Health Scrutiny Panel

19 September 2013

Time 2.00pm **Public meeting?** YES **Type of meeting** Scrutiny

Venue Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Room Committee Room 3 (3rd floor)

Membership

Chair Cllr Claire Darke (Labour)
Vice-chair Cllr Paul Singh (Conservative)

Labour	**Conservative**	**Liberal Democrat**
Cllr Ian Claymore	Cllr Neil Clarke	No members
Cllr Susan Constable		
Cllr Milkinder Jaspal		
Cllr Zahid Shah		
Cllr Thomas Turner		

Information for the Public

If you have any queries about this meeting, please contact the scrutiny team:

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Some items are discussed in private because of their confidential or commercial nature. These reports are not available to the public.

Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1. **Apologies for absence**

2. **Declarations of interest**

3. **Minutes of the previous meeting (18.7.13)**
[For approval]

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

DISCUSSION ITEMS

5. **Special Needs Dental Service**
[Tracy Harvey – To receive a report on Special Needs Dental Service update on progress following consultation on proposals to reconfigure Dental Services for Patients with Special Needs and Urgent Access services.]

6. **The Royal Wolverhampton NHS Trust - Patient Experience**
[Jamie Emery – To receive a report on Friends and Family Test, the work of The Patient Advice and Liaison Service (PALS) and complaints]

7. **Public Health Services in the Local Authority - Children's Public Health and Transformational Change**
[Ros Jervis - To receive an update reports on progress against performance targets]

8. **Update on the CCG response to Robert Francis - NHS Wolverhampton City Clinical Commissioning Group**
[Manjeet Garcha - To give presentation on progress]

9. **CCG Proposal for quality and assurance report to the Health Scrutiny Panel**
[Richard Young – To present report]

10. **Health and Wellbeing Board - Joint Health and Wellbeing Strategy**
[Viv Griffin - To present draft report]

INFORMATION ITEMS

11. **Choose and Book system** [1]- Gwen Nuttall (Chief Operating Officer) Royal Wolverhampton Hospital Trust–briefing on how the system is working.

12. **Consultation on the Mid Staffordshire Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase Consultation** – David Loughton The Royal Wolverhampton NHS Trust to present briefing.

13. **Health Scrutiny Panel Work Programme 2013/14**
[Earl Piggott-Smith – update on draft work programme]

EXCLUSION OF PRESS AND PUBLIC

Exclusion of press and public
[To pass the following resolution:

That in accordance with Section 100A(4) of the Local Government Act 1972 the press and public be excluded from the meeting for the following items of business as they involve the likely disclosure of exempt information on the grounds shown below.]

Part 2 – exempt items, closed to the press and public

Item No.	*Title*	*Grounds for exemption*	*Applicable paragraph*
	None		

[1] Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

Health Scrutiny Panel Meeting

Minutes – 18 July 2013

Attendance

Members of the Panel

Cllr Claire Darke (chair)
Cllr Neil Clarke
Cllr Ian Claymore
Cllr Susan Constable
Cllr Zahid Shah
Cllr Paul Singh

Other Councillors

Staff

Earl Piggott-Smith	Scrutiny Officer
Kathy Roper	Head Of Young Adults Commissioning - Community

Other Officers

Diane Lee	Assistant Chief Executive (West Midlands Ambulance Service)
Nick Henry	General Manager (West Midlands Ambulance Service)
Lisa Thacker	Acting Compliance Manager(Care Quality Commission)
Payal Patal	Compliance Inspector (Care Quality Commission)
Mark Lane	Commissioning Strategy Manager (NHS Wolverhampton City
Wendy Ewins	Clinical Commissioning Group)

Part 1 – items open to the press and public

Item No.	*Title*	*Action*

MEETING BUSINESS ITEMS

1. **Apologies**

Apologies for absence were received from Cllr Milkinder Jaspal and Cllr Thomas Turner

2. **Declarations of interest**

There were no declarations of interest received.

3. **Minutes of the previous meeting (23 May 2013)**

Resolved:

That the minutes of the meeting held on 23 May 2013 be approved as a correct record and signed by the Chair.

4. **Matters arising**

Cllr Sue Constable reported on the visit to Penn Hospital and the very much improved facilities being developed for patients and staff. Cllr Darke reported on the development of the Community Café. The Panel agreed to receive a report on progress on the impact of the new facilities in delivering better patient outcomes.

The Panel were advised that the date for the opening of the new development had been changed to 14.8.13 (12pm - 4pm) and all were encouraged to attend.

Cllr Claire Darke confirmed that the Panel were invited to attend the Future Health and Wellbeing Board Meeting Day on 31.7.13 to discuss responses to the recommendations of the Francis Inquiry. Cllr Darke queried if all Panel members had been sent an invite to the meeting

Resolved:

That all Panel members be sent an invitation to the meeting on 31.7.13, if this has not already been done. — Kathy Roper

5. **Schedule of Outstanding Minutes**

Earl Piggott-Smith presented the report to the Panel. The Panel were advised that there had been discussions with Cllr Darke and officers about whether items listed were still relevant to the work of the Panel. Earl Piggott-Smith explained that suggestions had been received from officers about those topics that could be actioned or removed. It was proposed that, subject to the agreement of Cllr Darke, that those items still considered relevant would be incorporated into the panel work programme report, rather than including them in a separate report.

Resolved:

That the work programme report be updated to include those items from the schedule of outstanding minutes still considered to be relevant to the work of the Panel. — Earl Piggott-Smith

DECISION ITEMS

6. **West Midlands Ambulance Service**

A joint report on the performance of West Midlands Ambulance Service was presented by Diane Lee and Nick Henry.

Diane Lee updated the Panel on the governance arrangements since it was authorised as Foundation Trust on 1.1.13. The service was licenced on 1.4.13. Diane Lee highlighted the importance of the staff and the public in the governance structure and the work being done to become to encourage people to be active foundation trust members.

The members of the Panel were encouraged to consider becoming Foundation Trust Members themselves. Diane reported that staff have to opt out of being a member of the new governance structure. Diane Lee briefed the Panel on the performance of the Trust against national quality standards. The service is monitored by MONITOR.

Cllr Singh asked for an example of where the issue raised by the public or staff had led to change in a decision of the Executive. Diane Lee responded that the process is still at an early stage as there are people who are new – there is an expectation that over time they will take a more active role in the decision making process.

Nick Henry briefed the Panel on the progress of introducing make ready service and details of the new ambulance station re-configuration.

Nick Henry commented on the changes in demands from the past when peak activity was during the winter period - the service is dealing with increased volume of activity outside this period.

Cllr Darke queried the impact of the current heat wave on the demand for the service. It was stated that the service is coping well during the weather.

Cllr Darke queried the reference in the papers about fines being made for delays in transfer of patients at Royal Wolverhampton Hospital. Nick Henry explained the conditions which would lead to a fine being made where there has been a delay. Nick Henry explained that the service has a good working relationship with the hospital and efforts are made to deal with problems relating the transfer of patients when they arise.

Cllr Claymore welcomed the presentation and queried the effectiveness of the accountability that the public have over the executive. Diane Lee explained that the governance structure had been running in shadow form and there was a robust induction process. The public is likely to have an influence during the drafting of the Quality Accounts.

Resolved:

That the report be received.

7. **Care Quality Commission**

Lisa Thacker and Payal Patal gave a joint presentation about the role and responsibilities of the Care Quality Commission (CQC).

Lisa Thacker gave an overview of the assessment of residential care schemes across the Wolverhampton and the progress of registering GP practices. The work is being done in phases – in the first phase 62 GPs in Wolverhampton had their details checked against original registration details of the registered activities. In total, there are 1400 GPS to be visited.

CQC have to give a GP and dental practices at least 48 hour notice before they inspect. Lisa Thacker reported that most concerns about GP practices were linked to infection control.

Lisa Thacker highlighted the role of the CQC in wanting to work more closely with Health Scrutiny Panels and to share information. Lisa Thacker explained changes to planning of future inspections.

In addition there are future themed planned inspection which will look at the quality of dementia care and young people services.

Cllr Darke queried the number of establishments repeatedly moved from being compliant with national standards to being non-compliant, following an inspection. Lisa Thacker explained that a possible explanation could be that schemes may be failing a different national standard than before following an inspection.

Cllr Darke queried the impact of the outcome from the review of Winterbourne View and the Francis Inquiry in how the CQC undertakes its assessment work. Lisa Thacker explained that there are further planned changes to be announced as a result of the findings from the Francis Inquiry. The appointment of the Chief Inspector of Hospitals and Chief Inspector Adult Social Care will impact on the work of the CQC. Lisa Thacker also explained that a new quality rating scheme is being be piloted.

Lisa Thacker explained planned changes to the assessment criteria that will be introduced made in response to the findings and recommendations of the Francis Inquiry.

Cllr Paul Singh queried if the inspectors adopt a 'tick box' approach when reviewing an establishment against the national standards. Payal Patal explained that the CQC does not have a tick list approach – the issues to be investigated will be determined by intelligence received about the standard of care and also the findings from their inspection of the establishment. Lisa explained that all establishments are assessed against the 16 essential national standards, which is supported by national regulations.

Cllr Paul Singh queried complaints from residents about the difficulty in getting timely appointments to their GP and whether issue was covered as part of the inspection. Lisa Thacker explained that during inspections they will talk to people in the waiting room, to find out their experiences about the quality of service. The information collected will be used to give an overall assessment of the quality of the service.

Cllr Shah queried complaints about a dental practice with poor hygiene standards, but was still able to continue practice. Lisa Thacker said that she would be happy to discuss the concerns outside the meeting.

Resolved:

That the report is received and that a draft of the scrutiny work programme is sent to the CQC for information. — Earl Piggott-Smith

8. **NHS Wolverhampton City Clinical Commissioning Group**

Mark Lane presented a report on progress against those parts of the service which were rated as red and the work being done to improve the situation. Mark Lane reported that four of the five conditions detailed in Table 1 of the report have now been completed.

Mark Lane explained that a formal review of the A&E service is planned - this work will be done by NHS England. Mark Lane reported on the work of the diabetes project – the work involves other partners. The challenge facing different partners is how to best integrate dementia care services.

Mark Lane outlined the key strategic service priorities. A report on urgent care provision will be presented to Health and Well Being Board at the end of July 2013.

Resolved:

That the report is received and that the Panel receive further progress reports when available. Mark Lane

9.. **Winterbourne View – progress report**

Kathy Roper presented a report to brief the Panel on progress in implementing recommendation arising from the report A National Response to Winterbourne View Hospital. Kathy Roper outlined the progress of implementing The Concordat: Programme of Action arising from the above report.

Kathy Roper confirmed that all existing learning disability cases had been reviewed as part of wider work being done to improve the quality of care and strengthen commissioning arrangement and the key achievements to date. Kathy Roper explained that they try to avoid out of area placements because of the difficulties in monitoring the quality of care.

Cllr Claymore queried the process for monitoring the implementation of the action plan. Kathy Roper explained that progress is monitored by the Winterbourne View Action Group and also by the Health and Well Being Board.

Resolved:

That the report be received.

10. **Health Scrutiny Panel Work Programme 2013/14**

Earl Piggott-Smith presented to a report detailing the agenda for future meetings of the panel. The Panel were invited to suggest topics they would like added to the work programme. The Panel agreed to add the topic of Tobacco Control to the work programme. The report will also cover the issue of Shisha Bars

Resolved:

That the report be received. The topic of tobacco control to be added to the scrutiny work programme.

Earl Piggott-Smith

INFORMATION ITEMS

11. **Royal Wolverhampton NHS FT Quality Account 2012/13**

Earl Piggott-Smith presented a final draft of the health scrutiny submission for information.

Agenda Item No: **5**

Health Scrutiny Panel

19 September 2013

Report Title	Update Report: Dental Services for People with Special Needs
Classification	Public
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Well Being
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Primary Care NHS England
Accountable officer(s)	Tracy Harvey — Dental Contract Manager Tel — 011382 51715 Email — tracy.harvey1@nhs.net

Recommendations for action:
The Panel is asked to comment on the progress made to date and to agree to receive a more detailed report on health service outcomes after April 2014:

The contents of the report.

1.0 Purpose of the Report

This report is provided as agreed last year with the scrutiny panel to advise it of the service changes following the public consultation on changes to dental services for people with special needs.

2.0 Background

Wolverhampton City Primary Care Trust undertook a service review of its special needs community dental services; the outcomes resulted in service redesign to refocus the service to people with special needs, following a full three month public consultation. Historically an excellent service was provided to a wide range of people including those with an urgent need.

The prior specification diluted the services ability to seek out and market itself to those with special needs. A full three month public consultation was undertaken and a process to reconfigure the service was undertaken. The consultation was effective in cataloguing patient and carer as well as staff comments and views. These views have been incorporated in the new service specification.

Essentially the urgent access and routine dental services to people without special needs were removed and re provided elsewhere and a service directed specifically to those with special needs commenced on 1st April 2013. It is important to note that the definition of special needs in use is quite specific to those with significant problems and is determined by to a dentist's assessment of a patient using a national scoring system.

3.0 Progress/Outcomes to date

The service has been running since 1st April 2013 and underwent significant changes. Therefore it is relatively early on to give much information regarding health and service outcomes. However from the monitoring of the data and feedback directly from the service the following is known:

Case Finding Strategy

As part of the new service reconfiguration the service developed a case finding strategy which describes the case finding approach and methodology undertaken for patients who meet the criteria for the new service.

Work is underway with organisations, institutions and other special groups to identify individuals who are eligible to attend the Special Care Dental Service who do not currently access dental care. Historically around 200 patients were identified as meeting the high case mix level. Public health data indicates that several times this number of people would be eligible for this service. Individuals who meet the service criteria will be offered an appointment at one of the clinics, on the mobile dental unit or if necessary on a domiciliary basis for an assessment of their dental needs and treatment if appropriate.

Scoring Special Care Patients
The service case mix score all patients using the tool developed by the British Dental Association. Patients scoring a case mix score of 15 and above will be eligible for the service. From data reviewed early on the service is demonstrating a higher number of patient's contacts that fall into that category of a person with complex and or multiple needs. The re-provision of routine access clinics has allowed the service to develop a different approach to case finding special needs patients and early indication identifies that this level of clientele will only improve.

Referral policy
A new referral policy has been launched for General Dental Practitioners (GDPs) and will be taken to other referrers as part of the case finding action strategy. GDPs are required to case mix score their referrals and only patients with a case mix of 15 and above will be accepted into the service for treatment.
Early indication from the service is that the referral process is greatly improved and the service and patient group is better understood by GDPs and other referrers.
This has been the result of the service launch, the communication and case finding strategy and improved information on RWT website. The service now has a low number of inappropriate referrals and these are mainly on the grounds that the patients referred are out of area rather than on clinical grounds.

Discharge Criteria
Patients who score less than 15 on the case mix score at the end of treatment will be discharged to General Dental Practice for their regular dental care.

Mobile Dental Unit
The use of the mobile unit has strengthened following service reconfiguration. The mobile unit now services to the harder to reach groups targeted groups/locations will include:

-Vulnerable group's e.g. homeless/addiction/mental health resource centres
-Shared care clinics - doctors surgeries or health centre locations
-Special schools
-Day centres for learning disability adults
-Residential or nursing homes providing complex fillings and extractions where patients are unable to travel to a clinic
-Complex individuals for example agoraphobic patients who find it impossible to leave their homes

Staff Feedback
The service is only 5 months into its new configuration, and although the early signs are positive it is important to note that the service is still in a settling in period after the enormous changes in staffing and a reduced number of locations.

The service is receiving appropriate referrals, is treating special care dental patients and is identifying new patients through the case finding strategy. The provider has received comments about travelling to the new locations but the three locations were used previously and are not entirely new to patients.

The public consultation outcomes supported a reduction in the number of locations. The service has advised it does receive a number of enquiries about access to urgent dental care. This was to be expected given the historic basis of the service.

To date no complaints have been received by the commissioning team.

4.0 Equalities Implications

The service now seeks out those with special needs via its case finding strategy those, whereas before this group was underrepresented in the special needs service.

5.0 Schedule of background papers

- February 2012, Specialised Dental Service for People with Particular Needs Consultation Document, Wolverhampton City Primary Care Trust

- April 2012, Conclusions of Public Consultation – Dental Service for Patients with Special Needs, NHS Black Country

Agenda Item No: **6**

Health Scrutiny Panel

19 September 2013

Report Title	**The Royal Wolverhampton NHS Trust - Patient Experience Friends and Family Test ,the work of The Patient Advice and Liaison Service (PALS) and Complaints**
Classification	Public
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Well Being
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	**The Royal Wolverhampton NHS Trust**
Accountable officer(s)	Jamie Emery — Patient Experience Lead Tel — 01902 695363 Email — jamieemery@nhs.net

Recommendation(s) for action or decision:
The Panel is recommended to:

1. Comment on results of the Friends and Family Test and the work being done respond to patient and visitor complaints about the quality of the services provided.

1.0 Purpose

1.1 The purpose of this report is to present feedback provided to The Royal Wolverhampton NHS Trust from patients carers and relatives via the Patient Advice and Liaison Service, Complaints and the results of the Friends and Family Test. This report is presented at the invitation of the Panel

2.0 Background

2.1 The profile of patient experience has increased dramatically in recent years and the need to improve experience is also widely acknowledged in policy, rhetoric and in the new systems and structures. The Darzi Review in 2008 represented a pivotal moment in the need to consider experience alongside safety and quality. This was strengthened by the white paper published in 2010, 'Equity and Excellence: Liberating the NHS'.

The need for NHS organisations to do this in today's healthcare environment is not so much based purely on a legislative obligation. More so, there is a need to be locally engaged with users to build trust, reputation and understanding across the various geographical areas and within communities.

The relationship of healthcare provider and patient has evolved over recent years and is continuing to do so apace. Patients and carers increasingly see themselves as consumers of healthcare services and the word '*service'* in the NHS banner is becoming ever more relevant to how healthcare is being provided and received. The NHS is familiar with the challenges of providing safe and effective care and treatments. Our challenge over the years ahead lies in continuing to provide high quality healthcare in a way that meets need and expectation.

Public expectations of what a health service should deliver are also increasing. Post war and younger generations have different expectations to those before and are increasingly computer literate. They have wider access to technology. This is now and will be used further to express opinions and research matters relating to health and health services. This presents an opportunity to the Trust in how it develops services based on the needs and feedback of patients.

Understanding patient satisfaction and experiences are therefore crucial to an organisation's ability to react to what patients and carers want and need; understanding that how we do things is just as important as what we do.

Key policy drivers are:

- The NHS Constitution.
- NICE Quality Standards for Patient Experience in Adult NHS Services.
- NHS Operating Framework 2012/13.
- NHS Outcomes Framework.
- Quality Accounts.
- Section 242 The Statutory Duty to Involve.
- Essence of Care.
- Equity and Excellence: Liberating the NHS.

- Healthy Lives, Healthy People.
- The Government response to the Francis Report.

3.0 Progress, options, discussion, etc.

3.1 Implementation of the Friends and Family Test in hospitals shows the intent and requirement to shift culture. Whilst this can be a crude or blunt measure, it does present a reliable and sensitive indicator of the changes of how patients and carers feel about healthcare services.

Data and narrative provided for discussion and comment.

4.0 Financial implications

None

5.0 Legal implications

None

6.0 Equalities implications

None

7.0 Schedule of background papers

None

Patient Experience Feedback Data – Summary

The Royal Wolverhampton NHS Trust (RWT) collects and analyses Patient Experience data from a range of sources. The following charts show the findings from some of these sources.

It is vital that patient experience data is viewed in the context of a range of methods rather than relying on one single source to obtain a representative view of patient experience.

Figure 1: Inpatient Friends and Family Test April 2012 – August 2013

From an initial baseline of 69 in April 2012, RWT has maintained an FFT score around the low 70's having peaked at 79 in July 2012. This has kept RWT in line with the national and regional average scores for FFT.

To ensure the FFT at RWT remains representative further work will be done regarding response rates. Other methodologies are in place help us to understand the FFT score in more detail.

Figure 2: A&E Friends and Family Test April – June 2013

Whilst RWT FFT scores in the A&E department are disappointing, the Department has witnessed severe pressure in recent times. RWT has performed well in terms of the response rate and in this respect some of the scores returned for comparator Trusts are not wholly representative as some response rates are very low and therefore open to wide variation.

Further work is due to start imminently in A&E asking further questions of patients which will help us to better understand the scores.

Figure 3: Friends and Family Test Response Rates and Scores by Ward Q1

Analysing FFT data in this way helps us to understand which wards are performing well with FFT and which need further support. For example ward c25 has a high response rate and high patient numbers combined with a high FFT score. Further questions are asked of patients through the FFT methodology (Figure 7 below) which help us understand the scores by ward.

Figure 4: www.patientopinion.org.uk – Feedback January – June 2013

The Patient Opinion website is a rich source of qualitative information which helps us to analyse feedback provided anonymously and from the comfort of patient's and relative's homes.

The themes from the last 8 months of stories posted by patients show the contrast between positive and negative feedback. This is helpful in understanding what we do well for patients as well as what we can improve upon.

Figure 5: Formal Complaints Themes July 2012 – June 2013

Analysis highlights the 8 key subject areas which account for 93% of the issues complained of. Investigation of clinical concerns often indicates it is not the care and treatment provided, it is how it has this been explained. In this respect 6 of our top 8 complaint themes above can in many instances be related to an over-arching theme of communication.

Figure 6: PALS Themes October 2012 – June 2013

PALS themes tend to mirror those evident in formal complaints. In addition RWT receives many enquiries via PALS regarding administrative and organisational issues such as verifications of outpatient appointments or concerns about their cancellation. Also enquiries about operation waiting times are often received.

Figure 7: Discharge Survey (Real Time) April – July 2013

Questions 2-5 were selected as they were highlighted as areas for action by the findings of the 2012 National Inpatient Survey (NIS). Whilst there has been a significant improvement against the NIS baseline, this has to be viewed in the context of differing methodology. Surveying patients at the point of discharge will have a positive bias opposed to patients who have reflected on their experience and are completing a survey away from RWT premises. Nonetheless RWT has seen month on month improvement to June. Whilst the July and August figures dipped they are an improvement on the April baseline.

Figure 1: Inpatient Friends and Family Test April 2012 – Aug 2013

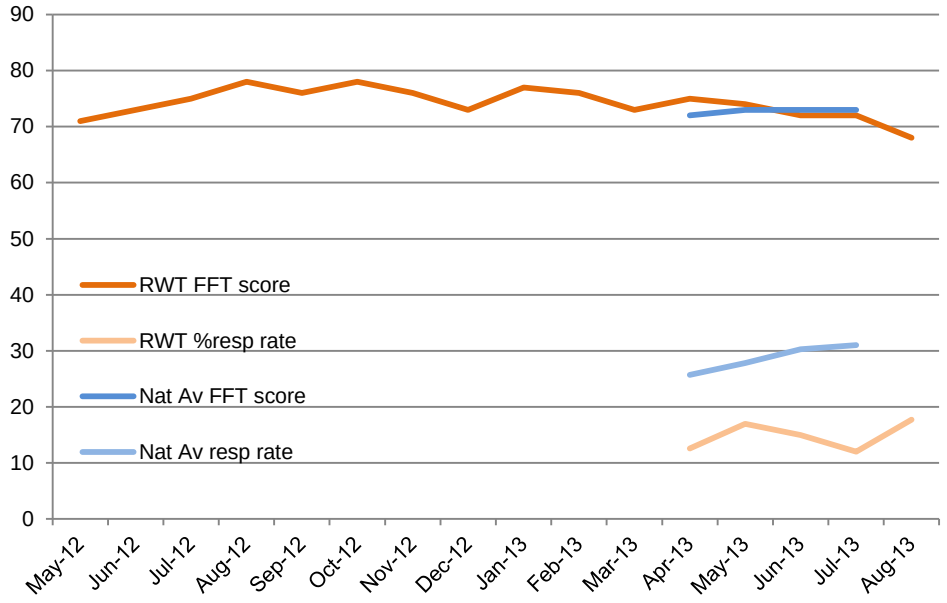

Figure 2: A&E Friends and Family Test April – Aug 2013

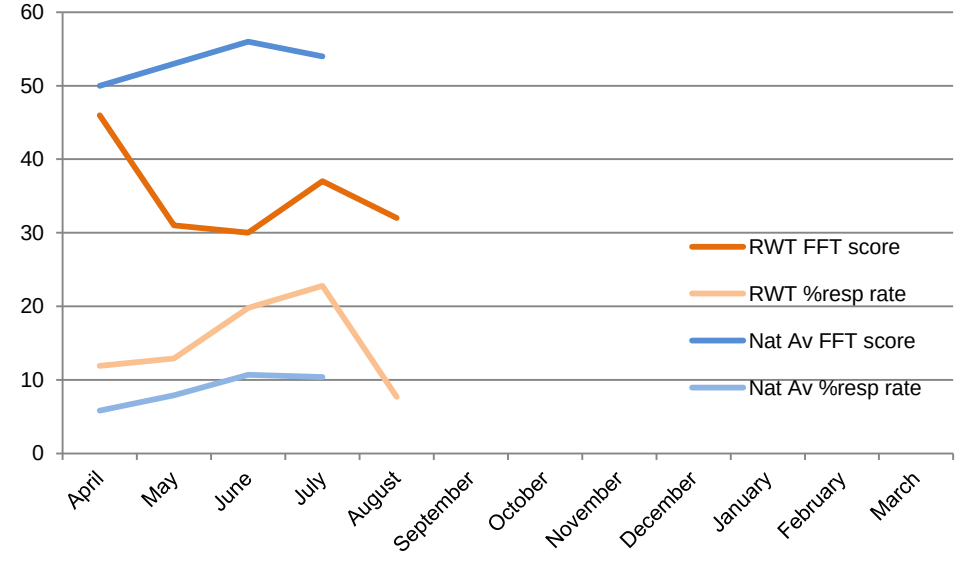

Figure 3: Friends and Family Test Response Rates and Scores by Ward Q1 2013

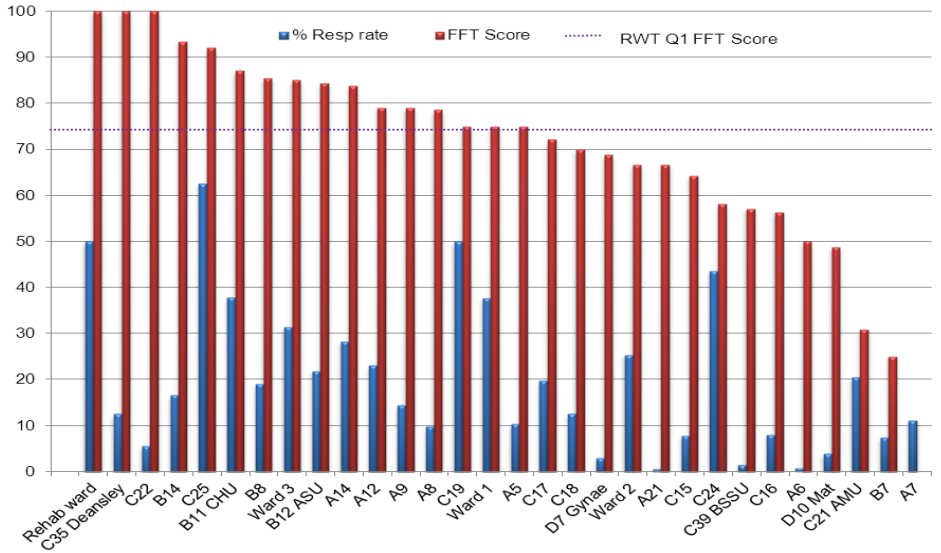

Figure 4: www.patientopinion.org.uk and www.nhs.uk - Feedback January – August 2013

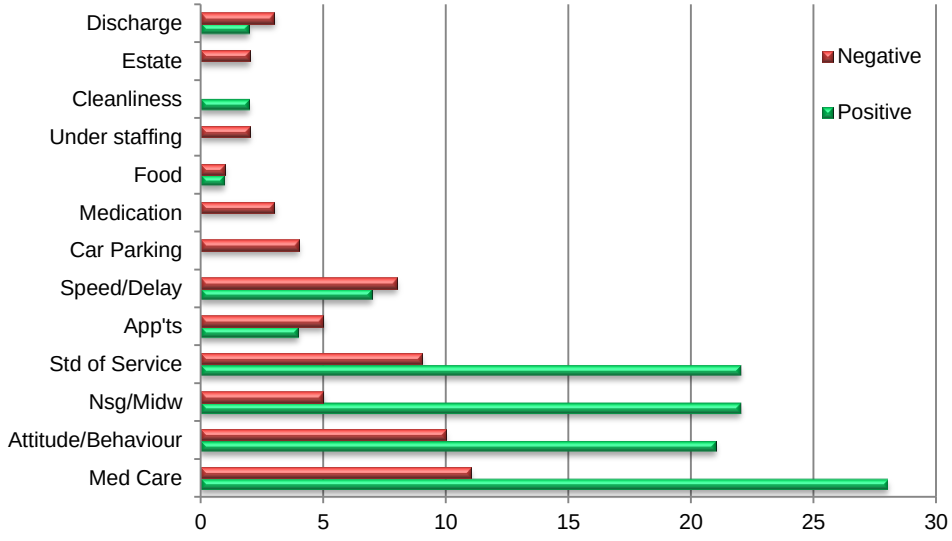

Figure 5: Formal Complaints Themes July 2012 – June 2013

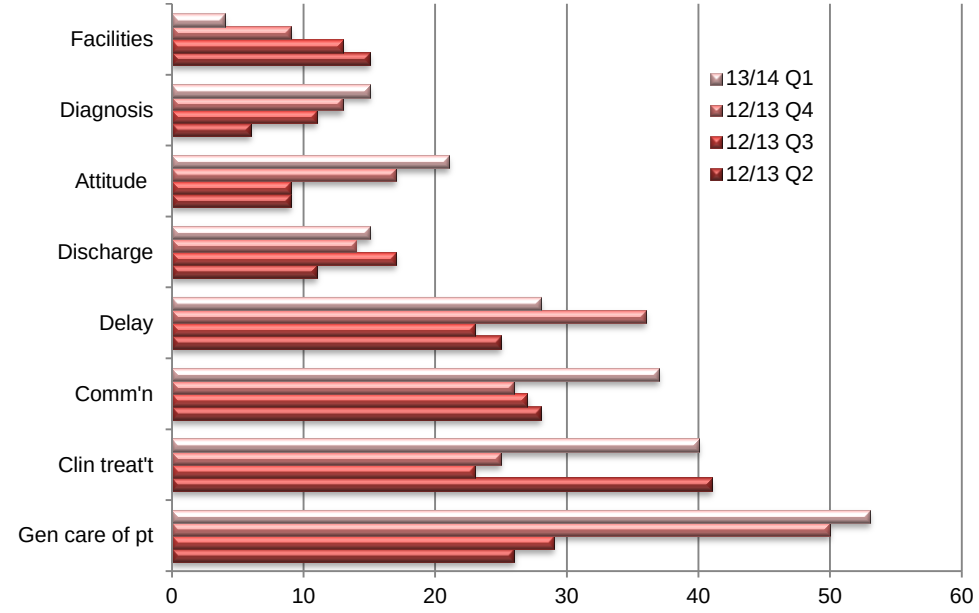

Figure 6: PALS Themes October 2012 – June 2013

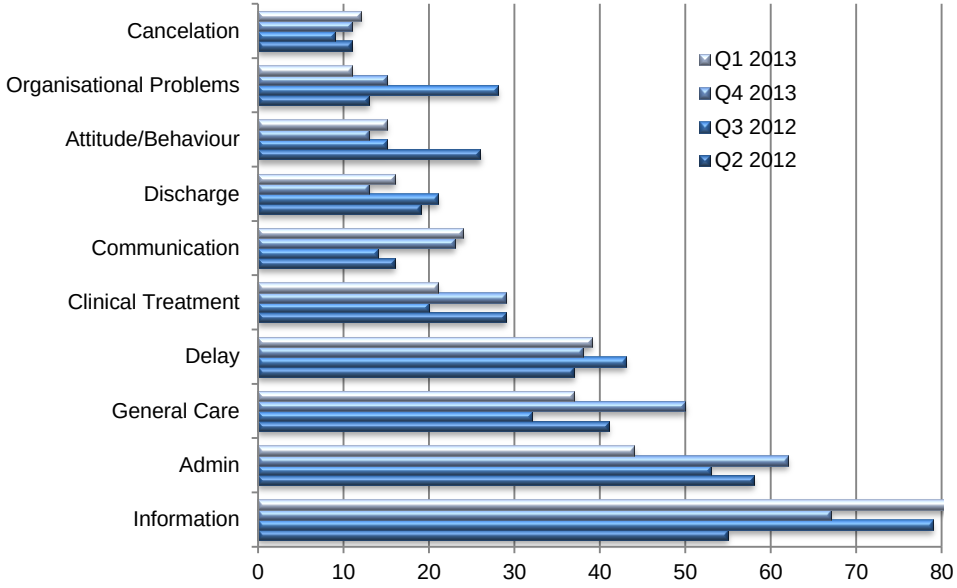

Figure 7: Discharge Survey (Real Time) April – August 2013

Question	RWT Nat Survey (n=415)	Apr-13 (n= av 421)	May-13 (n= av 538)	Jun-13 (n= av 442)	Jul-13 (n=av 481)	Aug-13 (n=av 549)
Did you feel cared for?	NA	92.3%	95.5%	96.0%	95.5%	93.6%
Pain control	79%	91.3%	94.7%	95.4%	93.6%	92.0%
Responses to patient buzzers	60%	74.4%	78.6%	81.6%	77.2%	75.8%
Discussing worries and fears	54%	88.3%	86.5%	91.5%	92.7%	86.0%
Involvement decisions about discharge	65%	85.6%	87.2%	88.6%	88.1%	86.6%
RWT Score	**64.5%**	**86.5%↑**	**88.6%↑**	**90.6%↑**	**89.4%↓**	**86.8%↓**

≥95%
≥85%-<95%
<85%

Health Scrutiny Panel

19 September 2013

Report Title	Public Health Updates on Commissioning Children's Public Health Services and Public Health Transformational Budget
Classification	Public
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Well Being
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Community / Public Health
Accountable officer(s)	Ros Jervis — Director of Public Health for Wolverhampton Tel — 01902 554211/551372 Email — Ros.jervis@wolverhampton.gov.uk

Recommendation(s) for action or decision:

The panel is recommended to receive the updates on:

- The collaborative working arrangements related to Children's Public Health Services
- The process for receiving, appraising and approving bids for 'transformation initiatives' from the transformational fund.

Recommendations for noting:

The panel is asked to scrutinise the direction of travel in developing the Commissioning of Children's Public Health Services across the new commissioning organisations and to note the process for agreeing and approving transformational initiatives.

1.0 Purpose

1.1 In response to the paper presented by the Director of Public Health at the 23rd May 2013 Scrutiny Panel, updates were requested on the new arrangements for the commissioning of children's public health services and on the process for approving transformational initiatives.

1.2 This paper outlines the commissioning arrangements from 1st April 2013 and the developments that have occurred to date.

1.3 The panel expressed a wish to understand further the impact this fragmentation of the commissioning of children's public health services may have and how those responsible for these services will work together to maximise the benefits for children and minimise any risks.

1.4 This paper also outlines the process design for approving and allocating funding to departments that seek funding from the transformational fund.

2.0 Background

2.1 The restructure of the NHS in England saw local leadership for Public Health moving to the Local Authority. The Council has new leadership roles in:

- Taking action to improve health, tackling the causes of ill-health and reducing health inequalities.
- Promoting and protecting health
- Promoting social justice and safer communities

This restructure has resulted in significant changes in the roles and responsibilities for commissioning children's public health services, resulting in a complex commissioning framework for children's services. This includes elements of some services being split between commissioning organisations. This paper focuses on the collaborative working relationships being established to oversee these changes to the commissioning of Children's Public Health Services in Wolverhampton.

3.0 Commissioning landscape

As a direct result of the Health and Social Care Bill responsibility for commissioning Children's service has been split by lead commissioner as follows:

Public Health (PH), Wolverhampton City Council, Lead commissioner for:

School nursing, excluding immunisations
Breast feeding peer support
Sexual Health
Vulnerable women's midwife
Child weight management
Food Dudes
Grants to various young people's services e.g. sexual health, substance misuse, healthy schools

NHS England (NHSE) Area Team with Public Health England (PHE) Lead Commissioner for:
School nurse immunisations
Antenatal and newborn screening programmes

NHSE Area Team Lead Commissioner for:
Child Health Information Services until 2015 (when it is expected to return to Local Authority PH Commissioners)
Health Visitors until 2015 (when it is expected to return to Local Authority PH Commissioners)

PH, Wolverhampton Clinical Commissioning Group (CCG) and NHSE Area Team Collaborative commissioning of:
Healthy Start Programme
Maternity Services (CCG is lead commissioner)

4.0 Initial Meeting and next steps

4.1 With such a complex landscape it is important that there are robust communication channels between the four responsible agencies in order to provide the necessary assurances, avoid duplication but also to maximise the beneficial outcomes these services can provide for children and young people in this City.

4.2 By way of an introduction and to maximise the opportunities that collaborative working arrangements could provide, all agencies including the Council's children's commissioning team met in the form of a scoping workshop on 21st May 2013. A joint work programme is under development based on outcomes from this workshop.

4.3 The purpose of the meeting was to:

- Agree membership and representation
- Provide assurance for the DPH from NHSE area team and PHE against nationally agreed specifications and Key Performance Indicators (KPI's).
- Identify the basis for future working arrangements and the development of a joint action plan.

4.4 Since 1st April 2013 there has been considerable reorganisation with three new organisations forming on that date and transfer of funds across 3 organisations: LA, CCG and NHSE. This has resulted in the need to ensure business continuity is not affected as organisations start to embed. At the same time new ways of working and clarity on roles and responsibilities is critical.

4.5 It was agreed that membership of this group should include:

- Public Health, LA
- PHE – Screening and immunisation teams
- NHSE Area Team
- Commissioning Manager, CCG
- Clinical Lead for Children's Service, CCG
- Head of Service, LA
- Children's Centre Lead, LA
- Head of Midwifery RWT

- Business Manager for Children's Service, RWT

4.6 Key Issues identified at the initial scoping meeting included:

- Understanding the new and developing structures
- Key challenges, including financial pressures, particularly relating to health visiting and the Family Nurse Partnership (FNP) Programme
- Information needs and opportunities for sharing information.
- School nurse immunisation services and the funding to be identified for handover to NHSE and the need to unpick this funding stream.
- Agreeing priority areas and that tackling infant mortality is joint priority for all agencies
- Understanding how commissioning responsibilities will develop and change, with some services due to transition to the LA in 2015 and the opportunities for joint working with the CCG.
- The need to map all Wolverhampton services for 0-5 year olds

4.7 Next steps include the development of a robust plan to promote collaboration and effective joint working. This will be supported by a communication plan and a schedule of regular meetings. Terms of reference for this group are currently in draft and will be agreed at the next meeting which is anticipated to be late September to allow each organisation time to understand their roles and responsibilities.

5.0 Transformational Fund

5.1 As Public Health returns to the Local Authority after many decades, there comes with this move a fresh opportunity to improve the health of the population, particularly the health of the more vulnerable in our society. Specifically, this is about a new opportunity to address the wider determinants affecting physical and mental health, such as a sense of connectedness, income, education, employment and housing.

5.2 The Public Health Transformational Fund is a £1 million pot of money to support the development and implementation of initiatives which improve the health and well-being of the population. Its primary aim is to support the embedding of Public Health outcomes into directorates across the Council, so that improving the health of the population becomes 'everyone's business' within the Council. Additional objectives are to encourage creativity and partnership working.

5.3 The Public Health Delivery Board has provided oversight of the development of criteria and accompanying processes for receiving, appraising and approving bids for the Transformational Fund. These processes have been developed with support from the Big Lottery Fund.

5.4 Representatives from the Council's Corporate Delivery Board will play a key role in appraising bids; this input will also support awareness amongst Assistant Directors across the Council about the range of initiatives that Public Health can facilitate, as well as stimulate more creative ideas from senior officers within the Council.

5.5 The Health and Well-Being Board is the final place where recommendations for funding are to be received and ratified or approved.

5.6 The process and funding criteria are being presented to the Health & Wellbeing Board on 4th September for final ratification.

6.0 Financial implications

6.1 Funding for Public Health is being provided to the Council from the Department of Health in the form of a ring-fenced grant. The funding settlement for Public Health for 2013/14 is £18.770 million. Activity arising from any of the key stands and priorities for public health throughout the year will be delivered within the approved budgets held under Public Health from the ring-fenced allocation.

6.2 A Transformational Fund is £1 million has been set aside to support the development and implementation of initiatives which improve the health and well-being of the population.
[AS/09092013/Z]

7.0 Legal implications

7.1 There are legal implications arising from the transition of public health functions to and from local authorities. The Public Health service is now responsible for the delivery of several new statutory responsibilities for the council and as a result need to be able to assure compliance. There is also a complex statutory framework underpinning public health otherwise there are no direct legal implications arising from this report.
[FD/09092013/C]

8.0 Equalities implications

8.1 Health improvement through effective commissioning strategies is a key priority for Public Health. As these strategies are developed through the year they will be subject to an equalities impact assessment.

9.0 Environmental implications

9.1 There are no direct environmental implications resulting from this report. However the services that public health commissions and future public health funded projects may seek to make a positive impact on public health through improvements to local environmental conditions.

10.0 Human resources implications

10.1 There are no direct human resource implications arising from this report. However the services that public health commissions and future public health funded projects may have implications for the workforce.

11.0 Schedule of background papers

Report to Health Scrutiny Panel - Public Health Services in the Local Authority 23rd May 2013

Agenda Item No: **8**

Health Scrutiny Panel

19 September 2013

Report Title	Update on NHS Wolverhampton City Clinical Commissioning Group response to the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
Classification	Public
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Well Being
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	NHS Wolverhampton City Clinical Commissioning Group
Accountable officer(s)	Manjeet Garcha — Executive Nurse / Quality Lead Tel — 01902 444741 Email — manjeet.garcha@nhs.net

Recommendation for action:

The Panel is recommended to:

To scrutinise the progress made by NHS Wolverhampton City Clinical Commissioning Group (CCG) in implementing recommendations from the report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

1.0 Purpose

1.1 The attached presentation gives an overview of the key themes from final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC and the progress made by Wolverhampton CCG in implementing them.

1.2 The presentation also gives a brief update on other relevant national policy developments since the publication of the report

2.0 Background

2.1 Robert Francis QC published his report on 6.2.13 which detailed of list of 290 recommendations arising from the review of the care provided at Mid Staffordshire NHS Foundation Trust. The report highlighted a number of key themes of concern for providers and commissioners of health services.

3.0 Financial implications

3.1 *None*

4.0 Legal implications

4.1 *None*

5.0 Equalities implications

5.1 *None*

6.0 Schedule of background papers

6.1 Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary-6.2.13 - Chaired by Robert Francis QC

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Clinical Commissioning Group

Robert Francis 2 Report to Health Scrutiny Committee

Manjeet Garcha

Executive Nurse / Quality Lead

WCCG

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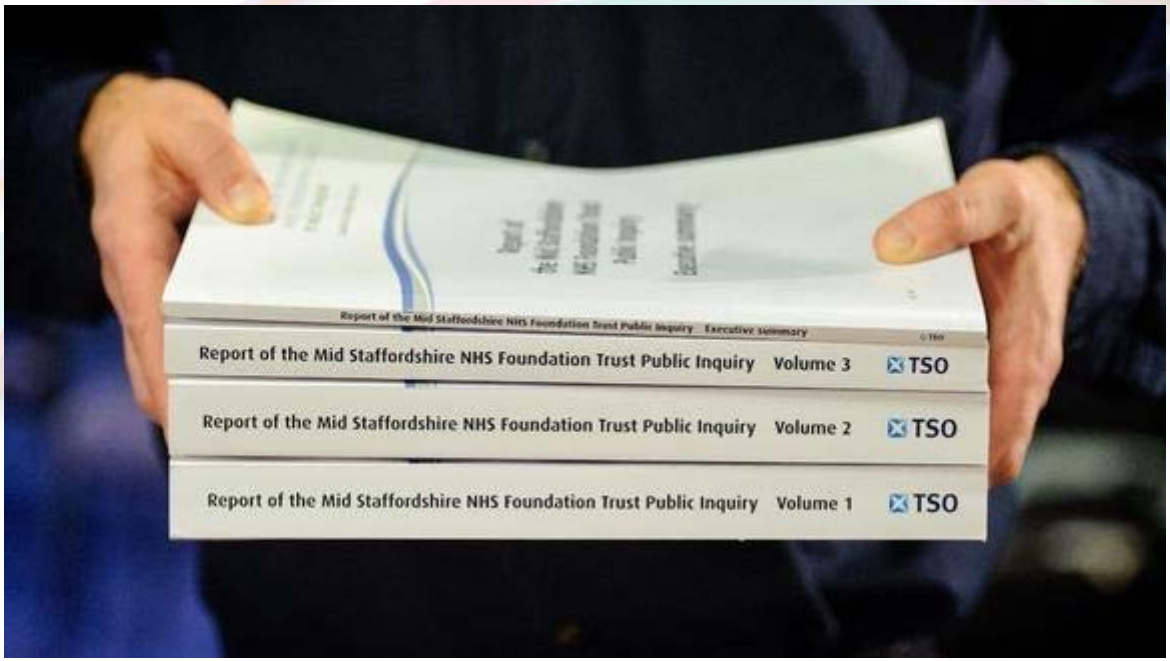
NHS
Wolverhampton
Clinical Commissioning Group

Publication 6 February 2013



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Final Report

- Executive Summary plus 3 volumes
- 290 recommendations (21 are primary care specific)
- Key themes:
  - Culture
  - Fundamental standards of compliance and means of enforcement
  - The need for greater openness, transparency and candour
  - Improved support for compassionate, caring and committed nursing
  - Accurate, useful and relevant information
  - Better healthcare leadership

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Letter to Secretary of State 5 February 2013

- About Mid Staffs and the wider NHS…
  - Culture focused on business not patients
  - Culture of false assurance
  - Measured ‘things’ rather than impact on patients
  - Accepting of mediocrity, tolerance of poor standards / risk
  - Assumption that ‘someone else’ would do it…
  - Failure to build positive culture particularly in nursing (and medicine)
  - Lack of corporate memory because of multi-level reorganisation

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National reports published since 2001

		Recommendation
2001	The Report of the Public Inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995	198
2002 - 2005	The Shipman Inquiry (6 Reports).	190
2009	Mid Staffs Review - Dr David Colin Thomé	24
2009	Mid Staffs Review - Professor Alberti	23
2010	Colin Norris Inquiry 2010	32
2010	RF 1 - March 2009 (Robert Francis QC)	18
2010	The Airedale Inquiry 2010 (Kate Thirlwall QC)	6
2013	RF2 - February 2013 (Robert Francis QC)	290
	Total recommendations	**781**

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Robert Francis is determined his report will not *'sit on the shelf'*

"There has been an unfortunate history of reports after hospital disasters being welcomed and nothing much then happening."

"As you know, I gave a set of recommendations designed to change the culture of the NHS, to put patients at the centre, a culture which puts patients and their safety first.

"It is so important these recommendations are implemented. That is why I recommended every organisation in the NHS should publish to what extent they want to take on the recommendations and then consider reviewing it regularly".

Robert Francis QC
February 2013

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Our focus is continually on:

- Preventing problems in Wolverhampton
- Detecting when they occur quickly
- Taking action promptly
- Ensuring robust accountability
- Staff training and motivation
- Time to care

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Situation so far (1)

- Board reports / discussions March and June 2013
- Wolverhampton – city wide response July 2013
- Communicated RF2 recommendations to GPs and primary care
- Developed and monitored the delivery of the action plan
- **Undertaken a scoping exercise as a baseline measure**
- Monitoring delivery of standards via CQRs and Q&S Committee
    - Preserving corporate memory
    - Unrelenting scrutiny
    - Contracting for quality as well as quantity
    - Safeguarding patients
- Increased focus on building relationships between commissioner/providers, wider NHS and regulators

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A reminder of key issues discussed by The Board

- Statutory Duty of Candour.
- Ban on clauses intended to prevent public interest disclosure.
- Complaints Review- Ann Clwyd due 2013 (local analysis mandated).
- Monitoring patient and staff experience /feedback.
- Transparency- QAs to include comparable data from set of quality indicators linked to NHS OF.
- Board Accountability and banning 'gagging clauses', 3 stage failure regime which includes quality and finance failures.
- Improved quality outcomes of CCG investments .
- Extended role of LA (H&SC Act 2012) to include PH, H&WB Board and Health Watch.
- FT pipeline, monitor and CQC and TDA (target for all aspirant FTs extended beyond 2014).

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The CCG scoping exercise included

- Alternative sources of service provision
- Complaints
- Public engagement
- Intervention and sanctions for substandard services
- Putting patients first
- Performance managers and regulators
- Lines of responsibility
- Quality metrics

Situation so far (2)

- Confirmed and ongoing assurance that RF2 recommendations are integral to all commissioning decisions.
- Ensuring a strong voice at local QSGs feeding into regional deliberations
- **Note:** NHS England will intervene if the CCG is not achieving

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Situation so far (3)

- CCG is compliant with majority of standards
- We are working towards others including:
  - Further developments with neighbouring CCGs who purchase same services
  - CCG is working with the Area Team to produce a Primary Care Strategy
- Obtaining assurance that where we commission services Trusts / Nursing Homes have developed action plans which have been endorsed by their Governing Bodies / Boards
- Seeking evidence of monitoring of the action plans to assure the quality of care for our patients

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National Picture

- Hunt for new CEO for NHS England – change of direction?
- Sir Professor Bruce Keogh – mortality review, ongoing safety reviews
- CQC Chief Inspector of Hospitals *'deep dives'* – RWH due imminently....
- Professor Don Berwick Report August 2013 – *'improving the Safety of Patients in England'*

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Don Berwick report 6 August 2013

- Recognise with clarity and courage the need for systemic change
- Abandon blame – develop trust
- Reassert primacy of working with patients
- Use quantitative data with caution (primacy of better care)
- Transparency is essential – *"expect and insist"*
- Responsibility for safety and improvement are quickly / strongly established
- Give staff help to learn and develop
- Apply modern methods for quality control, improvement and planning
- Infuse staff with pride and joy in their work

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Further updates

- Trisha Curran providing strategic support on quality (previously at East & West Midlands SHA)
- Work will be ongoing to ensure the RF2 recommendations, and those of other current or forthcoming reports are embedded in all we do.
- The CCG Board will receive a report at its meeting in October 2013 detailing action and key milestones against recommendations related to RF2, and any quality issues in particular, with quarterly updates after that.
- The CCG Q&SC will monitor and manage on going progress with action plans.

Agenda Item No: **9**

Health Scrutiny Panel

19 September 2013

Report Title	Proposal for quality and assurance report to the Health Scrutiny Panel
Classification	Public
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Well Being
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Wolverhampton Clinical Commissioning Group
Accountable officer(s)	Richard Young — Director of Commissioning Strategy & Solutions Tel — 01902 445797 Email — richard.young@nhs.net

Recommendation(s) for action or decision:
The Panel is recommended to:

- To review the proposed format and content of the report and provide feedback in regards to regular reporting to the panel

Proposal for CCG reporting Wolverhampton City Council Scrutiny Panel

Purpose

- To propose to the Scrutiny panel a standard report in order for the panel to maintain an overview of the commissioning activity of Wolverhampton CCG

Background

- Wolverhampton Clinical Commissioning Group (CCG) currently reports on the delivery of its strategic objectives, as encapsulated within its Integrated Commissioning Plan, to the Wolverhampton health and Wellbeing Board.
- At the request of the Scrutiny Panel, Wolverhampton CCG has been asked to propose the content of a quarterly operational performance report in regards to its commissioning activity.

Options (if applicable) and discussion/appraisal

- The CCG proposes that it provides a report on the following performance domains on a quarterly basis:

    - Good quality of care for local people
    - Delivering the NHS constitution
    - Improving health outcome

- These are key performance domain areas on which the NHS England assesses and assures the CCG in terms of its ability as an NHS commissioning organisation.

- Further detail on the content of these domains and current performance is included within the attached 3 slides

Financial implications (including code)

- None

Legal implications (including code)

- None

Equalities implications

None

Balanced Scorecard Domains

Good quality care for local people

Indicator	THE ROYAL WOLVERHAMPTON NHS TRUST	BLACK COUNTRY PARTNERSHIP NHS FOUNDATION TRUST
Providers(where CCG commissioning constitutes more than 5% of the provider income)	**RL4**	**TAJ**
Please identify the percentage of provider income for CCG:	**46**	**38**
Is this CCG the lead or associate commissioner?	**Lead**	**Lead**
Has local provider been subject to local enforcement action by the CQC?		
Has local provider been flagged as a 'quality compliance risk' by Monitor and/or are requirements in place around breaches of provider licence conditions?		
Has local provider been subject to enforcement action by the NHS TDA based on 'quality' risk?		
Does feedback from the Friends and Family test (or any other patient feedback) indicate any causes for concern?		
Has the provider been identified as a 'negative outlier' on SMHI or HSMR?		
Do provider level indicators from the National Quality Dashboard show that MRSA cases are above zero?		
Do provider level indicators from the National Quality Dashboard show that the provider has reported more C difficile cases than trajectory?		
Do provider level indicators from the National Quality Dashboard show that MSA breaches are above zero?		
Does provider currently have any unclosed Serious Untoward Incidents (SUIs)?		
Has the provider experienced 'Never Events' during the last quarter?		

CCG:	
Clinical Governance	
Concerns about quality issues being discussed regularly by the CCG governing body	

Has the CCG self-assessed and identfiied any risks associated wit the following:

Concerns about the arrangements in place to proactively identify early warnings of a failing service	
Concerns around the arrangements in place to deal with and learn from serious untoward incidents and never events?	
Concerns around being an active participant in its Quality Surveillance Group?	
EPRR	
If there was an emergency event in the last quarter, has the CCG self assessed and identified any areas of concern on the arrangements in place for dealing with such an event?	
Winterbourne View	
Has the CCG self assessed and identified any risk to progress against its Winterbourne View action plan?	

Balanced Scorecard Domains

Delivering the NHS Constitution

Indicator	Operational Standard	Lower Threshold	Current QTD Performance	YTD Performance
Referral to Treatment waiting times for non urgent				
Admitted patients to start treatment within a maximum of 18 weeks from referral	90%	85%	91.88%	91.88%
Non-admitted patients to start treatment within a maximum of 18 weeks from referral	95%	90%	98.62%	98.62%
Patients on incomplete non emergency pathways (yet to start treatment) should have been waiting no more	92%	87%	96.11%	96.11%
Number of patients waiting more than 52 weeks	0	10	1	1
Diagnostic test waiting times				
Percentage of Patients waiting 6 weeks or more for a diagnostic test	1%	6%	0.18%	0.18%
A & E waits				
[Provider 1]Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	90%	95.08%	95.08%
[Provider 2]Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	90%		
[Provider 3]Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	90%		
Cancer patients - 2 week wait				
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	88%	93.96%	93.96%
Maximum two week wait for first out patient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)	93%	88%	93.82%	93.82%

Cancer waits - 31 days				
Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers	96%	91%	98.71%	98.71%
Maximum 31 day wait for subsequent treatment where that treatment is surgery	94%	89%	98.28%	98.28%
Maximum 31 day wait for subsequent treatment where the treatment is an anti-cancer drug regimen	98%	93%	100.00%	100.00%
Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	89%	99.17%	99.17%
Cancer waits - 62 days				
Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer	85%	80%	90.70%	90.70%
Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	85%	95.24%	95.24%
Maximum 62 day wait for first definitive treatment following a consultants decision to upgrade the priority of the patients (all cancers)	No operational	No operational	93.90%	93.90%
Category A ambulance calls			**W Mtlnds Amblnce**	
Category A calls resulting in an emergency reponse arriving within 8 minutes (Red 1)	75%	70%	82.49%	82.49%
Category A calls resulting in an emergency reponse arriving within 8 minutes (Red 2)	75%	70%	75.63%	75.63%
Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95%	90%	97.69%	97.69%
Mixed sex accomodation breaches				
Minimise breaches	0	10	3	3
Cancelled Operations				
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding data within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice	Not Rated	Not Rated		
Mental Health				
Care Programme Approach (CPA): The proportion of people under adult mental illness specialities on CPA who were followed up within 7 days of discharge from psychiatric in patient care during the period	95%	90%	97.17%	97.17%

Balanced Scorecard Domains

Improving health outcomes

Indicator	Baseline position	Current QTD Indicator Value	YTD Indicator Value	Unit
5. Treating and caring for people in a safe environment an protecting them from avoidable harm				
Incidence of healthcare associated infection (HCAI) i) MRSA	0	0	0	Number of Cases
Incidence of healthcare associated infection (HCAI) i) C difficile	16	21	21	Number of Cases
6. Others				
Are providers (defined in Domain 1) meeting the 15% response rates on FFT ?	No	**0**		
Is the CCG progressing as expected in the IAPT tragectory submitted during the planning round?	Further development required	**0**		

Local priorities (Self-Certification)	Are you on track to deliver against this local priority?	
LOCAL PRIORITY 1	Further development required	
LOCAL PRIORITY 2	Further development required	
LOCAL PRIORITY 3	Further development required	

Agenda Item No: **10**

Health Scrutiny Panel

19 September 2013

Report Title	Health and Wellbeing Board - Joint Health and Wellbeing Strategy
Classification	Public
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Well Being
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Community / Health, Wellbeing & Disability
Accountable officer(s)	Viv Griffin — Assistant Director Health, Wellbeing & Disability Tel — 01902 55(5370) Email — vivienne.Griffin@wolverhampton.gov.uk

Recommendation

The Panel is asked to review and comment on the Health and Wellbeing Strategy which sets out the priorities for the Health and Wellbeing Board for 2013/14 and beyond.

1.0 Purpose

1.1 Health Scrutiny Panel is asked to comment on the priorities set within the Health and Wellbeing Strategy (Appendix 1) and to note the implementation plans outlined in the strategy.

2.0 Background

2.1 Health and Wellbeing Boards have the legal responsibility to publish a Joint Health and Wellbeing Strategy with the aim of improving health and wellbeing in their area. In developing the attached Health and Wellbeing Strategy the Board seeks to:

- Influence planning and delivery of integrated local services based on assessed needs and available assets
- Inform commissioning decisions to ensure they are focussed on the needs of service users and communities. This includes those services commissioned by the NHS England and Public Health England
- Tackle factors that impact upon health and wellbeing across service boundaries
- Influence commissioning of local services beyond health and care to make a real impact upon wider determinants of health
- Drive collective actions of NHS and local government, both commissioners and providers. Local authorities, CCGs and NHS Commissioning Board will need to have regard of the Joint Health and Wellbeing Strategy as they draw up their commissioning plans
- Engage with communities in the improvement of their own health and wellbeing
- Make best use of collective resources to achieve improved outcomes on the agreed priorities to be addressed
- Identify a robust evidence base
- Build on past work
- Link to the City Strategy –"Prosperity for All"

The Strategy is based on the five key health and wellbeing priorities identified by the Board:

- Wider Determinants of Health
- Alcohol and Drugs
- Dementia
- Mental Health
- Urgent Care

For each of these areas it commences with an implementation plan and outlines key outcome targets against which plans can be performance managed.

3.0 Financial implications

3.1 There are no financial implications associated with this report. [MK/05092013/S]

4.0 Legal implications

4.1 There are no legal implications associated with this report. FD/06092013/G]

5.0 Equalities implications

5.1 An equalities analysis has been completed for the Joint Health and Wellbeing Strategy.

6.0 Schedule of background papers

6.1 None.

Wolverhampton Joint Health and Wellbeing Strategy – 2013-2018

Ensuring good health and a longer life for all in Wolverhampton

Including the first phase implementation plan

August 2013

Foreword by Chairman of Wolverhampton's Health and Wellbeing Board

We are delighted to launch our first Health and Wellbeing Strategy for Wolverhampton. We believe this strategy is a significant step forward for the health and wellbeing of the City.

We are used to positive partnership working between Local Government and the NHS in Wolverhampton and we are also used to working hand in hand with the public. This document finds us all speaking with one voice on behalf of the new Health and Wellbeing Board in an attempt to tackle the most pressing health problems our City faces today.

Health and Wellbeing in Wolverhampton faces a number of significant challenges but we are determined to tackle these challenges by working together to achieve long term gains.

Our understanding of the issues facing Wolverhampton has been strengthened by an in depth consultation on this strategy's supporting Joint Strategic Needs Assessment with the public and our many partners.

It is important that we can measure the changes to services we intend to make and the improvements in health outcomes we hope to achieve. We have therefore included targets throughout the document. Many of these measures are ambitious and we intend to progress each of the key priorities.

We look forward to continuing to work with the public and our partners to make sure this remains a joint venture.

Councillor Sandra Samuels Chairman of the Board

1. Introduction

1.1 Overview

Welcome to Wolverhampton's Joint Health and Wellbeing Strategy. This is an overarching strategy for the city, together with an action plan for its implementation. It has been developed by leaders from across the local community working together through Wolverhampton's Health and Wellbeing Board. They have a collective focus – to improve health and wellbeing for all – so individuals and communities are able to live healthier lives, and to reduce some of the stark gaps in health experienced across the city.

1.2 Why we need a strategy

Health and Wellbeing Boards have the legal responsibility to publish a Joint Health and Wellbeing Strategy with the aim of improving the health and wellbeing in their area. This strategy provides a roadmap and gives a clear sense of direction. In developing the Health and Wellbeing Strategy, we seek to:

- Influence planning and delivery of integrated local services based on assessed needs and available assets
- Inform commissioning decisions to ensure they are focussed on the needs of service users and communities. This includes those services commissioned by the NHS England and Public Health England
- Tackle factors that impact upon health and wellbeing across service boundaries
- Influence commissioning of local services beyond health and care to make a real impact upon wider determinants of health

- Drive collective actions of NHS and local government, both commissioners and providers. Local authorities, CCGs and NHS Commissioning Board will need to have regard of the Joint Health and Wellbeing Strategy as they draw up their commissioning plans
- Engage with communities in the improvement of their own health and wellbeing
- Make best use of collective resources to achieve improved outcomes on the agreed priorities to be addressed
- Identify a robust evidence base
- Build on past work
- Link to the City Strategy –"Prosperity for All"
- Link to the Clinical Commissioning Group 'Integrated Commissioning Plan' and the vision of working closely and collaboratively with partners to deliver the 'Right Care in the Right Place at the Right Time'

1.3 Intelligence that has been used to shape the Joint Health and Wellbeing Strategy

The strategy needs to be focused on both health and wellbeing. Many factors can influence people's health and wellbeing including health issues such as heart disease caused by smoking and obesity and wider determinants such as feeling safe, being socially included and maintaining independence. The outcome priorities selected in the strategy have been chosen to reflect the full range of health and wellbeing priorities. The strategy heavily draws upon the evidence base outlined in the Joint Strategic Needs Assessment (JSNA). The JSNA is based upon the data drawn from the National Outcomes Frameworks for Health, Adult Social Care and Public Health. Data from about 120 indicators included in the national outcome frameworks has been analysed and presented to the Health and Wellbeing Board. The Health and Wellbeing Board reviewed this list of indicators and created a shortlist of outcomes where joint working can add value or which are current challenges to improving health and wellbeing in Wolverhampton. These were grouped and 2013-14 work will focus on groups 1 and 2 and detailed briefings have been produced to provide a useful evidence resource for these key health issues. The JSNA will be continually

updated to take account of the most recent versions of the outcomes frameworks in order to provide a detailed and up to date picture of health and wellbeing in Wolverhampton.

1.4 *Input from local people including the public, patients, partners and stakeholders*

Representatives of the Healthwatch, public, patients, partner organisations and other stakeholders undertook the same process as the Health and Wellbeing Board and prioritised a shortlist of outcomes. The outcome from these processes was highly compatible. Changes were made as a result of this input.

2. Strategic Direction

2.1 Our vision

Ensuring good health and a longer life for all in Wolverhampton.

2.2 Our goals

We want to improve the health and wellbeing of our most disadvantaged people and reduce inequalities in health and well-being across the city.

We want to raise the aspirations of people so they are motivated to take healthy choices to enable them to live longer, healthier and happier lives.

We want to create environments where the healthy choice is the easiest choice and support improvement in the wider determinants of health such as employment, poverty and housing that affect people's health and their ability to make healthier choices.

2.3 Our strategic priority outcomes

- ✓ Increase life expectancy
- ✓ Improve quality of life
- ✓ Reduce child poverty

2.4 Guiding Principles

The guiding principles underpinning the implementation of our Health and Wellbeing Strategy are outlined below:

- *Knowledge-led decision making* – understanding and interpreting information in all its forms – data, research and evidence, experience and expertise - and setting it within a local context is essential and will enable us to make the best possible decisions.

- *Innovation* – demand, need and expectations are increasing whilst we also face significant financial difficulties. We therefore have to think differently and do things differently. This will mean transformational change in some areas of providing services. We aim to deliver the ambitions of the strategy through being dynamic, forward-thinking and within a culture of innovation.

- *Integration* – many organisations and stakeholders will have a key part to play in successfully delivering our health and wellbeing ambitions. Some, if not all of these, are long-standing and difficult. The only way they can be tackled is through an integrated and joined-up approach across partners.

- *Outcome focused* – often strategies are full of impressive ideas that aren't measurable. It is our intention that this strategy is clearly focused on delivering outcomes and demonstrating change.

- *Value* – whether in a time of financial challenge or of plenty, we have a duty to make sure that the services we deliver or commission offer the greatest possible value in terms of quality, cost and outcome. For every initiative we implement, we aim to demonstrate the expected return in these terms of our investment.

3. Priorities Chosen by the Board

3.1 Being focussed

Wolverhampton faces considerable needs around health and wellbeing. We know this, because our JSNA process reviewed the national outcomes frameworks and highlighted 51 indicators (out of a total of 105 where we had local data) where we can be sure that Wolverhampton is performing worse than the England average. However, there is a danger that if the Health and Wellbeing Board tries to focus on all these areas of need that resource and energy will be spread too thinly to have an impact. Therefore, in the first phase, the Health and Wellbeing Board has decided to focus on a small number of priority areas.

The top five priorities identified by the Health and Wellbeing Board were:

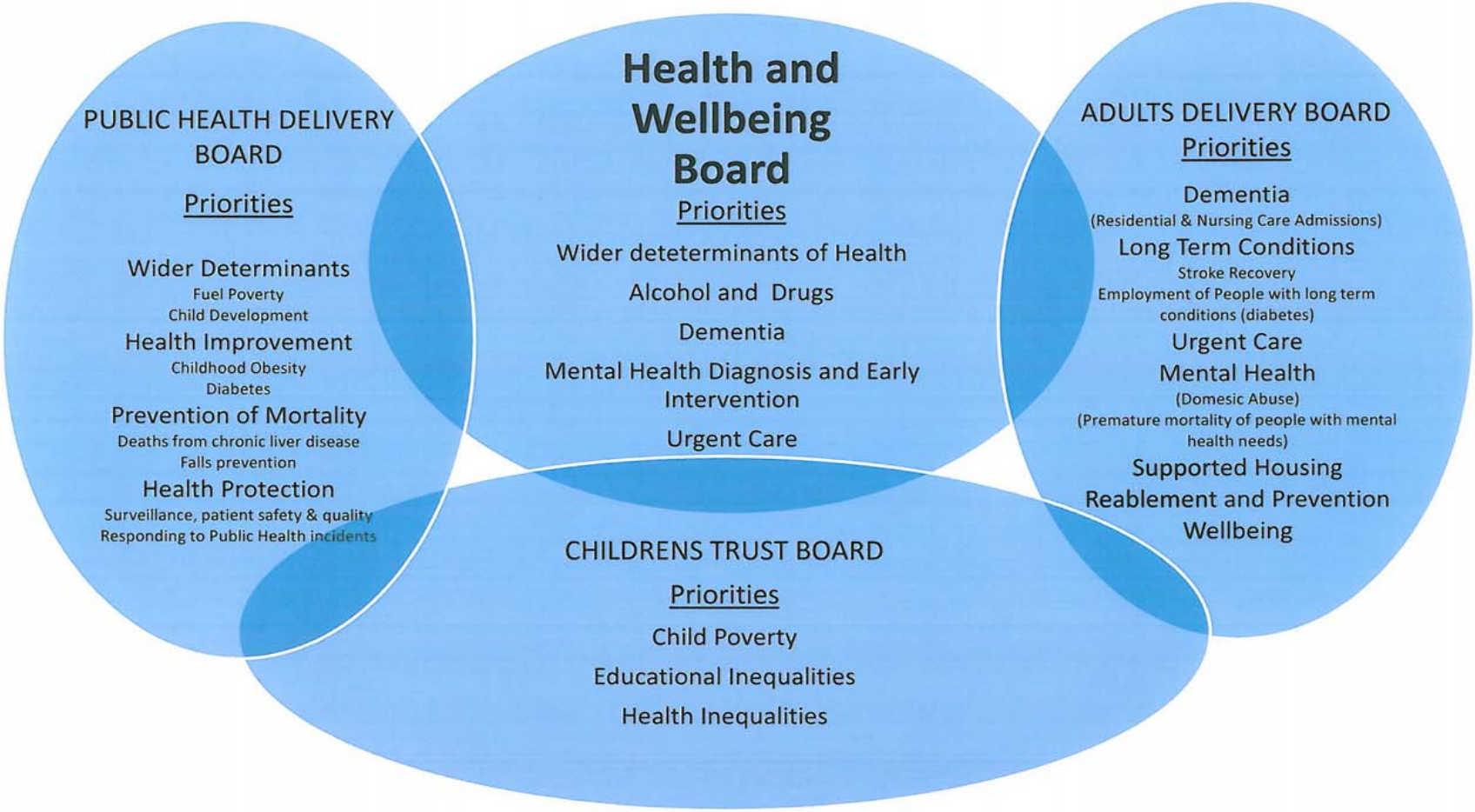
- **Wider Determinants of Health**
- **Alcohol and Drugs**
- **Dementia (early diagnosis)**
- **Mental Health (Diagnosis and Early Intervention)**
- **Urgent Care (Improving and Simplifying)**

In considering these priorities the Board identified the wider determinants of health as being a longer term priority and the other priorities as being of a short or medium term priorities. The Board has focused on those priorities which are key health issues identified in the JSNA; which are vital to the city and where, through partners working together, the Board can make a difference.

In addition to the Health and Wellbeing Board's priorities the priorities of the Board's three key sub-groups have been agreed as follows:

Sub-Group	**Priority**
Adults Delivery Board	▪ Dementia (Early diagnosis and residential and nursing care admissions) ▪ Long Term Conditions (Stroke Recovery and Diabetes) ▪ Urgent Care (Reducing demand) ▪ Mental Health (Diagnosis and early intervention, domestic abuse and premature mortality of people with mental health needs) ▪ Supported Housing, Re-ablement and Prevention ▪ Wellbeing
Children's Trust Delivery Board	▪ Child Poverty ▪ Educational Inequalities ▪ Health Inequalities
Public Health Delivery Board	▪ Wider determinants of health (Fuel poverty and child development) ▪ Health improvement (Childhood obesity and diabetes) ▪ Prevention of mortality (Deaths from chronic liver disease and falls prevention) ▪ Health protection

DELIVERING THE HEALTH AND WELLBEING BOARD PRIORITIES



Priorities

The health and wellbeing priorities have been selected to provide a number of high level evidenced based priorities which are a challenge to resolve and span organisational responsibilities. The JSNA and consultation with partners provided the evidence for the priorities and the sub-groups of the Board have endorsed the priorities and added to them. The priorities are also reflected in the Clinical Commissioning Group Integrated Commissioning Plan which highlights:

- **Dementia**
- **Urgent Care**
- **Diabetes**

as its priorities.

The Board will review progress made against its priorities at each meeting and they will be reviewed and refreshed annually.

PRIORITY 1 WIDER DETERMINANTS OF HEALTH

Lead Agency: Wolverhampton City Council (Public Health Department)

Sponsor: Ros Jervis (Director of Public Health)

Project Manager: Consultant in Public Health

Partners: All agencies/departments

What is the issue?

The health and well-being of individuals and populations across all age groups is influenced by a range of social, economic and environmental factors. We, as individuals, cannot always control them and they influence and often constrain the 'choices' we make and the lifestyle we lead.

The social determinants of health have been described as 'the causes of the causes' (of ill health). They are the social, economic and environmental conditions that influence the health of individuals and populations. They include the conditions of daily life and the structural influences upon them, themselves shaped by the distribution of money, power and resources at global, national and local levels. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances. There is a clear link between the social determinants of health and health inequalities, defined by the World Health Organisation as "the unfair and avoidable differences in health status seen within and between countries".

Lack of income, inappropriate housing, unsafe workplaces and poor access to healthcare are some of the factors that affect the health of individuals and communities. Similarly, good education, inspired public planning and support for healthy living can all contribute to healthier communities. Professor Sir Michael Marmot in his Strategic Review of Health Inequalities in England, Post 2010 – 'Fair Society Healthy Lives' presented an evidence-based strategy for the reduction of

health inequalities with a focus on policies and interventions that address the social determinants of health.

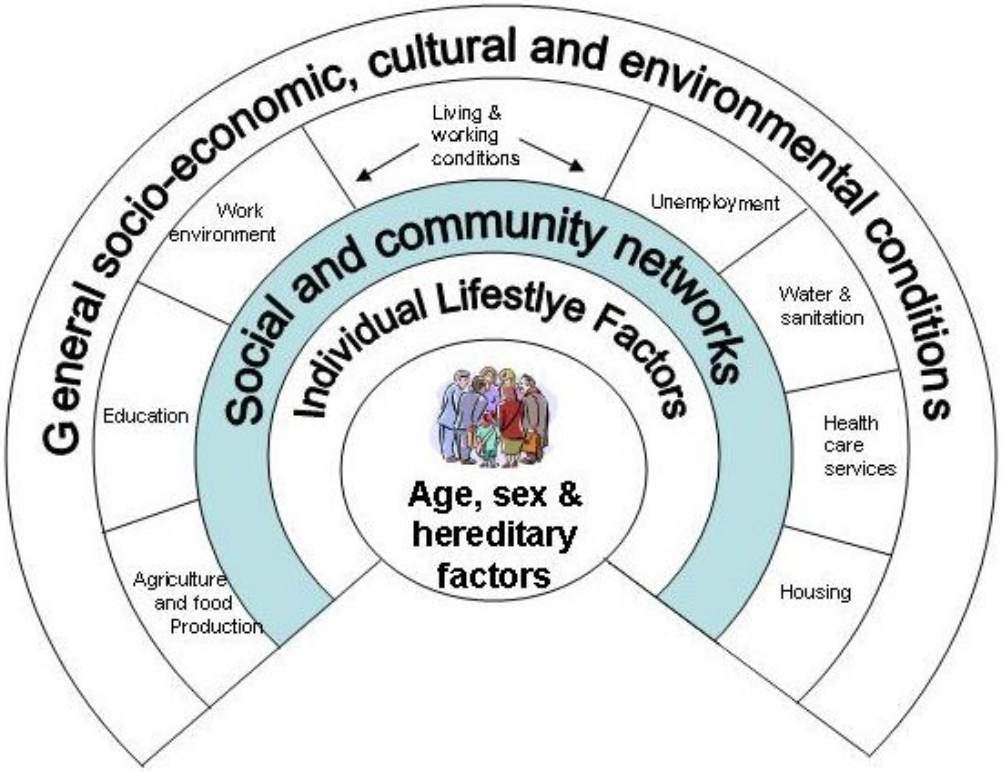
Why is it important

Addressing the contribution of the wider social determinants of health is crucial to health and wellbeing as we cannot make the large scale progress we need to make on tackling the big health issues of the 21st century, particularly on diet and weight issues, alcohol consumption, smoking, reducing health inequalities and tackling the big killers of cancer, CVD and respiratory illness, without systematic improvement across these areas. One of the difficulties in tackling health inequalities on the ground is a failure, for numerous reasons, to get a proper grip on the social determinants of health. Therefore the Health and Wellbeing Board consider this to be a key underpinning priority.

A model for the social determinants of health

A model often used to illustrate the wider determinants is the Dahlgren and Whitehead (1991) 'Policy Rainbow', which describes the layers of influence on an individual's potential for health (Figure 1). Some of these factors are fixed (core non modifiable factors), such as age, sex and genetics but there are other, potentially modifiable factors expressed in the diagram as a series of layers of influence including: personal lifestyle, the physical and social environment and wider socio-economic, cultural and environment conditions.

Figure 1: The Determinants of Health – the Policy Rainbow



The Rainbow model explained:

- In the centre of the figure, individuals possess age, sex and constitutional characteristics that influence their health and that are largely fixed.
- Surrounding them, however, are influences that are theoretically modifiable by policy. First, there are personal behaviour factors, such as smoking habits and physical activity.
- Second, individuals interact with their peers and immediate community and are Influenced by them, which is represented in the second layer.
- Next, a person's ability to maintain their health (in the third layer) is influenced by their living and working conditions, food supply, and access to essential goods and services.
- Finally, as mediator of population health, economic, cultural and environmental influences prevail in the overall society.

The size of the contribution of each of the layers to health has been estimated from research in the US as follows:

- 30% from genetic predispositions
- 15% from social circumstances
- 5% from environmental exposures
- 40% from behavioral patterns
- 10% from shortfalls in medical care

Therefore, 60% of what determines good or poor health comes from potentially modifiable circumstances of an individual's life – either directly related to the social and economic circumstances or related to behavioral patterns that will have been developed based on life experiences. Therefore taking action on improving the wider social determinants of health can have a huge impact on the health of Wolverhampton residents and impact on reducing health inequalities.

Figure 2 shows that local authorities are well placed to address these social and economic determinants of health as the services that can make a difference fall within their remit.

Figure 2: The social determinants of health and examples of local government services and activities that can make a difference

Source: adapted from Campbell F (ed.) (2010) The social determinants of heath and the role of local government. In http://publications.nice.org.uk/health-inequalities-and-population-health-phb4

What is the position and evidence in Wolverhampton?

The JSNA evidence from the various outcomes frameworks and in particular the Public Health Outcomes Framework spine charts highlights indicators relating to the wider determinants of health where Wolverhampton scores badly against national benchmarks. Children have a worse experience in a number of areas related to income deprivation and education, for example:

- 31% of children live in poverty – 10% higher than the England average
- 52% of children have a good level of development at age 5 – compared to 59% nationally
- Unauthorised absences at school are higher than average
- Amongst older age groups, 7.6% of 16- 19 year olds are not in education, employment or training – higher than the England average.

Indicators also show areas for improvement relating to adults and older people with higher rates of violent crime, more people affected by noise, higher numbers of homeless people and more households affected by fuel poverty.

However, there are other important indicators that measure the impact of social and environmental factors on the population, for example unemployment, educational attainment amongst adults, and demographic characteristics such as population structure and ethnicity. A broader measure of the wider determinants of health, the Index of Multiple Deprivation (IMD) is a composite index used to identify the most deprived areas across the country. The index combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for small population areas in England.

The IMD shows that 52% of Wolverhampton's population falls into the poorest 20% of the national spread of social deprivation – i.e. over half of Wolverhampton's population live in the poorest areas in England which impacts on life expectancy and premature mortality rates in the City.

There are also stark differences within Wolverhampton itself between those living in the most and least deprived areas of the City – all of which results in males living on average, 6 years less in the most deprived areas compared to the least deprived areas and nearly 4 years difference for females.

How does it link to other strategies and priorities in Wolverhampton?

A consideration of the health impact should be a part of all local government department strategies which address the wider determinants of health. Strategies should consider, as standard, the question: – 'How does this strategy contribute to improving the health and wellbeing of Wolverhampton residents and in particular the most disadvantaged?' All strategies should be reviewed to examine the opportunities to promote health and new strategies should include a consideration of the opportunities to improve health and wellbeing and reduce health inequalities.

Strategies that have particular impact on the wider determinants are:

- Children, young people and families plan
- Transport
- Housing
- Education /Lifelong Learning Strategies
- Employment/Economic Regeneration
- Planning
- Environment/ Trading Standards
- Parks and Leisure

What is the evidence of effective interventions?

Action in partnership, in sectors such as housing, education, transport and employment offer real opportunities to improve health and reduce the health gap. It is important that partners are aware of the opportunities that exist to improve health outcomes in many of the core functions of local government and other agencies, not only in the services

that are delivered but in the way in which services are delivered to make sure that those who need them most are receiving them. Whilst in some areas the research evidence base could be strengthened, there are opportunities for local action to tackle the wider social determinants of health in the following areas:

Examples of opportunities for local action to tackle the wider social determinants of health

Wider social determinant:	***Example of opportunity:***
Community engagement	Enhancing mechanisms for getting people engaged and involved in things that matter to them
Housing and regeneration	Working with partners who provide housing or care services to address issues such as : quality of housing, ensuring that homes are safe (injury prevention) and addressing issues of fuel poverty.
Education	Investing in early years and in the quality of schooling which provide social, health and economic returns in the future
Community safety	Reducing crime and violence
Spatial planning	Healthy places result in healthy people. Planning authorities can do a great deal to plan for healthy environments. Not just those which promote physical activity but also promote mental wellbeing by including green space and opportunities to interact with others
Food and nutrition	Planning for food resilience and ensuring availability and access to healthy food
Transport	Particularly around injury prevention, including traffic calming measures and including walking and cycling in transport plans
Children's services	Those who deliver and commission children's services make a huge contribution to the social, mental and physical wellbeing of young people, providing them with vital skills and social capital which lead to better life chances as they grow up
Leisure and cultural services	Providers and commissioners of leisure and cultural services have the potential to influence health not simply through offering activity and promoting healthy lifestyle but also in the way culture shapes an area and communities within
Employment and the work environment	Fair employment and decent working conditions are major contributors to health and well-being. Workplaces also provide opportunities for health promoting interventions

The National Institute for Health and Clinical Excellence has produced a series of public health guidance in this area and also local government public health briefings (http://publications.nice.org.uk). Briefing 4 on Health inequalities and population health outlines NICE's recommendations for local authorities and partner organisations on population health and tackling health inequalities, many of which arise from the social determinants of health.

An 'asset model' takes as its starting point the need to identify and build on the positive features of individuals and communities, utilising such capacities and capabilities as exist to further empower them. This is in contrast to the usual 'needs led' deficit approach to tackling health and wellbeing issues. Assets can operate not just at the level of the

individual but, importantly, at the level of the group, neighbourhood, community and population. For example, these assets can be social, financial, physical, environmental, educational, employment related.. Conceived of in these ways, they relate directly to the social determinants of health and can provide an alternative way of dealing with the causes of ill health by looking for positive patterns of health and strengthening those social bonds and ties that go far in sustaining health, even in the face of disadvantage. Asset mapping is being undertaken in key neighbourhoods of Wolverhampton consistently affected by wellbeing and resilience issues and this work will inform a model of good practice in taking forward an asset based approach.

What are the planned actions, timescales and leads?

The return of public health to the Local Authority has provided an opportunity to address public health outcomes, including Domain 1: Improving the wider determinants of health, through a £1 million Public Health Transformational Fund. Bids of up to £250,000 per annum are invited from council directorates in partnership with other external agencies, for example the voluntary sector, public or private sector organisations, to be ratified by the Health and Wellbeing Board. The primary aim of the fund is to support the embedding of outcomes into directorates across the council so that improving the health of the population, and addressing health inequalities through the wider determinants becomes 'usual practice'

In addition to the Transformation Fund supporting the embedding of a culture of working 'upstream', there are a series of other actions that can support this process, for example:

- Review the extent to which existing NICE guidance relating to the wider social determinants of health has been implemented in Wolverhampton
- All City Council strategies adopt a 'health impact' approach. https://www.gov.uk/government/publications/health-impact-assessment-tools
- Existing relevant strategies (see 4 above) are reviewed to assess the potential for improving the health of Wolverhampton residents and reducing inequalities

- Refresh of the JSNA to include more intelligence on the wider social determinants of health, in particular to understand the risk factors for poor health outcomes

How will progress be measured?

Key high level targets:

Before measurable changes to population health can be achieved, there will need to be some underpinning actions and more integrated working to address upstream interventions before actual benefits to the population's health are achieved. For Year 1 the key deliverables are related to the Transformation Fund, i.e:

- Successful implementation of the Public Health Transformation Fund and approval of good quality projects to address factors such as education, skills, employment, housing, social capital/social connectedness.
- Each project that is approved will have associated evaluation and success criteria agreed as part of the approval process.

Progress will be monitored quarterly through the Public Health Delivery Board.

PRIORITY 2 ALCOHOL AND DRUGS

Lead Agency: Wolverhampton City Council (Public Health Department)

Sponsor: Ros Jervis (Director of Public Health)

Project Manager: Juliet Grainger (Substance Misuse Commissioning Manager)

Partners: West Midlands Police, YOT, CCG, GPs, Pharmacists

What is the issue?

Drug and alcohol dependency is a complex health disorder with social causes and consequences. No single factor can predict whether or not a person will become addicted. The risk of addiction is influenced by a person's personality, social environment, biology and age. The more risk factors an individual has, the greater the chance that taking drugs or harmful drinking can lead to addiction with a host of consequences for an individual's health for example drug use is linked to everything from heart and respiratory problems to psychosis and seizures, while heavy drinking is known as a causal factor in more than 60 medical conditions. Added to that is the increased likelihood of suffering violence and having unprotected sex that is seen among heavy drinkers.

Nationally, numbers using drugs have fallen gradually in recent years, in both adults and children. This success has been widely welcomed, and may be due to a combination of factors from better access to treatment and health promotion campaigns to a wider cultural shift away from traditional drug use and there is a growing concern about the use of so-called legal highs – substances that mimic the effect of banned drugs.

By comparison, alcohol-related problems among adults have been getting worse on many measures. Both hospital admissions and deaths linked to drinking have increased since the early 1990s. Overall it is estimated over 1million people in England have mild, moderate or severe alcohol dependence. About a third of these will face challenges that are similar to those people who are dependent on drugs.

There isn't really such a thing as a 'typical drug user', though people dependent on heroin and/or crack cocaine are statistically more likely to be white, male, in their thirties and from a background of high social deprivation. Alcohol misuse is also more common among people from deprived backgrounds – the most deprived fifth of people are up to three times more likely to have an 'alcohol related death' - but some of the largest rises in alcohol consumption have been seen among higher income groups in the past decade. Children growing up in families where parents are dependent on drugs or alcohol are seven times more likely to become addicted as adults[i]. Despite the relatively high number of injecting drug users, England has one of the lowest rates of HIV and hepatitis C among this group thanks partly to public health programmes such as needle and syringe exchange programmes. Cannabis is the most popular drug among occasional or casual users but no causal link between current cannabis use and the future use of more problematic drugs such as heroin or crack has ever been proved. [1]

The cost to the country in dealing with the consequences of alcohol and drug problems is significant. The bill for alcohol stands at about £20 billion a year once the economic, crime and health costs are taken into account and for drugs it tops £15 billion. However, Home Office research has shown that spending £1 on drug treatment saves £2.50 in crime and health costs of drug addiction.

What is the position and evidence in Wolverhampton?

Estimates show that there are 2,135 Opiate/Crack users and 5,264 dependant drinkers aged 16 years and over. There is no official estimate for the prevalence of drug use by young people at Local Authority level. However results of the Wolverhampton Health Related Behaviour Survey show that 25% of primary school pupils and 48% of secondary school pupils said that they have had an alcoholic drink, 5% of primary school pupils said they had been offered drugs, 12% of secondary school pupils revealed that they have been offered cannabis while 6% had taken an illegal drug; 3% of them in the month before the survey.

[1] Tackling drugs and alcohol. Local government's new public health role. Local Government Association http://www.local.gov.uk/c/document_library/get_file?uuid=ef73ac40-827e-4e7f-bb27-9b19fff157c0&groupId=10171

Mortality

Alcohol abuse is one of the leading causes of premature mortality in the city. Primary care mortality data shows that between 2006 and 2010 it was the third highest contributor to years of life lost (YLL) after infant mortality and CHD. Alcohol related mortality rates have increased over the last few years.

- Alcohol is currently one of the biggest contributors to Years of Life Lost (YLL) in Wolverhampton.
- In the period 2001-2005 it ranked 5th as a cause of YLL with 4,293 years of lives lost to alcohol related liver mortality
- The latest data- 2006-2010 shows that it has moved up to 3rd with 5,221 YLL

Top 10 causes of death and top 10 sum of YLL 2006-2010

Rank	Condition	Numbers	Rank	Condition	YLL
1	CHD	594	1	Infant deaths	9000
2	Disease of the respiratory system	403	2	CHD	7006
3	Lung cancer	389	3	**Alcohol related Liver mortality**	**5221**
4	**Alcohol related Liver mortality**	**236**	4	Disease of the respiratory system	4461
5	Stroke	227	5	Accidents	4444
6	Colorectal cancer	150	6	Lung cancer	4078
7	Breast cancer	140	7	Suicide & Injury Undetermined	3231
8	Accidents	130	8	Stroke	2626
9	Diseases of the nervous system	121	9	Diseases of the nervous system	2281
10	Infant deaths	120	10	Breast cancer	2269

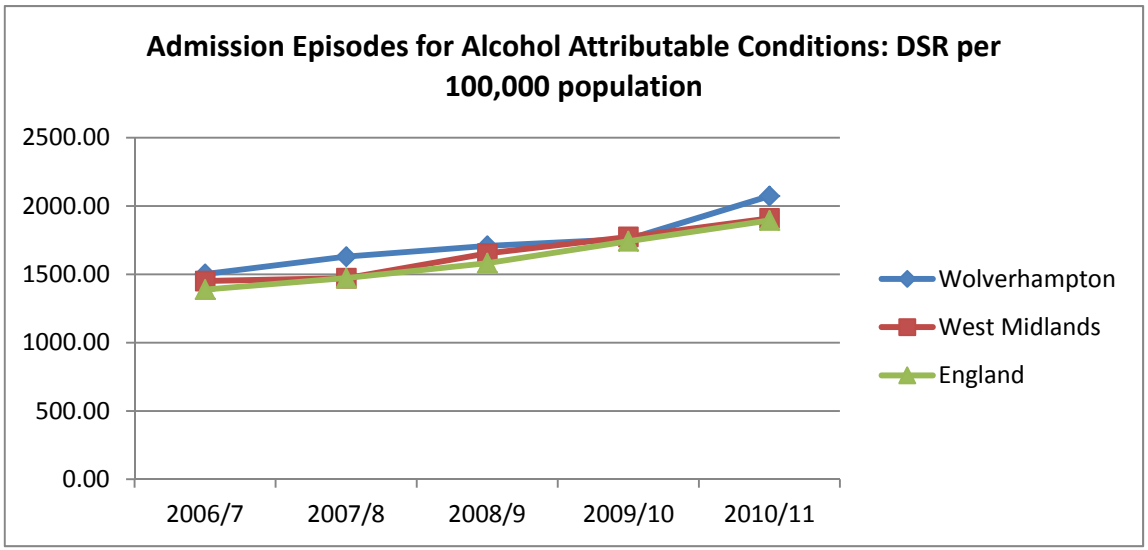
Source: Primary care mortality file

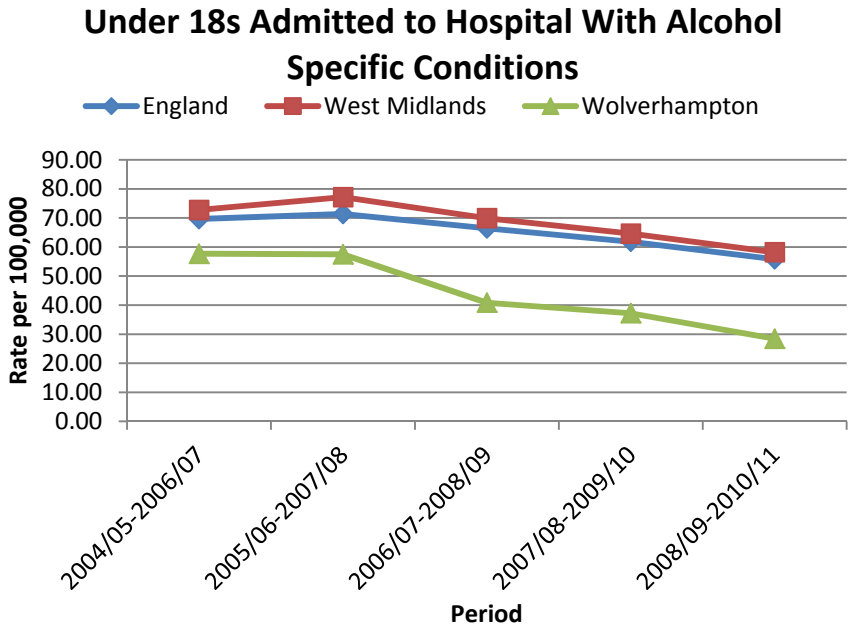
- The years of life lost annual potential for improvement shows the gap between the local value and the national average and gives an indication of the number of years of life lost that could be saved if the local value decreased to the national level.
- After infant mortality, alcohol has the biggest potential for improvement; between 2006 and 2010 494 YLL could have been saved if the rate of alcohol related mortality in Wolverhampton had been similar to the national rate.
- Alcohol related mortality has been on an upward trend over the last 17 years in Wolverhampton. In the last 3 years this trend has begun to level off, however, the gap to the national average remains almost double and rates are much higher than for the local authority comparator group, 'Centres with Industry'.
- The number of deaths related to drug use, published by the Office for National Statistics (ONS) at a national level show that there were 1,772 male and 880 female drug poisoning deaths (involving both legal and illegal drugs) registered in 2011, a 6 per cent decrease since 2010 for males and a 3 per cent increase for females.
- In 2011 the drug poisoning mortality rate was 63.8 deaths per 1 million population for males and 29.9 deaths per million population for females, both were unchanged compared with 2010.
- Deaths involving heroin/morphine decreased by 25 per cent compared with 2010, but they were still the substances most commonly involved in drug poisoning deaths (596 deaths in 2011).
- Locally the numbers are very low with only 52 deaths recorded between 1994 and 2012.

Hospital Admissions

As well as being a top cause of death, alcohol misuse also contributes to other health problems and impacts on service utilisation, in particular hospital activity. Hospital admissions for conditions related to drug use are generally lower.

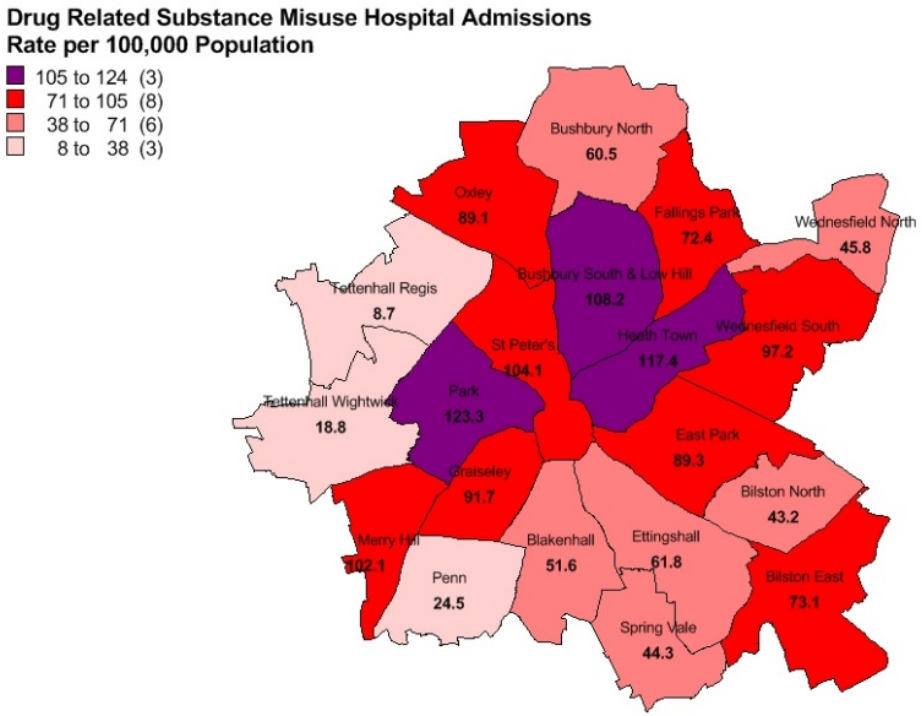
- In 2010/11, there were 2073 hospital admission episodes for alcohol-attributable hospital admissions per 100,000 population in Wolverhampton; nearly an 18% increase on the previous year.
- The rate of alcohol-attributable hospital admission episodes has seen a slow but steady increase over the past five years. However, the gap between the Wolverhampton rate and the national average is increasing.


Admission Episodes for Alcohol Attributable Conditions: DSR per 100,000 population
2500.00
2000.00
1500.00
1000.00
500.00
0.00
2006/7
2007/8
2008/9
2009/10
2010/11
Wolverhampton
West Midlands
England


Under 18s Admitted to Hospital With Alcohol Specific Conditions
England
West Midlands
Wolverhampton
Rate per 100,000
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00
2004/05-2006/07
2005/06-2007/08
2006/07-2008/09
2007/08-2009/10
2008/09-2010/11
Period

- In contrast, hospital admissions for under 18s have shown an increase over the past 9 years and Wolverhampoton is significantly below the national and regional average.
- Between 2009 and 2011 there were 457 admissions related to substance misuse. This equates to a rate of 1.9 admissions per 1,000 population.
- The majority of admissions were for poisoning by narcotics. Mental health and behavioural disorders due to the use of opioids also represented a relatively high proportion of admissions.
- Between 2009 and 2012 there were 199 admissions for drug related conditions. This equates to a rate of 80 admissions per 100,000 population.

Rate of Drug Related Hospital Admissions 2009-2012



Source: Wolverhampton Public Health Department

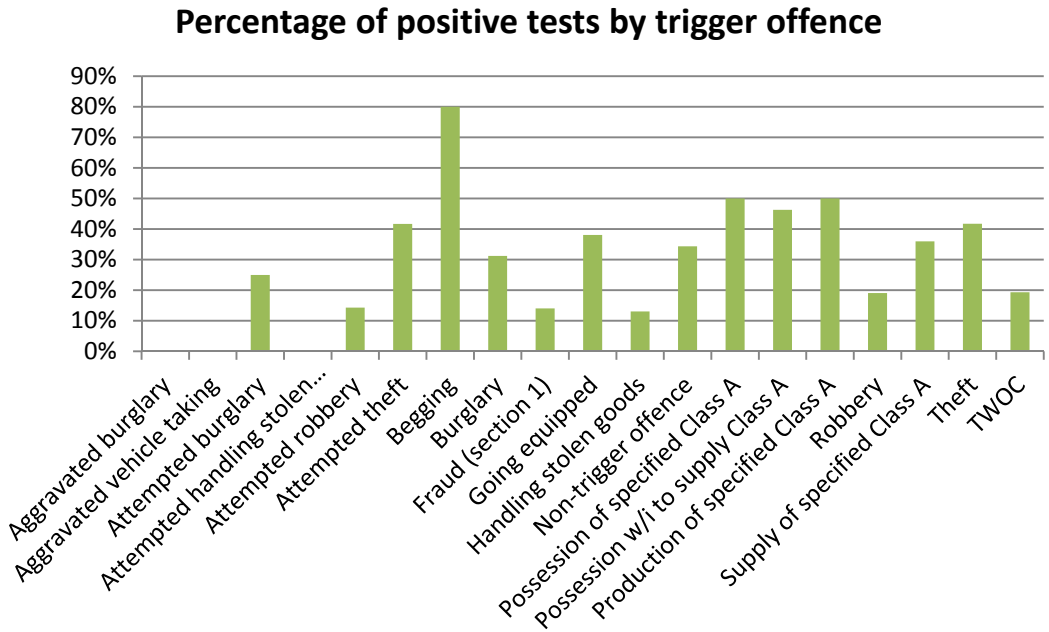
Rates of drug related hospital admissions during 2009-12 where highest in wards in the north east of the city and parts of the south west. Heath Town, Park and Bushbury South and Low Hill had the highest rates of admissions.

Services need to continue to engage people from the identified wards into treatment and reduce the risk of hospital admissions.

Crime

Alcohol has been identified as a factor in violent crime nationally and drug use tends to go hand in hand with acquisitive crime such as theft, shoplifting and robbery. However it is difficult to get an accurate picture of the extent of these crimes across the city because there is no consistent way of determining if an offence was fuelled by alcohol and/or drugs. Over half of young people and approximately a third of adults who come into substance misuse treatment every year in Wolverhampton come through criminal justice pathways.

- Any crime that the police deem to have been influenced by alcohol or where the offender may have been intoxicated is recorded with an 'alcohol Involved' marker.
- During 2011/12 there were 701 such crimes out of a total of 18,084 crimes recorded in Wolverhampton. The majority of these were assaults. This equates to just 4% of crimes in Wolverhampton.
- While this is an illustration of the role of alcohol in violent crime, it is thought that this figure does not give an accurate picture and is a significant underestimate of the actual number of crimes involving alcohol. As a guide, national estimates suggest that 55% of violent crimes are committed whilst the offender was under the influence of alcohol.
- Wolverhampton keeps a data base of people presenting to A&E after an assault and it shows that a proportion of assaults are committed when either the offender or the victim are intoxicated.
- Between February 2010 and January 2013 there were 1,234 attendances to A&E for assault related injuries. 54% of them were alcohol involved. 47 (7%) of the alcohol related assaults were domestic violence.
- The drug intervention programme which is a critical part of the government's strategy for tackling drug addiction gives the local police force powers to perform a drug test on any offender committing a 'trigger offence'.
- During the financial year 2011-12 there were 1,898 Wolverhampton residents who had tests successfully completed at Wolverhampton and Wednesbury police stations. 679 or 36% had a positive result. The chart below shows the test results for each trigger offence.



- This shows the link between drug use and certain types of offences. Offenders arrested for begging, production and/or possession of specified substances, possession with intent to supply, theft, and attempted theft and going equipped to steal had the highest probability of testing positive.
- Approximately 4% of drug offences were committed by young people under the age of 18.

Child Protection

Alcohol and drug abuse can affect an individual's ability to be a good parent to their children and this has an impact on social care and child protection.

- Wolverhampton Children's Social Care takes referrals from various sources for a wide range of issues affecting young people including substance misuse.

- In the 12 month period ending February 2013, there was a total of 3,406 referrals to children's social care, 144 (4.2%) were for substance misuse related issues. 92% of referrals moved on to receive an initial assessment while a small number were signposted to other services or no further action was taken.
- Of the 1,465 adults in drug treatment in 2011/12, 40% were parents or had some other contact with children. Similarly of the 759 adults in alcohol treatment, nearly 40% were parents or had contact with children.
- Parental substance misuse can be a factor to a child becoming looked after by the Local Authority. The number of looked after children in Wolverhampton has seen a significant increase over the past few years. It is currently not known how many of these involved substance misuse but a local case file audit of looked after children undertaken by Dartington Social Research Unit in conjunction with Children's Services, estimated approximately a quarter.

How does it link to other strategies and priorities in Wolverhampton?

Children and Young People's Plan (2011/14)

Action on alcohol and drugs will aim to:

- prevent children and young people from coming into contact with alcohol and drugs
- make sure there are effective young people's substance misuse services
- identify and address "hidden harms" and child protection issues that may be present in the children of substance misusers.

Safer Wolverhampton's Priorities

- Substance misuse is a priority for SWP

Taking action on alcohol and drugs will support reductions in crime and anti-social behaviour.

Wolverhampton's City Strategy (2011-2026)

Area 2: We are working to *Empower People and Communities* by
- doing things earlier and preventing things from happening

Area 3: We are working together to *Re-invigorate the City* by
- improving the city centre

Wolverhampton Alcohol Strategy 2011-2015

Priorities seek to improve alcohol treatment services and tackle alcohol related crime and disorder, including domestic violence and anti-social behaviour and the impact alcohol has on communities, children, young people and families.

- Supporting a whole community approach to changing alcohol habits
- Developing a well-managed -night time economy
- Combating alcohol related crime and disorder and increase community safety due to alcohol misuse
- Improving health and alcohol treatment services in Wolverhampton

What is the evidence of effective interventions?

There is a wide range of evidence of effective interventions for drugs and alcohol. However, there is a strong focus on ensuring that individuals can recover from dependency, primarily: -
Strategy 2010- Reducing Demand, Restricting Supply, building Recovery: supporting people to live a Drug free Life

The Strategy sets out the Government's approach to tackling drugs and addressing alcohol dependence, both of which are key causes of individual, family, societal and community harm. It sets out a fundamentally different approach to

preventing drug use in communities, and for drug and alcohol dependency, with the goal of recovery as its foundation. It sets out a whole system approach to commissioning recovery focused services. In relation to alcohol, the strategy aims to ensure that people who are alcohol dependent are provided with treatments, interventions in a holistic way (addressing any housing, employment or other social issues as well as the alcohol problem) which gives the best opportunity for recovery.

The Strategy describes the following "best practice outcomes":

1. Freedom from dependence on drugs or alcohol
2. Prevention of drugs related deaths and blood borne viruses
3. A reduction in crime and re-offending
4. Sustained employment
5. The ability to access and sustain suitable accommodation
6. Improvement in mental and physical health and wellbeing
7. Improved relationships with family members, partners and friends, and
8. The capacity to be an effective and caring parent

<u>NICE Guidance, e.g.</u>

- NICE Public Health Guidance 24- Alcohol-use Disorders: Preventing the Development of Hazardous and Harmful Drinking, (June 2010)
- NICE CG 100 - Alcohol Use Disorder: Diagnosis and Clinical Management of Physical Complications (June 2010)
- NICE CG 115 – Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol
- NICE PH guidance 43, Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection, December 2012

Models of Care

- MoCAM Models of Care for Alcohol Misusers, provides best practice guidance for local health organisations in delivering a planned and integrated local treatment system for adult alcohol misusers. MoCAM outlines the activities and services which should be commissioned. Services should be delivered on a stepped model of care, starting with the provision of advice and information and moving to in-patient detoxification or residential services.
- Models of Care for treatment of adult drug misusers (NTA, 2006)

High Impact Changes for Alcohol

The Department of Health highlights seven practical measures, which if implemented at a local level have been identified as making the biggest difference to tackling alcohol related harms, including

- Improve the effectiveness and capacity of specialist treatment (community and hospital settings)
- Appoint an alcohol health worker (in hospital settings)
- Alcohol IBA – provide more help encourage people to drink less

What are the planned actions, timescales and leads?

A key strand will be to support the prevention agenda to provide a whole community approach to changing alcohol habits in Wolverhampton as driven through the alcohol strategy action plan.
Planned actions centre on ensuring that specialist treatment services are available and that "recovery" is achieved for individuals in a holistic way, encompassing, for example, housing, employment and other key factors.
A new integrated recovery focused substance misuse service (alcohol, drugs and young people's services) has been commissioned and procured. 'The service has been operational since 1 April 2013. The new model of service delivery will begin on 1st July 2013.
A single point of contact (SPOC) will be provided for referrals into drugs, alcohol and young people's substance misuse services to ensure quick and appropriate access into services.

A children's and young people's substance misuse service, including transition services for those aged 18-25 years old, if it is deemed that adult substance misuse provision is not appropriate.
The service will include alcohol and drugs pharmacological and psychosocial interventions (including identification and brief advice for hazardous and harmful drinkers) provided in the community. This is in addition to a drugs and alcohol service at New Cross hospital (provided through a hospital liaison nurse service).

Community and enterprise provision will be the vehicle for providing wrap around support and driving recovery. In addition to pharmacological and psychosocial interventions, a key strand of the service will be providing help and support to ensure individuals can address any social problems they may have (for example housing issues) and access employment and training. This is important as wider problems often impact on individual's substance misuse and affect their chances of recovery.

How will progress be measured?

Key high level targets:

Reduction in 3 year average alcohol related mortality rates per 100,000 all ages population from a baseline of 19.6 in 2008 – 2010.

Improvement to the top quintile of performance nationally for:

- Percentage of drug users in treatment who complete treatment and do not represent within 6 months (OPIATES)
- Percentage of drug uses in treatment who complete treatment and do not represent within 6 months (NON-OPIATES)

In addition quarterly monitoring and review meetings will be held with the provider and a suit of performance indicators have been established (some of which are performance related (PBR) and these will be used to identify and measure progress with Wolverhampton Alcohol Strategy and this will be the focus of monitoring meetings.

PRIORITY 3 DEMENTIA

Lead Agency: Wolverhampton City Council (Community)

Sponsor: Anthony Ivko (Assistant Director, Older People and Personalisation)

Project Manager: Steve Brotherton (Head of Older People's Commissioning)

Partners: All agencies/ Departments

What is the issue?

Dementia can affect anyone whatever their gender, ethnic group, age or class, however it is particularly prevalent in the population aged 65 years and over and with a growing aging population the number of people with dementia is set to significantly increase. Raising awareness of dementia across all sectors and the importance of delivering a person centred response is critical to making a real difference to the health and well-being of individuals and their families.

What is the position and evidence in Wolverhampton?

- There are 3000 people living with dementia in Wolverhampton
- This figure is forecast to rise by 44% over the next 20 years, representing an increase of 75 people per year
- Only 40% of people with dementia in Wolverhampton are on a GP dementia register
- It is predicted that the number of people diagnosed with an early onset dementia is underestimated by three times (Dementia UK 2007)
- One third of people with dementia are living in care homes (1000 people in Wolverhampton) with two thirds of the care home population at any one time made up of people with dementia (Alzheimer's Society 2007)

- Conversely, two thirds of people with dementia are living independently in their own homes (2000 people in Wolverhampton
- 40% of people in hospital have dementia; the excess cost is estimated to be £6 M per annum in the average General Hospital; co morbidity with general medical conditions is high; people with dementia stay longer in hospital, have poorer quality outcomes and one third of people with dementia admitted to hospital never return home (Alzheimer's Society, 2009)
- In a national survey of 1000 GPs only 47% said they had sufficient training to diagnose and manage dementia; 58% said they felt confident about giving advice about management of dementia-like symptoms (National Audit Office, 2010)
- Alcohol-related dementia is under-recognised and may account for up to 10% of all dementia cases –around 70,000 people in the UK. (British Journal of Psychiatry); 300 people in Wolverhampton
- An Alzheimer's Society Report in 2007 estimated the annual cost of dementia for the United Kingdom at more than £17 billion, or £25,000 per person (Alzheimer's Society 2007). Applying these figures to Wolverhampton gives a total annual cost of dementia to the Wolverhampton economy of £75 million pounds (3000 people X £25,000 per person). The Kings Fund predicts that the cost of dementia in England will rise to £34.8 billion by 2026 (Kings Fund 2008).

The following table gives a more detailed breakdown on the projected population of people with dementia in Wolverhampton:

POPPI (2011): Wolverhampton People with Dementia Population Projection

Age	2009	2015	2020	2025	2030
65-69	133	145	142	149	165
70-74	264	264	295	289	306
75-79	488	493	504	562	556
80-84	757	778	825	848	966
85+	1301	1520	1739	2034	2323
Total	**2943**	**3200**	**3505**	**3883**	**4315**

How does it link to other strategies and priorities in Wolverhampton?

The response to dementia in Wolverhampton has been developed through a partnership approach involving all key stakeholders, including Wolverhampton Clinical Commissioning Group, Royal Wolverhampton Trust, Black Country Partnership Foundation Trust, and Wolverhampton Public Health. This response is underpinned by the following:

- The Living Well in Later Life Strategy 2012-15 sets the direction for services for older people, focussing on prevention, aiming to improve the quality of life & independence of older people, and increasing participation in service planning & community activities. It targets the 20% of older people who are most at risk of entering the downward spiral of isolation and ill health, include people with dementia
- The Joint Dementia Strategy (2011) was co-produced through a series of workshops, attended by over three hundred people, and a range of consultation events. It adopts a person centred philosophy that recognises people with dementia as people first and foremost who have the same rights as everyone else to lead healthy, happy and fulfilling lives. The strategy focuses on the delivery of five key priorities: Good Quality Early Diagnosis and Intervention; Improved Quality of Care in General Hospitals; Living Well with Dementia in Care Homes; Reduced Use of Antipsychotic Medication; Improved Support for Carers
- The Joint Reablement Forward Plan (2011-2013) outlines the commissioning intentions with regard to reablement activity, emphasising the need to focus on the person and their individual circumstances as presented at every stage across all pathways
- The following outcomes frameworks:

    - *NHS Outcomes Framework 2013/14*
        - Enhancing quality of life for people with dementia
        - Estimated diagnosis rate for people with dementia
        - A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life

- *Adult Social Care Outcomes Framework 2013/14*
  - Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services
  - Proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services
  - Permanent admissions to residential and nursing care homes
  - When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence
  - Delayed transfers of care from hospital, and those which are attributable to adult social care
  - People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual

- *Public Health Outcomes Framework for England, 2013-2016*
  - Increased healthy life expectancy
  - Reduced differences in life expectancy and healthy life expectancy between communities

There are further local and national strategies that have informed the local response:

- NICE Quality Standard 1 for Dementia
- NICE Quality Standard 30. Supporting People to live well with dementia(2013)
- NICE Quality Standard 13. End of life care for adults
- NICE Clinical Guideline 42. Dementia: supporting people with dementia and their carers in health and social care
- NICE: Support for commissioning dementia care (2013)
- The Adult Social Care: Choice Framework (2013)
- Caring for our future: reforming care and support (2012)
- Living well with dementia: a national dementia strategy (2009)

- Care Quality Commission: Position statement and action plan for older people, including people living with dementia
- Improving quality of life for people with long term conditions (2012)
- Whole System Demonstrator Programme: Telehealth and Telecare (2011)
- Prime Minister's Challenge on Dementia
- Think Local; Act Personal

What is the evidence of effective interventions?

- To improve awareness and education, Worcester University Association of Dementia Studies has delivered two training modules to external market and public sector providers. These modules have concentrated on developing dementia leaders (hire and fire positions) and champions (front line worker position) with each organisation required to nominate a representative for each of these modules. These two people are then tasked to go back to their organisation and deliver person centred changes that improve the health and well-being of people with dementia
- To improve quality, Bradford University School of Dementia have carried out a dementia care map of local care homes across the City. An Action Plan with the aim of improving well-being was delivered to the home and a follow up map completed six months later to check progress
- To improve in-patient experience and outcomes, a dementia ward has been developed at New Cross hospital in addition to an outreach service to other wards
- To improve quality, Dementia Care Matters have carried out an evaluation of the wards at New Cross hospital and made a quality and cost comparison with the University Hospital in Birmingham
- To improve community based resources, six dementia cafés have been established across the City, one café for Asian elders and one café for African Caribbean elders
- To raise public awareness, two Prime Minister Challenge conferences were held to launch the development of a dementia friendly City, including people with dementia as key note speakers, banks, building societies, retailers and faith groups

What are the planned actions, timescales and leads?

The following Action Plan has been agreed by Adult Delivery Board:

Action	Timeframe	Assigned Lead Organisation/Individual/s
Common Assessment Framework (CAF) – Project to commence 01 September 2013		
To establish a CAF project group	Within 30 days	Black Country Partnership Foundation Trust
To agree in principle a multi-agency CAF approach	Within 60 days	
To review CAF processes and understand its potential application for dementia	Within 60 Days	
To agree and deliver a CAF paper with recommendations to Adult Delivery Board	Within 90 Days	
Information Sharing Protocols – Project to commence 01 September 2013		
To review City wide information sharing protocols	Within 90 days	Wolverhampton City Council
Dementia Pathway - Project to commence 01 September 2013		
Through the multi-agency Joint Dementia Strategy Steering Group formulate and agree a revised pathway for dementia	Within 90 days	Joint Commissioners
Reablement – Project to commence 01 September 2013		
To establish a dementia reablement project group	Within 30 days	Wolverhampton City Council
To develop a reablement approach for people with dementia	Within 60 days	"
To agree and deliver a multi-agency reablement paper with recommendations to Adult Delivery Board	Within 90 days	"
Home as a Hub – Project to commence 01 September 2013		
To establish a dementia hub project group	Within 30 days	Wolverhampton Clinical Commissioning Group
To agree the scope of services in a dementia hub	Within 60 days	"
To agree and deliver a multi-agency dementia hub paper with recommendations to Adult Delivery Board	Within 90 days	"
Refresh of Joint Dementia Strategy		
To deliver a refreshed Joint Dementia Strategy & Implementation Plan	By 31 March 2014	Joint Commissioners

How will progress be measured?

Progress will be measured against the following statements where people living with dementia in Wolverhampton are able to say:

- *'I was diagnosed early*
- *'I understand, so I make good decisions and provide for future decision making'*
- *'I get the treatment and support which are best for my dementia and my life'*
- *'Those around me and looking after me are well supported'*
- *'I am treated with dignity and respect'*
- *'I know what I can do to help myself and who else can help me'*
- *'I can enjoy life I feel part of a community'*
- *'I'm inspired to give something back'*
- *'I am confident my end of life wishes will be respected'*
- *'I can expect a good death'*

In terms of integrated working, three core areas have been highlighted as critical in order to enhance the experience and outcomes for people with dementia:

1. Information Access and Care Planning: Grounded in in a commitment to ensure that timely information is available and managed safely across the system, ensuring that people with dementia only need to tell their story once
2. Home as the Hub of Service: Grounded in a commitment to ensure that living at home and retaining independent living is regarded as a default outcome consideration, including the development of early intervention; prevention & rehabilitation and community based opportunities, making 'home' a positive and realistic alternative for people with dementia
3. Developing the Community Capacity to Care: Grounded in a commitment to deliver a whole city approach, including developments with commercial sector partners to ensure a full range of life opportunities are available for people with dementia.

All of this will be evaluated by identifying:- reduced costs in health & social care; a shift in public expenditure from intensive to preventative services; increased numbers of older people engaged in local groups and networks; increased satisfaction of older people with their quality of life; reduction in health inequalities.

PRIORITY 4 MENTAL HEALTH

Lead Agency: Wolverhampton City Council (Community)

Project Sponsor: Viv Griffin (Assistant Director – Health, Wellbeing and Disability)

Project Manager: Sarah Fellows

Partners: All agencies

What is the issue?

It is acknowledged that at least one in four people will experience a mental health difficulty at some point in their life and that one in six adults and one in ten children in England under 16 years have a mental health difficulty at anyone time. It is also understood that half of those with lifetime mental health difficulties experience symptoms by the age of 14 *(No Health without Mental Health, 2011)*. We now know that mental illness is the largest disease burden upon the NHS, up to 23% of the total burden of ill health and the largest cause of disability within the United Kingdom *(No Health without Public Mental Health, Royal College of Psychiatry 2010)*, and that mental ill health often starts before adulthood and continues through life.

There are significant personal, social and economic costs, with particular risks from birth, into childhood and as young people move into adulthood and as they enter periods of physical and psychological change and development. It is also understood that physical health is inextricably linked to mental health. Poor mental health is associated with obesity, alcohol and substance misuse and misuse and smoking, and with diseases such as cardio-vascular diseases and cancer, *(No Health without Public Mental Health, Royal College of Psychiatry 2010).*

Mental health is a vital element therefore of the of the quality of life, physical health, emotional and social well-being and economic success and educational achievement of individuals, families and communities, and a key contributing factor in reducing the impact/s of physical ill-health, unemployment, homelessness, drug and alcohol misuse and crime.
It has been identified that the costs of mental health problems to the economy in England have been estimated at £105 billion - in comparison, the total costs of obesity to the UK economy are £16 billion a year and £31 billion for cardiovascular disease , and that in 2010/11, £12 billion was spent on NHS services to treat mental disorder, equivalent to 11% of the NHS budget and that treatment costs are likely to double in the next 20 years as by 2026, the number of people in England who experience a mental disorder is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million (*No Health without Public Mental Health, Royal College of Psychiatry 2010).*

The cross–departmental mental health strategy '*No Health Without Mental Health' (2011)*, describes mental health as *'everyone's business'* and details the Government's aim to '*mainstream*' mental health within England, to establish and develop parity of esteem between mental and physical health, and to improve outcomes for all building and developing on previous National and Local priorities and work programmes in terms of improving existing services for people with mental health problems and addressing the wider and underlying causes of mental ill health. This includes an emphasis on the importance of promoting good mental health and intervening early, particularly in childhood and teenage years to prevent mental illness from developing and to reduce the impact of mental health difficulties when they do occur. The Strategy takes a life course approach therefore, recognising the importance of good maternal and parental mental health, protecting and promoting well-being and resilience through early and developmental years, and into adulthood and then on into our later years.

Addressing the impact and burden of mental ill health is a priority nationally and locally therefore, and mental health services have developed in Wolverhampton in keeping with national policy guidance in recent years –including improved access to psychological therapies (IAPT), an Early Intervention in Psychosis Service for those aged 14 years, integrated approaches to delivering health and social care, and the development of teams and services locally that were compliant with the model/s described within National Service Framework for Mental Health: modern standards and service models *(Department of Health, 1999)* – it is timely to now place a focus upon mental health promotion and prevention, intervening early when mental ill health occurs.

It is imperative therefore, the Wolverhampton our Health and Well-being Strategy is able to describe and deliver a cross agency programme of priorities that can meet the mental health promotion and early intervention needs of our population, while recognising and responding to the unique characteristics of the people that live in our City. To do this we will need to work together to reduce the impact of the stigma of mental ill-health, to deliver improved outcomes for people with mental health difficulties, - for example in terms of housing and employment - and provide focused interventions for people that fall into the most vulnerable groups, such as those from Black and Minority Ethnic communities, communities with high levels of deprivation and people who are unemployed, people who experience physical ill-health, people with co-occurring conditions, children and young people who are transitioning to early adulthood and / or have parents or carers with poor mental health, people without stable family and / or social support, people who are subject to / at risk of abuse and bullying and people leaving care.

It is important to continue to improve access to services therefore but also to develop an approach that provides mental health promotion initiatives, and particularly to imbed this approach within early and school years where the impact of these initiatives is understood to be potentially higher in terms of improving life term outcomes such as improved mental health, improved educational outcomes, improved employment, and reduced levels of anti-social behaviour, crime including violent crime, and reduced suicide *(No Health without Public Mental Health, Royal College of Psychiatry 2010)*.

We must aim therefore to deliver a range of mental health promotion interventions across the life span to prevent mental illness, promote well-being, improve emotional health and well-being, and increase resilience in individuals, families and communities. Improving and strengthening resilience is a key concept in terms of developing protective versus risk factors with specific interventions such as parenting programmes, improved maternal care and mental health promotion programmes for employers, schools and colleges, and all-age communities and groups. It is important to provide interventions which apply across the life course that protect health and well-being and promote resilience to adversity, with early and appropriate intervention if mental health difficulties occur. Strategies to promote parental mental health and effectively treat parental mental illness are also important as are targeted approaches to support the mental health needs of Older People including interventions to prevent and treat dementia, and to promote good mental health and well-being in later life, including, recognising and promoting the contributions older people make to families and communities, and to develop reablement initiatives as part of this plan to allow people who have been affected by

disability or ill-health to move to a position of increased self-support and self-management, improving self-esteem and self-efficacy and facilitating greater levels of social inclusion. This approach is a key strategic priority for the Joint Commissioning Unit in terms of helping people with mental health difficulties to recover and engage in a more active role within their families and communities, whilst increase their personal autonomy and self-direction.

What is the position and evidence in Wolverhampton?

A detailed needs analysis of Wolverhampton prevalence data in 2010 identified the following key factors.

- QOF data of psychotic registers reported the prevalence to be comparable with national data at (0.7%)
- QOF depression registers reported a similar prevalence (5.5%) to national predictions
- Low-level depression was thought to be more prevalent among Wolverhampton adults since 2.4% of the population (5,615 people) were claiming incapacity benefit (IB) on the grounds of mental health, which equated to 42% of those claiming the benefit. This is slightly higher than the regional average (39.5%), and the national average (41%)
- QOF indicators for mental health were slightly below the national achievement levels
- The average suicide rate in Wolverhampton was 11.6, compared with the national average of 8.3. There was also a large discrepancy between different wards in Wolverhampton, which further highlights the health inequality in the city
- The percentage of people with a long term limiting illness in Wolverhampton (21%) was slightly higher compared to West Midlands (19%) and also above the England average (18%).

The Wolverhampton Community Mental Health Profile 2010/11(Department of Health 2013) has identified the following:

- Wolverhampton has slightly higher than average directly standardised rate for hospital admissions for mental health (Local Value 184, National Average 172)
- Significantly lower than average directly standardised rate admissions for Alzheimer's disease and Dementia (Local Value 49, National Average 80)
- Wolverhampton has lower than average proportion of referrals for IAPT (Improving Access to Psychological Therapies Local Value 53.2, National Average 60.1)

- Slightly lower than average numbers of people receiving care and support as part of the on Care Programme Approach, rate per 1,00 population (Local Value 5.8, National Average 6.4)
- Higher than average contacts with mental health services per 1,000 population (Local Value 413, National Average 313)
- Lower than average in year bed days for mental health, rate per 1,000 population, (Local Value 184, National Average 193)
- Significantly higher than average contacts with Community Psychiatric Nurses, rate per 1,000 population (Local Value 274, National Average 169)

Key drivers for the current Mental Health Commissioning Strategy include the 6 priorities of 'No Health without Mental Health' (Dept. Health 2012), which are:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Services have been configured and aligned from 2012 to provide IAPT (Integrated Access to Psychotherapy) as part of the Primary Care facing Well-Being Service and a strong emphasis is placed upon providing psychological therapies across all elements of the service model as a whole in keeping with national drivers.

In addition in February 2012 a Needs Analysis of CAMHS prevalence data revealed the following key factors:

- When comparing local use of services against a national prevalence tool utilisation of services last year suggests that there is an under use of universal and targeted services, an over use of specialist services and a significant increase in the use of in-patient hospital provision.

- Over the fiscal years 2011/12 and 2012/13 the requirement for hospital admissions rose by over 100%. The purpose of 75 % of in-patient admissions was to prevent harm to self.

- The Crisis Support and Home Treatment Service is providing support and treatment to significantly more females than males – most recent data tells us that 35% of referrals to this service were following acts of deliberate self-harm. In addition there is an increase in females in school years 11 and 12 accessing the Multi Agency Support teams for support.

- The Crisis Support and Home Treatment Service has also experienced a significant increase in requests for specialist assessment out of hours (an increase of 273%) as well as planned telephone support out of hours (an increase of 294%).

- Overall the Crisis Support and Home Treatment Service have received experienced a 25% increase in routine referrals.

- From April 2012 to date there have been 149 admissions to the paediatric wards at New Cross Hospital of children and young people who have engaged in acts of self-harm.

- Public Health data identifies that in 2011 there were no suicides of people aged under 18 years that were resident in the City. In 2012 there are known to have been 3 incidents of suicide in the under 18 age group, the youngest being a child aged 13 years. Each incident is the subject of a serious case review.

- Referrals into services regarding the mental health of teenage mothers, children and young people in contact with criminal justice services and referrals from substance misuse services into children and young people's mental health services are not consistent with national prevalence data for these high risk groups, suggesting under representation within mental health services. This includes data regarding referrals into mental health services for those classed as 'children in need' and looked after children. Only 17% of the looked after children population are known to children's and young people's mental health services currently.

- Prevalence data suggests that as many of 10% of young people aged 18-25 years are currently accessing adult mental health services. Specialist teams within children's and young people's mental health services have reported difficulties referring young people into adult mental health services, with poor use of transition protocols / processes, and differing criteria regarding referral into adult mental health service provision.

- The School Census Spring 2012 in Wolverhampton shows that the school age population is more diverse than the ethnicity of the City as a whole. Specialist teams and multi-agency support teams are being accessed by predominantly white British families. Children and young people from Black and Minority Ethnic groups are significantly underrepresented in the data regarding children and young people accessing mental health and psychological support services in the City.

All of the above information has been used to inform the development of the Wolverhampton Emotional and Psychological Well-Being Strategy for Children and Young People however it should be noted that within Adult and Children and Young People's Mental Health Services and Commissioning a strong emphasis should now be placed upon Public Mental Health to provide a focus upon providing mental health promotion and prevention for the whole population of our City, including hard to reach groups and people who have established mental health conditions.

How does it link to other strategies and priorities in Wolverhampton?

This Mental Health Priority links to a number of other strategies, initiatives and priorities. These include:

- Mental Health Strategy Re-fresh (including CAMHS Strategy, i.e. Strategy for the Emotional, Social and Psychological Well-Being of Children and Young People
- NHS Outcomes Framework 2013/14
- Social Care Outcomes Framework 2013/14
- QIPP
- No Health Without Mental Health (2011)
- No Health Without Public Mental Health (2011)

- Dementia Strategy
- Children and Young People's Plan

What is the evidence of effective interventions?

The Joint Commissioning Panel for Mental Health *'Guidance for Commissioning Public Mental Health Services' (JCP-MH, 2012)*, identifies that mental well-being is associated with a wide range of improved outcomes in health, education and employment, as well as reduced crime and antisocial behaviour such as, better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved social functioning and better quality of life. The guidance also suggests that Public Mental Health should form a key part of the strategic plans of Health and Well-being Boards, and that this should involve:

- Strong data intelligence which details the current and future mental and physical health needs of the local population and both an assessment of the risk factors for mental disorder and the protective factors for well-being in the local population.
- A Health and Well-Being Board Mental Health 'champion'.
- A Strategic Plan to deliver appropriate interventions to promote well-being, prevent mental disorder, and provide early and pro-active treatment for mental disorder, ensuring that people with increased risk of mental disorder and poor well-being are proportionately prioritised in delivery of interventions ('proportionate universality').
- Strong collaboration and partnership working across all agencies to ensure a combination of initiatives that will address the broad range of social, cultural, economic, psychological and environmental factors at all stages of the life-course.

The JCP-MH guidance also highlights a wide-ranging body of good evidence to suggest the efficacy of public mental health interventions to reduce the burden of mental disorder, enhance mental well-being, and support the delivery of a broad range of outcomes relating to health, education and employment and further identifies that although current spending on prevention and promotion is less than 0.001% of the annual NHS mental health budget investment in the promotion of mental well-being, prevention of mental disorder and early treatment of mental disorder results in significant economic savings - including in the short term - across health, social care and criminal justice areas.

The JCP-MH guidance suggests that preventing disease can occur as follows:

- Primary prevention, which aims to **prevent ill health** by focusing upon the wider determinants of illness and utilises approaches that target the majority of the population
- Secondary prevention, which involves the **early identification** of health problems and early intervention to treat and prevent their progression
- Tertiary prevention, which involves working with people with mental ill health to **promote recovery and prevent or reduce the risk of relapse**

The JCP-MH guidance also suggests that promoting health can occur as follows:

- Primary promotion involves promoting the health and well-being of the **whole population**
- Secondary promotion involves targeted approaches to groups that have or are at risk of **developing poor health** and well-being
- Tertiary promotion targets groups with **established health problems** to help promote their recovery and prevent relapse.

The table below describes suggested Public Mental Health Interventions adapted from the JCP-MH Guidance, the outcomes of the NHS Confederation / New Economics Foundation, 'Five Ways to Well-being' (2011) and the five key outcomes of Every Child Matters / The Children's Act (2004) and the stakeholder involvement required:

Mental Health Promotion	Mental Health Prevention	Early Intervention	Five Ways to Well-Being / Outcomes from 'every Child Matters'	Key Stakeholders
• Starting Well • Developing Well • Living Well • Working Well	• Mental Disorder and Dementia • Health Risk Behaviour including alcohol and	• Treatment of Mental-Disorder and sub-threshold Mental Disorder	• Connect • Be Active • Take Notice • Keep Learning	• Public Health England • Universal and Primary Care Services • Secondary and Tertiary

Mental Health Promotion	Mental Health Prevention	Early Intervention	Five Ways to Well-Being / Outcomes from 'every Child Matters'	Key Stakeholders
• Ageing Well	substance misuse • Inequality • Discrimination and Stigma • Suicide and self harm • Violence and Abuse including bullying	• Promotion of physical health and prevention of health risk behaviour in those developing mental disorder • Promotion of recovery through early intervention • Recognition of Mental Disorder	• Give • Stay Safe • Keep Healthy	Care Services • Substance Misuse Use Services • Local Authorities • Social Care Providers • Education establishments • Housing Providers • Criminal Justice Services • Third Sector and Community Organisations • Faith groups • Environmental Planners

The JCP-MH Guidance (2012) suggests a number of ways that evidence supports that Public Mental Health promotion and prevention can reduce the impact and burden of mental ill-health and disorder. These include:

- 'Promote well-being and resilience with resulting improvements in physical health, life expectancy, educational outcomes, economic productivity, social functioning, and healthier lifestyles'.
- 'Prevent mental disorder, health risk behaviours and associated physical illness, inequalities, discrimination and stigma, violence and abuse, and suicide and deliver improved outcomes for people with mental disorder as a result of early intervention approaches'.
- 'Prevent mental disorder in childhood which leads to poorer outcomes and inequalities in adulthood, higher levels of unemployment and lower earnings, higher risk of crime and violence and higher risk of adult mental disorder'.

- ‘Prevent mental disorder during adulthood which leads to poorer outcomes and inequalities poorer educational achievement, higher risk of homelessness higher unemployment, higher rates of debt problems, increased suicide and self harm levels, increased health risk behaviours, including poor diet, and less exercise.’
- Deliver ‘economic savings by reducing the costs of mental disorder through prevention and improved outcomes as a result of early intervention, economic savings associated with improved well-being, such as reduced welfare dependency, reduced use of health and social care services, less crime and greater social cohesion.’
- Deliver ‘economic savings resulting from reduced health risk behaviour and subsequent physical illness.’
- Deliver ‘economic benefits associated with improved well-being due to improved educational outcomes, higher employment rates, and greater economic productivity.’
- Deliver ‘improved resilience and ability to cope with adversity, reduced emotional and behavioural problems in children and adolescents, reduced levels of mental disorder in adulthood reduced suicide risk, better general health, less use of health services and reduced mortality in healthy people and in those with established illnesses’.
- Deliver ‘improved educational outcomes, healthier lifestyle and reduced health risk behaviour including reduced smoking and harmful levels of drinking, increased productivity at work, reduced absenteeism and reduced burnout, higher income, stronger social relationships, increased social/community participation, reduced antisocial behaviour, crime and violence.’

Local initiatives should therefore focus upon identifying risk and protective factors for mental well-being, such as identifying high risk groups and developing and supporting initiatives to access employment / higher economic status, increase social net works and engagement and opportunities for education and physical activity, and developing emotional and social literacy life skills, including developing skills in relation to communication, problem solving and resilience. Different levels of emotional and cognitive resilience or ‘capital’ include:

- Emotional and cognitive: includes optimism, self-control and positive personal coping strategies
- social: includes networks and resources that enhance trust, cohesion, influence and cooperation for mutual benefit within communities
- Physical health

- Environmental: includes features of the natural and built environment which enhance community capacity for well-being
- Spirituality: incorporates a sense of meaning, purpose and engagement as well as religious belief for some. ‘

There is a compelling case, therefore to deliver a robust plan to provide a range of mental health promotion and prevention interventions across a ‘life course’ approach to improve the mental health and well-being of our resident population, to identify and target risk factors and develop and promote protective factors, working in partnership across agencies to reduce the burden of mental ill-health across upon a range of personal, social, familial and economic outcomes.

What are the planned actions, timescales and leads?

The planned actions, timescales and leads are described in the table below:

Priority Area	Set of High Level Action / Outputs	Timescales	Lead/s
1. Re-fresh / revisit the mental health data within the JNSA	To provide strong data intelligence which details the current and future mental and physical health needs of the local population, including levels of unmet need and both an assessment of the risk factors for mental disorder and the protective factors for well-being in the local population across the life span	By October 2013	PHE and SF
2. Promote good / positive mental health and well-being	Including universal proportionality i.e. targeted well-being promotion to facilitate recovery of those at risk of developing mental health difficulties and those with mental health difficulties. Sign up to ‘Time to Change’ campaign to tackle stigma locally	By October 2013	PHE and SF and MG and Education Lead

Priority Area	Set of High Level Action / Outputs	Timescales	Lead/s
	Develop Resilience Strategy for Wolverhampton as part of CAMHS Strategy and Adult Strategy re-fresh, which will deliver targeted mental health promotion interventions within schools and the wider community and utilise simple telehealth options where possible. Align with 'Five Ways to Well-Being' and Stay Safe Keep Healthy outcomes of 'every Child Matters'	By January 2014	
3. Address health risk behaviour in those with mental health difficulties and / or those at risk of developing mental health difficulties	Work with Public Health England to co-ordinate approaches for identified target audiences regarding: • Alcohol • Cannabis (skunk) • Tobacco • Obesity	By January 2014	PHE and SF and MG
4. Describe Early Intervention Care Pathways from Universal to Primary and Secondary Care for all care clusters in Adult Mental Health, i.e. 0-3, 4-8, 10-17, and 18-21, and diagnostic groups in CAMHS	• As part of CAMHS Strategy and Adult Strategy re-fresh, develop Early Intervention Care Pathways for all care clusters • Work with GPs and Provider Leads • Align with NICE Guidance • Identify pathways for key target groups	Drafts by April 2014	SF, MG SS and Provider Leads

Priority Area	Set of High Level Action / Outputs	Timescales	Lead/s
5. Re-fresh Care Programme Approach Policy across all agencies to promote reablement across all care clusters, and prevent relapse and re-admission/s where possible	• As part of CAMHS Strategy and Adult Strategy re-fresh • Work with GPs and Provider Leads • Align with NICE Guidance	Draft by April 2014	SF, MG SS and Provider Leads
6. For all of the above describe pathways for hard to reach groups.	• As part of CAMHS Strategy and Adult Strategy re-fresh. To include engagement initiatives for people from BME Groups, Looked After Children, people who are homeless, unemployed, are living with physical health difficulties and /or living in areas of socio-economic deprivation and people who are Disabled and /or have a Learning Difficulty	By January 2014	SF, MG SS and Provider Leads

How will progress be measured?

Progress will be measured via a dashboard developed by the Mental Health Strategy Steering Group and reported to the JCU Development and Delivery Group, Adult Delivery Board and Health and Well-Being.

The Dashboard will include a number of KPIs including:

- Access to Early Intervention Services
- Access to Psychological Therapies
- Numbers of people moving to recovery who are receiving Psychological Therapies
- Numbers of people entering employment
- Delivery of Mental Health Promotion initiatives
- Numbers of people leaving care and hospital and entering reablement / intermediate care

PRIORITY 5 URGENT CARE

Lead Agency: Wolverhampton City Clinical Commissioning Group

Project Sponsor: Richard Young (Director of Strategy and Solutions)

Project Manager: Rox Modiri

Partners: Local Authority, Royal Wolverhampton Trust, Black Country Partnership Foundation Trust, West Midlands Ambulance Service, South Staffordshire Clinical Commissioning Group

What is the issue?

Urgent and Emergency Care has been highlighted in the press both locally and nationally due to the extreme pressure that the entire system is under. The focus of attention has been on the pressures felt by the Emergency Department and the ambulance service, however the entire system has experienced increased activity and patients experiencing longer waits to be seen and treated and Wolverhampton is no exception.

What is the position and evidence in Wolverhampton?

The Joint Urgent and Emergency Care Strategy Board has been developed with partners from WCCG, SES&SP CCG, RWT, WCC and WMAS coming together to undertake a review of urgent and emergency care in Wolverhampton, develop an urgent and emergency care strategy and a commitment to work with our patients to develop a cohesive and sustainable way forward. In order to deliver the strategy but also to manage the wider Urgent & Emergency Care system, the Strategy Board will morph into the Urgent & Emergency Care Board. The board will continue to include health and social care leads who are both clinicians and managers but will also widen the membership by including patients, public health and mental health trust and communication representatives.

How does it link to other strategies and priorities in Wolverhampton?

Taking the views of our patients and stakeholders, and the extreme pressure the system is under, a cohesive vision for urgent and emergency care has been developed.

"Our vision is for an improved, simplified and sustainable 24/7 urgent and emergency care system that supports the right care in the right place at the right time for all of our population. Our patients will receive high quality & seamless care from easily accessible, appropriate, integrated and responsive services. Self-care will be promoted at all access points across the local health economies and patients will be guided to the right place for their care and their views will be integral to the culture of continuous improvement."

Urgent and Emergency Care Strategy Objectives:

- Improved Assessment and Discharge
- Managing Patient Expectation by clinicians working together
- Standardising and Improving Quality in Urgent Care by ensuring services are high quality and clinically robust
- Improve Timely Access to Services by improving access and operating hours
- Encourage Self-Care (wherever possible) by communicating with our patients
- Use of Risk Stratification by managing patients who are at high risk of admission into hospital
- Improved Communication by using technology and promotional campaigns
- Seamless and Consistent Urgent Care Services by ensuring all providers are managed through a system approach
- Explore and Develop Alternative Solutions by ensuring new solutions to improve quality within the system are identified, considered and delivered

Expected Benefits of Strategy:

- Appropriate reduction of ED attendances by 2016 by ensuring our pathways are correct
- Appropriate reduction in Emergency Admissions by 2016
- Patients arriving at ED by ambulance will be assessed by a nurse within 15 minutes.
- The sustainable delivery of the 95% ED target will be achieved 98% of the time
- An increase in Primary Care appointments by April 2015
- An increase in Mental Health Practitioners within the ED to improve urgent care provision for patients in crisis by April 2014

Wolverhampton Surge Planning Group –
The Surge Planning Group provides resilience support to the current Urgent & Emergency Care system by advising on tactical changes to manage surges in activity across Wolverhampton. The primary focus is on the urgent care system, the impact of pressure on those services and the decisions that need to be taken to alleviate the immediate pressures. This group will work to deliver the A&E Recovery Plan and will be overseen by the U&EC Board.

What is the evidence of effective interventions?

What are the planned actions, timescales and leads?
TBC

How will progress be measured?
TBC

Appendix 1 – Health and Wellbeing Board shortlisted outcomes – spine chart

Key:

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

Regional Key:

National average
Wton LA peers
Worst — Best
25th Pecentile 75th

	Indicator	Local Number	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Group 1	Alcohol related admissions per 100,000 2008-09	4628	1715.9	1582.7	2856.4		784.3
	Alcohol related mortality all ages 2007-09	164	22.3	10.4	33.6		2.2
	Children in Poverty 2010	17365	30.8	20.9	57.0		3.9
	Year R obesity rates 2009-10	333	12.2	9.8	14.7		5.4
	Year 6 obesity rates 2009-10	659	24.7	18.7	28.6		10.7
	Obesity rates in adults 2006-08 (estimated)	n/a	27.3	24.2	32.9		13.2
	% employed with long term conditions						
	% employed with long term conditions (Mentally ill and LD)						
Group 2	Male disability free life expectancy 1999-2003	n/a	58.3	61.7	50.4		71.5
	Female disability free life expectancy 1999-2003	n/a	60.8	64.1	54.0		71.3
	Incidents of domestic abuse						
	Circulatory disease mortality under 75 2007-09	639	85.2	70.5	122.1		37.9
	Prevalence of diabetes 2009-10	13886	6.9	5.3	7.9		3.3
	Infant mortality rates 2007-09	65	6.5	4.7	10.6		0.7
	Perinatal mortality rates 2007-09	123	12.1	7.6	14.7		2.0
Group 3	Child development at 2 years						
	Good development at age 5 2010	n/a	52.1	55.7	41.9		69.3
	Mortality rate for people with mental illness						
	Permanent admissions to residential and nursing homes per 100,000 2009-10	340	180.0	160.0	315.0		25.0
	An indicator on recovery from stroke						
	Early cancer diagnosis stages 1 and 2						
Group 4	Under 18 conception rates 2007-09	788	56.3	40.3	69.4		14.6
	Homeless households 2009-10	339	3.4	1.9	8.3		0.1
	Maternal smoking prevalence 2009-10	626	20.5	14.5	31.4		4.5
	Fractured proximal femur emergency admission rates 2008-09	n/a	130.0	98.0	141.2		0.0
	Access to green space 2005	n/a	29.2	87.5	12.4		97.3

[i] Tackling drugs and alcohol. Local government's new public health role. Local Government Association, January 2013. http://www.local.gov.uk/c/document_library/get_file?uuid=ef73ac40-827e-4e7f-bb27-9b19fff157c0&groupId=1017

Agenda Item No: **11**

Health Scrutiny Panel

19 September 2013

Report Title	Choose & Book System – update report
Classification	Public
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Well Being
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	The Royal Wolverhampton NHS Trust

Accountable officer(s)	Lisa Myatt	Head of Patient Access
	Tel	01902 695958
	Email	Lisa.myatt@nhs.net

Recommendation(s) for action or decision:
The Panel is recommended to:

1. Raise awareness of the “Choose & Book” system and encourage its further use.

Recommendations for noting:
The Panel is asked to note:

1. The purpose of “Choose & Book” and the benefits to the wider patient population.

1.0 Purpose

1.1 The purpose of the report is to give a brief overview of how “Choose & Book” works and to further encourage its use through awareness by the general public

2.0 Background

2.1 “Choose & Book” is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.

There is an option for the GP to book the appointment there and then with the patient present, or if the patient wishes to consider their options, the patient can choose to make an appointment at a later time either by ringing the national appointments line or by making the appointment via the internet

3.0 Progress, options, discussion, etc.

3.1 The application was originally procured as part of the National Programme for IT in 2003, and has been progressively introduced into the NHS from 2005 onwards.

Currently between 50-55% of all GP referrals are made using the “Choose & Book” system nationally, with the use in Wolverhampton usually being consistently above the national average by between 2%-5%

Every healthcare provider organisation that offers the ability to book into clinical services via “Choose & Book” has a duty to ensure there is sufficient capacity available at any time. The number of “failed bookings” is monitored on a weekly basis and the figures published on the “Choose & Book” website.

The latest published information shows nationally 12% of bookings are unable to be completed due to slot issues which usually relate to capacity. The Birmingham and Black Country Area Team, which the Royal Wolverhampton NHS Trust sits within, also reported 12% of failed bookings, however the Royal Wolverhampton NHS Trust reported 6% for the same period. This is largely due to a very small number of specialties where the Trust faces particular challenges around capacity pressures usually generated by increasing referral volumes most notably, in orthopaedics and general surgery.

Close working relationships currently exist between the Trust and the Wolverhampton Clinical Commissioning Group, and performance and utilisation are regularly monitored across both organisations. A maximum threshold of 10% failed bookings is stipulated in the contract between the Clinical Commissioning Group and the Trust, and failure to achieve this target can attract potential financial penalties.

Further awareness by patients continues to be encouraged by all available avenues and the continued support of the Health Scrutiny Panel is welcomed

4.0 Financial implications

4.1 None

5.0 Legal implications

5.1 None

6.0 Equalities implications

6.1 None

7.0 Schedule of background papers

7.1 None

Office of the
Trust Special Administrator
of MSFT

Mid Staffordshire NHS
NHS Foundation Trust

Maintaining high quality, safe services for the future

Having your say

Consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals.

Please read this important document and complete the consultation response form.
Your views are important.

This consultation begins on Tuesday 6 August 2013 and finishes at midnight on Tuesday 1 October 2013

For more information about the consultation, or to request a summary of the information provided in this document in a different format or language*, please get in touch with us.

* Requests for information in a different language will be provided in a document format where possible, and if not possible, via an interpretation service.

Jeśli potrzebują Państwo pomocy w przetłumaczeniu niniejszego dokumentu na inny język*, chcą otrzymać go w innym formacie lub potrzebują dodatkowych informacji, prosimy skontaktować się z nami na podany niżej adres.
* Prośby o informacje w innym języku będą realizowane – o ile będzie to możliwe – poprzez udostępnienie dokumentu drukowanego. Jeśli nie będzie to możliwe, zapewnimy usługę tłumaczenia ustnego.

دستاویز اس کے دیگر کسی زبان میں ترجمے کے لیے اگر آپ کو مدد درکار ہے*، کسی اور فارمیٹ میں چاہیے ہے یا آپ کو مزید معلومات درکار ہے تو، برائے مہربانی درج ذیل تفصیلات کے ذریعے ہم سے رابطہ کریں۔
* کسی مختلف زبان میں درکار معلومات، اگر ممکن ہو تو دستاویزی شکل میں فراہم کی جائے گی اور اگر ایسا ممکن نہ ہو تو، ہم ترجمانی کی خدمت فراہم کریں گے۔

ਜੇ ਤੁਹਾਨੂੰ ਇਸ ਦਸਤਾਵੇਜ਼ ਦਾ ਅਨੁਵਾਦ ਕਸੇ ਦੂਜੀ ਭਾਸ਼ਾ* ਵਚਿ ਕਰਨ ਲਈ ਮਦਦ ਦੀ ਲੋਡ਼ ਹੈ, ਇਸਨੂੰ ਕਸੇ ਦੂਜੇ ਫਾਰਮੇਟ ਵਚਿ ਚਾਹੁੰਦੇ ਹੋ, ਜਾਂ ਇਸ ਸਬੰਧੀ ਹੋਰ ਜਾਣਕਾਰੀ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ ਕਰਿਪਾ ਕਰਕੇ ਹੇਠਾਂ ਦਤਿੇ ਵੇਰਵਆਿਂ ਤੇ ਸਾਨੂੰ ਸੰਪਰਕ ਕਰੋ।
* ਕਸਿੇ ਵੱਖਰੀ ਭਾਸ਼ਾ ਵਚਿ ਜਾਣਕਾਰੀ ਲਈ ਕੀਤੀਆਂ ਗਈਆਂ ਬੇਨਤੀਆਂ ਮੁਮਕਨਿ ਤੌਰ ਤੇ ਦਸਤਾਵੇਜ਼ ਫਾਰਮੇਟ ਵਚਿ ਪ੍ਰਦਾਨ ਕੀਤੀਆਂ ਜਾਣਗੀਆਂ, ਜੇ ਅਜਹਿਾ ਮੁਮਕਨਿ ਨਹੀਂ ਹੋਇਆ, ਤਾਂ ਅਸੀਂ ਤਰਜਮਾਨੀ ਸੇਵਾ ਮੁਹੱਈਆ ਕਰਾਂਗੇ।

Si vous avez besoin d'assistance pour traduire ce document dans une autre langue*, si vous souhaitez le consulter dans un autre format ou pour tout complément d'informations, veuillez nous contacter à l'aide des coordonnées indiquées ci-dessous.
* Tout complément d'informations dans une autre langue sera, si possible, fourni dans un format documentaire ; si cela s'avère impossible, nous vous fournirons un service d'interprétation.

Ak potrebujete pomoc s prekladom tohto dokumentu do iného jazyka*, potrebujete ho v inom formáte alebo vám treba viac informácií, obráťte sa na nás prostredníctvom nižšie uvedených kontaktných údajov.
* Žiadosti o informácie v inom jazyku budú – ak je to možné – poskytnuté formou dokumentu, ak to nie je možné, poskytneme vám tlmočnícke služby.

Ja jums nepieciešama palīdzība pārtulkot šo dokumentu citā valodā*, nepieciešams cits formāts, vai vajadzīga papildu informācija, lūdzu, sazinieties ar mums – kontaktinformācija norādīta zemāk.
* Informācijas pieprasījumi citā valodā tiks pēc iespējas sniegti dokumenta formātā, ja tas nebūs iespējams, mēs piedāvāsim mutiskās tulkošanas pakalpojumus.

Если вам необходима помощь с переводом данного документа на иностранный язык*, вам необходимо изменить его формат или получить более подробную информацию, обращайтесь к нам по указанным ниже контактным данным.
* Информация на иностранном языке по возможности будет предоставлена в письменном виде, в противном случае мы предоставим услуги устного перевода.

如果需要我们帮助您将本文档译成另一种语言*，需要另一种格式，或者要求更多信息，请按下面的方式联络我们。
*如有可能，则我们会以文档格式提供所请求信息的另一语言版本。如无此可能，则我们会提供口译服务。

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*若可能，我們會以文件格式提供所請求資訊的另一語言版本。若無此可能，則我們會提供口譯服務。

Visit our website
www.tsa-msft.org.uk

Call us (freephone)
0800 408 6399

Email us
TSAconsultation@midstaffs.nhs.uk

Send your response to us:
Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG

Contents

Foreword

Professor Hugo Mascie-Taylor, Alan Bloom and Alan Hudson

The Trust Special Administrators (the TSAs)

Every patient is entitled to expect high quality and safe health services from the NHS.

This responsibility to local people has underpinned the work of the TSAs of Mid Staffordshire NHS Foundation Trust (MSFT or the Trust).

There is another important responsibility to all taxpayers who rightly expect every pound spent on health services to be spent efficiently.

We are the TSAs appointed by Monitor, the health care regulator, on 16 April 2013 following its decision to use its powers to intervene at MSFT.

We are:

- Professor Hugo Mascie-Taylor, an experienced clinician and medical leader; and
- Alan Bloom and Alan Hudson, senior partners at EY, a major consultancy firm.

Chapter 3 sets out more about our role and duties.

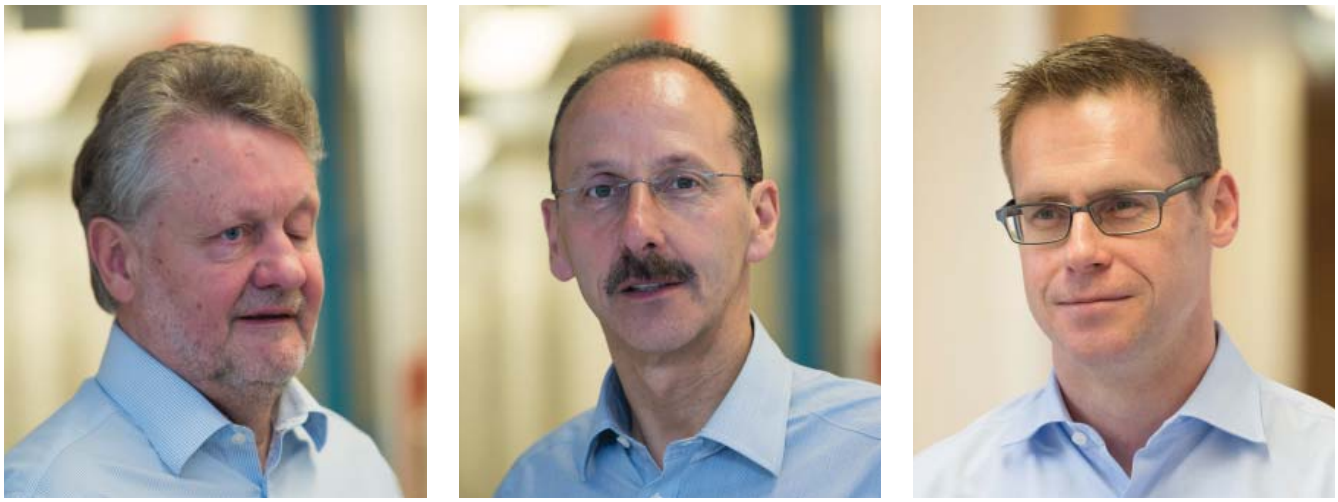
Some have questioned why the TSAs are undertaking this process at MSFT now, when recent inspections at Stafford and Cannock Chase hospitals show services are safe.

It is important to recognise that the Care Quality Commission (CQC) in recent times has indicated that the Trust is safe, however, the CQC does not take into account the long term financial and staffing difficulties the Trust has and will continue to experience.

This broader assessment was undertaken by the Contingency Planning Team in 2012/13 when it was asked by Monitor to look at the Trust's future. It concluded the Trust won't be able to provide safe care within the available budget for the foreseeable future and there are shorter term safety issues in certain areas of activity, such as A&E, and medium and longer term safety issues in others.

Following this assessment we were appointed as TSAs to oversee the Trust's current services but importantly to also plan for health services for the long term future.

We would like to take this opportunity to acknowledge the hard work and dedication that MSFT's staff have continued to demonstrate following our appointment



From left to right: Professor Hugo Mascie-Taylor, Alan Bloom and Alan Hudson

while continuing to give patients good care and attention. We thank all staff for their commitment.

We do not wish to dwell on the Trust's difficult history. Instead we are concentrating our efforts on finding a long term solution for the Trust's present problems. These problems are listed below:

- **MSFT provides services to relatively small numbers of patients; some patients in the area are actively choosing to use other hospitals.**

  On a related and important point, this means staff may not see enough cases to maintain and improve their skills and ultimately keep patients safe.

- **It is difficult to attract and retain enough doctors and nurses.**

  The Trust therefore has a high number of temporary staff which is very expensive. It has also had to take on extra staff in recent years to improve care levels.

- **This means the cost of running the Trust is far too high for the number of patients the hospitals serve compared to similar hospitals. The Trust does not earn enough money to cover its costs, nor will it in the future.**

These problems must be solved. To avoid a continuation of the current situation where the Trust is in the impossible position of trying to provide its current range of services safely within its budget, it is essential the difficult job of planning to provide safe, affordable services into the future is done now. This is the task we have undertaken.

Our guiding principles are to make recommendations, which are described in this document, for safe services within the budget available that are provided as near to patients' homes as possible. We expect these recommendations, if approved, would be implemented over the next two to three years.

Our proposals involve very close working with other hospitals and success will also be dependent on much better collaboration with GPs and community services.

We recognise that other hospitals in the area currently face their own challenges and would not be able to take on additional patients from MSFT until they are ready to do so.

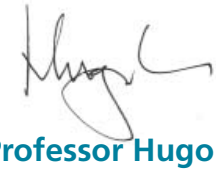
These recommendations have been drafted with the input of many, including local people and leading national experts, whom we wish to thank.

Our draft recommendations also have the support of the Stafford and Surrounds and Cannock Chase Clinical Commissioning Groups (the CCGs), who buy health services on behalf of patients in the area, and NHS England, who support CCGs as well as commission some services directly.

Most people go to Stafford and Cannock Chase hospitals as outpatients or to have diagnostic tests. Our draft recommendations do not impact these services. In fact these services may even be enhanced. Our proposed solution would allow 91% of patient visits to the hospitals to continue in the future.

We encourage you to read this document thoroughly with an open mind and to consider the reasons for our draft recommendations. Then tell us what you think.

We value what you think and we want as many people as possible to respond to this consultation by its deadline of midnight on Tuesday 1 October 2013. We would like to reassure you that we will consider the views of the people, groups and stakeholders who respond before finalising our recommendations. These will then go forward to Monitor and the Secretary of State for Health.



Professor Hugo Mascie-Taylor

Alan Bloom

Alan Hudson

What is this document for?

This document sets out and seeks your views on the TSAs' draft recommendations for the future of safe and high quality health services for people who use Stafford and Cannock Chase hospitals.

The TSAs have met patient and public representatives, local authorities, local GPs, health service commissioners, hospital doctors, nurses and other hospital staff, neighbouring NHS trusts and other health care providers as well as patients and members of the public as part of the work in developing their draft recommendations.

Chapter 4 describes how the TSAs have gone about producing their draft recommendations. More information is available in the draft report on the TSA website at www.tsa-msft.org.uk.

This is a consultation document and the TSAs would like to hear your views on the recommended changes. Should you require an explanation of any of the terms used in this document, please see the glossary on pages 58 and 59.

Many people wrote to the TSAs prior to this document being published. The TSAs value all of the views that people choose to share. However, it is important for you to know that this consultation stage is a legal process and it is important to comment upon the draft recommendations contained in this document if you wish for your views to be taken into account.

Having your say

There are various ways to find out more, get involved and tell us what you think. These are detailed in Chapter 11. You can provide your views by completing:

- the printed response form included with the printed consultation document and returning it using the Freepost envelope provided; or
- the online response form which can be accessed via the TSA website at www.tsa-msft.org.uk.

Question

Question boxes like this one appear throughout this document. These are the questions in the response form. Each question box contains the specific consultation question we would like you to answer.

To ensure your views are considered, we must receive your response form no later than midnight on **Tuesday 1 October 2013**. A second-class Freepost envelope is provided for printed response forms. Please ensure you post it in plenty of time.

You can request a printed response form and Freepost envelope, via freephone (0800 408 6399) or via email (TSAconsultation@midstaffs.nhs.uk).

Finally, if you have any complaints about the consultation please contact:

The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA


Main Entrance
Main Entrance

1 Is change needed or should we go on as we are?

You might ask: Why is change needed just as things are improving at Stafford and Cannock Chase hospitals?

Care at Mid Staffordshire NHS Foundation Trust (MSFT or the Trust) has improved over the last couple of years according to inspectors and thousands of local people now safely use Stafford and Cannock Chase hospitals' services.

In recent times the Care Quality Commission (the CQC), the regulator of all health and social care services in England, has indicated that the Trust is safe. However, the CQC does not look at the long term financial and staffing difficulties that the Trust has and will continue to experience. The Contingency Planning Team said in 2012/13 these are both warning signs that the Trust will not be able to provide safe care, within budget, in the medium to longer term.

The roots of these problems are the troubled history of the Trust and its size – it is one of the smallest in England based on the number of people who might use its services now and in the future, known as the catchment population. This small size brings particular challenges and difficulties.

In the near future, it is likely that standards of care will slip compared to the wider NHS in England leaving local people worse off. Indeed, in some areas of the hospitals' activity there are far more imminent safety issues, for example, A&E.

This is why experts say doing nothing now is unacceptable.

This chapter examines in detail why it is not in anyone's interest for nothing to change. It explains why change must happen.

The reasons for change

Future patient safety

Future local patient safety is at stake. If nothing changes, people may still be treated at Stafford or Cannock Chase hospitals but they won't necessarily be getting their treatment in the most appropriate place or seeing the doctor or nurse with the best mix of skills and experience.

There is a national trend for centralising some services at larger specialist centres. This is driven by the need to offer patients the opportunity to see experienced doctors and nurses who see large numbers of patients with their particular illness or to access scarce and expensive technology. Good national examples of this are cancer and heart disease. Additionally, in some life-and-death emergencies (for example, stroke), patients at these bigger centres have a better chance of surviving with fewer lasting effects.

Independent medical studies* on the NHS have also separately found that both 24-hour seven-day consultant cover and the scale of a larger specialist centre is critically important to the treatment of patients.

The reasons for this are:

1. **Larger centres have greater numbers of more experienced specialist doctors available at all times.** Smaller hospitals like Stafford and Cannock Chase aren't able to take on enough specialist doctors to have constant cover. Some key services at Stafford, such as A&E, already have limited opening hours for these reasons. A&E opening hours at Stafford won't change in the future because local commissioners, the buyers of hospital services, don't believe it's the best way to provide this service safely and economically.

2. **Relatively more people die if they are admitted to hospital on an evening or a weekend when fewer or no consultants are on duty.** This fact has been established by studies. Stafford and Cannock Chase hospitals already have significantly less specialist doctors than recommended by the latest national guidelines to give constant cover safely for some specialist services.

3. **Stand-alone smaller hospitals can't give their specialist doctors enough breadth of experience of patients for their essential skills to be kept up to date.** Larger specialist hospitals have more patients so their specialist doctors' skills are kept current and they learn new techniques. Clinical experts say Stafford and Cannock Chase hospitals will never treat enough patients to keep specialist doctors' skills current. Guidance from the Royal College of Surgeons states that a district hospital should serve a catchment population of at least 300,000 to ensure services are of sufficient scale, and a specialist hospital should ideally serve a population of 450,000.

Difficulty in hiring and keeping the right staff

Recruitment and retention is another related and important point. Some smaller hospitals find it harder to attract and retain the most experienced and sought-after staff. Posts must therefore be filled temporarily.

Stafford Hospital's history also deters staff from joining permanently so even more posts are filled temporarily. The Trust has also had to take on more staff in recent years to address serious care failings. Staffing hospitals this way is expensive and these extra costs add to the Trust's problems.

Being fair to all NHS patients

The Trust is already spending far more than it earns and there is no safe way to reduce its costs sufficiently. It will inevitably slide further into debt costing taxpayers more and more.

MSFT is failing its legal duty to local people to provide safe and high quality services within the funding available.

The Trust cannot go on spending more money than it earns. There is a fixed budget for the whole NHS; patients elsewhere in the NHS lose out every time MSFT is bailed out.

*Academy of Medical Royal Colleges, December 2012, Seven Day Consultant Present Care and Royal College of Physicians, September 2012, Hospitals on the Edge? The Time for Action

For every pound that has to be found to prop up MSFT, there is a pound less to spend on health services for other patients in England.

We have included more on MSFT's financial problems in Chapter 2, but put simply, each year the Trust earns around £150m but it costs about £170m to run. To put that into perspective it spends around £20m more than it earns each year in income.

Last year it needed an additional £21m of taxpayers' money to cover its everyday costs. If nothing changes and this amount is needed every year, then in just ten years the Trust will have soaked up an additional £210m with no end in sight. This £210m could pay for hundreds of thousands of operations.

Taxpayers are forced to pay but the Trust's finances aren't improving and every bail-out means it slides further into debt.

The Trust has tried to reduce its costs but still loses money. Without additional taxpayers' help the Trust would need to cut its costs so severely that it would not be able to afford to pay enough staff to provide its current range of services safely. This would inevitably put lives at risk.

It is unacceptable to allow this situation to continue, especially in a climate when all NHS organisations are expected to make the most of the budget they have.

Making sure the NHS meets future needs

The population is ageing and this is placing ever greater demand on the NHS. Therefore the NHS must adapt. Stafford and Cannock Chase hospitals are no different. In fact the situation is more serious in this local area as it has a high proportion of older people.

Services currently don't effectively meet the needs of older people in the area; services need to be more integrated, which means they need to work together in a structured way. If nothing changes, then many older people in the area will not get the kind of care that will help them to stay well, independent and out of hospital.

Medical advances and improvements in treatment mean it's no longer necessary for some people to be admitted to hospital if they do not need to be. These advances also mean that the length of patients' stays can be minimised. People are often better served getting care in a planned way in or nearer to their home. This approach reduces repeat emergency hospital admissions which are distressing and unnecessary for some patients. In the future treating people this way will be a better use of the NHS's resources and will help people stay well and out of hospital.

Facing up to the issues

The Trust has tried hard to find solutions to the serious problems it faces but cannot come up with a realistic plan for the reasons we have explained.

Action must be planned in a considered way to meet the needs of the local patients and allow services to be given by the most appropriate doctor, nurse or other health professional so patients in the future receive the highest quality and safest services within the budget available.

These are worrying issues but we must face them now and not underestimate how important it is to find a long-lasting solution.

In reality, a failure to face up to the problems now in order to safeguard high quality services, will make things worse for local people in the future.

The TSAs are responsible for ensuring this blueprint for change is developed in everyone's best interests.

2 The financial problems

To appreciate the financial challenges faced by Mid Staffordshire NHS Foundation Trust (MSFT or the Trust) it is helpful to look at the issue from the patients' perspective.

NHS patients will only get the services they need if money is not wasted through inefficiency. This is the responsibility of all NHS organisations.

For this reason hospitals are paid for providing treatment at a rate that is set to make the most of each and every pound without compromising on the essential quality and safety of services.

MSFT has been found to be more expensive to run than most other trusts. Its debts are mounting because it costs far more to provide its services than the Trust receives in payment for patient treatments.

Staffing levels and back office costs are very high for the size of Stafford and Cannock Chase hospitals and MSFT has been overspending since 2010. Since 2010 it has received cash injections of additional taxpayers' money totalling £42m in order to pay its staff and suppliers (£21.0m in 2011/12 and £21.4m in 2012/13).

In 2013/14 it is anticipated that MSFT will overspend by another £20m on the day to day running of the Trust. When you add the money that it will spend on its buildings, plant and equipment, this additional funding required is estimated to increase to £36m in 2013/14.

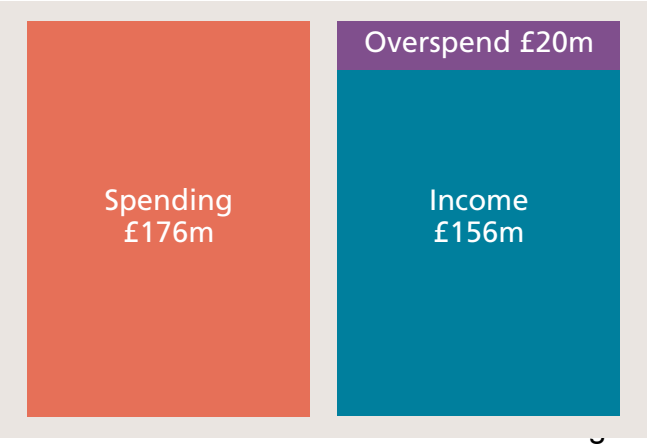
What are the underlying causes of the Trust's financial problems?

The Trust has two major challenges that are driving its financial problems:

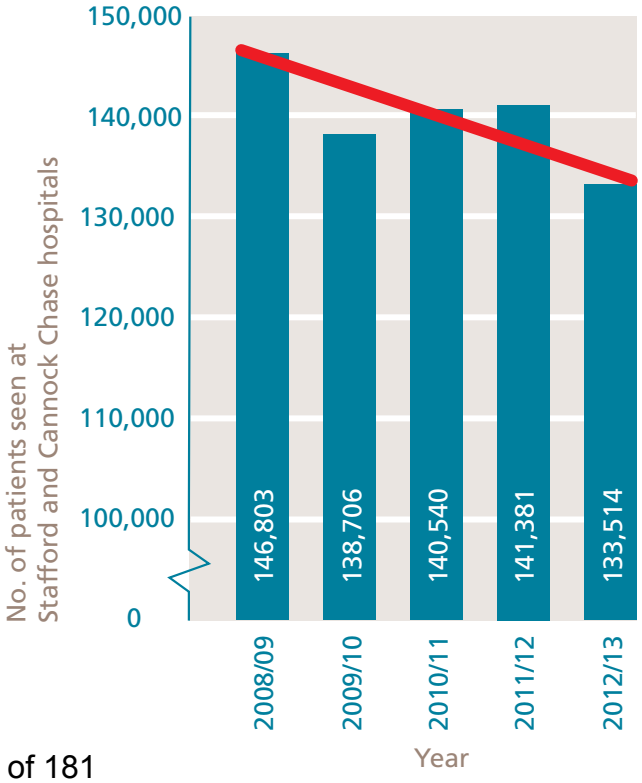
1. The Trust does not see enough patients

The population served by the Trust is already small and some patients are exercising their choice and are asking to be treated elsewhere.

Estimated income vs spending for 2013/14 (excluding monies spent buying and maintaining buildings, plant and equipment)



MSFT patient numbers



As a result, the Trust has not treated all the extra patients it needed to balance its books. In fact, the number of patients seen by the hospitals has fallen over time.

2. The Trust costs too much to run

In 2009/10 the Trust took on significant numbers of staff in response to major, well-publicised concerns over the quality of care. The Trust was not able to afford all the extra staff it needed and this means it has had to borrow money each year since to pay for this.

MSFT's staff costs are also high because it is experiencing recruitment and retention problems and has to use too many temporary and agency staff which are expensive. This is partly due to its reputation and partly because good candidates often choose to work for larger teaching hospitals. These problems, as well as national shortages, mean 20% of consultants at Stafford and Cannock Chase hospitals are temporary and too many nursing shifts are still being covered by agency nurses. Permanent junior doctors and managers are also proving hard to recruit.

The Trust also continues to overspend every year because as a small Trust it spends a higher proportion of its income on managing its buildings. It is very unusual for a small Trust like MSFT to operate two hospitals, which increases its costs.

Overall MSFT is not as efficient as most other trusts. Analysis of all hospitals operated by the NHS show that MSFT's costs are 18% higher than the national average (see chart opposite).

No way out of its financial difficulties

Close examination of the Trust's finances by the Contingency Planning Team in 2012/13 showed that in order to resolve its financial problems, MSFT would need additional cash of at least £70m over the next five years even if it makes cost savings of 7% every year.

The Trust has been trying to cut its costs but has not managed to achieve 7% savings annually. In 2012/13 it reduced costs by 6% and it has budgeted to achieve cost savings of less than 4% in 2013/14.

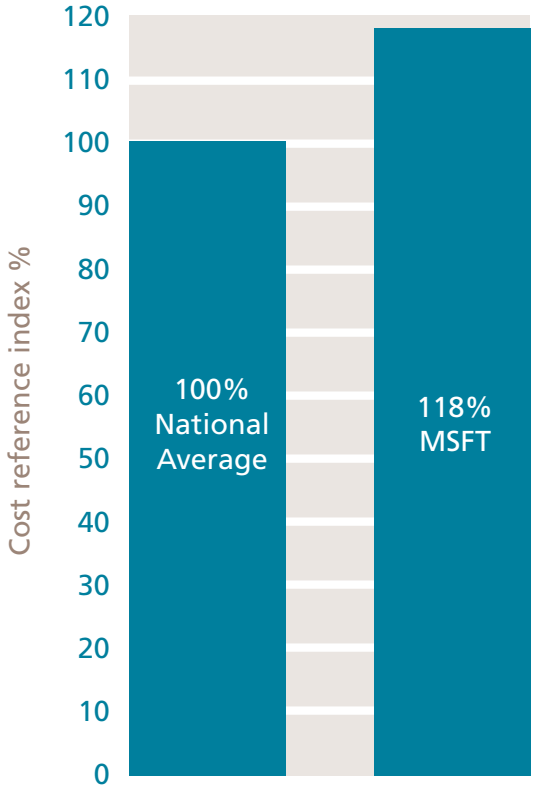
In a recent survey, NHS finance directors agreed that savings are harder to make with every year that goes by. In 2012 only 5 out of 45 Trusts surveyed* made 7% savings. No NHS Trust has ever saved that amount every year for five consecutive years.

Therefore it is not surprising that MSFT doesn't think it can achieve the required 7% savings each and every year. To put this into perspective the Trust would have to cut its staff wage bill by 25% to achieve this target whilst treating the same number of patients. External experts and the Trust agree that this would cause significant safety issues at the hospitals.

So cutting costs to this level is not the solution but doing nothing is not a realistic alternative either. If nothing is done, the financial situation will continue to worsen and the Trust will be unable to provide the quality of care that local people require.

You can find out more about what will happen if nothing changes at MSFT in Chapter 1.

Cost of running MSFT vs national average (2011/12)



* King's Fund quarterly report September 2012

3 What is the role of the TSAs?

The TSAs were appointed on 16 April 2013 by Monitor, the health care regulator, after its decision to intervene at Mid Staffordshire NHS Foundation Trust (MSFT or the Trust) to protect future health services for local people.

The TSAs, who report to Monitor, have two roles:

- to take overall responsibility for the running of the Trust; and
- to develop and consult locally on a draft report about how local patients should continue to receive high quality and safe services over the long term, before making final recommendations to Monitor and ultimately to the Secretary of State for Health.

What exactly has Monitor asked the TSAs to do?

The TSAs have been tasked by Monitor to assess and develop recommendations on how clinically and financially sustainable health services can be provided for local people in the future.

Chapter 1 explains why MSFT cannot currently provide clinically or financially sustainable services.

So what do the terms "clinically and financially sustainable" services actually mean?

These technical phrases may be referred to during the consultation at meetings or in other consultation material. This section seeks to explain in plain English what is meant by these terms.

The term **"clinical sustainability"** means the ability to provide good quality, safe services for patients for the foreseeable future. The TSAs were asked to consider the next ten years.

The term **"financial sustainability"** means the ability of a hospital to balance its books for the foreseeable future.

How will the TSAs achieve this?

The TSAs must come up with recommendations that achieve both clinical and financial sustainability. To focus on one at the expense of the other could create an imbalance that means quality may suffer or, on the other hand, that services are unaffordable. The TSAs are following a legal timescale which is designed so that they can focus on developing a plan for achieving the rapid and essential change needed.

On Thursday 13 June 2013, the TSAs formally asked Monitor for an extension of 30 working days to finalise the draft recommendations and an extra 10 working days for the public consultation to take into account the summer holiday period. On Wednesday, 19 June 2013, Monitor formally granted this extension request.

The revised timescale therefore includes a 40 working day public consultation to get the views of those most affected by the draft recommendations. This takes place after an initial 75 working-day period spent developing the draft recommendations.

The Trust Special Administration timeline

Day 1	**Tuesday 16 April 2013** Appointment of the TSAs takes effect
Within 75 working days*	**Wednesday 31 July 2013** Publication of the TSAs' draft recommendations
Within 5 working days	**Tuesday 6 August 2013** The formal consultation process on the TSAs' draft recommendations begins
40 working days*	**Tuesday 1 October 2013** The formal consultation process on the TSAs' draft recommendations ends
Within 15 working days	The finalised report on the TSAs' recommendations is sent to Monitor
Within 20 working days	The final report is reviewed by Monitor and submitted to the Secretary of State
Within 30 working days	The Secretary of State decides on what action is to be taken

Although the TSAs will consider previous work done by a group of experts, called the Contingency Planning Team, on behalf of Monitor between September 2012 and March 2013, the TSAs have complete discretion and flexibility to develop their own draft recommendations.

The TSAs are open-minded and are taking into account the views they receive before they finally decide on their recommendations to Monitor and the Secretary of State for Health.

To do this effectively, they will gather local opinion from a wide range of people and organisations in the local area including patients, the public, staff, other NHS trusts, MPs, GPs, local authorities, patient representative groups and the local consumer champion for health services called Healthwatch. Critically, the TSAs have also listened to what the local Clinical Commissioning Groups (the CCGs) for Stafford and Surrounds and Cannock Chase, who are the buyers of the hospitals' services and who are led by local GPs, have said about which services must continue to be provided locally and those they intend to commission from Stafford and Cannock Chase hospitals in the future.

Throughout the process, the TSAs have and will continue to gather, analyse and consider large amounts of information about MSFT, the services it provides and the population it serves.

Chapter 4 tells you more about how the TSAs have gone about developing their draft recommendations.

Summary

The task of the TSAs is to find a planned solution that means high quality and safe services continue to be delivered for local patients in the future within budget. The TSA process allows the Trust's difficulties to be tackled swiftly but in a planned way so services for patients are not put at risk by short-term or quick-fix solutions.

*On 19 June 2013 Monitor granted an extension of 30 working days for the publication of the TSAs' draft recommendations and an extension of 10 working days to the public consultation period

4 How have the TSAs gone about developing their draft recommendations?

The TSAs must develop clinically and financially sustainable recommendations that provide high quality and safe services for the future.

The reasons for the appointment of the TSAs to Mid Staffordshire NHS Foundation Trust (MSFT or the Trust), their objectives and the details of the legal timetable are set out in Chapters 1 and 3.

This chapter describes how the TSAs have approached developing the draft recommendations set out in this document.

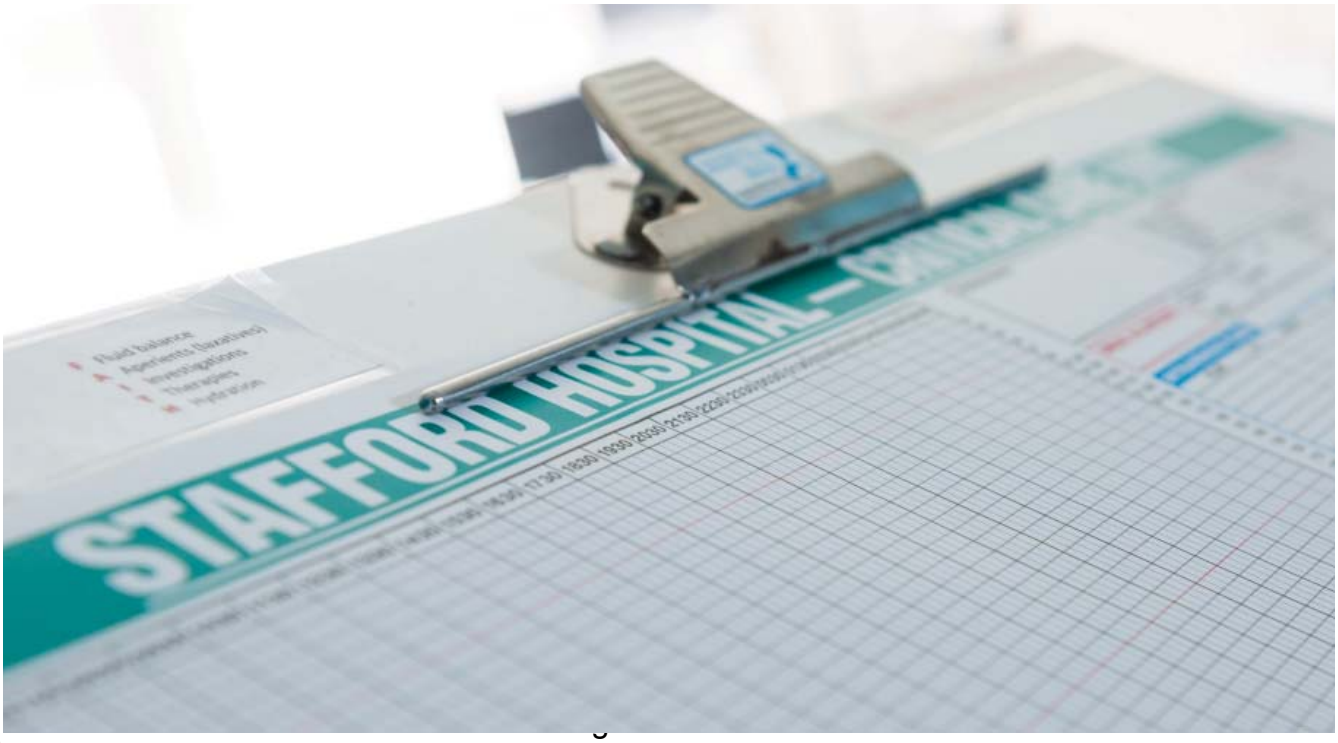
The TSAs' guiding principles have been to come up with a solution based on high quality, safe services provided as near to patients' homes as possible without incurring the significant financial losses that have been a problem to date. They are also determined that they won't simply shift the problem elsewhere.

The TSAs' draft recommendations are set out in detail in later chapters.

Location Specific Services (LSS) for Stafford and Cannock

By law, the TSAs began the process with a list of the minimum services that must be provided locally known as Location Specific Services (LSS). This list was drawn up by the Stafford and Surrounds and Cannock Chase Clinical Commissioning Groups (the CCGs). These groups buy health care services on behalf of local people. They say the LSS must continue to be local whatever additional services the TSAs may recommend.

The TSAs have developed proposals that provide services over and above the LSS. Further information on the TSAs' draft recommendations is set out in Chapters 6, 7 and 8.



The LSS are:

For Stafford	Outpatients services
	Patient-facing diagnostics (ie, x-rays, blood and urine specialist tests)
	Day case chemotherapy (a medical treatment for cancer patients)
	Pre- and post-natal care
	Inpatient hospital beds for patients who are no longer very unwell and can be moved nearer to home safely following treatment at a specialist centre
For Cannock	Outpatients services including pre- and post-natal care
	Patient facing diagnostics

The CCGs say that in addition to the above services, the LSS listed below must only carry on being local until other hospitals are in a position to take on more patients and provide these services instead of Stafford Hospital:

For Stafford	Current 14/7 A&E (this means no change to the opening hours and broadly the same service presently run out of Stafford Hospital)
	Routine obstetrics (services for women with normal pregnancies)
	Selected emergency (non-elective) admissions/inpatients (eg, frail people with pneumonia)
	Selected elective admissions for a range of medical specialities (eg, control of heart failure)
For Cannock	None specified

Finally, the CCGs recognise that if the LSS are provided in Stafford and Cannock, then the relevant support services, such as anaesthetics, will also have to be provided locally.

How do local commissioners say they will buy services in the future?

CCGs plan for the future as part of their role as buyers of health services on behalf of patients. They take into consideration the make-up of the population they serve and any particular characteristics, such as the number of older people, prevalent health problems and advances in how or where treatments are best administered.

The TSAs took into consideration the CCGs' planning in developing their draft recommendations. The CCGs want to reduce the number of patients that are admitted to hospital because it is no longer the best way for many patients to maintain their health. The CCGs want to make use of medical advances which now mean people can be treated in a planned way closer to home. Treating people this way is known to be a better use of NHS resources and experts say it helps people stay well and avoid hospital.

These "commissioning intentions" have been published by the CCGs and have influenced the formulation of the TSAs' proposals.

The CCGs also identified in their commissioning intentions that they would like more services to be delivered locally in addition to the LSS, as long as they can be delivered in a clinically and financially sustainable way.

The TSAs have talked with the CCGs about the delivery of the LSS and other services and the TSAs' draft recommendations reflect these discussions and have the support of the CCGs and NHS England.

How might other hospitals and health care providers help to provide LSS and more?

The TSAs are able to look outside the Trust to find a way forward. They have carried out a process called a "market engagement exercise" which was designed to allow any health care provider, including other hospitals, to propose a solution for delivering the services currently provided by Stafford and Cannock Chase hospitals. The TSAs said providers must at a minimum provide the LSS, which means keeping those services and providing them locally.

The TSAs widely advertised the process and detailed information was sent out to providers who expressed an interest. Those interested were given a list of requirements. This included making clear how the proposals would benefit patients. They were also asked to explain how quality and safety would be assured and to state the financial implications of their proposals.

Fourteen proposals were received from twelve organisations. The proposals which provided for the widest range of services and confirmed that they were able to deliver them in a clinically sustainable way were:

1. from University Hospital of North Staffordshire NHS Trust (UHNS) which submitted a proposed solution for Stafford; and
2. from The Royal Wolverhampton Hospitals NHS Trust (RWT) which included a proposed solution for Cannock.

These two proposed solutions now form the basis of the TSAs' draft recommendations. The proposals are simply being used to develop a possible blueprint for future services. There are still a number of parties, including, in particular Walsall Healthcare NHS Trust, who are interested in providing the services, especially to Cannock.

The TSAs understand that UHNS, RWT and other local health providers currently face their own challenges and are not yet ready to take on more services from Stafford or Cannock Chase hospitals. The TSAs' draft recommendations, if approved, would only be implemented when the affected health providers are deemed ready to take on the additional work from MSFT. It is anticipated that this would happen over a period of two to three years, subject to the safe provision of services in the interim.

Who is contributing to developing the draft recommendations?

The TSAs, following a legal process developed by Monitor, are required to engage with local CCGs, patients and staff, plus a range of national regulatory bodies including the Care Quality Commission (the CQC), clinical experts, other hospitals and health organisations and NHS England as part of their work in developing a solution for MSFT.

The TSAs have seen all these people as well as many others in a comprehensive series of meetings.

For example, as the clinical quality and safety of the solution is vital, Joint TSA Professor Hugo Mascie-Taylor has set up three advisory groups:

- a national Clinical Advisory Group (CAG) jointly chaired by the Academy of Medical Royal Colleges. The group's membership is made up of the Royal Colleges for all the relevant medical specialities including physicians, obstetricians, gynaecologists, surgeons, paediatricians, pathologists, radiologists, anaesthetists, public health physicians, GPs and emergency doctors;
- a national Nursing and Midwifery Advisory Group made up of senior nurses in the NHS; and
- a local clinical reference group of senior doctors from local hospitals and local commissioners.

The CAG and Nursing and Midwifery Advisory Group, together known as the National CAGs, used their knowledge of their respective Royal College guidelines and professions for safe care to advise on the proposed solutions including the issue of recruitment and retention of key staff, which is a particular problem for MSFT.

The local clinical reference group assessed the proposed solution from their professional viewpoint for safety and whether it will be workable locally in the long term.

Independent scrutiny of the recommendations

The TSAs want to ensure that their proposals are reviewed by a separate and independent group of credible and knowledgeable individuals, called the Health and Equality Impact Assessment Steering Group.

This group, which includes patient and public representatives, will independently and impartially assess and report on the impact of the TSAs' draft recommendations on the health of local people. Their final report will be published following the formal consultation period.

It will particularly focus on some of the characteristics protected by the Equalities Act 2010: age, disability, sex (gender), pregnancy and maternity, race, religions and beliefs. The Steering Group will also be reaching out to the community to understand the impact on sexual orientation and gender reassignment (transsexual people).

They have also decided to include socioeconomic deprivation and rural isolation as additional characteristics, and to look at the impact of the draft recommendations on people with combinations of characteristics, for example, the poor elderly.

The TSAs secured an experienced and independent chair: Sophia Christie, who has extensive experience of leading NHS organisations, with no connection to the TSAs or the Trust.

5 The TSAs' draft recommendations and the local context

Stafford and Cannock Chase hospitals cannot continue as they are. The impact of their current challenges is already being felt both within the hospitals themselves and by other neighbouring hospitals that are having to do more. There is no alternative but to make significant change. If things continue as they are, this change will happen in an unplanned, unmanaged and potentially unsafe way.

This will not only adversely impact patients at Stafford and Cannock but will also put even more pressure on other local hospitals. Therefore, change needs to happen in a planned and structured way over the coming months and years to ensure that patients continue to receive high quality, safe services for the future.

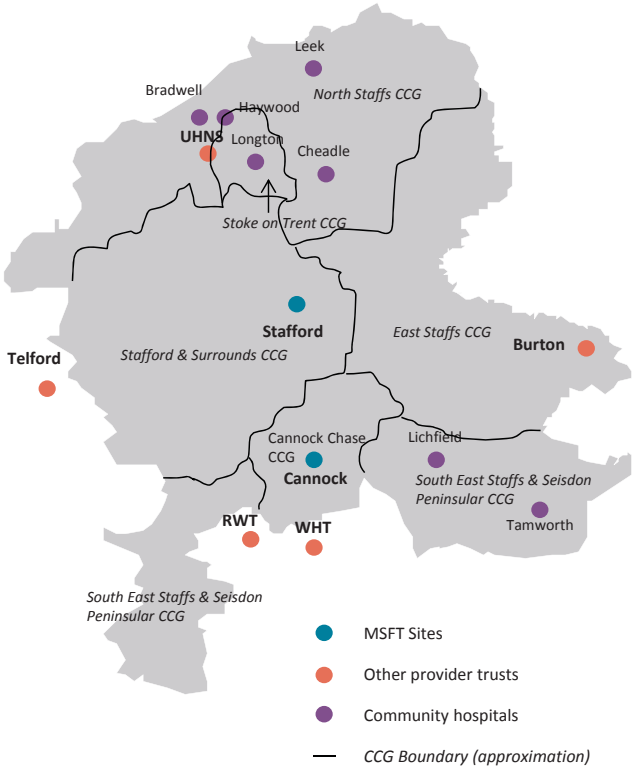
Faced with this problem, the TSAs' starting point in developing their draft recommendations has been the statements of the Stafford and Surrounds and Cannock Chase Clinical Commissioning Groups (the CCGs) of those services which must be provided in Stafford and Cannock, the so-called "Location Specific Services" (LSS). Applying the TSAs' guiding principles which seek to have safe, high quality services provided as close to patients' homes as possible within the budget available, the TSAs have had initial discussions with a number of health providers.

Through these discussions the TSAs have developed proposals that provide services over and above the LSS. Each of these services and the way in which they will operate in practice is set out in the next two chapters.

Hospitals in all areas work together. There are already examples of services that are provided for the people of Stafford and Cannock by other local hospitals, for example, cardiac services which are currently provided by University Hospital of North Staffordshire NHS Trust (UHNS) and stroke services which are currently provided by The Royal Wolverhampton Hospitals NHS Trust (RWT).

The map below shows the geographical locations of Stafford and Cannock Chase hospitals, other local provider trusts and community hospitals.

Local provider trust and community hospital map



At the heart of the TSAs' proposals is the critical need for Stafford and Cannock Chase hospitals to work seamlessly and efficiently with other local health and social care providers so that local people continue to get the best care now and in the future.

To achieve this however the answer does not just lie in what hospitals can do for patients:

- It is essential as part of any plans to change services, that agreements are reached with the relevant health organisations which ensure that people who either do not need to go to hospital or do not need to spend so much time in hospital, are treated in a planned way, closer to home.
- Critically, where the TSAs' proposals require more ambulance transfers, there will be a need to ensure that the ambulance service is given more resource to manage the extra demand.

The TSAs have been speaking to the relevant health organisations and the ambulance service.

The work the TSAs have done in the last 75 days has produced a proposed solution that will allow 91% of patient visits to Stafford and Cannock Chase hospitals to continue in the future.

Most people who go to Stafford and Cannock Chase hospitals do so as outpatients or to have diagnostic tests. Both of these types of services will continue to be provided under the TSAs' draft recommendations and in fact these services may even be enhanced.

At the public meetings held by the TSAs at the start of the process and in the correspondence received from the public since the TSAs' appointment, questions have regularly been raised about the accuracy of the travel times presented by the Contingency Planning Team. It is important to recognise that 91% of patient visits to Stafford and Cannock Chase hospitals will continue under the TSAs' draft recommendations. However, the TSAs are revisiting the impact of their proposed solution on the travel time on the 9% of patient visits to other hospitals. The TSAs will include their analysis of this in their final report.

The National Clinical Advisory Groups (the National CAGs) that have been advising the TSAs have both confirmed that, in their opinion based on the evidence they have seen, the TSAs' draft recommendations are clinically safe and sustainable and would also improve the recruitment and retention of critical staff at MSFT.

However, these medical experts are keen to continue working with the TSAs over the coming months as both they and the TSAs recognise that there is further detailed work to be done around staffing and night time cover arrangements.

The next chapters set out in detail the TSAs' draft recommendations:

- Chapter 6 looks at how the TSAs' draft proposals will affect services at Stafford Hospital;
- Chapter 7 covers the implications for Cannock Chase Hospital;
- Chapter 8 looks at who would run Stafford and Cannock Chase hospitals in the future under the TSAs' draft recommendations;
- Chapter 9 refers to the anticipated financial consequences of the TSAs' draft recommendations; and
- Chapter 10 looks at what these proposals would mean for you and your family.

These are the draft recommendations that are subject to this public consultation and on which the TSAs are seeking your views. Further information on the TSAs' draft recommendations can be found in the draft report which is available on the TSA website at www.tsa-msft.org.uk.

At the end of the public consultation the TSAs will consider the feedback received before finalising their recommendations which will go on to Monitor and the Secretary of State for Health for approval. If approved, the TSAs expect that these recommendations would be implemented over the next two to three years, subject to the safe provision of services in the interim.

More information on the next steps of the TSA process can be found in Chapter 12.

The following tables set out clearly which services will and will not be provided at Stafford and Cannock Chase hospitals under the TSAs' recommendations. It also shows which services are not currently offered at the hospitals. An explanation of the terms used below can be found in the glossary on page 58 and 59. Further detail on what the TSAs' draft recommendations would mean for you and your family are also included in Chapter 10.

Summary of Stafford Hospital services

Services to be provided at Stafford Hospital in the future

- 14/7 consultant-led A&E
- Acute medicine inpatients
- Level 2 critical care with Level 3 stabilisation and transfer
- Pre- and post-natal care
- Surgical and medical day cases
- Some urgent minor and trauma procedures
- Short stay elective surgery
- Outpatients (medical/surgical specialities and paediatrics)
- Day case chemotherapy
- Renal dialysis*
- Diagnostics
- 14/7 paediatric assessment unit

New or enhanced serviced under the TSAs' draft recommendations

- Physician led rapid access clinics
- Step down/rehabilitation beds
- Frail and Elderly Assessment service

Services currently provided at Stafford Hospital which will not be provided in the future

- Some emergency surgery
- Some emergency trauma
- Births
- Neonatal services
- Paediatric inpatients
- Level 3 critical care

A large number of services are not currently provided at Stafford Hospital, nor will they be in the future

These include:

- Major trauma
- Some medical conditions – including stroke and heart attack

* Services currently provided at Stafford Hospital by other local providers

Summary of Cannock Chase Hospital services

Services to be provided at Cannock Chase Hospital in the future

- 16/7 minor injuries unit*
- Day case medical procedures
- GP led intermediate care beds*
- Pre- and post-natal care
- Outpatients (medical/surgical specialities)
- Diagnostics

New or enhanced serviced under the TSAs' draft recommendations

- Elective surgery for some surgical conditions
- Day case surgical procedures
- Consultant intermediate care beds

* Services currently provided at Cannock Chase Hospital by other local providers

Services currently provided at Cannock Chase Hospital which will not be provided in the future

- All current services remain

A large number of services are not currently provided at Cannock Chase Hospital, nor will they be in the future

These include:

- A&E
- Acute inpatients
- Emergency surgery and trauma
- Obstetric or midwife-led births
- Paediatrics

6 Recommendations for Stafford

Emergency and urgent care

The TSAs do not propose any changes to how the vast majority of local patients currently use the consultant-led A&E department at Stafford Hospital.

Stafford Hospital's A&E department will remain open between 8am and 10pm every day. Patients needing help overnight will continue to go to other hospitals as they do now.

The TSAs are of the view that other local hospitals may not be able to maintain safe A&E services should Stafford Hospital's A&E department close, given the additional pressure this would place on them.

The TSAs believe that the extremely difficult recruitment and retention issues currently experienced at Stafford Hospital A&E, could be much reduced by rotating senior doctors and nurses between hospitals in an agreement with a neighbouring hospital. The TSAs have been discussing with University Hospital of North Staffordshire NHS Trust (UHNS) how this could work. The TSAs are satisfied that this is a good solution to the safety issues that are caused by the recruitment problems at Mid Staffordshire NHS Foundation Trust (MSFT or the Trust) which means it has too few specialist staff to cover A&E's opening hours.

Under the TSAs' draft recommendations, ambulances will continue to take patients with signs and symptoms of stroke, some cardiac problems and major trauma to larger specialist centres such as UHNS. Patients with these signs and symptoms are not currently taken to Stafford Hospital.

The ambulance service will take patients who may need emergency surgery and very sick adults and children straight to a larger hospital. The local health providers and the ambulance service will work closely together to ensure the right patients are taken to the right place.

The TSAs agree with the leading doctors and nurses, who have been engaged during this process, that medicine is becoming increasingly specialised.

This means that it is highly likely that some patients who are currently treated at Stafford Hospital may over the course of time be better off getting treatment elsewhere to benefit from medical advances.

Recommendation 1

Stafford Hospital should continue to have a consultant-led Accident and Emergency (A&E) department between the hours of 8am and 10pm daily.

Question

How far do you support or oppose the recommendation around the Accident and Emergency (A&E) department at Stafford Hospital?


ACCIDENTS
&
EMERGENCIES
West Midlands Ambulance Service NHS
NHS Trust
EMERGENCY AMBULANCE
NHS
AMBULANCE
Ambulances are for life threatening conditions and emergencies only
Choose well and get the right treatment
Dial 999 for choking, stroke, chest pain, unconciousness and serious blood loss
Choose well.
AMBULANCE

6 Recommendations for Stafford

Inpatient services for adults

The TSAs recommend that inpatient services for adults with medical problems, currently provided at Stafford Hospital, will continue to be provided, although depending on their medical condition they might be transferred to a more appropriate specialist unit (where they can be cared for more safely).

Recommendation 2

An inpatient service for adults with medical problems will continue to be provided at Stafford Hospital for those who need to be in hospital.

Question

How far do you support or oppose the recommendation around the inpatient service for adults with medical problems at Stafford Hospital?

As well as retaining acute services for adults, the TSAs believe that health services could be better organised for older people who make up a significant proportion of the local population and whose health needs are the greatest.

More could be done to prevent many of these patients from being admitted to hospital. If local health services were provided in a more integrated way then many local people would get the kind of care they need to stay well, independent and out of hospital.

This view is in line with the stated commissioning intentions of the Stafford and Surrounds and Cannock Chase Clinical Commissioning Groups (the CCGs), who buy health services on behalf of patients. The TSAs want to see closer working between health and social care providers to make sure patients are treated in the right place, helped to stay well and to avoid unnecessary hospital admissions.

The TSAs therefore also recommend the present inpatient service for older people is developed and patients who are not very ill, but cannot cope entirely on their own at home, are assessed appropriately so they can get their treatment at home or in the community when it is safe to do so.

In addition to providing the current inpatient service for people with medical problems, under the TSAs' draft recommendations this service will be enhanced to ensure the needs of frail elderly people are met. A newly created Frail Elderly Assessment service will receive referrals from A&E, GPs, community care providers and others. Consultants specialising in medicine for older people, known as geriatricians, will run the unit by day and senior specialist nurses will take over at night. Patients will be referred to other hospitals or care providers when required.

Recommendation 3

As well as retaining the present inpatient service, a 14/7 Frail Elderly Assessment service is created to provide a one-stop assessment for older people and to take referrals from a wide range of sources. The unit should be staffed by geriatricians to ensure greater links with the community. The Frail Elderly Assessment service should have clear referral systems in place so older people get the most appropriate care.

Question

How far do you support or oppose the recommendation around a Frail Elderly Assessment service at Stafford Hospital?

The TSAs also recommend that a "step down" facility is created to allow patients who have received specialist treatment at another hospital to be transferred back to Stafford to recuperate closer to home. As many people using these step down facilities are likely to be older people, the facilities would largely be staffed by community geriatricians. This would help ensure consistency in care when the patient goes home.

Recommendation 4

Beds should be available at Stafford Hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer to home.

Question

How far do you support or oppose the recommendation that beds should be available at Stafford Hospital for recovering patients?

Question

Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around inpatient services for adults at Stafford Hospital?

6 Recommendations for Stafford

Maternity services

Approximately 1,800 babies are born at Stafford Hospital each year, making it one of the smallest consultant delivered units in the country. Leading national clinical advisors to the TSAs say this small number of births means Stafford Hospital will not be able to provide the recommended level of consultant cover to provide safe maternity services within budget in the long term.

The situation cannot be improved by getting neighbouring hospitals to rotate their staff through Stafford Hospital, as the TSAs propose for A&E services, as there are simply too few babies born in the hospital.

When the TSAs invited other health care providers to propose how they might take on the maternity services currently delivered by MSFT, for the same reason, not one offered a consultant-led maternity service at Stafford.

The TSAs therefore recommend that the service continues only until other local hospitals have the capacity to deliver a service for more pregnant women. The service should stop when other local hospitals have the capacity to deliver a service for more pregnancies. This capacity will be increased across a number of local providers to ensure patients have a choice of where they have their baby.

An alternative to this would be to have a Midwife-led Maternity Unit (MLU), however, the TSAs cannot recommend this again because of the small number of births at Stafford Hospital. Around 50% of births in Stafford would be suitable for midwife-led delivery, however, nationally collected statistics show of those women who could safely deliver at a MLU, many choose not to when given the choice. This means that a Stafford MLU would see on average less than one birth per day and the TSAs are concerned that this would be too few for the midwives to keep their skills up to date and deliver babies safely.

Whilst this safety issue could be resolved by networking with other local hospitals to safely provide an MLU in Stafford, the fact remains that the very small number of births simply makes this service too expensive to run. The TSAs have a responsibility to make proposals that are financially sustainable and this is why the TSAs recommend that no babies are to be born at Stafford Hospital in the long term.

Under the TSAs' draft recommendations pregnant women would however receive routine consultant led pre- and post-natal care at Stafford Hospital overseen by consultants from neighbouring hospitals. However, women with complications identified later on in their pregnancy or with high-risk complications would attend a larger specialist hospital. UHNS has proposed offering this service.

Recommendation 5

No babies should be born at Stafford Hospital's consultant-led delivery unit as soon as other local hospitals have the capacity to deliver a service for more pregnant women. The TSAs' plan is designed to ensure there is sufficient capacity at neighbouring hospitals so that mothers-to-be have a choice of where they have their baby.

Consultant led pre- and post-natal care should be delivered in partnership with UHNS so that local patients can still attend routine appointments at Stafford. Women will have the choice to go elsewhere if they prefer.

Question

How far do you support or oppose the recommendation around maternity services in Stafford?

6 Recommendations for Stafford

Services for children

There are currently too few consultants at Stafford Hospital to meet the safety guidelines from the Royal College of Paediatricians for an inpatient service for children. The TSAs cannot simply increase the number of consultants to solve this problem as there are not enough patients who use these services to justify this financially, nor would there be enough work for the doctors to be able to maintain their skills.

When children are so unwell they need inpatient treatment, the TSAs recommend this be provided at a larger specialist hospital where doctors see more patients and can quickly give the right treatment. Stafford Hospital will therefore no longer admit children as inpatients.

Recommendation 6

Children should no longer be admitted as inpatients to Stafford Hospital and the service should stop as soon as other local hospitals have the capacity to accept them safely. Patients should be transferred to larger specialist hospitals for appropriate inpatient care.

Question

How far do you support or oppose the recommendation around the inpatient service for children at Stafford Hospital?

Under the TSAs' draft recommendations, most children in need of urgent or emergency care will still go to Stafford Hospital to be assessed between 8am and 10pm every day, and will be seen by consultant emergency physicians in A&E.

Where the children cannot immediately be discharged by A&E and they are not very sick but they require short term monitoring, they will be assessed by the existing Paediatric Assessment Unit (PAU). Ambulances will take very sick children straight to a larger specialist hospital for treatment. If very sick children arrive at A&E by other means they will be transferred to a larger specialist hospital.

The TSAs recommend that the PAU at Stafford operates the same hours as A&E being 8am to 10pm and that it be led by specially trained nurses supported by paediatricians from University Hospital of North Staffordshire NHS Trust (UHNS), who are doctors specialising in children's care. This will allow the PAU to quickly and safely deal with many children. The TSAs have already had initial positive discussions with UHNS about this.

Recommendation 7

Children will continue to be assessed at Stafford Hospital's existing Paediatric Assessment Unit (PAU) during its present opening hours of 8am to 10pm every day. The PAU will be led by specially trained nurses who will consult with paediatricians from UHNS. Referrals will either be through A&E, GPs or other health care professionals as they are now.

Question

How far do you support or oppose the recommendation around the Paediatric Assessment Unit (PAU) at Stafford Hospital?

UHNS currently provides a Paediatric Hospital@ Home service which primarily cares for children who are discharged from hospital but who continue to need additional support at home.

The TSAs are working with the local commissioners to determine the potential for having a similar service in South Staffordshire, which will enhance the current community paediatric service already provided in the area by Staffordshire and Stoke on Trent Partnership Trust. This service helps to reduce the number of children admitted to hospital and allows some children to be treated safely and more appropriately at home.

Question

Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around services for children at Stafford Hospital?

6 Recommendations for Stafford

Major emergency surgery

The TSAs recommend patients who need major emergency surgery are treated at larger specialist hospitals with only minor procedures continuing to be performed at Stafford Hospital.

This already happens for patients with serious injuries, known as major trauma, and those requiring vascular surgery who are already taken by ambulance to University Hospital of North Staffordshire NHS Trust (UHNS).

The change means ambulances will take people who obviously need major emergency surgery direct to a larger specialist centre instead of Stafford Hospital. This will affect patients with emergency surgical needs, for example, to have an appendix removed or with bowel obstruction.

The TSAs took this decision because medical experts say the number of patients who are treated for these sorts of conditions at Stafford Hospital is too small.

To put this into perspective, there are currently only four unplanned procedures performed in theatre at Stafford Hospital each day, most of which are not major or life threatening. This is too low for it to continue because the theatre team will not be able to keep their skills up-to-date. In addition, most of the time the emergency team is not needed but to provide the service it must be staffed around-the-clock which makes it very expensive to run.

If a patient does arrive at A&E and is in need of surgery, or if a patient is already at Stafford Hospital and requires surgery, Stafford Hospital will provide diagnostic services and consultants at Stafford will consult surgeons at UHNS about the patient's needs. The patient will then either undergo a minor surgical procedure at Stafford Hospital or, if needed, the patient will be stabilised and transferred to UHNS. This model of care is regarded as acceptable by the Royal College of Surgeons and the Royal College of Physicians. There are different proposals for services that affect emergency treatment of very young and older people and pregnant women who need emergency or urgent hospital treatment. See pages 26-30 to find out more about how these services are affected by the TSAs' draft recommendations.

Recommendation 8

Major emergency surgery should no longer be carried out at Stafford Hospital with the exception of minor surgical procedures which can be dealt with by A&E or where the patient can be stabilised by A&E and scheduled to return to Stafford Hospital for minor surgery. Most major emergency surgery would instead be provided by a local larger hospital such as UHNS or The Royal Wolverhampton Hospitals NHS Trust. The TSAs have already had initial positive discussions with UHNS about this.

This means there will no longer be a surgical assessment unit on-site. A&E consultants at Stafford Hospital will be able to consult surgeons remotely at larger hospitals about patients' surgical needs. Patients would then be transferred to another hospital for surgery where required.

Question

How far do you support or oppose the recommendation around major emergency surgery at Stafford Hospital?

6 Recommendations for Stafford

Critical care

Critical care is a service which provides close monitoring and support for very sick patients. Under the TSAs' draft recommendations there will be a change in the need for critical care at Stafford as major emergency surgery would no longer be provided at Stafford but instead performed at University Hospital of North Staffordshire NHS Trust (UHNS).

Some critical care will, however, need to remain at Stafford Hospital to support very ill patients who arrive at A&E or inpatients that become very unwell. This will include a high dependency area and the 24-hour, daily presence of anaesthetists who could intubate patients and supervise their ventilation prior to transfer to UHNS.

This model of critical care would allow patients who require a short period of intensive care to be treated at Stafford Hospital. However, very unwell patients who need this type of care for more than a few hours would be stabilised and then transferred to a larger specialist hospital.

This approach is already successfully used across England to transfer sick children to regional centres. The TSAs recommend that a similar system of stabilisation and urgent transfer to a larger specialist hospital be used for adult patients. The TSAs have already had initial discussions with the ambulance service about how patients could be safely and effectively transferred in this way.

The specialist staff currently employed in critical care should be integrated into a network which means they will be rotated with other staff in neighbouring hospitals to ensure that they get enough experience day to day of patients to keep their skills up to date. The TSAs have already had initial positive discussions with UHNS on this and this approach is strongly recommended by the National Clinical Advisory Groups (the National CAGs).

Recommendation 9

A small critical care area should be retained at Stafford Hospital so that very ill patients who come to A&E or inpatients who become very unwell can be kept stable prior to urgent transfer to a larger specialist hospital.

Current staff on the critical care unit should work as part of a clinical network established with a neighbouring hospital. UHNS has proposed offering these services and the specialist staff to network with Stafford.

An urgent transfer service should be established for very ill adults which is the same as the approach already used successfully across England to transfer sick children to regional centres.

Question

How far do you support or oppose the recommendation around the critical care unit at Stafford Hospital?


Lloyds TSB

6 Recommendations for Stafford

Elective care and day cases

Elective care is the term used to describe care which is planned, for example, most surgical operations. Day cases are examples of planned care when the inpatient treatment is completed within a day. Hospitals can plan for this type of care as they know what the problem is and the treatment that is required in advance. This allows the hospital to make best use of its resources, such as operating theatres and other facilities.

Elective surgery

Elective surgical procedures are carried out by a range of different surgical specialists. At Stafford, under the TSAs' draft recommendations elective surgery would include orthopaedic, ENT, oral and maxillofacial and plastic surgery operations. University Hospital of North Staffordshire NHS Trust (UHNS) has proposed delivering these services from Stafford Hospital. All other specialities will be provided at UHNS for Stafford residents unless they choose an alternative provider.

The TSAs recommend that Stafford patients have their orthopaedic operations nearer to their homes in Stafford Hospital following discussions with UHNS. Orthopaedic operations for Stafford residents are currently provided at Cannock Chase Hospital.

Day case services, including general surgery, orthopaedics, urology, gynaecology and oral surgery will also continue to be available at Stafford Hospital.

Medical treatment

Patients with a range of medical conditions requiring elective care may be offered treatment on a day case basis, for example, chemotherapy for patients with cancer and endoscopy.

The TSAs recommend that day case medical treatment such as endoscopy and other services remain at Stafford Hospital.

Recommendation 10

Elective care and day cases should remain in Stafford. This would include orthopaedic surgery.

Question

How far do you support or oppose the recommendation around elective care and day cases at Stafford Hospital?


GUILDHALL
SHOPPING CENTRE
Stafford
Market
Stafford
BOROUGH COUNCIL

7 Recommendations for Cannock

The TSAs recommend existing services that are currently provided at Cannock Chase Hospital continue to be provided at the site and that the range of services be extended where possible. Discussions continue with the National Clinical Advisory Groups (the National CAGs) about the level of overnight staff cover required. This will be confirmed before the range of services is extended.

The local commissioners say that the TSAs' draft recommendations must include Location Specific Services (LSS) for Cannock for the long term. The LSS for Cannock are defined as outpatient services including pre- and post-natal care and patient facing diagnostics. More information on LSS can be found on page 16.

The TSAs' draft recommendations in addition to the LSS for Cannock are based around three broad areas:

- step down care and rehabilitation (patients who have received treatment at another local hospital to be transferred back to Cannock Chase Hospital);
- elective inpatient surgery (non-emergency operations that can be planned in advance); and
- day cases (surgical and medical hospital treatment provided without an overnight stay).

The TSAs acknowledge that, over time, the delivery of health services evolves and must change to meet patients' needs as defined by the CCGs.

Whilst the TSAs are looking at ways to increase the services currently provided at Cannock Chase Hospital, given the size of the building, it remains a possibility that the hospital buildings will still not be 100% used and the TSAs may have to consider how to use the extra space.

It is also important to recognise that Cannock residents currently use a range of services at Stafford Hospital. This section also highlights how recommendations for Stafford Hospital in previous chapters affect Cannock patients.

There are a range of services currently provided in Cannock, by providers other than Mid Staffordshire NHS Foundation Trust (MSFT or the Trust). These services include the Minor Injuries Unit (MIU) and the intermediate care service (Littleton Ward). The TSAs' draft recommendations will not affect these services.

Emergency and urgent care for the population of Cannock Chase

Cannock patients with minor injuries will continue, as they do now, to go to the MIU at Cannock Chase Hospital, which is open between 8am and midnight every day.

Patients with more serious health emergencies will not always be taken to Stafford Hospital. Ambulances will sometimes instead go to The Royal Wolverhampton Hospitals NHS Trust (RWT) or Walsall Healthcare NHS Trust A&E departments.

The exact nature of the emergencies that would go to hospitals other than Stafford will need to be agreed between the hospitals and the ambulance service. It would also depend on where in Cannock the patient is taken ill or injured.

Step down care and rehabilitation

The TSAs recommend that a step down and rehabilitation facility is created to allow patients who have received specialist treatment at another hospital to be transferred back to Cannock Chase Hospital to recuperate closer to home.

The TSAs want to see closer working between health and social care providers to make sure patients are treated in the right place, helped to stay well and to avoid unnecessary hospital admissions.

This view is in line with the stated commissioning intentions of the local CCGs who intend to commission fewer services from hospitals and aim to transfer more care nearer to or in patients' homes.

Recommendation 11

Beds should be available at Cannock Chase Hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer to home.

Question

How far do you support or oppose the recommendation that beds should be available at Cannock Chase Hospital for recovering patients?

Elective inpatient surgery

Elective inpatient surgery means planned operations that involve an overnight stay for one or more days. There are many different types of surgical procedures that can be described in this way.

The TSAs recommend that these types of procedures carry on at Cannock Chase Hospital.

Patients from Cannock and Stafford requiring orthopaedic surgery, which is typically a procedure involving bones and joints, are presently treated at Cannock Chase Hospital.

The TSAs recommend that Stafford patients have their orthopaedic operations nearer to their homes in Stafford Hospital following discussions with University Hospital of North Staffordshire NHS Trust (UHNS) which has proposed delivering services for Stafford Hospital.

However, one of the hospitals proposing to provide services at Cannock Chase Hospital has also proposed increasing the scope of elective inpatient surgery, including orthopaedics, for patients in and south of Cannock. This proposal is under review.

The TSAs recommend spare operating theatre time may be used for other types of surgery.

At Cannock, under the TSAs' draft recommendations, an enhanced range of elective surgery such as general surgery, breast surgery, urology and gynaecology could be provided. Where there is a choice of locations to receive treatment, patients and GPs will, as now, have a choice of where to go. This is likely to be influenced by where the patients live.

Recommendation 12

Elective surgery is retained at Cannock Chase Hospital. There should be new surgical specialities introduced, enhancing the current range of elective inpatient services for Cannock patients. This recommendation assumes that the ongoing discussions with the National CAGs regarding safe overnight staff cover can be successfully resolved.

Question

How far do you support or oppose the recommendation around elective inpatient surgery at Cannock Chase Hospital?

Day cases (surgical and medical)

Advances in medicine mean that more planned procedures can be carried out in a day or less which means patients don't need to stay overnight.

The TSAs recommend Cannock Chase Hospital continues to offer this service for patients needing surgical and medical treatment, including rheumatology, as it does now.

It is possible that the range of conditions that can be treated on a day case basis at Cannock Chase may increase. Current discussions with RWT indicate that general surgery, breast surgery, urology, ENT, orthopaedics, dermatology, plastic surgery and gynaecology could be provided at Cannock Chase Hospital.

Recommendation 13

The current range of day case procedures (surgical and medical), including rheumatology services, should continue at Cannock Chase Hospital and the range be increased where possible.

Question

How far do you support or oppose the recommendation around day case procedures at Cannock Chase Hospital?

8 Who runs Stafford and Cannock Chase hospitals in the future?

The TSAs have endeavoured to make Stafford and Cannock Chase hospitals the places where most people go to get treatment wherever possible. However, as part of the TSAs' draft recommendations some services would move to other larger hospitals.

To enable this all to happen in a clinically and financially sustainable way, the hospitals' current services must operate as part of a "clinical network" with other local hospitals and social care providers. This is central to the TSAs' draft recommendations.

It is vital for the future safety of the services operated out of the hospitals that staff are rotated as part of a clinical network. This resolves a major problem common to many services provided at Mid Staffordshire NHS Foundation Trust (MSFT or the Trust): there are insufficient patient numbers to keep specialist doctors' and nurses' skills up to date and it is difficult to provide enough specialist consultants to give round-the-clock cover.

Networking also means health services can be reorganised to meet patients' needs more effectively as the TSAs recommend close formal working between all local health and social care providers to give patients better care. For example, this is the way the Frail Elderly Assessment service will work (see pages 26 and 27).

To allow for the TSAs' draft recommendations to work in a way that does not negatively impact the safety of services at other hospitals or their financial position, it is proposed that MSFT as an organisation be dissolved. This means that whilst Stafford and Cannock Chase hospitals will remain open they will no longer be operated by MSFT.

The most obvious outward sign to patients will be a change of the "name over the door" at both hospitals to indicate which trust operates the services.

Recommendation 14

To allow for the TSAs' draft recommendations to work in a way that does not negatively impact the safety at other hospitals or their financial position, it is recommended that MSFT as an organisation be dissolved.

Question

How far do you support or oppose the recommendation for MSFT to be dissolved, with the services at Stafford and Cannock Chase hospitals managed and delivered by another organisation or organisations in the future?

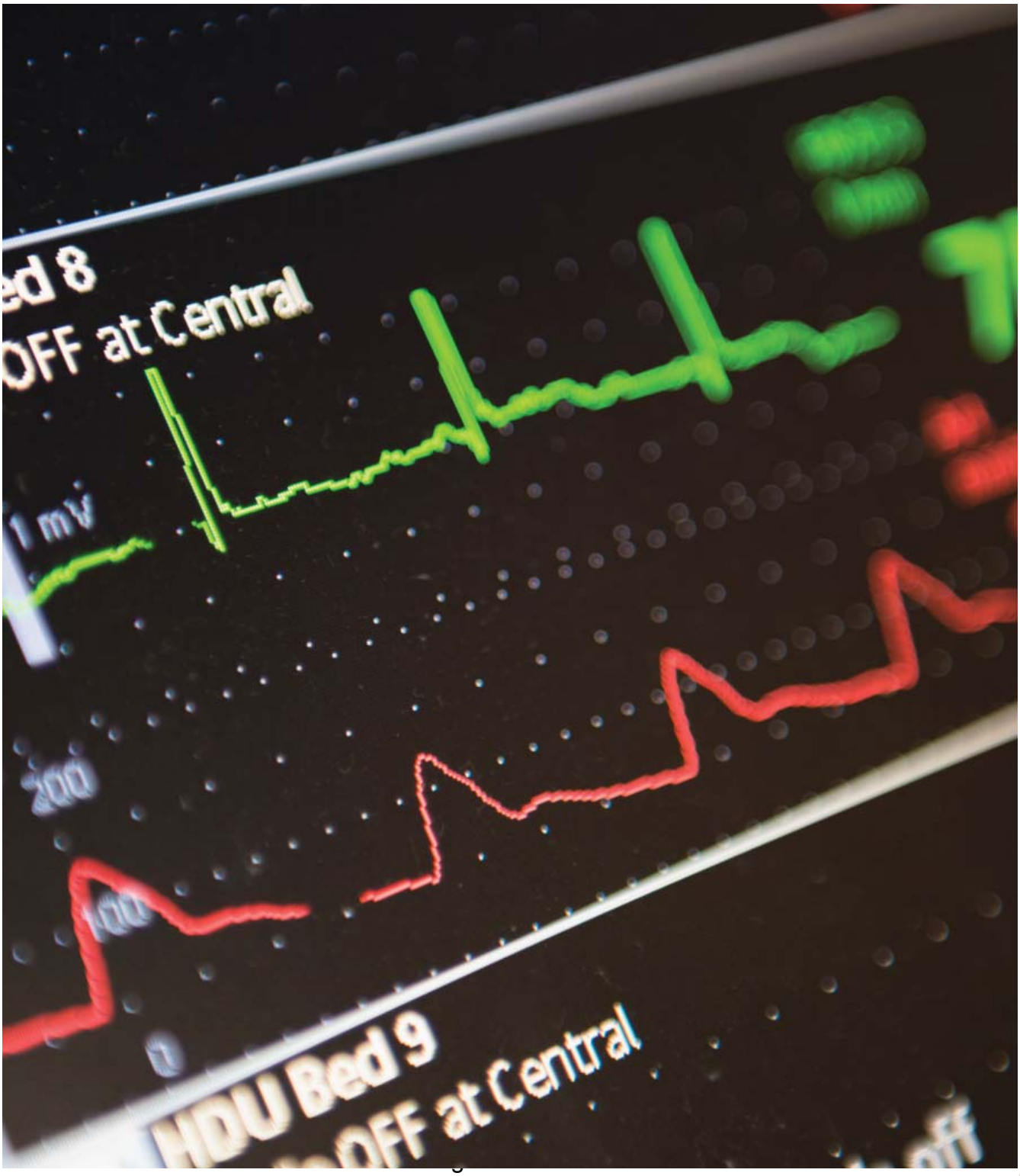
The discussions that the TSAs have had so far with other local trusts and through the market engagement exercise show it is likely each of the hospitals will be run by different organisations. Although nothing has been decided based on the TSAs' engagement with providers to date, it is unlikely that one trust or organisation will wish to run the services on both sites.

Together, the proposals put forward by University Hospital of North Staffordshire NHS Trust (UHNS), which proposes running Stafford Hospital, and The Royal Wolverhampton Hospitals NHS Trust (RWT), which proposes running Cannock Chase Hospital, offer the widest range of services to be run locally. This is why the TSAs have opted for this combination on which to base their draft recommendations, however,

discussions continue with other health providers, including Walsall Healthcare NHS Trust in particular.

Any final recommendations approved by the Secretary of State for Health involving UHNS or RWT may require the integration of some parts of MSFT, UHNS or RWT. Further work and discussions are required not only with UHNS and RWT but also other local providers, the relevant health organisations and local commissioners to further progress this solution. Information about other stakeholders who may be consulted is included in the draft report.

The TSAs expect to be able to include more information in their final report on when MSFT will be dissolved and who would provide the services at Stafford and Cannock Chase hospitals. For further details about the timeline and next steps, please see Chapter 12.



9 Financial implications of the TSAs' draft recommendations

Good patient care depends upon the effective and efficient use of the limited money available to the NHS to spend.

Chapter 2 sets out Mid Staffordshire NHS Foundation Trust's (MSFT or the Trust) financial problems and why change is essential to ensure patients get the best care possible within the budget available.

At present the Trust costs far too much to run compared to the income it receives. Forecasting shows its anticipated day to day running costs will result in an overspend of £20m in the year to 31 March 2014. If capital costs, such as equipment, are included the funding needed increases to over £36m.

Carrying out the TSAs' recommendations, set out in Chapters 6, 7 and 8, coupled with improving the efficiency of the hospitals, could reduce this overspend considerably.

In addition, substantial cost savings will be achieved if MSFT no longer exists as an organisation and Stafford and Cannock Chase hospitals are run by other trusts. This is because this will enable a reduction in the management and back office functions which are currently undertaken at MSFT, therefore allowing savings to be made. Further information on who might run Stafford and Cannock Chase hospitals in the future can be found in Chapter 8.

The TSAs anticipate that their recommendations would be implemented over a transition period of two to three years from the current situation to the position once the draft recommendations have been agreed and implemented.

The chart on the page opposite illustrates how the £20.2m anticipated overspend could be reduced during this transition period.

The **purple** coloured bar shows the anticipated overspend of £20.2m for 2013/14.

The **blue** coloured bar shows a total of £40.8m of measures that will improve the financial position within two to three years.

The **orange** coloured bar shows a total of £29.1m of additional costs which will worsen the financial position during the next two to three years.

The **brown** coloured bar shows the anticipated overspend of £8.5m for the year to 31 March 2018, the first full year of the TSAs' proposals. However, this may be reduced if the TSAs are able, working in conjunction with other local trusts and commissioners, to make further improvements, either during the transition period or afterwards.

This chapter describes the measures that could improve the financial position, the additional costs which may worsen the financial position and the remaining issues still being discussed with local trusts and the Stafford and Surrounds and Cannock Chase Clinical Commissioning Groups (the CCGs) which may reduce the overspend to zero within the next few years.

Ways to improve finances

The TSAs have looked at a range of savings which come from either reducing costs or improving the way in which services are delivered to patients. The TSAs have used the vast experience of their team and the work they have done across the NHS, to estimate per annum savings in a number of different categories.

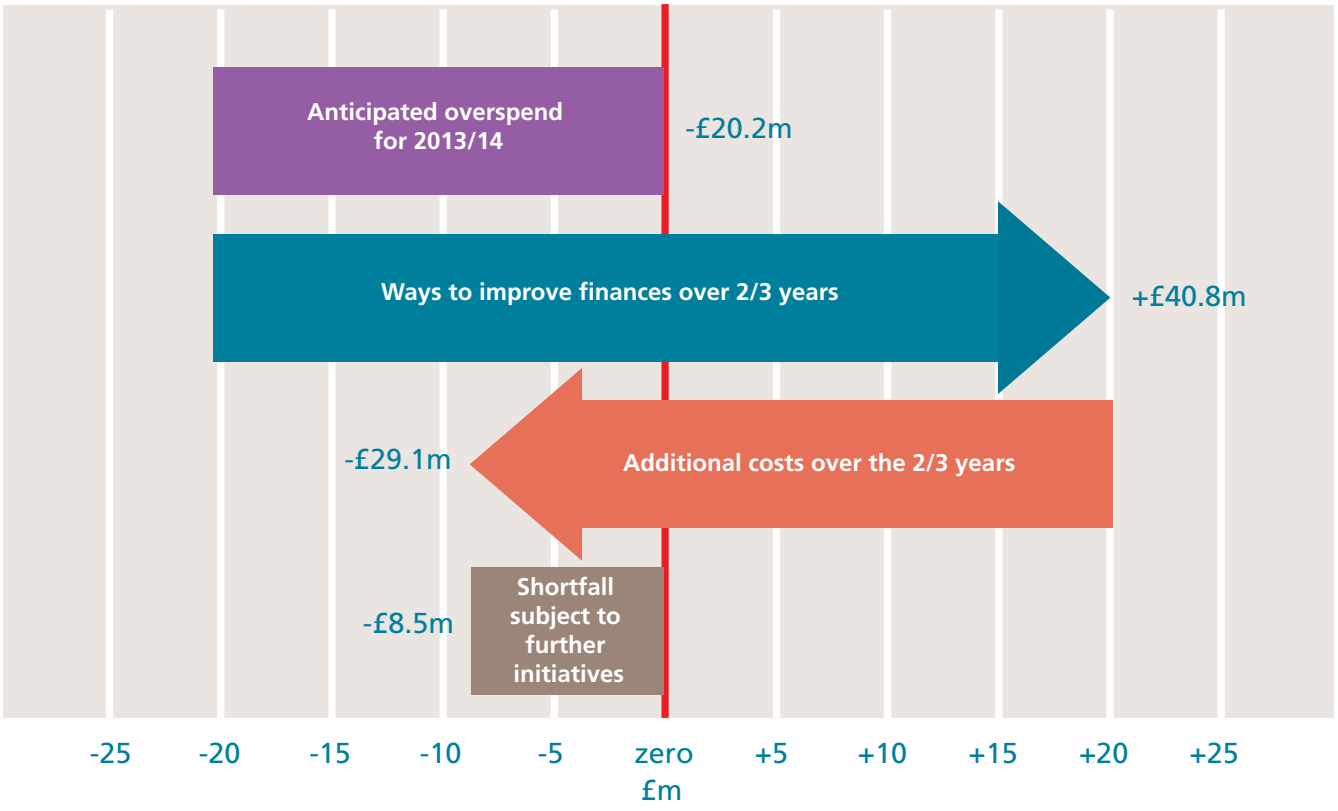
- Over £11.6m can be saved each year by reducing executive management and back office functions as a result of carrying out the TSAs' proposals and reducing the

general level of overheads to the NHS average. MSFT's current level of costs are 18% above average.

- £8.6m can be saved from a combination of a reduction in various clinical and ward costs that will no longer be required if the TSAs' draft recommendations are approved and there is a significant increase in the level of collaboration with other major local providers such as University Hospital of North Staffordshire NHS Trust (UHNS), The Royal Wolverhampton Hospitals NHS Trust (RWT) or Walsall Healthcare NHS Trust. Additionally the local providers, the TSAs and the CCGs believe the TSAs' draft recommendations will in effect reduce the time that people need to spend in hospital therefore decreasing the number of beds currently used at UHNS, RWT, Stafford and Cannock Chase.
- £6.2m can be saved from staff and non-staff services. Closer networking with other local hospitals will reduce Stafford and Cannock Chase hospitals' need for high numbers of temporary staff and correct the balance of senior posts to more junior posts.
- £4.0m can be saved by reducing surplus space at both hospitals. It could be rented out or returned to the Secretary of State for Health.
- The TSAs also estimate a further £10.4m of general cost improvements, such as more bulk purchasing, can be achieved during the transition. This is in line with savings expected of all NHS trusts.

Overall these performance improvements and cost savings which include the financial benefits of MSFT no longer existing as an organisation, total £40.8m and equate to approximately 8.5% savings/improvements per year. The TSAs believe this is achievable and would bring the running costs of Stafford and Cannock Chase hospitals in line with the national average.

Financial impact of the TSAs' draft recommendations



Additional costs

The TSAs' proposals will have significant clinical and financial beneficial effects, but there are some additional costs directly arising:

- In order to be ready for all the changes that the TSAs propose, there will be additional costs for building, equipment and a backlog of maintenance. Some of this money will be spent at other local hospitals to enable them to be part of the TSAs' solution. The rest will fund work at both the Stafford and Cannock Chase sites. The implications of this are an extra allowance which has been included to cover wear and tear on this new capital expenditure and the cost of borrowing these funds, which will total approximately £10.5m.
- Inflation affects the NHS in the same way as every other organisation. The TSAs know MSFT's costs will increase over the next two or three years with drug and other costs usually exceeding general inflation trends; prices are generally rising by an average of 4% per year. But the likelihood is MSFT's revenues will go down in the same period. The rates all NHS hospitals are paid for providing certain services are scheduled to fall in the same period. The combined impact of these two factors is estimated at £17.4m.
- The TSAs recommend some services are no longer provided at Stafford Hospital and are in future provided by nearby hospitals. This has led to discussions with the ambulance service about increasing their capacity to ensure that people can get to hospitals quickly in an emergency. This is forecast to cost a further £1.2m per year.

These additional costs created under the TSAs' draft recommendations total £29.1m.

After taking account of the anticipated shortfall of £20.2m and the factors above, the TSAs believe the shortfall at Stafford and Cannock Chase hospitals at the end of three years would be £8.5m.

However, there are still points for discussions between the TSAs, other local hospitals and the CCGs which may reduce this overspend further, hopefully to zero.

The TSAs expect to be in a better position to say how they can further reduce the £8.5m by the time the final report is submitted to Monitor in October 2013.

The areas for further possible savings/improvements are set out below:

- The TSAs are talking to the local trusts to see if there are ways of reducing the bill for additional building, equipment and refurbishment costs at their hospitals as well as at the Stafford and Cannock Chase sites.
- The TSAs and local hospitals are talking to the local CCGs about further ways of appropriately shortening the time people need to be in hospital and, as importantly, finding ways of helping people to avoid going to hospital in the first place. This is a commitment across the NHS. Modern medical thinking is that this is better for the majority of patients and will ensure hospitals are used more effectively to treat those who are very ill.
- The TSAs working with local trusts to achieve further cost improvements, above and beyond those which have been previously referred to.
- The TSAs are looking at whether it is possible, in conjunction with other local trusts and organisations, to use even more space positively at Cannock. Other discussions are going on in parallel to see if there are other ways of using the space and generating more income if local trusts do not need to use all of the space.

Conclusion

The TSAs believe their recommendations provide an opportunity to significantly reduce the overspend at the Stafford and Cannock Chase sites and provide the opportunity for further savings/improvements to reduce this overspend to zero.

10 What would these proposals mean for you and your family?

Most people visit Stafford and Cannock Chase hospitals as outpatients or to have diagnostic tests. The TSAs' draft recommendations do not affect these services and in fact 91% of all current patient visits to Stafford and Cannock Chase hospitals will continue in the future. Further detail on the TSAs' draft recommendations can be found in Chapters 6 and 7.

The tables below set out a selection of the most commonly used services at Stafford and Cannock Chase hospitals and detail, in the majority of occasions, what will happen to those services under the TSAs' draft recommendations, allowing you to see what these recommendations mean for you and those who currently use the hospitals. Where there is a choice of locations to receive treatment, patients will, as now, have a choice of where to go.

Services for patients in the Stafford area

✓ **Services provided at Stafford Hospital**

	Current provision	Provision under the TSAs' draft recommendations
Ante-natal (women seen before the birth of their babies)	✓	✓
Asthma	✓	✓
Audiology	✓	✓
Back pain	✓	✓
Bariatric surgery	Specialist centre	Specialist centre
Below knee amputation	UHNS	UHNS
Bleeding in early pregnancy	✓	✓
Blood tests	✓	✓
Bowel surgery	✓	✓
Brain surgery	Specialist centre	Specialist centre
Breast screening	✓	✓
Breast surgery	✓	✓
Broken ankle	✓	✓
Bronchoscopy	✓	✓
Caring for new born babies/special care baby unit	✓	UHNS
Cataract	Cannock Chase Hospital	✓
Chest infection	✓	✓

	Current provision	Provision under the TSAs' draft recommendations
Child assessment unit	✓	✓
Child inpatient admission	✓	UHNS
Colonoscopy	✓	✓
Complicated skin diseases	✓	✓
CT scan	✓	✓
Cuts	✓	✓
Cystoscopy	✓	✓
Dehydrated elderly patients	✓	✓
Deliveries of babies	✓	UHNS
Diabetic patient with a hypo	✓	✓
Diabetic ulcer	✓	✓
DVT (formation of a blood clot in a deep vein)	✓	✓
Ectopic pregnancy	✓	UHNS
Epileptic fit/seizure	✓	✓
Fracture clinics	✓	✓
Gallstones removal	✓	✓
Gastroscopy	✓	✓
Gynaecological surgery	✓	✓
Health check for new babies	✓	✓
Heart attack	UHNS	UHNS
Hernia repair	✓	✓
Hip fracture (broken hip)	✓	UHNS
Hip replacement	Cannock Chase Hospital	✓
Home deliveries	✓	✓
Hysteroscopy	✓	✓
Investigation of anaemia	✓	✓
IVF	Specialist centre	Specialist centre
Kidney stones	UHNS	UHNS
Knee replacement	Cannock Chase Hospital	✓
Liver transplant	Specialist centre	Specialist centre
Lumps, bumps and cysts (minor surgery)	✓	✓
Minor abdominal pain	✓	✓
Minor head injuries	✓	✓

	Current provision	Provision under the TSAs' draft recommendations
Minor injuries	✓	✓
MRI	Cannock Chase Hospital	Cannock Chase Hospital
Neuro surgery	Specialist centre	Specialist centre
Oral surgery	✓	✓
Outpatient clinics	✓	✓
Pain clinic	✓	✓
Pancreatic cancer (surgery)	UHNS	UHNS
Plastic surgery	✓	✓
Pneumonia	✓	✓
Post-natal (women seen after the birth of their babies)	✓	✓
Rehabilitation and postoperative care	✓	✓
Renal dialysis	✓	✓
Self poisoning	✓	✓
Serious allergies	✓	✓
Shoulder surgery	Cannock Chase Hospital	✓
Simple fracture of arm	✓	✓
Spinal surgery	UHNS	UHNS
Sprains and strains	✓	✓
Stomach cancer (surgery)	UHNS	UHNS
Stroke	UHNS	UHNS
Sudden worsening of bronchitis	✓	✓
Suddenly confused elderly people	✓	✓
Suspected meningitis	UHNS	UHNS
Throat and nose procedures	✓	✓
Thyroid procedures	✓	✓
Ultrasond scan	✓	✓
Urinary tract infection	✓	✓
Xray	✓	✓

It is assumed that complex procedures are currently performed at other local hospitals.

Services for patients in the Cannock area

✓ **Services provided at Cannock Chase Hospital**

	Current provision	Provision under the TSAs' draft recommendations
Ante-natal (women seen before the birth of their babies)	✓	✓
Back pain	✓	✓
Bariatric surgery	Specialist centre	Specialist centre
Below knee amputation	UHNS	UHNS
Blood tests	✓	✓
Brain surgery	Specialist centre	Specialist centre
Breast screening	✓	✓
Breast surgery	Stafford Hospital	✓
Caring for new born babies/special care baby unit	RWT/WHT	RWT/WHT
Cataract	✓	✓
Child admission	Stafford Hospital	RWT
Colonoscopy	Stafford Hospital	✓
Complicated skin diseases	✓	✓
CT scan	✓	✓
Cuts	✓	✓
Cystoscopy	Stafford Hospital	✓
Deliveries of babies	Stafford Hospital	RWT/WHT/other provider
Ectopic pregnancy	Stafford Hospital	RWT/WHT/other provider
Gallstones removal	Stafford Hospital	✓
Gastroscopy	Stafford Hospital	✓
Gynaecological surgery	Stafford Hospital	✓
Heart attack	RWT	RWT
Hernia repair	Stafford Hospital	✓
Hip fracture (broken hip)	Stafford Hospital	RWT/WHT/other provider
Hip replacement	✓	✓
Home deliveries check	✓	✓
IVF	Specialist centre	Specialist centre
Kidney stones	RWT/WHT/Stafford Hospital	Cannock Chase Hospital/ RWT/WHT
Knee replacement	✓	✓
Liver transplant	Specialist centre	Specialist centre
Lumps, bumps and cysts	Stafford Hospital	✓

	Current provision	Provision under the TSAs' draft recommendations
Major stroke	RWT	RWT
Minor injuries	✓	✓
MRI	✓	✓
Neuro surgery	Specialist centre	Specialist centre
Ophthalmology	✓	✓
Outpatient clinics	✓	✓
Pain clinic	Stafford Hospital	✓
Pancreatic cancer (surgery)	UHNS	UHNS
Plastic surgery	Stafford Hospital	✓
Post-natal care	✓	✓
Post-natal (women seen after the birth of their babies)	✓	✓
Rehab and postoperative care	✓	✓
Renal dialysis	✓	✓
Sexual health	✓	✓
Shoulder surgery	✓	✓
Spinal surgery	UHNS	UHNS
Sprains and strains	✓	✓
Stomach cancer (surgery)	UHNS	UHNS
Suspected meningitis	RWT/WHT	RWT/WHT
Ultrasond scan	✓	✓
Xray	✓	✓

It is assumed that complex procedures are currently performed at other local hospitals.


Mid Staffordshire NHS
NHS Foundation Trust
Cannock Chase Hospital
Main Entrance - Level 2
Level 1 Entrance
Minor Injury Unit
This Hospital does not have an Accident and Emergency Department
The Nearest A & E Department is at Stafford Hospital,
Weston Road, Stafford, Tel 01785 257731

11 Having your say

Your views are extremely important and the TSAs are keen to hear from as many people, groups and stakeholders as possible. If you need help with reading this document in your first language or an alternative format, you can contact the TSAs using the details below.

The TSAs will be working with groups in your communities to involve people whose views are not always heard, for example, groups representing particular individuals such as older people or those representing people with a particular health condition.

Below are the key ways in which you can find out more, get involved and tell the TSAs what you think.

Response form

Please use the printed response form, available from Tuesday 6 August 2013, to give the TSAs your views on the draft recommendations set out in this document.

You can request a printed response form and Freepost envelope via freephone (0800 408 6399) or email (TSAconsultation@midstaffs.nhs.uk).

Alternatively, from Tuesday 6 August 2013 you can complete the response form online via the TSA website at www.tsa-msft.org.uk.

Public meetings

Public meetings are being held to enable anyone with an interest to find out more about the draft recommendations, ask questions and provide their views. Details of the public meetings can be found on the TSA website at www.tsa-msft.org.uk and have been advertised locally.

Patient and public representative groups

The TSAs will be meeting and working with patient and public representative groups such as Engaging Communities Staffordshire. You may wish to submit your feedback via these groups.

Deadline

To ensure your views are considered the TSAs must receive your response form by no later than midnight on **Tuesday 1 October 2013**. A second-class Freepost envelope is provided with printed consultation documents, so please ensure you post it in plenty of time. Responses received after **midnight on Tuesday 1 October 2013** will be too late to be accepted or considered.

Feedback analysis

Ipsos MORI, an independent research organisation, will collect and analyse all the responses to this consultation, including response forms and feedback given at public meetings. The findings will help the TSAs to form their final recommendations to Monitor and the Secretary of State for Health.

Further information

If you have any queries about how to complete the response form, questions about the consultation or would like to request additional copies or alternative versions of this document, please contact the TSAs on:

- Freephone: 0800 408 6399
- E-mail: TSAconsultation@midstaffs.nhs.uk

12 Next steps

This consultation closes at **midnight on Tuesday 1 October 2013**. To ensure your views are considered we must receive your response form before then.

The TSAs then have 15 working days to review the feedback received and to develop their final recommendations.

These final recommendations will be set out in the TSAs' final report which will be submitted to Monitor, the health care regulator, by **Tuesday 22 October 2013**.

The final report is then put forward to the Secretary of State for Health who will make a decision by **Tuesday 31 December 2013** on the TSAs' recommendations about the future of services for local people who use Stafford and Cannock Chase hospitals.

Ipsos MORI, an independent research organisation, will also prepare a report analysing the feedback received during the consultation. This will be published alongside the TSAs' final recommendations.

The Trust Special Administration timeline

Day 1	**Tuesday 16 April 2013** Appointment of the TSAs takes effect
Within 75 working days*	**Wednesday 31 July 2013** Publication of the TSAs' draft recommendations
Within 5 working days	**Tuesday 6 August 2013** The formal consultation process on the TSAs' draft recommendations begins
40 working days*	**Tuesday 1 October 2013** The formal consultation process on the TSAs' draft recommendations ends
Within 15 working days	The finalised report on the TSAs' recommendations is sent to Monitor
Within 20 working days	The final report is reviewed by Monitor and submitted to the Secretary of State
Within 30 working days	The Secretary of State decides on what action is to be taken

*On 19 June 2013 Monitor granted an extension of 30 working days for the publication of the TSAs' draft recommendations and an extension of 10 working days to the public consultation period

Glossary of terms

14/7	Fourteen hours a day, seven days a week
16/7	Sixteen hours a day, seven days a week
A&E	Accident and emergency is a service available for people who require treatment for medical emergencies
Acute	Conditions and illnesses with short durations and rapid onsets
Anaesthetist	Medical professional specialising in the administration of anaesthetics
Ante- and post-natal care	Maternity services before and after birth
CAG	A national clinical advisory group, set up by the TSAs and jointly chaired by the Academy of Medical Royal Colleges. The group uses their knowledge of their respective Royal College guidelines for safe care to advise on the proposed solutions including the issue of recruitment and retention of key staff, which is a particular problem for MSFT
Chemotherapy	Delivery of cancer drugs
Clinical Commissioning Groups (CCGs)/Commissioners	The buyers of hospital services
Clinical network	Operation of services together with other local hospitals and social care providers
Clinical reference group	A local group of senior doctors from local hospitals and local commissioners
Clinically sustainable	The ability to provide good quality, safe services for patients for the foreseeable future. The TSAs were asked to consider the next ten years
The CQC	The Care Quality Commission, the regulator of all health and social care services in England
Commissioning intentions	The CCGs' plan how they will buy services for the future. They take into consideration the make-up of the population they serve and any particular characteristics, such as the number of older people, prevalent health problems and advances in how or where treatments are best administered
Community Geriatricians	Medical professionals who provide care to older individuals covering the period before a medical crisis which may or may not result in an admission to hospital and after a medical crisis
Community hospitals	A local hospital providing healthcare services
The Contingency Planning Team	The team who undertook an assessment on the MSFT's future in 2012/13 on behalf of Monitor
Critical care	Provision of constant, close monitoring and support from equipment and medication to keep normal body functions going
Day case	Where the inpatient treatment is completed within the day
Dermatology	Medical conditions relating to the skin
Diagnostic services	Services which support the diagnosis of disease or injury ie, x-ray
Elective care	Care which is planned for, for example, most operations
Endoscopy	Visual examination of the internal body
ENT	Medical conditions relating to the ear, nose or throat
EY	A major consultancy firm at which Alan Bloom and Alan Hudson are senior partners
Financial sustainability	The ability of a hospital to balance its books for the foreseeable future
Geriatricians	Doctors specialising in the care of the elderly
GP	General Practitioner
Gynaecology	Medical conditions, usually of the genitourinary tract, relating to women
Inpatients	Patients admitted to hospital and stay at least one night
Intubate	Insertion of a tube through the mouth or the nose and into a patient's lungs to help them breathe

Ipsos MORI	An independent research organisation who will collect and analyse all of the responses to this consultation, including response forms and feedback given at public meetings
Level 1 critical care	Patients recently discharged from a higher level of care or needing additional monitoring or clinical support
Level 2 critical care	Patients receiving basic single organ support or requiring extended pre or post operative support
Level 3 critical care	Patients requiring advanced respiratory or multi organ support
Local people	Individuals who live within the Stafford and Surrounds CCG and Cannock Chase CCG catchment areas
Location Specific Services (LSS)	The minimum services which must be provided locally as determined by the Stafford and Surrounds and Cannock Chase CCGs
Market engagement exercise	A process undertaken by the TSAs allowing any healthcare provider, including other hospitals, to propose a solution for delivering the services currently provided by Stafford and Cannock Chase hospitals
Maternity services	Services provided to women in the run up to, during and shortly after pregnancy
MIU	Minor Injuries Unit
MLU	Midwife-led Maternity Unit
Monitor	The health care regulator who appointed the TSAs on 16 April 2013 following its decision to use its powers to intervene at MSFT
MSFT or the Trust	Mid Staffordshire NHS Foundation Trust, the organisation which runs Stafford and Cannock Chase hospitals
The National CAGs	The Clinical Advisory Group (CAG) and the Nursing and Midwifery Advisory Group
Nursing and Midwifery Advisory Group	A national group made up of senior nurses in the NHS set up by the TSAs. The group uses their knowledge of their respective Royal College guidelines for safe care to advise on the proposed solutions including the issue of recruitment and retention of key staff, which is a particular problem for MSFT
Obstetrics	Medicine relating to childbirth and midwifery
Oral and maxillofacial	Medical conditions related to the head, neck, face and jaws
Orthopaedic	Medicine relating to bones and muscles
Outpatients	Someone who attends a hospital or clinic to see a consultant or health professional for treatment that does not require an overnight stay
Paediatrics	Medicine relating to children
Paediatrics@home	A team of specially trained nurses who will make sure that children's conditions are satisfactorily resolved once sent home
PAU	Paediatric Assessment Unit
Pathology	The medical study and diagnoses of diseases
Patient facing diagnostics	Services which support the diagnosis of disease or injury ie, x-ray which is undertaken in an outpatient setting
Physician	Doctor specialising in medicine
Radiology	The use of imaging in the diagnosis and treatment of diseases
RWT	The Royal Wolverhampton Hospitals NHS Trust
Surgical assessment unit	Assesses patients who require an emergency surgical, orthopaedic and gynaecology review
The TSAs	The Trust Special Administrators who were appointed by Monitor, the health care regulator, on 16 April 2013
UHNS	University Hospital of North Staffordshire NHS Trust
Urology	Medical conditions relating to the urinary tract
Vascular surgery	Speciality of treating the blood vessels of the body
WHT	Walsall Healthcare NHS Trust

Visit our website
www.tsa-msft.org.uk

Email us
TSAconsultation@midstaffs.nhs.uk

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0800 408 6399

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Send your response to us
Freepost Plus RSGR-CRGE-EHLE
MSFT-TSA Consultation
Ipsos MORI
Research Services House
Elmgrove Road
Harrow
HA1 2QG

Agenda Item No: **13**

Health Scrutiny Panel

19 September 2013

Report Title	Health Scrutiny Panel Draft Work Programme 2013/14
Classification	Public
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Well Being
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Office of the Chief Executive/Policy Team
Accountable officer(s)	Earl Piggott-Smith Scrutiny Officer Tel 01902 55(1251) Email earl.piggott-smith@wolverhampton.gov.uk

Recommendation for action or decision:
The Panel is recommended to:

1. The Panel to discuss and agree a list of possible topics for the 2013/14 scrutiny work Programme.

1.0 Purpose

1.1 The purpose of this report is give members of the Health Scrutiny Panel the opportunity to discuss the current work programme and if necessary agree changes.

1.2 Topics should be selected on the basis that they fall within the remit of the panel and also contribute to supporting the achievement of key council priorities. The selection of topics should also be assessed against the following criteria listed below:

- Public Interest – concerns of local people should influence the decisions chosen
- Ability to change – priority should be given to issues that the Panel can realistically influence
- Performance – priority should be given to areas in which the Council and Partners are not performing well
- Extent – priority should be given to issues that are relevant to all or a large part of the Council
- Replication – work programmes must take account of what else is happening to avoid duplication

2.0 Background

2.1 The Panel considered a previous draft of the work programme report at their meeting on 18 July 2013. The Chair and Vice Chair attend agenda planning meetings with key officers to manage the agenda for future meeting to determine the best way of scrutinising the issues selected.

3.0 Financial implications

3.1 There are no financial implications arising from the recommendations in this report. [GE/13092013/B]

4.0 Legal implications

4.1 There are no legal implications arising from the recommendations in this report. [FD/12092013/K]

5.0 Equalities implications

5.1 The members of the panel are asked to consciously consider the need to eliminate discrimination, advance equality of opportunity and foster good relations between different groups of people, when determining the content of reports listed in the work programme. The members of the Panel are asked to reassure themselves that the content of the report will meet the requirements of the Equality Act 2010.

6.0 Environmental implications

6.1 There are no environmental implications arising from this report.

7.0 Schedule of background papers

7.1 18 July 2013 - Health Scrutiny Panel Work Programme 2013/14 – Health Scrutiny Panel

7.2 23 May 2013 - Health Scrutiny Panel Work Programme 2013/14/Development of the Work Programme – Health Scrutiny Panel

Draft Health Scrutiny Work Programme – 2013/14				
Meeting Date	Agenda Item	Issue	Method	Lead Officer(s)
7 November 2013	Public Health Services in the Local Authority	Progress report on Health Improvement Health Protection	Discussion	Ros Jervis FFPH, Director of Public Health Wolverhampton City Council
	The Royal Wolverhampton NHS Trust Quality Accounts 2012 – 13	Report on progress in achieving improvements in areas highlighted as priority for action in the Quality Accounts - End of Life Care	Discussion	David Loughton,Chief Executive, The Royal Wolverhampton NHS Trust
	The Royal Wolverhampton NHS Trust - Patient Misuse of Hospital Services	To receive update report on progress	Discussion	Gwen Nuttall, Chief Operating Officer, The Royal Wolverhampton NHS Trust
19 December 2013	Health Watch Wolverhampton – Work plan	Review of progress against priorities	Discussion	Maxine Bygrave, Chair Wolverhampton Health Watch
	Mental Health Strategy	Review of the Mental Health Strategy and briefing on developments at Penn Hospital	Discussion	John Campbell Chief Operating Officer Black Country Partnership NHS FT and Debbie Mason, Divisional Director for Mental Health
	The Royal Wolverhampton NHS Trust – Foundation Trust Application	Update on approval of Foundation Trust application by Monitor[1]	Discussion	David Loughton,Chief Executive, The Royal Wolverhampton NHS Trust

[1] Monitor is the sector regulator for health services in England. Monitor has an on going role in assessing NHS trusts for foundation trust status, and for ensuring that foundation trusts are well-led, in terms of both quality and finances

	Response by local partners to the Government report 'Patients First and Foremost' arising from the Mid Staffordshire NHS Foundation Trust Public Inquiry	Review of progress in implementing agreed actions from Health and Wellbeing Away Day – 31 July 2013 and the Government requirement that all NHS hospitals should set out publicly how they intend to respond to the Francis Inquiry conclusions.	Discussion	Tbc
	Development of a Joint Urgent Care Strategy	Report on progress and options being considered	Discussion	Jonathan Odum MD FRCP Medical Director, The Royal Wolverhampton NHS Trust
6 February 2014	The Royal Wolverhampton NHS Trust Quality Accounts 2012 – 13	Report on progress in achieving improvements in areas highlighted as priority for action in the Quality Accounts Urgent Care	Discussion	David Loughton,Chief Executive, The Royal Wolverhampton NHS Trust
27 March 2014	The Royal Wolverhampton NHS Trust Quality Accounts 2013 – 14	Report on progress against priorities set for 2013/14 and the priorities for improvement in 2014/15.	Discussion	David Loughton,Chief Executive, The Royal Wolverhampton NHS Trust
	West Midlands Ambulance Service – Quality Accounts 2013/14	Report on progress against priorities set for 2013/14 and the priorities for improvement in 2014/15.	Discussion	Diane Lee Assistant Chief Executive Officer, West Midlands Ambulance Service