley under 5's programme board was set up to ensure the delivery of the Health Visitor (HV) Implementation Plan including, increasing the HV workforce, monitoring delivery against the section 7a specification, supporting the transformation of the service in line with local health priorities and providing assurance re the commissioning of the Family Nurse Partnership (FNP) and overseeing its expansion.

The Board will also oversee the transition of the commissioning responsibilities for 0-5 aged public health services from NHS England to the Local Authority. Currently chaired by Local Area Team and vice chaired by OPH.

The board will

- Provide scrutiny of provider performance to reach their workforce trajectories by March 2015
- Effectively implement the national Health Visiting service specification ensuring delivery against the national targets.
- Provide oversight and scrutiny of provider performance through monitoring of quarterly performance indicators and quality standards
- Review any risks or incidents identified within the service.
- Provide intelligence re the delivery of the Healthy Child Programme (HCP) to the national transformation team and the Nursing Directorate NHS England.
- Make appropriate plans for the safe integration of commissioning arrangements into Local Authority arrangements.

- Further develop co-commissioning arrangements
- Ensure the compliance of the FNP licence and the scrutiny of the fidelity goals and the service expansion

Family Nurse Partnership -A separate board has been set up to provide governance to this partnership. It is chaired by OPH has multiagency representation and reports into the 0-5 Programme Board.

Transfer Preparations

- First phase of due diligence has been undertaken
- OPH in a strong partnership position to receive transfer
- Support and commitment at a strategic level including the Health & Wellbeing Board
- Regional 0 – 5 Oversight group set up and functioning well
- Improved communication and support from Local Areas Teams to ensure safe transfer

4.0 Finance

- Transfer allocations are based on resident population not GP registered.
- Financial allocations agreed and additional commissioning resource secured within the ring fenced Public Health grant.
- Principles of an 'open book' accounting procedures and information sharing will be maintained for this transfer and onward contract monitoring.
- National consultation on Future financial baseline agreement exercise on allocations completed in January 2015
- Current contract value in 2015/16 **£4,757,599** with some additional funds for 2 x extra FNP nurses.

5.0 Next Steps

- To finalise the contract and key performance indicators for the 2015/16 contract.
- To oversee the arrangement re the financial transfer and contract novation in October 2015
- Ensure processes for due diligence are in place.
- To share guidance from national local authority and NHS England communication channels
- To work in partnership with Children's Services and the current provider to scope an integrated 0-5 offer with a key focus on Children's Centres and parenting programmes.

- Provide Public Health Leadership and support to the HV workforce to deliver a local service based on local need.

6.0 Recommendations

Members of the committee are asked to note the contents of this report.

7.0 Supporting Documents (available on request if required)

- Department of Health, *Health Visitor Implementation Plan: A Call to Action.* (February 2011).
- NHS England, *2015-16 National Health Visiting Core Service Specification* (October 2014).

Karen Jackson
Deputy Director of Public Health
DMBC

Contact Officer:
Bal Kaur
Consultant in Public Health
DMBC

Agenda Item No. 8

Health Scrutiny Committee – 26th March 2015

Report of the Lead Officer to the Committee

Responses arising from previous meetings

Purpose of Report

1. To consider updates and responses arising from previous presentations

Background

2. Investigations into the planning, development and delivery of services regularly involve information requests by members so as to better identify with issues. Clearly some queries cannot be answered immediately with some prompting further scrutiny, or consultation, prior to being reported back to Committee.

3. To keep members updated, responses and resultant recommendations are presented at appendix 1 for review.

Finance

4. Costs linked to Council responsibilities will be met through existing resources.

Law

5. Section 111 of the Local Government Act 1972 authorises the Council to do anything which is calculated to facilitate or is conducive or incidental to the exercise of any of its functions.

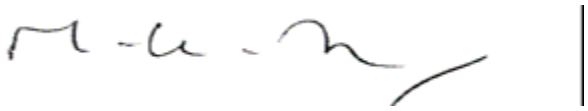
6. The Health and Social Care Act 2012 places the scrutiny of health, care and well-being services by local authority members onto a statutory footing.

Equality Impact

7. Health Scrutiny can be seen as contributing to the equality agenda in the pursuit of improving care for all. This implies a challenge to ensure that services meet the needs of all sectors of the community to make this an even greater reality in Dudley.

Recommendation

8. Members endorse proposals presented at Appendix 1.



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Mohammed Farooq – Assistant Director Corporate Resources

LEAD OFFICER FOR HEALTH SCRUTINY

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Documents used in the preparation of this report:-

1. Minutes of January and February 2015 Committees.

Appendix 1

Dudley Group of Hospitals (DGH)

Query

Clarification was sought on what was considered to be a reasonable time to respond to the patient call bell. It was considered that a time should be specified particularly for vulnerable patients as they needed reassurance and if they knew that they would be seen within a certain time, for example within 10 minutes, they may be less anxious and agitated.

It was stated that it was difficult to allocate a specific time that could be considered as being "reasonable", particularly as people's perceptions and definitions of a "reasonable time" varied. It had therefore been agreed that it would be better to ask patients if calls had been answered within a reasonable time.

Response

A benchmark for call bell answering was agreed and piloted on a number of surgical wards, as the attached poster indicates, with the aim for no longer than 30 seconds. This has now been rolled out to all wards. As well as asking patients their experience of this issue, as we discussed, the Matrons themselves also undertake a monthly audit of wards observing a number of issues about what happens on a day to day basis. One of the topics of this audit is checking call bell answering.

Query

Members paid particular interest in the annual community patient survey among other key surveys in-place to test quality. Further information was sought on the target groups, the questions asked and who was responsible for setting community targets.

Response Community Patient Survey

We conduct an annual patient survey across our community services in line with other annual national surveys such as inpatients. We have also recently rolled out the national friends and family test (FFT) survey to community areas providing patients with an opportunity to give their views as often as they would wish. The annual survey is reported through the quality accounts and FFT will begin to be reported nationally soon (date yet to be confirmed).

Query

Details of a specific stage 4 ulcer case were requested to determine lessons learnt for quality improvement

Response

A nonagenarian patient with dementia who was grossly emaciated and frail was admitted following a fall at a nursing home. The fall resulted in a fracture neck of femur requiring surgery. On admission, the patient had a wound on the shoulder, which healed during the hospital stay and also had had a Grade 3 ulcer on the sacrum. The patient's treatment was complicated by a number of acute and long term medical conditions which severely restricted the patient bodily functions. The investigation indicated that although the patient was correctly placed on a nimbus air mattress and two hourly turns both of these should have occurred earlier than they did. The family was kept fully informed.

Query

At the January meeting members acknowledged the importance of acting swiftly to tackle budget pressures in the context of being placed into special measures. However concerns remain about additional burden on nurses created by absorbing elements of band 3 HCW roles. Members sought details demonstrating how the Trust would ensure a safe and sustainable transition of responsibilities for both patients and staff?

Response

Discussions and investigations with every lead nurse on the wards established that, based on the needs of patients, Band 3 care workers were either not using their extra skills at all or using them for a small percentage of their time. This was unlike the Emergency Department (ED) and the Emergency Assessment Unit (EAU) where patients immediate needs required them having tests etc that the Band 3 care workers can undertake. It was decided therefore that Band 3 care workers were not required on the wards but should be retained in the ED/EAU areas.

All existing ward based Band 3 staff were offered to apply for one of the Band 3 posts in ED/EAU or remain on the wards at Band 2. All of the staff who wished to retain their banding and move to ED/EAU has done so except one individual who changed her mind and decided to stay on the ward. The rest of the staff decided to stay on the wards at Band 2. There is no evidence that this change has affected patient care in a negative way. This occurred at the same time that there was a review of all nursing posts across the Trust and an extra £3 million was invested in nursing staff.

Query

Members considered evidence indicating problems gathering feedback from vulnerable groups particularly where communication was a barrier. However, it was noted that one of the methods currently used to obtain information from patients with learning disabilities was by setting up a specific Forum tailored to that individual's needs whereby the patient attended with their carer and questions were asked about their care plans and how improvements could be made.

Response

The Trust conducts 'real time' surveys as well as the nationally required surveys reported by the CQC. These surveys help provide real time information and views from our patients directly back to the wards to make improvements. Whilst conducting the surveys we give equal opportunity for any more vulnerable patients to take part including for example patients living with dementia where our dementia team will help our survey coordinator to collect the responses if needed. We have arrangements with our learning disability nurse and would always seek to ensure any patient who wants to share their views has the support in order to do this.

Dudley Walsall Mental Health Trust (DWMH)

Query

Glossary of terms / 'jargon buster' for mental health was referenced.

An on-line resource with wider NHS relevancy is available at www.nhsconfed.org/acronym-buster

Query

Clarification was sought on the development of the **'Think Family' Protocol**

Response

This protocol is still being finalised however the Trust has committed to share a draft as it nears completion.

Query

A recent profile of Bed Occupancy was requested along with a breakdown of current cases by ethnicity. Greater detail on dementia care training programmes was also .

Response

Bed Occupancy to Period January 2015

Period	Beds Available	Beds Occupied	% With Leave	% Without Leave
Nov-14	2,970	2,762	93%	82%
Dec-14	3,069	2,780	91%	77%
Jan-15	3,069	2,562	83%	72%

Ethnicity breakdown of current patients – please see table below

Dudley residents current caseload patients

Ethnicity	Total
Missing	414
African	23
Any other Asian background	53
Any other Black background	21
Any other ethnic group	29
Any other mixed background	30
Any other White background	165
Bangladeshi	2
British	5,839
Caribbean	56
Chinese	8
Indian	74

Irish	20
Not Stated	424
Pakistani	128
White and Asian	10
White and Black African	4
White and Black Caribbean	54
Grand Total	**7,354**

** Data as of: 06/02/2015*

** Data includes Secondary and Mental Health Primary Care Data

Current Dementia Care Training Initiatives – March 2015

	What it is	Who it's for	Outline	Who is providing this
AWARENESS	Fundamentals of Care Programme	HCA/Support Worker Roles from all service areas	Person centred care, dignity and respect are common themes throughout the programme, encouraging delegates to reflect on their own practice and experience. The programme makes use of 'Barbara's story' which is a film endorsed by the DOH for use in dementia awareness training as depicts the experience of a lady with dementia, attending out patients within an acute hospital setting. The film provides an interpretation of how this might be experienced through the eyes of a patient and the impact of staff behaviours, both positive and negative. The programme also includes an overview of dementia session delivered by staff from older adult services.	Trust L&D
	Overview of Dementia Classroom Session – tailored for teams	Team based training for Early Intervention, Criminal Justice, CAMHS, Carers, Substance Misuse & Eating Disorder	-Recognise the role of all healthcare professionals in addressing the dementia challenge irrespective of client group -Recognise early signs of dementia & understand when future treatment is necessary	Becky Willis/ Jo Marshall

		teams	& sign post to appropriate services -Be able to describe the four main types of dementia, understanding the differences and similarities and risk factors -Be able to differentiate between features of organic cognitive impairment, depression & delirium -Understand the role of medication	
	E-Learning for Healthcare introductory module	Prioritsed for staff in Older Adult Ward teams with a view to rolling this out to staff in acute service line, community service line & remaining staff in Recovery & Early Intervention Service lines. Admin staff in front line roles.	-Describe dementia, its effect on the brain, & its common signs & symptoms -Identify some of the complex difficulties experienced by people with dementia -Challenge some of the common myths & negative attitudes about dementia -Identify ways of communicating effectively with someone with dementia -Describe the importance of living well with dementia & how the health care profession can facilitate this -Discuss other sources of support for those with dementia & their carers -Outline the elements of best quality practice in caring for the individual with dementia, to include end-of-life care	E-Learning for Healthcare via OLM/ESR
PRACTITIONER	Dementia Training Centre certificated e-learning programme – Working with People with Non-Cognitive Symptoms of Dementia (4	Registered Professionals working within Older Adult Services & Medical Workforce (incorporates tier 1 awareness level training for this staff group) Promoted through the Dementia Current	**1)Introduction to Dementia** -To understand the general clinical features of various types of dementia -To understand the demographics & risk factors of dementia -To understand how symptoms vary across various stages of dementia -To understand the various cognitive symptoms underlying dementia **2)Non Cognitive Symptoms of Dementia** -To understand the epidemiology of non-cognitive symptoms in dementia -To understand the causative factors of non-cognitive symptoms of dementia -To be aware of the considerations when assessing someone with non-cognitive symptoms of dementia	http://dementiatrainingcentre.co.uk/

	Modules)	Awareness Bulletins	-To understand the management principles for non-cognitive symptoms of dementia **3)Working with People Living with Dementia** -Have insight into the experience of dementia -Understand the concept of personhood -Understand person centred care in the context of dementia care -Understand the emerging concepts of relationship centred care -Be aware of how the approaches to working with people with dementia can positively impact on the care provided & care environments **4)Psychological Interventions to Manage Challenging Behaviour** -To develop a better understanding of the causes of challenging behavior from the persons perspective -To become familiar with the importance of communication in understanding behavior -To find out some of the factors influencing the emergence & maintenance of behavior we can find challenging -To become familiar in methods in which challenging behavior can be assessed, understood & addressed -To develop an understanding of some psychological approaches to dementia care that might help prevent challenging behavior occurring	
	Creativity & Dementia Workshop	Staff from Older Adult Services	-Identify a range of creative activities which may be used with people with dementia -Identify ways in which creative activities can be beneficial for people with dementia - Consider how they might utilise creative activities within their own clinical areas	Jo Marsahll/ Becky Willis
	Dementia Capable Care: Behaviours® Programme	Staff from Linden, Cedars, Holyrood, Malvern, Beeches & Birch	-Develop an understanding of dementia and age related cognitive conditions and describe how an abilities-based model of support can minimise the impact of the condition on individuals and their families. -Identify behaviour that indicates an escalation towards aggressive and violent behaviour and take appropriate measures to avoid, decelerate and/or de-escalate crisis situations. -Use suitable and acceptable physical interventions to reduce or manage risk behaviour. -Identify the impact of crisis events and describe post crisis responses which can be used for personal and organisational support and learning	Crisis Prevention Institute & Trust Lead MAPA® Trainer

	Dementia Practice Development Forums using the Dementia Workbook	Pilot with staff from Older Adult Services	Follow up forums to consolidate learning and embed principles into practice following above training inputs with a specific focus on person centered care and working with challenging behaviors – pilot with a view to wider roll out.	Dr Caroline Formby and colleagues
EXPERT	Post Graduate level Dementia Pathways	Identified staff from Memory Service, Linden & Holyrood	**PG Certificate in Dementia Studies** 60 Credits (1 x Core Module and 1 x Option Module): • Understanding Experiences of Dementia *(30 Credits)* (C) • Dementia Training: Skills and Approaches *(30 Credits)* (O) • Evidence-Based Dementia Practice *(30 Credits)* (O) • Any other relevant module available within the School *(30 Credits)* (O) **PG Diploma in Dementia Studies** 60 Credits equivalent to PG Certificate PLUS 60 Credits 60 credits (1 x Core Module and 1 x Option Module): • Dementia Training: Skills and Approaches *(30 Credits)* (O) • Evidence-Based Dementia Practice *(30 Credits)* (O) • Research Methods Module *(30 Credits)* (O) (Core Module if undertaking empirical research at MSc) • Any other relevant module available within the School *(30 Credits*)(O) **MSc in Dementia Studies** 120 Credits equivalent to PGDip PLUS 60 Credits (1 x Option Module): • A piece of empirical research (subject to completing research methods module as part of the PG Diploma) *(60 Credits)* (O) • Practice-Based Project *(60 Credits)* (O)	Bradford University

Proposal

Members note the responses outlined above and keep a watching brief as appropriate.