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TRAFFORD COUNCIL

AGENDA PAPERS FOR

HEALTH SCRUTINY COMMITTEE

Date: Thursday, 7 March 2019

Time: 6.30 p.m.

Place: Committee Room 2 and 3, Trafford Town Hall, Talbot Road, Stretford, M32 0TH

A G E N D A **PART I** **Pages**

1. **ATTENDANCES**

To note attendances, including Officers, and any apologies for absence.

2. **MINUTES** 1 - 10

To receive and, if so determined, to agree as a correct record the Minutes of the meeting held on 24 January 2019.

3. **DECLARATIONS OF INTEREST**

Members to give notice of any interest and the nature of that interest relating to any item on the agenda in accordance with the adopted Code of Conduct.

4. **QUESTIONS FROM THE PUBLIC**

A maximum of 15 minutes will be allocated to public questions submitted in writing to Democratic Services (democratic.services@trafford.gov.uk) by 4 p.m. on the working day prior to the meeting. Questions must be relevant to items appearing on the agenda and will be submitted at the meeting in the order in which they were received.

5. **SINGLE HOSPITAL SERVICE**

(a) **SINGLE HOSPITAL SERVICE PROGRAMME UPDATE** 11 - 14
To receive a report from the Deputy Programme Director of the Single Hospital Service.

(b) **PENNINE ACUTE HOSPITALS NHS TRUST TRANSACTIONS PROGRAMME UPDATE** 15 - 24
To receive a presentation from the Senior Responsible Officer for the Pennine Acute Trust Transactions Programme.

6. **DIABETIC SERVICES** 25 - 30

To receive a report from the Corporate Director of Commissioning.

7. **PHYSIOTHERAPY** 31 - 40

To receive a report from the Corporate Director of Commissioning.

8. **TRAFFORD URGENT CARE CENTRE** To Follow

To receive a presentation from the Acting Corporate Director of Adult Services.

9. **HEALTHWATCH TRAFFORD** 41 - 64

To receive the latest report from HealthWatch Trafford.

10. **TASK AND FINISH GROUP WORK**

(a) **COMMUNITY SERVICES** (Verbal Report) Verbal Report
To receive an update from the Chair of the Committee.

(b) **PERIOD POVERTY** (To Follow) To Follow
To receive a report from the Task and Finish Group.

11. **GREATER MANCHESTER JOINT HEALTH SCRUTINY COMMITTEE** Verbal Report

To receive an update from the Vice Chair of the Committee.

12. **URGENT BUSINESS (IF ANY)**

Any other item or items (not likely to disclose "exempt information") which, by reason of special circumstances (to be specified), the Chairman of the meeting is of the opinion should be considered at this meeting as a matter of urgency.

13. **EXCLUSION RESOLUTION (REMAINING ITEMS)**

Motion (Which may be amended as Members think fit):

That the public be excluded from this meeting during consideration of the remaining items on the agenda, because of the likelihood of disclosure of “exempt information” which falls within one or more descriptive category or categories of the Local Government Act 1972, Schedule 12A, as amended by The Local Government (Access to Information) (Variation) Order 2006, and

specified on the agenda item or report relating to each such item respectively.

SARA TODD
Chief Executive

Membership of the Committee

Councillors R. Chilton (Chair), S. Taylor (Vice-Chair), S.K. Anstee, J. Bennett, J. E. Brophy, Mrs. A. Bruer-Morris, A. Duffield, Mrs. L. Evans, Mrs. D.L. Haddad, S. Longden, J. Slater, D. Acton (ex-Officio) and D. Western (ex-Officio).

Further Information
For help, advice and information about this meeting please contact:

Alexander Murray,
Tel: 0161 912 4250
Email: alexander.murray@trafford.gov.uk

This agenda was issued on **Wednesday, 27 February 2019** by the Legal and Democratic Services Section, Trafford Council, Trafford Town Hall; Talbot Road, Stretford, Manchester, M32 0TH

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HEALTH SCRUTINY COMMITTEE

24 JANUARY 2019

PRESENT

Councillor R. Chilton (in the Chair).
Councillors S. Taylor (Vice-Chair), J. E. Brophy, Mrs. A. Bruer-Morris, A. Duffield, Mrs. L. Evans, Mrs. D.L. Haddad, S. Longden and J. Slater.

In attendance

Martyn Pritchard	Accountable Officer, Trafford CCG
Sara Radcliffe	Corporate Director of Commissioning
Stephen Gardner	Deputy Director of the Single Hospital Service, MFT
Rebecca Demaine	Associate Director of Commissioning
Heather Fairfield	Chair of HealthWatch Trafford
Diane Eaton	Corporate Director of Adult Service
Judith Lloyd	Executive Member for Health and Wellbeing
Peter Forrester	Head of Governance
Karen O'Connor	Community Nurse, Macmillan
John Walker	Associate Director of Operations, GMMH
Alex Cotton	Senior Commissioning Manager, Trafford CCG
Leigh Lord	Head of Medicines Optimisation
Alexander Murray	Democratic and Scrutiny Officer

APOLOGIES

Apologies for absence were received from Councillors S.K. Anstee, J. Bennett, D. Acton and D. Western

35. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions were received from the public.

36. MINUTES

RESOLVED: That the minutes of the meeting held 12 December 2018 be agreed as an accurate record and signed by the Chair.

37. DECLARATIONS OF INTEREST

The following declarations of personal interests were reported to the meeting:

- Councillor Brophy in relation to her employment within the NHS.
- Councillor Bruer-Morris in relation to her employment within the NHS.
- Councillor Longden in relation to his employment as Joint Director of Chauden Limited
- Councillor Taylor in relation to her employment by the NHS.

38. MEDICINES OPTIMISATION AND PRESCRIBING

The Head of Medicines Optimisation from Trafford CCG gave a brief overview of the report that had been circulated with the agenda. The Committee were informed of the CCG's programme of medicine optimisation across the borough. This was a prolonged piece of work that involved the reviewing of individual patient's medications or repeat prescriptions, in line with guidance from the Greater Manchester Medicines Management Group, by the Medicines Optimisation Team. This work had recently been expanded to include pharmacists in Care Homes with positive results.

The Committee were then told of the engagement activities that the CCG had undertaken with residents and NHS guidance regarding the expansion of the programme. This meant that drugs that were more cost effective when bought over the Counter, the prescription of gluten free products, and other products relating to a number of 'self-limiting' conditions would no longer prescribed by Trafford GPs.

Following the overview the Committee were given the opportunity to ask questions. Councillor Brophy asked whether there would be any long term effects on people who suffer coeliac disease. The Head of Medicines Optimisation responded that they would continue to monitor those who were impacted by these decisions to ensure that they were not suffering as a result.

Councillor Bruer-Morris asked whether the CCG had considered advertising the difference in cost of prescription against over the counter medicines. The Head of Medicines Optimisation replied that this was something they planned to do.

After the Committee's questions the Chair asked them whether they supported the prescribing changes within the community. Councillor Slater raised issue with the removal of gluten free food prescriptions for low income families and those who received universal credit. The Committee discussed these points and all agreed that the Committee supported the prescribing changes except in the circumstances mentioned by Councillor Slater. The Chair asked that this be re-evaluated by Trafford CCG and an update be provided at the next Committee meeting in March.

RESOLVED:

1) That the report be noted by the Committee.
2) That the Committee support all changes listed within the report with the exception of the prescription of gluten free products for low income households and people on universal credit.
3) That an update be brought to the Committee meeting in March.

39. TRAFFORD MENTAL HEALTH TRANSFORMATION UPDATE

The Associate Director of Commissioning for Trafford CCG gave a brief overview of the report the Committee had received and went through the main goals laid out in the paper. The inequality in life expectancy between those suffered from mental

health issues and those who did not was a high priority for both Trafford CCG and the Council's Public health team.

The Associate Director of Operations for Greater Manchester Mental Health NHS Foundation Trust (GMMH) informed the Committee of the new primary care delivery model. This model consisted of four teams which were spread out across the borough with one placed in each one of the four neighbourhoods. It was hoped that by being located in areas and placed with GPs the teams would be able to connect with residents in areas where community engagement had always been low. Each team had a varied skill set which was the result of partnership working between GMMH, MFT, CCG and the Voluntary sector. The new model was to be rolled out in stages to enable learning throughout the process to ensure that it was sustainable.

The Committee were informed about the role of the Care Navigator team within the model. Care Navigators were a team of professionals who went out into the Community in order to engage with people rather than waiting for them to come to services. When the team identified an individual who required support they would then link them to support through social prescribing and voluntary groups.

Councillor Haddad stated that there appeared to be a gap between the aspiration and the detail within the report. The GMMH officer responded that the Model was vague as the service would be built up and the details filled in as it was rolled out. The Committee were told that GMMH were already operating a similar model successfully in other areas of Greater Manchester and the team would now adapt it to Trafford. The Associate Director of Commissioning added that a more detailed operational model could be provided.

Councillor Haddad noticed that the report did not mention schools despite them being such an important partner in tackling mental health problems among children and young people. The Associate Director of Commissioning responded that this gap had been noted at a recent mental health partnership meeting and that the CCG were already looking at how to develop that relationship. The Executive Member for Wellbeing spoke about the work that the Health and wellbeing Board were doing in relation to Mental Health across a person's whole life course. The Council were working with the CCG on the transformation of mental health services and would support them in linking with schools where possible.

Councillor Taylor requested that case studies about the effectiveness of care navigators and the use of this model to understand how it benefits patients. The Associate Director of Commissioning agreed that the next update to the Committee would include case studies.

Councillor Brophy stated that there appeared to be a gap as the service did not appear to support people with learning disabilities who were more likely to develop mental health issues. The Councillor then asked whether the model had any provision for the education of GPs as they often did not refer patients with mental health issues to services available to help with those issues. The Associate Director of Operations responded that they were currently going out to inform GPs about the model and their role in referring patients.

Councillor Duffield Declared an interest as she worked in North Manchester as part of the Be Well service.

Councillor Duffield asked about the work that they had been doing in North Manchester and what they had learnt. Councillor Duffield then asked whether there were figures for how many people they would be engaging with in Trafford. Councillor Duffield also asked how they planned to engage with GPs in the area. The Associate Director of Operations answered that the learning that had been gained from the work in North Manchester had directly influenced and informed the design of the service in Trafford. The numbers of people that they would be working with were unknown and GMMH were focused on ensuring that they provided a quality service to whoever they engaged with. The Associate Director of Commissioning told the Committee that the model had been developed with input from GPs from the start and throughout its creation.

The Chair of HealthWatch Trafford asked whether funding for the service had been guaranteed going forward. The Associate Director of Operations said that he did not have the figures to hand but that they could be provided after the meeting. The Associate Director of Commissioning added that the service had guaranteed funding for the first year from the 1st April 2019. This funding came from the transformation funding that Trafford had been awarded which would not be recurring. In addition to the funding data the Committee would be provided with detail as to staffing structure and recruitment strategy.

Councillor Evans raised concerns of delivering a service when the number of patients was not known and wondered if there were any solid figures that the service had been developed upon. The Councillor also asked whether there was a social media aspect of the service for engaging hard to reach young people. The Associate Director of Commissioning responded that whilst there were not any solid numbers the transformation had been based upon models and estimates. Those details were not available at the meeting but the Associate Director of Commissioning offered to circulate the information after the meeting.

The Chair summed up that the Committee would endorse Model of mental health services as recommended by the report. The Chair commented that the new direction that the service was going was a positive start but there was a lot of work which needed to be done to flesh out the model so that it met its aspirations.

RESOLVED:

1) That the report be noted.
2) That the Committee endorse the Integrated Primary Care Model for Mental Health Services.
3) That a more detailed operational model of the service be provided to the Committee.
4) That any further updates delivered to the Committee are to include case studies showing the efficacy of the model.
5) That the Committee is to receive information regarding the funding, staffing, and recruitment of the service.
6) That the models and estimates used in the development of the model be shared with the Committee.

40. END OF LIFE CARE

The Senior Commissioning Manager from Integrated Commissioning Unit told the Committee that although the current position seemed as though the figures were static there had actually been a reduction in the number of people who had died in hospital since 2015. The Committee were informed that Trafford was the highest performing area in Greater Manchester for the percentage of people who had three hospital admissions or more in the last three months of life who died at home.

The CCG had performed a self-assessment of End of Life (EOL) care looking at the whole health and social care system and evaluating it against the ambitions for palliative care. The self-assessment had been completed in partnership with key stakeholders from care homes, primary care services, and hospitals. This exercise had identified a number of barriers within the system and an action plan had been drawn up to address them. Advanced care planning, end of life prescribing, and training of primary care staff were all identified as key elements to improve palliative care.

Since the self-assessment was done there had been a number of improvements made. This included all those involved in end of life care using Emiss, the development of advanced care plans, and improved forms and questions used by GPs. The next stage was to develop a one person profile which would capture who a person was and their wishes for the end of their life. This work was being done with two Trafford Care Homes which had been identified as providing high quality care.

In order for palliative and end of life care to be improved work needed to be done to tackle the stigma around talking about death. This was needed so that the discussions could begin sooner enabling planning to be completed in a timely manner. There had already been a number of community engagement events across Trafford and more were planned going forward. The Senior Commissioning Manager informed the Committee of the education and training programmes would help to address some of the issues around a lack of knowledge within care homes.

Chair asked about none recurrent funding mentioned on page five of the report and whether that could be recurrent. The Senior Commissioning Manager responded that the funding was £12000 for a role which was to train champions within care homes. These Champions would then be able to train other staff within the care homes and so the funding did not need to be recurrent.

Councillor Bruer-Morris asked what the impact had been of getting all those who worked in palliative and end of life care to use Emiss. The Senior Commissioning Manager described how Emiss supported the palliative care information systems and ensured that the information was available for GPS and professionals. The Committee were told that this development had been an improvement and had enabled a more person centred approach.

Councillor Bruer-Morris asked a follow up question about the levels of staff turnover.

The Corporate Director of Adults Services informed the Committee that whilst there was a lot of movement of staff across Trafford most of the people that left simply switched employer rather than leaving the borough. The Council were working with Trafford CCG on a training offer which would track staff across Trafford this would enable a better understanding of the true staff turnover in the area. The system would also mean that when someone moved from one provider to another they would not need to have repeat training.
Councillor Haddad noted that this work aimed to replicate the success of St Anne's in a care home setting and she asked whether this was possible. The Community Nurse responded that there were a number of homes already delivering this level of end of life care. She recognised that in order to get homes to this level requires some investment in resources and training and the team were focusing upon supporting those homes that were yet to get this in place.

Councillor Haddad asked whether the Care homes were able to provide the equipment needed for this care. The Community Nurse replied that as long as homes had a syringe driver and trained staff they were able to deliver the care that they were talking about.

The Chair of HealthWatch Trafford asked how many people had died within Care Homes compared to how many died within hospital. The Senior Commissioning Manager did not have the figures at the meeting said that they would be provided afterwards.

Councillor Duffield asked about personal health budgets and whether they were being used within Trafford. The Senior Commissioning Manager informed the committee that there had been a lot of work done around personal health budgets and working closely with partners across Greater Manchester. The offer in relation to palliative care was still in its infancy and being developed in partnership with St Anne's Hospice.

Councillor Duffield then asked about Trafford's housing strategy and whether there was adequate development to support people to be able to stay in their own homes rather than going into care homes or hospital. The Associate Director of Commissioning informed the committee that the ICU had been asked to be involved in the older persons housing task and finish group and would update the committee on the work of that group at a later stage rather than give an uninformed opinion.

RESOLVED:

1) That the report be noted.
2) That the numbers of people dying in care homes and hospital be provided to the Committee.

41. ALTRINCHAM HUB

The Accountable Officer for Trafford CCG introduced the short report and added a couple of comments. The CCG were looking to develop the building in three ways. The first way was to use the building for health and social care, second was wider public sector use, and finally looking at other options, what these might be was still to be determined. Details of those that have signed up could not be shared at the meeting but regular updates would be provided to the Committee.

The Chair stated that the report did not give any details that were not already available. The Chair realised that there was commercial sensitivity around the agreements of use of the building but asked that this be made clear within the report so that someone reading the report knows that work is ongoing and cannot be shared. The Chair also raised issue with the length of the report given the small amount of information that was in it and he advised the Accountable Officer that future reports should be more concise and to the point.

Councillor Duffield stated that she was aware that NHS England had commissioned a report to investigate what had happened with regards to this project. The Councillor added that this project was of great interest to Trafford residents due to the large sum of public money that had gone into the building. The Councillor expected that a report would be brought to the committee and she hoped that when it was that it would be made public so that residents would be able to understand what had happened.

The Accountable Officer assured the Committee that he would take the comments about the report supplied on board. He added that as the report had been commissioned by NHS England it would not be up to Trafford CCG to make it public or not but the Committee's comments would be passed this onto NHS England.

Councillor Duffield added that whilst the limitations were understood she wanted to make it clear that as a representative of the people of Trafford it was expected that the details as to what had led to these circumstances would be made public.

Councillors Taylor, Bruer-Morris, and Haddad also raised their concerns about the Altrincham Hub and supported Councillor Duffield's comments that there needed to be public scrutiny of this project and lessons learned from the mistakes that had been made.

RESOLVED:

1) That the report be noted.
2) That the Committee requests that the report Commissioned by NHS England be brought to the Committee when available.

42. SINGLE HOSPITAL SERVICE

The Deputy Programme Director, Single Hospital Service for Manchester NHS Foundation Trust (MFT) gave a brief overview of the programme of work covering where it started and the thoughts behind it. The main focus of the project had been upon Manchester but it was also recognised that the service provided the majority of care for Trafford Residents as well. The report to the Committee had been provided with a larger report which gave details as to all that had been done within the first year of the service.

The Deputy Programme Director then went through the highlights of the one year report and the Committee were told that whilst some projected. The Committee were informed that it was anticipated that the service would deliver more benefits in years two and three. The Deputy Programme Director then spoke about the acquisition of North Manchester Hospital and that it was expected to be happen

towards the end of March 2020. There were a number of issues with the hospital and MFT were working to ensure that its addition did not destabilise the trust.

The Chair thanked the Deputy Programme Director for the report and added that the Committee had always been concerned about the addition of North Manchester to the trust. The Chair noted that the report covered just three services in detail and asked for an update on all services. The Deputy Programme Director responded that the single hospital service team were putting together an overall review which would be shared that with the committee once it was completed.

The Corporate Director of Commissioning added how the visibility of MFT had greatly improved with Mandy Bailey being the key contact for all services within the area. MFT were also the approved provider for Trafford's community services and so the working relationship between the organisations would be even more beneficial going forward.

Councillor Bruer-Morris asked whether the removal of the nursing bursary had impacted upon the level of recruitment. The Deputy Programme Director Spoke about the staffing issues which MFT had but he stated that their issues were not as great as many other organisations had. The reason that MFT performed better than others in this regard was due to the reputation and scale of the organisation which enabled them to address a number of issues.

Councillor Duffield asked what precautions MFT were taking in order to deal with the potential issues that Brexit could cause regarding supplies of medicines and funding.
The Deputy Programme Director responded that MFT were following the national guidance regarding Brexit. The largest issue was around staff not feeling welcome within the country. The Committee were told that MFT would be looking to recruit more staff from India later in the year.

RESOLVED:

1) That the report be noted
2) That the Deputy Programme Director be thanked for attending the meeting.
3) That the additional information on services to be sent to the Committee as soon as possible.

43. TRAFFORD DEMENTIA STRATEGY

The Interim Director of Public Health was not in attendance as the report was an update on the progress of the creation of the strategy. The Chair stated that the aging well strategy was to be added to the Committee's work programme for early in the next municipal year. The Chair then asked the Committee for any questions. The Chair of HealthWatch Trafford stated that there was a pressing need within Trafford for something to be put in place for people with challenging behaviour as it was very difficult for them to find a place in the area.

The Corporate Director of Commissioning responded that the ICU would provide more information for the Committee on the ageing well strategy. She also stated

that the comments about the pressing need for provision for people with challenging behaviour would also be fed back to the team.

RESOLVED:

1) That the report be noted.
2) That the ageing well strategy be added to the Committee's Work programme.

44. HEALTH WATCH TRAFFORD

The Chair thanked HealthWatch for the work that they have done and excellent the reports delivered to the Committee. The Chair stated that while the clinical work at ascot house was excellent there was an issue around patient engagement and experience. This was something that the committee would look at as part of their work going forward.

Councillor Bruer-Morris noted that there was a woman who had to have a male carer wash her and the comments made about Trafford Council not being great at signposting residents to services available. The Corporate Director for Adults Services thanked HealthWatch for the report and for highlighting these issues. The Committee were assured that the report would be taken back to the team at Ascot house so that they could address the issues raised.

RESOLVED:

1) That the reports be noted.
2) That the issues highlighted by HealthWatch Trafford be taken back to the team based at Ascot House.
3) That patient engagement and experience at Ascot House be added to the Committee's work programme.

45. GREATER MANCHESTER HEALTH SCRUTINY COMMITTEE

The Vice Chair gave a brief update on the work that had been covered at the most recent meeting of the Greater Manchester Joint Health Scrutiny Committee (GMJHSC). Warren Heppolette had updated the GMJHSC on the work that was being done with the Voluntary sector across GM. The work was focused upon readdressing the balance between statutory and community services as organisations were often delivering services in ways that were not the best for people. GM were looking at how the voluntary sector could help deliver services in better ways due to their small size, local knowledge, and varied approaches. GM had a wealth of volunteers and voluntary organisation available in the area which were undervalued and had not been fully utilised. The Vice Chair stated that she would like the Committee to look at voluntary sector engagement in Trafford.

The Corporate Director of Commissioning informed the Committee that she had met with the Trafford Voluntary collective. The Collective was a new collaboration between voluntary groups across Trafford which enabled organisations like Trafford CCG to engage with all of the voluntary providers in the area. It was hoped that through the collective the sector would have a larger voice and a more strategic role within the borough. The CCG were looking to work with Warren

Heppolette in order to develop these relationships further going forward. The Executive Member for Health and Wellbeing added that Trafford were developing social prescribing in Trafford and the Voluntary sector were a key element in delivering those services across the borough.

The second main item on the GMJHSC agenda looked at the three key strategies that were ongoing across GM. The three strategies were the primary care workforce strategy, the creation of local care organisations, and the commissioning strategy. The focus of all of these strategies was that they encouraged an increase in place based services and social enterprises. Greater Manchester had been broken down into 68 areas each of about 40 – 50 thousand people and looking at developing services and community in each of those areas. GM were also looking at simultaneously developing a digital offer for people across the region. The Vice Chair commented that she felt that the work being done at the GM level linked in well with the Work being done in Trafford. The Vice Chair then asked officers to send a link to the Committee Papers to the rest of the Committee for information.

RESOLVED:

1) That the update be noted.
2) That voluntary sector work be added to the Committee's work programme.
3) That a link to the Greater Manchester Joint Health Scrutiny Committee meetings be sent to Committee Members.

The meeting commenced at 6.30 pm and finished at 8.43 pm

TRAFFORD COUNCIL

Report to: **Health Scrutiny Committee**
Date: **07 March 2019**
Report for:
Report of: **Stephen Gardner, Deputy Programme Director, Single Hospital Service**

Report Title

Single Hospital Service Update

1. Summary

1.1. This report provides an update on the latest position for the Single Hospital Service (SHS) programme, and specifically progress with the proposed acquisition of North Manchester General Hospital (NMGH).

2. Introduction

2.1. This paper provides an update for the Trafford Health Scrutiny Committee on the Single Hospital Service (SHS) Programme. Previous reports have included extensive details about the work to realise integration benefits from the creation of MFT, but this update will focus on the proposed acquisition of NMGH by Manchester University NHS FT (MFT).

3. Background

3.1. The proposal to establish a Single Hospital Service for Manchester, Trafford and surrounding areas was built on the work of the independent Single Hospital Service Review, led by Sir Jonathan Michael. The Single Hospital Service Programme has been operational since August 2016.

3.2. The Programme is being delivered through two linked projects:

- Project 1: The creation of MFT through the merger of Central Manchester University Hospitals NHS Foundation Trust (CMFT) and University Hospital of South Manchester NHS Foundation Trust (UHSM). MFT was created on 1 October 2017 and integration of the two predecessor organisations is underway.

- Project 2: The planned acquisition by MFT of NMGH. The acquisition is expected to take place by 31 March 2020.

4. Progress to date – Integration

4.1. Good progress continues with the Integration Programme. MFT has produced a report that summarises the activities and achievements in the first full year of operation (the MFT Year One Report), and this has previously been shared with the Health Scrutiny Committee.

4.2. A short animated video has also now been created. The video details at a high level some of the achievements MFT has been able to realise as a result of the merger, and is being used to communicate key integration messages to staff, partner organisations and

the public. A link to the animation is included below:
https://www.youtube.com/watch?v=HP4BQ-8l7jI

4.3. As a consequence of the efforts made by all staff, MFT has a firm platform to begin to operationalise large, complex schemes to promote additional patient and organisational benefits.

5. Proposed Acquisition of North Manchester General Hospital

5.1. The second stage in the creation of a Single Hospital Service is to transfer NMGH, currently part of Pennine Acute Hospitals NHS Trust (PAHT), into MFT.

5.2. NHS Improvement (NHS I) has set out a proposal for MFT to acquire NMGH as part of an overall plan to dissolve PAHT and transfer the remaining hospital sites (Bury, Oldham and Rochdale) to Salford Royal NHS Foundation Trust (SRFT).

5.3. The transaction process is being undertaken in line with the national NHS I Transaction Guidance with oversight provided by a Transaction Board established at the end of November 2017. The Board is chaired by Jon Rouse, Chief Officer for the GMH&SCP. Associated sub-committees / groups have also been established and these have appropriate multi-agency involvement.

5.4. One of the challenges in completing this work is the need to ensure the strategic cases submitted by SRFT and MFT are complementary i.e. not contradictory or in any way inconsistent with the two-lot proposal. In this context, MFT continues to work collaboratively with MHCC, PAHT, SRFT, and NHS I and colleagues at GMH&SCP to ensure the two transactions associated with the dissolution of PAHT are progressed as efficiently as possible.

5.5. The expectation is that the Strategic Case for the proposed acquisition of NMGH will be considered by the MFT during March, and then submitted to NHS I before the end of the month. NHS I will then undertake the required assurance process. Subject to this assessment, the process will then move on to the Business Case stage. These timescales are consistent with NMGH being brought into MFT by 31 March 2020.

5.6. The SRFT process to acquire the residuum of the PAHT services is expected to progress in parallel with the NMGH transaction.

5.7. MFT engagement with NMGH staff is increasingly positive. A further NMGH Staff Engagement session took place on the 13 February 2019. Toli Onon, Joint Medical Director of MFT, attended the session to share her experiences of the merger. The session was well attended and feedback was very positive. MFT will continue to attend NMGH staff engagements on a bi-monthly basis.

5.8. Irrespective of the challenges and complexities, MFT remains committed to the realisation of the plan to fully establish the Single Hospital Service for Manchester by transferring NMGH to MFT at the earliest practicable opportunity. On this basis, MFT will continue to engage with all key stakeholders and in particular, work with Greater Manchester Health and Social Care Partnership in its role to oversee the plan to dissolve Pennine Acute Hospitals NHS Trust.

6. Conclusion

6.1. This report provides an update on the progress of the Single Hospital Service Programme. The report explains that MFT is progressing plans to acquire NMGH though this is proving to be a complex process. The Health Scrutiny Committee is asked to note the progress made to date.

Recommendation(s)

The Health Scrutiny Committee is asked to:

(i) Note the current position of the Single Hospital Service Programme.

Contact person for access to background papers and further information:

Name: Stephen.Gardner@mft.nhs.uk
Extension: 0161 701 4963

Background Papers:

Implications

Relationship to Policy Framework/Corporate Priorities	
Financial	
Legal Implications:	
Equality/Diversity Implications	
Sustainability Implications	
Staffing/E-Government/Asset Management Implications	
Risk Management Implications	
Health and Safety Implications	

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GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

The Pennine Acute Hospitals NHS Trust

Transactions Programme Update

Thursday, 7 March, 2019
6.30 pm
Trafford Town Hall in Committee Rooms 2&3

What are the future plans for The Pennine Acute Trust?

- A new ownership and long-term management arrangement for the hospitals currently run by Pennine Acute Trust (PAT) is essential to support the future clinical, financial and workforce sustainability of acute hospital services in the North East sector and across Greater Manchester

- Two legally separate but intrinsically linked processes (transactions) are underway to split PAT; both elements will require formal approval at national level.

1. NHS Improvement has invited Salford Royal to put forward proposals for the formal acquisition of the Royal Oldham, Fairfield General Hospital and Rochdale Infirmary hospital sites to be part of Salford Royal's group of healthcare services, called the Northern Care Alliance NHS Group (NCA).

2. This proposal coincides with the plans for MFT to formally acquire the North Manchester General Hospital site to transfer to MFT as part of its group of hospitals. The future plans for NMGH is part of the longstanding plan to create a Single Hospital Service for the City of Manchester and Trafford.

What is the PAT Transaction and future roadmap?

- A PAT Transaction Board, independently chaired by GM HSCP, is overseeing the formal transactions and proposed changes in ownership.

- The Board comprises senior leaders from NHS Improvement, GM HSCP, PAT, Salford Royal FT, Manchester University Hospitals FT, Manchester Commissioners (MHCC), and all CCGs and Local Authorities on the PAT footprint.

- The PAT Transaction Board aims to complete the transactions and to formally split PAT in the second half of 2019-2020 (by 31 March 2020), subject to rigorous due diligence, agreement of financial plans and approval of business cases.

- Salford Royal has been running Pennine Acute Trust and its services under a management agreement since 2016/17 under the NCA group arrangements.

- The NCA is governed by a Committees in Common where both Salford Royal and Pennine Acute NHS Trust Boards have devolved its decision making to CiC.

- Mr Pat Crowley has been appointed as “Non-conflicted” Director on PAT Board.

How will this benefit patients? The Northern Care Alliance

The planned transfer of Oldham, Bury and Rochdale sites to SRFT under the NCA will benefit patients by:

Improved population health

- Integrated systems eliminating unwarranted variations in health outcomes
- Standardisation eliminating unwarranted variations in processes of care
- Alignment with GM and wider population health priorities
- Sharing CQC "Outstanding" rated best practice from Salford Integrated Care Organisation

Improved patient experience

- Sharing best to practice to deliver reliable and excellent care to patients
- Timely access to diagnostics, care and specialist care
- Consistency and equity of services
- Improved pathways across all local care organisations
- Improved patient outcomes through standardisation
- Empowering patients to deliver self care

Improved finances

- Opportunity to share the cost of commissioning services
- Procurement savings maximising economies of scale
- Maximise research income
- Improved healthcare value through economies of scale
- Reduction in duplication will optimise cost reduction

Improved staff experience

- A culture of broader understanding and shared purpose
- Ability to attract and retain more staff through brand and specialist services
- Improved brand and reputation will increase pride
- Economies of scale leading to enhanced employee benefits
- Standardisation and training empowers staff in their role

How will this benefit patients?

How will the planned transfer of NMGH to MFT benefit patients?

Quality of Care	Reduce variation in the effectiveness and safety of care. Improve access to specialist care.
Patient Experience	Reduce fragmentation, reduce duplication. Transfer care closer to home.
Workforce	Support the provision of a 7 day service. Improve the recruitment and retention of appropriately skilled workforce.
Financial/Operational Efficiency	Improve operational performance. Ensure resource is focussed appropriately.
Research and Innovation	Improve access to clinical trials. Ensure learning from research and innovation is consistently implemented.
Education and Training	Widen student and trainee exposure, optimise curriculum delivery.

The legal Transaction process and timescales

Stage 1: Strategic Cases

- Acquirers set out their respective cases (reasons and benefits) for acquiring the relevant parts of Pennine Acute (SRFT: Oldham, Bury and Rochdale and MFT : North Manchester)

- Financial modelling is being prepared by all partners together with a review of consequences for patients and funding if the transaction were not to go ahead

- Strategic cases are due to be submitted to NHSI for their approval in early 2019

- These cases are being developed in line with national guidance and include in-depth financial due diligence.

Stage 2: Full Business Cases

- Development of full business cases

Communications and engagement

Approach and principles

- Joint Communications and Engagement Plan in place and led by GM HSCP
- Delivery of the plan supported by a number of Communications Leads who are members of the communications working group (membership consists of GM HSCP, NCA/SRFT, MFT, CCGs and NHS Improvement)
- All communications are developed collectively by the working group and address feedback and insight from stakeholders
- Plans and narratives align with partner organisations
- Providers produce their own staff communications based on the key messages and core content agreed by the working group
- Providers and commissioners use their established channels of communication to inform their staff and other key stakeholder audiences at key milestones within the process (channels include; face to face briefings, bulletins, newsletters and online intranet communications)
- Public and patient communication and engagement around future plans for PAT hospitals and services will increase during 2019/20

Summary

All partner organisations involved are committed to working through a series of complex processes in order to secure the best future for patients and staff.

The GM ambition remains the same:

- The proposed plan is for Salford Royal (SRFT) to formally acquire Oldham, Bury and Rochdale hospitals as part of the new Northern Care Alliance NHS Group (NCA)

- Coinciding with SRFT's acquisition of Oldham, Bury and Rochdale sites, it's intended North Manchester General Hospital (NMGH) will transfer to Manchester University NHS Foundation Trust (MFT)

Questions and Discussion

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TRAFFORD COUNCIL

Report to: **Health Overview and Scrutiny Committee**
Date: **7th March 2019**
Report of: **Director of Commissioning Trafford CCG**

Report Title

Diabetes Update

Summary

This paper aims to provide an overview and update of the Diabetes redesign work within Trafford

Recommendation(s)

To note the report

Contact person for access to background papers and further information:

Name: Naomi Ledwith
Extension:

Background Papers: None

Background

Diabetes care is one of the major challenges facing the NHS and the quality of care provision varies throughout the country. Diabetes is a major cause of premature mortality with at least 22,000 avoidable deaths each year. Due to the increasing obesity levels in the UK it is expected that the incidence of Type 2 Diabetes will increase and as a result it is estimated the number of people with diabetes in the UK will rise to 4.6 million by 2030. This makes it the long term condition with the fastest rising prevalence and if not managed properly, diabetes, can lead to serious life-threatening and life-limiting complications.

Although diabetic care in the UK has improved significantly over the years and the levels of premature mortality in the UK are lower than in 18 other wealthy countries. In spite of these developments there is still room to improve services delivery.

Currently, only around 1 in 5 people with diabetes are achieving all 3 of the recommended standards for glucose control, blood pressure and cholesterol. Moreover, the complications relating to diabetes are wide reaching, including;

- The most common reason for renal dialysis and the second most common cause of blindness in people of working age
- Increases the risk of cardiovascular disease by 2 to 4 times
- Increases the risk of chronic kidney disease, from an incident of 5-10% in the general population to between 18% and 30% in people with diabetes
- Results in almost 100 amputations each week, many of which are avoidable (approximately 8 out of 10)

Trafford's population is 240,000 and the estimated prevalence tells us that there are 12,594 diabetics aged 17+ registered with GP's within Trafford. We can roughly assume that approximately 90% circa 11,425, of these people are Type 2 diabetics.

This paper highlights the primary care diabetes pilot project and the wider ambition to roll out a new model for diabetic care in Trafford.

Trafford CCG has developed a diabetes strategy which will aim to lead to increased quality of care and improved outcomes for Trafford patients with or at risk of developing diabetes.

Diabetes Hub Pilot

The first phase of implementation for the strategy has resulted in a pilot scheme that aims to provide improved quality of diabetic care closer to home whilst delivering increased value for money. The pilot operates from Partington Family Practice and after a suitability assessment the service is offered to 25% of the diabetic patients registered at both Partington Family Practice and Partington Central Surgery, where 1 in 12 people are Diabetics. The pilot is run by Dr James Hider and he is supported by Dr Clive Marchi who is a hospital practitioner in diabetes.

The pilot has been operational for 9 months and offers:

- Enhanced diabetes care for patients of Partington this includes patients with well manged diabetes patients from secondary care and patients with poorly managed diabetes from primary care
- Clinical assessment and appropriate and timely interventions for patients
- All patients referred into the hub have their diabetes 8 care processes recommended by the National Institute for Health and Care Excellence (NICE). These processes ensure that people living with diabetes are monitored closely to prevent their condition from getting worse and leading to further complications.
- Improved access to services closer to home
- A service that has a strong emphasis on patient education and self-management, thereby promoting active and healthy lifestyles
- Medication reviews to ensure optimal diabetes control

Data analysis from a recent pilot hub evaluation has shown that benefits have already been delivered; there has been a 26% reduction in reduced hospital 1st appointments and 36% reduction in follow up appointments. These reductions will result in financial savings for the CCG and better quality outcomes for the patients.

There has been an 18% increase in patients who have had all 8 care processes recorded allowing better monitoring of their diabetes.

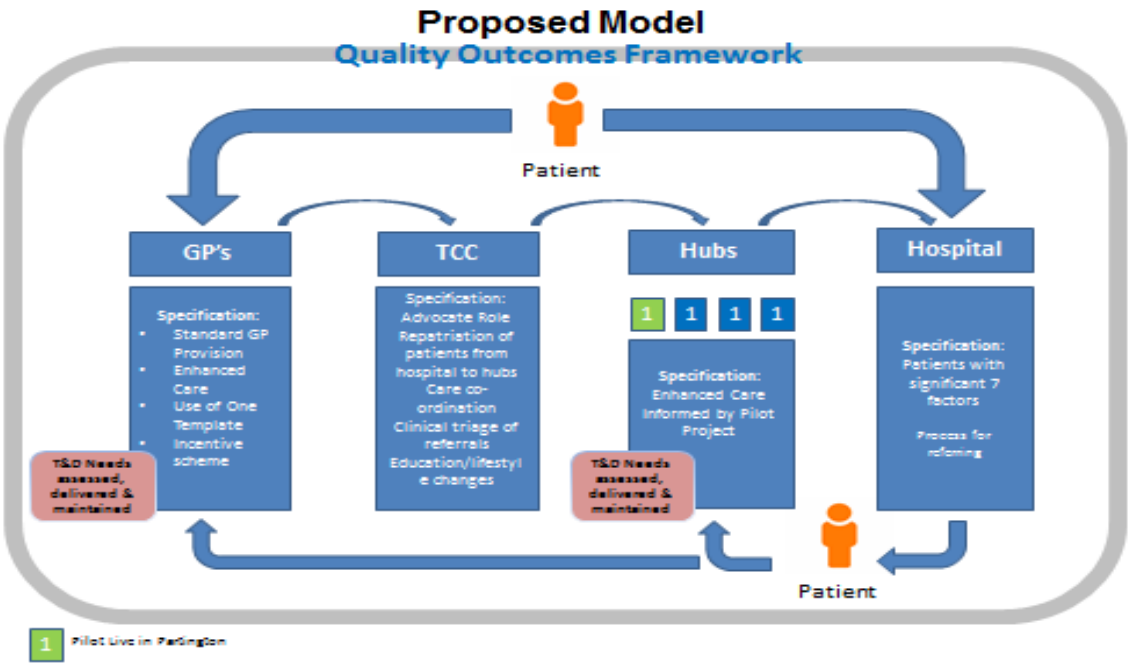
Dr James Hider who runs the pilot in Partington has recently been on national television recently with one of the patients from the Partington hub who has managed to reverse his diabetes with a complete lifestyle overhaul and support from the Diabetes hub.

https://news4trafford.co.uk/2019/02/07/a-partington-man-who-lost-6-stone-and-reversed-his-diabetes-is-inspiring-others-to-take-part-in-a-diet-plan-that-saved-his-life/

Diabetes Programme

The longer term aim is to roll out the diabetes hub model across all Trafford neighbourhoods. Within the new diabetic model of care it will be clear what patients can expect from their general practitioner and if required provision of enhanced diabetic care in locality settings such as the one in partington with only specialist diabetic care being referred into hospital.

Ultimately this will reduce the spend on secondary care, not just for first and follow up appointments for diabetic management, there will be longer term benefits from less in-patient admissions from complications that arise from poorly managed diabetes. Such as amputations, blindness, kidney problems.



The principles of the

- Implementation of a sustainable diabetic care model based on consistent pathway methodology
- A model that will operate within a Quality Outcomes Framework
- Delivers patient and value driven outcomes
- Aligns to CCG 7 priorities
- Delivery tracked and managed using PMO methodology (Logic Model)
- Seamless patient journey
- Collaborative approach to delivery
- TCC provide the advocate role for the model
- Outcomes are measureable and reportable
- Prevention and patient education
- Reducing variation through innovation

The Trafford Coordination Centre (TCC)

The TCC is supporting the diabetes redesign work in the following ways:

GP Referrals

All GP referrals sent to the TCC for booking into secondary care are being triaged by the CCG's diabetes clinical lead. Where the clinical lead feels that the patient could still be treated in primary care he contacts the GP in question to provide advice & guidance – and the referral to secondary care is prevented.

This has been in operation since November 2016 and to date 27% of referrals have been prevented for secondary care referral.

Repatriation of Partington Patients

The Partington Pilot is in the process of accepting patients who no longer need secondary care treatment. A cohort of patients has been identified and agreed.

The TCC has commenced contracting these patients to ensure they understand what is happening, provide reassurance on their future care and answer any questions the patient has.
This will then be the start of the development of the diabetes advocate role for the TCC.

Advocate Role

The TCC is currently developing the diabetes advocate role to support the wider Trafford diabetes population.
The Hospital Practitioner from Trafford General Hospital is preparing a training package for the TCC nursing team.

The advocate role will aim to help the patient:

- Improve diabetes control by reducing blood glucose levels
- Lose weight and reduce waist size
- Identify healthy foods, increase choice & drink alcohol in moderation
- Become more active
- Increase confidence and ability to look after your own health
- Improve blood pressure and blood cholesterol levels
- Improve quality of life, manage stress, sleep well (to improve mental health)
- Understand and ultimately reduce the medication you have to take for diabetes
- Stop/reduce smoking

TCC is a critical element of the diabetes redesign work and the throughput of patients interacting with this service will be managed as part of the neighbourhood roll out of the new model.

Summary

The programme of work for the wider diabetes model is currently at business case development stage, this programme will form part of the large scale Transformation portfolio of work for 19/20.

A number of workshops have been carried out a stakeholder group has been established to enable this programme of work. The clinical leadership is provided by clinicians who are involved in diabetic care on a day to day basis. Part of the focus for the stakeholder groups is to ensure that and any current challenges are being captured to ensure that they are being addressed and prevented in the redesign of the service.

Diabetes is 1 of 3 clinical priorities along with respiratory and mental health for the CCG they will form part of the 19/20 Transformation Programme and a key enabling programme for these priorities is the primary care quality standard for both general practice and relevant enhanced care standards that will be delivered through neighbourhood hubs such as the one being piloted for diabetes.

The next stage as part of the business case development stage will include data and evidence gathering, cost benefit analysis and implementation planning.

Health scrutiny are requested to note the positive developments in this area and support the development of the wider programme to roll out the model across Trafford neighbourhoods.

TRAFFORD COUNCIL

Report to: **Health Overview and Scrutiny Committee**
Date: **7th March 2019**
Report of: **Director of Commissioning Trafford CCG**

Report Title

Physiotherapy

Summary

This paper aims to provide an overview and update on the Community Services which deliver physiotherapy as part of the clinical pathway.

Recommendation(s)

Health Scrutiny Committee are asked to note the paper and request further detail on any of the individual services to be provided at future meetings.

Contact person for access to background papers and further information:

Name: Naomi Ledwith
Extension:

Background Papers: None

Background

The Chartered Society of Physiotherapist definition is as follows:

Physiotherapy helps restore movement and function when someone is affected by injury, illness or disability.

Physiotherapy is provided as part of a number of community services delivered by Pennine Care FT. Physiotherapy is also provided in secondary care following trauma or surgery.

This report focusses on the main community services which involve physiotherapy.

These are:

- Community MSK Service
- Community Rehabilitation Service & Outpatients
- Community Neuro Rehabilitation Services
- Pulmonary Rehabilitation

The community services also provide physiotherapy as part of Ascot House Therapy Led Intermediate Care Service, the Community Enhanced Care (CEC) Service Urgent Therapy team as well as the Children's Therapy Services (Physiotherapy/Occupational Therapy). We understand Health Scrutiny Committee has received presentations previously on Ascot House and the CEC Urgent Therapy Team.

Community Musculoskeletal (MSK) Service

Trafford CCG commissions an adult Community Specialist MSK Integrated service with the aim of treating more patients within the community setting and within a single integrated pathway of care. The service commenced on 1st July 2016 and will end in June 2021.

The integrated service comprises MSK physiotherapy and podiatry, along with specialist orthopaedic, rheumatology and pain management. The specialist service is separate to the main contract and while the lead provider is Pennine Care FT which delivers the physiotherapy and podiatry elements of the service, the specialist elements of the service - orthopaedic/rheumatology and specialist pain services, are delivered through a sub-contract arrangement with Manchester Foundation Trust (formerly University of South Manchester FT).

The aim of the service is to:

- Offer a single pathway of care for patients with musculoskeletal conditions and ensure the patient sees the most appropriate clinician to improve their care.

- Reduce unnecessary demand on secondary care services and improve waiting times and rates of conversion to surgery.
- Improve patient experience and confidence through prevention and self-management.

GPs refer patients to the service via the Trafford Coordination Centre (TCC) . The referral is then forward to the Single Point of Access for referral processing, then on to the MSK service for clinical triage. Where the referral is considered inappropriate for the service (e.g. where secondary care treatment is required) then the referral is passed back to the TCC to contact the patient, offer choice of provider and book the appointment.

The service has demonstrated a number of positive outcomes:

- Shared Decision Making between clinician and patient, evidenced on patient care plan
- Assessment clinics - patients are assessed & given initial advice/exercises then can opt back in for treatment if needed
- My Health My Community website – averaging over one hundred views per week, alongside information/exercise leaflets
- Introduction of a Pain app for chronic pain management
- Close working relationship with Trafford Leisure as part of the pain management programme and a new pilot “escape pain” supporting patients with Osteoarthritis hip and knee.
- Group sessions for patients
- GP education is through liaison - each GP practice has a named person from the MSK physiotherapy and specialist team to liaise with around any queries or educational needs.
- Conversion to surgery to surgery rates have improved significantly (awaiting latest data from Performance team)
- Reduced secondary care and independent sector activity
- Reduced MRI and Ultrasound scans ordered by GPs
- Positive patient feedback through friends and family test and one line feedback form
- The service has also submitted a business case to the CCG for a portable Ultrasound Scanning Machine so patients can receive the scans at the assessment. This is currently being discussed with MFT radiology before being considered by the CCG.

<u>Current Demand</u>

Overall the demand on the service is virtually in line with what was identified in the contract, although there are variations for the individual elements of the service as set out in the table below:

	Apr - Nov 18	Apr - Nov 18 (Av / Month)	18/19 contract target / month	Diff (Nos)	Diff (%)
Community Physio / Podiatry	**6892**	**862**	**769**	**93**	**12.0%**
Ortho / Rheum	**1755**	**219**	**384**	**-165**	**-42.9%**
Pain	**354**	**44**	**34**	**10**	**30.1%**
Total	**9001**	**1125**	**1187**	**-62**	**-5.2%**

In total the Physiotherapy and Specialist service will treat over 14,000 patients in the current year.

The main issue with the service is meeting the waiting times KPI as set out in the contract.

The service is expected to see and treat 95% of patients within 4 weeks. Currently only 20% of patients are meeting this target for physiotherapy. PCFT has provided assurance that all urgent referrals are seen within 2 weeks and in December Pennine Care reported that average routine waiting times for physiotherapy is between 5-7 weeks.

There a number of reasons for this including: physiotherapist vacancies in the service, patients not attending for appointments (DNAs - 14% in January, 10% previously), and the referral process. A joint CCG & PCFT Steering Group meets monthly and an action plan has been agreed to improve performance, which included temporarily reintroducing assessment clinics with shorter assessment times and exploring introducing a new system for booking referrals via the Community EMIS system. Further data is awaited, including a capacity & demand review, before a trajectory can be agreed as to when the waiting time KPI will be met. It is hoped this can be agreed at the next steering group meeting in March.

A GP survey was carried out recently with the waiting time being the major concern for GPs as patients are going back to the practice to chase up appointments as well as concerns over the referral process and referral template. A response to the survey is being prepared through the MSK Steering Group, which will include a quarterly update for GPs around waiting time performance and shared learning.

The transition of the Community Services to Manchester University Hospital Foundation Trust (MFT) does provide significant opportunities to develop the Community MSK service further, given MFT currently provide the specialist element of the service.

Community Rehabilitation Service and Outpatients

Trafford's Community Rehabilitation service is comprised of 4 teams which are based in each of Trafford's neighbourhood and an outpatient rehabilitation team.

The service sees patients in their own homes and provides a comprehensive assessment of individual need which leads to the development of a patient centred rehabilitation programme, which aims to enable the patients to gain maximum independence with activities of daily living and mobility.

The rehabilitation programme runs for up to six weeks and is managed by occupational therapists, physiotherapists and experienced support workers. Community Outpatients Team also delivers Trafford's Stability Training and Movement Programme (STAMP). This programme provides 8 weeks of classes which focus on:

- Improving balance and stability
- Improving mobility and reducing the need for walking aids, where possible
- Provide strategies to reduce the risk of falling and support patients to introduce them into daily life.
- Highlight health improvement opportunities available in Trafford

In addition to supporting patients to remain at home and access self-management tools, the community rehabilitation teams also offers support for patients with declining health, including rehabilitation to maximise function where a chronic disease or its impact has significantly changed.

The team works with patients to develop advance plans, and work closely with district nurses, Community Neuro Rehabilitation Team, social care, and community matrons to ensure patients receive appropriate support in accordance with their wishes. This service includes support regarding provision of mobility and functional aids, and appropriate onward referrals.

<u>Current Demand</u>

Demand for community rehabilitation services is increasing. In Pennine Care's latest performance report (December 2018) it is reported that the number of referrals for Trafford's Community Rehabilitation Service has increased by 32% compared to the same period in 2017/18.

An increase in referrals has also been seen for Community Outpatients, with particular waits being reported for STAMP (Stability Training and Movement Programme) classes. At the end of December 2018 33 patients were waiting for outpatients rehabilitation (a reduction of 6 from the previous month) and 6 of which have been waiting over 18 weeks.

In addition to the natural growth in demand due to Trafford's aging population, the increase in demand for community rehabilitation highlights the impact of the successful introduction of the frailty index in General Practice. The frailty index was introduced into General Practice to improve the earlier identification of older people who are at high risk of adverse health outcomes, enabling preventative interventions such as focused rehabilitation to improve mobility to be provided ahead of an event such as a fall.

Trafford CCG and Trafford Council are committed to improving proactive management of frailty and in reducing the number of falls experienced by our residents. Subsequently, as more residents are being identified earlier a need was recognised for clearly articulated referral pathways between commissioned services and to ensure each service was being utilised by seeing the right patients, at the right time.
In October 2017, in response to national data which suggested that Trafford performs poorly with regards to the number of falls when compared to similar areas, the CCG began working closely with partner organisations across the Trafford healthcare economy to agree and implement a new falls referral management pathway.
Through collaborative design across all partners (including the CCG, Council, Fire and Rescue Services, Ambulance Trust, Age UK, Trafford Leisure and Pennine Care) the new referral pathway, coordinated via the Trafford Co-ordination Centre (TCC), ensures that as many patients as possible are accessing the preventative multi-factorial interventions set out in NICE guidance:

- strength and balance training
- home hazard assessment and intervention
- vision assessment and referral
- medication review

The increase in demand for community rehabilitation in Trafford can, at least in part, be attributed to successful implementation of this the frailty index and falls referral pathway as patients are directed to services earlier. Whilst meeting this demand remains an ongoing challenge for our community providers it must be noted that such schemes have ensured more of our residents age well and remain their independence for longer and thereby over time will support the reduction of urgent acute episodes of care.

Pennine Care continues to implement service improvements and initiatives to support the management of capacity and demand pressure. These include:

- An assessment day for all patients waiting over 18 weeks for STAMP classes. In addition to assessing patients this day was utilised to review the appropriateness of referrals received by the service and if any referrals could be supported via organisations such as Age UK or Trafford Leisure Trust.

- Implemented a project to encourage improved adoption of self-management by patients. Patients involved in this project are sent motivational messages by the service, encouraging participation in their at home exercise programmes. This is to support continued rehabilitation and improvement outside of the face to face programme delivered by the service. Improvement has been noted in those patients who have participated in this project.

- Begun to develop new ways of delivering STAMP education to compliment the programme, including by PowerPoint presentation and in through a patient handbook.

To ensure sufficient capacity is available to meet future need, the community rehabilitation service will be considered as part of the wider therapy review which will be undertaken as Trafford's Community Services transition to Manchester University Hospitals NHS Foundation Trust (MFT).

Community Neuro Rehabilitation Service

Trafford's Community Neuro Rehabilitation Service provides specialist rehabilitation to patients aged 18 or over who have an acquired brain injury or have neurological conditions within a community setting, predominately in a patient's home. The service delivered is provided by two pathway teams, stroke and neuro rehabilitation, who deliver care through a multidisciplinary approach. Each pathway team consists of (or has access to) a clinical neuropsychologist, physiotherapists, occupational therapists, speech and language therapists, dieticians and nurse specialists.

The Trafford Community Neuro Rehab Team (CNRT) has a pivotal role in facilitating a patient's discharge from acute and post-acute hospital based rehabilitation back into the community. The timeliness and coordination of this care, delivered through individualised care plans, is vital in ensuring patients are in acute services only when clinically necessary and for only as long as medically required and in supporting patients to maximise their rehabilitation potential and to remain at home for as long as possible. The service also accepts a high number of referrals from community and primary care for patients who require a re-referral to the service for specific rehab intervention.

<u>Current Demand</u>

Trafford's CNRT has longstanding extensive waiting times to access the service and for specific professions within the team. Specific professions within the team with the most significant waits are physiotherapy and occupational therapy.
In 2018 this issue was raised as a priority concern for both the CCG and Pennine Care where it was noted that immediate steps were required to stabilise the service is in the short and medium term, whilst opportunities for longer term sustainability were considered.

To provide some stability to the service in the short and medium term, a proposal was developed focusing on reducing the number of patients waiting to access the service, the length of time waiting and to explore opportunities to maximise the efficiency and clinical time of substantive team to manage the internal waiting list and existing caseload.

This proposal was presented to the CCG's Quality, Finance and Performance Committee on 2nd October 2018, where a non- recurrent investment of £106,348 was agreed to support the short-term employment of additional physiotherapy and occupational therapy capacity; the two areas with the greatest capacity and demand pressures.

To maximise the impact of the investment provided, it was agreed that the scope of this project would focus on:

1) Reduction of length of time waiting to access the service for first intervention
The investment agreed would be used to employ additional locum capacity to focus on the assessment and treatment of those patients who had been waiting the longest and were yet to receive any intervention. This would reduce the waiting time from the longest wait of 52 weeks to 10 weeks (one month over the 6 week access KPI for this service). This target has been modelled as the highest possible reduction with the envelope of the agreed additional investment.

2) Maximising operational capacity and efficiency
To run concurrently with the waiting list initiative, this review is taking a systematic approach to ensure that all avenues were being explored to maximise the team's clinical capacity and efficiency in managing the internal waiting list (where a patient is currently under the care of one specialism i.e. Speech and Language Therapist but is currently waiting to receive input from another professional such as physiotherapy) and those new referrals to the service outside of the waiting list.

To support the management of the internal waits within the service, Pennine Care are providing additional 6 week physiotherapy capacity and additional support workers to the substantive team.

Following the employment of two locum physiotherapists, the waiting list initiative started on 1st December 2018. To date the reduction in the number of waits for neuro physiotherapy have reduced significantly from 81 waits to 31 waits in a period of 8 weeks, which is ahead of estimated position of 65 waits. In the main this has been due to those patients waiting not requiring as intensive input following face to face assessment.

Following implementation there has also been a significant impact on the number of patients waiting and the length of time they are waiting; with patients waiting for first intervention for physio stroke having been reduced from 47 weeks to 26 weeks and

physio neuro form 41 weeks to 27 weeks within an 8 week period. There are currently no concerns regarding delivery against physio trajectory by the end of the project. Whilst the additional investment from the CCG and the extensive work undertaken by Pennine Care has had a significant impact, the challenges of capacity and demand pressures remain ongoing. To ensure continued improvement following the end of the initiative and sustainability in the long term, this service has been identified as a priority service for review and development during the transition of community services from Pennine Care to MFT, with governance for this programme ultimately reporting up to the Board overseeing the transition.

Pulmonary Rehabilitation

Pulmonary rehabilitation (PR) is a programme of exercise, education and personalised management planning for patients with mild to severe Chronic Obstructive Pulmonary Disease (COPD) whose function is affected by the disease. In Trafford, the PR service is provided by Pennine Care NHS Foundation Trust (PCFT).
The service is overseen by the respiratory physiotherapist Occupational therapists and support workers and provides courses of rehabilitation lasting 8 weeks, delivered from various venues across Trafford. Treatment includes an initial assessment to ensure that the patient is suitable for PR, to determine the baseline outcome measures, and to confirm the personalised plan for the individual patient.
Referrals are received from GPs, practice nurses; specialist nurses/AHPs within secondary care; secondary care consultants.
Pulmonary Rehab benefits patients by:

- improving muscle strength so oxygen can be used more efficiently
- supporting patients to better cope with being out of breath
- improving fitness and confidence
- improving mental health

<u>Current Demand</u>

The service is experiencing an ongoing increase in referrals (a yearly increase of 17% as of December 2018) which is contributing to current long waits. Of 275 referrals received up to December 2018; 22 were waiting longer than 18 weeks. In response the service has undertaken an internal capacity and demand review with the following findings:

- The referral criteria will remain the same with the service investigating whether all patients are clinically appropriate for PR and signposting to other services where necessary
- A reduction in length of the programme from 8 to 7 weeks and an increase in the number of patients accommodated into the programme sessions at some

locations (these changes remain within the parameters of national guidelines and are not expected to have any negative impact on patient outcomes)

- The long waiters are reviewed regularly and are offered alternative locations, with the exception of those whose clinical needs dictate they need to attend the programme on a hospital site
- Waiting times will continue to be monitored via PCFT internal governance & CCG performance, quality and information groups with escalation to HILG and CCG Performance and Contract Board if the waits/increase in referrals remain challenging
- Moving forward the service will be reviewed as part of the planned joint rehabilitation services review

Ascot House

Ascot House provides an intermediate care service with 36 beds available. The service runs under a Therapy led model, which includes physiotherapy, occupational therapy and social work support as required.

Avoidable hospital admission is prevented by the therapy team who provide frequent and intensive therapy to identified individuals via a step up facility

The team also provides short term therapy and rehabilitation to identified people who are medically well enough to be discharged from hospital, enabling them to return to their own address post.

Next Steps:

- To ensure sufficient capacity available in the services to meet future need, all the community rehabilitation services will be considered as part of the wider therapy review which will be undertaken as Trafford's Community Services transition to Manchester University Hospitals NHS Foundation Trust (MFT)

Enter & view Report:

healthwatch Trafford

The Knoll Residential Home

109 Church Road

Urmston

Manchester

M41 9FJ

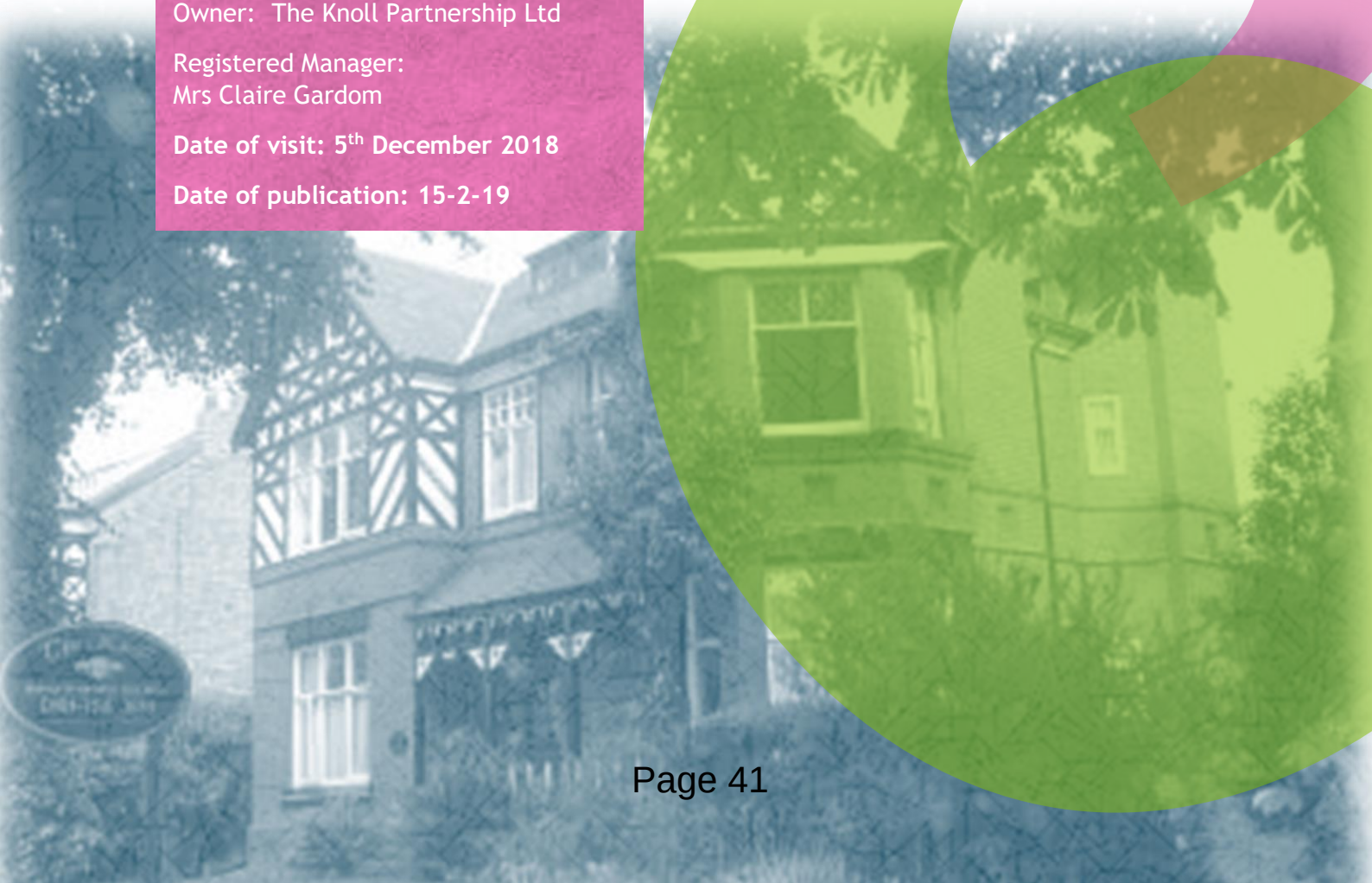
Tel: 0161 755 3818

Owner: The Knoll Partnership Ltd

Registered Manager:
Mrs Claire Gardom

Date of visit: 5th December 2018

Date of publication: 15-2-19



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What is Enter & View?

Part of the local Healthwatch programme is to carry out Enter and View visits. Local Healthwatch representatives carry out these visits to health and social care services to find out how they are being run and make recommendations where there are areas for improvement. The Health and Social Care Act allows local Healthwatch authorised representatives to observe service delivery and talk to service users, their families and carers on premises such as hospitals, residential homes, GP practices, dental surgeries, optometrists and pharmacies. Enter and view visits can happen if people tell us there is a problem with a service but, equally, they can occur when services have a good reputation – so we can learn about and share examples of what they do well from the perspective of people who experience the service first hand. The aim of the Healthwatch Enter and View visits is to give relatives and carers a perception of what daily life it is like for residents living at a care home and whether the home is somewhere they would place their family member.

Healthwatch Enter and Views are not intended to specifically identify safeguarding issues. However, if safeguarding concerns arise during a visit they are reported in accordance with Healthwatch safeguarding policies. If at any time an authorised representative observes anything that they feel uncomfortable about they need to inform their lead who will inform the service manager, ending the visit. In addition, if any member of staff wishes to raise a safeguarding issue about their employer they will be directed to the Care Quality Commission [CQC] where they are protected by legislation if they raise a concern.

Acknowledgements

Healthwatch Trafford would like to thank the owner, Registered Manager, staff and residents of The Knoll and the relatives of the residents for their contribution to the Enter and View programme.

Disclaimer

Please note that this report relates to findings observed on the specific date set out above. Our report is not a representative portrayal of the experiences of all service users, only an account of what was observed and contributed at the time.

Executive Summary
Findings

- The Knoll is a residential home providing care for up to 10 elderly residents. At the time of the visit there were nine residents at the home, however, we were informed the current vacancy had been filled.

- The Knoll is a detached Victorian house with accommodation provided over two floors. The home offers eight single bedrooms and one shared bedroom. There is a secure garden area to the rear of the property.

- The Manager kindly agreed to mail out 10 questionnaires to relatives of residents living at the home, three completed questionnaires were returned to us. The completed relatives' questionnaires we received informed us that residents living at The Knoll Residential Home were treated with kindness and compassion, to see responses please go to: https://healthwatchtrafford.co.uk/wp-content/uploads/2019/01/The-Knoll.pdf

- On entering the home, there is a large variety of notice boards displayed on the walls with information for residents and visitors.

- On the day of the visit we observed the Manager and staff interacting with residents in a friendly and responsive manner.

- The members of staff we spoke to told us that they were extremely happy working at the home and that the Manager was very approachable and supportive.

- Average costs are £575 per week.

- A CQC inspection of The Knoll took place in June 2017. Following the inspection, the home was given a '*Good*' rating. To access the CQC inspection report please go to: https://www.cqc.org.uk/location/1-123297631

- The owners of the Knoll Residential Home and its sister home Fairways Residential Home have taken ownership of a brand-new purpose-built care home [Bowfell House] situated in the Flixton area of Urmston. The new home will accommodate up to 40 residents and is scheduled to be completed in summer 2019. The residents and staff will move from the Knoll's current address to Bowfell House following building completion.

Recommendations and Good Practice

- *Consider encouraging staff to speak to relatives about their loved one's general health, hobbies and interests, please see page 21 Appendix B, relative questionnaire.*

- *Consider how to include extra seating for visitors in the communal lounge areas. [Please see comments on page eight].*

- *Consider improving the signage to various areas of the home to enable visitors to navigate the home. [Please see comments on page eight].*

Good practice identified:

The Knoll Manager has taken advantage of a Trafford Local Authority Partnership initiative at a cost of £500 to obtain 50 credits to enable staff working at the home to access an assortment of relevant training. The Knoll Manager informed us that obtaining training for staff is a costly business and since the austerity measure taken by Local Authorities meant the end to free training the benefits of accessing training through this initiative far outweighs the initial costs.

Consider adoption of the other good practice initiatives:

http://www.bbc.co.uk/rd/blog/2017-02-bbc-rem-arc-dementia-memories-archive

A programme to encourage reminiscence in people with dementia.

https://www.carehome.co.uk/news/article.cfm/id/1574414/paper-armband-care-workers-malnutrition.

This is a paper armband, which can be routinely used to identify changes in nutrition or hydration.

https://www.nice.org.uk/guidance/ng48
A link to the National Institute for Health and Care Excellence [NICE] for 'Oral health for adults in care homes'

Manager's response to the above good practice initiatives

"we already do lots of work, particularly with work done via our in-house Activity Co-ordinators for reminiscence".

"We already follow NICE guidance and have oral care policies in place".

Purpose of the Visit

The visit to the Knoll Residential Home is part of an ongoing planned series of visits to care homes to discover what residents and their families think about the health and social services that are provided and examples of good working practice by:

- Observing and identifying best practice in the provision of care homes for vulnerable older people requiring social care or nursing care.
- Observing residents and relatives engaging with the staff and their surroundings
- Capturing the experience of residents and relatives

An Enter and View visit is not an inspection.

Strategic Drivers

We are using all/some of the following criteria for the timing of our visits.

- Ageing population in Trafford requiring care homes
- Good practice
- Length of time since the last Care Quality Care [CQC] visit so that we are not placing an unfair burden on care home management and staff by having two visits in close proximity.
- Where any issues of concern are raised with Healthwatch either by a resident or their carer. Residents' family/carers will be asked to complete a questionnaire anonymously.
- If there are specific questions of quality of care raised by Trafford Council, Healthwatch [as an independent body] will consider whether a visit is warranted.
- When invited by care homes to publicise good practice or points of learning.
- CQC and partners 'dignity and wellbeing' strategy:
- http://www.cqc.org.uk/content/regulation-10-dignity-and-respect
- Changes in management of the home.

These visits are a snapshot in time, but our reports are circulated widely and can be used by care homes to acquaint the public with the services offered.

Methodology

This was an announced Enter and View visit.

Contact was made with the home explaining our reasons for the visit. Posters were supplied to alert our visit to staff, residents and family members.

We sent a questionnaire to the Manager of the Knoll and received responses prior to the visit (Appendix A).

We sent a questionnaire to residents' family and carers for them to respond anonymously (see Appendix B). As these visits are not inspections, we have framed our questions in such a way that they reflect how residents and their carers feel about the quality of service on offer, *[the responses to Appendix B are summarised on page 13]*.

We have also observed governance arrangements to see how the home is run and assessed whether we feel it meets standards the public should expect.

We looked at local intelligence including CQC reports. The CQC inspected the home in June 2017 and gave a 'Good' rating. *Please see page 3 of this report*.

We were guided by staff on the residents who we could approach to answer our questions. We observed eight residents and talked to six, we spoke with one relative and three members of staff.

Healthwatch Trafford Authorised Representatives

- Marilyn Murray [Lead Representative]
- Sandra Griesbach

The visit

Introduction

Healthwatch Trafford visited The Knoll Residential Home in December 2018

What is the difference between care home and nursing home?

Both types of home provide accommodation, supervision from staff 24 hours a day, meals and help with personal care needs, but a nursing home also have registered nurses on duty at all times. This means that they can provide care for people with more complex needs and those who need regular nursing interventions.

The Knoll is a residential care home registered to provide personal care for up to 10 elderly residents, the home also provides end of life care and is privately owned by The Knoll Partnership. For further information see link: http://www.knollcarepartnership.co.uk/

The Knoll is a moderately sized detached Victorian house situated on a main road close to Urmston Town Centre. There is a small front garden leading to the front entrance of the home and a small garden to the rear. A tarmac area at the rear of the property provides car parking space for a limited number of cars. Accommodation is over two floors; the homes has eight single bedrooms and one twinned bedded room. The home has a communal lounge and dining room. There is a stairlift and an external wheelchair lift. The home has access to a veranda looking onto the rear of the property. Urmston Town centre has good amenities and good transport connections to the surrounding areas. At the time of the visit there were no vacancies at the home.

General Observations

Access to the home is through a security coded door, fronted by wide steps. There is a full wheelchair lift at the rear of the property. The doorbell notifies staff of visitors and staff allow entry. On entering the home, the visitors signing-in book is strategically place for people to use. Sanitizing gel is available on entering the home and throughout the building. The walls of the entrance hall displayed a considerable assortment of information, including; the home's CQC registration, the Trafford Dignity in Care Award [2017] and Investors in People.

The home is clean and smelt fresh on entering and throughout the building. The Knoll is a Victorian building in need of updating.

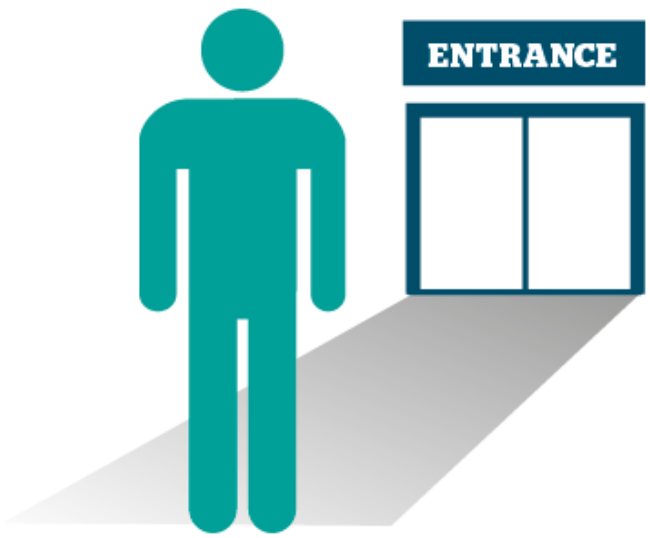
We were greeted by the Manager. We noted that staff wore different colour coded uniforms to denote their position at the home. All staff appeared caring and welcoming. We were encouraged by the Manager to go around the home and talk to residents and staff.

The Manager explained the Knoll Partnership are building a new care home, 'Bowfell House' in Flixton that is currently being built and scheduled for completion in summer of 2019. The new home will accommodate up to 40 people, residents from the Knoll and its sister home 'Fairways' will transfer into the new purpose-built home on completion. The Manager expressed her enthusiasm and delight for this new development, which will benefit residents and staff alike.

The dining room and communal lounge are situated on the ground floor. The dining room is a large and pleasant space that looks out onto the front garden. At the time of our visit we witnessed members of staff using the dining room to eat their lunch while pleasantly interacting with residents and visitors in the room. The dining room also housed a computer used by members of staff. Visitors we spoke to informed us that staff always make people welcome when they come to visit the Knoll.

There is communal lounge in the centre of the building with a sun room extension that leads onto the veranda looking out over a garden area at the rear of the property. At the time of the visit we observed a number of residents seated or sleeping in chairs dotted around the communal lounge. At the time of the visit we felt that there was a lack of additional seating for visitors.

On entering the home, the stairs, ground floor communal areas, toilets/bathroom and some residents' bedrooms lead off from the entrance hall. The home has one bathroom upstairs and a fully accessible disabled shower room downstairs.



We observed two bedrooms on the ground floor whose doors were open, both bedrooms appeared clean and tidy. The bathroom/wet room on the ground floor is clean and uncluttered, the room has a call bell that is easily accessible for residents.

On moving around the home, all corridors were tidy and uncluttered. Handrails were strategically placed around the building and we observed fire extinguishers throughout the home. We found that the signage to various areas of the home was displayed but not highly visible. This did not appear to impede residents as we observed them navigate the home with ease to access the rooms they wanted to visit. All areas of the home are clean and odour free.

Activities

The Manager informed us that there are two Activity Co-ordinators working at the home, *please see Manager's full responses regarding activities Appendix A.* At the time of the visit we witnessed an Activity Co-ordinator delivering a musical chair exercise incorporating a 'catch and throw' ball game in the lounge, some residents who took part in the activity appeared to enjoy it.

There is a television set in the communal lounge, which was being used for the morning's musical exercise. We observed photographs displayed in the lounge of residents enjoying day trips out organised by the home. *Please see Mangers full response in Appendix A.*

Fundamentals

During the visit we didn't see any residents drinking or with drinks nearby, however, the enter and view team visited the home at 1:00pm, a time when the dinner period appeared to be over with plates cleared away before our arrival.

The kitchen area is small and clean. The residents we spoke to told us that they were happy with the food, informing us that the food was good, one resident stated: "the food is excellent". We were told that changes have been made to menus when residents have made staff aware of their dislike for certain items on the menu. The Manager stated that the home constantly asks for feedback from residents. *Please Appendix A for Manager's response.*

We received a comment from one relative through the relative questionnaires who expressed the following view regarding the building:

"…. the facilities at the Knoll are a bit restricted due to the fact that it is an old building, with a small kitchen but they make the best of it".

When we asked if residents choose what they wish to wear. We were told that all residents are asked and supported to choose what they want to wear.

Care

The ambience of the home was very calm and comfortable. The social interaction between staff and residents appeared friendly and caring. Members of staff we spoke to during the visit told they were happy in their work and enjoyed caring for the residents of the Knoll.

Residents we talk to told us that they are looked after well and if they had a problem they would ask for help. One resident told us:

"….I cannot fault it here, I would recommend it [the home] to anyone"

Another stated:

"…the staff cope with me and others, full marks to them".

Though we received just three completed questionnaires all informed us that they were happy with the care that their loved ones are receiving at the Knoll. We receive the following two comments from residents, one who stated:

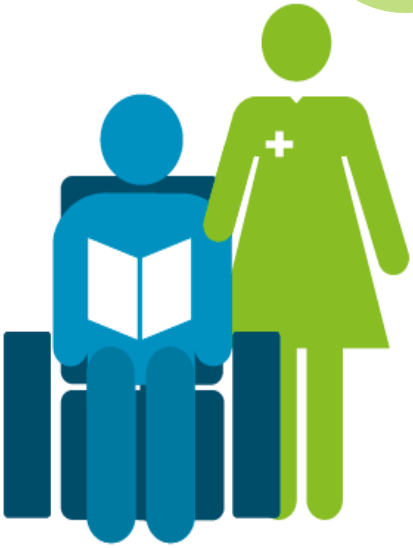
"I am a little bit lonely sometimes"

Another who said:

"If staff had a little more time to talk to us, but no, I am extremely lucky to get in here".

Profile of residents

On the day of the visit all residents living at the Knoll were elderly female, some residents were living with various levels of dementia, currently there are four residents without diagnosis.



Management of the Home

The following comments should be read in conjunction with **Appendix A**. The Manager has been in her post at The Knoll for more than 15 years and is extremely happy at the prospect of caring for her residents and staff in a brand new purpose-built care home. The transfer of residents will be managed carefully.

When we asked the Manager what the percentage of residents at the Knoll were living with dementia, we were informed that the majority of residents are living with various levels of dementia.

We asked about using the 999-emergency ambulance service, the Manager told us that it depends on the paramedics, some can be unresponsive and slow to respond, it really depends on the paramedic on duty at the time. The Manager added, that she wonders if paramedics view people in their 90s, as not a priority.

The Manager gave a recent account of a resident being discharge from Salford Royal back to the home. A resident was taken to Salford Royal, and the Manager informed staff at the hospital when discharging the resident back to the home not to do so in the evening as only one member of staff would be on duty. The request was ignored, and the resident was discharge at 12:30am. The Manager reported this action as a safeguarding issue to Trafford Safeguarding team on 21-8-18 and to date [5-12-18] had not received any response from the Safeguarding team. When the resident was brought back to the home she had a skin tear and when questioned about the tear the Manager told us that the ambulance staff were not helpful.

When we asked about accessing GP Practices, the Manager stated the home has a good relationship with the all the GPs apart from one GP [named]. The following statement from the Manager highlighted her concerns about a GP at the Practice:

> *"he [GP] gives a poor service, poor accountability and is rude". The Manager went on to say that the GP has refused to come out to residents at the home who are in their 90s. Subsequently, the home must then liaise with the residents' relatives to ask them to approach the GP as he is refusing to come to the home".*

When we asked about accessing a dentist, the Manager stated that it is "very difficult to source a professional when trying to obtain a dentist for residents at the home".

Prior to our visit, we asked what measures were taken if a resident has a fall, the Manager informed us that all falls are recorded and gave examples of action taken. *Please see Appendix A for Manager's response*. On the day of the visit the Manager informed to us that referrals to Falls Clinics do take a long time and that GPs are often reluctant to make referrals.

On enquiring about residents' food and liquid intake, we were informed that fluid charts are available if there is a concern with a resident, and the home has close links with the dietician and makes referrals on a timely basis should they be required. *See Appendix A.*

When we asked how residents and their families provide feedback or raise any concerns, we were told the home has both formal and informal structures in place and regular family meetings where residents and relatives are asked for feedback, positive or negative. *See Appendix A.*

We received the comment below from a relative with regards to staff talking regularly to relatives about their loved ones:

"with reference to section one [question on general health, bathing/personal care, hobbies/interests and medication], we can find out this information if we approach the staff, but they don't give this information unless you ask".

The Manager praised Local Authority Adult Social Care team [named the individuals] for the support they have given to her as Manager of the Knoll. The Manager went on to explain that the free training opportunities provided in the past for staff working in the care home industry by Local Authorities has disappeared over the last 10 years. Therefore, this new Partnership is a brilliant system that enables care home Managers to keep abreast of training and best practice. It enables information sharing with other care home Managers and enables care home staff to obtain the up-to-date relevant training to provide the correct support to the residents living in care homes.

When asked about advance directives, we were informed that all families are asked to help develop care plans for palliative care and this includes the use of advanced directives.

When we ask if there was anything else she would like to include in the report. The Manager wondered why the Knoll and her sister home the Fairways situated nearby are visited by different CQC inspectors. The Manager explained that it can be extremely frustrating and bewildering at resulting CQC reports that produce very different outcomes, which appear to be very different depending on the individual inspector.

Please note that any issues raised around the CQC and Local Authority processes will be raised in the monthly Joint Quality Improvement meetings, to whom this report will be submitted.

Deprivation of Liberties [DOLs][1]

When we asked about accessing Deprivation of Liberties Safeguards [DoLs] we were informed that the home had put in the following:

- a re-extension on 23.8.18 with Trafford, no reply to date [5-12-19].
- Put in an extension on the 22-2-18, didn't hear anything and chased up on the 22-8-18 and still waiting to sign off.
- Another outstanding DoLs from March 2018 and there are four more DoLs outstanding.
- request for a dietician to attend a resident at the home. Waited 18 weeks, the resident passed away before the dietician was due to attend.

[1] *The **Deprivation of Liberty** [**DoLs**] Safeguards are an amendment to the Mental Capacity Act 2005. They apply in England and Wales only. The Mental Capacity Act allows restraint and restrictions to be used but only if they are in a person's best interests.*

*Deprivation of Liberty Safeguards. The (**DoLS**) are part of the Mental Capacity Act and aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.*

Summary of relatives' responses to questionnaire

(see relative questionnaire in appendix B)

We left 10 relative questionnaires with the Manager of the Knoll to send out to relatives of residents living the home. We received three completed questionnaires from relatives. All the relative questionnaires informed us that they felt that their family member is treated with kindness and compassion. To see the full results of the residents' questionnaire we received back, you can find them at: https://healthwatchtrafford.co.uk/wp-content/uploads/2019/01/The-Knoll.pdf

Below are the comments we received from relatives and carers. Please note that, whilst we received three completed questionnaires from relatives and carers not all choose to complete the comment box section.

1. *"The Knoll is well run and the management, particularly [named], are kind, caring and efficient. The facilities at the Knoll are a bit restricted due to the fact that it is an old building, with a small kitchen but they make the most of it".*

2. *"With reference to section one [in the relative questionnaire], we can find out this information if we approach the staff, but they don't give this information unless we ask".*

Appendix – A
Management questionnaire and responses

Please note that responses are listed as they were received.

Pre-visit questionnaire for the Manager of

The Knoll Residential Home

Q1. How do you facilitate your residents and their families in raising any concerns they may have? Do you do this on a routine basis and, if so, how often?

We have both formal and informal structures in place. Informally we build very strong personal relationships with our residents and visitors; this enables the individuals concerned to talk to us openly about any concerns they may have.

More formally we operate daily service checks. These checks encourage all members of the senior leadership team to ask all our residents how they feel that day, how their meal was, if they have any concerns, if there's anything we can do for them. We hold residents meetings every 6 months (the last of which was held on 26/11/18) and regular families meetings (latest one held 27/11/18). Throughout the meetings we ask for all feedback – positive and negative so we can develop our plans for future developments.

Q2. Do volunteers come into the in the home? If so what type of activities do they do?

We have a very full activities schedule which includes 2 employed activity co-ordinators as well as regular slots given over to music therapy and exercise classes. We have volunteers from those who are undertaking DoE schemes and college placements. We are currently investigating local community groups to see what they can offer. We also have local schools and nurseries who visit the home on a regular basis.

Q3. Do other organisations come into the home? If so who are they and what do they offer?

Acorn House – local nursery bringing children in to sing and craft with residents

St. Monica's RC primary – to sing and put on performances

Zoolab – unusual animals for residents to hold and learn about

Apetito – for tasting sessions and meal planning

Music for health – activities and instruments

To name but a few ……

Q4. Do residents have fresh fruit and vegetables on a daily basis`?

Yes, we have salad items and fresh fruit available at all times. Two vegetables are offered with every main meal. Fresh fruit salads are regularly made and some residents will chose fruit after their meal rather than the desserts available.

Q5. Are drinks available and within easy reach? Are drinking levels monitored and recorded in care plans where there are concerns?

Yes, we are very dedicated to ensuring all nutritional needs are met, including sufficient fluid intake. Hot and cold drinks are very regularly offered throughout the day and night and can be requested at any time. We have fluid charts available whenever we have concerns.

Q6. Do you seek advice from nutritionists where there are concerns (residents losing weight or experiencing any level of pain)?

We have close links with Caroline (dietician) and will make referrals in a timely basis should they be required. We closely monitor all weights and MUST scores and have several members of our team who have been on MUST training courses. Every resident has an in depth nutritional care plan.

Q7. How do you gauge that residents enjoy their food and drink?

We have in depth care plans and regularly review menus in conjunction with residents. We include meals on our daily service checks, dine with residents, ask for feedback in meetings and via our QA systems. We also look at basic indicators such as stable weights and weight gain.

Q8. Does a single GP practice cover the medical needs of the home or do residents retain their own family doctor?

Residents are encouraged to keep their own GP if this is their preference. If someone is moving from another area, we ensure consent paperwork is completed and request information on preferred GP practice.

Q9. Which healthcare professionals visit the home at your request e.g., chiropody/podiatry, physiotherapy, district nurse, dentist or social worker?

Podiatry District nurses Social workers OTs and physios Tissues viability nurses Continence advisory service

Q10. If professionals do not come into the home, how do you access their services?

Any other services we require would be referred to in a timely fashion. This will be in line with their protocols and procedures – for example via the single point of access.

Q11. Are residents likes and dislikes recorded in care plans?

Yes, we have a distinct area of our system for recording this information.

Q12. Are residents encouraged to talk about their past lives and how do you encourage this? Examples might include local history books, old photographs or films.

Yes, all our residents work on their own life history books. We have one-page overviews and previous experience plans. In January we are starting on new one-page profiles. Our activity co-ordinators work hard to ensure all residents are involved. They spend time on a one to one basis, looking at old books from the library, their own personal photo albums, sensory work with music and quizzes and building on reminiscence sessions.

Q13. Do residents have choice over what they wear each day?

Yes, all residents are asked to choose their own clothes. If they struggle with the level of choice, we can restrict it to two or three items and offer full support. The level of support required is recorded within care plans.

Q14. How do you cope with making reasonable adjustments in relation to residents with dementia, learning disability or other special needs such as autism or challenging behaviour?

All are care team are trained in dementia, both theoretically and practically. We use signage and equipment to ensure residents can be as independent in their choices and daily living as they would like.

Q15. How do you address the needs of people from minority ethnic groups or of different cultures and faiths?

Person centred care planning is central to everything we do and this includes recognising people's personal identities and appreciating and valuing cultural differences. We have ministers from different faiths available for us to access as required. We have members of the team who have attended equality and diversity training.

Q16. Do you have visiting faith leaders in the home?

We do. Historically we have had different faith groups visiting the home. Currently we have a Catholic minister and priest who visits weekly.

Q17. Do you encourage family and friends to think about having advance directives?

All families are asked to help develop care plans for palliative care. This includes the use of advanced directives and DNACPRs [Do Not Attempt Cardiopulmonary Resuscitation].

Q18. Do you invite the community to bring in pets?

We have had local groups such as Zoolab and an Owl Sanctuary bring their animals in and visitors and members of the care team have brought their pet dogs in.

Q19. Do you have regular meetings with residents' families?

Yes, as question one above. We have 6 monthly families meetings and endeavour to meet with families every month or two to discuss care plans and look at what works well for each individual.

Q20. Do you take residents out into the community?

We do. Our activity co-ordinators work very hard at this. We visit the Toy Library at the Delamere School, we have lunches out at The Roebuck several times a year (next one 06/12), Coffee and Craft on Church Road, Parkers Garden Centre in Flixton, Charity Shops and parks. This year we have also visited the Imperial War Museum and The Trafford Centre.

Q21. If a resident falls, what measures do you follow? Do you call a GP, the ambulance service or utilise other measures? Do you record falls in every care plan, however minor or major?

All falls are recorded in the accident book and the individuals care plan. All falls are audited and tracked. The measures taken are different in different circumstances. Healthcare professionals are referred to as necessary. If there is injury or potential injury, then advice will be sought. If a resident has regular falls referral to the falls clinic via GP will be made. Our audits will allow us to identify any trends and patterns. All falls are appropriately recorded and 48 hour monitoring instigated. All statutory notifications are made in a timely fashion.

Q22. What preventative action do you utilise to prevent falls? Have you access to a falls advisor?

We have bed and chair sensors, risk assessments, FRASE assessments, all the care team are trained in appropriate manual handling operations. We will make referrals to the falls clinic as required and we have team members who have undertaken falls prevention training.

Q23. What feedback have you had from residents in the last three months which have resulted in change?

We had a couple of items on the menu that the residents didn't like so we removed those items and have asked our providers to host another tasting session. We constantly ask for feedback.

Q24. How do you keep abreast of good practice? Examples might include e-learning packages, formal training, mentoring, staff appraisal?

The management team are proactive in seeking out learning opportunities. The manager is currently undertaking a leadership course. We attend conferences and meetings which support us in our role and keep us up to date with legislative changes or innovations in best practice.

We have recently updated our whole system of team meetings, supervision and appraisal. We were also one of the first homes to get on board with Trafford's new training scheme.

Q25. How do you prevent residents' feelings of loneliness or isolation?

We believe we know our residents well and by doing so we can support them in their daily living activities.

Q26. What are the practical everyday things that would help you to provide the best possible care for your residents? Please describe?

We put the residents at the centre of everything we do and constantly seek to tailoring their care to their specific needs. The activity schedule is varied and interesting. We seek to engage all residents in the own care planning, planning activities and just finding the time to talk.

Feel free to continue any answers onto a separate piece of paper if necessary, but please add the question number to the answer.

Appendix - B
Relatives' questionnaire

1. Do staff talk to you regularly about your loved one's: -			
General Health?	[ ] Yes	[ ] No	[ ] Don't know
Bathing and personal care?	[ ] Yes	[ ] No	[ ] Don't know
Hobbies/interests?	[ ] Yes	[ ] No	[ ] Don't know
Medication?	[ ] Yes	[ ] No	[ ] Don't know

2. Do you think that your loved one; -			
Is happy with the care received?	[ ] Yes	[ ] No	[ ] Don't know
Has plenty to occupy them?	[ ] Yes	[ ] No	[ ] Don't know
Enjoys their meals?	[ ] Yes	[ ] No	[ ] Don't know
Enjoys the company of other residents?	[ ] Yes	[ ] No	[ ] Don't know
Is lonely?	[ ] Yes	[ ] No	[ ] Don't know

Do you know whether: -			
Staff know about the work or family interests of your loved one?	[ ] Yes	[ ] No	[ ] Don't know
Take them out into the community (shops/libraries, local events etc.)	[ ] Yes	[ ] No	[ ] Don't know
Are they treated with kindness and compassion?	[ ] Yes	[ ] No	[ ] Don't know

Are you:-			
Consulted on changes needed to care plans?	[ ] Yes	[ ] No	[ ] Don't know
Are you kept informed about the home's developments/plans etc. (i.e. Carers/residents meetings)?	[ ] Yes	[ ] No	[ ] Don't know

Please add in any other comments or observations you would like to make in the box below.

Would you recommend this home to anyone else?

[ ] Yes [ ] No [ ] Maybe

Overall, on a scale of 1 to 10, how would you rate this home?

(with 1 being very poor and 10 being excellent

out of 10

Distribution

This report will be sent to the following organisations:

The Care Quality Commission (CQC)

Trafford Council:

- Trafford Health Overview and Scrutiny Committee
- All Age Commissioning Team

Trafford Clinical Commissioning Group (CCG)

Healthwatch England

Chief Nurse, NHS Trafford CCG and Corporate Director of Nursing Trafford Council

The provider visited

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