CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel
29 March 2018

Time 1.30 pm **Public Meeting?** YES **Type of meeting** Scrutiny

Venue Training Room, Ground Floor, Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Membership

Chair Cllr Jasbir Jaspal (Lab)
Vice-chair Cllr Wendy Thompson (Con)

Labour	**Conservative**
Cllr Greg Brackenridge	Cllr Patricia Patten
Cllr Hazel Malcolm	
Cllr Peter O'Neill	
Cllr Phil Page	
Cllr Martin Waite	
Elizabeth Learoyd	Healthwatch Wolverhampton
Shelia Gill	Healthwatch Wolverhampton
Dana Dooby	Healthwatch Wolverhampton

Quorum for this meeting is four Councillors.

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1 **Apologies**

2 **Declarations of Interest**

3 **Minutes of previous meeting** (Pages 3 - 10)
[To approve the minutes of the previous meeting as a correct record.]

4 **Matters Arising**
[To consider any matters arising from the minutes.]

DISCUSSION ITEMS

5 **Winter Planning 2017/18 - Update Report** (Pages 11 - 56)
[Joint update report on effectiveness of actions taken by WCCG, CWC and RWHT to support local systems to prepare for and deliver resilient performance through winter 2017/18.]

6 **Urgent and Emergency Care 7 day Services** (Pages 57 - 64)
[Dr Jonathan Odum, Medical Director, RWHT, to present report]

7 **Update on the work of the suicide prevention stakeholder forum** (Pages 65 - 72)
[Neeraj Malhotra, Consultant in Public Health, to present report]

8 **Public Health Transformation Public Consultation** (Pages 73 - 92)
[John Denley, Director of Public Health, to present report]

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 25 January 2018

Agenda Item No: 3

Attendance

Members of the Health Scrutiny Panel

Cllr Greg Brackenridge
Cllr Jasbir Jaspal (Chair)
Cllr Peter O'Neill
Cllr Patricia Patten
Cllr Wendy Thompson (Vice-Chair)
Cllr Martin Waite
Shelia Gill, Healthwatch Wolverhampton
Dana Tooby, Healthwatch Wolverhampton

Witnesses

Margaret Court	Children's Commissioning Manager
David Loughton CBE	Royal Wolverhampton Hospital NHS Trust
Jeremy Vanes	Royal Wolverhampton Hospital NHS Trust
Dr Helen Hibbs	Wolverhampton CCG
Dr Jonathan Odum	Royal Wolverhampton Hospital NHS Trust

Employees

John Denley	Director of Public Health
Kate Warren	Registrar in Public Health
David Watts	Director of Adult Services
Majel McGranahan	Public Health Registrar
Earl Piggott-Smith	Scrutiny Officer

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
Apologies for absence were received from Councillors Malcolm, Mattu and Page and Elizabeth Learoyd.

2 **Declarations of Interest**
There were no declarations of interest.

3 **Minutes of previous meeting (16 November 2016)**
Correction: The minutes to be amended to show that David Watts, Director of Adult Services and Dana Tooby as having attended the meeting. The minutes were approved as correct record of the meeting, subject to the above change.

4 **Matters Arising**

There were no matters arising from the minutes of the meeting.

5 **CAMHS Transformation Plan Refresh 2017-20**

Margaret Court, Children's Commissioning Manager, presented the CAMHS Transformation Plan. The Children's Commissioning Manager explained the background to the development of the plan and the progress made against the original performance targets. The plans were submitted to NHS England to show progress made and was approved.

The Children's Commissioning Manager commented that the figures detailed in para 3.2 were incorrect and a revised table would be sent to members.

The Children's Commissioning Manager explained how funding detailed in para 3.3 of the report would be used improve the access young people should mental health support services.

The panel thanked the Children's Commissioning Manager for the presentation

The panel discussed the digital counselling offer. The Children's Commissioning Manager explained that this offer is currently available in Dudley, Walsall and Sandwell and the plan is to introduce the scheme in Wolverhampton. The Children's Commissioning Manager advised the panel that the £262,500 funding will only be used for specific training of staff and not for the commissioning of services. The funding of £197,000 has not been committed and will be held for 2020/21 to respond to changes in needs of young people in the future – the idea is that the fund will be used to help meet the mental health needs of young people.

The panel queried the existence and use of research about the impact of bullying on mental health when developing programmes. The Children's Commissioning Manager commented on the important role of schools in meeting their responsibilities for pastoral care. The panel discussed the need for schools to improve the quality of care to young people and the high rates of suicide and self-harm among young people. The panel discussed the work of the Suicide Prevention Stakeholder Forum which had looked at the issue of provision of support to young people with mental health issues and queried the role of schools.

The Children's Commissioning Manager advised the panel that the schools had become better at dealing with mental health issues but accepted there was level of inequality in support available across schools. The Children's Commissioning Manager commented on the support provided by the street triage scheme and the plans to roll out the scheme city wide.

The Children's Commissioning Manager commented on the work being done in Sandwell MBC with schools and the charter scheme it had introduced as evidence of the quality of mental health support. The Children's Commissioning Manager advised the panel that there were early discussions about doing something similar in Wolverhampton and improving the quality of crisis care provision across the Black Country Region. The Children's Commissioning Manager advised the panel that a new service specification is being drafted which is aimed at integrating the street triage service.

The Children's Commissioning Manager added Wolverhampton does not have high numbers of young people needing specialist treatment.

The panel discussed the merger of mental health providers and the risk that quality of service will be based on the lowest common denominator in order to plan services. Dr Hibbs commented on the preventative work being on the Black Country CAMHS strategy and reassured the panel of the work of the WCCG to improve the current offer.

The panel queried the issue of evidence of long waiting times between a mental health assessment and statement for young people and the person getting the specialist treatment needed where is considered as appropriate.

Dr Hibbs advised the panel of the work done directly with doctors to improve the situation – there are plans to launch a new strategy in February 2018. The strategy will look at gender issues and their different needs. The Children's Commissioning Manager added this is an area of concern for the service about lengthy waiting times and the need for provision between low level support and specialist support - the aim would be to provide a referral to a service within a week. The Children's Commissioning Manager added that there is a need to review the current provision.

The panel discussed concerns about the provision of support in schools to young people who are victims of bullying and the argued for the need for the current offer to be monitored. The Children's Commissioning Manager responded that work is being done with schools and colleges to improve the situation and co-ordination of services and staff are committed to make a positive difference to young people needing support. The panel agreed to receive an update on the progress against action plan key performance indicators for the CAMHS transformation plan.

The panel thanked the Children's Commissioning Manager for her presentation.

Resolved:

The Children's Commissioning Manager to present update report on progress to the panel meeting on 15 November 2018.

6 **Oral Health Needs of Older Adults**

Kate Warren, Consultant in Public Health, introduced the report on oral health to the panel. Kate Warren introduced Majel McGranahan who gave a presentation of the main points of the report and invited panel members comments.

The panel discussed concerns about the poor state of dental health of people prior to moving into a care setting and the work done by staff to identify any problems at an early stage before the situation worsened. The Consultant in Public Health responded that when compared to other areas Wolverhampton achieved 98% of people who had dental care plans included as part of their assessment and there were other examples of good practice.

The Consultant in Public Health commented on the work of the Care Quality Commission (CQC) monitoring team to check on the quality of care provided in establishments.

The Consultant in Public Health added that the quality of care provided in this area is affected by staff turnover and encouraging people with different care needs to have dental checks done.

Shelia Gill, Healthwatch Wolverhampton, commented on the findings from recent 'inspect and views' and highlighted concerns about residents getting routine access dental hygiene and care.

The organisation was not aware of the findings of the West Midlands Care Home Dental Survey in Care (2011) and would like to receive further information. Majel McGranahan explained that the report is on the agenda for a future meeting of Health Wellbeing Board meeting.

The panel discussed the issue of the accuracy of the database and the sharing of information to better understand gaps in service provision. The panel discussed the reliability of data based on self-reported information and expressed concern about the lack of data about the state of oral health in adults with learning disabilities.

The panel discussed the plans for future developments listed in section 4 of the report. The panel requested a progress reports against the areas for improvement presented to a future meeting of the panel.

David Watts, Director of Adult Services, agreed to share information on the findings from Care Quality Commission on state of oral health in care homes among residents.

Resolved:

1. Dr Kate Warren, Consultant in Public Health, agreed to present a report on future developments in areas listed in the report to improve the oral health in older adults in Wolverhampton to panel meeting on 19 July 2018.
2. David Watts, Director of Adult Services, to share with the findings of oral health survey of residents produced by the Care Quality Commission with the panel.

7 **Update report on the Public Health Outcomes Framework and changes to the Public Health Service**

John Denley, Director of Public Health, outlined the report which set out the future vision for how the service will work in the future. The Director of Public Health outlined the Public Health Outcomes Framework and the areas that the service intends to focus on in the future. The Director of Public Health commented that the service will be working on getting the basics rights and work with other agencies, such as Wolverhampton Homes, on tackling the factors that impact on wider determinants of health.

The Director of Public Health explained the proposed restructure of the service will be mean a reduction from 108 to 45 posts. The consultation on the plans will end on 19 February 2018.

The Director of Public Health, explained how existing services funded and or delivered will be affected by the plans. The service has received 300 responses and the target is to get 1000 responses by the end of the consultation.

The Director of Public Health, explained the reasons for needing to change how services are delivered and the desire to reduce variations in the quality of care received and health outcomes between different wards across the city.

The Director of Public Health wanted the panel to support the proposed way forward for the reasons stated in the report. The Director of Public Health, wanted to improve position of Wolverhampton in the national performance tables for key health outcomes in the future.

The Director of Public Health, commented on the vision for public health and the objectives that will be used to measure progress. The aim is for Wolverhampton to be in the top quartile for performance for local authorities. The panel discussed possible quick wins that could show evidence of progress towards achieving this.

David Loughton, RWHT, supported the approach to delivering public health in the future and the lack of evidence about the effectiveness of services aimed at encouraging and supporting behaviour change. David Loughton highlighted the issue of lack of success with work to encourage women to stop smoking in pregnancy and the evidence of women who do not attend ante natal clinics – it is reported that 18% of women smoke during pregnancy and the costs of providing services.

The panel welcomed the report and supported the plans for reconfiguring public health services in the future.

Resolved:

The panel agreed to note the report and support the proposed changes to the delivery of public health services in Wolverhampton.

8 **Dementia Friendly Community - Briefing Paper**

The panel agreed to note the briefing paper. The Chair encouraged panel members to attend the event to celebrate the City of Wolverhampton being granted Dementia Friendly Community Status.

9 **Patient Mortality Rates**

Dr Jonathan Odum, Medical Director, RWHT, presented a report on published hospital mortality statistics and analysis of the results for the panel. Dr Odum explained the method for calculating individual hospital mortality rates which is used to compare performance of hospitals in England.

Dr Odum explained that the calculation of standardised mortality rate is based on a complex formula, as detailed in the report. Dr Odum added that the reported results of increased mortality rates for RWHT do not show evidence of poor quality care or ‘avoidable’ deaths at the hospital. However, the results are being analysed to identify deaths that may have been avoidable and any learning used to improve future practice.

Dr Odum explained that Wolverhampton traditionally had a Standardised Mortality Rate(SMR) of 100 – however this figure has increased to 115 since the opening of the new emergency department which may explain why there have been more deaths than expected. The death rate figure is based the count of adults over the age of 18 years. The hospital has the lowest death rate in the West Midlands region.

The panel queried the impact of the opening of new emergency department on the increase in mortality rate. Dr Odum explained that a new triage and assessment procedure has been introduced which had been very successful in managing patient flows – the changes had led to a reduction of 2000-3000 admissions to hospital a year.

Dr Odum explained that the Swan end of life care model had been introduced at the hospital which has resulted in fewer people being referred to the palliative care team and increased the hospital mortality rate. The Swan programme offers dedicated support to patients in the last days of life and to their families into bereavement and beyond.

Dr Odum reassured the panel again there was no evidence to suggest that the increase in mortality rates for RWHT was due to poor quality care, but work will continue to be done to review procedures to see what further changes are needed to improve the situation.

The panel thanked Dr Odum for his presentation.

The panel queried if the increase in the number of people who needed hospital admission after being assessed was a factor as they would be at higher risk of death.

Dr Odum explained the patients are managed in a different way following the opening of the accident and emergency centre and figures are affected by the fact that the hospital has a high percentage of people who die in hospital rather than being discharged to a hospice or home.

The panel discussed that given the reasons for the increase in death rates and the value in dedicating time and resources in trying to understand when there was no evidence to suggest that they were due to poor quality care.

David Loughton, RWHT, explained that changes in SMR and Summary Hospital-level Mortality Indicator(SHMI) referenced in the report act as ‘smoke alarm’ and that it was important that it should not be ignored. David added that it is important for the hospital to investigate if there are any common factors to explain changes in death rates by carefully anaylsing the data and whether any were avoidable.

Dr Odum explained that the hospital will also investigate death within 30 days of a patient being discharged to investigate the reason. Dr Odum explained the challenges facing the hospital in caring for patients who are elderly and frail.

The panel discussed the hospital policy of end of life care. Dr Helen Hibbs, WCCG, commented on the number of people with cancer diagnosis and the work being done with GPs to improve early diagnosis and appropriate referrals to hospital for treatment. Dr Hibbs added that the CCG is expecting to see improvements in the next year.

David Watts commented on the introduction of ‘red bag’ which contains important information about the patient and their wishes for future care. David agreed to present an update report on progress of the scheme to the panel in March 2018.

Resolved:

The panel agreed to note the findings and agreed to monitor the performance of standardised mortality rates at RWHT against national standards and receive an update on progress at a future meeting.

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Agenda Item No: 5

Health Scrutiny Panel

29 March 2018

Report title	Winter Planning 2017/18 – Update Report
Report of:	David Watts, Director of Adult Services, City of Wolverhampton Council David Loughton, Chief Executive of Royal Wolverhampton NHS Trust Helen Hibbs, Accountable Officer – Wolverhampton Clinical Commissioning Group
Portfolio	Adult Social Care Health and Well Being

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

1. Note and scrutinise the information relating to NHS and Local Authority adult social care winter planning preparedness, achievements and outlook for 2017/18.

1.0 Introduction

1.1 An update has been requested to inform the Health Scrutiny Panel on overall progress in ensuring best use of hospital and community resources for people in the City of Wolverhampton in the context of annual winter planning.

1.2 Wolverhampton health and social care economy continues to mature and sustainably embed whole system change. This has been particularly evident during the last 12 months. The joint and individual agency winter planning work undertaken by organisations has been essential.

1.3 The period since October/November 2017 has been one of the most challenging on record for the acute and community trust with health and social care partners. Significant national attention on Delayed Transfers of Care (DTOC) remains as this is not an isolated local problem and has presented as a high-profile issue for most health and care systems.

1.4 Winter planning for acute and community Trusts and Clinical Commissioning Groups (CCGs) traditionally commences in June/July prior to the coming winter. This follows local and regional reviews of the previous winter and lessons learnt. Management of the winter period in the health sector is generally highly prescriptive about actions that should be taken and reporting mechanisms that will be undertaken throughout the period.

1.5 Management of the winter period and other emergency pressures is led by the Wolverhampton Health Economy A&E Delivery Board, chaired by Dr Jonathan Odum from the Royal Wolverhampton Trust (RWT.) It has senior membership from key partner organisations - Wolverhampton CCG, City of Wolverhampton Council, Black Country Partnership NHS Trust, West Midlands Ambulance as well as regulators from NHS Improvement and NHS England. Along with all other health and care systems, we are required to produce a resilience plan annually which details the actions that organisations will undertake in order to manage their winter pressures. See **Appendix 1** for a copy of the Wolverhampton Health Economy Winter Plan 2017/18.

1.5 Whilst achieving significant improvement in DTOC for Wolverhampton residents there has still been immense pressure at RWT, due to flows of patients from adjoining geographical areas. This would have been significantly more challenging over the recent period if local performance improvements in the City of Wolverhampton had not been achieved. Issues and achievements by agencies in the system are outlined in the report.

2.0 Pressures on the health and social care system

2.1 Financial challenges for both the NHS and Social care have been well documented throughout the year. Social care leaders and the Local Government Association (LGA) continue to challenge for a longer term sustainable financial settlement for social care. Similarly, NHS leaders have highlighted the significant funding challenge faced across the health system.

2.2 Additional funding has been made available, as detailed below. Whilst all additional monies have helped with current pressures, the amounts have been criticised for falling short of NHS, Local Government and independent analysis of requirements to sustain the systems.

2.3 In the Spring 2017 Budget announcement the Chancellor announced an additional £2 billion for social care over three years as senior leaders highlighted the impact under-funding of social care was having on the NHS. This money is referred to as the "improved Better Care Fund" (iBCF). The money tapers over three years with no guarantee of provision after 2019. Therefore, plans need to be careful in avoiding long-term pressures in adult social care budgets. This funding was also closely linked to improving DTOC. The sums for Wolverhampton were £6.4 million (2017-2018), £3.9 million (2018-2019) and £1.9 million (2019-2020).

2.4 In Autumn 2017, the chancellor announced an additional £6.3 billion of funding for the NHS, which consisted of:

a) £2.8 billion of additional resource funding over 2017-2018, 2018-2019 and 2019-2020 for the NHS in England for day to day spending on, for example, surgeries and treatments.

b) £3.5 billion of capital investment for buildings and facilities in the NHS in England by 2022-2023, including:

- £2.6 billion for the NHS's Sustainability and Transformation Partnerships for improvements in facilities
- £700 million to support turnaround plans in those trusts facing the biggest challenges, and to tackle the most urgent and critical maintenance issues
- £200 million to support efficiency programmes that will, for example, help reduce NHS energy bills, and fund technology to allow more staff time to be directed towards treating patients.

2.5 An additional £350 million in-year was also announced to support the NHS through the winter period. Well in advance of this, senior health leaders including Simon Stevens (Chief Executive, NHS England), were highlighting the risks heading in to the winter period and the challenges that acute hospital trusts and primary care would face.

2.6 The additional money was initially intended to be allocated to hospitals that did not have co-located urgent care or primary care centres. Wolverhampton already has co-location of the Emergency Department and an Urgent Care Centre, managed by Vocare, in the main hospital building. Therefore, it was not until early September 2017 that Wolverhampton Health Economy received confirmation that it would receive capital monies that would enable RWT to build and combine an Ambulatory Emergency Care and Frailty Unit on the first floor of the Urgent Care Centre at New Cross Hospital. The Trust was allocated £895,000. The frailty section was opened just before Christmas and the ambulatory section was completed at the end of January. The full potential and impact of this Unit on the management of emergency patients is still being realised, clearly. However, with increased staffing and recruitment it is expected that our health and care system and patients will see improved care throughout 2018-2019.

2.7 The final sign-off of this business case between the Trust and the WCCG is due for completion in March 2018.

2.8 In addition to the financial challenges, various issues such as General Practitioner (GP) and nursing recruitment have been highlighted as pressure points for the NHS.

2.8 Seasonal flu rates have also been significantly higher locally, regionally and nationally and have impacted on the need to admit people with acute respiratory problems to hospital. The Trust has had positive flu (A&B) strains identified resulting in more admissions. This increase in number of positive flu patients has resulted in additional pressure on the Trust. The severity of illness has resulted in increased length-of-stay for patients, especially those with other co-morbidities.

2.9 On the 3 January 2018, RWT raised its escalation to a Level 4, the highest level. Quick actions in the local system enabled de-escalation to a Level 3 on the same day and a Level 2 the following day. As a result of an increase in admissions for flu, the Trust enacted its Flu Continuity Plan in January. This is part of the RWT Business Continuity Plan through which RWT designated two wards for patients diagnosed with flu. In order to ensure this was successful, RWT also purchased enhanced flu testing equipment that meant that patients could be swabbed for flu in the Emergency Department and results would be returned within four hours. If the results were positive, patients could be transferred to the designated wards. This resulted in some patients waiting longer than the mandated four hour target for admission. However, patient safety and that of those who might come into contact with patients with flu was deemed important. Flu spreads easily and can cause unwell patients further complications. Patients who were in contact with positive flu patients (i.e. in the same bay) are prescribed Tamiflu where appropriate.

2.10 RWT has also had to enact its severe weather plan on two occasions. Once in December 2017 and the other more recently at the end of February/ beginning of March 2018 as a result of significant increase in snow fall. This resulted in RWT having to call for assistance from staff and the public who had access to 4-wheel drive cars to enable staff to be transported to work. In order to ensure that patients who were ready for discharge could arrive home safely via non-emergency transport some outpatient appointments were rescheduled. Staff working in the community also had to prioritise calls to those patients who were most in need of visits, either from the community or health visitor team. Accommodation was provided on the Trust site for those staff who knew they would not be able to return home and then return to work. The response from the staff across the organisation has been exceptional to ensure that full 24/7 service was provided to all patients.

2.11 Pressures in acute hospitals in neighbouring authority areas have led to some ambulances being diverted to RWT. This has again increased pressure on the hospital on days where that has occurred.

3.0 Summary of Council DTOC performance and local improvement

3.1 The majority of delays for Wolverhampton residents occur at the local acute hospital trust, RWT. Therefore, for this report, RWT is the primary focus. However, there has also been improvements with respect to Wolverhampton residents in other local Trusts where delays have occurred including Dudley Group and Penn Hospital.

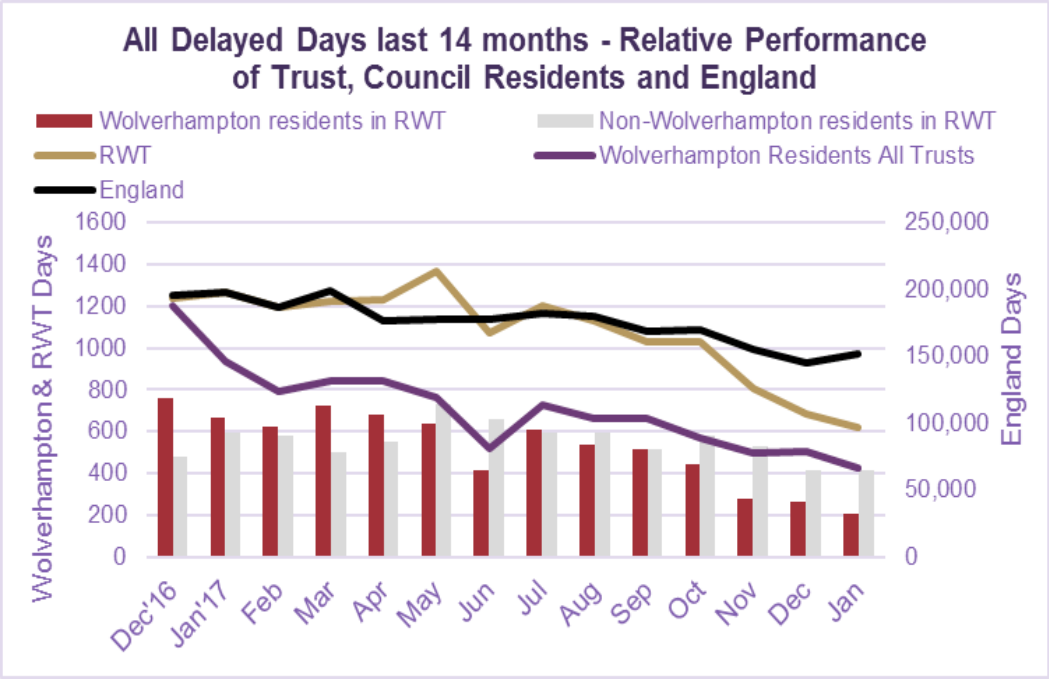
3.2 Sustained improvement has been evidenced for Wolverhampton residents over a period of approximately 21 months. However, this report focuses on the last 14 months up to and including January 2018. The key source of data used is published approximately 6 weeks after the end of each calendar month explaining why February 2018 data is not included at the time of writing.

3.3 The last fourteen months data from December 2016 to January 2018, is set out in Figure 1. This shows a significant reduction in the overall levels of recorded monthly delayed days.

3.4 Over this period the improvement for Wolverhampton residents has been more significant than for RWT, who routinely treat patients from other health and social care systems, with a trajectory that initially was more in line with the national trend until October.

3.5 However, the rate of RWT reduction has picked up pace in the last three reported months. Additionally, the graph shows that the overall performance for Wolverhampton residents has improved at a greater pace at RWT than for other health and social care systems that have patients in RWT.

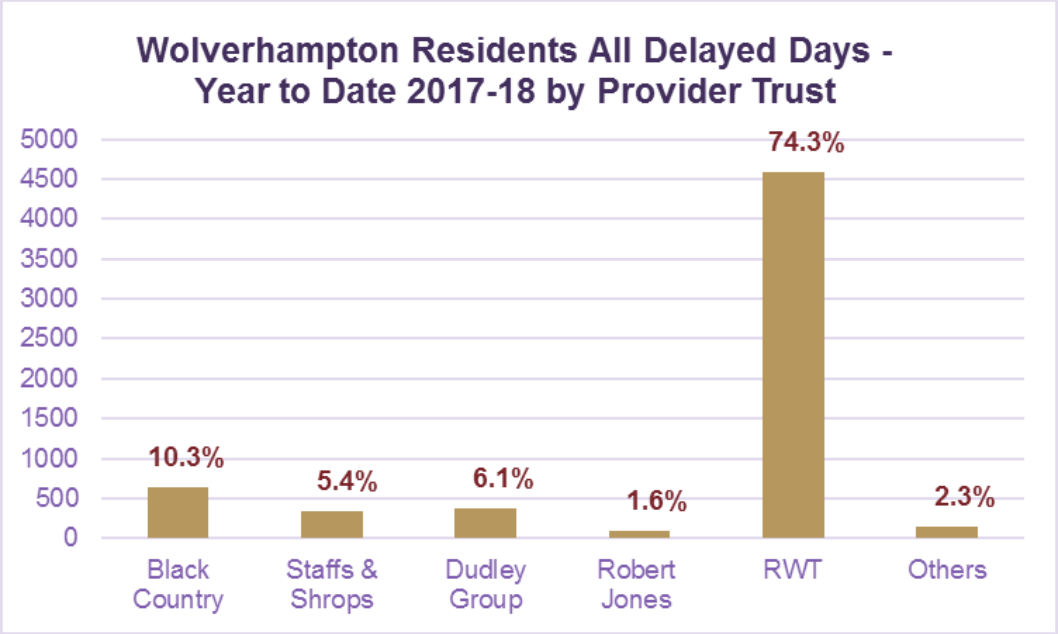
Figure 1 - Relative performance between December 2016 and January 2018 (Source: NHS Statistics)



3.6 The overall reduction between December 2016 and the latest DToC figures published for January 2018 show a reduction of 65% for Wolverhampton residents and 50% for RWT. In comparison the national reduction is 22%.

3.7 Delays for Wolverhampton residents have the potential to occur in any Trust in the country. However, as shown in Figure 2, RWT remains the predominant health care provider for the city. The proportion of delays recorded in RWT increased from 70% at the end of 2016-2017 to 74.3% in the year-to-date at the time of writing. In contrast, the proportion of delays for the BCPFT reduced from 19% at the end of 2016-2017. However, these are in the context of the overall reduction in delayed days.

Figure 2 – Proportions of Wolverhampton Delays in Provider Trust for Year-to-Date 2017-18 (Source: NHS Statistics)



3.8 A quarterly performance "Dashboard," developed jointly by the Department of Health and Department for Housing, Communities and Local Government, was published in July 2017. This contained a set of measures indicating how health and social care partners in every Local Authority area in England are performing at the interface between health and social care.

3.9 Included in the Dashboard is a breakdown of delayed days per 100,000 of the local population aged 18 and over and the detailed expectations for Delayed Transfers for both Local Authorities and NHS Trusts based on baseline figures from February 2017. These expectations are linked to the NHS England (NHSE) Mandate for 2017-2018 which states that that DTOCs should equate to no more than 3.5% of all hospital beds by November 2017.

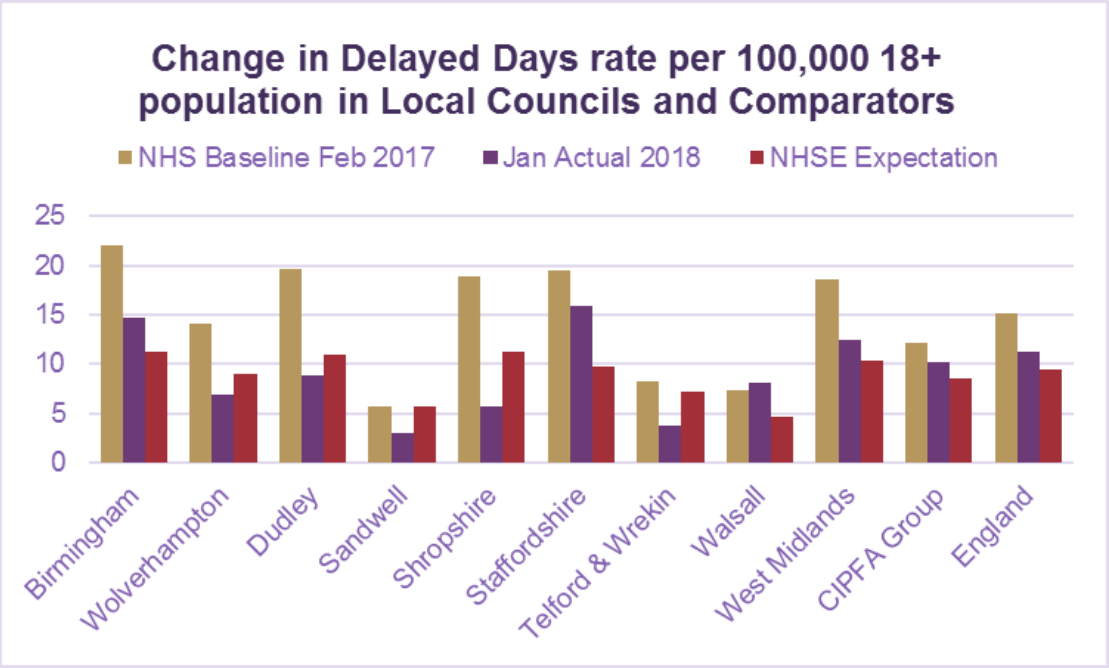
3.10 This has allowed health and care systems to compare themselves to similar areas and have conversations about good practice. The Dashboard also provided greater transparency for those local areas that were not performing well to enable improvement

support to be targeted.

3.11 Figure 3 shows benchmarking across a number of areas including:

a) Detailed benchmarking against geographically closest West Midland Authorities
b) Benchmarking against West Midlands average
c) Benchmarking with CIPFA nearest statistical comparator average
d) Benchmarking with England Average

Figure 3 – Expectations and change in rates of delayed days per 100,000 18+ population (Source: NHS Statistics)

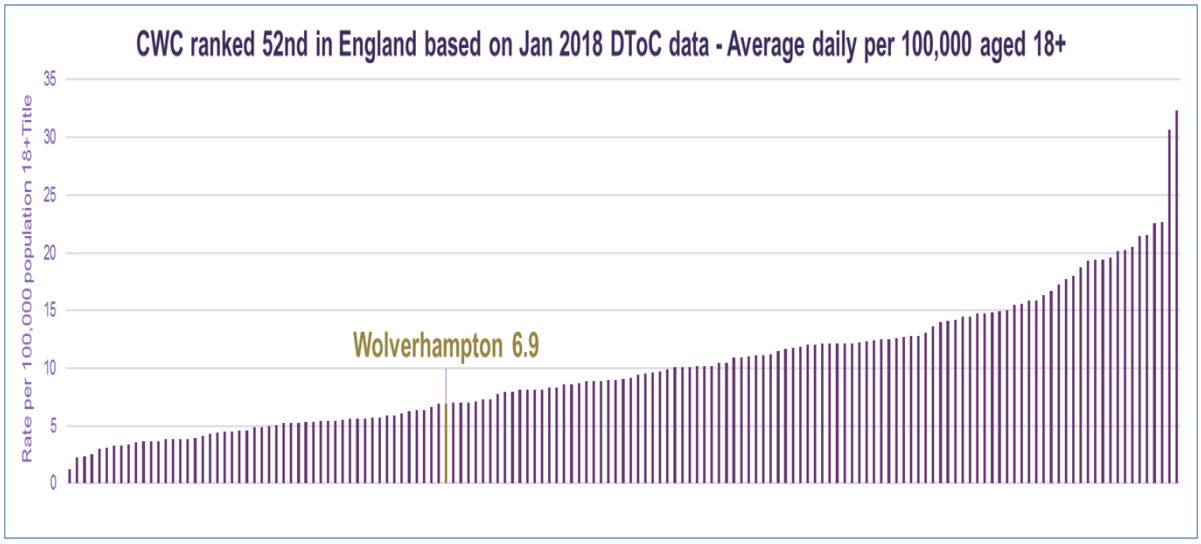


3.12 Figure 3 shows that five of the eight geographically closest council areas shown, including Wolverhampton, met or exceeded the NHSE expectations for the rate of delayed days per 100,000 18+ population.

3.13 Overall, the West Midlands average has improved since the February 2017 baseline but is not yet meeting NHSE expectations. Comparators produced by the Chartered Institute for Public Finance and Accountancy (CIPFA) have shown improvement but fell slightly short of meeting NHSE expectations which is a similar picture for the England average. Wolverhampton has both improved and is exceeding NHSE expectations as at January 2018 for all delays.

3.14 Figure 4 ranks the latest month's DTOC data (January 2018) measured as a daily rate per 100,000 of the population aged 18 or over. The figure of 6.9 for Wolverhampton places the city 52nd out of the 151 Local Authority area in England reporting delays during the month. This now means that Wolverhampton is in the upper-mid quartile for performance which represents genuine progress.

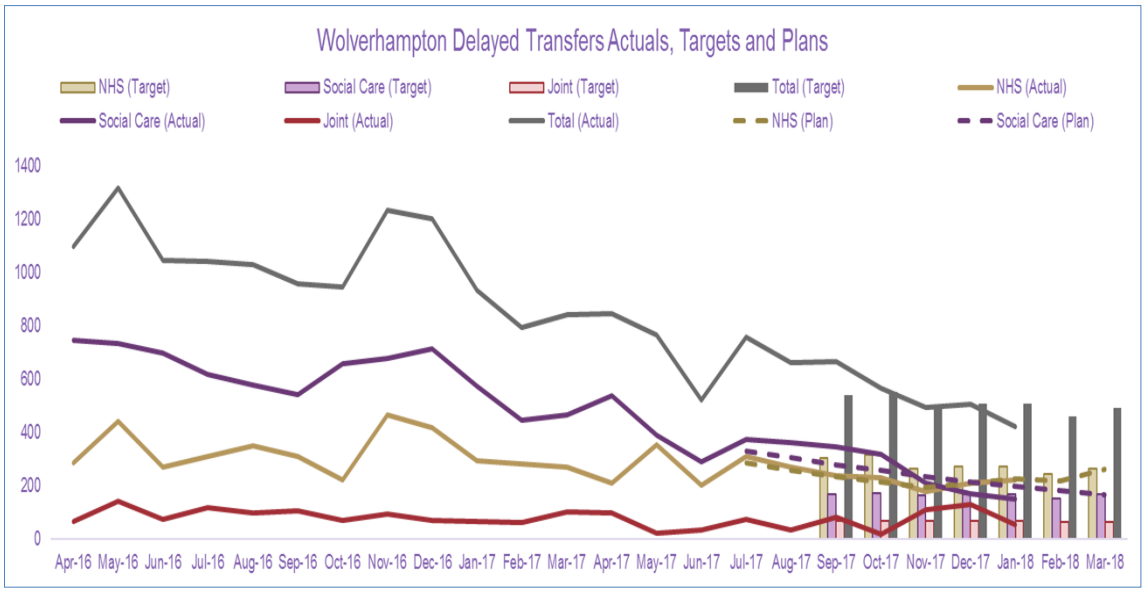
Figure 4 – Expectations and change in rates of delayed days per 100,000 18+ population (Source: NHS Statistics)



3.15 In comparison, Wolverhampton was ranked 96th based on the same measure for its performance between February and April 2017 which was reported as part of the quarterly NHS and Social Care Interface Dashboard, published by NHS England in July 2017.

3.16 Figure 5 demonstrates the improvement that has been made using the now recognised primary indicator for delayed transfers of care ("bed days delayed" rather than "number of people.") The table sets out the number of delayed bed days for all Wolverhampton citizens anywhere in the country. This includes both acute and non-acute hospitals.

Figure 5 – Wolverhampton Delayed Days actual performance against target (Source: NHS Statistics)



3.17 Targets were set by NHSE and the Department of Health (DH) from September 2017 and the bar charts set out those expectations with the line graphs showing performance against those targets. Nationally published data runs approximately six weeks behind with January's data being published on the 8th March 2018. These figures show that in January 2018 the local system exceeded the NHSE target by 70 delayed bed days.

3.18 The Council and local NHS partners agreed that the important target is the overall total (the khaki green clustered column represents this target and khaki green line is actual performance) and had jointly communicated a realistic timescale of 31st March 2018 to achieve and sustain performance at NHSE target levels through the Better Care Fund submission for 2017-19. This submission was accepted and approved by NHSE.

4 Actions taken and recognition of the improvement

4.1 Other actions have been taken which have added to the improvement which has been achieved as follows.

4.2 Rapid Intervention Teams

Following a successful pilot, Wolverhampton CCG has commissioned a nurse-led community Rapid Intervention Team (RIT), provided by RWT. This team responds to patients in their own home who are experiencing an exacerbation of their condition with the aim of avoiding hospital admission. The RIT can be accessed by a patient's GP, the Emergency Department or West Midlands Ambulance Service. A recent audit has shown that the team receives an average of 14 referrals per day. The team record that only approximately 15% of patients seen by the service result in an emergency admission – an admission avoidance rate of 85%.

4.3 Step-up Beds

Wolverhampton CCG commission four "Step-up" beds which can be accessed by the RIT in order to avoid a hospital admission. These nursing home beds can be utilised for patients under the care of the RIT for up to seven days. This enables the team to provide more intensive nursing care to patients when required whilst still avoiding an emergency admission to hospital.

4.4 Admission Avoidance Beds

In addition to the Step-up Beds in the nursing home, Wolverhampton CCG have also worked with a local residential home through the winter period to make available two "admission avoidance" beds for patients with non-medical needs but who need some support for a number of days to enable them to return home safely.

4.5 GP Access

GP practices are working collaboratively to provide additional appointments both in the week and at weekends for their patients. This gives patients more choice of accessing medical advice and treatment and avoiding use of hospital Emergency Care.This provides additional resilience in the system.

4.6 The following chart summarises some of the work completed, the factors that have led to current achievements and updates on where this has been recognised.

What we did	Success factors	Where this is recognised
• Red to green • The red bag project • Quality assurance meetings • Streamlined assessments • Discharge hub • Additional Very sheltered housing – step down • Additional domiciliary reablement	• Close working – Ops and commissioning • Knowing our data & using it • Holding our position consistently • Strong, consistent arguments • Influencing with regional and national bodies • Empowered and supported managers • Hard work	• ADASS regionally • The National Better Care Support Team • Social Care Institute of Excellence (SCIE) • NHS England • Royal Wolverhampton Trust • Clinical Commissioning Group • The LGA

5.0 Impact on Health and Wellbeing Strategy Board Priorities

Which of the following top five priorities identified by the Health and Wellbeing Board will this report contribute towards achieving?

Wider Determinants of Health	X
Alcohol and Drugs	☐
Dementia (early diagnosis)	X
Mental Health (Diagnosis and Early Intervention)	X
Urgent Care (Improving and Simplifying)	X

6.0 Decision/Supporting Information (including options)

6.1 The purpose of this Report is to inform Health Scrutiny Panel of progress to date and all relevant information has been included above.

7.0 Implications

Please detail any known implications in relation to this report:

- Financial implications – the financial context of the winter planning activity was outlined at paras 2.3- 2.6 above. The key issue for the City of Wolverhampton and all local areas is sustainability over time when national financial settlements are not known.

- Risks – the uncertain financial context means that is hard to be completely confident that the real achievements which have been made over the last year can be sustained over the long-term. The representations made by both Local Authority and NHS leaders to address this situation were outlined at para. 2.1 - 2.2

8.0 Schedule of background papers

8.1 None.

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Wolverhampton Health Economy

Winter Plan 2017/18

Covering the period of 1 Dec 2017 to 31 March 2018 (including Easter)

Table of Contents

1. WOLVERHAMPTON HEALTH ECONOMY

Wolverhampton Health Economy is committed to continual system and service improvement to ensure services for patients are accessible, safe and of a high quality. Planning for system resilience is key to ensuring that the services can continue to deliver these quality services at times of pressure.

System pressure is experienced all year round however the Winter period brings with it added risk factors such as Flu, Norovirus, poor weather conditions/colder temperatures, extended Bank Holidays.

This plan sets out how our local system plans to continue to deliver this and the additional steps we are taking to ensure the system remains stable and resilient throughout the extended winter period. W'ton AE Delivery Board is sighted on the WMAS Winter Plan and is assured that this plan will address the challenges faced by this health economy. Through local representatives, this plan has also been received and commented on via the lead commissioner (SWB CCG).

This plan is owned and monitored by the Wolverhampton AE Delivery Board who continue to review capacity and demand across the whole system. The AE Delivery Board consists of members from multiple stakeholders:

Organisation	Members
NHS Wolverhampton CCG	Chief Officer and/or
NHS Wolverhampton CCG	Director of Strategy and Transformation *
Royal Wolverhampton Trust	Chief Executive (Chair – Delegated to Medical Director) *
Royal Wolverhampton Trust	Medical Director
Royal Wolverhampton Trust	Chief Operating Officer (Vice Chair) *
West Midlands Ambulance Trust	Director of Clinical Commissioning and Service Development (deputising for CEO) *
Black Country Partnership NHS Foundation Trust	CEO *
Local Authority	Director of Adult Services *
NHS England	Operations Director *
NHS Improvement	Senior Delivery and Improvement Manager *
Staffordshire CCGs	Director of Operations *

The AE Delivery Board has oversight of the Better Care Programme and is cognisant of the work being delivered through this forum.

In addition, the CCG is mindful of the wider programmes of work across the Black Country and West Midlands. The West Midlands Ambulance Service is a key member of the AE Delivery Board and the local Urgent Care Centre is a member of the Integrated Urgent Care system. This affords the health economy the opportunity to work across organisational boundaries and ensure winter plans are aligned.

The AE Delivery Board closely monitor all the programmes of work detailed within this Winter Plan. Appendix 1 details the Programme Plan and progress towards implementation of many projects aimed at improving flow, reducing admissions and improving patient experience.

2. WIDER HEALTH AND SOCIAL CARE SYSTEM PREPARATION

2.1 Early Winter Planning

In order to plan appropriately for Winter 2017/18, the CCG and RCMT undertook at Winter Health economy debrief. This required all key stakeholders to participate in a round table discussion into the challenges faced by last Winter and actions moving forward into winter of 17/18. The event was well attended and all stakeholders participated. Key points of note were the Cyber Attack and the impact this had on NHS111 services with regards to patient demand but also on the operational ability of organisations/services across the area. Of particular benefit was the Trusted Assessor function which has been further developed throughout the year.

Key actions moving forward were:

- RCMT to progress the Mental Health Capacity Grid
- Local Authority to progress engagement with out of area (Staffordshire)
- RWT to look at how an increased number of patients can be transferred from ED to the UCC at point of triage
- CCG to pursue pathways for frail elderly in the community.

It was noted that the health economy felt they were in a robust position moving into the winter period of 17/18.

The urgent care centre has made rotas available early to ensure staff can book into shifts via the online booking system

2.2 Primary Care Provision

Practices across the city are working within their respective groups to provide a range of additional services that have been developed to assist us in continuous improvement in access to general practice. Many practices continue to open beyond core hours offering additional appointments to improve access to their practice, this will continue during the winter period. In addition practices are implementing different consultation types including telephone and online consultations with range of professionals such as General Practitioners, Advanced Nurse Practitioners & Clinical Pharmacists. Such provisions will be available during weekdays, weekends and bank holidays.

There are also a range of other enhanced services provided by many practices although not all in the city comprising of in-reach to care homes. Care homes with greatest need are being supported by the Primary In-reach Team(s) during core hours and by 111's *6 project during out of hours. There are currently 18 residential homes benefiting from this service and this will rise to 38 from September. The aim of the service is to ensure residents have access to timely medical advice and review so that they continue to reside in the RCH. The GPs will ensure that care plans exists for all residents, that it is regularly reviewed and that this forms the basis for the work of all the staff who provide support. This enhanced the level of care (GP or other clinician) helps to reduce avoidable hospital admissions.

Other enhanced services that will also be taking place include risk stratification, peer review (pro-active & reactive), end of life care planning, minor injuries and a number of basket services such as dressings, suture/clip removal, pessary changes, post-surgery checks to name but a few.

The purpose of all of these measures is to reduce the burden on A&E or out-patient secondary care appointments and provide shorter waiting times for treatment, interventions that are safe and clinically effective giving access to timely health interventions.

2.3 Integrated Urgent Care Development Plans

Wolverhampton CCG is part of the West Midlands commissioning collaborative for integrated urgent care (IUC). We are working within an alliance of providers who are delivering the components of IUC; NHS 111 call handling and triage, a clinical assessment service (CAS) and out of hours (OOH) services. Across the West Midlands there are a number of shared priorities, as set out below, which Wolverhampton patients will benefit from:

- Direct Booking from NHS 111 / IUC CAS into GP Surgery
- Access to the Patient Records via MIG
- IUC CAS Advanced Clinician Module

A new key priority area being added to this list is integration with West Midlands Ambulance Service NHS FT. This will facilitate access for crews & paramedic to a clinical desk 24/7 and ensure that lower acuity calls can be passed from 999 into the IUC service offer. Detailed delivery plans are being agreed at a West Midlands footprint.

Additional priority areas are also in the pipeline but may not be in place for this Winter period. These will aid integration between services and improve patient experience:

- Wider Prescribing from the IUC CAS
- Mental Health Crisis Resolution in the IUC CAS
- Direct Booking/Kiosks in ED
- IUC Dashboard
- Condensed ITK PEM Messages
- SMS Messages for Appointment Confirmation
- SMS Message for Self-Care Advice

Locally we are also moving forward with our own priority areas, these include:

- NHS111 Care Home *6 project – care homes call NHS111 *6 and will be put through to a GP at the 111 Clinical Hub. This is an alternative to calling 999 where appropriate. This is currently live in at least 15 care homes.

- NHS111 primary care pilot – when GP practices are at full capacity, they can ‘switch off’ their surgery on the Directory of Services and advise patients to call NHS111. If the patient requires a GP (see or speak to) within the following 24 hours, they are passed through to the UCC.

Both of these schemes aim to ensure the patient is managed by the right clinician in a timely manner and reduce unnecessary pressure on the ambulance service or ED.

2.4 WMAS

2.4.1 Ambulance Response Programme

WMAS were part of the pilot for the Ambulance Response Programme (ARP) and therefore all of the required changes in operational processes have already been fully implemented across the West Midlands.

WMAS have highlighted the following achievements following implementation of the ARP:

- Significant shift of focus, towards ensuring the correct capacity of Paramedic Emergency Ambulances are available to service the demand

  (Previously peak outputs each day - 215 Ambulances and 99 RRVs, Under ARP Phase2 – 310 Ambulances and 14 RRVs)

- Providing faster response to patients across all categories
- Ensuring priority patients such as Stroke cases get to hospital quicker
- Consistent delivery regardless of high demand periods
- 96% of resources now have a Paramedic on board and will 100% by Winter 2017
- RPI Reduced from 1.23 to 10.7 – saving nearly 100,000hours
- WMAS responding to +8% more demand (+69,000 incidents)
- WMAS utilising -4.5% less resource (-50,000 resources to scene)
- The number of patients transported to hospital has fallen from 62% to 60%
- Less Control / Dispatch staff required to handle a simpler model
- Wastage reduced by two-thirds in Paramedics on RRVs needing to travel with an Ambulance
- Total Fleet mileage reduced by 5%
- Total Fleet assets reduced, whilst the Emergency Ambulance Fleet has increased by +69
- Total number of Estate locations reduced 50% (+64)

Next steps for WMAS are set out below:

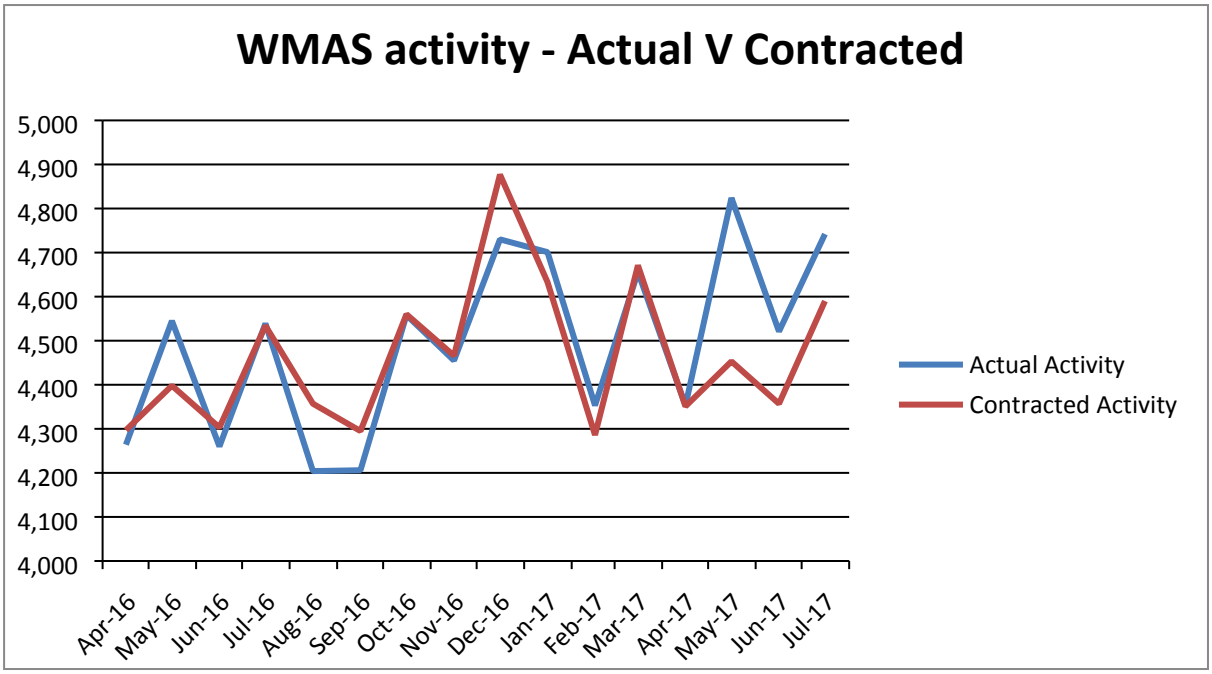
- Ensure 100% of all resources are Paramedic crewed (currently 96%), and ensure all patients are assessed and treated by a Paramedic, utilising only 1 resource
- RPI will be further reduced
  Improve (reduce) the time to Hospital for key patient groups (Stroke and Cardiac)
- Reduce the number of patients transported to hospital

- Further reduce the number of sites where resources respond from
- With further improvements to dispatch methods, it is intended that both fleet mileage and control staffing could be further reduced.

2.4.2 WMAS activity

The demand for ambulance services by Wolverhampton patients has shown an increase in the Q1 of 2017/18 resulting in activity of 3.89% above contract at July 2017 - outstripping the level of growth commissioned. See table 1 below.

Table 1 – Ambulance activity April 16 to date



This is not unique to Wolverhampton. Whilst this is challenging for Wolverhampton Health Economy, the percentage increase is lower than the current Black Country average. Commissioners are working to understand where this growth originates from. WMAS have addressed the system pressures with their winter plan which is attached at Appendix 2 for information.

We also note that winter resilience monies are made centrally available to WMAS and will work as part of the regional commissioning arrangements to understand how this will be committed.

Within the Wolverhampton areas, WMAS are struggling to hit the 75% target for Category 1 calls however Wolverhampton report 72.5% for July which was the highest in the Black

Country. In an attempt to understand and support WMAS, the AE Delivery Board is investing in additional HALOs to ensure minimal delays in handovers and turnarounds to facilitate crews being able to respond to the calls quickly.

See and Convey volume has seen a drop down to 60.4% (July 17) from 62.5% (Year to date – 2016/17). This has been partly down to the introduction of the Rapid Intervention Team in the community.

2.5 Support to Care Homes

- Geriatrician/ANP input into care homes
- Targeted intervention into care homes by the QNAs
- Assessing compliance with the BGS Guide on care home medicine
- Red bag scheme - 'hospital transfer pathway' to provide prompt and efficient transfer of clinical care, when a patient / resident moves between care home and hospital.
- Targeted training to support admission avoidance from harms e.g. falls prevention, Pressure injury prevention
- Training in early detection and management of deteriorating residents
- Training in quality improvement tools and methodology to promote safe practice and improve quality
- Promoting best practice through lessons learnt from serious incidents
- Living well to the very end - Patient and family-centred care collaborative approach to improving End of Life Care in Wolverhampton Residential Homes.
- Multiagency approach in admission avoidance through monitoring of harm free care and quality

2.6 Service and system escalation processes

The CCG has invested in the Regional Capacity Management Team (RCMT) for a number of years in order to support robust planning and capacity management across the system. The RCMT can provide support to providers across the system and through a number of means can support the management of pressures as they emerge and robust planning.

The RCMT is able to provide regular data and information in real time, retrospectively and predictively which the CCG utilises and shares with partners as appropriate.

The RCMT also hosts the Escalation Management System which offers a mechanism for providers to communicate the current level of escalation and particular pressure points quickly to all parts of the system. This comprises a set of triggers which give

detail of particular pressure points and lead to the generation of an overall escalation level. Key urgent care services are utilising this functionality on a daily basis which is aiding a wider understanding of flows and pressure points.

As pressures are identified and alerts cascaded out across the system, organisations should refer to the agreed escalation action cards and undertake the appropriate actions to facilitate de-escalation at the earliest opportunity. Our shared ethos is not only to manage current pressures but to also prevent any further escalation. As part of declaring an escalation level, providers are required to estimate time to de-escalation and this is based upon all partners fulfilling their agreed responsibilities. At higher levels of escalation multi agency teleconferences can be convened where actions are agreed collectively and constructive challenge is employed.

The health economy are expecting to implement the OPEL framework again this winter and will maintain oversight of reporting to ensure speedy response where required.

The CCG Executive team also participate in an on-call rota to ensure Executive level input is available across the Black Country out of hours to respond to incidents and pressures in the system. This rota is in effect year round and covers holiday periods. The CCG maintain an in-hours rota of senior managers.

2.7 On-Call Arrangements

During the In-hours period, Wolverhampton Health Economy have on-call arrangements in place. This is managed through a CCG rota of senior managers/executives. The CCG also have 3 x Weekly teleconferences with RWT where system pressure is discussed.

During the Out of Hours period, the CCG is part of the Black Country Exec on-call rota. This is managed by Sandwell Switchboard who have the latest rota.

Both In-hours and out of hours, any provider or local authority can escalate issues directly with the CCG.

The acute and community provider has a 3 tiered on call system. The first is the on-site, patient flow and local bleep holder cover. There is a silver tier on call manager on call 24/7, supported by a gold level, director level on call support 24/7. Both silver and gold command are on site 7/7.

2.8 Communications

AE Delivery Board recognises the benefits to having robust communication with patients/public. For economy of scale, the CCG work with the CSU who manage the standard media campaign on behalf of the Black Country.

The objectives from the 2017/18 campaign will be:

Clinical perspective:

- Increase flu vaccination take-up in the target groups:
  -Carers
  -Pregnant women
  -Long term conditions
- Reduce pressure on urgent care and A&E using V08 data/ A&E attendance figures
- Increase calls to 111

Marketing perspective:

- Facebook engagement and evaluation
- Twitter engagement and evaluation
- Media reports
- Web statistics
- Video and animation views and engagement
- Benchmarking data through quizzes
- Face to face engagement and feedback

The overarching aim is to encourage people to take ownership of their health and to access the right service for their health needs.

In relation to Flu, the campaign will target:

- Long term conditions (e.g. asthma)
- Pregnant women – continuing success in 2016/17
- Children aged 2-4
- Carers

In relation to encouraging self-care:

- Frail older people
- Carers
- Parents of 0-5s
- Voluntary & community sector – e.g. Age UK, carers groups, children's centres

To complement the NHS England winter Stay Well campaign, locally we will ensure that we are communicating details of service opening times over all bank holiday periods and

ensuring that the directory of services is updated where there are variations to operational hours.

We are currently exploring opportunities within the STP for aligning our winter communications plans to ensure consistency of message and best use of available resources. As part of this we are looking at novel and innovative mechanisms to engage with local populations.

Our escalation plan also sets out how, as a system, we will manage communication with one another. Our principles for communication are as follows:

- All partners will sign up to the Escalation Management System (EMS) and opt to receive notifications when organisations escalate
- Organisations will proactively initiate communication with relevant partners to resolve issues at an early stage
- Teleconferences will only be called where delivery of benefits to the system can be identified, when they are required all relevant organisations must commit to participating in the call
- WCCG will ensure that all relevant messages are communicated across its member general practices
- A joined up approach will be taken across all health and social care organisations when communicating messages

We understand that NHS England is likely to deploy the OPEL framework again this winter. We will review reporting requirements once they are released and consider whether we should amend how the level is calculated/weighted.

2.9 Flu campaign

2.9.1 Public Health campaign

Public Health are working with and supporting NHS England priorities and programmes. In addition they have worked with and supported RWT in proposing new ways of reaching the eligible population for flu vaccination whilst patients may be accessing other services within the trust I.e. Those on dialysis, seeing consultants, pregnant women through maternity checks etc.

Public Health are working in conjunction with the CCG to look at both good and not so good performing GP practices with the view to assist them in improving vaccination rates (not just for flu). In addition there is work ongoing with pharmacists in encouraging flu vaccines through them in the community.

Finally Public Health will be writing to all care and nursing home owners/managers to promote flu vaccination for residents and staff. We are hoping to try and capture these figures to help us focus resources next year.

2.9.2 Flu Campaign – UCC

Flu Vaccines to be promoted to all staff within the UCC to ensure all staff take part. Agreed escalation plans are in place and daily calls in place to assess the shift rota fill. Local Management will be on site to manage pressures.

2.9.3 Flu Campaign – RWT

Each year the NHS prepares for the unpredictability of flu. For most healthy people, flu is an unpleasant but usually a self-limiting disease with recovery generally within a week. However, there is a particular risk of severe illness from catching flu for:

- older people
- the very young
- pregnant women
- those with underlying disease, particularly chronic respiratory or cardiac disease
- those who are immunosuppressed

For the 2016/17 campaign RWT vaccinated 72% of its front line staff. For the 2017/18 campaign we are aspiring to achieve 70% uptake.

The organisation is fully committed to supporting the national campaign and employs a small Occupational Health & Wellbeing Service who currently provides the year Flu campaign. The organisation is aware that the Flu is a key factor in NHS resilience. It impacts on those who become ill, the NHS services that provide direct care as a result, and on the wider health and social care system. The annual immunisation programme helps to reduce unplanned hospital admissions and pressure on ED. It is therefore a critical element of the system-wide approach for delivering robust and resilient health and care services during winter.

Learning from success and failures from last year's campaign a working group has been established with previous managers involved. Within the team it has been highlighted that senior management, time & resources are required in order to sustain an effective Flu campaign, vaccinating our front line staff, to ensure our staff, patients, and families are not affected but also achieving the CQUIN.

CASE FOR IMPROVEMENT

The 2016/17 campaign was a difficult campaign and we didn't reach our target until December which was the last month which counted towards the uptake in vaccines. There was no allocated funding available to the campaign which resulted in OH&WB to endure the cost. Reduced staffing levels within the OH&WB team, admin services and no bank work provisions resulted in restricted delivery of service. Due to less admin services we were unable to have real time data and unable to target areas efficiently.

Additional Resource has been approved to support this years' campaign.
Admin support – to ensure data entry into the ESR system is accurate, up-to-date and efficiently input. This will allow real time data to be presented at the relevant meetings and for Trust Board. This will allow the Flu team to target areas where necessary and can identify where myth busting/education & training may be required.

Additional bank hours - at an enhanced rate for peer vaccinators to continue the vaccinating in their own time. 24/7 service required for a 24/7 organisation.

IPAD's – IPDA'S to be issued for peer vaccinators to use when they are vaccinating. The data input will be sent directly to the admin support for ESR who will be managing this.

Renovation – Renovation to a room at RWT so fridges to store the Flu vaccines can be kept.

Fridges – The Pharmacy Department are unable to store the Flu vaccines due to capacity issues. Fridges will need to be ordered to avoid disruption to the campaign.

Advertisement – Schedules, myth busting and other Flu posters will need to be printed via RWT's medical illustrations team.

Donation – It has been agreed by senior managers that a donation will be made to a charity following closure of Flu campaign 2017. The donation will be based on the percentage of those vaccinated.

2.9.3 Flu Campaign – Mental Health Services

[wording to be inserted when received from Denise Tooth]

2.10 RED BAG Initiative

2.10.1 The Red Bag Project is based on the Vanguard Project and aims to deliver a variety of key outcomes including, meeting NICE guidance for transfer of care along the hospital pathway (NG27), reduced length of stay in hospital, increased communication and patient experience. In Wolverhampton we have combined this project with the CCG quality team to deliver advanced end of life care plan training in conjunction with the Red Bags.

2.10.2 An implementation group consisting of LA, CCG, Ambulatory care, RWHT and care home staff has been formed. To date 9 care homes supporting 267 residents have agreed to participate, currently awaiting confirmation from the remaining homes in the city.

2.10.3 The paperwork and implementation guidance has been received from the Vanguard Team and localised paperwork is completed in draft form. Training and implementation is due to commence early September with identified care homes. The first 50 bags are due for delivery mid-September with the remaining 950 bags due on 7th November. An official launch of the project is being scoped for October 2017 with the training commencing prior to the delivery of the bags to ensure care homes can implement the process without delay.

2.11 Investment underpinning System Resilience

In 2017/18 the AE Delivery Board has received a financial resource of £1.3m to reinvest into Wolverhampton health economy. In addition the CCG has allocated both sanctions money and incentives money into the AE Delivery Board budget to reinvest in to the urgent and emergency care system resulting in approximately £1.7m.

AE Delivery Board has committed a large proportion of these funds already. See table 1 below. This leaves a contingency fund which the AE Delivery Board will need to consider for investment over the Winter Period.

Table 1 - 2017/18 schemes

GP support to Resource Centres (CCG)	£24,000.00
Wolverhampton Voluntary Sector Council Scheme (WVSC)	£123,504.00
Additional Social Workers for Ward Huddles	£224,944.00
P3 Homeless Charity	£109,540.00
Dementia project	£16,989.00
Increased AMPs	£50,000.00
Additional Patient Flow Co-ordinators	£213,415.00

Additional Porters	£105,000.00
4 hour Minors Trial	£76,666.00
Red Bag Initiative (via LA)	£40,000.00
Extended Access in Primary Care (Bank Holidays and Christmas)	£67,973.88
WMAS Handover delays	£1,887.00
Ambulance activity NEPTS	£20,000.00

3. PATIENT FLOW – ACCESS ROUTES TO NON-ADMITTED CARE

3.1 Referral Routes

Where ever possible, there are options available to avoid unnecessary admissions to the Acute Trust. To facilitate this, Wolverhampton Urgent Care Triage & Access Service (WUCTAS) is a single point of access for GPs and Health Care professionals in the community to access services for patients. The options available include both services in the community as well as those within the Acute Trust.

Community Services:

3.1.1 Admission Avoidance Team

The Admission Avoidance team are an integrated team providing a number of key functions to support the healthcare system. The team provide a rapid response to patients suffering an exacerbation of a health condition. The team accept referrals from Primary Care, Urgent Care, WMAS and other Community based nursing services.

The team provide a time limited intervention to ensure the patient is assessed, a care plan developed and treated at home, thus reducing demand on the Acute Trust.

The team also consists of a dedicated support function for the care home sector by the **Home Intervention Team**. This team support residents to remain in their usual place of residence whilst being treated for an acute episode, again reducing the demand on the Acute Trust. They are supported by a Consultant Geriatrician and a Respiratory Consultant who provide telephone support and input into a virtual ward round.

Both teams provide a seven day service across the city.

The CICT service operates seven days per week providing rehabilitation support to people in their usual place of residence to reduce the need for extended length of stay in hospital. They operate in an integrated manner with the Rapid Intervention and home intervention teams to ensure a holistic approach to out of hospital care.

The team work in partnership with the **Local Authority reablement** teams ensuring patients requiring ongoing reablement are assessed and referred for support to remain in their usual place of residence.

Their aim is to:

- Prevent hospital admissions (and re-admissions)
- Support patients in their usual place of residence to remain as independent as possible following a hospital admission
- Prevent patients from having to move into a residential home until absolutely necessary

The **Hospital at Home** team provide a seven day service delivering time limited interventions to support patients with acute illness. The aim of the service is to reduce hospital admissions by providing community based care for any individual who requires intensive treatment and/or support to prevent hospital admission or facilitate early hospital discharge. The service operates from 8am – 10pm seven days per week.

The CCG also commissions a '**step up' bed facility** to support the Admission avoidance teams. These beds are clinically managed by the Rapid Intervention team supported by a local GP. The aim of the service is to provide a community bed based service to support the following cohort of patients

- Those who following an intervention from Community Rapid Intervention services, require a monitored/supervised period of care

Access is to the beds is via the Rapid Intervention team. Length of stay is limited to up to seven days to ensure maximisation of capacity and a reduction in reliance on bed based care.

This facility is available seven days per week.

3.1.2 Urgent Care Centre

The Urgent Care Centre in Wolverhampton has been commissioned as a Type 3 AE which sees, as a minimum, minor illness/minor injury. The service operates 24 hours a day, 7 days a week and is expected to meet the four hour national standard. This service is accessible either directly as a walk in patient, booked via NHS111 or triaged from ED. The benefits of this service being co-located with ED means that patients who choose ED, can be redirected to the GP led UCC which is situated directly above ED.

3.1.3 Primary Care Streaming at front door of ED

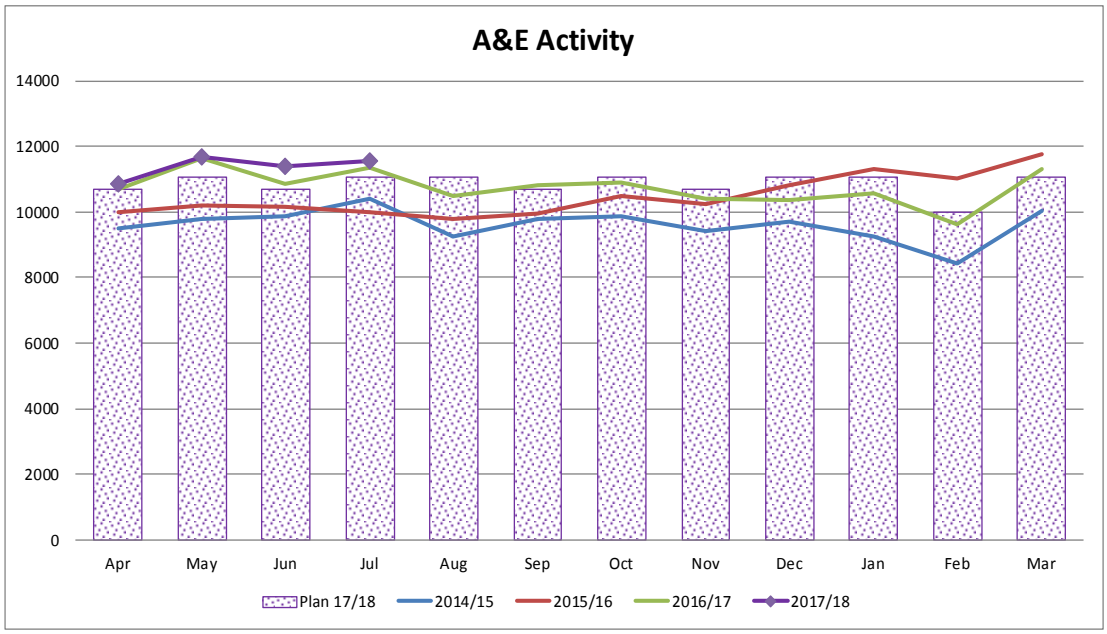
For those patients who present to ED either inappropriately or are unsure which service will meet their needs, Wolverhampton implemented streaming at the front door of ED in April 2016 when the co-located Urgent Care Centre was opened.

However, this proved to be challenging for a number of reasons including confidentiality and inability to undertake initial physical assessment. To develop streaming further, staff at the Urgent Care Centre are trained to undertake ED Triage and now work with ED colleagues to jointly triage patients that present to ED. The number of patients who are passed between the UCC and ED has dropped since the development of Joint Triage. This leads to a smoother patient journey and reduced time to be treated.

Acute Trust Services:

Once a patient has accessed ED either via ambulance or by self-presenting, every effort is made to ensure the patient is managed within the four hour standard and is only admitted to a bed where clinically required. Activity trends in ED are detailed in table 2 below.

Table 2 – Activity Trends



3.1.4 Clinical Input into ED/Admission Avoidance

Physician A Model

- Previously all medical consultants contributed equally to an on-call rota with 2 consultants working in the AMU each day from early afternoon to early evening during the week, and just 1 consultant 'on take' in AMU at the weekend. This has been remodeled into 2 rotas.

- Physician A – 12 acute medicine and acute-minded consultant physicians supported by an SpR and 2 junior doctors work in ED 10:00 to 21:30 7 days per week on a 12 person rota.
- Physician B – The remainder of the medical consultants working in AMU from 13:00 to 21:30 performing a rolling post take ward round tailored to the patient needs and dependent on previous Physician A input and handover.
- This model was co-designed by a clinically led work stream including membership from the ED and Medical teams as part of the development of the new Urgent and Emergency Care Centre. The model launched when the centre opened in November 2015. The estate developments included a modest increase in ED cubicle capacity (10%) but no change in AMU beds. The old acute medicine ambulatory area was closed and not recreated and the aim was to deliver elements of ambulatory care from ED.

The principles behind the new model were:

- Create a small team of like-minded medical consultants that could adapt to a changing landscape, keep up to date with evolving ambulatory options and develop good working relationships with the ED team
- Patients will be assessed and prioritised according to clinical need and in an area where rapid treatment escalation is possible – all medical patients would be assessed by the ED team in the first instance
- Joint, face to face senior decision making between ED and Medical teams allowing both to understand each other's aims and challenges and to learn from each other. Previously the ED team received negligible feedback on patients after admission to AMU
- Senior decision making at the earliest opportunity, improving diagnostic accuracy and efficiency and facilitating early interventions in time critical conditions. Patients receiving a consultant review within 14hrs
- Equity of service for all patients independent of day of week of attendance or mode of referral
- Acute medicine philosophy including championing the 'home first' principle
- Brokering with specialties to facilitate review and treatment in HOT clinics or other ambulatory settings where possible
- Support the ED team with first assessments of medical patients during surges in demand

The impact of the Physician A model is evident in table 3 and 4 below.

Table 3 – Non Elective Activity (as a %)

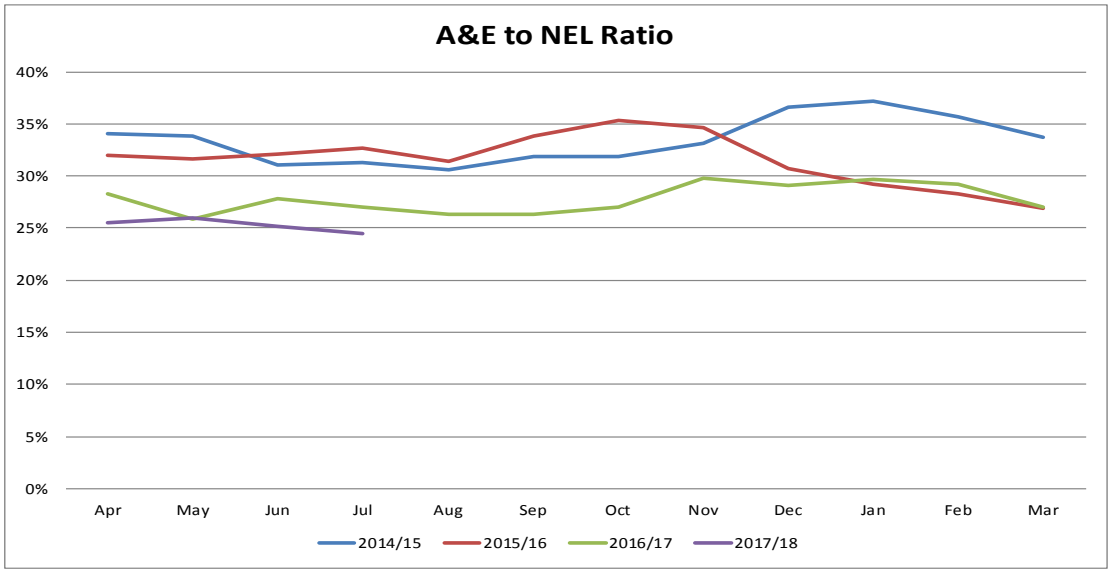
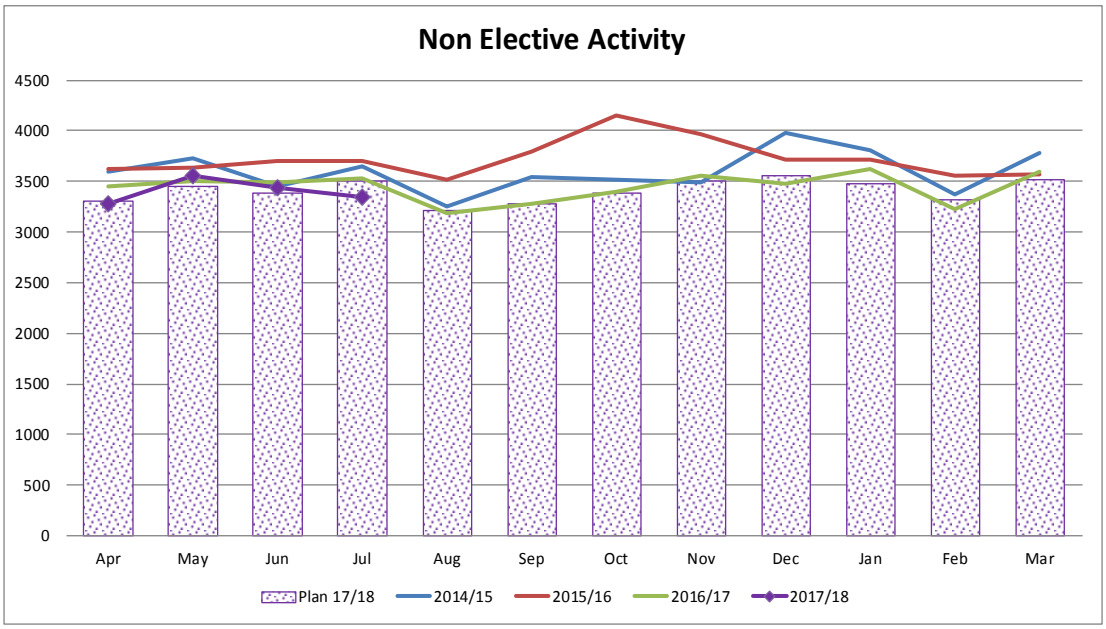


Table 4 - Non Elective Activity (actual) against plan



3.1.5 Preventing Avoidable Breaches

The Trust has developed a recovery action plan to reduce the number of patients breaching the 4 hour target. This has resulted in the overall performance increasing from 88.9% in Q4 2016/17 to over 92.5% for every month in 2017/18. There are a number of key elements contained within the plan, some of which are already mentioned in this document.

In summary, the key developments are:

- Introduced Patient Flow coordinators to support faster decision making and patient flow
- Continue with dedicated portering support for Emergency Department and AMU

- Recruited to a number of key posts including 3 Paediatric Consultants, 1 Adult Consultant, 1 Specialty doctor and 2 MTI doctors.
- Joint triage implemented with ED with UCC staff to enable observations and physical assessment to take place. This facilitates more effective triage and ultimately patients are moved faster
- Development of frequent attenders project with CCG and WMAS – looking at earlier intervention and development
- Patient Flow rapid improvement events facilitated by Human Factors Project. To look at new ways of working in Majors and Minors, combination of staff groups to include: Consultants, Middle Grade, Junior Doctors, Nurses, HCA and Physician A.
- Human factors training for all relevant staff to be rolled out with all relevant staff trained by October

3.1.6 Mental Health Services

AWAITING UPDATE FROM DENISE TOOTH - BCPFT

3.1.7 Ambulatory Care/HOT Clinics

In the 1st September the Trust was informed that a capital bid to develop a frailty and ambulatory care unit, next to the current Clinical Decision unit was approved.

Subject to internal and external (CCG) business case approval, the trust will further develop the Ambulatory care model from January 2018, providing a facility designed to assess, diagnose and treat patients in a day case facility who would otherwise have had a 0-2 length of stay.

4. FLOW WITHIN THE HOSPITAL SYSTEM

4.1 Use of Safe Hands Technology

Safe hands technology allows the Trust to used real time information to manage the hospitals hot site (New Cross Hospital) bed capacity.

In order to ensure maximum utilisation of the technology, The Trust has established a Patient flow Group which reports into the SafeHands Delivery Group, chaired by the Chief Operating Officer. The Patient Flow Group has a work plan and progress is monitored via a suite of key performance metrics. The metrics capture admission, transfer, discharge, Discharge to Assess, Safer bundle and Red to Green initiative.

In real time, the Trust is currently achieving 61% against a target of 70% for capturing pending discharge dates and 56% against a target of 90% for confirmed discharges within

the SafeHands system. Progress is being supported by the huddles in medicine and ward rounds within surgery.
Good progress is being made on the number of patients discharged by 16.00; again work is progressing within the wards and directorates to increase this percentage.

Work is on-going on how to capture Red to Green results within the SafeHands system as currently this is not captured in any of the available modules. The Trust is one of the four National pilot sites for the utilisation of Tele-Tracking and once the other Trusts go live we will be able to benchmark progress against agreed key performance indicators.

4.2 Use of daily huddles and super huddles on medical wards

Huddles/ board rounds provide the single point of reference, ideally at the start of each day, when key multi agency staff come together to review the clinical and discharge needs of each patient. The multi-disciplinary team must verify daily discharges and prediction of patients who will leave hospital within the next 48 hours. Accurate information will be entered into tele- tracking at time of the huddle/ward round, giving date and time of discharge. Key elements of the process include:

- The Consultant is accountable for the safe transfer of patients. The Consultant is the final decision maker regarding the decision to transfer a patient from the care of RWT. They are responsible for balancing the risks of remaining in hospital versus discharge on a daily basis. The role can be delegated to an appropriate medical grade.
- Band 7/ Shift Coordinator nurse is responsible for ensuring the required patient information is available and completion of action log/Safe Hands is up to date.
- Flow assistant provides support to clinical and therapy staff, advising and updating on progress of individual patient discharge plans
- Social care advises on suitability of patients for social care and progress of current social care assessments including any current barriers within the system
- Therapist advises on the progress of therapy assessments. This includes any further Physiotherapy or Occupational Therapy requirements and whether they are mandatory before discharge or can be delivered outside of the hospital setting with bridging support where necessary

4.3 Red and Green days

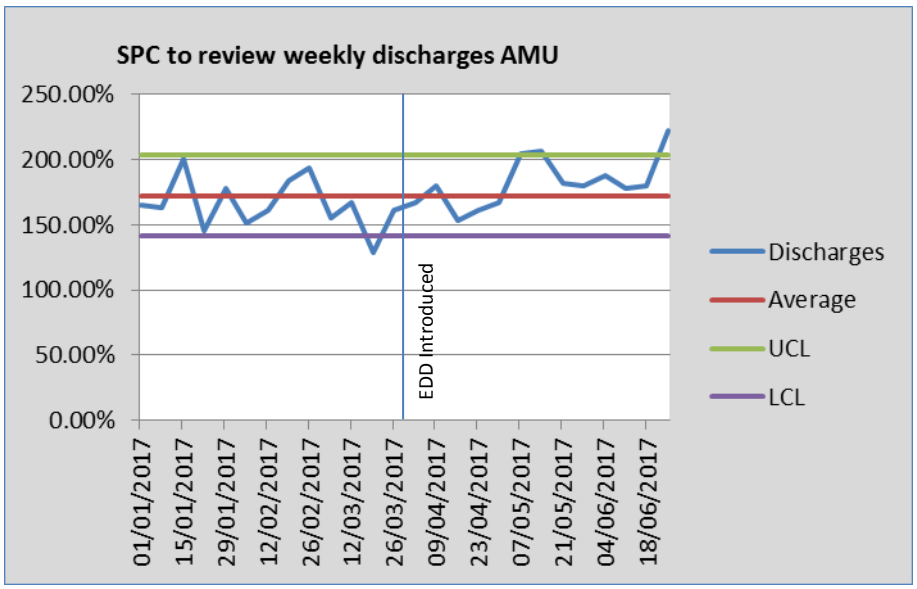
Red and Green Bed Days' are a visual management system to assist in the identification of wasted time in a patient's journey. A Red day is when a patient receives little or no value adding acute care. A Green day is when a patient receives value adding acute care that advances their progress towards discharge. Key elements of the process include:

- It is the responsibility of the board round lead at the daily huddle to ensure that All patients should be marked as a RED day, for the MDT to discuss whether or not status can be changed to green.

- When delays relate to awaiting tests/results, delays of over 12 hours for diagnostics, assessments, reviews etc. will be followed up. If they cannot be resolved that day, the delay should be highlighted to the Directorate management team to take appropriate action and resolve.

4.4 Use of Expected Discharge Date

RWT report on the proportion of patients admitted who have an expected discharge date on a weekly basis. These reports are distributed widely and reviewed at the Trust's Patient Flow Group, Clinical Directors meeting and individual directorate's performance meetings. The use of EDD in the Trust has been seen to have a positive effect in AMU. Once introduced at their Daily MDT, there was a significant rise in the number of discharges:



4.5 Use of SAFER bundles

The Trust is pioneering the use of the SAFEHANDS system to review the SAFER bundle. The elements of SAFER are:

- S – Senior Review for patients prior to 12pm
- A – All Patients have an EDD
- F – Flow, patients will be pulled from assessment wards prior to 10am
- E – Early Discharge. 33% of patients will be discharged from base wards before midday
- R – Review. A systematic MDT review of patients with extended lengths of stay

The SAFEHANDS system is used to record information against all of these metrics. These reports are monitored at the Trust's Patient Flow Group, Clinical directors meeting and Individual directorate's Performance meetings.

4.6 Stranded Patients

Patients whose delayed discharge relate to internal issues are addressed at the daily huddle MDT meetings. The review of patients under SAFER is presently focussing on those stranded patients who are medically fit but are delayed discharge due to external factors. These patients are discussed at the twice weekly senior MDT meeting to facilitate their safe discharge to an appropriate destination. This includes all delayed patients irrespective of age.

4.7 Occupancy rates

The Trust has closed two wards over the past year. The first was a rehabilitation ward that was closed due to clinical staffing levels; the second was a medical ward that was closed following the enhancements in ED and the reduced level of emergency admissions. This has had a hugely positive impact across the health economy and the level of bed occupancy has been at a safe level throughout this period.

Month	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	YTD
% Occupied	92.43%	93.35%	91.90%	91.62%	89.86%	83.81%	86.15%	86.00%	83.96%	88.18%	88.57%	89.31%	88.76%

Month	Apr-17	May-17	Jun-17	Jul-17
% Occupied	85.03%	85.67%	86.67%	85.89%

The Trust is planning for a similar level of bed occupancy for 2017/18 winter period. There is a small amount of escalation capacity that can be opened in extremis.

4.8 7-day Services

The Trust continues to ensure that access to a Consultant is available every day of the week. Additional support to these Consultants is provided from the junior doctors. The Trust is also planning to provide more senior nurses and therapists to ensure that care and flow for non-elective admission is the same on every day of the week

5. DISCHARGE

5.1 Eight High Impact Changes

5.1.1 Wolverhampton has undertaken a partnership self-evaluation against the High Impact Change Model for Managing Transfers of Care and has produced an initial action plan that will be submitted as part of the Better Care Fund 2017/19 Plan Submission with ownership by the A & E Delivery Board and oversight by the Better Care Fund Programme Board.

5.1.2 Partners have committed to the forming of a Task and Finish Group that will ensure that actions are clarified and detailed timelines established for delivery. The group will also ensure that the action plan is co-ordinated, delivered and reported back to A & E Delivery Board and BCF Programme Board for governance purposes.

5.1.3 The table below provides an overview of the result of the self-evaluation and where Wolverhampton expects to be in terms of implementation of the model by November 2017:

Change Description	Self-Evaluation (as at August 2017)	Expected position by November 2017
Change 1 Early Discharge Planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.	**Plans in Place**	**Established**
Change 2: Systems to Monitor Patient Flow. Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual	**Some aspects have Plans in Place and some Mature**	**Some aspects have Plans in Place and some Mature**
Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and positive outcomes for patients	**Established**	**Exemplary**
Change 4 : Home First/Discharge to Access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital	**Established**	**Mature**

and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow		
Change 5 : Seven-Day Service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs	**Mature**	**Mature**
Change 6 : Trusted Assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.	**Plans in Place**	**Established**
Change 7 : Focus on Choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options. The voluntary and community sector can be a real help to patients in supporting them to explore their choices and reach decisions about their future care.	**Mature**	**Mature**
Change 8 : Enhancing Health in Care Homes. Offering people joined-up, coordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.	**Established**	**Established**

5.2 Discharge Capacity

5.2.1 Social Care Reablement services currently operating at capacities at least 25% above the same period last year due to improvements achieved through Red2Green programme implemented in Bradley Resource Centre and HARP to reduce service user length of stays.

5.2.2 In the 2017 Spring Budget, central government announced additional funding for Adult Social Care over a three-year period. A number of proposals had been approved including the commissioning of additional homecare reablement from the independent sector. This would enable the twin tracked provision of both the internal reablement service provided by the City of Wolverhampton Council (CWC) and substantially increase independent sector reablement support. This Service will be inclusive for people with dementia and will be an occupational therapy led model.

5.2.3 Home Care Reablement embeds a philosophy and approach which supports people to build on their current assets and abilities which empowers individuals to 'do things for themselves' rather than having things done to them. This is a short-term provision, and encourages individuals to develop the confidence and skills to carry out these activities themselves and, consequently, removes or reduces the need for ongoing care, and other forms of support. It is recognised that maintaining and improving people's independence to enable them to return to their own homes remains the priority.

5.2.4 The Service approach will be one of enabling in order to:

- Prevent avoidable hospital admission
- Reduce/delay admission to residential care
- Facilitate safe discharge from hospital or other bed based facility
- Maintain or improve levels of independence.

5.2.5 It is anticipated that this Service will;

- Work with individuals to deliver reablement goals within the specified time period
- Reduce the need for longer term ongoing support from social care
- Deliver a high level of customer satisfaction
- Enable people to remain in their own home for longer
- Skills and tools to manage the challenges of living with dementia
- Increase confidence and self-esteem to remain independent for as long as possible in their own home.
- Reduce feeling of social isolation
- Improve emotional well-being

5.3 Placement without Prejudice

Within Wolverhampton a local policy is in place to use 'without prejudice' arrangements to facilitate discharge in circumstances where agreement has not been reached regards responsibility for funding future care requirements.

5.4 Discharge to Assess

Discharge to Assess (D2A) is currently being piloted across 4 wards with New Cross Hospital. There is a comprehensive role out plan which will embed the process throughout the trust by November 2017.

There has been significant engagement with a wide range of stakeholders to provide an understanding of the programme and the use of 3 distinct pathways to facilitate timely discharge from acute care.
The number of assessments completed within an acute setting will be minimised and a 'Home First' approach will maximise the potential for individuals to return to, and remain within, their usual place of residence.
An email address is in place for all D2A communications and tripartite funding has been agreed, initially on a 6 month basis, for dedicated clinical and administrative support to provide additional assurance around the new process.

5.5 Trusted Assessor

The model developed within Wolverhampton requires the appropriate clinician to complete the detail pertinent to their aspect of patient care.

The trusted assessor process is working effectively on the pilot wards and an electronic version of the document is under development and will be in place by mid –September. This will enable safe sharing of patient information with the services delivering support on discharge, streamlining the process.

6. DEMAND

6.1 Predicted Demand

The health system utilises predictive data that is generated by the RCMT, and data can be forecasted up to twelve weeks in advance. WMAS also provide forecast data based on previous activity. At the time of submitting this plan predictive data is not yet available for the majority of the winter period. System partners intend to review the activity projections as they are released by the RCMT and ensure capacity is planned accordingly.

The UCC uses historical data to predict/forecast activity numbers. The service has now been operational for 18 months and activity patterns can inform Winter planning. The service also takes learning from services across the country to aid in predicting peaks in ambulance activity.

6.2 Christmas & Bank Holiday Demand

Wolverhampton Doctors Urgent Care (WUCC) are carrying out statistical forecasting to provide a robust view of the calls anticipated over the winter period specifically focusing on the key dates throughout December 2017 and into January 2018. The forecasts will be agreed with the Executive Team and will be shared with CCGs / NHSE England reporting for analysis and assurance where required.

The key elements that are being undertaken to drive the forecasting model for the Wolverhampton UCC will include previous data from 2016 and 2017 to assess anticipated demand with modelling variations included to account for uplifted activity due to the weekend Christmas and New Year holiday period.

The priority activity days will be identified. The intraday breakdowns will be reviewed and, if required, actual activity can be tracked by hour over the key periods against predictions.

Forecasting identifies that, against standard activity assumptions additional shifts are required to enhance the rota over the 4 day Bank Holiday period. The rotas have been published based upon last year's staffing model using Boxing Day activity as this is one of the busiest days, whilst a full review is undertaken. From early December there will be a leave embargo during the peak activity dates. Enhancing the rota will include:

- Extending shifts for all staff
- Approved Agency usage
- Enhanced financial incentives for shift cover over the 4 day bank holiday
- Early promotion of key shifts / skill mix

7. RESILIENCE & CAPACITY (UCC)

7.1 Workforce capacity

The WUCC will be continually reviewed with shift amendments made closer to the priority activity dates to maintain optimum cover throughout, as well as on shift capacity management. With regard to increased service line capacity (ensuring service is delivered against key performance indicators) WUCC has access to mutual aid from across the Vocare Group with regard to remote triage and this will be invoked proactively to ensure service level compliance. We will also be sharing key updates of shift fill and ensuring the service has communication plans in place with agreed thresholds of contact with the CCG. These will be agreed prior to entering the busy periods.

Given the operational pressure normally encountered during Winter, local senior leadership with operational experience will form part of a local on-call system with on-site presence during the priority activity days. This will provide crucial oversight to the system during the Key periods. For assurance, organisational protocols are in place for system-wide communication and escalation.

WUCC aims to meet the current trajectory (KPI compliance) on each of the priority activity dates including streaming times. This will be continually monitored to ensure the best

possible performance achieved. Daily monitoring and reporting will be increased through the priority activity days and will include:

- 9.30 am Risk Assessment Shift meetings held – establishment of key activities, volumes, hotspots and actions to be taken if needed along with a review of previous 24 hours activity
- 10:00 am Internal Group wide Operational SITREP telephone conference led by Operational on call focussing on operational issues affecting delivery (eg: staffing, backlogs, weather) and agreeing corrective action across the group including mutual aid support.

*Additional SITREP meetings will be arranged where there are concerns raised for urgent action and follow up

7.2 Staffing (clinical and non-clinical)

All previous workforce engagement workstreams to improve clinical and non-clinical capacity to meet demand will be in fully implemented by the end of November 2017. The use of Agency will be for short term circumstances only. This means that the staffing of rotas will be managed in line with current rotas.

7.3 Weather and transport

WUCC receives weather warnings via the clinical commissioning group as well as weather alerts and forecasts from the Meteorological Office. This allows the organisation to put into operation the appropriate plans in a timely fashion. In the event of adverse weather such as snow, ice and flooding a control room will be activated in Staffordshire House, so there is a single focussed controlled event room. In addition, we will be encouraging staff to plan ahead and develop their own contingency plans.

Drivers will be available to use the GP OOH cars so that staffs are able to attend work. Contingency will include remote management of activity either with remote clinicians logging in or diverting calls elsewhere within the Vocare Group.

Any adverse conditions affecting the GP OOH service, all vehicles have 4x4 capability and access permitting critical home visits will, where possible continue, although, the majority of patients will be managed virtually or requested to attend a fixed base for an appointment.

Emergency Preparedness, Resilience and Response (EPRR) contingency will be invoked as appropriate.

7.4 Risk Management

The Key risk to delivering this Winter Plan will be the ability to manage demand should this present above forecast due to the alignment of Christmas over a weekend period, and to some extent represents a level of unmet need due to the prolonged closure of primary care. Pharmacy provision will reduce the immediate risks of increased demand and we will be

working closely with all stakeholders including the NHS111 & CAS services to ensure a stream lined process.

An annual leave embargo has been put in place to avoid a reduction in workforce during the highest demand period of the calendar. Senior managers will be available on site on each of the priority activity days working alongside the National Operational On Call Manager to maintain a local consistent presence and to support the Receptionists to maintain patient flow. We will also have access to IT & Clinical on Call throughout the period.

8. RISKS TO DELIVERY OF THIS WINTER PLAN

8.1 Staffordshire

As depicted in the Programme Plan, there has been tremendous progress in terms of taking forward many of the mandatory areas along with the locally agreed areas of work. However the risks associated to engagement from Staffordshire holds the largest risk to the local health economy. This is evident through the challenge in achieving the Delayed Transfers of Care targets of 3.5%. This risk has been added to the AE Delivery Board Risk Register and has been escalated to NHSE/I as it spans more than one health economy. AE Delivery Board, Acute Trust and Local Authority continue to progress this with urgency.

Staffordshire have developed and shared a SOP for recording and monitoring delayed transfers of care. This will be reviewed, agreed and monitored across the health economy.

Need to add in more assurance maybe

8.2 UCC

As detailed in the media, the provider of the Urgent Care Centre, Vocare, has been rated as Inadequate by the CQC. This will undoubtedly have an impact on staffing, recruitment and retention which in turn will impact on service delivery. The CCG are mindful of this and have put in place numerous steps to ensure there is high level of scrutiny and governance of the service and of the arrangements Vocare are putting in place. At the time of writing this report, the CCG are confident that Vocare have reviewed previous activity over the Christmas, New Year and Easter Period to ensure they are prepared to demand in 2017/18.

Appendix 1 AE Delivery Board Programme Plan

To be inserted once updated

Appendix 2 – WMAS Winter Plan

WMAS WINTER PLAN Version 2.1.pdf

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Health Scrutiny Panel
29th March 2018

Report title	Urgent and Emergency Care 7 day Services
Report of:	Medical Director Royal Wolverhampton NHS Trust
Portfolio	Adult Social Care Health and Wellbeing

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

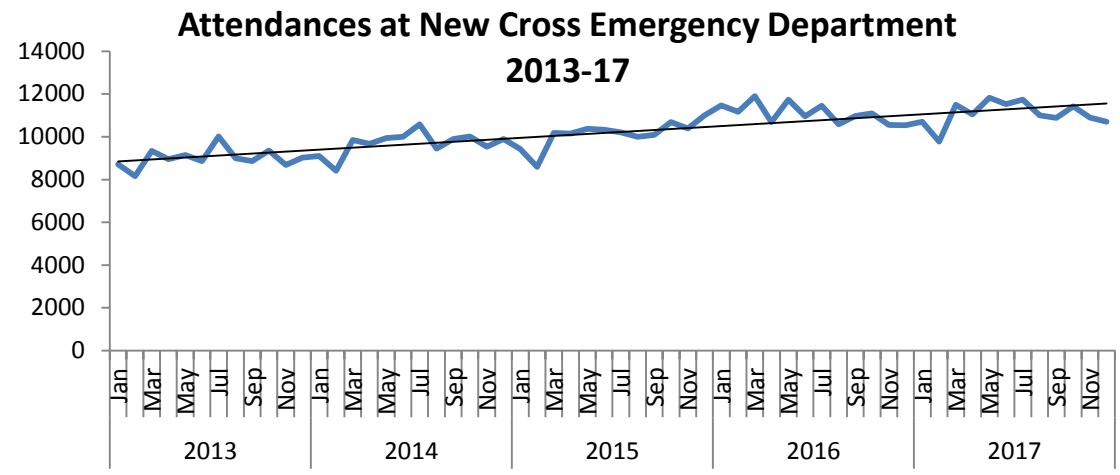
1. Be assured of current service delivery status
2. Support plans for future development which require cross organisation collaboration

1.0 Introduction

1.1 This report summarises the development of delivery of 7 day care for patients admitted to hospital as an emergency or urgent admission as defined by the NHS E Seven day forum. Achievement of the standards set by NHS England relies on cross organisation and agency cooperation and it is therefore relevant that the Health Scrutiny panel are aware of the success and barriers to achievement.

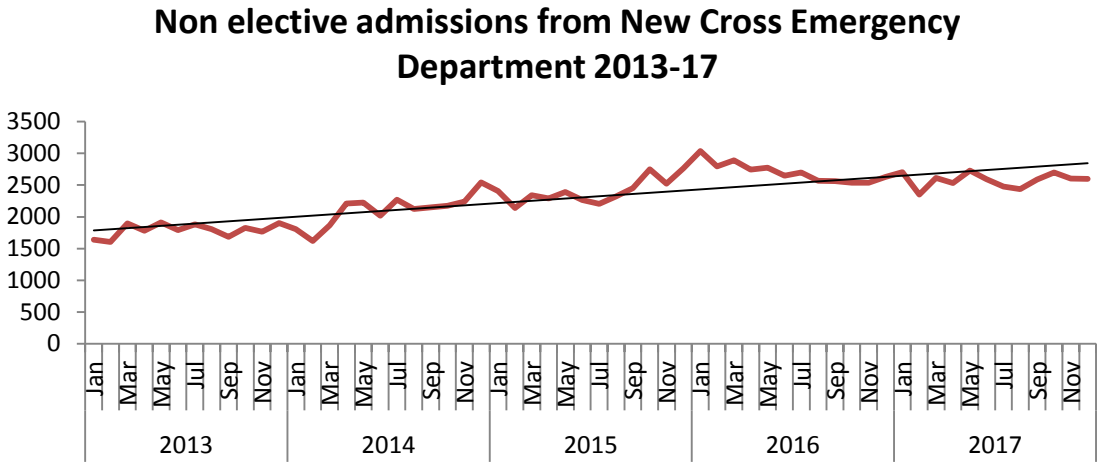
1.2 This initiative is set against the background of increasing attendances at Emergency Departments across the country including Royal Wolverhampton NHS Trust (RWT), see graph 1. Measures have been put in place to reduce the rate of growth and these show early signs of success. These measures include the triage and divert facility 111, increasing the capacity of paramedics to treat and discharge at scene, an expansion of community heath teams and diverting patients to co-located GP services.

Graph 1



1.3 Non elective admission to a hospital bed from ED has also increased over the years, see graph 2. A plateauing of these admissions occurred following the opening of the new Urgent and Emergency Care centre and the redesign of the medical take model, (Physician A and B).

Graph 2



1.4 Safe services including consistent flow of patients though the hospital is imperative in order that effective and quality services are maintained for patients. A 7 day service provision is one of the components that will support this flow

2.0 Background

The National Directive:

2.1 NHS E committed in 2015 to providing a 7 day service across the NHS by 2020. The expectation is that all patients admitted through emergency and urgent care routes (also known as non-elective), have access to consistent and equal clinical services on each of the 7 days of the week, at the time of admission and throughout the stay in an acute hospital bed.

2.2 The rationale for this is to improve safety, quality and efficiency of care, ensuring that senior decision makers are available to provide the same level of assessment, diagnosis, treatment and intervention on each day of the week. The expectation is that these senior staff will also be readily available to provide information to patients and relatives and to supervise junior staff.

2.3 In addition supporting services should be available so that the decisions of the senior team can be enacted in a timely manner and not be held up because of lack of staffing or facility resource.

2.4 It is important to distinguish this intention from an expansion in elective care. Whilst RWT does provide some elective services at the weekend there is no national or local imperative to expand this at the present time.

2.5 The national 7 day service emergency directive also runs alongside the General Practice Five Year Forward View, an intention of this to expand GP access to weekends and evenings.

The National Standards

2.6 As a measure of 7 day provision, ten standards were developed by the NHS Services, Seven days a week forum, chaired by Sir Bruce Keogh in 2013. These standards were endorsed by the Academy of Royal Colleges. Four of these standards were selected on the basis of their potential to positively affect patient outcomes. NHS E expects all Acute Trusts to be compliant by 2020.

2.7 RWT as one of twenty-six early implementer sites committed to achieving these four priority standards by end of March 2017.

2.8 The four priority standards are:

- All patients admitted as an emergency to be reviewed by an appropriate consultant within 14 hours of admission
- All patients to be reviewed daily via a consultant delivered ward round
- Seven day access to consultant directed and reported diagnostics
- Twenty-four hour access to consultant directed interventions e.g. endoscopy, emergency surgery.

2.9 The six other standards in brief are:

- Consistent patient involvement in decision making
- Consistent and timely multidisciplinary review
- Effective clinical handover between team members, led by a senior decision maker
- Timely and consistent access to mental health services
- Consistent access to support services to enable transfer out of hospital
- Attention to quality improvement by all members of the clinical team

2.10 Biannual national audits have been held each year to measure compliance.

Outputs: 4 Priority Standards

2.11 Working groups involving members from across organisations, RWT, Wolverhampton CCG, Black Country Mental Health Partnership and Wolverhampton Local authority first met in 2016 to conduct a gap analysis. Work has been ongoing to address these gaps. From necessity much of the work has been conducted by RWT

2.12 The outputs from RWT which have supported compliance against the 4 priority standards include:

- Redesign of consultant medical ' take' and acute medicine rota so that consultant ward rounds for those patients newly admitted to the Trust are run continuously between 8am and 10pm, 7 days each week
- Consultant job plans designed across the Trust so that all wards have a daily ward round and a review each evening
- Consultant of the week adopted in areas that had not previously used this model, particularly in Oncology and Respiratory directorates
- Doubling of consultants on call in Orthopaedic areas
- Introduction of documentation tools to aid communication between consultant and junior colleagues
- Interventional Radiology delivered via a network of Trusts (Dudley, Wolverhampton, Sandwell and Walsall).
- Additional consultant posts in some areas including Urology

2.13 The results of the RWT audits are as follows

Standard	October 2016	April 2017	October 2017
14hour Consultant review	63%	92%	90%
Daily Consultant review	73%	95%	Not audited
Access to Emergency and Urgent Diagnostics	Pass	Pass	Not audited

Access to Emergency and Urgent Interventions	Pass with exception of provision of weekend Interventional radiology	Pass	Not audited

2.14 National minimum compliance is set at 90%, hence RWT have met these standards for the last 12 months. Next audit is due April 2018.

2.15 However there are still some areas where vacancies or lack of resource means that compliance is not as robust as other areas. This is most marked in the care of the elderly teams (hard to recruit to area) and upper gastrointestinal surgery.

2.16 Changes to working practices across the Trust have been positive. Benefits include:

- Reduction in patient length of stay on wards where consultant of the week is adopted
- Increase in discharges on wards where consultant of the week is adopted
- Modest increase in weekend discharges but still below week day numbers.
- Qualitative date which suggests that junior doctors and nursing staff are better supported by consultants
- Qualitative data which suggests that relatives are better informed of progress and plans
- A reduction in clinical incidents in specific areas in comparison to the time before formal weekend inpatient working was introduced.

<u>Progress against 6 other standards</u>

2.17 Work has been ongoing against the other 6 standards (see 2.9 for description)

- Patient involvement/experience: RWT has analysed the data produced by the Family and Friends test. This has shown consistent outcomes independent of day of week of admission.
- Multidisciplinary review: Weekday working includes a morning MDT meeting in most areas. A pilot is currently being undertaken to extend this to weekends. However there is a deficit of staff members in some areas, see 2.18, and therefore full MDT meetings will not occur until this is addressed
- Handover between clinical staff should be the same independent of day of week in most clinical areas. This to be formalised in a Trust policy.
- The input from other agencies at weekends e.g. mental health or local authority has improved in recent years. However arguably the greatest remaining benefit to a “true” 7 day service for these patients would come from an extension into weekend services of those providers of continuing care packages both of bed provision and home support. This would support weekend discharges and support patient flow across the Trust.

2.18 Many of the 6 remaining standards require other supporting teams to provide a comprehensive service over 7 days. Progress is tabulated below

Team	Influencing Organisation	Current working status (March 2018)	Ideal future
Patient Flow Coordinators	RWT	Work across 7 days	To meet with Consultants as part of an MDT at weekends
Therapists	RWT	Work across 7 days	To meet with Consultants as part of an MDT at weekends
Pharmacists	RWT	Limited weekend working	Medicine reconciliation on wards
Senior Nurses	RWT	Limited seniority of nursing at weekends	1 senior nurse for each ward with a remit to attend MDT meetings
Social worker	LA	Weekend working in ED Saturday working for wards	Sunday working across wards, able to effect discharges into nursing homes, wider continuing care packages
Nursing Homes		Accept referrals Monday to Friday only	Nursing homes to assess and accept patients 7 days each week
Personalised support /HARP/Resource Centres	LA	Accept referrals Monday to Friday only	New packages of care to be accepted at weekends
Mental Health	BCP	24/7 service for Emergency Department. Limited support for children at the weekend No service available for ward cover	Comprehensive Children's service available Ward cover available
Community Nursing/Therapy teams	RWT	Available 7 days	As now
Step Down	WCGG	Monday to Friday V limited weekend facility	New packages of care to be accepted at weekends

Summary

2.19 The data describes the changes to service delivery which have positively benefited the care of patients attending for Emergency care at RWT.

2.20 Work is required to further expand provision. This may require an investment in resources in some areas as well as a change in culture.

2.21 RWT has had some support from Local Authority although there is more provision required.

3.0 Impact on Health and Wellbeing Strategy Board Priorities

Which of the following top five priorities identified by the Health and Wellbeing Board will this report contribute towards achieving?

Wider Determinants of Health	☐
Alcohol and Drugs	☐
Dementia (early diagnosis)	☐
Mental Health (Diagnosis and Early Intervention)	X
Urgent Care (Improving and Simplifying)	X

4.0 Decision/Supporting Information (including options)

None

5.0 Implications

5.1 Change in working patterns for some organisations and working teams

5.2 Potential investment in staffing resource required

6.0 Schedule of background papers

6.1 Further information on RWT 7ds performance and strategy can be found by contacting the report writer:

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Agenda Item No: 7

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

29 March 2018

Report title	Update on the work of the suicide prevention stakeholder forum
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and wellbeing
Wards affected	All
Accountable director	John Denley, Service Director Public Health and Wellbeing
Originating service	Public Health and Wellbeing
Accountable employee(s)	Neeraj Malhotra Consultant in Public Health Tel 01902 558667 Email Neeraj.malhotra@wolverhampton.gov.uk
Report to be/has been considered by	People's Leadership Team 19 March 2018

Recommendation(s) for action or decision:

The Panel is recommended to:

1. Provide feedback on the work of the suicide prevention stakeholder forum

Recommendations for noting:

The Panel is asked to note:

1. The update on the delivery of the suicide prevention strategy and action plan

1.0 Purpose

1.1 To provide members of the Health Scrutiny Panel with an update on the delivery of the suicide prevention strategy and action plan.

2.0 Background

2.1 A report was submitted and considered at the Health Scrutiny Panel on 25 May 2017, which provided members with information on the approach being taken to reduce suicides across Wolverhampton. The report informed members of Wolverhampton's suicide prevention needs assessment, strategy and action plan.

2.2 In summary, a suicide prevention needs assessment was undertaken in 2015. This was a collaborative effort by Public Health and the Samaritans. More than 20 local organisations were consulted as part of this needs assessment. Following completion of the needs assessment, the suicide prevention stakeholder forum was established. This forum has overseen the development of a strategy and action plan and reports to the health and wellbeing board.

2.3 The suicide prevention stakeholder forum continues to meet quarterly. Attendance at each meeting is very positive with representation across various services spanning voluntary sector, local authority services, health services, police and education.

2.4 Nationally, the government published their suicide strategy in 2012, since then annual progress reports have been published. These have provided local areas with guidance on what should be happening at a local level in respect of reducing suicides.

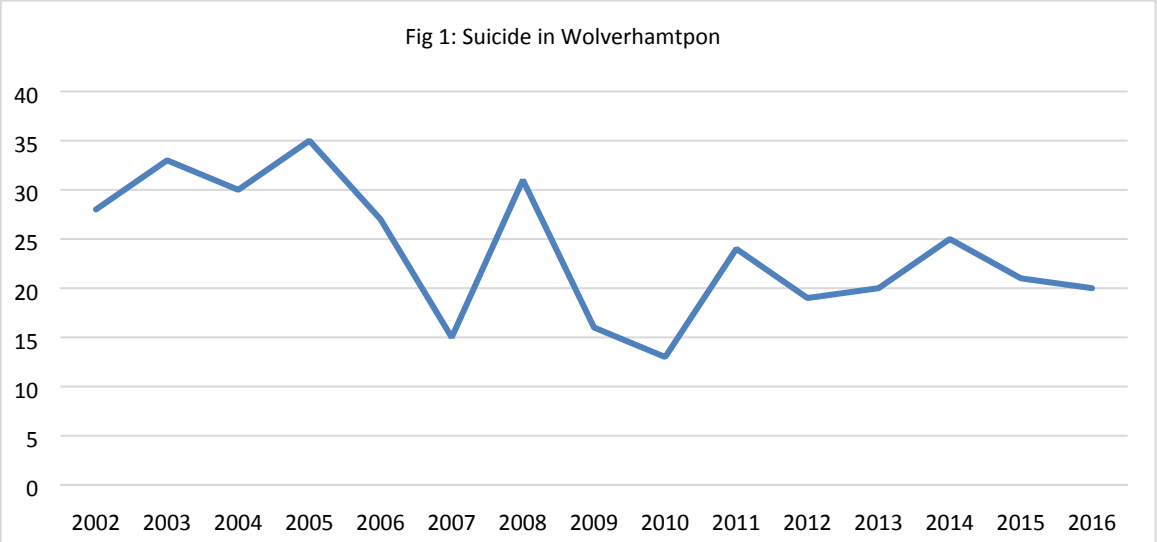
2.5 Regionally, the West Midlands Combined Authority has established an action plan known as Thrive West Midlands which is implementing the recommendations from the mental health commission. Thrive aims to deliver better mental health and wellbeing in the West Midlands. The programme identifies suicide as a key concern and has taken a zero-suicide approach, effectively meaning one suicide is one too many. Wolverhampton Public Health remains engaged with this programme through regional meetings.

3.0 Prevalence

3.1 Suicide is considered as a non-natural death which therefore requires the coroner to open an inquest. An inquest can in some cases be a lengthy process. Consequently, there is a time delay in the suicide prevalence data offered by the Office for National Statistics.

3.2 In 2016, there were 20 cases where suicide was concluded as the final underlying cause of death. For 2014 and 2015 this figure was 25, and 21 respectively.

Figure 1 below provides an illustration of suicides since 2002. Whilst there will always be fluctuations from year to year, there has been an overall downward trend since 2002.



3.3 Between 2014-2016 (3-year period) there were 66 suicides in Wolverhampton, this represents a suicide rate of 10.1 per 100,00. The England and West Midlands rate for the same period is 9.9 and 10.0 respectively.

3.4 Between 2013-2015 (3-year period) there were 66 suicides. From these, 58 were male and 8 female. The significantly higher number of males taking their life by suicide is in-line with national trends. In 2015, the highest suicide rate in the UK was for men aged 40–44. In the UK, men are around 3 times more likely to take their life by suicide than women.

3.5 It is recognised that suicide attempts are likely to be significantly higher than actual suicides.

4.0 Progress against the plan

4.1 As a result of the strategy, action plan and forum being in place, progress is being made to take a city-wide approach to reducing the risk of suicides occurring. In 2016, Government produced the 'Local suicide prevention planning – a practice resource' document, which provided local areas with guidance on implementation of recommendations set out in the national strategy.

4.2 The forum identified the need to benchmark local activity against the national guidance document. The benchmarking showed Wolverhampton to be in strong position with most recommendations in place and others in the process of being developed.

4.3 **Training:** The need to train professionals in understanding suicide, how to approach someone with suicidal thoughts and how to effectively respond was

identified in the national and local strategy. The forum has collectively carried out a range of activity to help upskill professionals.

4.4 The forum has promoted the new Zero Suicide Alliance's e-learning training across the partnership. This training has been cascaded to a number of services and positive feedback has been received from social workers, Citizens Advice Bureau staff, voluntary sector groups such as the Refugee Migrant Centre.

4.5 Media plays a key role in promoting positive messages around suicide. In response, a training workshop was delivered in conjunction with Samaritans on how to responsibly report suicide in media. Attended by a range of partners including journalists, Wolverhampton Homes, Wolverhampton College, Headstart, Starfish, Fire Service and Police the workshop was well received.

4.6 Through partnership working, suicide prevention training providers offered subsidised training for forum members. PAPYRUS, the national charity for the prevention of young suicide has delivered two Applied Suicide Intervention Skills Training (ASIST) workshops in Wolverhampton, both fully subscribed. This means there are now around 60 people in Wolverhampton who are ASIST trained and able to provide life-saving interventions with people at risk of suicide. PAPYRUS has also provided free training for a range of organisations in Wolverhampton, including Base 25 and The Way Youth Zone.

4.7 GPs play a critical role in early identification of suicidal thoughts and providing the appropriate support. The forum will be looking to deliver training to GPs in partnership with the CCG.

4.8 Colleagues from the University of Wolverhampton, who are part of the forum, delivered '3 minutes to save a life' training to various personnel throughout the University. The training continues to be delivered on a monthly basis and has been nationally recognised as best practice.

4.8 **Raising awareness**
As part of this priority the forum has reviewed Information portals such as the Wolverhampton Information Network (WIN) to ensure information on suicide prevention and mental health support services is accurate.

4.9 National campaigns such as Suicide Prevention Day, World Mental Health Day, Time to Talk Day (mental health awareness) have been promoted locally with support from partners. For example, Wolverhampton Wanderers football club supported partnership efforts in raising awareness of suicide through a photoshoot with players displaying messages of support. Messages were shared during football matches and through the club's social media channels.

4.10 Through partnership working the Wolves In Wolves project dedicated one of the sculptures to promoting messages around suicide prevention and promoting good mental health. The project was a flagship initiative across the City attracting significant national and international coverage. BBC news specifically covered the suicide prevention sculpture.

4.11 **Tailored approaches for specific groups**
Research and evidence recognises some sections of the community are more vulnerable to poor mental health and risk of suicide. National guidance recommends tailoring approaches for specific groups such as children and young people, LGBT community, older people. Wolverhampton has established workstreams around vulnerable groups to ensure a more tailored approach is taken.

4.12 The LGBT task group has been reviewing the support available to young LGBT people and has been working with colleagues from Headstart, Education Psychology, Wolverhampton Homes to help increase support. For example, the task group has worked with the new LGBT Proud To Be Me alliance, in promoting suicide prevention messages within the training they deliver to teachers and other professionals.

4.13 The children and young people task group has been reviewing the response from schools when a suicide occurs. As a result the group has fed into the Schools Critical Incident Protocol. The group are also seeking to review data from the Hospital Youth Service, with a view to looking at trends on self-harm and working with Headstart to ensure the workforce development offer includes suicide prevention. Work is also taking place specifically around older people and migrant communities.

4.14 **Data and surveillance**
There is a time lag between suicides occurring and official suicide data being published. In order to be more responsive to what is happening locally, it is recommended that a relationship with the coroner is established to receive more 'real time' data. This would enable a more dynamic response should it be required such as a hotspot location for suicide.

4.15 Despite a very positive and constructive meeting between Wolverhampton's Director of Public Health and the Coroner in 2017, establishing an on-going relationship with notifications being received routinely has been problematic due to lack of resources in the coroner's office. A regional approach is now being adopted to ensure some uniformity of communication between the coroner and the local Public Health teams within the region. This is being led by colleagues from Public Health England (PHE) and ties in with the Thrive West Midlands zero suicide work.

4.16 As an interim measure, PHE carried out an audit of coroner data for the period of 2015-2016, Wolverhampton assisted with the audit and shared the findings with the forum.

5.0 Next steps

5.1 The forum has been progressing well, this is evident when benchmarking progress against the national strategy and recommendations that came from the recent Health Select Committee's Inquiry into suicide prevention (2017).

5.2 Considering the good progress made, the forum is now at juncture where a review of the action plan is needed. A priority setting session is planned to take place within the forum's next meeting, taking place in May 2018.

5.3 The action planning will take stock of achievements to date and identify new priorities. Early discussion has focussed on the need to support middle-aged men.

5.4 Some areas of work such as receiving timely data from the Coroner will continue.

5.5 The current suicide prevention strategy for the City remains in place until 2019. Discussions will take place late 2018 to start the review and refresh process to ensure the strategy remains relevant.

6.0 Financial implications

6.1 There are no financial implications.
[MI/16032018/W]

7.0 Legal implications

7.1 There are no legal implications.
[Legal Code: TS/16032018/Q]

8.0 Equalities implications

8.1 Nationally, suicide is much more prevalent in males and there is a peak in the 30-34 years' age group. Stakeholder consultation identified migrants, men and deprived communities as being at the greatest risk of mental health problems locally. Sexual orientation is also a risk factor with the greatest risk being in gay men. The action plan has established workstreams to enable a tailored response to different groups and the increased risk they face and will continue to do so in the year ahead.

9.0 Environmental implications

9.1 None

10.0 Human resources implications

10.1 None

11.0 Corporate landlord implications

11.1 None

12.0 Schedule of background papers

Health Scrutiny Panel - Update on the work of the suicide prevention stakeholder forum - 25 May 2017

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Agenda Item No: 8

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

29 March 2018

Report title	Public Health Transformation Service Consultation
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing
Wards affected	All
Accountable director	John Denley, Director of Public health
Originating service	Public Health
Accountable employee(s)	Tel 01902 551095 Email John.denley@wolverhampton.gov.uk
Report to be/has been considered by	People Leadership Team 12 March 2018 Senior Executive Board 13 March 2018 Health Scrutiny 29 March 2018

Recommendation(s) for action or decision:

The Scrutiny Panel is recommended to:

1. Consider the findings of the consultation on the Public Health Service Transformation.
2. Comment on the proposed way forward for the areas considered, making recommendations to the Cabinet Member for Public Health and Wellbeing, as appropriate.

1.0 Purpose

1.1 To advise Health Scrutiny Panel of the outcome of the consultation on Public Health Service Transformation and set out the next phase of the transformational programme based on the feedback received.

2.0 Background

2.1 The Public Health vision is that by 2030 people will live longer, healthier and more active lives; every child will have the best start in life; the gap in healthy life expectancy between Wolverhampton and the England average will close and there will be increased protection from harm, serious incidents and avoidable health threats.

2.2 To prepare for a new approach to delivering public health it is proposed to transform the design of the service by offering expert advice and support to all parts of the Council and external partners, especially the NHS.

2.3 Secondly, there is a re-examination of the right approach to improving the health of residents at a population level. The new approach will involve moving away from providing 'traditional' behaviour change services to individuals and focusing more on making a difference to factors that influence healthy life expectancy at a population level. This change will require reviewing current commissioned services to check that they are aligned to the new public health vision.

2.4 Following Cabinet consideration of the re-examination of the health transformation report on commissioned services, 29 November 2017, the following recommendations were approved:

- An eight-week public consultation on the Public Health commissioning proposals for 2018-2019 onwards to meet the City's public health and wellbeing outcomes.

- Delegate the final decision on the commissioning proposals to meet the reduced grant allocation to the Cabinet Member for Public Health and Wellbeing. The decision to be made in consultation with the Director of Public Health who will provide assurance that the Council has complied with its public-sector equality duty responsibilities.

2.5 The consultation was subsequently initiated to gain views on the vision of public health service delivery going forward. This required insight from the wider public and people affected by public health service changes. From this it was envisioned that the development of an offer to provide a range of approaches for new ways of working to deliver public health outcomes would be developed. The consultation focused on the following aspirations:

- Support women to breastfeed

- Reduce the number of people who smoke
- Increase the number of children with a healthy weight
- Prevent health care acquired infection, particularly in nursing and Care Homes
- Improve young people's emotional and mental wellbeing.

2.6 The consultation approach was ambitious therefore multi-faceted, and the public have been engaged through the following routes:

- Universal public survey as a resident or user of outcomes described above
- Targeted – specifically with service users that will be impacted by the service changes
- Young People – streamlined questions from the original survey to increase participation from young people
- Stakeholder- To allow stakeholders to have their say about how we can work together to meet shared outcomes
- Network promotion - through Councilors, Community Groups, Organisations, Youth Council

2.7 The programme spanned a period of 8 weeks. The consultation started on 21 December 2017 and closed on 19 February 2018. The consultation was promoted through a series of press releases, City People, Social Media and via the corporate communications data base of approximately 1800 contacts. The survey was also publicised through the Council's corporate consultation page and advertised on customer services digital platforms located in the foyer of the Council.

2.8 Customer Services, 'Floor Walkers' were briefed about the consultation, which supported access to the survey for people waiting to be seen in reception. Those who opted to take part were signposted to the computer area located in the Council foyer. In addition, to boost wider public participation external specialist support was recruited and surveys were undertaken in various public buildings across the City.

2.9 The information was also disseminated widely to partners, organisations and forums these included: all Care Homes, Youth Council, Safer Wolverhampton Partnership forums, all Council Equality Forums, internal departments, University, GP's, Pharmacies, Schools, Strengthening Family Hubs, Health Visiting area teams, Maternity, Councillors, Heads of Departments, Children's Outpatient Services, Sexual Health Services, Recovery Near You, and CCG. Organisations were encouraged to engage their service users as appropriate to participate.

2.10 The scope of the consultation covered different ages and groups of the population. A steering group was established at the start of the consultation which included representation from the corporate equality team. This approach supported the prioritisation and monitoring of equality assessments. Targeted groups were then engaged to develop the equality assessments, arranging focus groups as appropriate i.e. counselling services for young people and child weight management. A targeted survey was established for service users so that information could be gathered where focus groups were not appropriate, i.e. Infection Prevention Service, Hospital Youth Service.

2.11 Methods of consultation have been careful to record the equalities profile of responses so that any diversity responses can be understood and can inform the future direction of service and policy.

2.12 The young person's survey was specifically streamlined to increase the response rate from young people which was marketed in schools and youth venues like The Way. We engaged with members of Wolverhampton Youth Council who also completed the young person's survey.

2.13 The survey had a separate tab that supported stakeholders to respond and have their say about Public Health Transformation and how joint outcomes could be met. This will allow partnership planning as to how outcomes can be achieved collaboratively and address any potential challenges.

3.0 Consultation Outcomes

3.1 The consultation received 1,239 responses across all four survey areas. This comprised 861 of the public, 72 targeted, 203 Young People and 103 Stakeholders. Given the public health outcomes being consulted on, affecting all ages but most specifically younger people, it is helpful that there is good representation from across all age groups, but particularly those aged 25 – 44 years.

3.2 The demographic analysis indicates that women are over represented in the responses, which is quite usual and is hard to counter-balance. However, there has been a high response rate overall so the male view has been considered. Those from a white ethnic back ground are slightly higher in the response rate than the general population. This translates to 69% identifying as female, 82% identified as heterosexual, 73% identified as white, 9.8% identified as disabled.

3.3 Smoking Cessation and Tobacco Control

3.3.1 Respondents who were smokers said they would most likely try and quit on their own or use online information. Non-smokers however, expressed a greater support for GP and pharmacy services. Smokers found national campaigns helped them think about quitting smoking. The vast majority of current/ex-smokers felt it was essential to create smoke free environments, especially around children. Most smokers would not consider vaping to stop smoking however there was a significant minority who were not aware of vaping or e-cigarettes.

3.3.2 In relation to children and young people and smoking, schools were often identified as the place were prevention work could be undertaken and having a role in it, by users, residents and stakeholders. Respondents mentioned a wide range of things that could be done to prevent or stop smoking in adults and children and, thus a wide range of partners and organisations could potentially have a role in supporting this agenda. For example, smokers as well as non-smokers thought there should be more enforcement around

where smoking can take place, specifically in public areas and health sites, as well the need to increase the price of cigarettes/tobacco.

3.3.3 **Proposed way forward**: With these findings in mind, public health will work with partners to develop smoke-free health and social care systems, make more public areas smoke free, and enhance the schools-based education plans, with emphasis on prevention. Considering new evidence around the safety and effectiveness of e cigarettes we will explore ways to promote and encourage smokers to consider e cigarettes as a harm reduction approach.

3.4 Child Weight Management

3.4.1 Where there was concern about a child's weight, the survey highlighted that for advice or information most participants said they would look online or visit the GP. Most respondents would do free activities such as walking, running or think carefully about shopping habits, and consider the availability of after school clubs. A notable suggestion made for how children's weight could be managed was the need for the creation of appropriate environments which enabled people to take part in physical activities.

3.4.2 Evidence from the consultation questionnaires indicates that there is demand for self-help services. There is a very strong preference by members of the public for accessing information online. Furthermore, in addressing weight concerns, respondents to the main consultation indicated a preference for lifestyle adjustments through self-help techniques, such as changing shopping habits and engaging in no-cost low-cost activities with their families (such as walking and cycling).

3.4.3 **Proposed way forward:** In response to and in mitigation to these considerations, Public Health could support the current child weight management provider (PASS) in accessing alternative funding for their programme. We will signpost families to reliable sources of online support and ensure that staff in GP practices are trained, this would also include promoting free activities across the city and within communities that are accessible for families, promote national campaigns, which are based on good evidence and develop a stronger link with planning policy.

3.4.4 We also know that preventing children from becoming overweight in the first place is essential. To achieve this, we will continue with our obesity prevention plan in primary schools; develop further our prevention plans in secondary schools and develop a 0-4 obesity prevention strategy to include all partners working with children in the early years.

3.5 Healthcare Acquired Infection Prevention

3.5.1 Overall all respondents supported care homes to have measures in place that would address the spread of infections. Stakeholders health partners, felt that this is a critical service that prevents onward transmission of infection and reduces hospital admission.

3.5.2 **Proposed way forward**: The consultation has identified that this is a key service with shared outcomes, therefore we propose to work collaboratively with Royal Wolverhampton Trust (RWT) and the Clinical Commissioning Group (CCG), to support a joined-up approach to the delivery of infection prevention across the city.

3.6 **Breastfeeding**

3.6.1 Midwives and breastfeeding support groups in the community were considered the best ways to support women to breastfeed by women who have experience of breastfeeding, those who had supported their partners to breastfeed, and by those who had no experience.

3.6.2 The overall feedback received showed there was a demand for face to face support, whether it is through voluntary support groups, or professional support, as well as the need to normalise breastfeeding in public.

3.6.3 Respondents would like or had welcomed and valued the experience, advice and support of women who had breast fed their baby. One of the places where people could get initial advice/support about breast feeding was immediately after birth and before they were discharged from maternity. However, on the whole respondents were not positive about their experiences and did not feel that staff had time to provide support required.

3.6.4 **Proposed way forward:** Public Health will work closely with The Royal Wolverhampton Hospital Trust (RWT) to enhance ways in which peer support groups could be developed and available to the women who need them most, in a timely manner. Public Health will also work closely with Children's Services and family support, to ensure the most vulnerable children in our City are given the best start in life. We will work to ensure all front-line staff make every contact count, by being able to offer breastfeeding advice. We will continue to achieve UNICEF baby friendly status by working through our partners.

3.7 **Young People's Emotional Health and Wellbeing**

3.7.1 To help improve Young People's emotional health and wellbeing, respondents suggested they would or be highly likely to seek advice from all the options provided (Young People's Service (such as The Way, Base 25, Believe to Achieve), online, school, GP surgery. Very few respondents would do nothing. 96.6% (424) of respondents think it is important that there is support available in hospital settings for Young People who have presented at A&E who have experienced violence, or have mental health concerns/harmful behaviors, and are identified to health and social care staff and can access on-going support.

3.7.2 It was suggested that this support could be provided through; faith centres, youth groups, hospital youth service, mental health teams, schools, Headstart/other charities, as resources to support the needs of young people's emotional health and wellbeing.

3.7.3 **Proposed way forward:** A new contract has been awarded to commence on 1 April 2018 to provide Emotional Health and Wellbeing Services to Young People and Families,

funded by the Clinical Commissioning Group (CCG), CWC and Headstart for young people up to the age of 18. The service will operate a single point of access and will be delivered through a range of different settings based on the needs of the child's and family. Public Health will consider business partnering arrangements that will support newly commissioned services for children and young people and work directly with schools to enhance the school offer. Public Health will also work with Children's Social Care and RWT to reassess how services in the hospital could be developed.

4.0 System Feedback: Health Partners

4.1 Feedback from RWT to the consultation supported the commitment of all stakeholders to work in partnership to deliver effective services. Their response highlighted the importance of face to face contact for breast feeding support and Making Every Contact Count (MECC) to support lifestyle choices. It was felt that a Tier 2 service was required to support a weight management offer which includes psychological and physical support. RWT are concerned about infection prevention risks and the wider impact on acute admissions and increased infections in care homes. In addition, the withdrawal of young people services was viewed as a reduction in the options for support to young people and a potential risk to the increase of A&E waiting times including demand on the Paediatric Assessment unit.

4.2 The CCG supported "the initiative to change to ensure that services have the widest impact, are evidence based and makes use of advances into technology". They highlighted that a targeted approach is required with pregnant smokers given the problem with infant mortality. It was felt that there are significant risks of stopping the infection prevention service about increased outbreaks in care homes. It was highlighted that the young people's counselling service has a good reputation with exemplary feedback. The Hospital service was recognised as critical for young people presenting at A&E who are not meeting the thresholds for entry into Child Adolescent Mental Health Services (CAMHS) but can who receive support through this service.

4.3 Public Health England (PHE) were concerned that health improvement gains from the personal support provided by local community infection prevention would be undermined, however, they agreed with making infection prevention control everyone's business. In terms of breastfeeding they commented that the way of working should include implementing the UNICEF UK Baby Friendly Initiative standards. Reliance on digital and online tools for women who want to breastfeed, smokers and families looking for weight management help and support were not felt to be equally available in more deprived groups. Those with additional needs, such as physical, sensory or learning disabilities, and people who do not speak or read English need to be considered.

4.4 PHE response stated that Wolverhampton is identified as already experiencing the implications of obesity and its associated health conditions. Investing in effective, evidence-based services to help people achieve and maintain a healthier weight can provide a return on investment. Finally, there was concern that without a dedicated stop smoking service in place inequalities between different parts of the city might increase.

The continuation of work to deliver smoke free messages through schools was supported with consideration about how to reach all those who need advice and support.

5.0 Next Steps

5.1 The response rate and the information received from the public and stakeholders demonstrates that the public are engaged and want to have a say about health approaches. This gives a solid platform to start discussions, to develop those concepts that the public have supported which will further build the Public Health offers. The process has also shown that there is immense value in having a robust consultation strategy.

5.2 The end of the consultation marks the start of on-going conversations with partners and public, strengthening relationships and maximising health outcomes. New ways of working take time to plan, develop and implement. It is an iterative process which needs to be worked through with partners and stakeholders. In order to start this, task and finish groups will work up the offers further based on the consultation findings, best practice guidance, research evidence and equalities, to ensure that there is a joined-up offer fit for the needs of our population.

6.0 Financial implications

6.1 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The total allocation for 2018-2019 is £20.8 million. Any costs associated with the delivery of these services will be contained within this overall allocation.
[MI/06032018/X]

7.0 Legal implications

7.1 The Council has a duty to improve the health and well-being of its population. There is a legal requirement to conduct a formal 8-week consultation based on potential changes.
RB/28022018/A

8.0 Equalities implications

8.1 To support this process working together with colleagues from the Equalities Team was undertaken from the onset of the Public Health transformation programme. An equality analysis was undertaken on each of the services affected and these focused on the equality impacts as understood using relevant data and research then available. A formal consultation on the actual and or likely impact of proposals was undertaken where gaps in knowledge were seen to be relevant and were required to be closed.

8.2 To support an approach that focused on those individuals who were more adversely impacted by the changes a targeted approach was developed, 72 people responded to the targeted survey and where appropriate focus groups were undertaken. In addition, and importantly, all methods of consultation used were supported by questions asking respondents to identify their equalities identities.

8.3 In summary, the equality analyses conducted so far have provided outline intelligence that services that were being provided, supported only small numbers of the population, for example those provided to help people stop smoking and those to support breastfeeding. Therefore, services may not be delivered as they have been traditionally, since evidence, local research and the consultation has highlighted that residents want different options for accessing lifestyle advice and support including self-help.

8.4 These findings indicate that any adverse impacts will be limited in number and scope. With any mitigating actions resulting from the study of feedback from diverse respondents finally developed, access to groups of the population with protected characteristics can be expected to improve. Monitoring will be in place to check that actions intended and outcomes worked for actually materialise.

8.5 Equality analysis of services like infection prevention and the counselling service highlighted that all groups benefited from the services, with BME over-represented for the counselling service. From all the data, we have been able to assess up to this point, negative or positive impacts or importantly, gaps in our knowledge about likely impacts on individuals or on particular groups in the community have been considered. The findings will be addressed and mitigated (where required) as part the public health offer going forward.

8.6 However, there are some instances of potential differential impact i.e. a service ending would disproportionately affect one group of people. The completed equalities assessments will be built into each area affected to ensure that any gaps are addressed through the next phase of the transformation and that these disproportionate impacts are mitigated, for example by working with local libraries to ensure that people who do not have access to a computer at home can be supported to access online information or printed copies.

8.7 A final suite of equality analyses will be completed by service managers prior to, and in support of Executive decisions. These will incorporate and respond to the diversity data collected. Consequently, those interventions developed by the transformation programme will be directly informed by the findings from specifically targeted consultation and supported by other relevant data and research held previously. In this way, these final decisions will be those that the Council can be confident are the best that resources permit to be provided to support the diversity of Wolverhampton's Public Health requirements.

9.0 Environmental implications

9.1 No environmental implications have been identified relating to the consultation and engagement process.

10.0 Human resources implications

10.1 Public Health funding supports the Hospital Youth Link Service through Children's services therefore there are human resource implications in relation to the two posts that will need to be considered and managed in line with human resource procedures.

11.0 Corporate landlord implications

11.1 No corporate landlord implications have been identified relating to the consultation and engagement process

12.0 Schedule of background papers

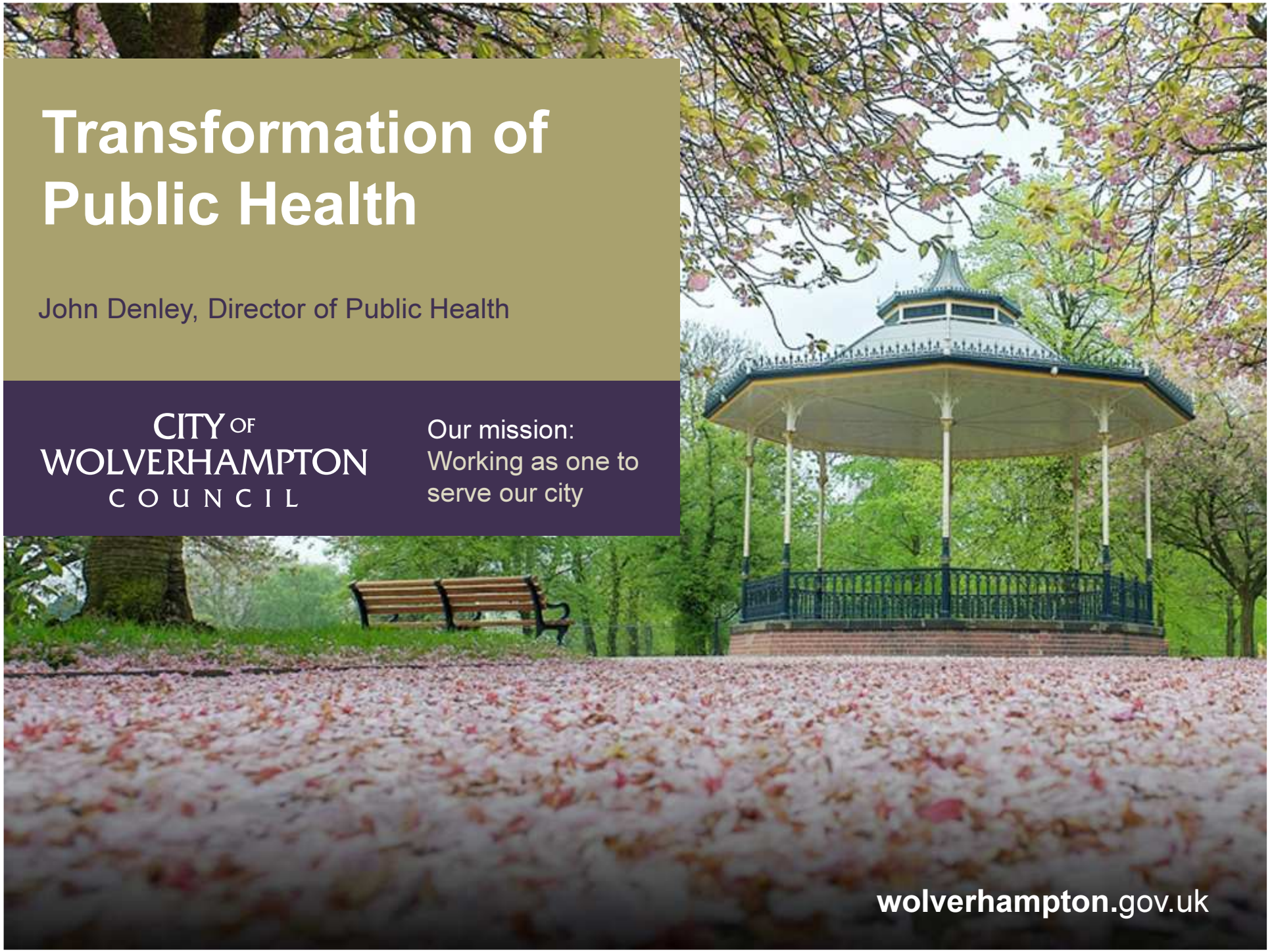
12.1 Cabinet paper dated 29 November 2017 on Public Health Commissioning Proposals for 2018-2019 onwards.

Transformation of Public Health

John Denley, Director of Public Health

CITY OF WOLVERHAMPTON COUNCIL

Our mission:
Working as one to serve our city



Consultation

- Potentially contentious service areas under review
- Many of the proposed changes related to directly delivered help or support to individuals
- Embraced the opportunity to consult - provided a real opportunity to engage and ‘sense check’ with the values and ‘frame of reference’ of the residents of Wolverhampton
- Response
  - Number of respondents **1,239**
  - This comprised of **861** of the public, **72** those that were targeted, **203** Young People and **103** Stakeholders.
  - Demographics: good, representative, spread across all groups and areas of the city

Areas considered

- Reduce the number of people who smoke (including pregnant women)
- Support women to breastfeed
- Increase the number of children with a healthy weight
- Prevent healthcare associated infection, particularly in nursing and care homes
- Improve young people's emotional and mental wellbeing

Reduce the number of people who smoke (including pregnant women)

We found:

- A significant difference between the views of smokers and non-smokers
- Smokers:
  - wanted to quit on their own, or use online support
  - said national campaigns help them think about quitting
  - want it to be harder to smoke, and harder to smoke around children
  - felt it was essential to create smoke-free environments, especially in public spaces
  - felt it was important to teach children in schools about the effects of smoking
- Non-smokers felt GPs and pharmacies would be helpful in quitting smoking

We propose:

- Promote and use national campaigns/material
- Create smoke-free environments
- Enhance schools-based plan, particularly prevention
- Smoke-free City ambition

Support women to breastfeed

We found:

- Residents and stakeholders consistently said that early support (in the first 10 days) is vital, and they value face to face contact
- Mothers would prefer expertise through their midwifery team and wanted breastfeeding support groups for guidance and social support
- Breastfeeding shouldn't be viewed as a single issue in isolation, but part of a package of early support

We propose:

- Working in partnership with RWT to enhance early support from the midwifery team
- Explore how to support capacity of volunteers (e.g. intergenerational support)
- To continue to achieve UNICEF Baby Friendly status

Increase the number of children with a healthy weight

We found:

- People preferred to look online or visit the GP for advice/information
- Families would prefer encouragement through free activities such as walking or running
- People would prefer to think carefully about shopping habits
- Wanted better environments conducive to physical activity

We propose:

- Signpost families to reliable sources of online support and ensure that staff in GP practices are trained to do so
- Promote free activities across the City and within communities that are accessible for families
- Promote national campaigns, which are based on good evidence
- Develop a stronger link with planning policy

Prevent healthcare associated infection, particularly in nursing and care homes

We found:

- Low level of interest because people assume it is part of everyday practice, rather than an ‘add on’ service
- Stakeholders valued the current provision but wanted it to be joined up with other related services and work being undertaken across the city

We propose:

- Stabilise the current approach
- Bring together the work of the CCG, RWT the LA to ensure the valuable work is continued
- Combine the available resources and make the system more efficient
- Build on the CQC inspections where infection prevention is linked to rating

Improve young people's emotional and mental wellbeing

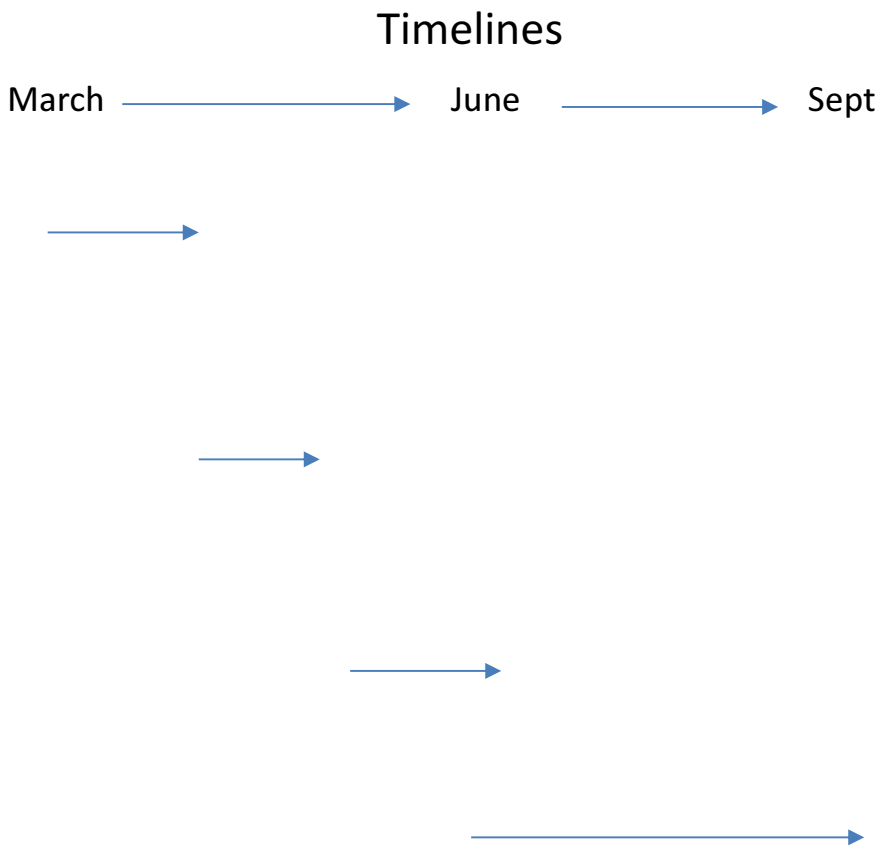
We found:

- Young People highlighted mental health as the number one priority for their generation
- Services and brands are isolated and offer varying non-specialist support
- Young people repeatedly asked for services across all settings to make support more accessible and consistent

We propose:

- Stabilise current provision in the short term with a view to integrate into current or developing pathways
- Provide public health input into commissioning of integrated Tier 2 pathways across CCG, Council, voluntary sector and schools

Next Steps



- Communicate findings of the consultation and proposals/intentions
- Coproduce, with key stakeholders, an offer for each of the areas considered
- Implement new offers
- Develop a framework for evaluation of the new approach

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