My Care My Way – Home First
Additional Questions & Answers

At the five public events during November & December 2016, each event included an open Q&A session for attendees to ask questions which were answered by the panel – these form part of the Feedback Report.

We also asked people attending the events to submit any additional questions, to be reviewed and answered after the events. This document lists all the additional questions that were submitted, with answers to each question.

The question number initial letter relates to the event at which the question was submitted:-
H = Hartshill, **L** = Leek, **C** = Cheadle, **M** = Moat House/Festival Park, **B** = Bradwell

Bed closures	
Temporary Closures	
LQ11	Why do you say that the beds have been closed are "temporarily" closed? They quite clearly are not temporarily closed as all the staff from Cheadle wards have been moved elsewhere or are being made redundant!
	These beds are temporarily closed as we are still going through a period of consultation and engagement. No decision will be made until we have gone through that process.
CQ15	Why was the decision to 'temporarily' close the beds at Cheadle Hospital made so quickly.
	Please see LQ11.
CQ19	You keep saying it is a temporary closure how can that be when people have been made redundant. Beds have been taken, work together as 6 weeks is max stay. You said on radio Stoke on Wednesday that this My Care/My Way system is not working, we could have told you that.
	Please see LQ11. It is the current system which is not working, My Care My Way is the proposed new model.
CQ16	How are the facilities ie. Building wards etc. being maintained during this period of 'temporary closure' as the only staff left in services are two porter/caretakers.
	The buildings are still being used for other things whilst the temporary closures are in place. There is money in the budget for the continued maintenance and overheads.
Other questions about bed closures	
CQ7	If there is a bed blocking issue-which is being looked at-why take away THE SAFETY NET OF COMMUNITY BEDS UNTIL THIS IS SOLVED?
	We need to be able to release the money from the beds to increase capacity in the community. This is a key element of the My Care My Way model. It is not safe to keep people in beds once they are medically fit for discharge.
CQ32	Why close the wards before the packages are in place.

	People should not wait in beds for packages of care – please see CQ32.
CQ38	The basic question has not been answered, ie. How does closing down an essential facility (community beds) help to improve RSUH efficiency?
	This isn't about closing down facilities, the My Care My Way principle is to return people to home, not retain them in a bed. By doing so we can shorten their length of stay and the waits for people to get into a bed based placement. My Care My Way also looks at keeping people at home rather than ending up in an acute bed. If you can reduce the number of people needing to go to hospital then you can also reduce the number of beds needed.
CQ46	If you have to close some community beds, then why not spread them over all community hospitals?
	Closing a couple of beds on individual wards would not release the same level of funds. This money is needed to increase capacity in the community.
CQ49	Why did you remove beds from Cheadle? You said there was a need for them elsewhere, so why not use them in Cheadle, and save the cost of moving them.
	The physical beds transferred to the Harplands, which provides EMI (Elderly Mentally Impaired) specialist care.
MQ6	Why was money spent upgrading community hospital wards prior to bed closures?
	Whist the wards were open we needed to make sure that they were safe and maintained.
CQ11	Is it realistic to shut Cheadle Hospitals as the area it serves covers very rural isolated communities with low personal car usage & almost absent public transport.
	Cheadle hospital is not closed.
BQ23	How does the closure of 26 beds at Brighton House have an impact on provision for the intermediate care in Silverdale?
	This decision was made by Staffordshire County Council. As we have built up an increased enablement service there is the potential to offer individuals who were placed at Brighton House care at home.

Community Care	
Staffing (including time and training)	
MQ1	I am currently working within a very busy district nursing team and I am also undertaking my specialist practice degree. I think that the model of care is good and I am fully aware that change is needed however my question is have you got the resources available in the community for us to do our job effectively and efficiently? As I feel we will have an increased caseload.

	As CCGs we have increased our funding of Community Nurse staffing across Northern Staffordshire and work closely with Staffordshire and Stoke-on-Trent Partnership NHS Trust to ensure that resources are there for patients when they need them. Please also see BQ13.
CQ9	Is there the skill-set available in the care homes? Often patients have to be admitted for IV antibiotics/blood tests etc. These could all be done in community beds and these are the hidden costs which are not taken on board.
	We are currently working on developing a IV at home pathway with the Staffordshire and Stoke on Trent Partnership Trust (SSOTP) and the GP federation. The skill set is in place already and is commissioned via the Intermediate Care team. Community phlebotomy service for blood tests is widely available and the CCGs are scoping near point testing to support diagnostics closer to home. It is important to remember that there are still community beds in place at the Haywood which delivers step up, short stay capacity for patients requiring a short period of additional tests, assessment and /or treatment.
HQ7	Are you going to increase District Nurses numbers in the Community?
	Please see BQ13.
LQ15	Have you considered using an organised volunteer force-the police have specials, the Fire Service Retainers and the Ambulance Service First Responders, Could there be a community care service of volunteers?
	There is a strong commissioned voluntary sector network, e.g. Saltbox and Revival. The services they provide include a be-friending service and people to take patients home, make follow up contact and make sure there is food, warmth etc. at home. These volunteers are not medically trained.
CQ14	Several staff in the care setting had left “care in the home” as they got no job satisfaction, due to lack of time, travelling, etc. Where are you going to get the staff from?
	This is domiciliary care which does not fall under the NHS. Enablement is health provision, and health is under the agenda for change guidance.
CQ25	Even with GP-based wrap-around services do you not still foresee that there will be an ongoing problem with GP recruitment?
	GP services are commissioned by NHS England – their reply is as follows:- There is a national challenge with GP recruitment, which is being responded through as part of the GP Forward view. It is planned that there will be doubling the rate of growth of the medical workforce to create 5,000 additional doctors working in general practice by 2020/21. NHS England are working closely with Health Education England to: • Increase GP training places to 3,250 a year to support overall net growth of 5,000 extra doctors by 2020 (compared with 2014). • Attract up to an extra 500 appropriately trained and qualified doctors from

	overseas. • Roll out 250 new post-certificate of completion of training (CCT) fellowships to provide further training opportunities in areas of poorest GP recruitment. • Attract and retain at least an extra 500 GPs back into English general practice. This will help support our position locally. However also as part of the GP Forward View, there are plans to broaden the skill mix and roles within the general practice team. Such roles include pharmacists, physiotherapists, paramedics, Urgent care practitioners, Physicians Associates, Nurse practitioners, mental health therapists. There also training programmes being implemented to help support the navigation of patients to appropriate alternative services to general practice and to help release GP clinical time within practice. Work is also commencing locally on getting positive messages out regarding how rewarding working as a GP is. There is also work ongoing with practices starting to work more collaboratively to help ease some of the workload and workforce pressures. It is anticipated that all these programmes of work collectively will ease the pressure on GPs time.
LQ12	Concerns over the impact of Brexit and staffing levels? A loss of freedom of movement? Effects on staff retention etc.
	The impact of Brexit remains to be seen. Staff planning is part of an ongoing process.
CQ31	What staff have you in place to care for people in the home.
	We commission Intermediate care, District nursing, falls service, community matrons, palliative care, out of hours nursing, specialist long term condition nursing, reablament services and we also invest into social care across Stoke and North Staffordshire. The CCG buys services, KPIs and outcomes and therefore staffing numbers against each of the services would need to be provided by the provider.
MQ17	What is being done to recruit more GPs?
	As CQ25
BQ10	50 staff 1000 hours, is this 20 hours per person per week? Is it better to employ 25 staff on a 40 hour week? This would give lower overheads in management etc.
	These figures allow for around 40% of an individual's time which will be taken on travel/administration, and includes an allowance for annual leave, sickness, training time etc. These 50 WTE (whole time equivalent) staff members will not always be working on face to face care.
BQ13	Have the numbers of district nurses, and retention of them been addressed (this does not include regrading/classifying of Health visitors)

	Health visitors are no longer the responsibility of the NHS, they have moved to the local authority. Community nurse staffing is a focus for the CCG and whilst recognising the absolute importance of District Nurses not all care that is required in the community from a nurse needs to be from a District Nurse. Therefore we are working with Staffordshire and Stoke on Trent Partnership Trust (SSOTP) to ensure that the correct nurse staffing levels are in place. This means that Associate Nurse Practitioners, Community Matrons, Staff Nurses, Health Care Assistants and District Nurses are available to provide the right care when it is needed.
CQ24	Is adequate training in place for quality domiciliary care?
	Domiciliary care is commissioned and provided through the local authorities either in house or via a framework provider. The Local Authorities are therefore responsible for ensuring that training and competencies are in place for the staff delivering care.
Feasibility – will it / can it work?	
HQ2	Is care in the community working and how well or is it an aspiration to get it started. Until care in the community is established then no community beds should close. If private nursing homes are used then there is ?? (illegible words).
	We know that Care in the community works well with good outcomes. Significant capacity is in place and the CCGs are working to bring additional capacity on line utilising the funds released through the temporary closure of the community hospital beds. The CCGs are not in a position financially to double run services and need to ensure that capacity is in place to meet demand.
CQ21	Can alternative care be properly provided in the 1° sector? The public perception is that it can't.
	The public perception is that hospitals and hospital care are the best for people – but a lot of people don't need that level of care. They need care at home which is appropriate for their needs.
CQ41	Where is the care in the community because it seems that it is family and friends that are picking up the bulk of the work and help to care for a number of friends because they have been sent home not able to walk or feed themselves?
	Please see BQ13.
CQ53	I well remember the last great "Bed Blockers" situation in the 1970, the NHS simply "dumped" tens of thousands of patients into the community for a newly created social services department to deal with, but redirected no money to cover the costs, as social services "No Longer" exists, or barely, and some elderly are accepting "Direct payments" it seems to be a case that NHS are trying to "Dump" patients in the community without proper planning again, as a means of protecting finances, for NHS Why?
	We have very clear and transparent plans which show that money needs to follow patients into community services rather than allocated to beds.

MQ11	How will patients be discharged sooner when their care needs at home may not be in place?
	Patients will be taken home with enablement services where further assessments of their care needs will be taken. This is expected to be within 3 days of when they are medically fit for discharge. This is the capacity which has been built into the system.

Patient Safety / Patient Care	
HQ12	A concern after hearing about hospital release back to home, is safety, especially as relatives of the patients released are elderly themselves who say they will look after them but in reality are not able. Who will take responsibility for the safety of discharged patients?
	Currently, 87% of patients are discharged home without any service or input from other professionals. Nationally best practice sees 90% of patients discharged home with no service. For the current 13 % of patients discharged either to a bed based service or home with support, the individual will receive any support from the receiving service. All needs will be assessed holistically and this is a model of care that functions successfully across other parts of the country and is held in high esteem by clinicians.
LQ2	Needs are going to vary, how are you going to ensure that each part of the package is suitable for that particular patient. What supervision is going to be available to ensure patient safety?
	Every patient that goes into the enablement service will be supported as their needs dictate on discharge. Through on going assessment support will either increase or decrease as the patient goes through their recovery.
LQ4	What supervision is going to be available to ensure patient safety?
	As a CCG we have systems and processes in place to monitor all NHS funded care. This already includes people who are placed in care homes, who receive Continuing Health Care (CHC) funding. Where we directly commission beds in care homes the quality monitoring will be as robust as the monitoring in NHS hospitals.
CQ48	Why are you putting people in this area at risk by taking the actions you are doing?
	We do not believe that this programme of work will be putting people at risk. Please see the other questions in this section which relate to patient safety.
MQ2	Will the patients have safe discharges and be assessed or deemed safe enough to go home appropriately? Where is the social input?
	Everyone will be assessed by a multidisciplinary team including colleagues from mental health, social care, the voluntary sector and community specialists to ensure it is safe for them to go home.
MQ12	Can you guarantee that patient care will stay at the same level or improve?

	We carry out a Quality Impact Assessment on all proposed changes to NHS care. This determines whether the change will have a positive, negative or neutral impact. If it is thought that there is a possibility of a negative impact then recommendations and changes are made to ensure this does not happen.
MQ13	How can you ensure that care homes are correctly manned, have the appropriate skills and work alongside primary care to ensure patient safety?
	The Care Quality Commission (CQC) regulates all care homes and this includes the staffing levels for their patients. Where we directly commission beds we will ensure through our quality mechanisms that the appropriate numbers of staff with the correct qualifications and competencies are available and we will utilise the contract to do this. Each person in the care home has a registered GP who have their professional requirements to deliver quality care to their patients. As a CCG we will also look at this in terms of any enhanced care provision whether that be the requirement for a GP, Physiotherapist, Social Worker, Occupational Therapist, Dietician etc.
BQ15	With regards to concerns about patients 'de-compensating' whilst in hospital wards is this due to: A lack of funding for therapeutic care in hospitals and under-staffing. How can you be assured that similar decompensation does not occur in patient and home dependant on social care provision – have you measured this and have evidence?
	The hospital environment does not lend itself to people continuing with independent living i.e. prescribed mealtimes, remaining on a bed, medication at certain times, inability to make your own drinks, chat with friends when you like (maintaining what you would do at home). A care home environment lends itself more to this, as it is less focussed on routine and more on homeliness, while still ensuring safety and care provision when required. In a care home environment you can have your own room, TV, personal possessions, your own bathroom and no restricted visiting. There are also things like social events in care homes that would not be possible on a ward.
BQ17	Decompensation occurs in patients in acute care beds – is there a difference for intermediate care beds?
	Please see question BQ15. Decompensation can occur across all beds. Within the My Care My Way model rehabilitation and enablement are absolutely key, and part of the care required in the ongoing intermediate beds.
BQ18	Given the well documented cuts to social care, which is in crisis, is the current policy to close Bradwell Hospital Wards a safe policy?
	We have to ensure that there are services available to our public when they need them. Keeping people in Bradwell Hospital, who do not need to be there, will increase their need for care when they are discharged. We are aiming that people leave hospital with the right care which will help them live more independently and require less social care in the long run.

Carers	
MQ30	What measures are being put in place to reduce the negative impact of Home First on unpaid/informal carers stress, before the person who is cared for returns home from hospital without rehabilitation being done?
	We do absolutely need to do more about caring for our carers, but we do not believe that MCMW would have a negative impact. We would aim to minimise any impact through support from individuals as needed. There would be more input during the rehabilitation phase.
MQ5	Do you realise a lot of informal carers are 65+ and unable to keep themselves fit and well due to caring responsibility?
	We recognise the valuable work of informal carers, and we would encourage anybody who needs additional support to contact the North Staffordshire Carers Association.
MQ8	How can you make sure that informal carers are supported and taken care of?
	Please see MQ5.

Prevention / Selfcare	
HQ6	CCGs need to let patient panel groups know what they can do in Doctors' waiting rooms to get home the messages about "Take Care of Yourself" = Preventative ideas-can you do that please?
	The CCGs recognise the important part Patient Participation Groups (PPGs) play in sharing these messages. Our next Community Conversation will focus on PPGs – please sign up to our newsletter to find out more. http://www.stokeccg.nhs.uk/stoke-ccg-membership-form http://www.northstaffsccg.nhs.uk/membership-form
HQ11	How can I convince my doctors to come in line with flo, monitoring equipment to help with my medical conditions, and with my self-management, where can I get help in exercise or anything else to keep me as fit as I can be?
	Flo sign up is through practice choice, so please discuss this directly with your practice. Your practice may also know of local options for keeping fit and exercising. If you have a community building or a community notice board this can also be a great place to start.
CQ47	Why are you not more supportive to organisations like Moorlands Home Link, who strive to provide preventative care in the area?
	We are currently reviewing all of the voluntary sector grants and contracts to align them to the principles of My Care My Way.

Estate – Cheadle Hospital	
CQ2	Is Cheadle Hospital a building that is owned, if so who is it owned by.
	All NHS buildings are owned by Whitehall (the Treasury). Staffordshire and Stoke on Trent Partnership Trust (SSOTP) manage the hospital.
CQ17	What are the plans for existing outpatient services at Cheadle Hospital. Some services i.e. Diabetes are already talking of finding new premises.
	The next phase of consultation will begin after NHS England has assured our proposals. At the earliest this will be from 8 May 2017, due to local council elections.
CQ20	What future plans for Cheadle Hospital? How can you put a price on people's lives.
	As CQ17.
BQ6	Why are empty wards in Cheadle Hospital still using resources such as heating/lighting? (Lights on but no-one home)
	These wards are temporarily closed and as such still need to be maintained.

Engagement	
CQ50	If decision is not yet made, why are beds disappearing (167 on 25/11/16)? Staff being recruited (District Nurses ET AL)? Silly, untrue Logo's Created? If "Consultation" is to take place why are these things in place.
	Any closures which are currently in place are temporary closures, and staff recruitment is in line with the My Care My Way model and principles. The next phase of consultation will begin after NHS England has assured our proposals. At the earliest this will be from 8 May 2017, due to local council elections.
HQ5	Why are the shop floor workers involved more in setting up services. I would welcome an involvement.
	Our engagement and consultation opportunities are open to all, so please take part.
HQ8	These events have not been advertised to the public, Why have they not been advertised? The public are not here in great numbers today because they do not know about the Event dates. I do hope that the CCGs do not claim that there "was a poor attendance at the events" – PUBLICITY NEEDS IMPROVING
	All events have been published using a variety of methods including the CCG websites, CCG social media (Twitter and Facebook), membership news, newsletters to GP practices,

	articles in partner newsletters (e.g. Healthwatch and VAST) and through local Patient Participation Groups (PPGs).
HQ9	This afternoon's event was only notified by E-mail to GP's yesterday (9/11/16) Why?
	The dates of the events were shared with practices on November 3rd.
LQ7	Why is so much information in engagement briefing differs so much to e-mail 14/11/16 (XX csu).
	All correspondence was based on the engagement briefing which can be found on our websites:- http://www.northstaffsccg.nhs.uk/my-care-my-way-home-first http://www.stokeccg.nhs.uk/my-care-my-way-home-first
CQ18	When and how will details of the consultant process be advertised.
	The next phase of consultation will begin after NHS England has assured our proposals. At the earliest this will be from 8 May 2017, due to local council elections. All information will be available on our websites (as well as through wider methods – please see HQ8). To receive our monthly newsletter, please join our membership scheme using the links below. http://www.stokeccg.nhs.uk/stoke-ccg-membership-form http://www.northstaffsccg.nhs.uk/membership-form
BQ15	What proportion of participants in the consultations were members of the public rather than people associated with healthcare organisations such as Health Watch.
	We did not collect this data as part of the survey.
MQ22	Do certain venues cost more than others, wouldn't it be better to use local meeting areas.
	We do use local meeting rooms, and try to ensure they are free of charge wherever possible. We are always looking for new venue ideas, and would welcome any suggestions.
BQ11	Has an equalities impact assessment been conducted relating specifically to the closure of the Bradwell wards.
	Both an Equality Impact Assessment (EIA) and Quality Impact Assessment (QIA) have been carried out for the My Care My Way model as a whole. An EIA was also completed on the engagement plan.

Finance	
Cost of beds	
CQ23	Were the costs of residential/nursing home beds costs to the NHS or users?
	There are two types of beds in care homes. Some are commissioned by the CCGs to provide continuing healthcare and rehabilitation services to support people following a hospital admission. These are paid for by the NHS and are free to the patient. The other kind of bed is a residential bed, commissioned by the Local Authority and means tested - so patients may have to contribute towards the cost.
CQ30	Could you please explain how it costs £210 (break down) to keep someone at home and £2100 to keep them in hospital?
	£210 is the average cost for a 15 hour care package. £2100 is the average cost for a community hospital bed per week.
CQ43	Please can you let me know the average cost of a 24 hours stay at the Royal Stoke Hospital?
	The cost of an overnight stay in hospital varies according to the location and the type of services needed. However, the Department of Health estimates a hospital stay is £400 per day.
HQ3	Why is a community hospital bed £2100 per week? How do you reach that figure? Why is it so much more expensive than a nursing home?
	The community hospitals are an expensive resource and the overheads associated are high. The CCGs pay an average of £2100 a week per bed which includes staffing costs, corporate overheads and indirect costs. The beds are funded via a block contract and the provider is not in a position to reduce the costs of the beds.
CQ10	Are community beds a facility which could be re-assessed i.e. reduce the cost down below the £2,100 stated. i.e. look at the cost/services provided to give an alternative to the high value now. So just providing an intermediate space between hospital & home?
	The CCG have already looked in to this but unfortunately it has not been possible. Please also see HQ3.
Personal Health Budgets (PHBs)	
BQ1	Where do you feel that Personal Health Budgets will feature in the My Care My Way – Home First Scheme?
	NHS England define a personal health budget as an amount of money to support the identified healthcare and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the local clinical commissioning group (CCG). That individual (if eligible) will decide if they want a personal health budget, and how they would like to spend it (subject to certain criteria).
BQ2	As My Care My Way Home First fits in with the Personalisation agenda, do you feel that Personal Health Budgets can be used to save funds in the longer term. How may these be used by clients?

	Please see BQ1.
Deficit	
BQ19	In 2010 NHS and CCGs nationally were in surplus – what are the reasons now, within 6 years for the CCG to be in deficit?
	There are a number of factors which have all had an impact, including increased demand and complexity, an aging population, more complex health needs, long term conditions and advances in medicine (which whilst positive can be more costly). The CCGs are being asked to achieve considerable savings to address this deficit.
BQ25	? 15 Million deficit also ? NHS will pick up the cost. Question is will the care be better or not?
	Across many services we are aware of waste, for instance repeat medicines received and not used, the way hospitals buy things and the way we organise care. There are efficiencies which can be gained whilst improving the quality of care and indeed the outcome for patients. Quality will be assured through our contracts and contract monitoring.
Other questions about finance	
HQ1	I seem to remember this government promised to put additional funding into the Better Care Fund. How much of this additional funding has been received by North Staffordshire?
	No additional funding has been made available by the government.
LQ10	What are you doing to fight the cuts and lobby against them?
	CCGs are politically independent, and as such are unable to take part in these activities.
LQ14	If private providers can make good profits from providing services to the NHS why don't the NHS provide them themselves and save money?
	The NHS is here to provide a service which is free at the point of delivery, not to make a profit.
MQ24	Is NHS money being used for social care?
	The NHS is supporting social care through both the Better Care Fund and pooled resources. It is the responsibility of the local authority to commission social care.
BQ16	Where is the investment in commonly, home based and patient centred services coming from? What is the plan?
	Planned investment in community services started over 3 years ago, and over 14 million pounds has been invested. A reduction in beds offers more opportunity for this provision, along with the opportunity to better provide prevention and primary care.
LQ5	In a climate where carers can still arrive at 11am to get a reablement patient out of bed and return at 6pm to put them to bed. How can you ensure that 'cost is not given priority over quality?' Money spent on poor care is money wasted.
	We are significantly increasing the enablement capacity to support this. Every effort will be made to provide care which supports individual need. The CCGs have invested an additional £3.9m into reablement services for 2017-18 to support the home first principles to support additional staffing in line with the Discharge To Assess model of care. The CCGs changes are not about cutting costs

	but reinvesting money into services that deliver better outcomes for patients.
CQ1	As a lay person, I see things simply. More money is needed for care, all care, can you not manage with less admin staff? A nurse who reported to her direct boss, 5/6 years ago, now has 3 people between her and her direct boss, why? Surely there is someone with common sense to look at admin, it isn't rocket science. Too many people in ivory towers believing their own publicity!!
	Since 2010 there has been a national drive to reduce management costs across the NHS. By working more closely together, North Staffordshire and Stoke on Trent CCGs are able to save money by reducing duplication.
CQ28	Can I ask why the cuts are always at the patient care end instead of in management posts where the salaries are much higher, and therefore would create more money if they were reduced.
	The My Care My Way model is not about cuts, it is about changing the way in which care is delivered, and helping patients to stay at home (where appropriate). Please see questionCQ1 for management costs.
MQ7	Is My Care My Way Home First in operation? If not when will it be in position, when you have no money to set it in motion.
	We have been putting in place the principles of My Care My Way for the past 3 years. The next phase of consultation will begin after NHS England has assured our proposals. At the earliest this will be from 8 May 2017, due to local council elections.

Other questions submitted at the events	
CQ12	Several years ago I was on the patient panel discussing the "new" NSRI and we were constantly being told that everything would improve as so many extra beds would be available in community hospitals, taking pressure off NSRI what has happened to this plan?
	There is recognition that thinking has changed, and national guidance is about the use of community home first principles as a means of providing rehabilitation rather than bed based care.
CQ34	What provision will there be for respite beds, never easy to get for people being cared for at home, but now you have removed the one's at Cheadle Hospital I assume it will be impossible. Other certified countries discharge people from hospital to rehab, and then home.
	There weren't any respite beds at Cheadle. We still have bed bases to support rehabilitation where appropriate.
BQ14	Given the continuous need to re-open the wards how does the CCG anticipate coping in Winter 2017.
	The CCGs believe that good winter planning is key, building in escalation capacity not just through beds but through whole system escalation capacity across community and primary care.
HQ4	What is the back-up plan when nursing homes close due to underfunding?

	Given our aging population, we have recognised the need to work closely with the care home sector and look at how we can support them. We currently have a pilot scheme of a care home matron for a 12 month period. We do recognise that it can be a volatile sector in terms of finance for organisations. We are mindful of the organisations we work with to ensure we do not have to move people around different care homes due to closures through lack of finance.
CQ42	What do you propose to do if you have sent someone home from an acute bed and it doesn't work-back to acute bed? We need an ????? "Local hospital".
	There is always the opportunity for patients to be readmitted to an acute centre if it is appropriate for their needs and we do still have access to community hospital beds which if appropriate can and will be used. This will be alongside community services to support people to stay at home.
MQ10	How are you going to ensure that the pressure of these complex patients being sent back into the community doesn't land completely on primary care (as there is not the capacity of community workers to handle this demand?)
	We have built robust community services that will have independent medical support and governance built into them. We are also working closely with primary care to ensure the links aren't lost.
CQ29	OOH's, DN's and MH - need more across 24/7- not enough support from alternative pathways. Why are they closing the HUB?
	Out of Hours (OOHs), District Nurses (DNs) and Mental Health (MH) are provided over a 24 hours a day, 7 days a week basis. The hub is going through a period of redesign which will align it to the principles of Keogh.
CQ13	Winter 2015 – I paid for respite so I wouldn't bed block at Leek Moorlands (I was no weight bearing after an accident). It was constantly on the news that NSRI were full. The manager of the care home in Stoke-on-Trent phoned NSRI to say she had 8 respite beds available. No one phoned her back as promised, or even asked about costs etc. Why Not?
	We are unable to comment on individual cases.
MQ3	Can you provide proof that DSTs are being performed as quickly and as efficiently in nursing home commissioned beds? Are there enough staff to complete the process?
	A DST is the assessment for long term funded care. The CCGs commission a full wrap-around team to support the process in line with the national guidance. Full training has also been provided via the Continuing Healthcare team. We are seeing turnaround times in line with those seen within the community hospitals.
CQ36	Just a thought if we (Moorlands Homelink) had to fold who would take up the care of these vulnerable people? The 4 questions could all be linked to the services we provide in Moorlands Homelink.
	Please see LQ15 and CQ47.

CQ8	Is it possible for paramedics/district nurses/voluntary sector services to meet regularly to discuss issues relating to help-using first hand expertise?
	There is an A & E board which meets and has representatives from all of these areas.
CQ40	I asked Marcus at Leek why the emergency mental health beds were not available locally. People have been taken to S. Wales, Kent, Scottish Borders etc. Also admitted to police stations, prisons and in a couple of instances nowhere could be found. As enforced admissions follow a legal process this is unacceptable, I am still awaiting an answer.
	We are currently working with North Staffordshire Combined Healthcare and Brighter Futures to provide four local emergency mental health beds to reduce the need for patients to go out of the area. These should be in place by April 1st 2017.
MQ20	Health tourism-what are you doing to stop this, non-English speaking bring their own interpreters.
	This is a matter of National Policy.
CQ58	Would you not agree that clear efforts should be made to stop: Theft from the NHS, Health tourists, including brits who return "Home" each year for a total medical, dentists, hospitals, and c. Resolve the overstaffing, inefficiency and empire building, for non-medical areas.
	As MQ20.
MQ19	Teenage mental health-what are current arrangements. Discharge at unrealistic times-Does Stoke discharge at night?
	Discharges from in-patient child and adolescent mental health services (The Darwin Unit) only take place within daytime hours. If the query relates to the Royal Stoke Hospital and a young person is admitted for a mental health related issue, NICE guidelines should be followed that any person under the age of 16 stays overnight and is reviewed by a child and adolescent mental health professional the next day. If a young person attends the accident and emergency department and does not require admission, a discharge may take place out of hours if this is appropriate, but a mental health assessment should take place. If these guidelines have not been followed we will follow this up if further details can be provided.
MQ4	Is it your intention to continue to commission AMG care packages?
	We are currently reviewing all contracts with private providers to ensure we have the best opportunities available.
MQ16	What % of people going to A&E should not be there,
	UHNM do not collect this data. However, the Health and Social Care Information Centre suggest around 13% of people who attend A&E are discharged without requiring treatment. The Royal College of Emergency Medicine found that 15% could have been treated in the community, though this is not to say that they all went to A&E 'inappropriately'.
MQ18	Has communication between Hospitals and Social Services (care) improved to prevent bed blocking-out of area.

	The Sustainability and Transformation Plan (STP) for Staffordshire is about joining up to look at a whole system solution.
MQ21	Has admin been improved- I personally had an appointment, it was cancelled 4 times each time I had a letter (4 pages) to cancel, then letter to re-appoint with 4 more pages. Can this system be improved?
	Please share your feedback with the Patient Advice and Liaison Service at the Hospital, all feedback is welcomed. Telephone: 01782 676450 or 01782 676455 or email: patientadvice.uhnm@nhs.net
BQ8	Pharmacies are under threat, what will the CCG's do to support them?
	Pharmacy services are commissioned by NHS England and not the CCGs but the CCGs has a Medicines Optimisation Team whose role is to make sure that clinicians are able to prescribe the right medicines at the right price so that patients get the right choice of medicine, at the right time.
BQ12	Has a fully costed and comprehensive survey been performed as to the care experience of patients discharged from Bradwell hospital.
	This would be a UHNM process on discharge.
BQ21	What is the projected increase in dementia related healthcare need in North Staffordshire? How does this need reflect provision projected over the same time frame?
	The following increases have been projected for dementia diagnosis over the next two years:- <u>North Staffordshire</u> 2017/18 estimated prevalence will increase to 2897 2018/19 estimated prevalence will increase to 2970 <u>Stoke</u> 2017/18 estimated prevalence will increase to 3007 2018/19 estimated prevalence will increase to 3062 Both North Staffordshire and Stoke on Trent CCG's invested in the memory service to ensure that the diagnosis rates can continue to rise in the past couple of years and it is expected that the above diagnosis rates will be achievable within the current capacity. The Dementia Primary Care Liaison Teams commissioned over the last year continue to support patients in the community. Work has just started on redesigning the Dementia Advisory Service into a Memory Support Service in order to provide support to both patients and carers.
BQ24	How many additional deaths of elderly people took place in Winter 2015 compared with the trend in the CCG's in Staffordshire. Has research established why this happened? (Increase in mortality among older people is a very worrying trend for residents in Staffordshire).
	Unfortunately the CCGs do not hold this data and are not aware of any research organisation having undertaken this piece of research.
HQ6	Need to have care package properly geared to care needs of service user. At present many of the "staff" assessing needs (especially in hospital) do not carry out a proper assessment of

	needs. (I have had 5 such assessments and the only that properly dealt with my needs was carried out by a Nurse Practitioner. For My Way My Care to be successful, care assessments needs to be accurate. Where "care" is needed carers should be properly trained to recognised standards (NV2 and above) and time allocated as necessary, at present domiciliary care is grossly inadequate.
	My Care My Way is about ensuring that we have one assessment undertaken by the MDT rather than several. You are navigated through the system and care is appropriate for your needs, not the needs of the service. Assessments will only be undertaken by those deemed competent to do so.
LQ6	Royal Stoke is a training hospital. Why are so many qualified nurses going elsewhere for employment, hospital has to rely on agency.
	The Trust is a medical (e.g. doctors) teaching hospital, not a nursing training hospital. The nursing courses are run by Keele University and Staffordshire University, which UHNM support. Though the sentiment is incorrect, qualified nurses are not leaving to go elsewhere and the Trust employs all the nurses trained locally by its university partners. But as one of the largest hospitals in the country, UHNM still need to recruit nurses from beyond their normal catchment area – hence the use of agency staff.
LQ8	I would like to know what plans are being made to inform the public about the Staffordshire STP. Thankyou
	Information about the STP can be found on the website: http://www.twbstaffsandstoke.org.uk/

Statements submitted by attendees at the events	
CQ59	Many people would prefer to be at a local hospital while their needs are being assessed.
LQ1	In the first instance you need prevention you need adequate resources to deal with health problems.
CQ4	I care for my mother at home and there is no help within the community because the nurses are under staffed.
CQ5	25% waiting for a package of care in a community bed demonstrates that care is not available. GP's-gate keeper-need more "to be more involved",
CQ54	GPs insufficient for current needs, number per thousands, European average is 35, ranging from Greece 6.3 to UK 2.8. This when doctors numbers have increased by more than 50% since 2000. We are also below the European average with the number of nursing staff.
MQ14	I carried out a DN care navigator trial approx. 7 years ago in which we were funded to appoint 2, 1 OWTE District Nursing Staff (ON registered-B6) who provided a ON link in the Acute Trust to work with the acute wards to assess patients for discharge potential. We achieved the patient discharge targets set, and I think this link is needed and could support smooth and timely transition of patients from the acute wards. We carried out a lot of education and insight into DN skills to ward staff as

	well. Thanks.
MQ15	I'm DN care navigator also assessed with S-O-T and North Staffs services.
CQ3	Black Friday meeting date-also during day when people are at work-totally unacceptable!!
MQ9	The public need to be informed/educated on struggles/demands/supply and demand issues, not just the minority who attend these events.
MQ23	New Model for Care cannot be implemented until everything is in place – comment.
LQ13	Concerns over rurality specifically in the Moorlands. Not any use to provide services for Biddulph, people in Leek-rural routes and public transport are poor.
CQ35	Regarding the Third Sector. As a trustee of Moorlands Homelink, a charity based in Cheadle giving services to the Elderly in Cheadle and the Moorlands area. My concern, regarding our charity is the funding we get from the CCG. This funding is vital to enable us to function as a service and is appreciated. We provide Day Care x 3 weekly, outreach groups in villages and Biddulph, bathing, be-friending by phone-link, voluntary transport and we have recently started pilot for providing Domiciliary Care and Meals on Wheels. All these services are vital to caring for the elderly living at home. A big majority of our Day Care Clients have Dementia and Alzheimer's. The money we receive is minimal to what it would cost the 'Establishment' would have to pay. ie. Saved money from closing beds, could be used to increase the grant which we receive. My Care My Way fits into very neatly to the services we provide, so we need more referrals, with quicker assessment of the client which says that the Health and Social Care need to get their act together and you both work together.
CQ27	I would echo the point that the 3rd sector cannot support NHS/Social Services on the cheap. I run a small (mental health) charity which supports people in the community-but I have to find 100% grant aid and get no funding from the NHS.
BQ9	Living independently service Staffordshire.
CQ33	All agents should work together.
CQ37	Regarding District Nursing-research needs to be done into the actual patients (hands on) contact they have with the patient. Give this some thought.
CQ45	No point-decision already made.
CQ51	Care quality commission are responsible for inspections and monitoring of residential care, Not Nursing Staff, as stated by a member of the panel.
CQ55	We are 3rd worst when it comes to beds per 1000. European average is 5.2, ranging from German on 8.2 and U.K. on 2.7.
CQ57	No one wants hospitalisation, but sometimes it's necessary and is then gratefully accepted, and in an emergency no one can beat our NHS.
BQ4	120 people on trolleys at Royal Stoke waiting for care packages.
BQ5	Please take time, make haste slowly.

BQ22	It is prevalence over time not point prevalence that should determine the financial provision for Care Services.
CQ6	Funding, Marcus declared that GP's are a scarce resource. "Capacity in the community" shows increased funding. All physical services have increased by millions, mental health services have increased by thousands-no parity!
MQ28	The changes are driven by a need to save money in the case of Staffs CCG of 10 million in 2016 alone. Therefore the changes are being made to deliver healthcare at less cost.
MQ26	Dom/care providers asking clients to only purchase microwave meals that take 8 mins because of time!
MQ27	No training for dom/care providers around dementia!
CQ44	If 10% of hospital beds are required for care in the area 10% of a growing aging population must be considered. Care at Cheadle Hospital was the best, I visited two of my grandparents there. North Staffs is not an option for local families, we need more funds from central government, the elderly have paid in all of their lives.
BQ7	People fall in between the cracks, prevention rather than a cure, dehydration in care homes.
CQ39	If Cheadle beds remain permanently closed, the main function of the hospital is lost, therefore, the hospital is redundant.
MQ25	Current situation people in community hospital for Months waiting for dom/care!
BQ20	New Model of Care – Is not working and does not exist as planned – this needs to be in place BEFORE Closure of beds.
LQ9	Please publish aims/plans (STP) Soon!
CQ22	Assessment needs to take place in the most appropriate place-which may well be a local community bed, which the individual will occupy briefly.
CQ26	Part of the problem for many people in N. Staffs. In losing community beds is the pan city of public transport.
CQ60	Your policy of closing beds at Cheadle and Leek hospitals will worsen the bed-blocking at UHNM Acute Hospital.
CQ56	If a patient can get an appointment - GP or hospital, there is usually insufficient time allowed for a proper/decent consultation to take place, why make it worse.
CQ52	How do you equate/justify the term 'bed-blockers' the hospital was built 400 beds below the total of the buildings it was replacing, 167 (25/11/16) have been lost, (with more to follow, no doubt) there is a "built in" bed shortage, of approximately 51.5% your entire philosophy is based on a demonstrably false premise, at a time when for several reasons the population is expanding rapidly.