CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Adult Social Care Scrutiny Committee**
held on Thursday, 20th May, 2010 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor B Silvester (Chairman)
Councillor C Beard (Vice-Chairman)

Councillors G Baxendale, S Bentley, D Flude, S Jones, W Livesley, A Moran, C Andrew, A Martin, C Tomlinson, A Thwaite and D Bebbington

Apologies

There were no apologies received.

28 ALSO PRESENT

Councillor R Domleo – Portfolio Holder for Adult Services
Councillor A Knowles – Portfolio Holder for Health and Wellbeing
Councillor O Hunter – Cabinet Support Member for Adult and Health Services
Councillor D Cannon – visiting Member

29 OFFICERS PRESENT

Phil Lloyd, Head of Adult Services, People Directorate
Sandra Shorter, People Directorate
Jill Greenwood, People Directorate
Jon Wilkie, People Directorate
Fiona Field, Central and Eastern Cheshire Primary Care Trust
Simon Whitehouse, Central and Eastern Cheshire Primary Care Trust
Fran Willshaw, Central and Eastern Cheshire Primary Care Trust
Helen Kershaw, East Cheshire Hospital Trust
Mike Flynn, Legal and Democratic Services
Denise French, Legal and Democratic Services

30 DECLARATION OF INTERESTS/PARTY WHIP

RESOLVED: That the following Declarations of Interest be noted:

- Councillor D Flude – Personal Interest on the grounds that she was a Member of the Alzheimers' Society and Cheshire Independent Advocacy;
- Councillor C Tomlinson – Personal Interest on the grounds that she was a patient of the Hawthorn Lane surgery, Wilmslow.

31 PUBLIC SPEAKING TIME/OPEN SESSION

There were no Members of the Public present who wished to address the meeting.

32 MINUTES OF PREVIOUS MEETING

RESOLVED: That the minutes of the meeting of the Committee held on 29 April 2010 be confirmed as a correct record subject to an amendment to the list of those present to identify Councillor R Domleo as Portfolio Holder – Adult Services and not as a member of the Committee.

33 THE CHESHIRE AND WIRRAL COUNCILS' JOINT SCRUTINY COMMITTEE

RESOLVED: That the minutes of the following meetings of the Cheshire and Wirral Councils' Joint Scrutiny Committee be received:

- 26 January 2010 – subject to a correction to the Declaration of Interest by Councillor C Andrew to read "on the grounds that she attends meetings of Nether Alderley Parish Council as the Local Ward Councillor";
- 12 April 2010.

34 CLOSURE OF HAWTHORN LANE SURGERY, WILMSLOW

Simon Whitehouse Director of Primary Care, Central and Eastern Cheshire Primary Care Trust (PCT), briefed the Committee on the current position with the closure of the Hawthorn Lane Surgery, Wilmslow.

The surgery was a single handed practice (the last single handed GP practice in the PCT area) and the GP, Dr Chung, had informed the PCT that he was to retire on 30 June 2010. The mid point meeting had considered the issue and supported the PCT in its preferred option of dispersing the patient list. The PCT had identified that there was sufficient capacity and choice within its patch to meet the needs of patients and liaison with other GP practices showed that local GPs were keen to work with the PCT and increase their patient lists.

The PCT had recently written to all practices most likely to be affected by the dispersion of Dr Chung's list. The PCT had also sent letters to all patients, and included a personal letter from Dr Chung, with letters translated into Chinese where necessary. The PCT were able to support practices with any language issues that may arise. Most patients would be able to have a choice of practice to transfer to. A number of patients lived in the Stockport area and the PCT had liaised with Stockport PCT for those patients.

Dr Chung had identified a number of vulnerable patients on his practice list and the PCT was working closely with those patients to help achieve the most appropriate outcome.

A freephone helpline had also been established.

RESOLVED: That

(a) the proposal to close the Hawthorn Lane Surgery Wilmslow be confirmed as a Substantial Development or Variation in Service, Level 3;

(b) the steps taken by the PCT to manage the closure of the Surgery and recognising the short timescales involved be endorsed;

(c) the dispersal of the patient list to other practices be supported; and

(d) the public consultations which had taken place, particularly involving the patients affected by the changes, be noted.

35 DR FOSTER REPORT - "HOW SAFE IS YOUR HOSPITAL?" - THE POSITION IN CHESHIRE EAST

Fiona Field, Director of Governance and Strategic Planning, Central and Eastern Cheshire PCT, briefed the Committee on Dr Foster. This was a private national company that looked at the performance of acute care. It produced annual public reports and sometimes league tables of acute care providers.

There had been a specific issue around mortality rates at both Mid Cheshire Hospital Foundation Trust and East Cheshire Hospital Trust. The Committee had therefore asked for a report to a future meeting and attendance by clinicians to discuss the issues raised by Dr Foster. Work at the PCT and two hospital trusts was almost complete and the issue could be fully considered at the next meeting.

RESOLVED: That the Dr Foster report and mortality rates be considered at the next meeting of the Committee on 1 July 2010.

36 EAST CHESHIRE HOSPITAL TRUST QUALITY ACCOUNT

Helen Kershaw, Associate Director of Nursing and Patient Care Standards, introduced the East Cheshire Hospital Trust's Quality Account.

She explained that the Trust had a number of quality and safety improvement initiatives underway including requirements from the PCT, standards from the Care Quality Commission and from the Trust's own Quality Strategy that had been introduced in 2008. The Quality Strategy had focused on 10 areas of patient safety and 5 on improving patient experience and improvement in 8 out of the 10 areas had been demonstrated. Two of the areas had been included as priority areas for 2010/11 – reduction of falls and reducing serious medication errors. In relation to reducing falls, various measures had already been introduced through a strategy and action plan but reducing falls had proved challenging. Further work was to be carried out including the introduction of functional electrical stimulation as recommended by the National Institute for Health and Clinical Excellence. In relation to reducing medication errors it was noted that most medication errors were minor and could be classed as prescribing, dispensing or administrative errors. Progress in reducing errors had not been as expected and a study had been undertaken to improve understanding of the issues. This had now resulted in some specific areas of work to try to reduce medication errors.

The Trust Board had agreed the following statements as underpinning principles for continuing to improve care given to patients:

- Do me no harm (safety)
- Make me better (clinical effectiveness)
- Be nice to me (patient experience)

The following areas were identified as priorities for 2010/11:

Do me no harm

- Reduce the number of falls sustained by patients;
- Protect patients from hospital acquired infection;
- Reduce the impact of medication errors on patients.

Make me better

- Reduce avoidable death, disability and chronic ill health from venous thromboembolism;
- Deliver evidence based interventions to patients with a diagnosis of acute myocardial infarction, heart failure, pneumonia, stroke or undergoing hip or knee surgery;
- Support the timely and effective discharge of patients to the most appropriate setting and provide timely information to GPs.

Be nice to me

- Ensure patients within the hospital's care were treated in privacy with dignity and respect which would include the provision of same sex accommodation unless it was clinically justified. All toilet areas and bays were same sex. In the critical care unit curtains were available around individual beds to enable greater privacy and one-to-one nursing took place;
- Ensure patients concerns and complaints were listened to, investigated appropriately and acted upon and lessons were learnt. The Committee was advised that all complainants were contacted within 48 hours;
- Develop all staff to ensure they acted as a role model, took personal responsibility, had courage to speak up and make voices heard;
- Improve incident reporting and be in the highest 25% of reporters.

The report included a list of audits both national and local that had been conducted in relation to the hospital Trust or in which the Trust had participated. An unannounced visit by the Care Quality Commission (CQC) had found the Trust was compliant with the Hygiene Code and the Trust had registered with the CQC without conditions.

The Trust had also improved on the Hospital Standardised Mortality Ratio (HSMR), which was a calculation that provided hospitals with a benchmark in relation to death in hospitals with a rate below 100 showing performance better than the benchmark. The Trust had shown a continuous reduction in HSMR with the latest risk (based on January – December 2009) of 88.0.

The National Inpatient Survey had placed the Trust in the lowest performing 20% for hand washing by doctors and hand washing by nurses and Ms Kershaw explained that this could in part be due to perception and staff had been advised to make patients aware that they had washed their hands by either specifically telling the patient this or through the use of hand gel at the bedside.

During the discussion the following issues/questions were raised:

- Role of visitors and visiting times - the Committee was advised that a Visitors' Charter was about to be launched with a list of expectations on visitors. Visiting times were generally fixed to ensure there was sufficient time to enable patients to rest but flexibility would be allowed if necessary, numbers of visitors per patient would usually be limited;
- How were medicines issued on wards? The Committee was advised that the qualified Registered Nurse who was looking after each patient would issue any required medicine;
- What stroke care was available? There was an acute stroke unit at the hospital and a CT scanner;
- What specific measures to ensure dignity and respect were in place? Patients were asked how they wished to be addressed and there was staff training to reinforce the importance of this action, a number of new volunteers had been appointed to assist at lunchtimes and a sticker system for high calorie drinks had been introduced to help with ensuring patients were drinking the required amount at the right intervals;
- Whether it was unhygienic for nursing staff to wear their uniforms on the way to work? A recent Department of Health document suggested that there were no risks to hygiene but to ensure a professional image and good perception staff were advised to cover their uniform when travelling to and from work;
- How was disruption from dementia patients dealt with? In response the Committee was advised that a side room would be used if available but side rooms would be prioritised for any patients with the MRSA infection;
- Did the Hospital Trust work with the Cheshire and Wirral Partnership NHS Foundation Trust (CWP) regarding patients with learning difficulties or mental health issues? The Committee was advised that there were close links with CWP and other organisations including the Dementia Society and Admiral Nurses;
- Staff turnover was not high;
- Whether future Quality Accounts could include an overview of performance perhaps in the form of a "traffic light" approach at the front to assist the Committee.

RESOLVED: That

1) the draft Quality Account for 2009/10 be received, and the information provided on the quality of care and services be welcomed;

2) the Trust's priorities for improvement and performance measures for 2010/11 be endorsed, and progress be reviewed if necessary in year and as part of the Quality Account for next year;

3) attention be drawn to the following issues:

a) the continuing reduction in the number of health care acquired infections be welcomed, noting in particular the demanding target of less than four MRSA cases for 2010/11;

b) that the hospital has succeeded in reducing hospital acquired pressure sores by 22% over the last year and that a further 5% reduction is sought for 2010/11 which is a challenging target;

c) reducing inpatient falls remains a priority area for the Trust as despite a number of initiatives the incidence has not been lowered. It is important to check whether the patients have a history of falls and carers should be included in this process. The focus on avoiding serious falls and minimising harm caused is welcome;

d) it is a matter of concern that the Trust is in the bottom 20% nationally for handwashing by medical staff according to the National Inpatient Survey but it is recognised that this may be due to lack of patient awareness and that the hospital is working to address these issues;

e) despite issues raised previously in the "Dr Foster" report the hospital has achieved a progressive reduction in the Hospital Standardised Mortality Ratio, moving from a rate higher than average in 2008 to being well below the national average in the period to December 2009 which means East Cheshire is a safe hospital;

f) that the Committee reviewed and commended a number of aspects of patient safety and experience and the steps taken by the hospital to improve, including

- Same sex accommodation is provided everywhere except in critical care areas;
- Detailed attention is given to hygiene including rigorous bed cleaning and disinfection given high bed turnover;
- Advice against bringing flowers onto wards and encouragement of visitor handwashing to reduce the risk of hospital acquired infection;
- Visiting times and the control of visitors from ward to ward including prohibition on sitting on beds.

g) that the hospital performs well in responding to complaints, generally achieving 100% of response targets. The Trust has also introduced new initiatives learning from complaints with the "Patients Passport" for people with learning difficulties as an example which has been well received;

h) that the format of the Quality Account, although prescribed, does not make it easy to focus attention on any areas of particular concern and it would be better if a "traffic lights" approach or similar could be adopted to highlight specific performance issues. Although the Trust was working to provide in future a "discretionary" summary to help, the issue should be drawn to the attention of the Department of Health, to consider altering the format of the Quality Account reports;

i) the importance of ensuring that reports such as these are written in plain English to enable them to be readily understood by a wide audience;

4) these comments be forwarded to the East Cheshire NHS Hospital Trust for inclusion in their Quality Account and to the Central and Eastern Cheshire Primary Care Trust and East Cheshire Local Involvement Network for information.

37 PROCEDURAL ITEMS - PROTOCOL AND CO-OPTED MEMBERS

The Committee considered a report of the Borough Solicitor containing a draft protocol setting out the arrangements between the Committee and the Central and Eastern Cheshire Primary Care Trust (PCT) and outlining further consideration regarding co-option onto the Committee.

The Committee was advised that the view of the Scrutiny Chairmen's Group was that co-option should not take place onto Scrutiny Committees (apart from where required by statute) but rather to allow co-option onto Task/Finish Groups or for specific scrutiny reviews. Members of the Committee also raised concerns about making the Committee too large and also noted the wide remit of the Committee about which Members were still learning.

The Committee considered the draft protocol which would help govern the working arrangements between it and the PCT. The protocol set out the respective roles and responsibilities and how the relationship between the Committee and the PCT would work in practice. The Protocol reflected the current legal framework for the conduct of health scrutiny and would be updated when new guidance from the Department of Health became available.

RESOLVED: That

(a) no action be taken on co-option onto the Committee and the position be reviewed in twelve months time; and

(b) the draft Protocol be approved and adopted subject to one amendment to paragraph 8.7 under the heading Level Three to include " Local Ward Councillors concerned would be informed of the proposals by the Secretary" and forwarded to the PCT for approval by the PCT Board.

38 "CARING TOGETHER"

Fiona Field, Director of Governance and Strategic Planning, Central and Eastern Cheshire Primary Care Trust (PCT), outlined the Caring Together programme. This involved the integration of health and social care services and was aimed at achieving earlier delivery of treatment and faster recovery. It would involve developing multi agency and multi disciplinary teams, development around buildings both existing and new build and integration of IT systems.

The mid point meeting had been fully briefed by Andy Bacon, Programme Director, and would continue to receive full briefings to enable in-depth consideration. Any specific pieces of work could be dealt with through Task/Finish Groups.

RESOLVED: That the update be noted.

39 DEALING WITH DEMENTIA

The Committee considered various items relating to dealing with dementia:

- The Council's response to the National Dementia Strategy – Jill Greenwood, Service Manager (Dementia) briefed on dementia - dementia caused a progressive decline in many areas of function including skills needed to carry out daily activities. As well as emotional impact, the financial cost was estimated at over £50 billion a year in the next 30 years. In 2009 in Cheshire East the total number of people aged 65 and over was 68,000 and of these 4810 were predicted to have dementia (of which 3153 were female). This figure was expected to grow by 88 % by 2030. The predominant users of Adult Social Care were people with mental health needs and home care was the largest component of community services provided for the over 65s. The Care Service Efficiency Delivery (CSED) programme was aimed at providing a fully integrated pathway. An audit of current services and how needs were met had been undertaken and current work was looking at future demographic need, any gaps in service delivery and joint working possibilities. Workshops on the programme had been held and well attended. Gaps in service included – crisis response/home treatment – 24 hour service, intermediate care (step up and step down service), lack of awareness/stigma, enhanced support for carers and clients. A draft strategy with options and resource implications would be produced for consultation prior to adoption and implementation of the final strategy.

  Alongside the development of the new strategy other work was underway including - to develop staff to undertake new and different roles, provision of a new dementia unit at Lincoln House, Crewe (to include a first stop shop including advice and information and a carers café), introduction of a dementia website for Cheshire East (Demenshare) to be launched on 5 July 2010. The Demenshare project was a partnership involving the Council, Age Concern Cheshire, Alzheimers Society, the Primary Care Trust and Opportunity Links and was an online resource that would enable people affected by dementia across Cheshire East to share and exchange their experience and knowledge.

- Sandra Shorter, Manager of Provision of Adult Social Care, briefed on the role of Community Support Centres in Transforming Adult Social Care - she explained the distribution and usage of the current beds at the Centres including vacancy rates. The in-house provider service had been renamed Care4CE (Careforce) and had three strategic priorities – reablement, complex needs and market cover. The existing service was to be transformed to meet these priorities. This would require having buildings that were fit for purpose, flexible well trained staff and viable cost

effective services. The current position was tired and out of date buildings, lean staff structures, under-occupancy at the Centres and high unit costs. A short term solution was to reduce spare capacity and increase cost effectiveness by rationalising a number of centres – by integrating the services of both Santune House and Lincoln House at Lincoln House (and thereby closing Santune House) and closing a second centre; investing in a purpose built dementia unit, enhanced staffing at remaining centres and more integrated working between Centre and community based staff. The Cabinet had approved a recommendation to undertake an exercise seeking views on the closure of provision at Cypress House. There were a number of reasons for this proposal including feedback from the previous consultation, the experience of upgrading old buildings, existing partnership arrangements with the health service, size of service and availability of alternative provision including Extra Care Housing, day services and bed provision.

- The Committee considered the report to the Cabinet on the Dementia Strategy. The report outlined that the strategy was to focus on the service to be delivered rather than actual buildings. The aim was to provide services in a different way not to reduce the services available. Part of the strategy was to close those Community Support Centres that were particularly problematic and located very close to another such Centre or significant facility such as extra care housing and to recycle the resources, subject to a robust business case, into the development of new services particularly for older people with dementia. The future service model currently proposed involved:

  - Two main specialist centres for dementia – one each in the north and south of the Borough;
  - Two main specialist centres for Adults with severe and complex conditions – one each in the north and south of the Borough;
  - New facilities to provide both short stay residential and nursing care in seamless, integrated and co-located services between the Council and PCT;
  - Investment in Assistive Technology to enable people to stay in their own homes for longer, funded from existing resources;
  - Investment and acknowledgement for carers and respite, funded from existing resources;
  - Maximising use of underutilised external provision;
  - Maximising use of Extra Care Housing developments in the Borough.

  The report outlined existing provision in Community Support Centres and usage which over all five centres showed an average vacancy rate of 21%. This had resulted in the proposed closure of Cypress House as an initial response prior to further work to develop the future service model as outlined above.

  - Jon Wilkie, Project Manager, Assistive Technology, briefed on a proposal to introduce an Adult Social Care wide strategy to support the integration of assistive technology into support planning for vulnerable people. Assistive Technology was defined as “any item used to increase, maintain or improve the functional capabilities of individuals with cognitive, physical or communication disabilities”. Assistive Technology could help with prevention by raising the level at which people needed social care. It could also help with reablement

by supporting effective assessment and prevent unnecessary admissions to care placements. It could help support people to regain skills which could help them remain in their own homes for as long as possible and increase their independence. This was what most people wanted and was less costly than admission into permanent care.

Various examples of the technological solutions available were reported to the Committee along with information leaflets and case studies.

- Councillor Beard provided a brief summary of the role of Admiral Nurses. The organisation had been in existence for 20 years and provided specialist Dementia Nurses. Many people with dementia were cared for most of the time by family who were unpaid and often suffered with depression. It was suggested that a presentation on Admiral Nurses could be made to a future meeting.

Members, in discussing the presentation, raised the following points:

- Whether savings proposed as part of the budget could be achieved;
- Whether there would be sufficient social workers to carry out assessments in future;
- Whether closure of facilities would mean that people would spend a lot of time travelling. In response, the Committee was advised that people tended to want to remain in their own homes and access existing facilities in their own communities;
- When in-patient care was required whether there would be sufficient capacity. In response, the Committee was advised that in severe cases of dementia, nursing care would be required.

RESOLVED: That

(a) the presentations and information on dementia and dementia services be received and noted;

(b) the specific proposals outlined at the meeting as part of the Council's dementia strategy be supported;

(c) a presentation be made to the next meeting of the Committee on Admiral Nurses and the role of Admiral Nurses also be referred to the Cheshire and Wirral Partnership NHS Foundation Trust for information and advice;

(d) the role and support to Carers be considered further at a future meeting; and

(e) information on how the budget savings could be achieved be circulated in writing to the Committee members.

The meeting commenced at 10.00 am and concluded at 1.00 pm

Councillor B Silvester (Chairman)