Mike Kelly FCIOB MCIM
Chief Executive

Our Ref	JG
Your Ref	HSC/JG
Date	9 June 2015
Please ask for	Julie Gallagher
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Legal & Democratic Services Division

Jayne Hammond LLB (Hons)
Solicitor
Assistant Director of Legal & Democratic Services

TO: All Members of Health Scrutiny Committee

Councillors : P. Adams, E Fitzgerald, L Fitzwalter, J Grimshaw, S Haroon, K Hussain, S. Kerrison (Chair), T Pickstone, R. Skillen, S Smith and R Walker

Dear Member/Colleague

Health Scrutiny Committee

You are invited to attend a meeting of the Health Scrutiny Committee which will be held as follows:-

Date:	Wednesday, 17 June 2015
Place:	Meeting Rooms A&B - Bury Town Hall Knowsley Street Bury BL9 0SW
Time:	7.00 pm
Briefing Facilities:	If Opposition Members and Co-opted Members require briefing on any particular item on the Agenda, the appropriate Director/Senior Officer originating the related report should be contacted.
Notes:	**Please note there will be a pre-meeting briefing for Elected Members only commencing at 6pm in the Irwell Room**

AGENDA

The Agenda for the meeting is attached.

Reports are enclosed only for those attending the meeting and for those without access to the Council's Intranet or Website.

The Agenda and Reports are available on the Council's Intranet for Councillors and Officers and also on the Council's Website at www.bury.gov.uk – click on **Agendas, Minutes and Forward Plan**.

Copies of printed reports can also be obtained on request by contacting the Democratic Services Officer named above.

Yours sincerely

Mike Owen

Interim Chief Executive

AGENDA

1 **APOLOGIES FOR ABSENCE**

2 **DECLARATIONS OF INTEREST**

Members of Health Scrutiny Committee are asked to consider whether they have an interest in any of the matters on the agenda and if so, to formally declare that interest.

3 **PUBLIC QUESTION TIME**

Questions are invited from members of the public present at the meeting on any matters for which this Committee is responsible.

4 **MINUTES** (Pages 1 - 4)

The minutes of the last meeting held on 19th March 2014 are attached.

5 **MATTERS ARISING**

6 **PENNINE ACUTE NHS TRUST MATERNITY SERVICES UPDATE**

A representative from Pennine Acute NHS Trust will report at the meeting.

7 **DELAYED DISCHARGE** (Pages 5 - 14)

Joanne Moore Divisional Director for Medicine, Pennine Acute NHS Trust will report at the meeting. Report attached.

8 **CHANGES TO BARDOC (BURY AND ROCHDALE DOCTORS ON CALL)**

Stuart North, Chief Operating Officer, Bury CCG will report at the meeting.

9 **HEALTHIER TOGETHER UPDATE**

Stuart North, Chief Operating Officer Bury CCG will report at the meeting.

10 **WORK PROGRAMME DISCUSSION**

A work programme report will be sent to follow.

11 **URGENT BUSINESS**

Any other business which by reason of special circumstances the Chair agrees may be considered as a matter of urgency.

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Minutes of: **HEALTH SCRUTINY COMMITTEE**

Date of Meeting: 19 March 2015

Present: Councillor P Bury (in the Chair)
Councillors P Adams, E FitzGerald, J Grimshaw, S Haroon, K Hussain, S Kerrison, N. Parnell, T Pickstone, S Smith and R Walker

Also in attendance: Linda Jackson; Assistant Director, Department of Communities and Wellbeing.
Tracy Minshull; Strategic Lead, Strategy and Development, Department of Communities and Wellbeing.
Ann Norleigh Noi; Senior Partnership Implementation Officer, Department of Communities and Wellbeing.
Pam Lievesley; Service Delivery Director, Bury, One Recovery.
Anita McWilliam; Team Manager, One Recovery Bury.
Debbie Chadwick; Drug and Alcohol Strategy lead, Forest Bank, Sodexo Justice Services.
Dr Kaushai; Lead Consultant, Addiction Dependency Solutions.
Ian Bruty, Peer Mentor
Dr Gillian Fairfield; Chief Executive Officer, Pennine Acute NHS Trust.
Gavin Barclay; Assistant Chief Executive, Pennine Acute NHS Trust
Nadine Armitage; Head of Partnerships, Pennine Acute NHS Trust.

Public Attendance: 3 members of the public were present at the meeting.

Apologies for Absence: Councillors: L Fitzwalter and J Mallon

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HSC.841 DECLARATIONS OF INTEREST

Councillor N. Parnell declared a personal interest in respect of minute HSC.572 as his partner is employed by Pennine Acute NHS Trust.

Councillor T. Pickstone declared a personal interest in respect of all matters under consideration as his partner works for the NHS.

Councillor J. Grimshaw declared a personal interest in respect of all matters under consideration as a member of the patients cabinet.

HSC.842 PUBLIC QUESTION TIME

There were no questions asked by the members of public present at the meeting.

HSC.843 MINUTES OF THE LAST MEETING

It was agreed:

That the Minutes of the last meeting held on 10th February 2015 be approved as a correct record and signed by the Chair.

HSC.844 MATTERS ARISING

There were no matters arising.

HSC.845 DRUG AND ALCOHOL SERVICE UPDATE

Tracy Minshull, Strategic Lead, gave a presentation providing an overview of Bury's drug and alcohol service. The aim of the presentation is to give assurance to the health overview and scrutiny committee that the new service provider, Addiction Dependency Solution is providing a quality service.

The Strategic Lead reported that it has been necessary to systematically transform the way drug and alcohol services are provided. The transformation will aim to break the service users cycle of dependency. The new service model will be different and will be based on a recovery care pathway.

The Senior Partnership Implementation Officer reported that as part of the procurement process an assessment of the current service was undertaken. As a result of the assessment, a vision was developed which formed part of the service specification;

"*Our vision is to commission a drug and alcohol service which is based on local need; adopts a whole system approach to provision; is outcome focused and recovery orientated; and, is responsive to both the needs of individual service users and emerging local trends."*

The Service specification stated that the new provider will:

- provide the provision of drug and alcohol service for adults in Bury
- Age range: 18 years and over
- Substances: Drugs: including 'legal highs', over the counter/ prescribed medications and alcohol.
- Contract duration: 3 years (with the provision to extend for further 12 months)
- Procurement process from: July 2012 to April 2014

The Service Delivery Director reported that there had been a number of challenges in managing the new service and implementing the new service model; the challenges have included, reviewing and adjusting the service model, transfer of staff, data and a change to a recovery model of service provision.

The Drug and Alcohol Strategy Lead, Forest Bank reported that the new system is

working well. Drug and Alcohol workers are able to get involved in treatment at an earlier stage, provide a single point of entry into the service and peer mentors.

Members of the Committee considered a verbal presentation from an ex service user, who had received help and support from the service to tackle his drug and alcohol addiction. The service user provided members of the committee with details of his experience of being an addict and the support he had received from the service. The service user is a peer mentor and helps other service users.

Those present were given the opportunity to ask questions and make comments and the following points were raised:-

In response to a question from Councillor Walker, the Senior Partnership Implementation Officer reported that due to changes in relation to the National Drug Treatment Monitoring System and a transfer of data to Public Health England, there has been a delay in providing up to date performance information.

The Strategic Lead reported that drug and alcohol services for those service users under 18 would be provided by Early Break.

In response to a Member's question, the Service Delivery Director reported that there is a monthly meeting held at the Carers Centre to provide support for carers of service users.

The Drug and Alcohol Strategy Lead reported that after care will be provided through the Recovery hub as well as via service user meetings, "bridging the gap" course and with support from Bury Employment and Skills.

In response to a Member's question, the Service Delivery Director reported that staff numbers have stabilised and the number of agency staff employed has reduced to one.

It was agreed:

1. Ian Bruty ex service user and Peer Mentor be thanked for his attendance and be commended for his recovery and support provided as a Peer Mentor.
2. The Strategic Lead will provide members of the Health Overview and Scrutiny Committee with an update in September in relation to the Drug and Alcohol Services Performance Data.

HSC.846 INTRODUCTION FROM THE CHIEF EXECUTIVE OF THE PENNINE ACUTE NHS TRUST

Members of the Committee considered a verbal presentation from Dr Gillian Fairfield, Chief Executive Officer, Pennine Acute NHS Trust, the purpose of her attendance will be to provide members of the committee with an update with regards to the Acute Trust.

The Chief Executive reported that the Trust will spend roughly £1.5m per day on providing healthcare services for local people. In the financial year 2014/15 the Trust saw 637,843 outpatients, 121,118 total inpatients and 72,511 day cases; delivered 9,899 babies made 148,340 visits to patients in their own homes; issued over 1 million items from the pharmacy and provided over 1.6 million patient meals.

The Chief Executive reported that in the same period there has been a significant reduction in the Trust's mortality ratio and it is now the second lowest in the North West of England, with a level of performance which means that statistically 20% fewer patients than expected died in our hospitals in 2013/14.

The Chief Executive reported that she has been in post almost twelve months and in that time she has reviewed the senior leadership and the clinical leadership team, as well as reviewing the governance structures and clinical care pathways.

The Chief Executive reported that the Trust had struggled to meet the four hour target for A&E in quarter three. A number of issues have coincided that have resulted in additional pressures on A&E. The Chief Executive reported that there are a number of patients (120) that are currently occupying beds that are fit to be discharged. A number of those patients are residents of Bury.

The Chief Executive reported that partners need to work together to ensure that services are properly integrated, this has worked very well in North Manchester General Hospital where multi-disciplinary teams are co-located.

The Chief Executive reported that the Trust would want to ensure that they are very much involved in the development of the Manchester devolution proposals.

The Healthier Together proposals are only part of the Trust's reconfiguration plan. The Trust plan to review all other services provided and will hold a second workshop event to discuss with partners the service provision going forward.

It was agreed:

1. That the Chief Executive of the Pennine Acute NHS Trust be thanked for her attendance.
2. Delayed discharge will be an agenda item at a future Health Overview and Scrutiny Committee.

HSC.847 HEALTH SCRUTINY EVENT UPDATE

Members of the Committee considered the Centre for Public Scrutiny Health Overview and Scrutiny Evaluation report.

It was agreed:

That future Health Overview and Scrutiny Committee reports, where appropriate, contain performance information.

HSC.848 THANK YOU TO COUNCILLOR BURY

Councillor Walker on behalf of the Committee thanked the Chair, Councillor Bury, for his hard work and commitment during the Municipal year.

COUNCILLOR PETER BURY
Chair

(Note: The meeting started at 7pm and ended at 8.45pm)

Agenda Item 7

The Pennine Acute Hospitals NHS
NHS Trust

Title of Report	Report on Delayed Discharges at the Pennine Acute Hospitals NHS Trust
Executive Summary	The paper outlines the operational challenge of managing delayed discharges. The paper describes the current processes to manage delayed discharges, the reasons for delays and the current actions that are being taken to address the issues. A new discharge planning group with multi agency support has been formed to improve discharge planning and minimise delays.
Actions Requested:	The Committee are asked to note the report and support the on-going actions identified in the paper.

Name	Joanne Moore	
Job Title	Divisional Director Medicine	
Month and Year	9th June 2015	

For queries contact: Nadine Armitage
Head of Partnerships
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Nadine.Armitage@paht.nhs.uk

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The Pennine Acute Hospitals NHS Trust

The Pennine Acute NHS Trust

Report on Delayed Discharges for Bury and Joint Health Overview & Scrutiny Committees

Introduction

This paper has been produced at the request of the Joint Health Overview & Scrutiny Committee and outlines the operational challenges in managing patient delayed discharges across the Pennine Acute Hospitals Trust footprint. Processes are in place to monitor delays daily in conjunction with key partners. However, there continues to be a number of challenges and opportunities for further reducing the numbers of delays to ensure patients return home, or to other services, at the earliest opportunity to liberate acute beds.

1. Definitions

There are two types of delayed discharge which are monitored and managed closely across the health economies on a daily basis. The first group are the Delayed Transfers of Care (DTOC) which are externally Sitrep reportable to bodies including Trust Development Agency (TDA) and Monitor. The data also contributes to the Better Care Fund (BCF) and AQUA dataset. These are agreed each day by a multi-disciplinary team including acute, community and LA colleagues and there are financial penalties applicable to the Local Authorities. The official definition of a Delayed Transfer of Care is:

a) A clinical decision has been made that patient is ready for transfer AND
b) A multi-disciplinary team decision has been made that patient is ready for transfer AND
c) The patient is safe to discharge/transfer.

This group are defined as:

- Awaiting completion of assessment
- Awaiting public funding
- Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)
- Awaiting residential home placement or availability
- Awaiting nursing home placement or availability
- Awaiting care package in own home
- Awaiting community equipment and adaptations
- Patient or Family choice
- Disputes
- Housing – patients not covered by NHS and Community Care Act

Table 1 below shows the number of reportable delays by site and for the Trust for 2014/15 as compared to other LA's and Greater Manchester Trusts.

Table 1: Sitrep delays 2014/15

Delayed Days Patient Snapshot by Local Authority

	2014/2015											
Local Authority	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Blackburn With Darwen UA	4	19	24	12	11	16	9	13	36	28	11	11
Blackpool UA	12	15	9	8	15	14	18	22	11	18	17	17
Bolton	31	10	16	22	15	11	8	7	8	12	23	14
Bury	14	11	24	15	12	25	18	7	5	7	9	12
Cheshire East	31	21	35	39	35	41	38	39	33	36	41	36
Cheshire West And Chester	18	29	21	21	16	25	20	39	21	20	21	21
Cumbria	38	45	50	47	35	44	48	38	34	41	52	39
Halton UA	14	6	9	4	6	2	5	7	9	11	8	10
Knowsley	3	5	6	12	3	4	10	4	3	7	1	7
Lancashire	81	120	118	98	134	133	140	90	117	135	105	107
Liverpool	39	45	37	32	31	27	31	45	33	34	32	35
Manchester	32	43	35	30	54	54	37	42	41	37	44	48
Oldham	9	6	4	7	7	5	7	11	9	11	5	8
Rochdale	16	8	18	18	10	16	17	13	12	13	13	14
Salford	9	19	20	14	2	6	20	16	23	21	13	10
Sefton	23	18	9	21	12	17	16	11	11	10	14	16
St Helens	4	3	6	5	6	4	0	2	6	9	8	4
Stockport	10	13	9	10	14	22	14	14	16	27	21	11
Tameside	8	5	4	2	5	11	8	8	9	32	31	45
Trafford	15	42	29	34	40	48	30	26	51	39	42	41
Warrington UA	20	27	10	21	22	28	22	9	13	16	30	24
Wigan	28	34	29	20	21	28	17	21	14	14	17	15
Wirral	9	9	4	8	4	8	6	5	8	8	6	8
Regional Neighbours	**468**	**553**	**526**	**500**	**510**	**589**	**539**	**489**	**523**	**586**	**564**	**553**

Delayed Days Patient Snapshot by Trust

	2014/2015											
Trust	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Bolton NHS Foundation Trust	24	6	13	18	10	8	2	6	6	10	21	11
Bridgewater Community Healthcare NHS Trust	2	0	1	0	1	3	0	0	0	0	1	1
Central Manchester University Hospitals NHS Foundation Trust	6	10	9	11	28	33	10	29	29	21	31	38
Greater Manchester West Mental Health NHS Foundation Trust	7	3	3	4	2	1	1	5	4	2	5	3
Manchester Mental Health And Social Care Trust	13	10	7	6	10	9	1	14	12	8	7	9
Pennine Acute Hospitals NHS Trust	33	27	44	38	34	45	9	24	16	21	17	27
Pennine Care NHS Foundation Trust	15	8	8	9	9	16	2	14	18	12	27	24
Salford Royal NHS Foundation Trust	12	27	22	22	12	12	0	18	27	35	25	21
Stockport NHS Foundation Trust	10	14	10	6	14	19	0	12	11	20	19	13
Tameside Hospital NHS Foundation Trust	3	2	2	0	2	0	3	3	3	27	14	27
The Christie NHS Foundation Trust	0	0	0	0	1	0	0	0	0	0	1	1
University Hospital Of South Manchester NHS Foundation Trust	21	50	40	34	41	55	16	19	48	43	40	30
Wrightington, Wigan And Leigh NHS Foundation Trust	24	32	22	16	11	20	0	16	6	6	2	0
Greater Manchester Area Team	**170**	**189**	**181**	**164**	**175**	**221**	**44**	**160**	**180**	**205**	**210**	**205**

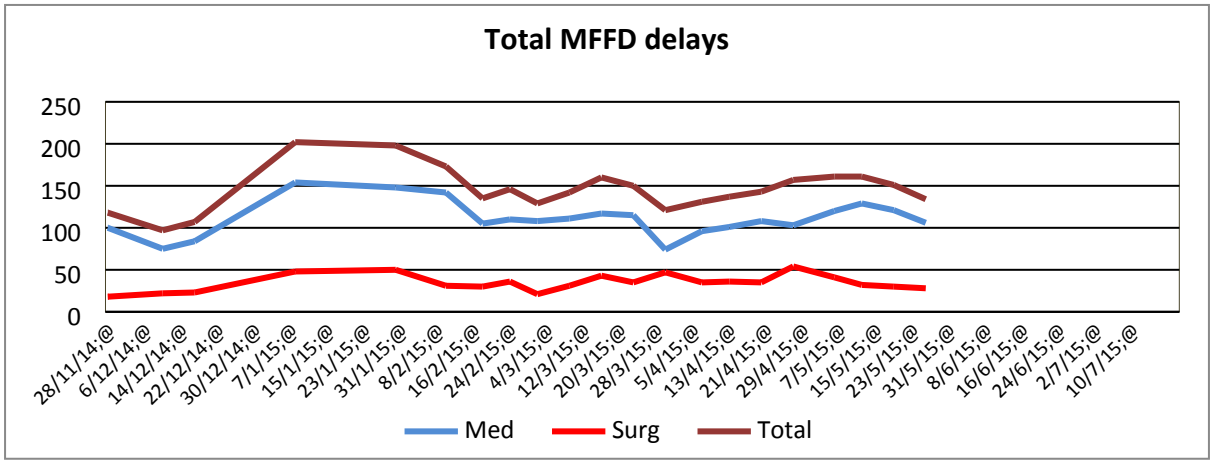
The second group of delays are those defined as Medically Fit For Discharge (MFFD) which is a much larger group than those which are externally reportable. The Trust Development Authority's (TDA) definition for medically fit patients is:

A patient that is medically fit for discharge is where a clinical decision has been made that the patient is ready to transfer. This is from a medical perspective only (usually the consultant or team that the patient is under). The patient therefore has not had a MDT decision at this point, and the patient may require further therapy or social care input prior to an MDT agreement and therefore not a reportable Delayed Transfer of Care delay. (TDA, 2015)

The Trust monitors the MFFD data on a daily basis and it is shared with partner organisations and commissioners 3 times per week. On average, across all hospital sites including Rochdale Infirmary, there are between 120 and 150 MFFD patients in the hospital at any time representing around 20% of the bed stock. Within this figure, approximately 80% are medical patients and 20% surgical patients. The medical patient delays are generally the most complex to resolve as are frail elderly patients with complex morbidities and care needs. It should be noted that the figure does not reflect those patients who are medically fit but have simple needs that do not require additional assessment.

Graph 1 below shows the most recent information since November 2014 covering the last 6 month period. It can be seen that at its peak over the extremely busy Christmas and New year period, the MFFD numbers rose to around 200 patients.

Graph 1: Summary MFFD patients last 6 months



2. MFFD Detail

The MFFD delays are collected daily in a total of 17 categories but for ease are summarised into 8 which largely follows the organisational splits. For the period Nov 2014 – May 2015 the distribution of delays is shown in Graph 2 and summarised as a proportion of total delays in Table 2 across the four PAHT sites.

Graph 2: Trend of MFFD delays by type

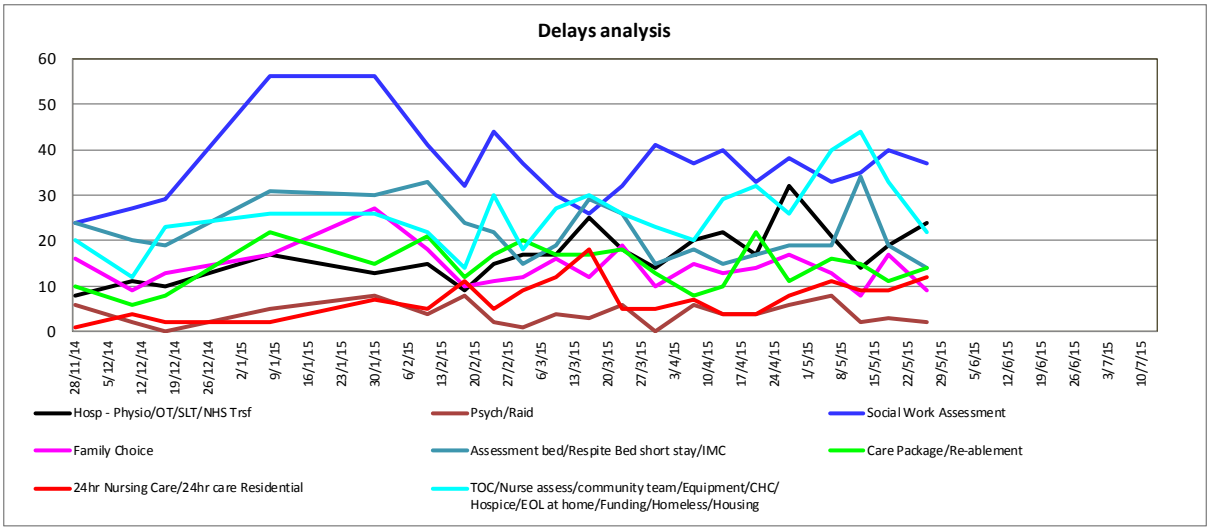


Table 2: Types of delays and proportion of patients delayed across all hospital sites

Delay Category	% of Patients Delayed
Social Work Assessment	26%
Long Term Health Services in Community	18%
Community Bed	16%
Therapy Assessments	12%
Family Choice	10%
Care Package/Re-ablement Service	10%
24hr Nursing Care/24hr care Residential	5%
Mental Health Services	3%
Total	**100%**

This data illustrates that patients awaiting a social work assessment is the most common reason for medically fit patients continuing to occupy an acute bed. However what must be considered as part of that process are patient's capacity to consent to assessment and ongoing care. This is a statutory requirement of the Mental Capacity Act 2005, in addition some of the delays are from LA's outside of the NE sector. It should also be noted that once an assessment has been completed the patient is likely to then need a service on discharge such as a care package or residential placement, which may lead to further delays should best interest meetings be needed.

It should also be noted that the number of days that a patient may occupy an acute hospital bed whilst medically fit is not collected daily. For some patients the delay can be relatively short and others much longer e.g. a patient requiring a therapy assessment is generally likely to be resolved faster than a patient requiring a nursing home placement.

The data is also captured by site and by Local Authority. This can of course change daily, however a snap-shot analysis of the most recent information from 3rd June 2015 shows the distribution as follows:

Table 3: Number of medical MFFD by site

Site	No. of medically fit patients	% of beds occupied by med fit patients	Proportion of total delays
ROH	33	16%	29%
NMGH	26	15%	23%
FGH	50	28%	43%
RI	6	33%	5%
Total	**115**	**20%**	**100%**

Table 4: Distribution of medical MFFD by local authority area and hospital site

Site	No. of medically fit patients	Proportion of total delays
Manch	8	7%
Bury	39	34%
Rochdale	35	30%
Oldham	29	25%
Other	4	3%
Total	**115**	**100%**

This data suggests a positive correlation between the number of delays in total and the distribution of patients across the four hospitals sites. The area with the lowest number of delayed discharges is Manchester with only 16 % of delayed discharges residing in the Manchester locality. It is also clear on a daily basis that delays are extended for those patients who are not on their local site.

There are some factors relating to the surgical and medical activities that differ across the Trust sites which may contribute to differences in delays e.g. All Acute and Stroke rehabilitation services area now centralised at FGH.

3. Current position

The reasons for the delays across all the sites are multi-factorial and community and LA partner organisations are working with the Trust to develop and implement solutions. Each site has a local economy action plan to improve A&E access performance and flow of

patients through the hospital beds and within the plans there are a variety of actions relating to this specific issue.

There are examples of very good collaborative working across the PAHT footprint to reduce the delay. The Assistant Director of Social Care for Bury Local Authority chairs an economy-wide Discharge Group which has senior representation from all organisations. This group has recently been re-energised and re-focused with commitment from all partners. At NMGH all staff involved in the discharge process from acute, community and local authority work as an integrated team based on the site and line-managed on a daily basis by one Trust manager. The much lower number of delays for Manchester LA and fewer delays in total for the NMGH site reflect this.

Staff are co-located on the FGH site, and soon completion of IT works will mean better access for staff to wireless to enable hot desking.

The Delayed Discharges Act made it a requirement that where the delay is attributed to a local Authority the Acute Trust could fine that Authority. This has not been consistently applied across the country. The Care Act 2014 provides flexibility in the discharge arrangement in that it makes it possible to not fine the LA but consider how to invest monies/ resources differently to support better discharge planning.

There remain however a number of challenges and areas for improvement including:

a) *Acute Trust*

- Accurate and consistent completion of referral forms to other organisations at ward level; this includes improving understanding of the multiple pathways available for patients on discharge
- Improvement of internal communications and escalation where progress has not been made
- Robust use of ambulatory care pathways to increase emergency admission avoidance
- Setting discharge dates on admission consistently

b) *Local Authority partners*

- Issues regarding resources and availability of social work staff to attend each site every day
- Care Provider capacity for intermediate care and reablement and different admission criteria across the NE sector
- Working towards a discharge to assess model
- Working on single site discharge
- One single trusted assessor documentation
- Consistent 7-day working
- Cross boundary cover for social workers

c) *Community partners*

- Capacity of Transfer of Care team to assess patients for Intermediate Care in addition to urgent Fast Track Continuing Health cases
- Capacity for delivery of IV antibiotics and fluids in care homes and community to prevent admission
- Capacity to discharge to assess rather than assess to discharge
- Cross boundary cover for nurse assessors

d) CCG's

- IV therapy services
- CHC funding without prejudice

4. Future partner working

Partners across the Pennine Acute footprint are continuing to work together on solutions to address the delays including:

- Working towards the one single site discharge (based on a recent pilot in UHSM). This will be driven through NE Sector discharge group.
- Working towards 7 day working for local authority
- Wider provision of reablement slots and packages of care
- Joint working agreement signed by all partners for CHC screened patients

The Health Scrutiny committee is asked to note this report.

June 2015

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