Health and Wellbeing Board

4 September 2013

Time 12:30pm **Public meeting?** YES **Type of meeting** Oversight

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

Room Committee Room 3 (3rd floor)

Information for the Public

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

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1. **Apologies for Absence (if any)**

2. **Notification of Substitute Members (if any)**

3. **Declarations of interest (if any)**

4. **Minutes of the previous meetings (3 and 31 July 2013)**
[For approval]

5. **Matters arising - Summary {Viv Griffin}**

6. **Chair's Update {Councillor Mrs Sandra Samuels}**

7. **Health and Wellbeing Board Forward Plan {Viv Griffin}**

8. **Draft Recommendations on the Future of Services for Local People Using Stafford and Cannock Hospitals – Consultation (Covering report to follow) {Dr Helen Hibbs}**

9. **Report of the Chair of the Adults' Safeguarding Board {Alan Coe}**

10. **Joint Strategic Needs Assessment (JSNA) for Wolverhampton (Ros Jervis)**

11. **Health and Wellbeing Strategy Mark 2 {Viv Griffin}**
    - **Mental Health Prevention and Early Detection {Viv Griffin}**
    - **Urgent Care {Richard Young}**
    - **Dementia Care {Anthony Ivko}**

12. **Feedback from Health and Wellbeing Board "Away Day" – Response to the Francis Inquiry (Viv Griffin / Carl Craney)**

13. **Winterbourne Review – Implications for Wolverhampton {Viv Griffin}**

14. **NHS Capital Programme (To follow) {Guy Carson}**

15. **Feedback from Sub Groups**
    - **Children's Trust Board {Sarah Norman}**
    - **Adults Delivery Board {Viv Griffin}**
    - **Public Health Delivery Board {Ros Jervis}**

16. **Bus Service Connections to New Cross Hospital [For Information Only] {Lydia Barnstable}**

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

Item No.	*Title*	*Grounds for exemption*	*Applicable paragraph*
	NIL		

Health and Wellbeing Board
Minutes – 3 July 2013

Attendance

Cllr Sandra Samuels (Chair) – Cabinet Member for Health and Wellbeing
Maxine Bygrave – Chair, Wolverhampton Healthwatch
Cllr Steve Evans – Cabinet Member for Adult Services
Cllr Val Gibson – Cabinet Member for Children and Families
Dr Helen Hibbs – Chief Officer, NHS Wolverhampton
Ros Jervis – Director of Public Health, Community Directorate
Tim Johnson – Strategic Director for Education & Enterprise
Bob Jones – West Midlands Police & Crime Commissioner

Staff

Viv Griffin	Assistant Director, Health, Wellbeing & Disability, Community Directorate
Les Williams	Operations & Delivery Director, Local Area Team, NHS England
Carl Craney	Democratic Support Officer, Delivery Directorate

Part 1 – items open to the press and public

Item No. *Title*

1. **Apologies for Absence**
Apologies for absence had been received from Chief Superintendent Neil Evans (West Midlands Police), Professor Linda Lang (Wolverhampton University), Sarah Norman (Strategic Director for Community) and Cllr Paul Singh (Shadow Cabinet Member for Health & Wellbeing).

2. **Notification of Substitute Members**
No notifications of any substitute Members had been received.

3. **Declarations of interest**
No declarations of interest were made relative to items under consideration at the meeting.

4. **Minutes of the previous meeting (1 May 2013)**
Resolved:
That the minutes of the meeting held on 1 May 2013 be approved as a correct record and signed by the Chair.

5. **Matters arising**

Viv Griffin presented a report which informed the Board of the current position with a variety of matters considered at the previous meeting and meetings of the former Shadow board.

Resolved:

That the report be received and noted.

6. **Chair's Update**

- **Wolverhampton Integration Pioneer Expression of Interest**

The Chair, Cllr Sandra Samuels advised the Board on the submission by the Adults Delivery Board of an expression of interest in participating in the Integration Pioneer pilot scheme being hosted by the Department of Health. She explained that the concept related to whole person care, trialling the full integration of health and social care budgets. A copy of the expression of interest was circulated at the meeting. She emphasised that joint working was the way forward especially in the light of the announcements made in the Spending Review and the continuing need to manage carefully scarce resources.

Bob Jones enquired if there were any further details in relation to the allocation of the additional funding for social care referred to in the Spending Review. Viv Griffin advised that clarifications in respect of the allocations were awaited but once they were received they would be shared with the Board. Les Williams reported that £3.8 b had been allocated across England and Wales and that plans for spending of sums allocated to individual authorities would need to be agreed by the Health and Wellbeing Board and signed off by the Clinical Commissioning Group and Leader of the Council respectively.

Dr Helen Hibbs advised that the workshop held in relation to the Integration Pioneer programme had been very successful and would enable increased joint working regardless of whether the bid was successful or not.

- **Mid Staffordshire Hospital Trust – Public Participation Exercise**

The Chair, Cllr Sandra Samuels reported that a letter had been sent, on behalf of the Board, to Les Williams, Operations and Delivery director, Local area Team, NHS England, expressing a desire to be consulted with regard to the future proposals in respect of the Mid Staffordshire Hospitals NHS Foundation Trust insofar as it referred to Cannock and Stafford Hospitals. Les Williams advised that the Trust Special Administrator would be announcing shortly the arrangements for the consultation proposals.

- **Wolverhampton University – Work Placements for Students on Social Care Courses**

The Chair, Cllr Sandra Samuels reported on an approach which had been received from Professor Linda Lang, University of Wolverhampton in relation to the bodies involved with the Board offering work placements to students from the University on Social Care courses. Cllr Steve Evans suggested that the Board could support the principle but that it would be for individual organisations to respond to the requests. Dr Helen Hibbs commented that the Clinical Commissioning Group would have no objections to the approach.

Resolved:

That the Chair's Update be received and noted.

7, **Role and Function of the Local Area Team, NHS England**

The Board received a PowerPoint presentation from Les Williams on the role and function of the Birmingham, Solihull and the Black Country Area Team of NHS England. He advised that it had not been possible to make an appointment to the post of Medical Director following interviews on 25 June 2013.

Maxine Bygrave enquired as to any proposals for increased working with the public especially in relation to complaints regarding service. Les Williams advised that it was proposed to hold a series of meetings with the individual Chair's of Local Healthwatch bodies to discuss this matter. He explained the current complaints procedure and improvements which were proposed. Bob Jones reported that public confidence in the current complaints procedure was low and on the need to provide access to the Local Area Team at a local level. Les Williams explained that while the Local Area Team did not have a presence in the city any complaints handed into individual surgeries or health centres would be forwarded on to the Local Area Team to deal with. Similarly, complaints could be passed to the Clinical Commissioning Group or the City Council for referral to the Local Area Team.

Bob Jones enquired as to whether the Local Area Team had responsibility for promoting and marketing the immunisation programme or whether it just managed the contract for immunisation. Les Williams reported on the close working relationship between the Local Area Team and Directors of Public Health and Public Health staff with regard to the promotion of the immunisation programme albeit that a marketing and promotion budget had not yet been defined fully. Ros Jervis confirmed her close working relationship with the Local Area Team and that of her staff and that a work programme had been developed jointly including the work of health visitors, the Family Nurse Partnership and in relation to the immunisation programme.

Resolved:

That the presentation be received and noted.

8. **Health and Wellbeing Board Forward Plan 2013/14**

Viv Griffin presented the Health and Wellbeing Board Forward Plan for 2013/14.

Resolved:

That the Forward Plan 2013/14 be received and noted.

9. **Health and Wellbeing Board Development/Focus Day – Francis Report**

Viv Griffin presented a report on the arrangements which had been made for a Development / Focus Day to be held on the morning of 31 July 2013 in connection with the Francis Report.

Resolved:

That the report be received and noted and the agenda and invite list be approved.

10. **Joint Strategic Needs Assessment / Joint Health and Wellbeing Strategy – Task and Finish Group Update**

Viv Griffin presented a report on the current position with the development of the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy. The JSNA was nearly ready for publication and would be published on the Council's website with hard copies also being available. The JSNA would be added to and updated throughout the year. The Joint Health and Wellbeing Strategy Mark 2 was now available. A further report on these documents would be submitted to the next meeting of the Board.

Resolved:

That the progress with the development of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy Mark 2 be noted and that a further report be submitted to the next meeting.

11. **Clinical Commissioning Group – Integrated Commissioning Plan**

Dr Helen Hibbs presented a report on the full Integrated Commissioning Plan

Resolved:

That the approved Integrated Commissioning Plan be received and noted.

12. **New Cross Hospital Public Transport Facilities**

Carl Craney presented a report on the existing public transport facilities serving New Cross Hospital and the continued work to improve public transport accessibility to the site. He explained that this matter had been referred to the Board by the Adults and Community Scrutiny Panel.

Resolved:

That the report be received and noted, the Chair be requested to write to the Integrated Transport Authority in relation to the need for further improvements to public transport accessibility to the site including an extension to the existing Metro service and that an update report be submitted to the next meeting.

13. **Alcohol Strategy – Progress Update**

Ros Jervis presented a report which provided the Board with an update regarding the implementation of the Wolverhampton Alcohol Strategy 2011 – 2015 highlighting the performance against the outturn for 2012/13 together with the revised action plan for 2013/14 following a review of the Strategy Action Plan which had been undertaken in early 2013.

Cllr Val Gibson referred to the large number of Planning Applications for change of use in her Ward for conversion of premises to sell alcohol and enquired as to whether any steps could be taken by the Board to oppose these applications. Ros Jervis explained that under the revised licensing legislation that the Public Health Department was now a statutory consultee on all licensing applications but that objections had to relate to the four licensing objectives and that, currently, there was not a licensing objective relating to public health. She informed the Board of the work which was undertaken in conjunction with the other Responsible Authorities, through the

Responsible Authorities Forum, to produce a collective response to such applications. She reminded the Board of the Cumulative Impact Policy in respect of Wolverhampton City Centre but that currently there was not a similar Policy in operation in Bilston.

Bob Jones commented that the licensing arrangements were not ideal and that reasons to refuse applications were limited. With regard to the Cumulative Impact Policy he advised that it had not resulted in many changes in the City Centre and that he felt its impact had been limited. He enquired as to the current position with the plan to extend the Drinking in Public Places Order and suggested that when it was launched there would need to be sufficient publicity and liaison with the Police with regard to the administration. Ros Jervis advised that there was still some work to be completed in respect of the Drinking in Public Places Order. She also referred to the difficulties encountered with regard to dual diagnosis where individuals had a problem with alcohol but also had other health issues. Bob Jones commented that it was not unknown for Mental Health Service providers to decline to treat individuals when their mental health issues were compounded by alcohol abuse.

Resolved:

That the update in relation to the implementation of the Wolverhampton Alcohol Strategy 2011 – 2015 and the performance against the Action Plan for 2012/13 be noted and the revised Action Plan for 20134/14 be endorsed.

14. **Feedback from Sub Groups**

- **Children's Trust Board**

Viv Griffin presented a report which informed the Board of the work of the Children's Trust Board.

Resolved:

That the report be received and noted.

- **Adults Delivery Board**

Viv Griffin presented a report on the work of the Adults Delivery Board in regard to the work plan for 2013/14. Cllr Steve Evans referred to the work which had been undertaken by the Council in response to the Winterbourne View review and on a number of errors contained in emails received from Mencap with regard thereto. He advised that the Council had met all of the target dates set in relation to this matter. Viv Griffin advised that each organisation had been asked to sign off a self-assessment in relation to this issue and on the work which had been undertaken with the Local Area Team on this issue.

Resolved:

That the report be received and noted.

- **Public Health Delivery Board**

Ros Jervis presented a report which advised the Board on the work of the Public Health Delivery Board and the development of an appropriate work plan. She also reported on the appointment of three Consultants in Public Health following an interview process which had concluded on 7 June 2013. Neeraj Malhotra had been appointed to the post of Consultant in Public Health – Transformational Change, Katy Spence had been appointed to the

post of Consultant in Public Health – NHS Facing and Health Protection and Glenda Augustine had been appointed to the post of Consultant in Public Health – Intelligence and Evidence.

Resolved:

That the report be received and noted.

Health and Wellbeing Board
Minutes – 31 July 2013

Attendance

Cllr Sandra Samuels (Chair) – Cabinet Member for Health and Wellbeing
Dr David Bush – NHS Wolverhampton
Maxine Bygrave – Chair, Wolverhampton Healthwatch
Dr Helen Hibbs – Chief Officer, NHS Wolverhampton
Cllr Val Gibson – Cabinet Member for Children and Families
Ros Jervis – Director of Public Health, Community Directorate - Wolverhampton City Council
Bob Jones – West Midlands Police and Crime Commissioner
Sarah Norman – Strategic Director- Community – Wolverhampton City Council
Cllr Paul Singh – Shadow Cabinet Member for Health and Well Being

Staff

Viv Griffin	Assistant Director, Health, Wellbeing & Disability, Community Directorate, Wolverhampton City Council
Anthony Ivko	Assistant Director, Older People and Personalisation, Community Directorate, Wolverhampton City Council
Carl Craney	Democratic Support Officer, Delivery Directorate, Wolverhampton City Council

In attendance

Dr Julian Morgans	Wolverhampton Clinical Commissioning Group (WCCG) Board Member and WCCG Urgent Care Lead, NHS Wolverhampton
Dr Jonathan Odum	Medical Director, Royal Wolverhampton NHS Trust
Richard Young	Director of Strategy and Solutions, NHS Wolverhampton

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Part 1 – items open to the press and public

Item No. *Title*

1. **Apologies for Absence**
Apologies for absence had been received from Cllr Steve Evans (Cabinet Member for Adult Services), Professor Linda Lang (University of Wolverhampton) and Les Williams (Operations and Delivery Director, Local Area Team, NHS England).

2. **Notification of Substitute Members**

No notifications of any substitute Members had been received.

3. **Declarations of interest**

No declarations of interest were made relative to items under consideration at the meeting.

4. **Draft Urgent and Emergency Care Strategy**

The Board considered a PowerPoint presentation and a report from Dr Julian Morgans, Wolverhampton City Clinical Commissioning Group (WCCG) Board Member and WCCG Urgent Care Lead, Richard Young, Director of Strategy and Solutions, WCCG and Dr Jonathan Odum, Medical Director, Royal Wolverhampton NHS Trust and Chair of the Joint Urgent and Emergency Care Strategy Board. The advised that the Draft Joint Urgent and Emergency Care Strategy had been developed to provide a cohesive response to the significant pressures which had been experienced within the Urgent and Emergency Care system. The existing system had not been designed to cope with the levels of current and predicted activity and under this system access to the most appropriate care facility was too confusing and complex for patients. This had been evidenced through discussions which had been held with patients who had confirmed that they were unclear as where they should go for urgent care needs. The Draft Strategy had been developed since the meeting of the Board held on 1 May 2013 and had taken into account the feedback received.

Ros Jervis suggested that the Draft Strategy should be revised further to reflect the incorporation of elements of prevention in order to encourage changes in patterns of behaviour if a “whole system” approach was to be adopted. She explained that this was not meant to deflect responsibility back to the patient but to emphasise the responsibility for preventative action. Dr Morgans advised that information and suggestions with regard to preventative measures would be included in all sub sets to the Strategy.

Bob Jones questioned as to whether the impending announcement from the Special Trust administrators at Mid Staffordshire Hospital and, in particular, the likely future operation of the Cannock Hospital had been factored into the Draft Strategy. He raised a series of further questions in relation to the Monitor Review of the role of “Walk In Centres”, the Review currently being undertaken by Bruce Keogh of NHS England into Accident and Emergency Departments and also whether the Strategy would communicate to the public at large “what this review means to me?” Furthermore, he enquired whether alternative provision to the service provided through the Phoenix Walk In Centre, via General Practitioners was affordable in the current economic climate.

Sarah Norman welcomed the revised Draft Strategy but queried as to whether sufficient data analysis had been undertaken to establish the conditions with which patients were presenting at the A&E Department and, conversely, what conditions they were presenting with when alternative options were available. She emphasised the need for the data to be based on analysis of data held rather than anecdotal evidence. She suggested that all parties would be in a better position to move forward if such analysis were to be undertaken, presented and discussed.

Dr Jonathan Odum responded that such data was not easily available and that local statistics indicated that only 15% of patients presenting to the A&E Department were admitted to Hospital. Given the range of services available across the city meaningful comparisons were difficult to make. National statistics indicated that 25% of presentations to A&E Departments should receive care in the community, but at NEW Cross Hospital this figure was believed to range between 10% - 25%. He assured the Board that further audit work on this area of concern would be undertaken. He suggested that a combined Accident and Emergency and Primary Care Centre was a possible solution with the patient being directed to the most appropriate Care Pathway. Dr Julian Morgans expressed the opinion that he believed that the figures presenting at the A&E Department at New Cross were more likely to be in the region of 25% who would be Primary Care cases. He reminded the Board of the propensity of patients to present at the most convenient health care facility rather than the most appropriate. Education of patients in relation to the most appropriate access point was paramount. Sarah Norman acknowledged the point now made but suggested that this needed to include reference to the interventions required.

Richard Young opined that it was virtually impossible to prevent patients presenting at A&E Departments and cited an example of a single patient presenting on over 500 occasions in a calendar year, with such presentations avoiding certain television programmes. The need to encourage a change in behaviour including patients taking responsibility for condition management was the ideal outcome but that this would be difficult to achieve. With regard to the question from Bob Jones on “what does this mean for me” he commented that it would be necessary to finalise the vision before such detail could be provided.

Maxine Bygrave commented on the need for behavioural change and that some patients would progress through the various healthcare stages, from Primary Care to Walk In Centre and then to the A&E Department. She drew to the attention of the Board the contents of the NHS Constitution insofar as it related to accessing services and of the need to ensure this was captured in the Strategy Document. Dr Julian Morgans responded that there was a need to transform the way in which services were delivered and that data was

available on where patients presented.

Anthony Ivko welcomed the manner in which the Draft Strategy had been produced but suggested that there was a need to identify the pressure points within the system. He suggested that with more rigorous analysis of data held this could be achieved. He also suggested that “Quick Wins” in areas such as early intervention were achievable and could be used to demonstrate that the system was being improved.

Cllr Val Gibson referred to the complexity of accessing the most appropriate service and opined that further work was required to develop clear pathways. She also suggested that the Draft Strategy was too wordy and should be edited to be more comprehensible to the general public. Dr Julian Morgans assured the Board that an Executive Summary of the final document would be produced for the consultation exercise. Richard Young reported that the Draft Strategy had been produced for consideration by such Forums as the Health and Wellbeing Board and would not be used for the consultation exercise.

Cllr Paul Singh suggested that a culture change was required and enquired as to whether, if this could not be achieved, whether the system could cope with the status quo. Dr Julian Morgans replied that continuation of the present system was not sustainable and of the need to improve access to the most appropriate care pathway in order to improve the service offered. Richard Young acknowledged the comments in terms of resource implications but stressed the requirement to consider also patient care and clinical outcomes. If the current system was not changed the quality of the service would suffer and stressed the need for difficult choices to be made.

The Chair, Cllr Mrs Sandra Samuels enquired as to the effect of an additional influx of patients if the A&E Department at the Mid Staffordshire NHS Foundation Trust Hospital was closed before any new facility was constructed and open to the public. Richard Young advised that an Emergency Care Sustainability Plan had been submitted to NHS England on 30 July 2013 but that this had been undertaken as a separate piece of work. He reminded the Board of the success of the local healthcare economy on doing more with fewer resources over a sustained period but commented that this could not continue indefinitely.

At this juncture Sarah Norman informed the Board of the outcome of the announcement of the Special Trust Administrators with regard to the future of the Mid Staffordshire Hospital NHS Foundation Trust and the implications for the Royal Wolverhampton NHS Trust. Dr Jonathan Odum explained his understanding on the reasoning behind the division of duties between Wolverhampton and Stoke on Trent Hospitals. He commented that there was an expectation that the position would change further over the coming years.

Dr Helen Hibbs advised that, in her opinion, the outcome was positive insofar as the capacity of New Cross Hospital would be expanded through the access to bed spaces at Cannock Hospital.

Resolved:

i) That the report be received;

ii) That a further revised iteration be submitted to the meeting of the Board scheduled to be held on 6 November 2013 taking into account the comments now made including;

- The need for behavioural change from patients;
- The need to explain fully the “Patient Journey”;
- The implications of “What this means to me” from the perspective of the patient;
- The need to explain why change to the existing system is required;
- The preparation of an Executive Summary including timescales for implementation of the various stages of the Strategy;
- The inclusion of reference to resources, both in terms of finance, staff, clinical care and clinical outcomes.

Wolverhampton City Council

OPEN EXECUTIVE INFORMATION ITEM

Health and Wellbeing Board **Date 4 September 2013**

Portfolio(s) Health and Well Being

Originating Service Group(s) Delivery – Central Services

Contact Officer(s)/ Carl Craney
Telephone Number(s) 555046

Title Summary of Outstanding Matters

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1. 0 SUMMARY

The purpose of this report is to appraise the Board of the current position with a variety of matters considered at meetings of the former Shadow Health and Well Being Board and the inaugural meeting of the Health and Wellbeing Board.

2.0 RECOMMENDATION

That the current position be noted.

3.0 PURPOSE OF THE REPORT

The purpose of this report is to appraise the Board of the current position with a variety of matters considered at meetings of the former Shadow Health and Well Being Board and the inaugural meeting of the Health and Wellbeing Board .

BACKGROUND

At previous meetings of the Shadow Board /Board the following matters were considered and details of the current position is set out in the third column of the table.

DATE OF MEETING	SUBJECT	LEAD OFFICER	CURRENT POSITION
19 JANUARY 2012	CHILD OBESITY – UPDATE	ROS JERVIS	Nothing further to report at this stage
29 MARCH 2012	ADULT OBESITY	ROS JERVIS	Nothing further to add at this stage.
7 NOVEMBER 2012	WOLVERHAMPTON ALCOHOL STRATEGY 2011 – 2015 – PROGRESS WITH IMPLEMENTATION	ROS JERVIS	Report to alternate meetings

1 MAY 2013	ALCOHOL AND CARDIO VASCULAR DISEASE – HEALTH CHECKS FOR PRIVATE SECTOR EMPLOYEES	ROS JERVIS	Report to a future meeting
1 MAY 2013	ALCOHOL AND CARDIO VASCULAR DISEASE – LIAISON WITH WEST MIDLANDS POLICE AND CRIME COMMISSIONER REGARDING OTHER MODELS TO REDUCE ALCOHOL CONSUMPTION	ROS JERVIS	Report to a future meeting
1 MAY 2013	CHILD POVERTY – TIMELINES, SIX TARGET WARDS AND MEMBERSHIP OF STAKEHOLDER WORKSHOP	KEREN JONES	Report to a future meeting
3 JULY 2013	JOINT STRATEGIC NEEDS ASSESSMENT AND HEALTH AND WELLBEING STRATEGY MARK 2	VIV GRIFFIN / ROS JERVIS	Report to this meeting
3 JULY 2013	BUS SERVICE CONNECTIONS TO NEW CROSS HOSPITAL	LYDIA BARNSTABLE	Report to this meeting

4. FINANCIAL / LEGAL / EQUAL OPPORTUNITIES / ENVIRONMENT IMPLICATIONS

4.1 None directly arising from this report.

5. SCHEDULE OF BACKGROUND PAPERS

5.1 Minutes of previous meetings of the former Shadow Health and Well Being Board and associated reports and previous meetings of this Board and associated reports.

HEALTH AND WELLBEING BOARD – FORWARD PLAN 2013/14

MEETING	TOPIC	LEAD OFFICER
4 SEPTEMBER 2013 (12:30 HOURS)	Feedback from "Francis Inquiry Away Day"	Viv Griffin (WCC)
	Joint Strategic Needs Assessment	Ros Jervis (WCC)
	Reports from Sub Groups	Viv Griffin/ Sarah Norman / Ros Jervis (WCC)
	Winterbourne Review - Implications for Wolverhampton	Viv Griffin (WCC)
	Bus Service Connections to New Cross Hospital	Lydia Barnstable (WCC)
	Health and Wellbeing Strategy Mark 2	Viv Griffin (WCC)
	NHS Capital Programme	Guy Carson (NHSCB)
6 NOVEMBER 2013 (14:00 HOURS)	Reports from Sub Groups	Viv Griffin / Sarah Norman / Ros Jervis (WCC)
	Mental Health Detection and Early Detection	Viv Griffin (WCC)
	Urgent Care	Richard Young (CCG)
	Alcohol and Drugs	Ros Jervis (WCC)
	CCG Commissioning Intentions	Richard Young (CCG)
	Draft Urgent and Emergency Care Strategy	Richard Young (CCG)

	Size and value of contracts in Social Care (broken down by service user category)	Mark Astbury (WCC)
	Changes to Benefits System	Anthony Ivko (WCC)
	Integration Pioneer Project – Update on outcome of expression of interest	Sarah Norman (WCC)
8 JANUARY 2014 (12:30 HOURS)	Reports from Sub Groups	Viv Griffin / Sarah Norman / Ros Jervis (WCC)
	Wider Determinants on Health	Ros Jervis (WCC)
	CCG Commissioning Intentions	Richard Young (CCG)
5 MARCH 2014 (14:30 HOURS)	Reports from Sub Groups	Viv Griffin / Sarah Norman / Ros Jervis (WCC)
	Alcohol Strategy Update	Ros Jervis (WCC)

Wolverhampton City Council **OPEN INFORMATION ITEM**

Health and Wellbeing Board Date **4 September 2013**

Originating Service Group(s) Wolverhampton Clinical Commissioning Group

Contact Officer(s)/ Telephone Number(s) Dr Helen Hibbs, Chief Officer
01902 444854

Title **MID STAFFORDSHIRE FOUNDATION TRUST**

RECOMMENDATIONS

- That the Board note the report, form their own opinion and respond to the public consultation.

1.0 Background

1.1 The Trust Special Administrator for Mid Staffordshire Foundation Trust has concluded their initial investigation and has now launched a formal consultation on the future of Mid Staffs Foundation Trust.

2.0 FINANCIAL IMPLICATIONS

2.1 None identified.

3.0 LEGAL IMPLICATIONS

3.1 There are no legal implications for Wolverhampton Clinical Commissioning Group.

4.0 EQUAL OPPORTUNITY IMPLICATIONS

4.1 None identified.

The Trust Special Administrator (TSA) has concluded that Mid Staffs Foundation Trust is not clinically or financially viable in the long term.

The proposals of the TSA are currently out to formal consultation which closes on 1 October 2013. The current consultation deals with services for Stafford and Cannock patients only. Any changes for Wolverhampton patients will need to be subject to a separate consultation at a later stage.

Cannock Chase Hospital

The current proposal sets out a plan which proposes the transfer of Cannock Chase Hospital to The Royal Wolverhampton NHS Trust. It is proposed that Cannock Chase Hospital will deliver locality specific services as set out by the Commissioners to include out patients, diagnostics and anti and post natal care. Also provided at Cannock Chase will be a rehabilitation ward and a centre for care of the elderly.

New Cross Hospital

The TSA solution recommends the transfer of some activity currently delivered on the Stafford site to New Cross. This is to include paediatrics, obstetrics and some emergency services. The current proposal maintains a daytime A&E service at Mid Staffs Hospital.

Wolverhampton Clinical Commissioning Group (CCG)

Wolverhampton CCG welcomes the transfer of Cannock Chase Hospital to The Royal Wolverhampton NHS Trust and sees that there is a possible opportunity to enhance clinical services provided to patients. Following the problems at Mid Staffs, The Royal Wolverhampton NHS Trust has already seen an increase in activity from South Staffordshire. The CCG believes that managing both the growth in activity from outside the Wolverhampton area whilst ensuring that any opportunities to access capital and revenue support for the project provides the best opportunity to enhance clinical services provided for the residents of Wolverhampton.

Both developing the New Cross and Cannock sites to their full potential and ensuring appropriate services are delivered at each site can be seen as an opportunity to provide significantly improved facilities and to future-proof our local hospital.

Wolverhampton CCG plans to work with neighbouring CCGs and to ensure that the development of services is clinically led during the on-going process.

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 ਕਸਿੇ ਦੂਜੀ ਭਾਸ਼ਾ* ਵਚਿ ਕਰਨ ਲਈ ਮਦਦ ਦੀ ਲੋਡ਼ ਹੈ, ਇਸਨੂੰ ਕਸਿੇ 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।

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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.

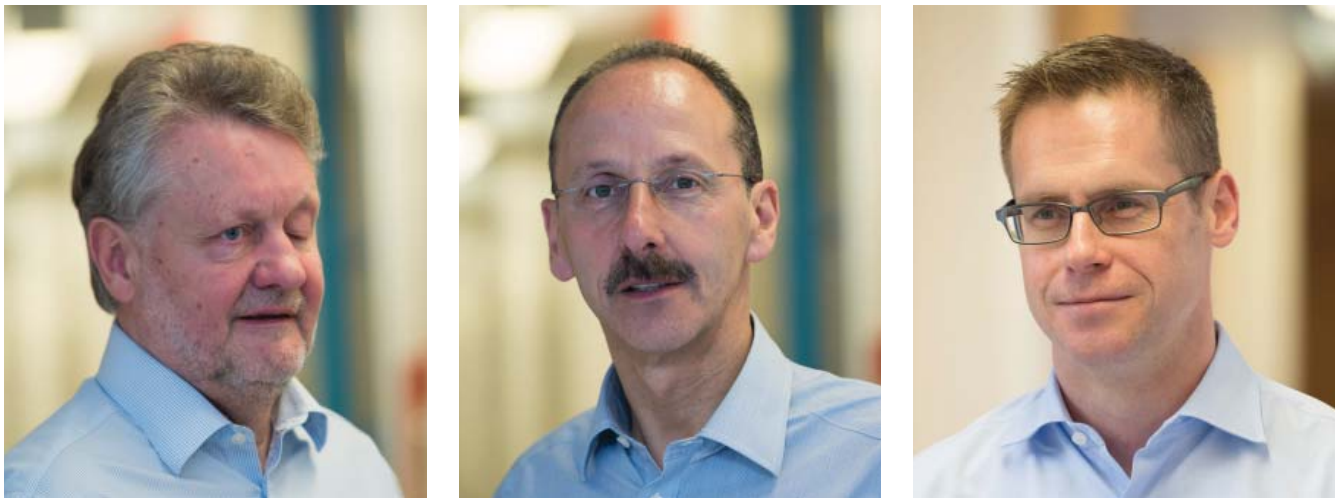
Some have questioned why the TSAs are undertaking this process at MSFT now, when recent inspections at Stafford and Cannock Chase hospitals show services are safe.

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.

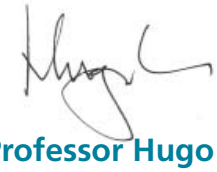
These recommendations have been drafted with the input of many, including local people and leading national experts, whom we wish to thank.

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.

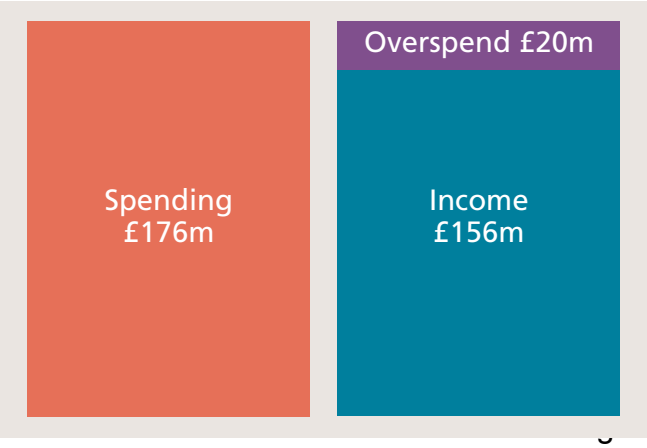
For this reason hospitals are paid for providing treatment at a rate that is set to make the most of each and every pound without compromising on the essential quality and safety of services.

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.

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



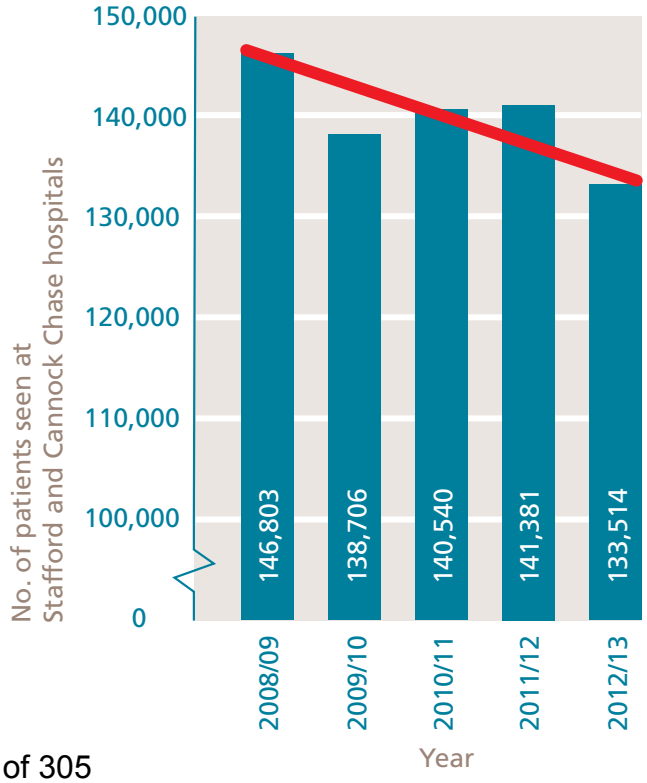
What are the underlying causes of the Trust's financial problems?

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.

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.

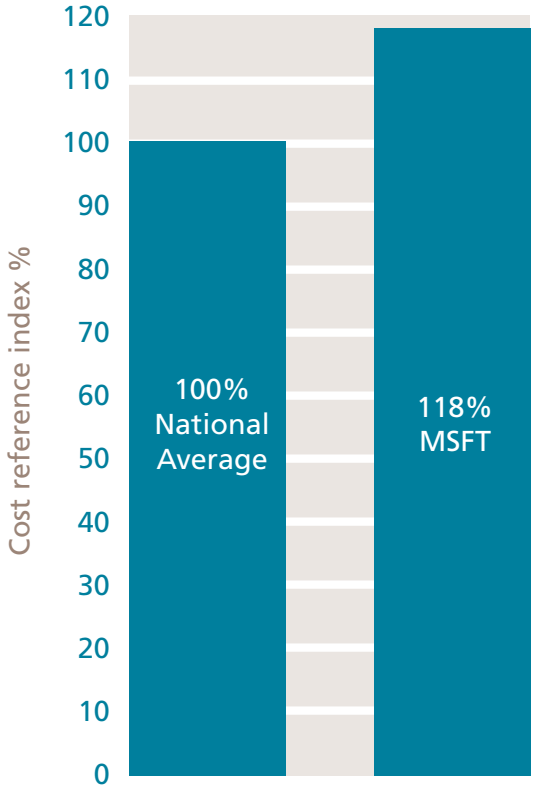
In a recent survey, NHS finance directors agreed that savings are harder to make with every year that goes by. In 2012 only 5 out of 45 Trusts surveyed* made 7% savings. No NHS Trust has ever saved that amount every year for five consecutive years.

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.

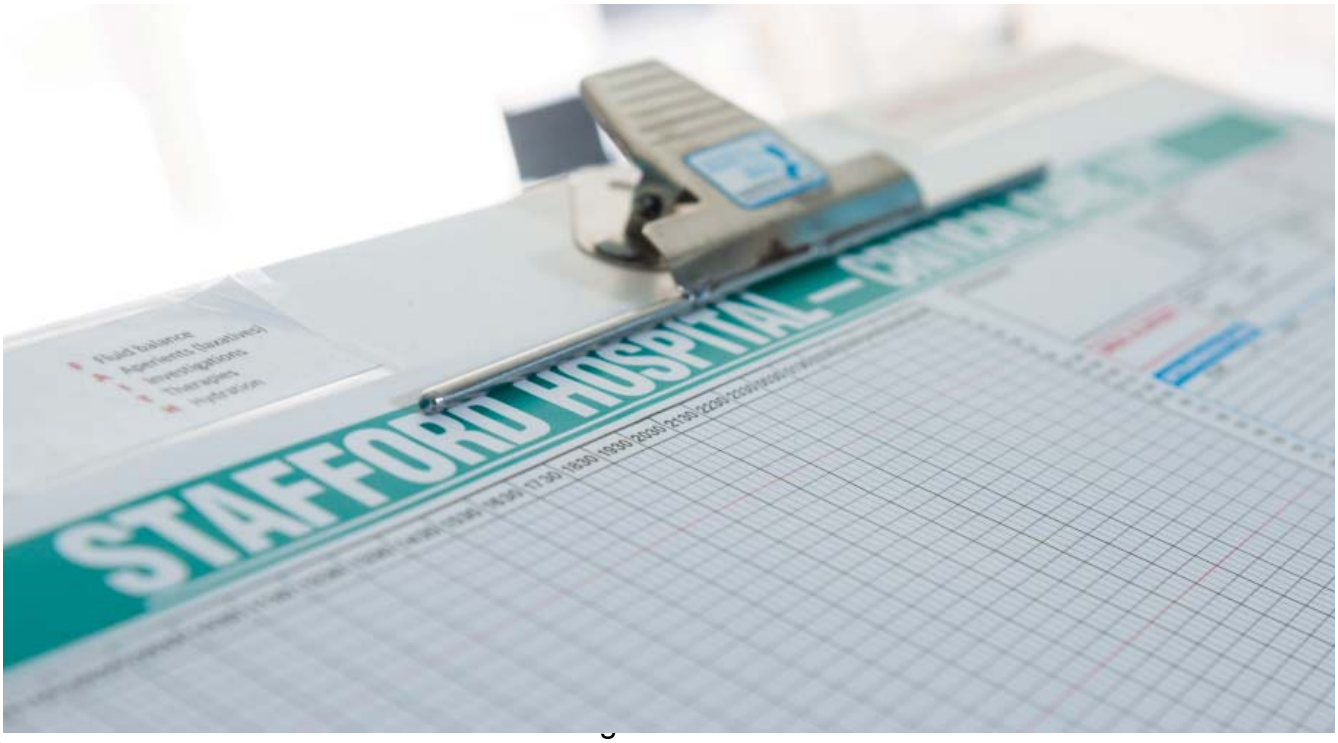
The TSAs' guiding principles have been to come up with a solution based on high quality, safe services provided as near to patients' homes as possible without incurring the significant financial losses that have been a problem to date. They are also determined that they won't simply shift the problem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

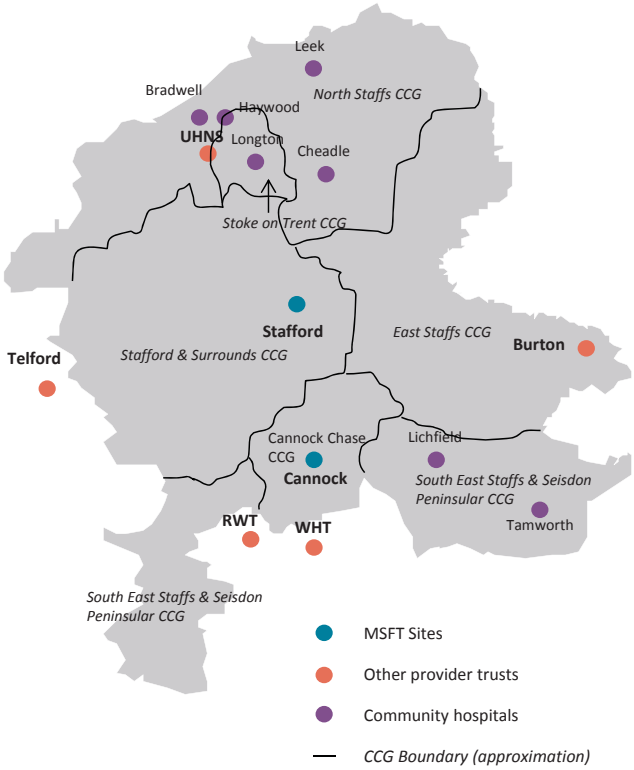
Faced with this problem, the TSAs' starting point in developing their draft recommendations has been the statements of the Stafford and Surrounds and Cannock Chase Clinical Commissioning Groups (the CCGs) of those services which must be provided in Stafford and Cannock, the so-called "Location Specific 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?

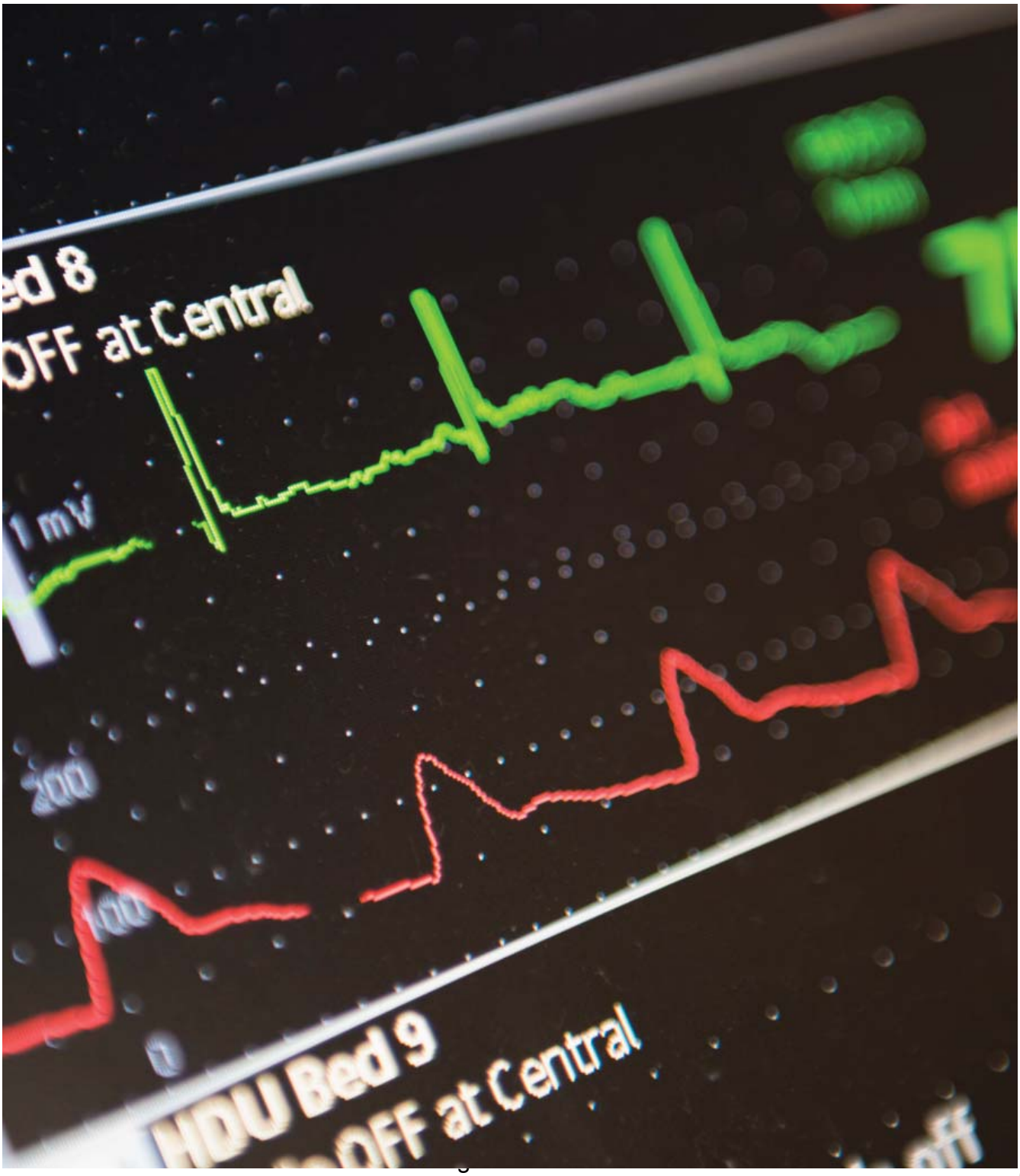
The discussions that the TSAs have had so far with other local trusts and through the market engagement exercise show it is likely each of the hospitals will be run by different organisations. Although nothing has been decided based on the TSAs' engagement with providers to date, it is unlikely that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

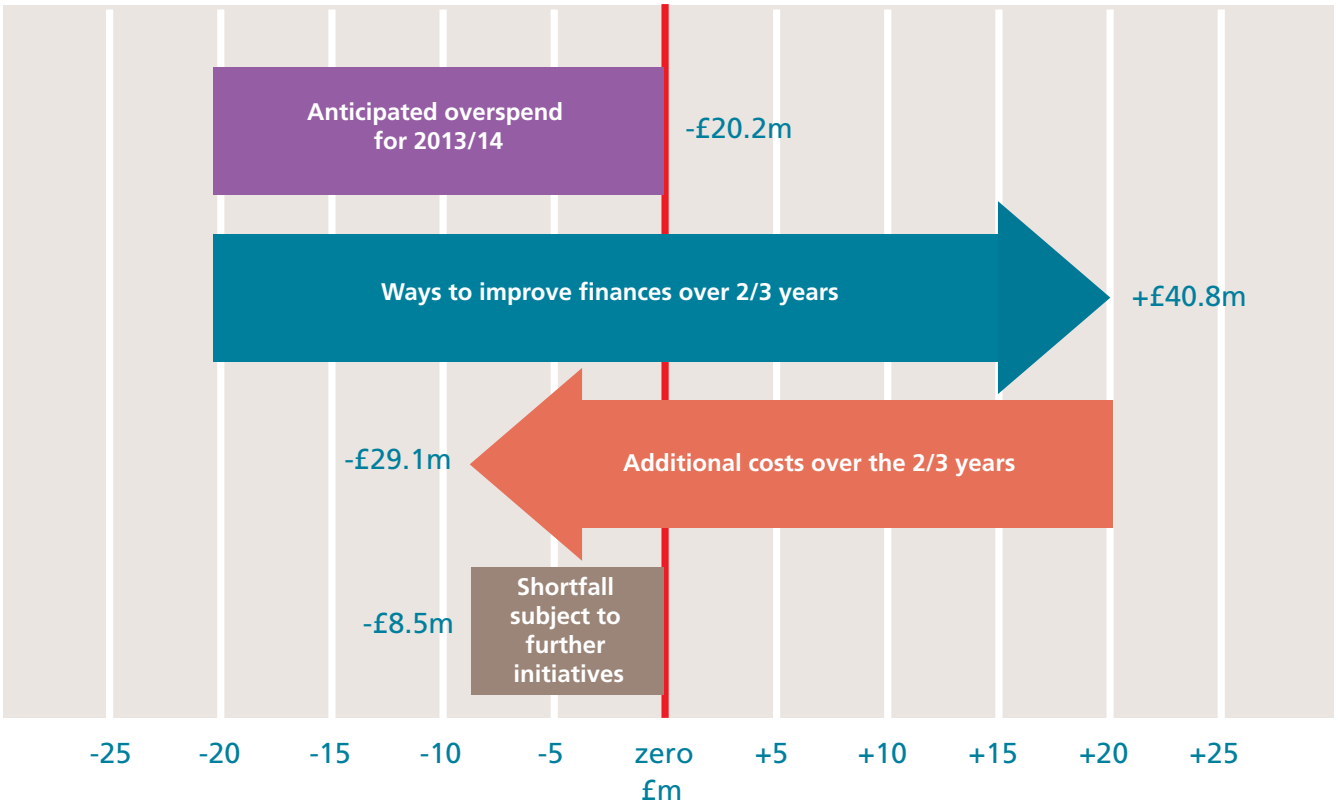
- Over £11.6m can be saved each year by reducing executive management and back office functions as a result of carrying out the TSAs' proposals and reducing the

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

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Research Services House
Elmgrove Road
Harrow
HA1 2QG

Wolverhampton City Council **OPEN DECISION ITEM**

Health and Wellbeing Board **Date 4 SEPTEMBER 2013**

Originating Service Group(s) **WOLVERHAMPTON SAFEGUARDING ADULTS BOARD**

Contact Officer(s)/ Telephone Number(s) **ALAN COE – INDEPENDENT SAFEGUARDING ADULTS CHAIR 01902 551991**

Title: **Report of the Chair of the Adults' Safeguarding Board to Wolverhampton Health and Wellbeing Board**

RECOMMENDATION

That the members of the Health and Wellbeing Board:

1.1 Note the content of report and support both collectively and individually the priorities set for 2013-2015;

1.2 Identify any issues not fully reflected in the annual report or the Board's future priorities;

1.3 Ensure their respective agencies continue to actively support the work of the Board by:

- Ensuring the agencies and organisations each year formally report on the workings of the Board to their respective governing bodies;
- reporting both to their own agencies and governing bodies on their own individual agency actions to help keep adults at risk safe;

1.4 Ensure that their representatives on the Board and relevant subgroups and task and finish groups are enabled to make a full contribution the safeguarding agenda.

1. PURPOSE

1.1 This report outlines the work undertaken by the Wolverhampton Adults' Safeguarding Board to support adults at risk remain safe as summarised in the 2012-13 Annual Report.

2. BACKGROUND

2.1 The Wolverhampton's Safeguarding Adults Board Annual Report 2012-13 reflects the complex and wide ranging agenda that the Safeguarding Adults Board, its working groups and partner organisations have all been working on during the year.
The Safeguarding Adults Board Ensures that all agencies responsible for safeguarding adults in the City work effectively and in partnership to keep people safe and reduce. The Board has an independent Chairperson and senior representatives from 14 organisations involved in safeguarding adults. Wolverhampton City Council has a lead role in coordinating safeguarding adults work at every level and supporting Safeguarding Adults Board member organisations in developing safeguarding adults practice and procedures. The Board has made good progress in the aims outlined in the Safeguarding Adults Board Priorities 2012 to 2013, particularly in the three areas below;

- **Prevention**
  Safeguarding Awareness raising sessions delivered to over 70 GP's in Wolverhampton

- **Improved Practice**
  The new Safeguarding Adults Multi-agency Policy and Procedures for the West Midlands and local practice guidance and threshold tool were launched Jan 2013

- **Transparency**
  Minutes of the open **Safeguarding** Board meetings are published on the Council website.

The Annual report provides more information and detail.

Included in the Annual Report are details of a range of initiatives including those that emphasise greater partnership:

In February 2013 a conference took place to highlight the issues surrounding forced marriage. This was organised by the Safeguarding Adults & Children Boards in partnership with West Midlands Police and the Wolverhampton Domestic Violence Forum and over 150 people attended the event. We are now working with partners across the West Midlands in developing staff guidance to better recognise and respond to it.

In January Wolverhampton hosted a specific event to launch regional procedures that ensure greater consistency of response to safeguarding concerns throughout the West Midlands;

There was a joint event hosted by the Adults Safeguarding Board and Learning Disability partnership Board to report on how the City was responding collectively to the implications of the Winterbourne View Serious case Review prompted by the Panorama programme in 2012 about the private hospital.

Reports of possible safeguarding adults concerns or alerts have continued to rise from 990 in 2011/12 to 1,172 for 2012/13 (indicating a rise in awareness of safeguarding adults' issues and the rights of adults at risk to be protected from abuse and neglect).

The Annual Report continues to demonstrate higher safeguarding referrals which are seen to be a sign of greater awareness of current concerns rather than a rise in the actual frequency of abuse or neglect. The data shows that for the first year neglect is the most common type of alleged abuse. The proportion of reported neglect cases has increased every year with a significant increase from 23% in 2011/12 to 30% in 2012/13.

1. Board Priorities for the future 13/14

The Board Priorities for the coming year 2013/14 are:

- **Priority One: Better outcomes-** Service User experience and involvement in safeguarding enquiries directs improved practice

- **Priority Two: Quality Assurance-** Ensure there are effective Multi- Agency Quality Assurance and Performance Management processes in place

- **Priority Three:** Information Sharing- improvements are made to how agencies can share personal information legally and ethically to enable adults to be protected from harm or unwarranted risk

- **Priority Four:** Prevention- there is a coherent inclusive approach by both Safeguarding Boards to community initiatives which protect disadvantaged groups

- **Priority Five**: Workforce Development: the workforce of all partner agencies have undergone save and robust recruitment processes and understand safeguarding issues as they relate.

Wolverhampton Safeguarding Adults Board

Annual Report 2012/2013

Leona at No.3
Paralympic swimmer
Caring sister
Threatened by brother-in-law

Derek at No.43
War Veteran
Fleeced by his neighbour
Robbed of his dignity

Mrs Kumar at No.72
Grandmother
Retired dinner lady
Starved by her husband

Mr Smith at No.10
Retired teacher
Loving father
Beaten by his wife

Board Partners

Wolverhampton Homes

West Midlands Care Association

West Midlands Police

Wolverhampton A Safe City

Staffordshire and West Midlands Probation Trust

WVSC Wolverhampton Voluntary Sector Council

West Midlands Fire Service

The Royal Wolverhampton Hospitals NHS Trust

Wolverhampton City Council

West Midlands Ambulance Service NHS Foundation Trust

Our Community you matter, we care

Black Country Partnership NHS Foundation Trust

NHS Wolverhampton Clinical Commissioning Group

wDF Wolverhampton Domestic Violence Forum

Wolverhampton Safeguarding Children Board

Wolverhampton age UK

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Introduction

Welcome to the 2012/13 annual report of the Wolverhampton Safeguarding Adults Board. This annual report is produced on behalf of the multi-agency Wolverhampton Safeguarding Adults Board and contains contributions from the wide range of agencies who are members of this Board.

There are too many stories of people who are financially exploited, bullied or receive such poor care that their health and wellbeing are put at risk. To guard against this, everybody has a role in trying to identify risks and prevent abuse occurring wherever possible. When somebody is harmed they need to feel confident that swift and effective action will be taken to ensure they are protected against further incidents. It is the job of Wolverhampton's Adult Safeguarding Board to make sure all the partner organisations work together to prevent abuse and also to protect people if they are harmed or exploited.

In the past twelve months we have made progress in reducing the likelihood of abuse and in lessening its impact when it does occur. We have more evidence of sound front line practice by social workers, nurses and doctors in identifying the signs of potential tension and strain that can lead to abuse and taking steps to reduce the risk of this turning into abuse. We also know that people who have been abused or felt they were at risk normally feel satisfied that through intervention and support they feel safer. Increasingly we are working with our close neighbours in Walsall, Sandwell and Dudley as we recognise areas such as raising awareness of abuse and ensure we share good practice and how we might deal with similar risks. I see evidence of the NHS, Police and other emergency services, voluntary agencies and the Council working better together. This year, GPs and their colleagues working in local surgeries have benefitted from training to help them identify and tackle abuse. All partners have been working to understand and apply the lessons coming out of serious national incidents such as the Panorama investigation into the failings of care in a private hospital and, closer to home; we are all learning how we can avoid the serious lapses in care that occurred at Mid Staffordshire Hospital. We have also helped raise awareness of abuse among family and informal carers.

In the following pages you can learn more about what we are doing both separately and together to protect those people most at risk of being harmed. I welcome feedback and advice about what more we can do and how we can do it better.

Alan Coe
Independent Chair

New Policy and Procedures and Regional Threshold Tool

Safeguarding is the national framework of guidance and laws designed to bring together different agencies concerned with the safety and welfare of adults who may be at risk of harm to both prevent and protect from abuse.
The Wolverhampton Adult Safeguarding Board oversees the effectiveness of the arrangements made by individual agencies and the wider partnership as a whole to safeguard adults from abuse in the city. The Boards function is not operational, it does not undertake safeguarding enquiries or investigations, it is however responsible for co-ordinating, planning, commissioning and keeping up to date with legislation and national developments. The Board therefore contributes to the wider aim of improving the safety and wellbeing of adults in Wolverhampton.

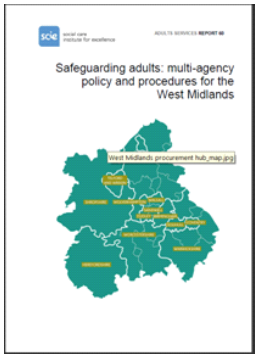
In 2012 the Board agreed to adopt the **Safeguarding Adults Multi-Agency Policy and Procedures for the West Midlands** which had been developed by a small working group of regional safeguarding leads, chaired by the Wolverhampton Safeguarding Manager Sandra Ashton-Jones. The working group was supported by SCIE (Social Care Institute for Excellence) and ADASS (Association of Directors of Adult Social Services). The new policy and procedures had their regional launch in July 2012 at an event held at the University of Wolverhampton. It was agreed that each of the Safeguarding Adult Boards across the West Midlands would adopt the new policy and procedures over the following twelve months. The Safeguarding Adults Multi-Agency Policy and Procedures for the West Midlands were implemented in Wolverhampton in January 2013. They will ensure consistency across the region which is of particular importance to organisations that provide services across Local Authority boundaries.

The key changes include;

- the introduction of the alert form to the process
- the change in terminology – from 'vulnerable adult' to 'adult at risk',
- 'Alleged perpetrator' to 'person alleged to be causing harm' and investigation planning meeting (IPM) to strategy discussion/meeting
- new timescales.

For further information please see attached link:
http://www.scie.org.uk/publications/reports/report60

The Board also agreed to adopt and implement **Regional Threshold** guidance. This is a tool to assist in deciding whether an incident or concern is progressed through the safeguarding procedure. The document asks pertinent questions around harm, frequency and severity and provides clarity and consistency in deciding 'what is safeguarding' and what is not. It also allows for partner agencies to, where appropriate, respond to poor practice issues without the need for initiating safeguarding procedures. This aims to prevent unnecessary investigations and at the same time enable valuable resources to focus on genuine safeguarding concerns.



The Structure and Work of the Board

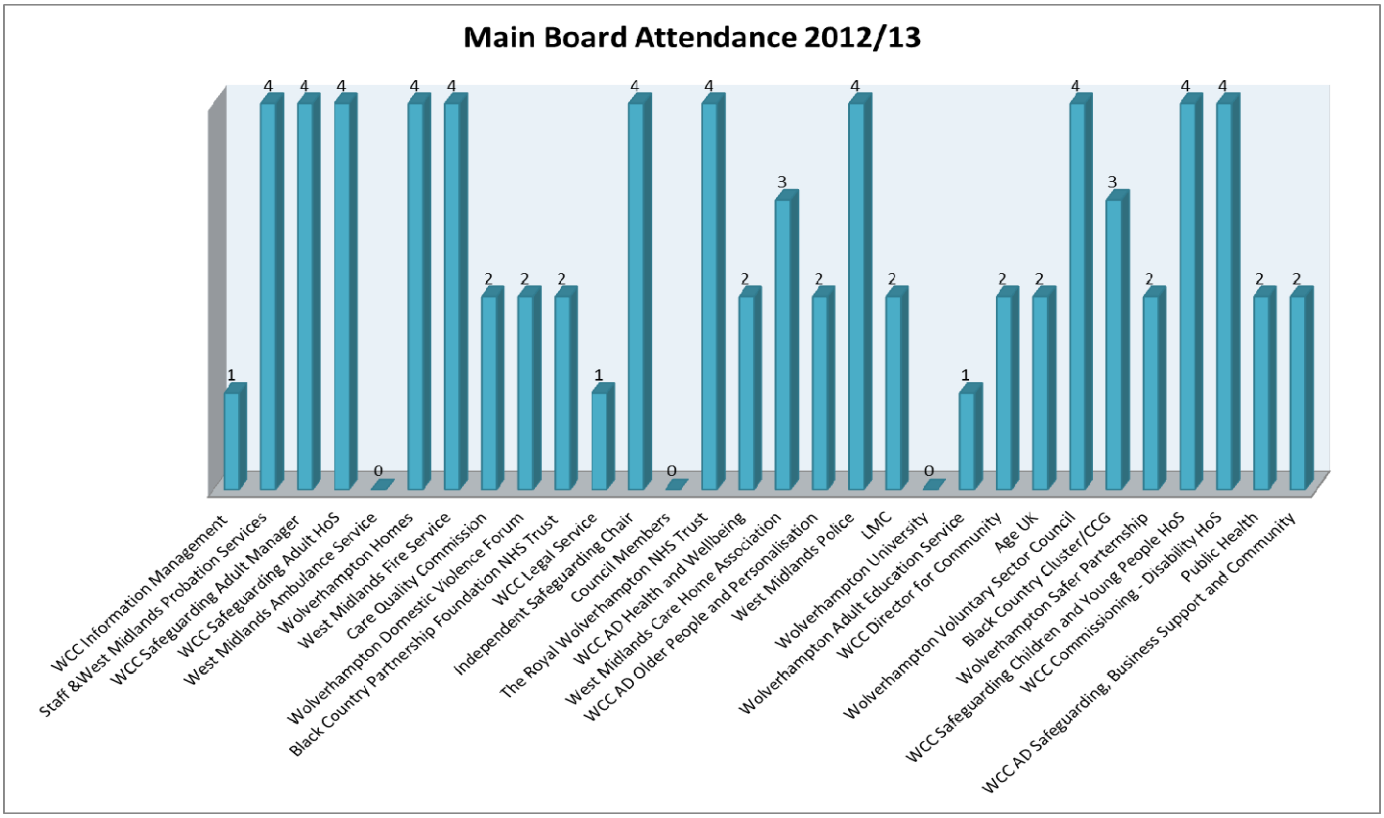
The Wolverhampton Safeguarding Adults Board (formerly the Safeguarding Vulnerable Adults Board) is well established and provides strategic leadership for adult safeguarding work and seeks to ensure there is a consistently high standard of professional response to situations where there is actual or suspected abuse.

The Board has an independent Chair, Alan Coe. In February 2013, Alan was also appointed to the role of independent chair of the Wolverhampton Children's Safeguarding Board. There are many advantages of having the same chairperson for the two Boards. A joint chair will help improve ways of preventative working as many issues are common to both adults and children, and there will be a greater emphasis on developing joint approaches to recognising and tackling abuse.

Fourteen agencies are represented on the Board see Appendix 1 for list of Board members. This year the Board has lost two organisations from the Board, the University of Wolverhampton and Wolverhampton Education Service, the latter will however continue to receive minutes. It is agreed that the Care Quality Commission will attend and report on their activity at one Board meeting each year. The Board also has the support of two elected Council Members who attend meetings when they are able to do so and have participated in various adult safeguarding events. The Board endorsed five observers from governing bodies of member organisations to attend the open part of the Board meeting. See Appendix 1 for Board membership details.

The Board has four meetings per year; it also has one development event which usually takes place in March. The minutes of all the meetings can be found on the Councils' Safeguarding Adult webpage:
http://www2.wolverhampton.gov.uk/health_social_care_2/adult_social_care/protecting_vulnerable_adults/

It is expected that the work of the Board is reported back by members to their organisations using their internal governance structures. Attendance at Board meetings is detailed below.



This year the Board has successfully jointly hosted two events with other partnership boards. In February 2013 a conference on forced marriage organised by the Safeguarding Adults and Children Boards in partnership with West Midlands Police and Wolverhampton Domestic Violence Forum took place.

Over 150 delegates attended who heard Jasvinder Sanghera and 'Yasmin' from Karma Nirvana speak movingly about their experiences of forced marriage. Other speakers included His Honour Judge Cardinal, Detective Sergeant Trudy Runham from West Midlands Police and Chaz Akoshile from the Forced Marriage Unit. Solicitor Monika Bindal from Birmingham City Council and Kathy Cole-Evans from Wolverhampton Domestic Violence Forum also contributed to the day.

The next step is look at developing a joint, children and adult's forced marriage and honour based violence protocol. Consideration is being given to this being developed regionally with neighbouring local authorities and West Midlands Police.

Jasvinder Sanghera (Karma Nirvana) is pictured here with
Judge Cardinal, Kathy Cole-
Evans (Wolverhampton Domestic Violence Forum)
Monika Bindal (Solicitor)
Dawn Williams (Head of Children's Safeguarding),
Penny Darlington (Head of Adults Safeguarding)

Also in February 2013 the Adult Safeguarding Board jointly hosted an event with the Learning Disability Partnership to look at the scandal of Winterbourne View Hospital and sought assurances that the same thing is not happening and will not happen in Wolverhampton.

The Board has not published any Serious Case Reviews during the year but completed a Serious Management Review following a large scale investigation. The purpose of the review was to establish whether there were lessons to be learnt from the circumstances of the case regarding the way professionals and agencies worked together to safeguard adults at risk and inform and improve inter- agency practice and information sharing.
As this was not a Serious Case Review the conclusions were not published. An action plan was developed and the Board has regularly monitored progress against the action plan.
The Board also decided to hold an extraordinary meeting in May 2012 to look at the recommendations that came out of a large scale safeguarding investigation undertaken in Solihull concerning the Castlebeck organisation. Castlebeck was the organisation responsible for Winterbourne View Hospital. The Board sought assurances that such incidents could not occur in Wolverhampton.

The Work of the Board's Working Groups

The Board has five working groups which carry out particular pieces of work or detailed analysis of specific issues and report back to the main Board. The working groups are scheduled to meet four times a year.

Attendance at the all of the working groups has been inconsistent and at times problematic. This has in part been caused by the reduction in capacity of many partner agencies as they struggle to do more with fewer resources. To address this, the Board is supporting innovative ways of implementing our priorities. This includes doing more in partnership with other local boards, getting more work done by time-limited Task and Finish groups and ensuring greater board leadership and oversight of our work programme. This has been reflected in proposals to be submitted to the June Board in 2013/14 cycle.

The working groups for 2012/13 were:

- Policy, procedures and strategy
- Communication, community engagement and marketing
- Workforce Development
- Quality assurance and performance management
- Mental Capacity Act/ Deprivation of Liberty Safeguards

A summary of the achievements and challenges faced by the working groups is attached in appendix 2.

Summary of Board Progress against 12/13 Board Priorities

1. Prevention

- Carers Task and Finish Group met to review Association of Directors of Adult Social Services recommendations. Carer's literature was reviewed and safeguarding workshops held.
- Adult Safeguarding Training delivered to over 70 GP's in the City
- Draft Trigger protocol devised to identify people who are potentially at risk, this is an on-going piece of work
- System developed to evaluate impact of safeguarding training
- Action Plans completed by Royal Wolverhampton NHS Trust and Black Country Partnership Foundation Trust to ensure effective hospital discharge
- Safeguarding Board Annual Self -Assessment tool reviewed and regional model approved.

2. Improved Practice

- A random sample of safeguarding cases are audited every quarter, learning is reported to Heads of Service and the Board
- Data reports detaining safeguarding performance and activity are submitted to each Board, including a summary on an annual basis at the end of year
- Wolverhampton Local Medical Council (LMC) is now represented at the Board by two GP's who have attended the Board meetings
- The Safeguarding Adults Multi- Agency policy and procedures for the West Midlands and local practice guidance for social work practitioners and service providers and partner agencies were approved and implemented
- The Safeguarding Board held a launch event for the new Policy and Procedure and Threshold guidance in January 2013.

3. Transparency

- The Board endorsed five observers from the governing bodies of member organisations can attend the open Safeguarding Board meeting
- Minutes of the open Safeguarding Board meeting are published on the Council website

An interview with Alan Coe, Independent Chair describing the work of the Board and raising awareness about Adult Safeguarding was filmed and hosted on You Tube and Wolverhampton Today's Facebook page http://www.youtube.com/watch?v=ggy_F6aoB94&feature=youtu.be

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- In order to gain the voice of people who have experienced adult safeguarding a sample of people has been identified. Contact has been made and interviews are taking place, undertaken by the Safeguarding Team on behalf of the Board.

Board Priorities 13/14

The Board Priorities for the coming year 2013/14 are:

- **Priority One:** Better outcomes**:** Service User experience and involvement in safeguarding enquiries directs improved practice.

- **Priority Two:** Quality Assurance: Ensure there are effective Multi- Agency Quality Assurance and Performance Management processes in place.

- **Priority Three:** Information Sharing: improvements are made to how agencies can share personal information legally and ethically to enable adults to be protected from harm or unwarranted risk.

- **Priority Four:** Prevention: there is a coherent inclusive approach by both Safeguarding Boards to community initiatives which protect disadvantaged groups.

- **Priority Five**: Communication and Engagement: there is a consistent and co-ordinated approach to how the safeguarding message for both adults, young people and children is disseminated to all groups and communities.

- **Priority Six**: Workforce Development: the workforce of all partner agencies have undergone save and robust recruitment processes and understand safeguarding issues as they relate to their role.

Partner Achievements

Wolverhampton City Council: Adult safeguarding is included as a key strategic priority for Partners contributing to the City Strategy. To look at how the Partnership is contributing to make the City a safer place to live and work, the Council is required to give bi-monthly update report to the Partnership on four areas: how it has implemented the Board's new adult safeguarding policy, what it is doing to 'hear' the voices of adults experiencing safeguarding processes; what it is doing to develop the workforce's response to safeguarding and finally, how it is will use a review by safeguarding peers to help improve the Council and partners safeguarding practice.

Many parts of the council contribute towards helping adults who may be at risk of harm keep safe. This includes services as diverse as Trading Standards, the Council's workforce development services through to social work operational teams who undertake direct enquiries sometimes jointly with the Police when a concern about abuse is received.

Specific safeguarding initiatives taken last year by Council services included:

Adult Social Care Services: There has been recognition that in the past, Councils have focused their attention on safeguarding processes such as the numbers of people about whom safeguarding concerns have been raised, rather than understanding what people felt had been achieved by a safeguarding intervention.

To change this, last year the Council improved its guidance and safeguarding systems for social work staff and managers. This included making sure that when a safeguarding allegation is being investigated; the social worker explains to the adult at risk what would happen understand their expectations of the investigation and checks out when it is completed if the person's expectations have been achieved. New systems were introduced in September to see if adult expectations had been achieved. Between 1 September and 31 January 2013, of the 125 completed safeguarding investigations, 96% of all adults at risk who were able to give their views indicated their expectations had been met.

Further changes have also been made to check that people who raised adult safeguarding concerns were advised that this had been looked into and, where appropriate, given more information.

The Council also made changes in two key areas of practice to establish whether its safeguarding practice was of good quality and better understand what adults felt about their experience of safeguarding practice. Firstly, it improved its existing quarterly sample quality checks to review how it had responded to safeguarding allegations and it began to plan how it could develop this further by quality checking more cases and across more of its work. This will be a priority for 2013-14. Secondly, it embarked on a system of gathering the views retrospectively of adults and/or their carers who had direct recent experience of safeguarding and to use this to change social work practice. This work is in its early stages but will continue during the next reporting year and is a priority for the Council for 13-14.

Children's Safeguarding: In February 2013 Alan Coe was appointed as the independent Chair for the Wolverhampton Children's Safeguarding Board, Alan now chairs both the Adult's and Children's Boards and one of the benefits is that there are common business interests which can be more easily managed when Boards need to be brought together to agree a coherent approach around common interest issues such as safe recruitment , transition, domestic violence, and safeguarding awareness raising and training.

During this last year the Children's Safeguarding Board has jointly hosted a one day conference with the Adults Safeguarding Board, Wolverhampton Domestic Violence Forum and West Midlands Police on Forced Marriage and is now involved in taking this forward to implement a local multi- agency process consisting of Policy and Procedures which is in line with that developed and used across the West Midlands region.

The Board has also developed a Hidden Harm- Parental Substance Misuse and the Effects on Children Multi-Agency Guidance; this guidance introduces a 'whole family' approach, including adults at risk. The guidance is to be launched to Partner Agencies across both the adults and children's workforce in July 2013.

Commissioners for people with a learning disability: Work has been undertaken with Adult Social Care and Heath colleagues to take forward the agreed recommendations following enquires into Winterbourne View. These have included carrying out reviews of some people with learning difficulties living in care and hospital settings and looking at alternative ways of them receiving help and support.

Trading Standards: The Council's Adult Safeguarding and Trading Standards services have been working in partnership to improve the services offered to Wolverhampton residents.

Trading Standards officers have provided training to the Adult Social work teams on how to spot victims of scams and rogue traders, what the Trading Standards service can do and how to contact them. In turn, officers from Trading Standards attended Adult Safeguarding in-house

Training on the new Safeguarding adults: multi-agency policy and procedure, to gain a better understanding of the referral process. This has led to an increase in the number of referrals relating to adults at risk being received by Trading Standards through the new channels and an improved understanding of what each service does. Training by Trading Standards was also extended to Local Policing Units, Local Neighbourhood Partnership wardens and professional carers and is on-going within the community to raise awareness of scams and what action to take.

One referral ultimately led to the successful prosecution of a mobility aids supplier, where both the company and salesman were found guilty of supplying unnecessary equipment costing £12,000 to a vulnerable homeowner.

Quality Assurance & Compliance Team: The team monitors a wide range of care and support Services commissioned by the Council and works closely with colleagues in safeguarding and commissioning as well as those involved in measuring the quality and safety of care services such as the Care Quality Commission and the Clinical Commissioning Group.

A set of outcome focussed Quality Standards developed by the team has recently been approved by the directorate; these will be used to measure the quality of care services and are an important element of the robust Quality Assurance System that is being developed to measure quality. They will help people using or thinking about using a care Service to think about what is important for them, and what they should expect from a Service.

West Midlands Police (WMP): The Black Country Vulnerable Adults Hub based at West Bromwich Police Station commenced on 14 January 2013. This is a six month pilot encompassing Walsall, Wolverhampton, Sandwell and Dudley, bringing together expertise into a specialised hub from the four local authorities working together with one team of officers from West Midlands Police. Initiated to foster a more cohesive approach to safeguarding, the hub aims to prevent any inconsistencies across the four Black Country Policing units in the way that incidents involving vulnerable adults are dealt with.

To ensure that the referral process is consistent and efficient all referrals will be made through a single route via a dedicated secure email address and telephone number. This ensures that our response to referrals is prompt and efficient.

The Black Country Vulnerable Adult Hub is more than just a referral team. It's a centre of excellence, responsible for reviewing all vulnerable adult referrals, setting initial crime investigation and safeguarding plans and sharing intelligence. Internal refresher training to our colleagues is being completed to ensure a better understanding of vulnerable adult abuse. The hub is a dedicated point of contact for safeguarding managers, and all Police staff.

Evaluation since January 2013 including partner's feedback has directed that the hub is working well, having a dedicated team, with a standardized approach across the Black Country providing best practice to safe guard vulnerable adults.

The workings of the Hub have now been approved by Birmingham Safeguarding Adult board, who will join the hub at the end of June 2013, providing three additional Police Officers from Birmingham. Five local authorities and eight local policing units are working in line with the remit of the hub. Phase Three will be September 2013 when Solihull and Coventry join the hub providing a force wide consistent approach to safe guarding adults at risk of harm.

West Midlands Police have a dedicated Vulnerable Adult web page on the Force Intranet, which provides detailed knowledge, awareness and signposting for members of the public and partner agencies who access the site for Adult Safeguarding guidance. In addition, WMP are in the process of launching a dedicated Vulnerable Adult Twitter account, which will provide increased awareness and national Safeguarding Adult updates.

This will be shared with all Safeguarding Partner Agencies in addition to all WMP staff and will be accessible to members of the public.
WMP have a formal Vulnerable Adult Delivery Plan, created and managed by DCI Martin Hurcomb, who leads on this portfolio for WMP. DCI Hurcomb represents WMP at the Wolverhampton Safeguarding Adults Board and leads on the National Vulnerable Adult agenda for the Association of Chief Police Officers with Assistant Chief Constable Gary Cann. The Delivery Plan is utilised as a quality and performance measurement tool by WMP to actively track and assess Vulnerable Adult work streams and overall progress. Much of the WMP Vulnerable Adult Delivery Plan supports national Vulnerable Adult work streams being developed by ACPO and the Home Office.
The WMP lead for Wolverhampton domestic abuse safeguarding, Detective Inspector Jenny Bean, has created a Multi-Agency Risk Assessment Conference (MARAC) Power Point presentation that explains the MARAC assessment process and how this protects all high risk victims of domestic abuse. DI Bean will present the presentation at a future Sub-Group and/or SAB for the benefit of Board members. DI Bean chairs all MARAC meetings for Wolverhampton and is actively engaged in the MARAC Steering Group.

Black Country Partnership Foundation Trust (BCPFT): The BCPFT is planning to integrate their risk management database with the recording of safeguarding alerts. The new IT system is currently being developed to coincide with other reporting data so triangulation can take place. The internal scrutiny of safeguarding alerts internally has improved via minor improvements being made to the database

The BCPFT has successfully recruited to two new posts. The Head of Safeguarding Adults will provide operational management to the team and ensure a wider focus with other aspects of safeguarding. An additional safeguarding practitioner has been appointed specifically to cover the

services provided in Wolverhampton and Dudley locations. Both post holders will take up post on 1 July 2013

A new process for awareness raising has been developed and implemented, which requires staff to receive training at induction and then three yearly. This is being monitored on a monthly basis and further specialist levels of training are currently under development based on the Bournemouth competency framework.

West Midlands Fire Service: A priority was set last year for Vulnerable Persons Officers to cascade 'Adult Safeguarding: Recognising & Reporting' Training to frontline fire crews, this remains a priority for the coming year and is on-going.

The development of the 'Wolverhampton Multi Agency Referrals Hub' to include agencies providing service to vulnerable adults and therefore increase appropriate referrals for home safety checks and for other services across Wolverhampton is on-going. The information sharing protocol and user agreement have both now been written and in a recent meeting with a public health colleague it was agreed that the Wolverhampton Multi Agency Referrals Hub' would move ahead.

The numbers of Vulnerable Persons Officers has increased, the target set last year was to have 13, and this has been exceeded as currently there are 16 so this target was achieved.

The West Midlands Fire Service Safeguarding Training (WMFS):

- The West Midlands Fire Service (WMFS) have been able to access Wolverhampton City Council's workforce development training programme for adult safeguarding.
- 7 staff (Vulnerable Persons Officers) have attended 'Adult Safeguarding: Recognising and Reporting' course
- 4 staff have attended 'Mental Capacity Act' training
- 2 staff have also attended 'Adult Safeguarding: Train the Trainer' course
- A WMFS representative attended the launch event of the pan West Midlands Policy and Procedures document
- WMFS delivered a joint workshop with mental health services at the Wolverhampton Citywide Information Sharing Protocol launch event (regarding sharing information amongst agencies).

Future development of safeguarding training:

- WMFS have established a working group to create a WMFS wide adult safeguarding: recognising & reporting training package to deliver to frontline operational crews

- Through a service level agreement, WMFS Vulnerable Persons Officers can now access Birmingham Care Development Agency (BCDA) classroom courses and e-learning courses free of charge and 'Learning Pool' e-learning courses free of charge

- Through a service level agreement, WMFS operational crews can now access Birmingham Care Development Agency e-learning courses free of charge

- The West Midlands Fire Service are developing an 'extended home safety check' service (to be piloted in Coventry this year) where our routine home safety checks will be extended to include frontline crews having to check for signs of any adult safeguarding issues (as well as child safety, carbon monoxide and signposting to healthy lifestyles services etc.)

- We will also be creating a training DVD to assist the fire fighters in how to carry out an 'extended home safety check' service, which will have a 'safeguarding' chapter (showing crews some of the 'signs' to recognise whilst carrying out a home safety check).

West Midlands Ambulance Service NHS Foundation Trust (WMASFT): West Midlands Ambulance Service NHS Foundation Trust (WMASFT) has continued to ensure the safeguarding of vulnerable persons remains a focal point within the organisation and the Trust is committed to ensuring all persons within the region are protected at all times.

West Midlands Ambulance Service NHS Foundation Trust serves a population of 5.36 million people covering an area of more than 5,000 square miles made up of Shropshire, Herefordshire, Worcestershire, Warwickshire, Staffordshire and the Birmingham, Solihull and Black Country.

For the year 2012/2013, 7562 safeguarding adult referrals were made. This has decreased from 7754 referrals in 2011/2012.

The primary justification for the reduction in the numbers of adult referrals is attributed to the situation regarding Care Concern calls. A Care Concern call surrounds an individual whom is not subject to harm being caused by a another individual/organisation (safeguarding) but more commonly as a result of one's own inability to cope with their current situation e.g. an elderly male self-neglecting. WMASFT until the start of 2012 always accepted Care Concern calls being passed via the safeguarding referral route. The Trust received an immense amount of pressure to cease this practice from partner agencies. WMASFT did cease this practice, however, following advice from the experts both within and external to the organisation the practice of receiving Care Concerns recommenced in September 2012. Clinical Notice was issued to inform the staff of the change. If the patient does not have capacity then a referral will be made under best interests. This is being constantly reviewed to ensure WMASFT are acting in accordance with the law.

The Safeguarding Team (together with the Education and Training Department) have delivered extensive education (Educare, Clinical Notices, VLE, Clinical Times and Weekly Briefing articles, direct training, mandatory workbook and University engagement). This has led to a the quality of referrals being substantially increased and can be evidenced by a reduction in the amount of concerns from partner organisation's in regard to our referrals.

The introduction of the Directory of Services has seen an improvement in the amount of direct referrals to partner agencies (Care Concern) and these are now as a result not being required to be passed via the Safeguarding line.

The success of the High Volume Service User scheme has resulted in many patients whom would have previously been subject to multiple referrals (often several a week) now being successfully managed by the safeguarding team and the operational leads resulting in a reduced number of referrals as there no longer is a need to make a call.

The Safeguarding Team have conducted an in-depth call audit and have established that over a one month period the call abandonment rate for the safeguarding line was 29%. We are unable to establish what percentages of these calls were never re-presented. The assumption is that it would be very low however we are unable to evidence that. We will be introducing a final question into the question set to establish the number of attempts to pass the call as a further level of assurance in the next audit.

Royal Wolverhampton NHS Trust (RWHT): The post of an independent domestic violence advisor (IDVA) which is externally funded was filled in October 2012 for a period of one year. The post holder is based in the Emergency Department receives Trust - wide referrals and undertakes an educational/awareness raising role across the Trust. The service has been well received.

Level 2 adult safeguarding training has been delivered by an independent training provider. Level 3 training will be completed July 2013 to identify practitioners. Staff have also received PREVENT training which is part of the Government's counter terrorism strategy.

Dignity Champions have been established across the organisation with a defined role. These have been established and their work contribution will be on-going.

Wolverhampton Probation: An adult safeguarding resource page has been created on the Probation intranet with links to appropriate resources. There is not a specific probation adult safeguarding policy but many of our procedures are linked to the agenda. Further work is outstanding, however, in terms of establishing their compliance with the new pan-regional procedures.

The Probation Service has reviewed its provision of interventions to the perpetrators of domestic abuse to confirm that they are appropriate in terms of reducing the risk posed to the adult victims of the abuse. This includes refining targeting to ensure maximise use of those programmes that provide independent support to those vulnerable to victimisation.

Probation has continued to deliver a range of interventions to convicted domestic abusers with a primary aim of reducing repeat victimisation. The Probation Service is now awaiting the roll out of a new nationally mandated programme; however, 'Building Better Relationships' which will further develop our work.

Mental Health Treatment Requirements are now established as a court disposal based on a

protocol involving probation, courts and the Black Country Partnership. They are primarily targeted at individuals whose health contributes to a risk of serious harm toward third parties.

West Midlands Care Home Association: The take up of Adult Safeguarding training by Care homes has been very positive and welcomed by care homes in the city.

Training sessions have taken place to look at the quality of Safeguarding Alerts completed by service providers in order to improve the quality and ensure appropriate detail is included on the Alert Forms.

All homes strive to adhere to the Care Quality Commission guidelines in terms of employment and recruitment. The issue of no Disclosure and Barring Service (DBS) adult first check for non - caring staff is a concern.

Community Safety Partnership: Purpose specific information sharing protocols have been developed for both the Families in Focus programme and to aid the work around tackling gang and youth violence. Partners have made a commitment to share information to progress these areas of work; some of the processes to aid the easier flow of information are still being finalised. Available data has been used to identify where our new and emerging communities are settling in the city. Further work, driven largely through partners in the third sector, has started to work closely with some of these communities to understand their support needs and address their concerns. Work funded is project based and therefore of a short term nature. A New Arrivals group established in the city has developed to coordinate the multi-agency response to emerging issues.

The multi-agency approach to reduce vulnerabilities of women and girls has been led by Wolverhampton Domestic Violence Forum; a strategy has been developed and adopted to guide improvements to tackle domestic violence, sexual violence, Forced marriage, female genital mutilation and honour-based violence. A highly successful forced marriage conference held earlier this year was effective in raising awareness of the issue with a view to increasing referrals into appropriate support services. A move to integrate the work around women and girls as part of safeguarding mainstream practice and guided by recommendations from the recently completed domestic homicide review, there will be a need to maintain the steady progress of improvement over the coming year.

Wolverhampton Homes (WH): In light of the development of the West Midlands Safeguarding Policy and Procedure, Wolverhampton Homes has reviewed its own procedures, amending where necessary and adopting common terminology to allow ease of information sharing across and between organisations. WH has also re-named its policy and procedure the again to run in parallel with the West Midlands approach to safeguarding.

Safeguarding awareness sessions have already been delivered to some 119 staff but there is the intention now to refresh this awareness by holding more sessions to be delivered by a specialist trainer. Planning for these sessions will start mid-July.

119 Wolverhampton Homes staff have undertaken Safeguarding Adults and Children training this was supplemented by staff briefings.

266 WH staff have received domestic abuse training.

Safeguarding training was provided by the Chartered Institute of Housing and the Domestic Abuse by The Haven (Refuge).

It is proposed that safeguarding becomes part of the Induction Course attended by all new employees from later in 2013. Discussions are on-going with Wolverhampton Homes Learning and Development Section in relation to the inclusion of this in the induction process.

Dementia awareness raising sessions have been arranged and will take place for front line staff in July 2013.

The Anti - Social Behaviour teams within Wolverhampton City Council and Wolverhampton Homes have joined forces to work as a city-wide team, tackling anti-social behaviour - the team now work from one location based at Old Heath Office and cover a wide range of issues relating to anti - social behaviour including hate crime.

Wolverhampton Homes Human Resources section is reviewing job roles in light of the changes in the definition for regulated activity with adults (as per Protection of Freedoms Act 2012).

A year-long campaign aimed at raising awareness of Hate Crime was run by Wolverhampton Homes during 2012. The campaign aimed to promote the reporting of Hate Crime and looked to generate wide, public support within the city to stamp out hate. The campaign asked individuals and organisations to publicly pledge to stop hate. The pledge being taken was:

I pledge that:

- If I see or hear hate crime towards me or anyone else in Wolverhampton I will report it
- I will tell my friends and family about the Stop Hate in Wolverhampton campaign
- I will respect other peoples' differences.

Wolverhampton Domestic Violence Forum (WDVF): Developing a joint training programme around Violence against Women and Girls for both Boards.

Initial discussions have taken place with both Boards with a view to developing a joint training programme that resulted in the first joint Board conference being held in Feb 2013; this one on Forced Marriage and so-called Honour Crime. The conference was well attended, had significant positive multi-media coverage, with outstanding evaluation and feedback from delegates. Work is ongoing to build on the success of this first event, including identifying further joint training and awareness raising opportunities around this agenda. There will be areas of joint learning arising from the domestic homicide review that will be addressed through a Task and Finish Group.

Developing and consulting on Violence against Women and Girls Strategy. This priority action has been completed. A compact-compliant consultation was undertaken prior to launching Wolverhampton's Violence against Women and Girls 3 year strategy 2013-2016. The strategy has integrated action plans that cover domestic violence, sexual violence, female genital mutilation, forced marriage, and so-called honour crime. The strategy and action plan is overseen by WDVF's Executive Board and progress will be reported to the Safeguarding Adult Board amongst other board structures.

WDVF supported the Safer Wolverhampton Partnership in setting up a process for conducting domestic homicide reviews. Unfortunately there was one such tragic domestic homicide in Wolverhampton in December 2011, and this prompted a multi-agency homicide review being undertaken. WDVF participated fully in the review, being the nominated lead for progressing three of the twenty four strategic recommendations from the review. The report will be released following Home Office approval, and progress monitored through WDVF Executive Board. There will be areas of joint learning arising from the domestic homicide review that will be addressed through a Task and Finish Group. Since the legislation came into force in April 2011 there have been over 20 domestic homicide reviews across the West Midlands, and SWP is currently progressing a mechanism to share these lessons with other local areas.

Clinical Commissioning Group (CCG): The Clinical Commissioning Group (CCG) recognises its statutory responsibilities for safeguarding adults and has appointed to its organisational structure an Executive Lead Nurse who is leading on the delivery & fulfilment of these responsibilities. This includes active involvement and attendance in the work of Wolverhampton Safeguarding Adults Board and targeted development work to be undertaken across the CCG and where necessary in conjunction with other stakeholders. Regular attendance at WSAB has occurred during the reporting period.

The CCG and Local Authority entered into a joint organisational approach to ensuring clinical quality outcomes are embedded into care homes across Wolverhampton by the joint hosting of the Care Home Quality Nurse Advisor.

The Care Home Quality Nurse Advisors (QNA) facilitates effective inter-agency information sharing and quality monitoring through the use of clinical monitoring tools. To date the role has introduced the Clinical Indicator Assessment Framework and the National Safety Thermometer to most Wolverhampton Nursing Homes enabling the timely identification of poor performance and providing a platform for targeted interventions to improve quality and performance.
The CCG is currently developing its Nursing Home Strategy; an integral component of the strategy will address gaps in clinical quality identified via the Clinical Indicator/Safety Thermometer and safeguarding referrals/themes. This will be achieved by delivering a nursing home improvement program that will provide Best Practice Guidance/Prioritised training and Manager Induction to drive clinical quality.

The QNA role is a conduit for Adult Safeguarding referrals into the CCG's Quality and Risk Team, providing the CCG with current, overarching knowledge of safeguarding issues in Wolverhampton. In turn the CCG contributes clinical quality monitoring and professional clinical advice to individual safeguarding investigations and Large Scale Strategy Meetings.

In partnership with the Safeguarding Team at the Local Authority the QNA and Senior Quality and Risk Team are in the process of developing protocols for health and social care that will enable the

reporting of all grade 3/4 pressure ulcers as a safeguarding ALERT in line with the West Midlands multi-agency policy and procedure.

The CCG is committed to developing and actively supporting continuous improvement in adult safeguarding and strives to ensure that the findings from the Safety Thermometer, Clinical Indicator Reporting Framework and continued close liaison with the care home sector go some way to assuring the quality of care being commissioned across the city.

Training/Workforce Development

The Council's Workforce Development Team and Adult Safeguarding Unit refreshed the training plan for 2012/13. Further development activity was commissioned from the specialist providers already working with Wolverhampton City Council. This ensured that there was consistency and continuity based on the evaluation of the programmes previously commissioned.

Below is a summary of the training attended by internal and external workforce in Wolverhampton during 2012/13. All Council workers who may come into contact with adults at risk have learning opportunities to help them understand and recognise what abuse is and how to respond should they come into contact with people that are experiencing abuse. However it became clear during the year that the Council does not centrally audit which of its staff has had safeguarding training, and who needs it. Having a workforce development plan which includes safeguarding awareness for council staff will be one objective for its workforce development service for 13-14.

Adult Safeguarding - Provider Managers	25
Adult Safeguarding - Recognising and Reporting	76
Adult Safeguarding Investigation	12
Mental Capacity Act Theatre Workshop	151

Safeguarding Vulnerable adults- Adult safeguarding DVD (train the trainer)

Work now needs to take place on a training need analysis for internal and external staff to give a better picture of the further needs in relation to awareness raising, part of this process will need to include helping providers understand the benefits of using the DVD or e learning for this purpose. In addition the benefits of use of the Learning Hub, in particular blended learning need to fully explore. In particular the opportunities for the whole of the internal workforce and better links with Children's Safeguarding service.

It has been identified by social care managers and staff that the modular programme was most beneficial and that an added benefit would be if it was accredited and formed part of CPD requirements in particular for Social Workers. This has now been achieved by working with Wolverhampton University and Marion Dakin Associates; this will be available in September 2013.

In order to promote awareness of the newly implemented Policy and Procedures six sessions were held between January and March to which over 200 people attended.

Performance 12/13

Key Findings

The number of alerts received has increased significantly to 1172. This increase can be attributed to increased public awareness through both safeguarding awareness activities organised by Wolverhampton City Council and Partner Agencies and also press coverage around abuse in Care Homes.

The number of alerts that are converted to referrals (triggering an investigation) has, at the same time decreased to 475 in the period. This decrease can be attributed to a more consistent and clear understanding of the safeguarding thresholds that lead to an investigation.

The proportion of "unknown" cases reported in the AVA return has increased due to an increase in the number of cases raised against homes rather than individuals, for these alerts there are no individually named adults at risk, the Alerts are raised against a particular service so many of the questions such as age, ethnicity etc do not apply.

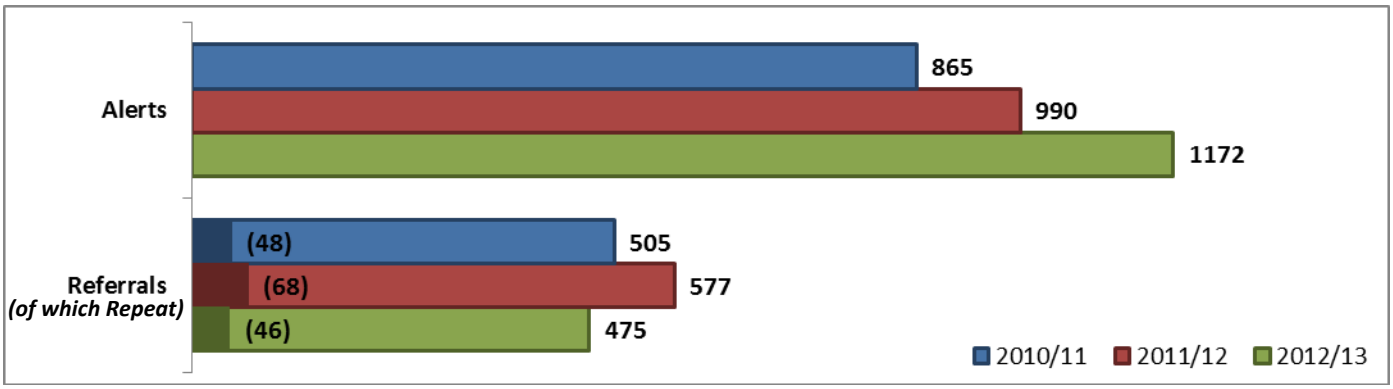
The proportion of cases where the person suspected to be causing harm was "unknown" has decreased significantly from 73% to 54% indicating an improvement in data collection and recording during the investigation process.

1 - Alerts and Referrals

The number of safeguarding alerts has increased every year for the last three years to 1172 alerts in 2012/13. This is an increase of 18% on the 2011/12 result.

	2010/11	2011/12	2012/13
Alerts	865	990	1172
Referrals	505	577	475
Repeat Referrals	46	68	48

The number of alerts that then go on to referral has decreased, with only 41% of alerts proceeding to investigation, down from 58% in both 2010/11 and 2011/12.

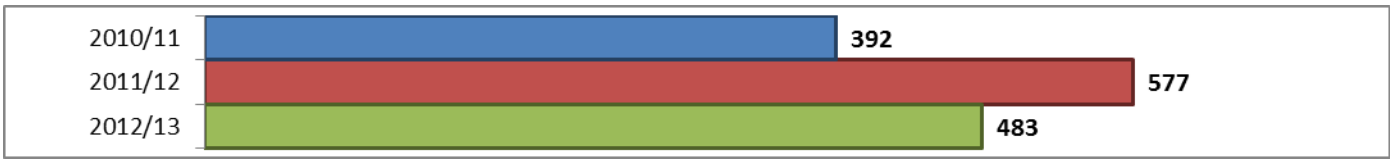


The continued increase in the number of alerts shows that there is increased awareness of Adult Safeguarding.

The decrease in the number of referrals can be attributed to the launch of the new Regional Thresholds which provide a more consistent and clear understanding of the safeguarding thresholds that lead to a safeguarding investigation.

2 - Completed Referrals

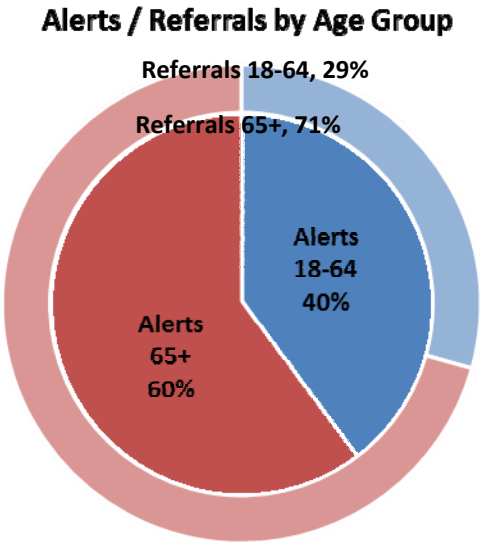
	2010/11	2011/12	2012/13
Completed Referrals	392	577	483

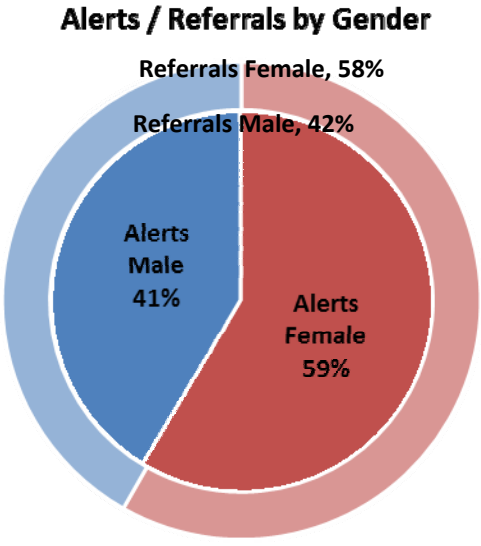


The number of completed referrals in the year has decreased due to a decrease in the number of safeguarding referrals received. This value in itself shows no underlying trends or issues.

3 - Alerts and Referrals by Age and Gender

	Alerts				Referrals			
	Female	%	Male	%	Female	%	Male	%
Age 18-64	217	50.1%	216	49.9%	57	43.2%	75	56.8%
Age 65+	419	64.2%	234	35.8%	205	64.5%	113	35.5%
Total	636	58.6%	450	41.4%	262	58.2%	188	41.8%





In the above pie charts the inner circle shows the proportions of alerts received and the outer bands represent the proportion of referrals. Ideally the two should match.

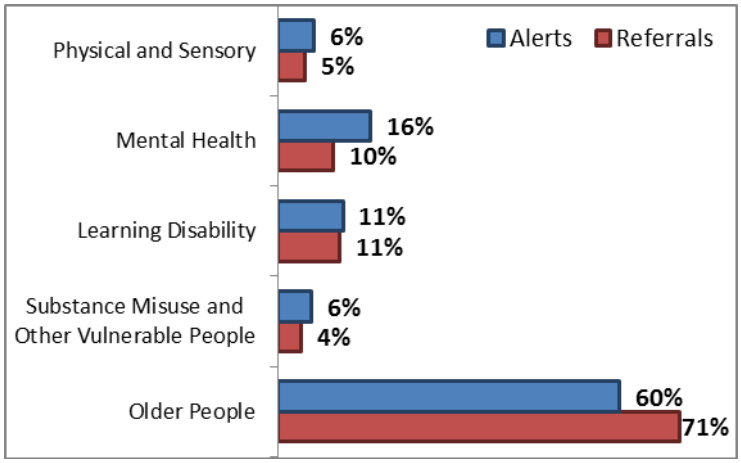
The breakdown by age shows that although 40% of alerts received are for people aged 18-64, only 29% of these then go on to become a referral. This indicates that safeguarding intervention is not required or is not appropriate in a larger proportion of 18-64 alerts. The higher proportion of alerts for people aged 65+ is expected due to the nature of safeguarding and adult social care.

The breakdown by gender shows a 59% female, 41% male split which is what would be expected based on the fact that a larger proportion of the 65+ population of Wolverhampton are Female.

4 – Alerts and Referrals by Primary Client Group

	Alerts		Referrals		Repeat Referrals	
	Number	%	Number	%	Number	%
Physical and Sensory Disability	69	6.4%	21	4.7%	2	4.7%
Mental Health	177	16.3%	44	9.8%	4	9.3%
Learning Disability	124	11.4%	49	10.9%	6	14.0%
Substance Misuse	6	0.6%	1	0.2%	0	0.0%
Other Vulnerable People	57	5.2%	17	3.8%	1	2.3%
Older People	653	60.1%	318	70.7%	30	69.8%

The breakdown by Primary Client Group (PCG) shows that the largest proportion of referrals for people aged 18-64 is Mental Health with 16% of all alerts. However, only 10% of referrals relate to clients with a Mental Health PCG. This is a conversion rate of 25% which is the lowest of all PCG i.e. 25% of alerts go on to referral.

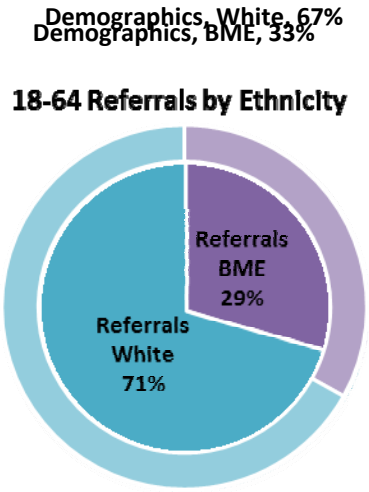


As per the age breakdown the 65+ group has the highest conversion rate of 49% of alerts going on to referral stage.

The pattern of repeat referrals is similar to the referrals column and so shown no cause for concern.

5a – Referrals by Ethnicity – 18-64

	2010/11		2011/12		2012/13		Demographics
	Number	%	Number	%	Number	%	
White	147	78.2%	132	74.2%	91	70.5%	66.9%
Mixed	5	2.7%	3	1.7%	3	2.3%	4.1%
Asian	21	11.2%	20	11.2%	19	14.7%	19.7%
Black	14	7.4%	19	10.7%	16	12.4%	7.3%
Other	1	0.5%	4	2.2%	0	0.0%	2.1%
Not Stated	2	-	1	-	3	-	-



The table above provides figures and the chart to the right shows the proportion of referrals in the centre compared with the demographic breakdown of Wolverhampton in the outer ring. Ideally both inner and outer should match.

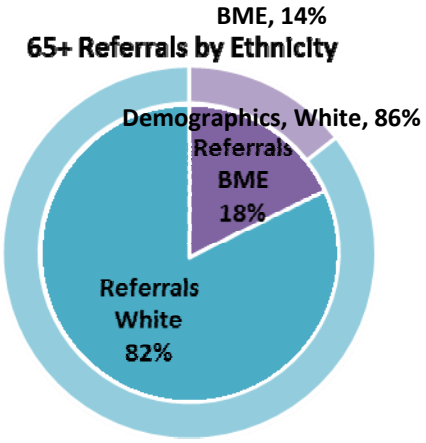
The breakdown of referrals by ethnicity for the 18-64 age group show that the proportion of referrals for Black and Minority Ethnic Groups (BME) is increasing year on year, and shows a small difference from the demographics. BME clients are marginally under-represented in safeguarding referrals.
Looking more closely it can be seen that there are a disproportionately high proportion of referrals relating to Black clients and a low proportion of referrals relating to Asian clients. This discrepancy also exists among service users and is therefore expected.

5b – Referrals by Ethnicity – 65+

	2010/11		2011/12		2012/13		Demographics
	Number	%	Number	%	Number	%	
White	262	84.8%	340	88.1%	260	82.3%	85.6%
Mixed	0	0.0%	0	0.0%	0	0.0%	0.6%
Asian	19	6.1%	19	4.9%	23	7.3%	8.2%
Black	27	8.7%	27	7.0%	31	9.8%	4.7%
Other	1	0.3%	0	0.0%	2	0.6%	0.9%
Not Stated	4	-	2	-	2	-	-

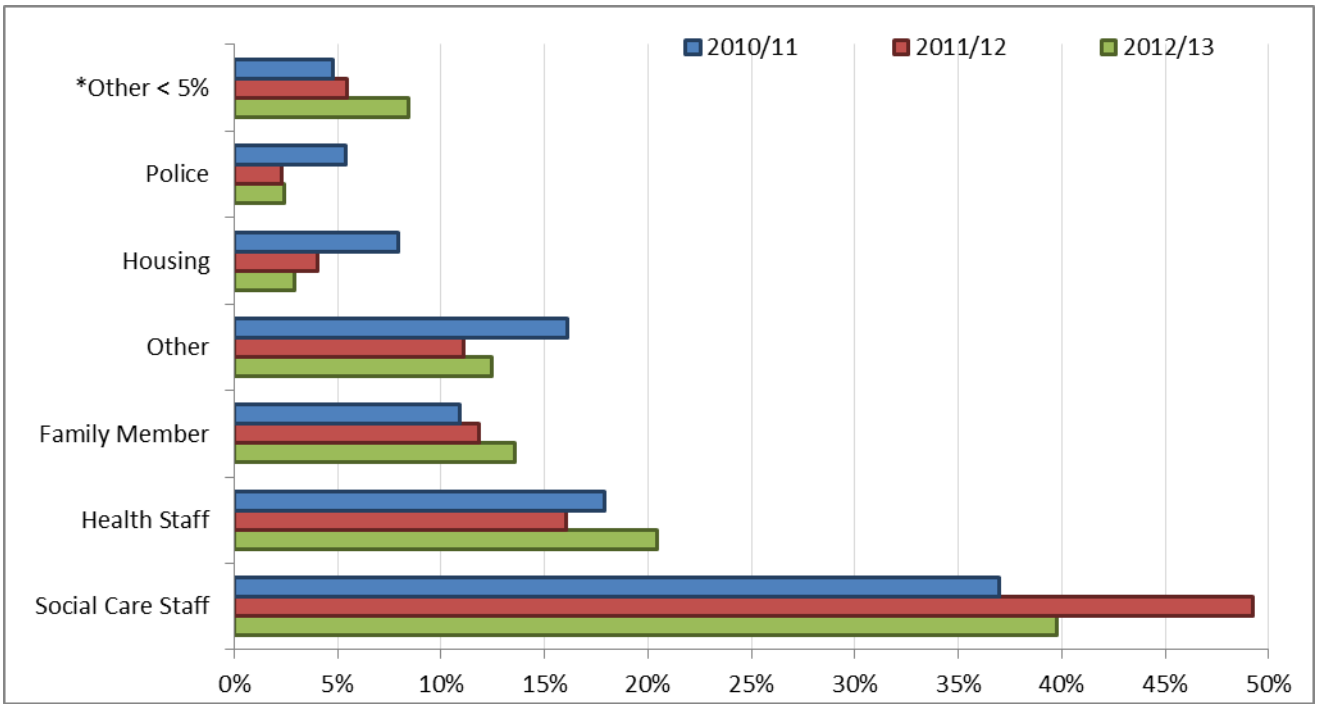
The table above provides figures and the chart to the right shows the proportion of referrals in the centre compared with the demographic breakdown of Wolverhampton in the outer ring. Ideally both inner and outer should match.

The breakdown by ethnicity for 65+ shows that BME are slightly over represented in safeguarding referrals. This can partly be accounted for by the fact that 16% of service users are BME. Also the 2012/13 over representation of BME result of 18% is in contrast to the under representation in 2011/12 of 12%. It may be possible to account for this change by the safeguarding awareness programme which targeted vulnerable BME adults.



6 – Sources of Referral

	2010/11		2011/12		2012/13	
	Number	%	Number	%	Number	%
Social Care Staff	186	37.0%	279	49.2%	179	39.8%
Health Staff	90	17.9%	91	16.0%	92	20.4%
Self-Referral*	9	1.8%	2	0.4%	9	2.0%
Family Member	55	10.9%	67	11.8%	61	13.6%
Friend / Neighbour*	4	0.8%	11	1.9%	9	2.0%
Other Service User*	1	0.2%	0	0.0%	0	0.0%
Care Quality Commission*	4	0.8%	14	2.5%	17	3.8%
Housing	40	8.0%	23	4.1%	13	2.9%
Education / Training / Workplace Establishment*	6	1.2%	4	0.7%	3	0.7%
Police	27	5.4%	13	2.3%	11	2.4%
Other	81	16.1%	63	11.1%	56	12.4%
Overall Total	503		567		450	



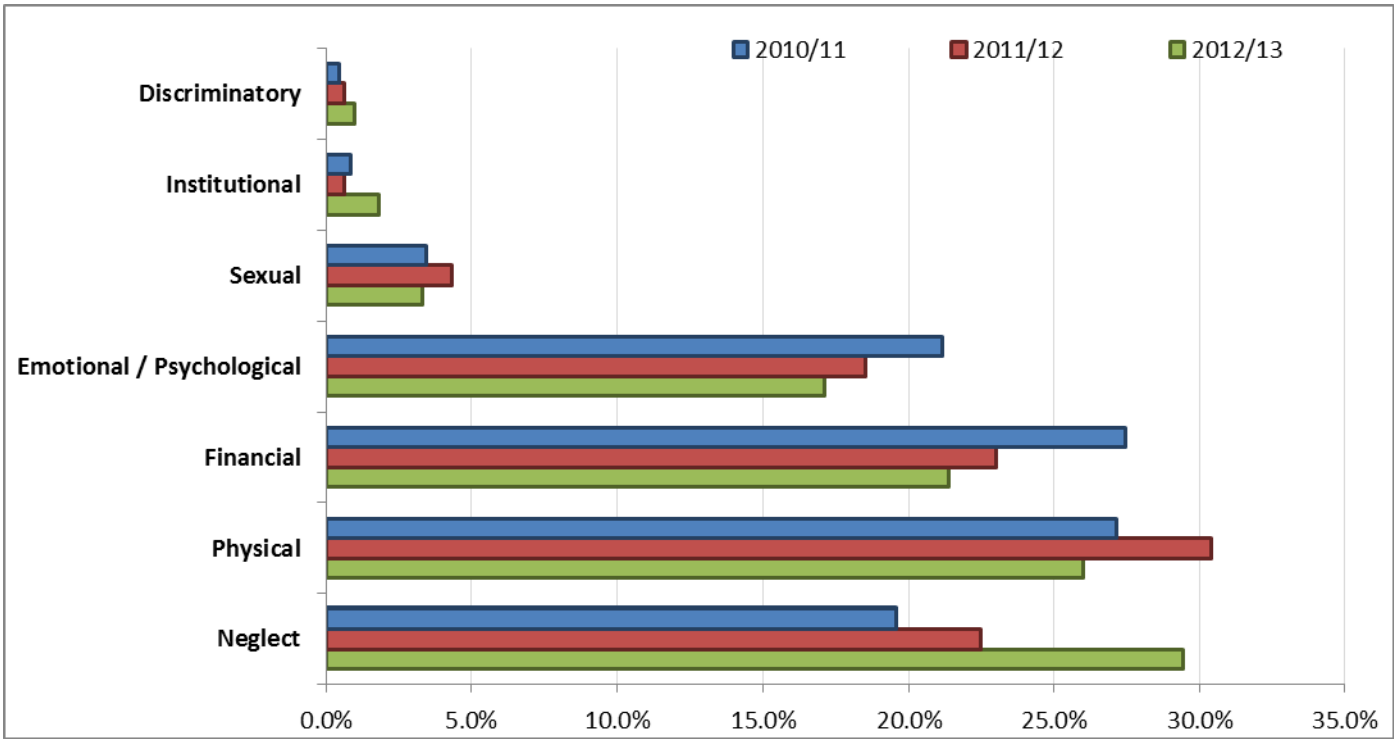
In 2012/13, as in previous years, the highest percentage of referrals came from Social Care Staff with 40% although this has fallen from 50% in 2011/12. The proportion of referrals from Health Staff has increased from 16% to 20% which can be attributed to activities carried out to increase awareness of Safeguarding.

The proportion of referrals recorded as “Other” source currently sits at 12% which indicates that a relatively large number of referrals come from anonymous sources or from sources which are not in the current list.

*Sources marked with a * have less than %5 of referrals in all years and have been combined in the bar chart.

7 – Referrals by type of Alleged Abuse

	2010/11		2011/12		2012/13	
	Number	%	Number	%	Number	%
Physical	190	27.1%	238	30.4%	158	26.0%
Sexual	24	3.4%	34	4.3%	20	3.3%
Emotional / Psychological	148	21.1%	145	18.5%	104	17.1%
Financial	192	27.4%	180	23.0%	130	21.4%
Neglect	137	19.6%	176	22.5%	179	29.4%
Discriminatory	3	0.4%	5	0.6%	6	1.0%
Institutional	6	0.9%	5	0.6%	11	1.8%
Overall Total	700		783		608	



Referrals may contain more than one type of alleged abuse and therefore the numbers are greater than the actual number of referrals.

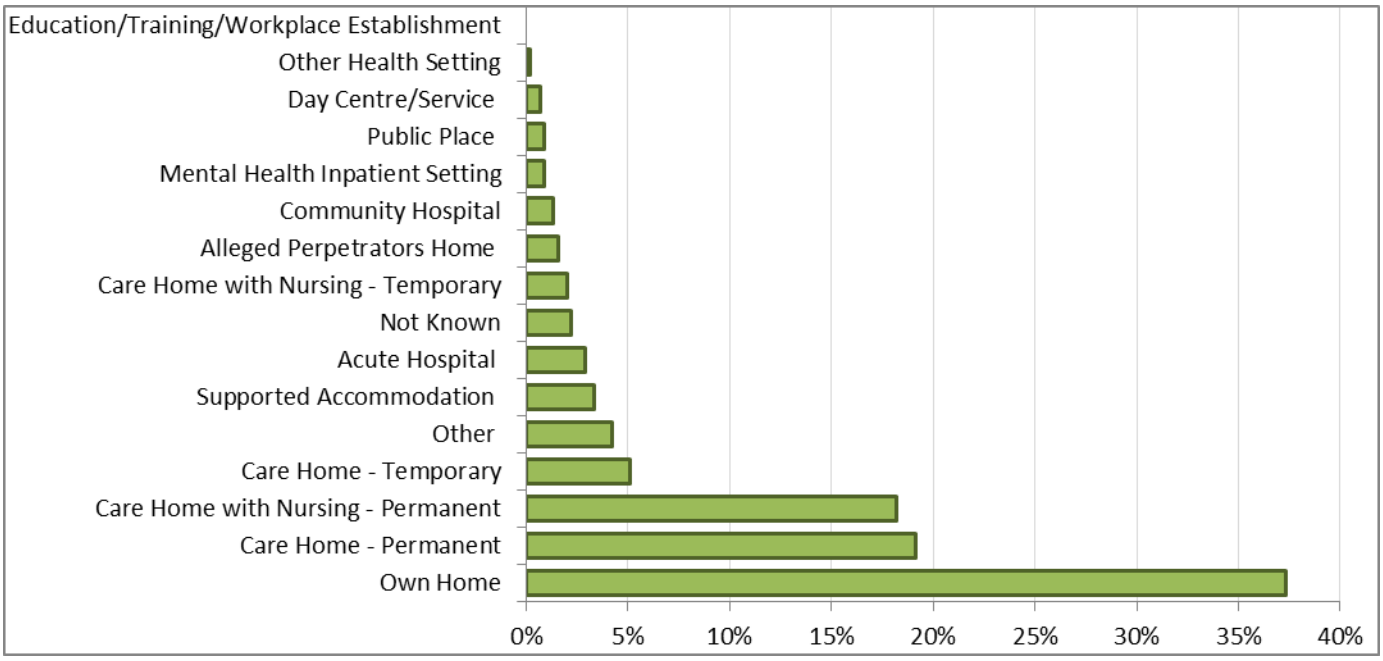
The above chart is sorted by proportion of referrals by nature of alleged abuse in 2012/13 i.e. in 2012/13 Discriminatory was the lowest proportion and Neglect was the highest proportion.

The data shows that for the first year neglect is the most common type of alleged abuse. The proportion of reported neglect cases has increased every year with a significant increase from 23% in 2011/12 to 30% in 2012/13. This increase can be attributed to several safeguarding investigations referring to care homes where neglect is the most likely form of abuse, along with press coverage of neglect in care homes which has resulted in increased awareness.

Looking specifically at 18-64 year olds Physical, Emotional and Financial abuse were the most commonly reported. This was common across all primary care groups, except Learning Disability where neglect was marginally more common than financial abuse.
For older people (aged 65 and over) the key themes of abuse were Neglect, Physical and Financial in that order.

8 - Location of Alleged Abuse

	2010/11		2011/12		2012/13	
	Number	%	Number	%	Number	%
Own Home	253	50.3%	225	39.7%	168	37.3%
Care Home - Permanent	71	14.1%	102	18.0%	86	19.1%
Care Home with Nursing - Permanent	81	16.1%	89	15.7%	82	18.2%
Care Home - Temporary	20	4.0%	18	3.2%	23	5.1%
Care Home with Nursing - Temporary	10	2.0%	29	5.1%	9	2.0%
Alleged Perpetrators Home	4	0.8%	7	1.2%	7	1.6%
Mental Health Inpatient Setting	2	0.4%	3	0.5%	4	0.9%
Acute Hospital	3	0.6%	13	2.3%	13	2.9%
Community Hospital	5	1.0%	12	2.1%	6	1.3%
Other Health Setting	2	0.4%	1	0.2%	1	0.2%
Supported Accommodation	14	2.8%	16	2.8%	15	3.3%
Day Centre/Service	4	0.8%	3	0.5%	3	0.7%
Public Place	11	2.2%	12	2.1%	4	0.9%
Education / Training / Workplace	2	0.4%	2	0.4%	0	0.0%
Other	16	3.2%	24	4.2%	19	4.2%
Not Known	5	1.0%	11	1.9%	10	2.2%

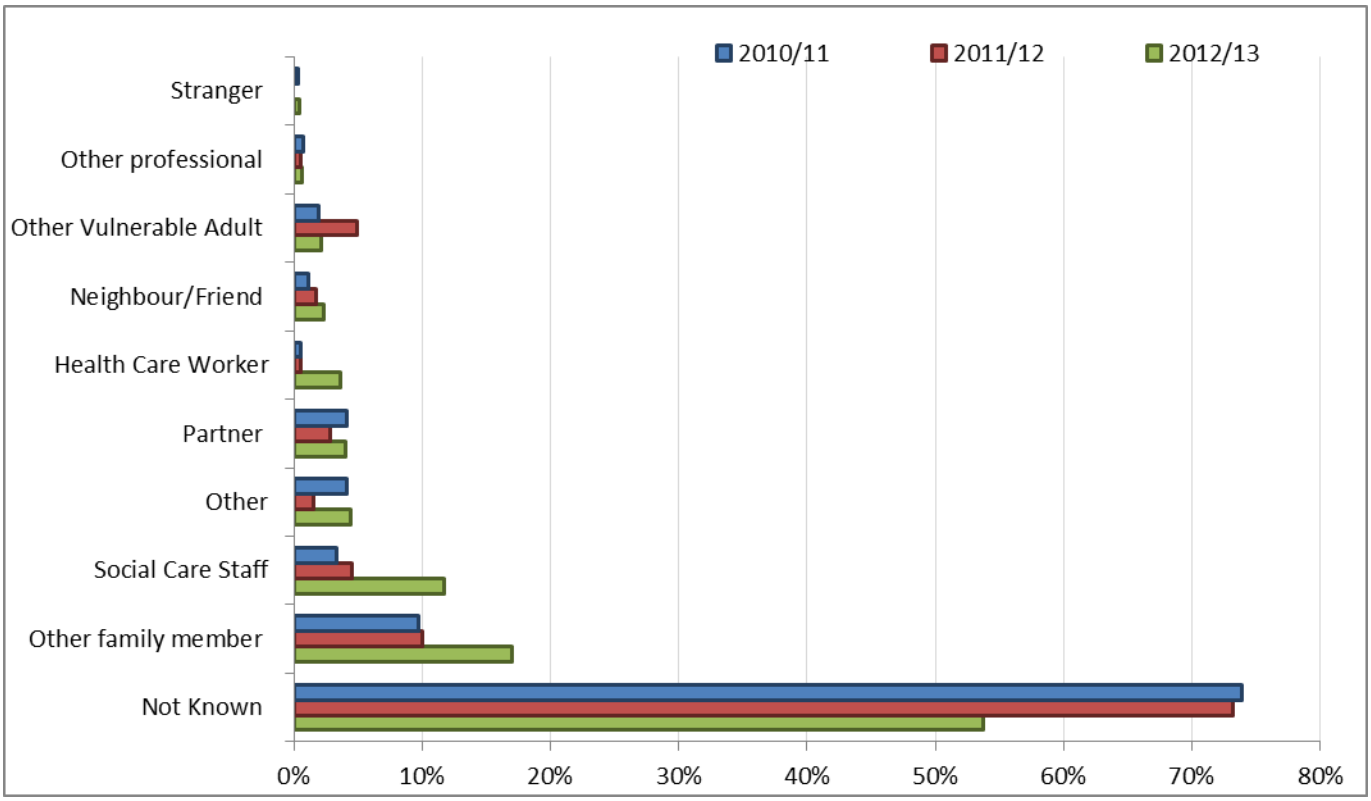


The most common location of abuse remains own home at 37% followed by Care Home – Permanent at 19% and Care Home with Nursing – Permanent at 18%.

Over the last 3 years the proportion of abuse taking place in the own home has been decreasing whilst at the same time abuse in permanent residential and nursing care homes has increased. This is can be attributed to the increased number of care-home referrals and investigations as well as press coverage around neglect in care homes.

9 – Relationship with Person alleged to be causing harm

	2010/11		2011/12		2012/13	
	Number	%	Number	%	Number	%
Partner	21	4.1%	16	2.8%	19	4.0%
Other family member	50	9.7%	57	10.0%	80	17.0%
Health Care Worker	3	0.6%	3	0.5%	17	3.6%
Volunteer/ Befriender	0	0.0%	0	0.0%	0	0.0%
Social Care Staff	17	3.3%	26	4.6%	55	11.7%
Other professional	4	0.8%	3	0.5%	3	0.6%
Other Vulnerable Adult	10	1.9%	28	4.9%	10	2.1%
Neighbour/Friend	6	1.2%	10	1.8%	11	2.3%
Stranger	2	0.4%	0	0.0%	2	0.4%
Not Known	380	73.9%	416	73.2%	253	53.7%
Other	21	4.1%	9	1.6%	21	4.5%
Overall Total	514		568		471	

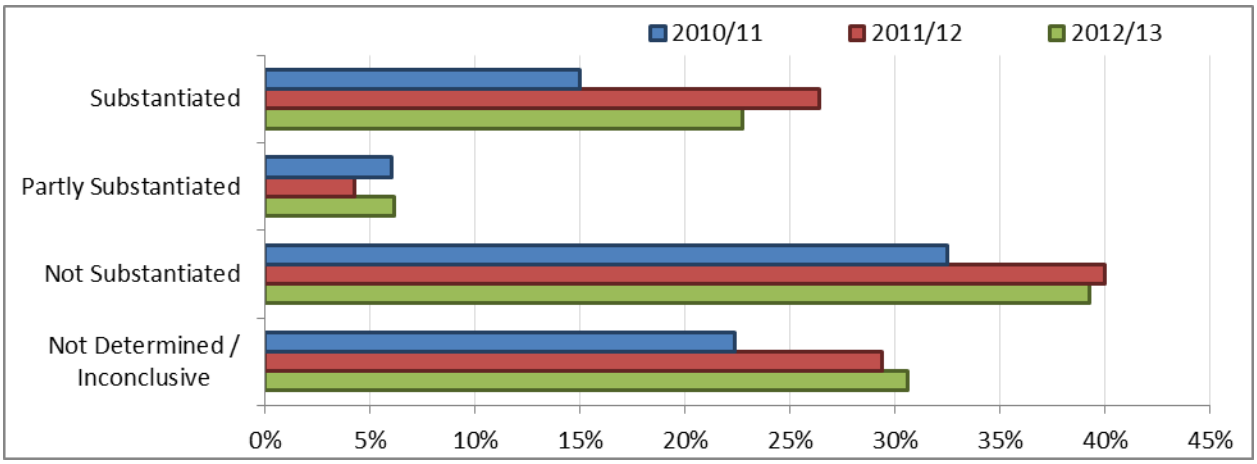


The data shows that over half of all referrals are recorded with the person suspected of causing harm as "Not Known". The result of 54% is an improvement, indicating that recording and quality of referrals is increasing but there is still a large improvement that could be made.

The largest proportion of known persons suspected to be causing harm is "Other Family Member" at 17%, followed by "Social Care Staff" at 12%. This broadly matches previous years trends, although with the high proportions of "Not known" in 2010/11 and 2011/12 any trends should be viewed with caution.

10 – Case Conclusion

	2010/11		2011/12		2012/13	
	Number	%	Number	%	Number	%
Substantiated	77	15.0%	150	26.4%	107	22.7%
Partly Substantiated	31	6.0%	24	4.2%	29	6.2%
Not Substantiated	167	32.5%	227	40.0%	185	39.3%
Not Determined / Inconclusive	115	22.4%	167	29.4%	144	30.6%
Overall Total	390		568		465	



In 2012/13 23% of cases were substantiated and 6% were partly substantiated.

The figures show that the proportion of substantiated cases has decreased from 2011/12 from 26% to 23% in 2012/13. However, partly-substantiated cases have increased to 6% meaning that there has been very little change in Not Substantiated and Not Determined / Inconclusive.

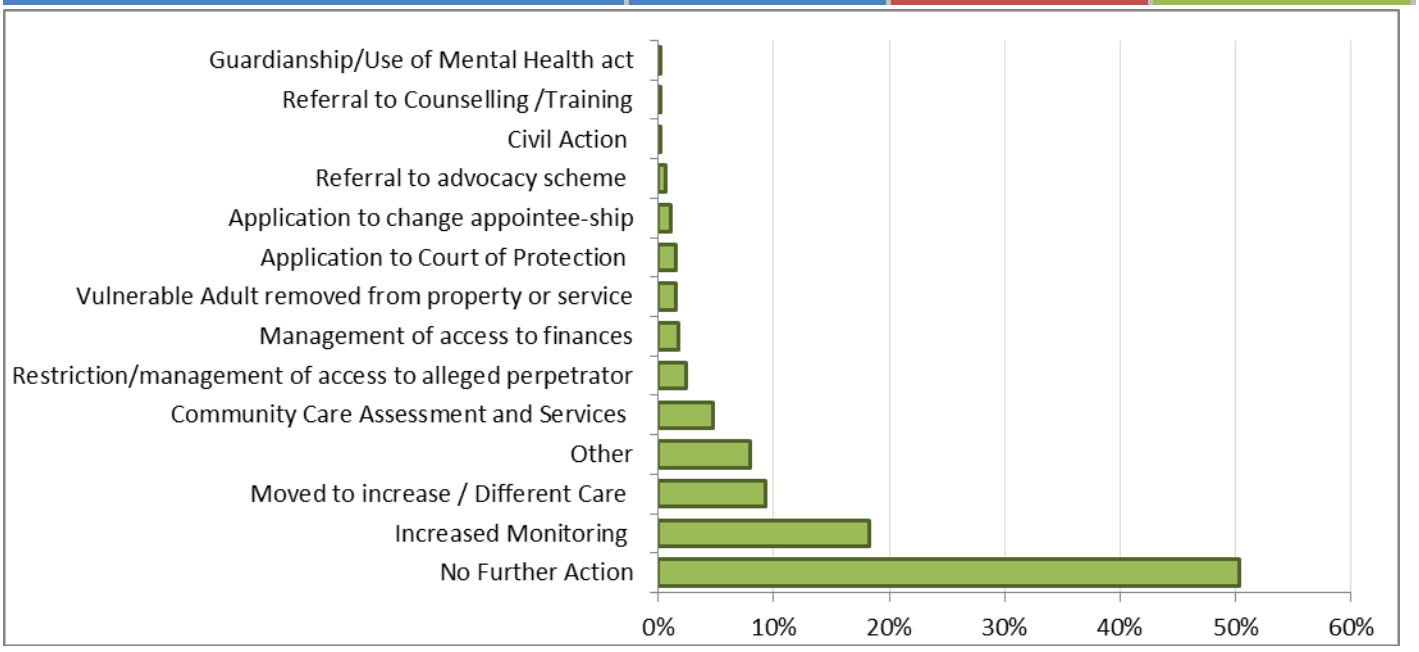
Looking at individual primary client groups the figures are broadly similar across all Ages / Primary Care groups and most deviations can be discounted due to the small numbers involved in some of the breakdowns.

The group with the highest substantiation rate are clients aged 85 and over with 30% substantiated and 2% partly substantiated.

Mental Health clients have the lowest substantiated rate of only 10% with a partly substantiated rate of 13% and 48% not substantiated. The reason for this is not clear but is likely to be due to the complexity of most Mental Health investigations.

11 – Outcomes for the Adult at Risk of Harm

	2010/11		2011/12		2012/13	
	Number	%	Number	%	Number	%
Increased Monitoring	64	16.4%	99	17.4%	85	18.3%
Vulnerable Adult removed from property or service	11	2.8%	10	1.8%	7	1.5%
Community Care Assessment and Services	23	5.9%	31	5.5%	22	4.7%
Civil Action	0	0.0%	1	0.2%	1	0.2%
Application to Court of Protection	5	1.3%	3	0.5%	7	1.5%
Application to change appointee-ship	3	0.8%	6	1.1%	5	1.1%
Referral to advocacy scheme	0	0.0%	0	0.0%	3	0.6%
Referral to Counselling /Training	1	0.3%	3	0.5%	1	0.2%
Moved to increase / Different Care	26	6.7%	29	5.1%	43	9.2%
Management of access to finances	6	1.5%	9	1.6%	8	1.7%
Guardianship/Use of Mental Health act	0	0.0%	1	0.2%	1	0.2%
Review of Self-Directed Support (IB)	0	0.0%	0	0.0%	0	0.0%
Restriction/management of access to alleged perpetrator	9	2.3%	14	2.5%	11	2.4%
Referral to MARAC	0	0.0%	0	0.0%	0	0.0%
Other	49	12.6%	50	8.8%	37	8.0%
No Further Action	193	49.5%	312	54.9%	234	50.3%
Overall Total	390		568		465	

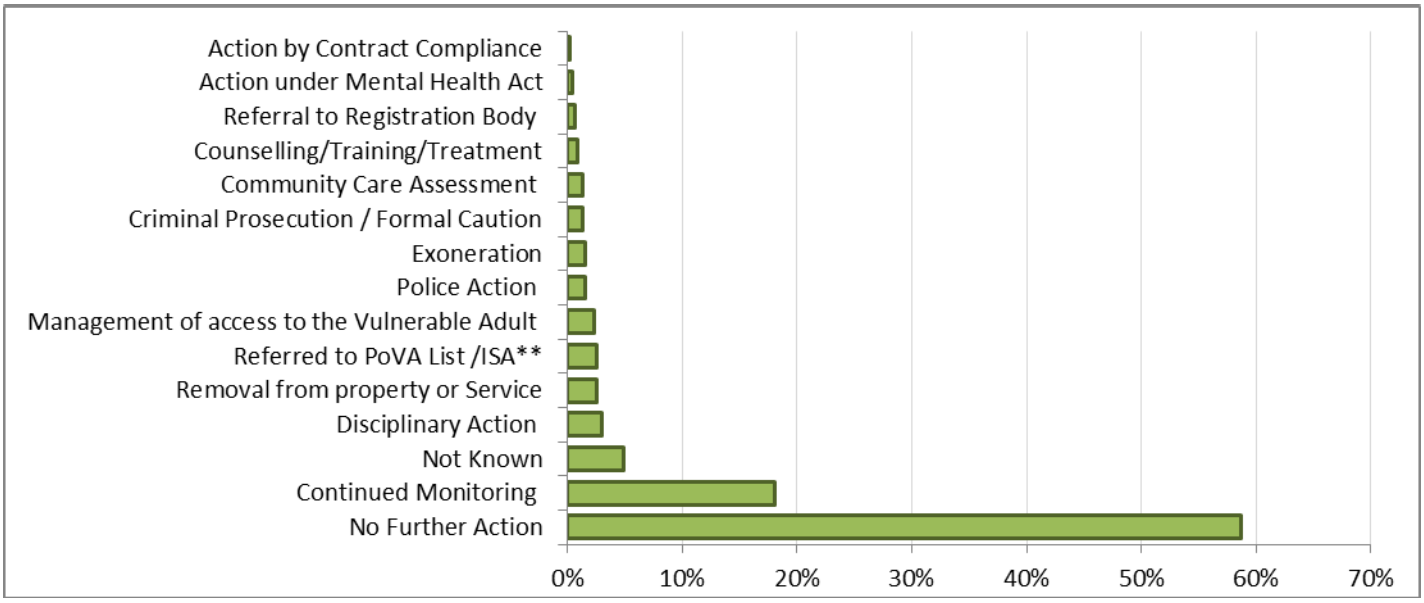


The proportion of cases where the outcome was “No further action” has decreased from 55% in 2011/12 to 50% in 2012/13 which, although an improvement, is very close to the 2010/11 result.

Increased monitoring remains the second most common outcome for the person at risk of harm, at 18%, which is showing a year-on-year increase, followed by moved to increase / different care at 9%.

12 – Outcomes for Person Alleged to be Causing Harm

	2010/11		2011/12		2012/13	
	Number	%	Number	%	Number	%
No Further Action	236	60.5%	320	56.3%	273	58.7%
Continued Monitoring	35	9.0%	86	15.1%	84	18.1%
Not Known	13	3.3%	30	5.3%	23	4.9%
Disciplinary Action	6	1.5%	15	2.6%	14	3.0%
Removal from property or Service	17	4.4%	32	5.6%	12	2.6%
Referred to PoVA List /ISA**	1	0.3%	4	0.7%	12	2.6%
Management of access to the Vulnerable Adult	17	4.4%	17	3.0%	11	2.4%
Police Action	16	4.1%	13	2.3%	7	1.5%
Exoneration	10	2.6%	13	2.3%	7	1.5%
Criminal Prosecution / Formal Caution	9	2.3%	2	0.4%	6	1.3%
Community Care Assessment	2	0.5%	2	0.4%	6	1.3%
Counselling/Training/Treatment	11	2.8%	18	3.2%	4	0.9%
Referral to Registration Body	1	0.3%	0	0.0%	3	0.6%
Action under Mental Health Act	1	0.3%	4	0.7%	2	0.4%
Action by Contract Compliance	13	3.3%	6	1.1%	1	0.2%
Action By Care Quality Commission	2	0.5%	6	1.1%	0	0.0%
Referral to Court Mandated Treatment	0	0.0%	0	0.0%	0	0.0%
Referral to MAPPA	0	0.0%	0	0.0%	0	0.0%
Overall Total	390		568		465	



The proportion of cases where the outcome for the person alleged to be causing harm was "No Further Action" remains high at 59% of all completed referrals which is an increase on the 2011/12 result of 56%.

The most common action taken is "Continued monitoring" with 18% of outcomes in 2011/12. This result has increased year on year.

The outcome "Not known" remains at 5% and may need to be monitored to ensure that the figure does not increase.

Specific examples of how safeguarding interventions have had a positive outcome for individuals are outlined below:

- *Woman in her forties with mental health difficulties, allegation of physical abuse by family member. Investigation undertaken and protection plan implemented, good partnership working between social worker, police, occupational therapist, psychologist and youth service, overall finding of investigation was inconclusive however protection plan and subsequent care plan was felt to have reduced the risk of abuse occurring in the future*

- *Woman in her thirties with mild learning disability, bi-polar affective disorder allegation of sexual abuse robust multi- agency protection plan put in place following criminal investigation, evidence of best interest decision making, effective use of Mental Capacity Act and Deprivation of Liberty Safeguards. Level of risk significantly reduced, evidence of good partnership working between social worker, police, psychologist, community nurse, service provider*

- *Man in his eighties with diagnosis of advanced dementia lives with family, allegation of physical abuse by family member/ carer. No evidence of abuse but due to Alert and subsequent investigation a risk management plan put in place involving GP, Community Psychiatric Nurse and Day Care provider and support to carer by Dementia Care Service.*

FEEDBACK FORM

Can you please help by providing us with feedback on the content of this report. You may wish to print off this page and return this in the post to:

Adult Safeguarding and Quality Assurance Team, Health & Wellbeing, 1st Floor, Civic Centre, St Peter's Square, Wolverhampton, WV1 1RL or alternately contact the Safeguarding Adult Team on 01902 553218/553259 to give verbal feedback.

To improve the report next year, can you please specify what areas you would like included:

_____
_____
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WHO CAN I TELL MY CONCERNS TO?

To make a referral ring Adults Social Care Services on 01902 551199.

If you would like any advice before contacting the number above, please ring 01902 553218.

In an emergency, ring 999.

Appendix 1

Wolverhampton Safeguarding Adult Boards Partner Organisations - Members & Their Representatives 2012-13

Alan Coe – Independent Chair
DCI Martin Hurcomb**—West Midlands Police**
Susan C Marshall—**Black Country Partnership NHS Foundation Trust/Mental Health, Wolverhampton PCT**
Manjeet Garcha **– Wolverhampton CCG**
Dawn Williams—**Wolverhampton City Council, Children's and Young Peoples Service**
Penny Darlington/Sandra Ashton-Jones**—Wolverhampton City Council, Adult Safeguarding and Quality Assurance Service**
Lynne Fieldhouse **—Wolverhampton Primary Care Trust/Royal Wolverhampton Hospital Trust**
Karen Samuels**— Wolverhampton City Council, Crime and Community Safety**
Neil Appleby**—West Midlands Probation Service**
Mark Henderson**—Wolverhampton Homes**
Geeta Patel**—Wolverhampton Voluntary Sector Council**
Kathy Cole-Evans**—Wolverhampton Domestic Violence Forum**
Councillor Steve Evans**—Wolverhampton City Council**
Sarah Norman**—Wolverhampton City Council, Director of Community**
Joy Blakeman—**West Midlands Fire Service**
Kathy Roper— **Wolverhampton City Council, Housing Support and Social Inclusion/Commissioning Younger Adults**
Julie Ashby-Ellis —**West Midlands Ambulance Service**
Fiona Davis—**Wolverhampton City Council, Legal Services**
Trisha Haywood—**Wolverhampton Branch, West Midlands Care Association**
Vivienne Griffin—**Wolverhampton City Council, Health and Wellbeing**
Anthony Ivko/ Helena Kucharcyzk—**Wolverhampton City Council, Adult Social Care and Housing Support/Information Management**
Rosie Paskins —**Age UK**
Dr Miles Manley/Dr Abdool Koodaruth**—Local Medical Council**
Lisa Thacker – **Care Quality Commission**

Appendix 2

Achievements and Challenges for Board Working Groups 2012/13

POLICY, PROCEDURES AND STRATEGY WORKING GROUP

Chair: Joy Blakeman, West Midlands Fire Service

Purpose:

The purpose of the working group is to:

- Ensure that the Board has a safeguarding policy and procedure which is current, specific and accessible and is being adhered to by all organisations, services and individuals who work with adults who need support
- Ensure that the Board produces an accessible annual summary of its work promoting adult safeguarding and for which the Board is accountable.

This working group was without a chair for many months, and was being chaired on a rotational basis by the small core group of members who regularly attended meetings. The West Midlands Fire Service Board member, Joy Blakeman agreed to chair the group earlier in 2013. Attendance has been regular by a small group of partner representatives, wider membership has been sought.

Summary of Achievements 2012-13.

- During 2012 much work was carried out by the regional Safeguarding Network in order to draft and finalise the Regional Pan West Midlands Policy. The working group provided a useful sounding board for updates regarding this piece of work
- The Regional Safeguarding Adults Threshold Guidance was drafted during 2013. Positive discussion was generated in the group and feedback to the document given. A final version was presented to the WSAB meeting in December 2012. The guidance document was launched in January 2013
- Policy Audit Checklist Tool -The idea behind this is to enable organisations to audit their own policies. A copy of the policy audit checklist tool that the Safeguarding Team use currently with services has been shared with members of the group (early 2013) for comments. The plan is for a model policy to be drafted alongside the policy audit checklist tool and for these documents to be endorsed by the Board. This piece of work is on-going, but a sound start has been made

Challenges:

- For a great part of 2012, there was no permanent Chair for this working group. The Council's Adult Safeguarding Manager stepped in to act as Chair and it was agreed that until a new and more permanent Chair could be found the role of Chair of the meeting

would be rotated. This issue was overcome late in 2012 when Joy Blakeman (from the West Midlands Fire Service) agreed to become Chair of this group

- Challenges have been gaining regular attendance from a wide variety of organisations. The working group met on three occasions, regular attendees have been: Wolverhampton Homes, Probation Service, PCT/CCG Representatives and council officers representing the Quality Assurance and Compliance Team and Adult Safeguarding Team. This issue has been raised at the Board and a letter from the Board's Chair was circulated to members in October 2012 seeking support. Possible solutions to this challenge were also discussed at the WSAB priority-setting day on 13 May. Discussion took place about what kind of working group structure would best fit the Board's priorities, and how to encourage wider and more sustained representation. A proposed structure will be presented to the June Board meeting
- Another challenge has been some confusion regarding the role of working groups in general and whether working groups are on-going or 'task and finish' groups utilised to implement a set piece of work and then come to an end. This challenge should be resolved when the proposed structure is discussed at the Board.

COMMUNICATION, COMMUNITY ENGAGEMENT AND MARKETING WORKING GROUP

Chair: Geeta Patel Wolverhampton Voluntary Sector Council (Up to March 2013)

Purpose:

The purpose of the working group is to:

- Promote greater knowledge of adult safeguarding with organisations working with people who are vulnerable and greater participation in the work of the Safeguarding Board
- Promote adult safeguarding within the wider community and groups who are marginalised
- Attract funding opportunities.

Summary of Achievements 2012- 13

- Case studies created and used to raise awareness in partner organisations of the types of abuse that adults at risk face
- Voluntary and Community organisations were informed about the types of abuse that adults at risk face by articles in the E- Bulletin. The following analysis is based on a 25% response rate to a survey which was sent to 105 people from Voluntary and community organisations who receive the e-bulletin
- 95% rated the case studies as good and excellent

- There was **80% agreement/strong agreement** that the safeguarding adults case studies has aided awareness and prevention

- In order to assess reasons for gaps in reporting adult abuse from the Asian community**,** the working group planned and implemented an Appreciative Inquiry session during November 2012. A report was presented to Board in March 2013 outlining further actions to be undertaken.

Challenges

- The group met on three occasions, membership and attendance at the meetings has been inconsistent. Regular attendees have been representatives from Voluntary Sector Council, Wolverhampton Homes, Local Neighbourhood Partnership and Safeguarding Team. The Crown Prosecution Service was also represented, but unfortunately due to a change in job role the representative has been unable to continue attending

- Consideration is currently being given to the feasibility of this group becoming regional with a Black Country focus and membership.

WORKFORCE DEVELOPMENT WORKING GROUP

Chair: Deborah Edwards - Royal Wolverhampton NHS Trust

Purpose:

The purpose of the working group is to:

- Support those people who work with adults who may need safeguarding, to have appropriate training to fulfil their role, recognise their responsibilities to safeguard individuals, and are held to account for this

- Assist managers to create a working environment where safeguarding is integrated into core business and sharing safeguarding concerns is encouraged.

Summary of achievements 2012-13

- The working group oversaw the development of an education framework for safeguarding adults for use by all partner agencies

- Devised a template to record training information for individuals to be completed in staff appraisals

- Devised case scenarios for organisations to use with staff to evidence competency.

Challenges

- The group met on three occasions during 2012-13, attendance has been inconsistent. It has since been agreed that the working group will cease in its current structure
- Effectiveness of training is yet to be measured, this will be done by auditing the appropriateness of alerts, it is agreed that this will take place six months after the education framework has been implemented. Audit tool to be developed.

QUALITY ASSURANCE AND PERFORMANCE MANAGEMENT

Chair: Julie Ashby-Ellis - West Midlands Ambulance Service

Purpose:

The purpose of the working group is to:

- Monitor that safeguarding activity is being completed in accordance with its policy and procedure
- That the experiences of people using safeguarding processes is used to inform practice
- Ensure that safeguarding activity is being accessed by all.

Summary of Achievements 2012-13

- The working group initiated the development of safeguarding performance indicators, this piece of work is on-going and will be completed by December 2013 Board
- The working group considered and approved a regional Annual Assurance Statement for Safeguarding Board members. The purpose of the statement is to ensure that the Board can be satisfied that agencies are working together to safeguard the citizens of Wolverhampton and improve outcomes.

Challenges

- The group met three times during the year, the group met three times during the year membership and attendance has been inconsistent, this has led to consideration by the Board to alternative ways of working and it has been agreed that a regional Quality Assurance and Performance working group will be established. This will benefit Partner Agencies who work across several local authority boundaries in the region and are currently required to attend a number of working groups across the Black Country.

Mental Capacity and Deprivation of Liberty Safeguards Working Group

Chair: Bruce Jackson - Mental Capacity Act/ DoLS Manager

Purpose:

The purpose of this working group is:

- To develop policy and practice for implementing the Mental Capacity Act (MCA) based on national guidance
- To ensure the direction taken for the implementation of the MCA is most relevant for the local population
- To promote a co-ordinated, multi -disciplinary approach to MCA
- To share good practice
- To coordinate the training for staff concerned with MCA
- To ensure best value for money and advise on reducing waste through duplication or inefficiency.

Summary of achievements 2012-13

- Mental Capacity Act/ Deprivation of Liberty Safeguards flashcards were produced and distributed
- Mental Capacity Act/ Deprivation of Liberty Safeguards Training Plan
- DoLS good practice quality indicators were considered using Department of Health guidance, this has now been subsumed into the work of the DOLS regional Managers Forum
- Recording of Mental Capacity Assessments now incorporated into local authority “Care First” electronic care records system
- Legal developments – updates provided by MCA/DoLS Manager
- CPR [Cardio - Pulmonary Resuscitation] – impact of “assisted suicide” debate.

Challenges

- Whilst the working group has met on four occasions this year, attendance has fluctuated To address this a decision was made that this working group will cease in its current structure and will be incorporated in the proposed Prevention workstream.

Wolverhampton City Council **OPEN DECISION ITEM**

Health and Wellbeing Board **Date 4 September 2013**

Originating Service Group(s)	**Community – Public Health**
Contact Officer(s)/	**Ros Jervis – Director of Public Health**
Telephone Number(s)	**01902 551372**
Title	**Joint Strategic Needs Assessment for Wolverhampton**

RECOMMENDATION

It is recommended that the Board:-

- Note the process for producing the Joint Strategic Needs Assessment (JSNA), led locally by the Joint Health and Wellbeing Strategy Task and Finish Group, and its focus on outcomes and links with the Joint Health and Wellbeing Strategy.

- Approve the JSNA for publication by the Joint Health and Wellbeing Strategy Task and Finish Group in conjunction with Wolverhampton City Council Communications team.

1. PURPOSE

1.1 The purpose of this paper is to remind the Board of the process that has been used to produce Wolverhampton's JSNA and seek final approval for publication as soon as possible.

2. BACKGROUND

2.1 **Background to the JSNA in Wolverhampton**

The Joint Strategic Needs Assessment (JSNA) is a tool to understand the needs of Wolverhampton residents and agree collective action. It is a process that identifies the current and projected health and wellbeing needs of the local population across the life course, and brings together evidence in the form of numerical data, insights from communities and other high quality published evidence. It informs the priorities of the Health and Wellbeing Board's Joint Health and Wellbeing Strategy and provides a shared evidence base for consensus on the key local priorities.

The Health and Wellbeing Board in its shadow form was involved in developing the JSNA, including interactive development sessions and prioritisation of shared outcomes.

2.2 **The process in Wolverhampton**

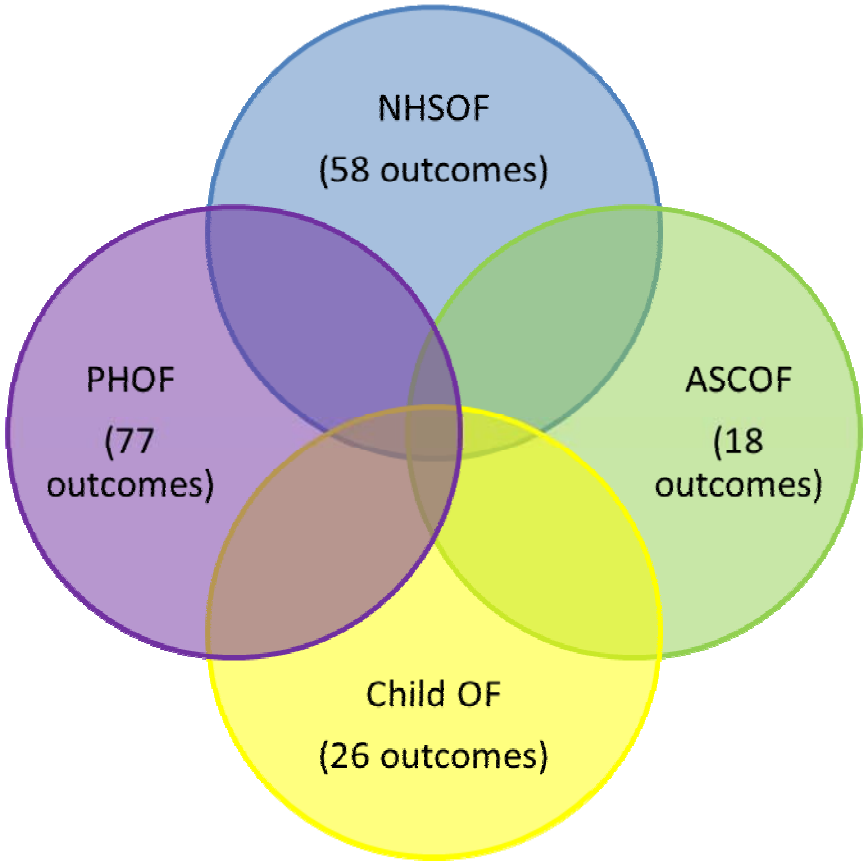
Wolverhampton's JSNA has focussed on the outcomes contained in the three national outcome frameworks :- Public Health (PHOF), NHS (NHSOF) and Adult Social Care (ASCOF), and an additional locally developed outcomes framework for Children and Young People. (See Figure 1)

The responsibility for producing the JSNA lies jointly with the local authority and clinical commissioning group and is locally discharged through the Joint Health and Wellbeing Strategy Task and Finish Group. This group has now agreed the final content of the JSNA and is seeking approval to publish in the immediate future in conjunction with Wolverhampton City Council Communications team.

The JSNA is made up of an overall document describing the process and 13 loose appendices which are designed to give more detail but which can be easily updated as required. These are attached, together with a draft covering letter (awaiting final approval). The overall JSNA will be presented in a folder.

The Task and Finish group has also agreed that the JSNA is an ongoing process and should be updated and refreshed annually so that the outcomes can be updated using the most up to date information. The Task and Finish Group will be responsible for further developments and proposals on the next phase of the JSNA

Figure 1: Outcomes Frameworks inform Wolverhampton's JSNA Process



2.3 **Priority outcomes**

The results of the JSNA process prioritised 40 outcomes categorised into 6 groups. In addition, the JSNA highlighted the wider social determinants of health as key to tackling the inequalities in health and life expectancy outcomes. For each of the outcomes in groups 1 and 2 a more detailed briefing has been produced. These briefings are designed to help commisioners tackle these important issues together.

The briefings will be available shortly and will inform further development of the JHWB strategy.

3 FINANCIAL IMPLICATIONS

3.1 There are no direct financial considerations arising from this report. However, the broader financial implications arising from the detailed Action Plans which will address the outcomes identified in the JSNA and prioritised by the HWB will be costed up and reviewed. Any actions arising from these Action Plans will have to be met within existing budgets.

[AS/19082013/S]

4. LEGAL IMPLICATIONS

4.1 There is a duty on upper tier local authorities and clinical commissioning groups to produce a JSNA. The preparation of a Joint Strategic Needs Assessment is a statutory requirement under section 116 of the Local Government and Public Involvement in Health Act 2007, as amended by the Health and Social Care Act 2012. Statutory

guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies issued by the Department of Health in March 2013 also regulates the process.

[FD/21082013/I]

5. EQUAL OPPORTUNITIES IMPLICATIONS

5.1 The JSNA process addressed equity and inequalities issues, particularly in the supporting briefing documents which examine routinely available information on equality issues.

6. ENVIRONMENTAL IMPLICATIONS

6.1 The focus in the JSNA on the wider social determinants of health has implications for promoting an environment that is beneficial to good health and wellbeing and which promotes healthy behaviours.

7. SCHEDULE OF BACKGROUND PAPERS

7.1 Previous papers on the JSNA have been presented to the shadow Health and Wellbeing Board and a Development Day in 2012 to agree the content of the JSNA.

JOINT STRATEGIC NEEDS ASSESSMENT

FOCUS ON OUTCOMES

Contents

1 What is the Joint Strategic Needs Assessment (JSNA)?

The Joint Strategic Needs Assessment is a process that identifies the current and projected health and wellbeing needs of the local population. It is a key building block in enabling the understanding of the needs of local people. It contains collective intelligence about local health and wellbeing need, and forms a key element of the Shadow Health and Wellbeing Board's overall understanding of health and wellbeing.

The Joint Strategic Needs Assessment is designed to underpin the commissioning priorities and strategic plans of the Local Authority and local NHS. Specifically it will be used to inform the Joint Health and Wellbeing Strategy that is currently being developed.

Joint Strategic Needs Assessments

- Must take account of the current and future health and social care needs of the entire population.

- Look beyond needs to examine local assets, including the local community itself, to meet identified needs.

- Explore inequalities in the local area and the factors that influence them such as poor housing, worklessness or crime and how these impact on health and wellbeing outcomes across the community

- Should adopt an 'outcomes-based approach', considering what will improve the outcomes that matter most to their populations. It should be informed by information and indicators from the national outcomes frameworks for the NHS, Adult Social Care, Public Health (and at clinical commissioning group level, the Commissioning Outcomes Framework), and identify desired outcomes to drive their joint health and wellbeing strategy. The Health and Wellbeing Board is the place where the national outcomes frameworks come together, supporting a primary focus on local priorities.

- There should be a focus on the things that can be done together. These will be identified by the Health and Wellbeing Board working together with local partners and understanding the added value of pooling resources (including people) in order to achieve a greater impact across the local system, to deliver improvements in health and wellbeing outcomes for the whole community, as well as to avoid duplication or bureaucracy.

- Joint Health and Wellbeing strategies should prioritise the issues requiring the greatest attention, avoiding the pitfalls of trying to take action on everything at

once. They will not contain a long list of everything that might be done, they will focus instead on key issues and actions that make the biggest difference.

The Joint Strategic Needs Assessment is not a document it is a process. There will be publications sharing the intelligence collected and methods used through the process. This is the first publication of the Joint Strategic Needs Assessment process.

The JSNA is also a key resource to be used for commissioning and all local organisations' commissioning plans should make reference to the needs identified in the JSNA.

2 JSNA process phase 1 – collating data on the outcome frameworks

The Department of Health has published three national outcome frameworks: NHS, Adult Social Care and Public Health. In addition, the Department of Health highlight that the development of an outcomes strategy for children and young people's health and wellbeing would support a co-ordinated approach in this area and therefore a children's outcome framework has been developed locally to respond to this.

For each of the outcomes on each of the outcome frameworks, where possible, data has been collated on the local position, the national position (including average and range of values) and the position of comparable local authorities. The data is presented in the form of 'spine charts' which summarise Wolverhampton's position (a circle) compared to the national average (the solid middle line) and the best and worst values in England.

However, in order to tell the story of the health and wellbeing needs contained in the outcomes frameworks spine charts and to identify opportunities for improving the health of Wolverhampton residents, a summary has been prepared as Appendix 1.

Appendix 1 – What Do the Outcome Framework Spine Charts tell us about health issues in Wolverhampton?

The spine charts are presented in the following Appendices

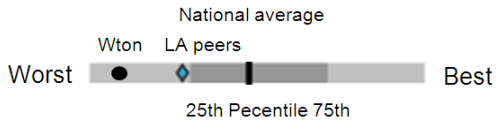
Appendix 2 – NHS Outcome Framework spine chart

Appendix 3 – Adult Social Care Outcome Framework spine chart

Appendix 4 – Public Health Outcome Framework spine chart

Appendix 5 – Children's Outcome Framework spine chart

Spine charts present the data in the format below:



The colour of Wolverhampton's data circle gives further information in relation to how Wolverhampton's value compares with the national average. For further information on interpreting spine charts, see Appendix 6.

3 JSNA process phase 2 – identifying Health and Wellbeing Board outcomes

The Health and Wellbeing Board focusses on outcomes where joint work can add value. Therefore a long list of outcomes is created by identifying outcomes that appear on more than one outcome framework. In addition the outcomes on the Public Health Outcome Framework identified as wider determinants are included because they require joint working with wider partners. This collection of outcomes will be referred to as the Health and Wellbeing Outcomes Framework (HWBOF).

Appendix 7 - Health and Wellbeing Outcome Framework at a glance

For each of the outcomes identified, data has been collated, where possible, on the local position, the national position (including average and range of values) and the position of comparable local authorities.

Appendix 8 – Health and Wellbeing Outcome Framework spine chart

4 JSNA process phase 3 – Identifying the Health and Wellbeing Board shortlist

The Health and Wellbeing Board reviewed the HWBOF to develop a shortlist. They focussed on:

- Outcomes where Wolverhampton performed significantly worse than England (those marked as red on the spine chart). A decision was made to include all these outcomes in the shortlist.

- Outcomes where no data was available, using local knowledge to judge if these should be a priority in Wolverhampton. A decision was made to include those outcomes which stakeholders considered represented important local health issues for Wolverhampton.

- Outcomes they considered important that were not included in the Health and Wellbeing spine chart. A decision was made to include some additional outcomes.

A major reference point was the importance of the wider social determinants of health as major factors that underpin and shape the 'choices' that individuals make and which in turn influence the health outcomes that they experience, for example, education, unemployment, housing, experience of crime. This shortlist was then prioritised using a voting system.

5. JSNA process phase 4 - Stakeholder Engagement

The Health and Wellbeing Board engaged a wide range of stakeholders in ratifying this shortlist.

Appendix 9 – List of stakeholders who were invited to contribute, the method of engagement and the numbers that engaged

As a result the prioritised shortlist was reviewed and changes made including:

- New outcomes added
- Outcomes given higher priority
- Discrimination of priority for outcomes ranked equally by HWB
- A separate list of outcomes developed identified by one stakeholder.

Appendix 10 – Changes made as a result of stakeholder engagement

The revised shortlist was then prioritised into 6 groups with 7 outcomes in each group.

Appendix 11 – Health and Wellbeing Board shortlisted outcomes
Appendix 12 – Health and Wellbeing Board shortlist spine chart

6 JSNA process next phases

The Health and Wellbeing Outcome Framework will be reviewed annually. The outcomes included in this framework may change due to changes in the nationally defined Public Health, NHS and Adult Social Care Outcome Frameworks.

Spine charts for the Health and Wellbeing, Public Health, NHS and Adult Social Care and Children's Outcome Frameworks will be re-produced annually using the most up-to-date data available.

This data will be reviewed by the Health and Wellbeing Board and as a result the shortlist of outcomes may change both in which outcomes are included and the priority of these outcomes. Stakeholders will be involved in these reviews.

The groups of outcomes will be considered in turn. In 2013-14 work will focus on group 1 and 2. In future years work will focus on the remaining groups in order.

For each outcome in groups 1 and 2 an outcome briefing has been produced containing a:

- Description of the outcome
- Needs profile
- Equity profile (age, gender, ethnicity, geography, disability)
- Review of the evidence base
- Service mapping
- Gaps in terms of need and equity
- Recommendations for action based on national good practice, local asset building, expert development and social marketing.

The Health and Wellbeing Board have developed a prioritisation framework which they will apply to the proposed actions Identified in the outcome briefings.

Appendix 13 – Health and Wellbeing Board prioritisation framework

The prioritisation framework will give each proposed action a score which will enable the proposed actions to be ranked. The Health and Wellbeing Board will need to decide a threshold that proposed actions will need to meet to be included in their strategy.

The briefings including the proposed actions that meet the threshold will form the basis of the Health and Wellbeing Strategy.

Glossary

ASCOF	The **Adult Social Care Outcome Framework** provides a broad, transparent and outcome focussed approach to presenting information on what adult social care has achieved.
COF	The **Children's Outcome Framework** is a locally developed framework including relevant outcomes from NHSOF and PHOF and additional outcomes considered relevant.
HWBOF	The **Health and Wellbeing Outcome Framework** is a locally developed framework which identifies the indicators on the national frameworks which benefit from joint working and therefore are the focus of the SHWB and JHWS.
JSNA	The **Joint Strategic Needs Assessment** is a process that identifies the current and projected health and wellbeing needs of the local population.
JHWS	The **Joint Health and Wellbeing Strategy** drives the collective actions of the NHS and local government, both commissioners and providers, and engages communities in the improvement of their own health and wellbeing.
NHSOF	The **National Health Service Outcome Framework** provides a national level overview of how well the NHS is performing, it provides an accountability mechanism between the Secretary of State for Health and the proposed NHS commissioning board and it acts as a catalyst for driving quality improvement and outcome measurement throughout the NHS.
PHOF	The **Public Health Outcome Framework** sets out the desired outcomes for public health and how these will be measured. The framework concentrates on two high-level outcomes to be achieved across the public health system. These are increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities
SHWB	The **Shadow Health and Wellbeing Board** is the key partnership for improving the health and wellbeing of Wolverhampton residents. It was formed in response to the Government's agenda for radical reorganisation of how health services are delivered and managed in England. The board will be in shadow form until April 2013, when it will become a statutory body. It involves representation from councillors, LA strategic directors, Director of Public Health, Clinical Commissioning Groups and LINk.
Spine Chart	Are a way of presenting local data in the context of national benchmarks. A guide of how to interpret spine charts can be found in Appendix 12.

Appendix 1: What do the Outcome Framework Spine Charts tell us about health issues in Wolverhampton?

The Department of Health has produced three outcomes frameworks, one each for public health, adult social care and the NHS, providing a focus for action and improvement across the health and care system. They include the main outcomes that represent the issues that matter most to population health and wellbeing. Wolverhampton has produced its own outcome framework for children and young people. Each of the frameworks has a number of 'domains' which cover the main areas for improvement and which can be used to track the whole pathway of disease, from factors that shape a person's life chances and their resulting health and wellbeing experience, reported in the Public Health Outcomes Framework (PHOF) to the quality and experience of care when it is needed, reported in the NHS and Adult Social Care Outcomes Framework (ASCOF). Indicators cover the whole life course from birth to death. The frameworks have some overlaps and similarities and give a comprehensive picture of the health and wellbeing needs of Wolverhampton residents and resulting commissioning challenges. This section tells the story of the health experience of Wolverhampton residents as identified in the indicators that make up the outcomes frameworks where Wolverhampton is experiencing poorer health than the average national population. The information is supplemented by additional public health intelligence where available.

Background - Wolverhampton Demographic profile

A knowledge of the demographic and socio-economic profile of an area is key to understanding and addressing health issues. Key demographics about the population of Wolverhampton can be ascertained from the 2011 census. The resident population is 248,470, an increase of approximately 10,000 compared to the last mid-year estimates. The average age in Wolverhampton is 39, which is similar to the England average, however, broken down by specific age groups, Wolverhampton has a slightly higher proportion of children aged under 16, however, the older age population is predicted to increase over the next 10 years, locally and nationally.

In terms of ethnicity, the majority of the population (68%) is from a white ethnic background with the remaining 32% from black minority ethnic backgrounds (BME). By far, the largest of the BME groups is Asian at 18.8%, followed by black and mixed at 6.9% and 5.1% respectively. This is quite different to the national distribution with only 14.3% from a BME background. The south east of the city has the highest proportion of BME residents.

Wolverhampton is the 21st most deprived Local Authority in the country, with 51.1% of its population falling amongst the most deprived 20% nationally. Deprivation is disproportionate across the city, with the more affluent wards in the West of the city.

Overall Vision - PHOF

The overall vision outlined in the PHOF is to improve life expectancy and healthy life expectancy and reduce health inequalities. Both males and females in Wolverhampton have lower overall life expectancy – 76.7 years for males and 80.8 years for females which is nearly two years less than the national average for both. In addition, a male in Wolverhampton can expect to live just over 58 years free of any disability and women can expect to live nearly 61 years in a healthy state – over 3 years less than the national average for males and two years less for females. Therefore, not only do Wolverhampton residents live shorter lives but they also spend more of their lives experiencing ill health and disability.

The indicators in the spine charts do not record the considerable inequality in experience in life expectancy and healthy life expectancy across Wolverhampton, but local analysis shows that there is a gap of approximately 7 years for men and 4 for women between those who are most and least affluent in Wolverhampton. This gap has remained fairly consistent over time.

How long a person lives depends on many factors, but the evidence is clear that the main contributory factor is the environment and life experiences that shape the resulting choices and chances to live a healthy and fulfilling life. The roots of the difference in life expectancy and healthy life expectancy figures are grounded in the things that shape these factors, for example the economic circumstances of a family,

educational attainment of children and parents, the environment, and housing conditions, all of which are classed as the wider social determinants of health.

In most cases, each death is preceded by a severe disease which may have been curable if detected and treated in its early stages. Early stage disease in many cases could have been prevented in the first place by adopting healthy lifestyles and right at the start of the disease pathway we know that poor life chances lead to the major causes of poor health in our communities and to health inequalities. The following sections track this pathway from health to death using the indicators in the frameworks - summarised in the Figure below.

Wider social determinants of health - PHOF

The data in the spine charts show that these wider social determinant factors start to have an adverse effect early - as many children in Wolverhampton do not get the best start in life. For example, 31% of children live in poverty – 11% higher than the England average. There is a clear link with deprivation as a high proportion of children reside in the most deprived areas of the city. Fewer children have a good level of development at age 5 – 52% compared to 59% nationally. In particular, there are inequalities regarding children who are eligible for free school meals and those where English is not their first language. Interestingly, there is little evidence of inequalities in terms of ethnicity, except for the Asian population who have a slightly higher proportion of good development than other ethnic groups.

For Wolverhampton, half days lost to unauthorised and authorised absences at school are higher than average, and amongst older age groups, 7.6% of 16 - 19 year olds are not in education, employment or training – higher than the England average. For this indicator, there is a difference between various ethnic groups with the black ethnic group consistently higher than the Wolverhampton average.

Indicators relating to the wider determinants of health also show areas for improvement relating to adults with higher rates of violent crime, more people affected by noise, higher numbers of homeless people and more households affected by fuel poverty when compared to national average figures.

These factors impact on the health choices that people can make which, over time are reflected in the health improvement indicators below.

Health improvement - PHOF

Health improvement indicators highlight where residents and families could make more healthy choices which would impact on their health and wellbeing. Again, some key outcome indicators relating to children are worse than the England average, for example, fewer mothers start to breastfeed their child and fewer carry on – 65% initiate breastfeeding compared to 74.5% nationally and by six weeks this has fallen to just under 42%. In addition, just over 18% of mothers continue to smoke through their pregnancy compared to nearly 13% nationally. From local data it is clear that the rates are disproportionate across different ages and deprivation groups. The younger mothers are more likely to smoke during pregnancy and are less likely to initiate breastfeeding and this is a similar picture for mothers from more deprived areas. There are also inequalities in terms of ethnicity, where mothers of white and mixed ethnic group record higher proportions of smoking during pregnancy and lower breastfeeding initiation rates. There is a higher proportion of under 18 conceptions in Wolverhampton with more recent data (since the last PHOF refresh) showing there were 208 during 2011, a rate of 43.9 per 1,000 population. This is higher than the national average of 30.7. Again, local data suggests that a high proportion of teenage conceptions are amongst mothers from deprived areas of the city.

Wolverhampton has consistently higher obesity rates then the national average for Reception Year and Year 6 children. The gap is wider for Year 6 children at 23.8%,- nearly 5% higher than the national average. The rate of obesity doubles between Reception Year and Year 6 and the largest acceleration is in Asian children. Unlike other indicators, the link with deprivation is not so apparent. Overweight and obesity and unhealthy eating in young people is a risk factor for adult obesity and the resulting health problems associated with obesity such as diabetes, heart disease and some cancers. Wolverhampton has a lower proportion of people eating healthily as adults and higher obesity rates. Nationally, nearly a quarter of adults are recorded as obese and this is nearly 28% in Wolverhampton. This will be a contributory factor to the very high prevalence of diabetes which is nearly as high as

the worst area in England. The prevalence of diabetes in Wolverhampton is consistently higher than the national average and is on the increase. The risk of diabetes is higher amongst Asian and Black ethnic groups and higher levels of hospital activity and mortality data for Wolverhampton residents are proxy indicators that supports this. Modelled estimates of diabetes prevalence suggests that the current rate in Wolverhampton is underrepresented by approximately 2%, given the census data which highlighted a higher Asian population than expected. This is a considerable cause for concern. Wolverhampton residents also record high rates of admissions for alcohol related conditions and it is also known that Wolverhampton is consistently higher than national and local comparators for alcohol related mortality. In terms of demographics there are gender and ethnicity inequalities but this is not consistent for hospital activity and mortality. Overall, residents record low happiness scores with over a third of residents recording lower than the national average scores.

Opportunities to diagnose problems early are also missed as breast, cervical and diabetic retinopathy screening programmes record low uptake. This last indicator is potentially particularly worrying given the high prevalence of diabetes. Both breast and cervical screening uptake is currently below the national target of 80%.

Health protection - PHOF

The health protection domain incudes those areas where protection of the population from disease is effective and includes areas of sexual health and vaccination.

Wolverhampton has high chlamydia diagnosis rates but this indicator will be related to the uptake and effectiveness of the chlamydia screening programme and is difficult to interpret. There is also a high percentage of people presenting with HIV in a late stage and low TB completion rates.

Vaccination (and the immunisation response it elicits) is one of the most effective public health interventions protecting individuals and populations against diseases that cause long term ill health, or even deaths. There are a number of national immunisation programmes in place in England including the routine childhood immunisation programmes and immunisation programmes targeted at individuals in

specified risk groups and adults. The spine charts show that vaccination coverage is low amongst Wolverhampton populations in the following areas:

Childhood vaccinations – population vaccination coverage in children is below the national average and below the optimum protective target set by the WHO (of 95%) for the following programmes:

- PCV vaccination at 2 years and booster at 5 years
- MMR1 vaccination at 5 years
- HPV vaccination

Adult immunisations - population vaccination coverage in adults is below the national average and below the optimum protective target set by the WHO (at 75%) for the following programmes:

- PPV vaccination in those aged 65 and over
- Flu uptake both in those aged 65 and over and those at risk.

Preventing people from dying prematurely - PHOF /NHSOF

This is a common area that spans the Public Health OF and the NHS OF, reflecting the impacts that the health improvement, wellbeing, and wider social determinants have on the numbers and causes of death and the impact on the NHS. Wolverhampton population has higher than the national average deaths from potentially preventable causes, and in particular, high premature mortality (aged under 75) from diseases relating to the circulatory system, cancer and chronic liver disease. Wolverhampton mortality rates for these indicators have been consistently higher than the national averages, however, more recently, the circulatory disease mortality rate has been declining. There are clear inequalities in terms of ethnicity, gender and deprivation. Males typically have higher mortality rates for all three causes. Mortality rates for those who reside in the more deprived areas are more than double compared to those in the least deprived areas. This is less apparent for cancer mortality where the gap is smaller. Asian and Black ethnic groups have higher mortality rates, suggesting inequalities regarding ethnicity; in particular, the Asian population has always seen high rates of alcohol related mortality, but local data suggests that this population has lower admission rates which highlights the

discrepancy between activity and subsequent death rates amongst the Asian population.

In relation to cancer, breast cancer survival rates are similar to the England average, but 5 year survival rates have fallen behind and are worse than the national average which may reflect the low screening uptake meaning that in some cases longer term outcomes are not as good as they could be.

Wolverhampton also records higher than national sight loss from preventable causes (which may be a consequence of the high diabetes prevalence) and also high rates of hip fracture emergencies, both of which local data shows have higher prevalence in the older population, which is a concern as it is known that this population is set to increase. Wolverhampton also has higher than average infant mortality among those aged 1 year and younger. Teenage pregnancy and smoking during pregnancy are risk factors - both of which are high in Wolverhampton. Breast feeding is a protective factor and rates are low in Wolverhampton. As mentioned previously these indicators are linked with deprivation and ethnicity inequalities.

Enhancing Quality of Life for People with Long Term Conditions/Helping People to recover from episodes of ill health following injury - NHS OF

The NHS and Adult Social Care OF are concerned with those residents who already have a serious and/or long term condition and who need care. The NHS Outcomes Framework indicators highlight some issues with emergency admissions amongst Wolverhampton residents which are high for adults with chronic conditions and also acute conditions that are usually managed in primary care and in addition for children with asthma, epilepsy and diabetes. There is also a low proportion of secondary care mental health service users in employment. An equity audit highlighted that certain BME groups are over represented in secondary care mental health services users and this therefore could highlight further inequalities in terms of employment for these groups.

Positive experience of care/support - NHS/ASC OF

Although over 4 out of 5 residents are satisfied, Wolverhampton residents are less satisfied with their GP surgery experience than the national average, 85% compared

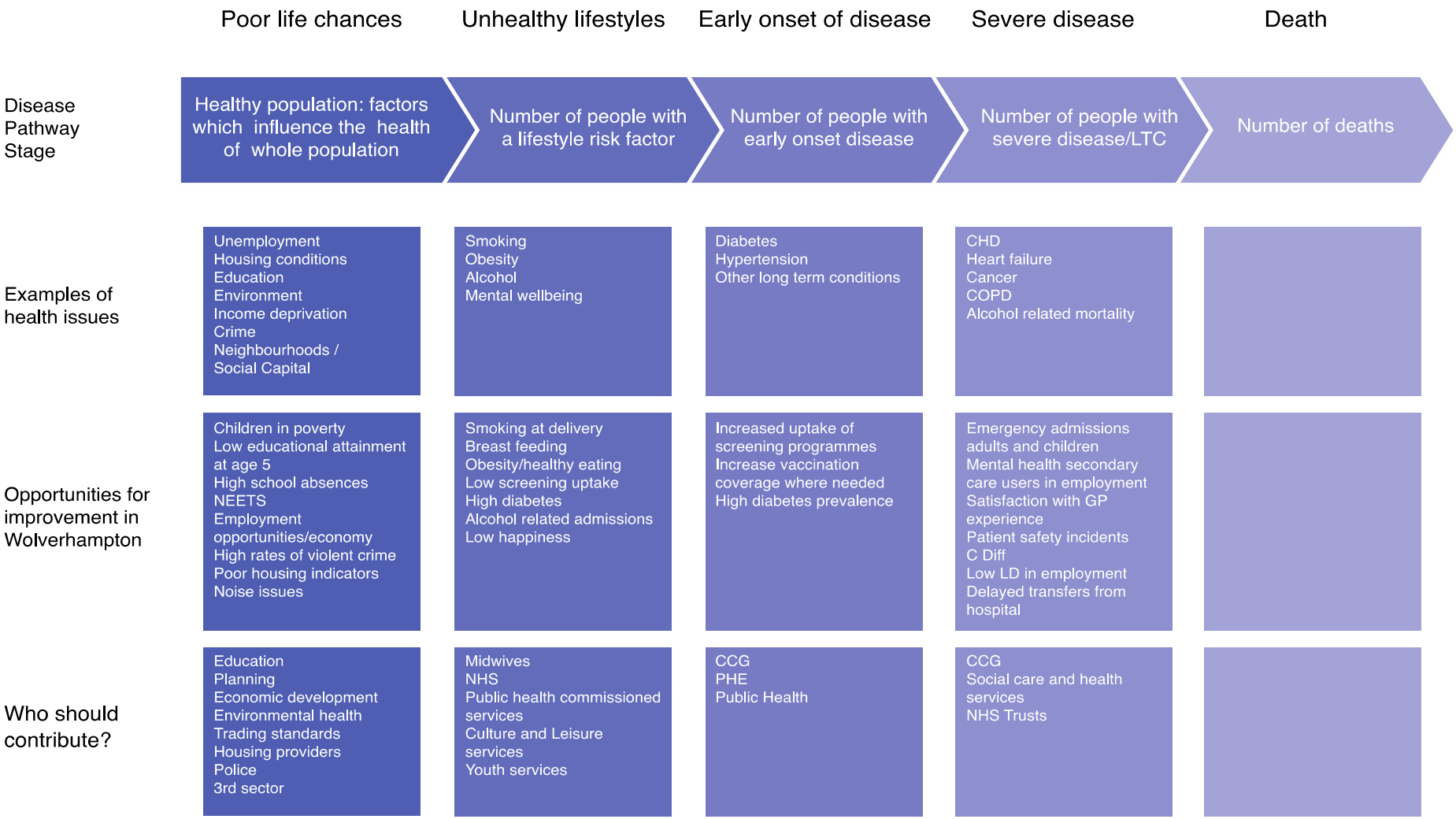
to 88%. There is also a higher proportion of delayed transfers of care from hospital and a higher proportion of delayed transfers due to adult social care.

Treat/care in a safe environment and protect from avoidable harm - NHS/ASC OF

In relation to treatment being provided in a safe environment, Wolverhampton records a high proportion of patient safety incidents - 9% compared to 6% nationally and higher incidence of C.difficile infections – with an infection rate of 39 per 100,000 bed days compared to 22 nationally.

There is also a lower percentage of adults with a learning disability in paid employment who live with their own families, and over double that rate of permanent admissions of younger adults (aged 18 to 64) to residential and nursing care homes.

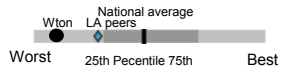
Pathway from health to disease and opportunities for improvement



Appendix 2: NHS Outcomes Framework 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:

No data

Still sourcing data

Needs source and discription

Completed by Wolverhampton Public Health Intelligence Team-September 2012

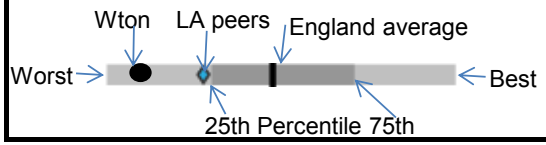
		Indicator	Local Number	Local Value	Eng Avg	Eng Worst	England Range	Eng 42.2
1. Preventing people from dying prematurely	1a	Mortality rate per 100,000 population from causes amenable to health care 2008-10	892	121.6	92.3	160.2		17.5
	1bi	Male life expectancy at 75 2008-10	n/a	11.1	11.4	9.5		19.3
	1bii	Female life expectancy at 75 2008-10	n/a	12.4	13.2	11.3		38.8
	1.1	Circulatory disease mortality rate per 100,000 population aged under 75 2008-10	641	85.0	67.2	123.2		4.4
	1.2	Mortality from chronic respiratory disease rate per 100,000 population aged under 75 2008-10	106	13.8	11.7	28.5		0.0
	1.3	Mortality from chronic liver disease rate per 100,000 population aged under 75 2008-10	132	19.3	10.1	31.0		98.2
	1.4i	Breast cancer survival at 1 year 2004-08	n/a	94.6	95.9	91.9		89.0
	1.4ii	Breast cancer survival at 5 years 2004-08	n/a	79.4	83.7	73.3		45.5
	1.4iii	Lung cancer survival at 1 year 2004-08	n/a	31.2	29.4	20.9		19.2
	1.4iv	Lung cancer survival at 5 years 2004-08	n/a	7.8	8.0	4.4		82.3
	1.4v	Colorectal cancer survival at 1 year 2004-08	n/a	74.7	74.2	64.2		66.2
	1.4vi	Colorectal cancer survival at 5 years 2004-08	n/a	49.1	53.0	41.4		30.3
	1.44vii	Cancer mortality rate per 100,000 population aged under 75 2008-10	935	125.2	110.1	159.1		
	1.5	*Premature mortality for secondary mental health services users*						2.2
	1.6i	Infant mortality rate per 1,000 2008-10	79	7.7	4.6	19.2		0.0
	1.6ii	Neonatal mortality rate per 1,000 2008-10	64	6.3	3.1	19.2		
	1.7	*Reduced premature mortality in people with learning disabilities-not an indicator?*						
2. Enhancing quality of life for people with long term conditions	2.0	*Health related quality of life for people with long term conditions*						71.0
	2.1	Recieved enough support from services to help manage long-term health condition	1406	65.0	64.0	55.0		
	2.2	*Employment of people with long term conditions*						33.7
	2.3i	Emergency hospital admissions for chronic conditions usually managed in primary care (adults)	605	249.1	181.8	375.0		91.1
	2.3ii	Emergency admissions for children with asthma under 19 April 2009 to March 2010	208	372.5	230.2	586.2		30.3
	2.3ii	Emergency admissions for children with epilepsy under 19 April 2009 to March 2010	63	112.8	78.8	176.4		14.9
	2.3ii	Emergency admissions for children with diabetes under 19 April 2009 to March 2010	52	93.1	65.7	123.5		
	2.4	*Health related quality of life for carers*						28.5
	2.5	% of secondary mental health services users in employment 2010-11	65	6.4	9.5	1.1		
	2.6	*Improved quality of life for those with dementia*						80.4
3. Helping people to recover from episopes of ill health or following injury	3a	Emergency hospital admissions for acute conditions usually managed in primary care	1758	687.5	457.2	946.1		7.5
	3b	% of emergency hospital readmissions within 28 days of discharge 2009-10	2408	10.3	11.2	13.1		0.5
	3.1i	Effective recovery following hip replacement 2010-11	n/a	0.5	0.4	0.2		0.4
	3.1ii	Effective recovery following knee replacement 2010-11	n/a	0.3	0.3	0.2		0.1
	3.1iii	Effective recovery following hernia 2010-11	n/a	0.1	0.1	0.0		0.2
	3.1iv	Effective recovery following varicose veins 2010-11	n/a	0.1	0.1	-0.1		32.1
	3.2	Emergency admissions for children with lower respiratory tract infections 2008-09	n/a	107.7	93.8	238.6		
	3.3	*An indicator on recovery from injuries & trauma*						
	3.4	*An indicator on recovery from stroke*						
	3.5i	*Proportion of patients with fragility recovering to previous levels of mobility at 30 days*						
	3.5ii	*Proportion of patients with fragility recovering to previous levels of mobility at 120 days*						99.3
	3.6i	Percentage of persons aged 65+ still at home 91 days after discharge from hospital into rehab 2010-11	230	87.2	81.9	44.9		
	3.6ii	*Proportion offered rehab following discharge from hospital*						94.8
4. Ensuring that people have a positive experience of care	4ai	Patients satisfied with their GP surgery experience 2011-12	4000	85.0	88.0	78.0		83.0
	4aii	Patients satisfied with their GP out of hours experience 2011-12	492	68.0	71.0	46.0		93.0
	4aiii	Patients satisfied with their Dental service experience 2011-12	1134	85.0	83.0	73.0		87.8
	4b	Patient experience of NHS inpatient care, overall satisfaction 2011*	n/a	74.2	75.6	67.4		88.5
	4.1	Patient experience of outpatient care overall satisfaction 2011*	n/a	77.9	79.5	71.0		85.0
	4.2	Responsiveness to inpatients personal needs composite score 2011*	n/a	65.8	67.4	56.5		86.8
	4.3	Patients experience of A&E 2008*	n/a	80.7	80.0	69.1		87.0
	4.4i	Patients satisfied with experience of making and appointment with their GP 2011-12	6323	78.0	79.0	64.0		97.0
	4.4ii	Patients successfully made an appointment with their Dentist 2011-12	1249	92.0	93.0	82.0		
	4.5	*Women's experience of maternity services*						
	4.6	*Survey of bereaved carers*						91.4
	4.7	Patient overall experience of community mental health services 2011 (by PCT)	n/a	87.0	86.8	81.8		
	4.8	*Children's and young peoples experience of healthcare*						1.9
5. Treat/care in a safe enviroment and protect from avoidable harm	5a	Patient safety incidents reported, % per admissions Oct 2011-Mar 2012*	4766	9.3	6.2	9.8		0.0
	5b	% of patient safety incidents resulting in severe harm or death Oct 2011-Mar 2012*	14	0.3	0.8	3.3		
	5.1	*Incidence of hospital related venous thromboembolism*						0.0
	5.2i	Incidence of health care associated MRSA infection 2011-12*	<5	0.9	3.2	10.8		0.0
	5.2ii	Incidence of health care associated C. difficille infection 2011-12*	173	39.0	21.8	51.6		
	5.3	*Incidence of newly acquired category 3 and 4 pressure ulcers*						4.2
	5.4	Incidence of medication error causing a patient safety incident Oct 2011-Mar 2012*	286	6.0	9.9	19.9		
	5.5	*Admission of full-term babies to neonatal care*						
	5.6	*Incidence of harm to children due to failure to monitor*						
		* data is for The Royal Wolverhampton NHS Trust						

Appendix 3: Adult Social Care Outcomes Framework spine chart

Significance Key :

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- Significance cannot be calculated

Chart Key:



Completed by Wolverhampton Public Health Intelligence Team-February 2013

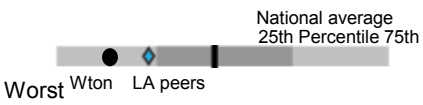
	Wton Number	Wton Value	Eng Median Value	Eng Worst	England Range	Eng Best
1A - Social care-related quality of life	64770	19.5	18.8	17.4		20.1
1B - % of people who use services who have control over their daily life	2850	77.5	75.9	62.5		82.7
1C(1) - % of people using social care who receive self-directed support	2385	50.7	43.7	3.9		90.6
1C(2) - % of people using social care who receive direct payments	825	17.5	14.0	3.9		43.0
1E - % of adults with learning disabilities in paid employment	15	2.4	6.6	0.9		25.8
1F - % of adults in contact with secondary mental health services in paid employment	60	5.5	7.3	0.9		30.7
1G - % of adults with learning disabilities who live in their own home or with their family	365	63.1	71.3	30.9		93.8
1H - % of adults in contact with secondary mental health services who live independently, with or without support	820	77.9	59.4	3.0		91.7
2A(1) - Permanent admissions of younger adults (aged 18 to 64) to residential and nursing care homes, per 100,000	70	45.1	17.8	67.1		3.3
2A(2) - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000	285	696.7	691.6	1239.3		170.6
2B(1) - % 65 and over still at home 91 days after discharge from hospital into reablement/rehabilitation (effectiveness service)	255	86.5	85.1	56.9		100.0
2B(2) - % 65 and over still at home 91 days after discharge from hospital into reablement/rehabilitation (offered service)	295	4.7	3.1	0.3		12.9
2C(1) - Delayed transfers of care from hospital per 100,000 population	27	13.9	8.2	30.6		0.5
2C(2) - Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population	17	8.7	2.8	15.8		0.3
3A - Overall satisfaction of people who use services with their care and support	2365	65.1	62.8	43.6		77.7
3D - % of people who use services and carers who find it easy to find information about services	2010	81.5	74.7	62.2		85.6
4A - % of people who use services who feel safe	2560	70.0	63.6	49.6		86.3
4B - % of people who use services who say that those services have made them feel safe and secure	2875	80.3	77.4	54.4		92.4

Appendix 4: Public Health Outcomes Framework spine chart

Key:

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

Spine chart explanation:



No data

Still sourcing data

Needs source and discription

Completed by Wolverhampton Public Health Intelligence Team-December 2012

Domain		Indicator	Local Number	Local Value	Nat Avg	Nat Worst	National Range	Nat Best
Vision	v1	Male life expectancy at birth 2008-10	n/a	76.7	78.6	75.5		80.6
	v2	Female life expectancy at birth 2008-10	n/a	80.8	82.6	80.2		83.8
	v3	Male inequality in life expectancy 2006-10	n/a	9.7	9.4	16.9		3.1
	v4	Female inequality in life expectancy 2006-10	n/a	5.8	6.5	11.6		1.2
	v5	Male disability free life expectancy 1999-2003	n/a	58.3	61.7	50.4		71.5
	v6	Female disability free life expectancy 1999-2003	n/a	60.8	64.1	54.0		71.3
	v7	Male inequality in DFLE 1999-2003	n/a	11.3	10.9	20.0		1.8
	v8	Female inequality in DFLE 1999-2003	n/a	10.6	9.2	17.1		1.3
1. Wider determinants	1.1	Children in Poverty 2009	17365	30.8	20.9	57.0		3.9
	1.2	Good development at age 5 2011	1514	52.0	59.0	48.0		74.0
	1.3	School absentees, % half days lost to unauthorised absence 2010-11	67	1.5	1.1	2.4		0.2
	1.4	First time entrants to the justice system, young people 2011	187	830.8	748.8	953.6		450.5
	1.5	NEET's at 16-19 years as at 2010-11	n/a	7.6	6.7	8.9		4.9
	1.6	% of Secondary mental health service users in settled accommodation 2010-11	850	83.7	66.8	33.3		83.8
	1.7	*People in prison who have a mental illness*						
	1.8	*% employed with long term conditions*						
	1.9	*Work sickness absence rates*						
	1.1	Road injuries and deaths 2008-2010	226	31.6	44.3	128.8		14.1
	1.11	*Incidents of domestic abuse*						
	1.12	Rate of violent crime 2010-11	4190	17.6	14.8	35.1		6.4
	1.13	% of reoffenders Q2 2009-Q1 2010	966	25.0	26.4	35.9		0.0
	1.14	Rate per 1,000 population affected by noise 2010-11	3795	15.9	7.8	66.7		1.3
	1.15	Homeless households 2010-11	324	3.3	2.0	10.4		0.1
	1.16	Utilisation of outdoor space for exercise/health reasons 2009-12	n/a	11.7	14.0	2.2		29.1
	1.17	Households that are in fuel poverty 2010	23836	24.3	16.4	27.1		4.6
	1.18	*Social connectedness*						
	1.19	*Older peoples perception of safety*						
2. Health improvement	2.1	% low birthweight babies, under 2500g 2010	267	7.7	7.0	11.5		4.3
	2.2i	Breast feeding initiation Q4 2011-12	2097	65.2	74.5	39.0		94.7
	2.2ii	Breastfed at 6-8 weeks Q4 2011-12	386	41.6	46.1	19.0		83.2
	2.3	% of women smoking at delivery Q1 12-13	148	18.3	12.7	28.0		1.0
	2.4	Under 18 conception rate 2010	760	55.5	38.1	64.9		10.8
	2.5	*Child development at 2 years*						
	2.6i	Proportion of Reception children classified as obese 2010-11	348	12.6	9.4	14.6		6.0
	2.6ii	Proportion of Year 6 children classified as obese 2010-11	595	23.8	19.0	26.5		10.7
	2.7	Accident admissions rate per 10,000 population for 0-17 year olds due to injury 2010-11	559	106.0	124.3	235.1		73.2
	2.8	Emotional wellbeing of looked after children 2010-11	n/a	13.8	13.9	10.1		22.8
	2.9	Children and young people smoking 2009	n/a	4.0	4.0	9.0		1.0
	2.10	Hospital admission as a result of self-harm, rate per 100,000 population 2010-11	360	158.4	212.0	509.8		49.6
	2.11	Health eating adults 2006-2008	n/a	22.5	28.7	19.3		47.8
	2.12	Prevalence of obese adults 2006-08 (estimated)	n/a	27.5	24.2	30.7		13.7
	2.13	% of adults physically active Oct 2009-Oct 2011	n/a	9.8	11.2	5.7		17.3
	2.14	Smoking prevalence in adults Q3 10/11- Q2 11/12	n/a	21.3	20.3	29.0		14.1
	2.15	% successful completion of drug treatment 2010	159	11.0	12.3	5.1		33.6
	2.16	*Prisoners with substance dependance not know to services*						
	2.17	Prevalence of diabetes 2010-11 (by PCT)	14846	7.1	5.5	7.7		3.5
	2.18	Alcohol related hospital admissions rate per 100,000 2010-11	5707	2073.0	1895.0	3276.0		910.0
	2.19	*% Cancer diagnosed in stages 1 and 2*						
	2.20i	Cervical screening uptake 2010-11 (by PCT)	47335	76.5	78.6	67.2		84.3
	2.20ii	Breast screening uptake 2010-11 (by PCT)	11987	73.4	77.4	59.8		85.1
	2.21i	*Non cancer screening programmes-HIV in pregnancy*						
	2.21ii	*Non cancer screening programmes-Syphilis, hepatitis B and susceptability to rubella in preg*						
	2.21iii	*Non cancer screening programmes-Sickle cell in pregnancy*						
	2.21iv	*Non cancer screening programmes-Newborn blood spot*						
	2.21v	Non cancer screening programmes-Newborn hearing (by PCT) 2009/10	3211	96.4	92.3	64.2		98.3
	2.21vi	*Non cancer screening programmes-Newborn physical examination*						
	2.21vii	Non cancer screening programmes-Diabetic retinopathy 2010-11 (by PCT)	12542	88.6	91.6	81.0		95.8
	2.22	Uptake of the NHS health checks programme 2011-12 (by PCT)	9926	12.8	7.2	0.0		28.9
	2.23iii	% self reported wellbeing-people with low happiness 2011-12	n/a	33.5	29.0	36.6		19.2
	2.24	Hospital admissions due to falls in persons over 65 2010-11	786	1452.8	2475.0	4844.4		1259.0

Appendix 4: Public Health Outcomes Framework spine chart

Key:

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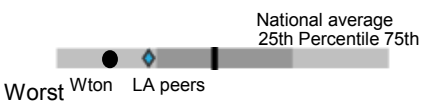
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

Spine chart explanation:



No data

Still sourcing data

Needs source and discription

Completed by Wolverhampton Public Health Intelligence Team-December 2012

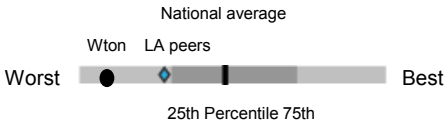
Domain		Indicator	Local Number	Local Value	Nat Avg	Nat Worst	National Range	Nat Best
3. Health protection	3.1	% of mortality attributable to air pollution 2010	n/a	5.8	5.6	8.3		3.6
	3.2	Chlamydia diagnosis rate per 100,000 15-24 year olds 2011	900	2733.5	1979.2	5995.0		464.0
	3.3i	Hep B vaccine coverage 2 year olds Jan-Mar 2012 (PCT's, note small numbers)	<5	50.0	69.0	0.0		100.0
	3.3ii	*BCG vaccine coverage 1 to 16 years*						
	3.3iii	DTaP/IPV/Hib uptake at 2 years at Jan-Mar 2012 (by PCT)	824	95.7	96.3	85.5		99.5
	3.3iv	Men C coverage at 2 years at Jan-Mar 2012 (by PCT)	807	93.7	95.3	82.0		99.5
	3.3v	PCV coverage at 2 years at Jan-Mar 2012 (by PCT)	766	89.0	92.5	72.7		100.0
	3.3vi	Hib/Men C booster at 5 years at Jan-Mar 2012 (by PCT)	751	90.9	91.4	70.1		99.0
	3.3vii	PCV booster at 5 years at Jan-Mar 2012 (by PCT)	724	87.7	91.4	68.4		96.8
	3.3viii	MMR uptake at 2 years at Jan-Mar 2012 (by PCT)	775	90.0	92.0	73.1		97.7
	3.3ix	MMR 1 dose coverage at 5 years at Jan-Mar 2012 (by PCT)	768	93.0	95.8	83.0		98.8
	3.3x	MMR 2nd dose uptake at 5 years at Jan-Mar 2012 (by PCT)	668	80.9	91.2	68.7		95.2
	3.3xi	TD/IPV booster at 13-18 years 2010-11 (by PCT, of those where data was available)	2744	17.4	18.6	0.3		100.0
	3.3xii	HPV vaccine uptake complete course at June 2012 (Provisional-by PCT)	828	61.8	82.6	45.2		97.6
	3.3xiii	PPV vaccination coverage 65+ 2010-11	26750	63.8	70.5	46.8		76.0
	3.3xiv	Flu immunisation uptake 65 and over 2011-12 (by PCT)	30141	70.6	74.0	64.8		81.5
	3.3xv	Flu immunisation uptake at risk groups 2011-12 (by PCT)	13553	50.0	51.6	43.4		66.3
	3.4	People presenting with HIV at a late stage 2008-2010	44	58.7	52.3	89.0		14.3
	3.5i	% treatment completion rates for TB 2011	n/a	74.1	84.3	0.0		0.0
4. Public health and preventing mortality	4.1	Infant mortality 2008-10	79	7.7	4.6	19.2		2.2
	4.2	Rate of tooth decay in children aged 5 years 2007-08 (completed every four years)	n/a	0.7	1.1	2.5		0.5
	4.3	Mortality rate per 100,000 population from causes amenable to health care 2008-10	892	121.6	92.3	160.2		42.2
	4.4	Circulatory disease mortality rate per 100,000 population aged under 75 2008-10	641	85.0	67.2	123.2		38.8
	4.5	Cancer mortality rate per 100,000 population aged under 75 2008-10	935	125.2	110.1	159.1		30.3
	4.6	Mortality from chronic liver disease rate per 100,000 population aged under 75 2008-10	132	19.3	10.1	31.0		0.0
	4.7	Mortality from chronic respiratory disease rate per 100,000 population aged under 75 2008-	106	13.8	11.7	28.5		4.4
	4.8	Mortality from infectious diseases, rate per 100,000 population 2008-10	95	8.3	6.7	14.0		2.0
	4.9	*Mortality rate for people with serious mental illness*						
	4.10	Suicide mortality rate per 100,000 population for persons all ages 2008-10	60	8.4	7.9	14.2		3.8
	4.11	% of emergency hospital readmissions within 28 days of discharge 2009-10	2408	10.3	11.2	13.1		7.5
	4.12iv	Preventable sight loss-sight loss certifications, rate per 100,000 population 2010-11	132	55.1	43.1	85.7		2.9
	4.13	*Health related quality of life for older people*						
	4.14	Hip fracture emergency admission rate per 100,000 for persons aged 65+ 2010-11	307	535.7	451.9	654.6		324.0
	4.15	Excess winter mortality ratio for persons aged all ages 2007-10	147	19.0	18.7	35.0		7.2
	4.16	*Dementia and its impacts*						

Appendix 5: Children's Outcomes Framework spine chart

Key:

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

Spine chart explanation:

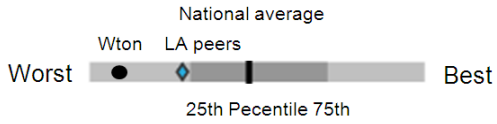


Completed by Wolverhampton Public Health Intelligence Team-September 2012

Area	Indicator	Local Value	Nat Avg	Nat Worst	National Range	Nat Best
Be healthy	Infant mortality 2008-10	7.7	4.6	19.2		2.2
	Under 18 conception rate 2010	55.5	38.1	64.9		10.8
	Teenage mothers (under 18) 2010-11	2.8	1.5	3.5		0.3
	Hospital admissions due to alcohol misuse (under 18) 2007-2010	37.2	61.8	154.9		18.6
	Children using alcohol 2009	12.0	15.0	23.0		3.0
	Substance misuse by young people 2009	8.3	9.8	16.5		2.6
	Children and young people smoking 2009	4.0	4.0	9.0		1.0
	Breast feeding initiation Q4 2011-12	65.2	74.5	39.0		94.7
	Proportion of Reception children classified as obese 2010/11	12.6	9.4	14.6		6.0
	Proportion of Year 6 children classified as obese 2010/11	23.8	19.0	26.5		10.7
	Rate of tooth decay in children aged 5 years 2007-08 (completed every four	0.7	1.1	2.5		0.5
	Hospital admission due to substance misuse (15-24) 2008-10	36.1	63.5	163.6		19.8
	Child mortality rate (aged 1-17) 2002-10	15.6	16.5	27.6		10.5
	% low birthweight babies, under 2500g 2010	7.7	7.0	11.5		4.3
	Breastfed at 6-8 weeks Q4 2011-12	41.6	46.1	19.0		83.2
	% of women smoking at delivery Q1 2012-13	18.3	12.7	28.0		1.0
	Hospital admissions for mental health 2010-11	37.9	109.4	722.1		36.8
	Hospital admissions for self harm 2010-11	176.4	158.8	359.5		34.3
Stay safe	Children in care 2011	94.0	59.0	142.0		20.0
	% of pupils who say they have been bullied 2009	10.9	9.6	14.4		5.6
	Homeless households 2010-11	3.3	2.0	10.4		0.1
	DTaP/IPV/Hib uptake at 2 years at Jan-Mar 2012 (by PCT)	95.7	96.3	85.5		99.5
	Men C coverage at 2 years at Jan-Mar 2012 (by PCT)	93.7	95.3	82.0		99.5
	PCV coverage at 2 years at Jan-Mar 2012 (by PCT)	89.0	92.5	72.7		100.0
	Hib/Men C booster at 5 years at Jan-Mar 2012 (by PCT)	90.9	91.4	70.1		99.0
	PCV booster at 5 years at Jan-Mar 2012 (by PCT)	87.7	91.4	68.4		96.8
	MMR uptake at 2 years at Jan-Mar 2012 (by PCT)	90.0	92.0	73.1		97.7
	MMR 1 dose coverage at 5 years at Jan-Mar 2012 (by PCT)	93.0	95.8	83.0		98.8
	MMR 2nd dose uptake at 5 years at Jan-Mar 2012 (by PCT)	80.9	91.2	68.7		95.2
	TD/IPV booster at 13-18 years 2010-11 (by PCT, of those where data was a	17.4	18.6	0.3		100.0
	HPV vaccine uptake complete course at June 2012 (Provisional-by PCT)	61.8	82.6	45.2		97.6
	Children in care immunisations 2011	93.4	79.0	20.0		142.0
	Accident admissions rate per 10,000 population for 0-17 year olds due to inj	106.0	124.3	235.1		73.2
	KSI rate for children 2008-10	24.9	23.6	64.2		2.1
	Chlamydia diagnosis rate per 100,000 15-24 year olds 2011	2733.5	1979.2	5995.0		464.0
Enjoy and achieve	% participation in at least 3 hours of sport/PE 2009-10	60.6	55.1	40.9		79.5
	Good development at age 5 2011	52.0	59.0	48.0		74.0
	% GCSE pass rate (5 A*-C, inc English and Maths) 2010-11	57.6	58.4	40.1		79.9
	% GCSE pass rate (5 A*-G) 2010-11	93.6	93.8	85.1		100.0
	% GCSE pass rate for children in care (5 A*-C) 2010-11	<5	12.8	0.0		40.0
Positive contribution	Children who have someone to talk to 2009	67.0	64.0	56.0		74.0
	% of children working securely at foundation level 2010-11	46.0	54.0	40.0		85.0
	Pupils who voted in school elections % 2007					
Economic wellbeing	School absentees, % half days lost to unauthorised absence 2010-11	1.5	1.1	2.4		0.2
	First time entrants to the justice system, young people 2011	830.8	748.8	953.6		450.5
	Children in Poverty 2009	30.8	20.9	57.0		3.9
	NEET's at 16-19 years as at 2010-11	7.6	6.7	8.9		4.9

Appendix 6 – Interpreting Spine Charts

Spine charts present the data in the format below:



The solid line down the middle of the charts represents the national average. The dark shaded area around the national average line shows the middle 50% of LA values in England. The lighter shaded area around the national average line shows the full range of LA values in England.

Wolverhampton's data is represented as a circle. The colour of this circle indicates whether our data varies significantly from the national average.

- Red - Wolverhampton is significantly worse
- Blue - there is no significant difference
- Green - Wolverhampton is significantly better
- Black – it is not possible to assess significance

The blue diamond represents the average performance of a group of local authorities who are similar to Wolverhampton in terms of demographics. This is not available for all indicators.

Where there is no shaded area and the black circle is at the beginning of the chart – there is no data available for this indicator.

In addition the local number, the local value and the national average, minimum and maximum values are also presented.

Appendix 7 – Health and Wellbeing Outcomes Framework at a glance

Improving the wider determinants of health
Objective - Improvements against wider factors that affect health and wellbeing and health inequalities
• Children in poverty • *School readiness (Placeholder)* • Pupil absence • First time entrants into the youth justice system • 16-18 year olds not in education, employment or training • People with mental illness or disability in settled accommodation • *People in prison who have a mental illness or significant mental illness (Placeholder)* • *Sickness absence rate (Placeholder)* • Killed or seriously injured casualties on England's roads • *Domestic abuse (Placeholder)* • Violent crime (including sexual violence) • Reoffending • The percentage of the population affected by noise • Statutory homelessness • Utilisation of green space for exercise/ health reasons • Fuel poverty • *Social connectedness (Placeholder)* • *Older people's perception of community safety (Placeholder)* • *Adult obesity (added by HWB)* • *Prevalence of diabetes (added by HWB)* • *Smoking in adults (added by HWB)* • *Self-reported wellbeing (added by HWB)* • *Prevalence of depression (added by HWB)*

Life expectancy
Objective - Preventing people dying prematurely
• Life expectancy (Male/ Female) • Under 75 mortality from cardiovascular disease • Under 75 mortality from respiratory disease • Under 75 mortality from liver disease • Under 75 mortality from cancer • *Excess mortality rate in adults with serious mental illness (Placeholder)* • *Early diagnosis of Cancer (Placeholder - added by HWB)*

Children's health
Objective -Improvements in Children's Health from neonatal to 19 years.
• Low birth weight of term babies • Breastfeeding • Smoking status at time of delivery • Under 18 conceptions • *Child development at 2-2.5 years (Placeholder)* • Excess weight in 4-5 and 10-11 year olds • Hospital admissions caused by unintentional and deliberate injuries in under 18s • Emotional wellbeing of looked after children • Smoking prevalence – 15 year olds • Infant Mortality • Tooth decay in children aged five • Chlamydia diagnosis (15-24 year olds) • Population vaccination coverage • Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s • Emergency admissions for children with lower respiratory tract infections • *Children and young people's experience of healthcare (Placeholder)* • *Admission of full time babies to neonatal care (Placeholder)* • *Incidence of harm to children due to 'failure to monitor' (Placeholder)* • Children at age 16 achieving 5 GCSE A-C (added by HWB) • Accident admissions for 0-17 year olds (added by HWB)

Health and Social Care
Objective -Enhance quality of life for people with long term conditions and help people recover from episodes of ill-health of following injury
• *Health related quality of life for people with long term conditions (Placeholder)* • Proportion of people feeling supported to manage their condition • *Employment of people with long term conditions (placeholder)* including people with mental illness and people with learning disability • *Health related quality of life for carers (Placeholder)* • *Quality of life for people with dementia (Placeholder)* • Proportion of older people (65 and over) who were still at home 91 days after discharge into rehabilitation • Proportion of older people (65 and over) who were offered rehabilitation following discharge from acute or community hospital • *Long term admission to residential, nursing or continuing care (added by HWB)* • *Fractured Proximal Femur Emergency Admissions (added by HWB)* • *Recovery from stroke (Placeholder - added by HWB)* • *Flu immunisation uptake (65+/ at risk) (added by HWB)*

Appendix 8: Health and Wellbeing Outcome Framework 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

Completed by Wolverhampton Public Health Intelligence Team-March 2013

		Indicator	Local Number	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Improving Wider Determinants of Health	2	Children in Poverty (2010)	17365	30.8	20.9	57.0		3.9
	3	School readiness (Placeholder)						
	4	School absentees, % half days lost to unauthorised absence 2010-11	67	1.5	1.1	2.4		0.2
	5	First time entrants to the justice system, young people 2011	187	830.8	748.8	953.6		450.5
	6	Young people not in education, employment or training (NEETs) 2011-2012	n/a	7.6	6.1	11.8		0.9
	7	% of Secondary mental health service users in settled accommodation 2010-11	850	84	67	33		83.8
	8	People in prison who have a mental illness (Placeholder)						
	9	Work sickness absence rates (Placeholder)						
	10	Road injuries and deaths 2008-2010	226	31.6	44.3	128.8		14.1
	11	Incidents of domestic abuse (Placeholder)						
	12	Rate of violent crime 2010-11	4190	17.6	14.8	35.1		6.4
	13	% of reoffenders 2010	840	25.8	26.8	36.3		17.3
	14	Rate per 1,000 population affected by noise 2010-11	3795	15.9	7.8	66.7		1.3
	15	Homeless households 2010-11	324	3.3	2.0	10.4		0.1
	16	Utilisation of outdoor space for exercise/health reasons 2009-12	n/a	11.7	14.0	2.2		29.1
	17	Households that are in fuel poverty 2010	23836	24.3	16.4	27.1		4.6
	18	Social connectedness (Placeholder)						
	19	Older peoples perception of safety (Placeholder)						
	20	Prevalence of obese adults 2006-08 (estimated)	n/a	27.5	24.2	30.7		13.7
	21	Prevalence of diabetes 2010-11 (by PCT)	14846	7.1	5.5	7.7		3.5
	22	Smoking prevalence in adults Q3 10/11- Q2 11/12	n/a	21.3	20.3	29.0		14.1
	23	% self reported wellbeing-people with low happiness 2011-12	n/a	33.5	29.0	36.6		19.2
	24	Prevalence of depression 2010-11 (by PCT)	23028	8.9	11.1	20.3		4.6
Life Expectancy	25	Male life expectancy at birth 2008-10	n/a	76.7	78.6	75.5		80.6
	26	Female life expectancy at birth 2008-10	n/a	80.8	82.6	80.2		83.8
	27	Circulatory disease mortality rate per 100,000 population aged under 75 2008-10	641	85.0	67.2	123.2		38.8
	28	Cancer mortality rate per 100,000 population aged under 75 2008-10	935	125.2	110.1	159.1		30.3
	29	Mortality from chronic liver disease rate per 100,000 population aged under 75 2008-10	132	19.3	10.1	31.0		0.0
	30	Mortality from chronic respiratory disease rate per 100,000 population aged under 75 2008-10	106	13.8	11.7	28.5		4.4
	31	Mortality rate for people with serious mental illness (Placeholder)						
	32	% Cancer diagnosed in stages 1 and 2 (Placeholder)						
	33	% low birthweight babies, under 2500g 2010	267	7.7	7.0	11.5		4.3
	34	Breast feeding initiation Q2 2012-13	538	63.1	74.6	38.3		95.5
	35	Breast feeding at 6-8 weeks Q2 2012-13	n/a	38.4	47.4	20.3		83.6
	36	% of women smoking at delivery Q1 2012-13	144	16.9	12.9	30.2		2.1
	37	Under 18 conception rates Sept '11 (Yearly rate rolled forward a quarter at a time)	n/a	46.7	32.0	57.6		13.2
	38	Child development at 2 years (Placeholder)						

Child Health	39	Proportion of Reception children classified as obese 2011-12	n/a	13.0	9.5	14.5		4.6
	40	Proportion of Year 6 children classified as obese 2011-12	n/a	24.2	19.2	28.5		10.3
	41	Accident admissions rate per 10,000 population for 0-17 year olds due to injury 2010-11	559	106.0	124.3	235.1		73.2
	42	Emotional wellbeing of looked after children (Placeholder)						
	43	Smoking prevalence -15 year olds (Placeholder)						
	44	Infant mortality rate per 1,000 live births 2009-11	n/a	7.3	4.4	8.0		0.0
	45	Rate of tooth decay in children aged 5 years 2007-08 (completed every four years)	n/a	0.7	1.1	2.5		0.5
	46	Chlamydia diagnosis rate per 100,000 15-24 year olds 2011	900	2733.5	1979.2	5995.0		464.0
	47	Hep B vaccine coverage 2 year olds Jul-Sep 2012 (no children eligible during this period)						
	48	BCG vaccine coverage 1 to 16 years (Placeholder)						
	49	DTaP/IPV/Hib uptake at 2 years at Jul-Sep 2012 (by PCT)	828	97.1	96.3	83.1		99.8
	50	Men C coverage at 2 years at Jul-Sep 2012 (by PCT)	817	95.8	95.2	78.1		99.9
	51	PCV coverage at 2 years at Jul-Sep 2012 (by PCT)	760	89.1	92.4	76.1		98.4
	52	Hib/Men C booster at 5 years at Jul-Sep 2012 (by PCT)	816	92.9	91.3	74.2		98.6
	53	PCV booster at 5 years at Jul-Sep 2012 (by PCT)	773	88.0	89.0	68.2		96.7
	54	MMR uptake at 2 years at Jul-Sep 2012 (by PCT)	800	93.8	92.2	77.2		98.6
	55	MMR 1 dose coverage at 5 years at Jul-Sep 2012 (by PCT)	831	94.6	93.9	80.4		99.1
	56	MMR 2nd dose uptake at 5 years at Jul-Sep 2012 (by PCT)	629	71.6	87.5	67.6		98.0
	57	TD/IPV booster at 13-18 years 2010-11 (by PCT, of those where data was available)	2744	17.4	18.6	0.3		100.0
	58	HPV vaccine uptake complete course at June 2012 (Provisional-by PCT)	828	61.8	82.6	45.2		97.6
	59	Emergency admissions for children with asthma under 19 April 2009 to March 2010	208	372.5	230.2	586.2		91.1
	60	Emergency admissions for children with epilepsy under 19 April 2009 to March 2010	63	112.8	78.8	176.4		30.3
	61	Emergency admissions for children with diabetes under 19 April 2009 to March 2010	52	93.1	65.7	123.5		14.9
	62	Children's and young peoples experience of healthcare (Placeholder)						
	63	Emergency admissions rate per 100,000 children u16 with lower respiratory infections 2010-11	233	444.8	405.4	730.5		53.7
	64	Admission of full-term babies to neonatal care (Placeholder)						
	65	Incidence of harm to children due to failure to monitor (Placeholder)						
	66	5 or more A*-C GCSE inc Maths & English 2011-12	n/a	56.2	58.6	40.8		86.4
Health and Social Care	67	Health related quality of life for older people (Placeholder)						
	68	Recieved enough support from services to help manage long-term health condition 2011-12	1406	65.0	64.0	55.0		71.0
	69	Health related quality of life for carers (Placeholder)						
	70	Improved quality of life for those with dementia (Placeholder)						
	71	Percentage of 65+ still at home 91 days after discharge from hospital into rehab 2011/12	255	86.5	85.1	56.9		100.0
	72	Proportion offered rehab following discharge from hospital (Placeholder)						
	73	Permanent admissions rate per 100,000 aged 65+ to residential and nursing care homes 2011-12	285	696.7	691.6	1239.3		170.6
	74	Hip fracture emergency admission rate per 100,000 for persons aged 65+ 2010-11	307	535.7	451.9	654.6		324.0
	75	An indicator on recovery from stroke (Placeholder)						
	76	Flu immunisation uptake 65 and over 2011-12 (by PCT)	30141	70.6	74.0	64.8		81.5
	77	Flu immunisation uptake at risk groups 2011-12 (by PCT)	13553	50.0	51.6	43.4		66.3
	78	Employment of people with long term conditions, mental illness and learning difficulties (placeholder)						

Appendix 9 – Stakeholder Engagement

Stakeholder	Engagement method	Numbers engaged
Service Users and Public	Survey Monkey	6
Voluntary Sector	Survey Monkey	7
Service Users/ Public/ Voluntary Sector	LINk Event	60
GPs	Survey Monkey	12
Public Health Staff	Survey Monkey	10
CCG Board Member	Survey Monkey	7
Providers	Survey Monkey	4
Council Officers	Survey Monkey	9
Pharmacy Staff	LPC AGM	40
Councillors	Survey Monkey	0

Appendix 10 – Changes made as a result of stakeholder engagement

As a result the following changes were made:

- Three additional outcomes were added:
    - Incidence of Harm to children due to a failure to monitor. This was prioritised in seven of the ten stakeholders' processes. Overall this outcome ranked 14th for stakeholders.
    - Accident admissions for 5 to 18 year olds. This was prioritised in six of the ten stakeholders' processes. Overall this outcome ranked 47th for stakeholders.
    - Self-reported wellbeing. This was prioritised in four of the ten stakeholders' processes. Overall this outcome ranked 36th for stakeholders.

- A number of outcomes priority position changed:
    - Circulatory disease mortality increased. This was ranked 14th by HWB compared with 5th by stakeholders.
    - Infant mortality increased. This was ranked 14th by HWB compared with 7th by stakeholders.
    - Under 18 conception rates increased. This was ranked 14th by HWB compared with 8th by stakeholders.
    - Smoking in adults decreased. This was ranked 14th by HWB compared with 24th by stakeholders.
    - Incidence of harm to children due to failure to monitor increased. This was not ranked by HWB compared with 14th by stakeholders.
    - Health related quality of life for people with long term conditions increased. This was ranked 28th by HWB compared with 16th by stakeholders.

- An additional 34 outcomes were raised by only one stakeholder group and therefore only considered by this group. Other stakeholders have not had an opportunity to prioritise them. A commitment is made to develop a process to consider these outcomes. This will be included in the Health and Wellbeing Strategy.

Appendix 11 – Health and Wellbeing Board Shortlisted Outcomes

Group 1		**Group 2**	
1	Alcohol related mortality all ages	8	Prevalence of diabetes
2	Children in poverty	9	Infant mortality
3	Childhood obesity	10	Quality of life for people with dementia
4	Adult obesity	11	Child development (development at age 2 and 5 years)
5	People employed with long term conditions (including those with mental health problems and learning difficulties)	12	Premature mortality for secondary mental health services users
6	Incidents of domestic abuse	13	Recovery from stroke
7	Circulatory disease mortality under 75	14	Long term admission to residential, nursing or continuing care
Group 3		**Group 4**	
15	*Cancer Mortality*	22	Homeless households
16	Early diagnosis of cancer	23	Maternal smoking prevalence
17	Under 18 conception rates	24	Emergency admissions for children (asthma, epilepsy, diabetes, LRTI)
18	Fractured proximal femur emergency admissions	25	Social connectedness
19	*Low birth weight babies under 1500g*	26	Self-reported wellbeing (% people with low happiness)
20	Households that are in fuel poverty	27	Work sickness absence rates
21	Incidence of harm to children due to failure to monitor	28	*Breast feeding initiation at 6-8 weeks*
Group 5		**Group 6**	
29	An indicator of young people's experience of care to be developed	36	*NEET's at 16-19 years*
30	Flu immunisation uptake (65+/ at risk)	37	*People affected by neighbourhood noise*
31	Accident admissions for 5-18 year olds due to injury	38	*Chlamydia diagnosis rates in 15-24 year olds*
32	Prevalence of depression	39	Admission of full-term babies to neonatal care
33	*Population vaccination coverage*	40	Older people's perception of safety
34	*Pupil absence (School truancy - days lost to unauthorised absence)*		
35	*Rates of violent crime*		

Indicators in italic have been added to shortlist as a result of change in data between 2012 and 2011

The following indicators have been removed as a result of change of data between 2012 and 2011: Access to green space, Smoking in Adults, Children at age 16 achieving 5 GCSE A-C, 65+ still at home 91 days after discharge from hospital into rehab and Health related quality of life for older people

Appendix 12: Health and Wellbeing Board shortlist 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

Completed by Wolverhampton Public Health Intelligence Team-March 2013

		Indicator	Local Number	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Group 1	1	Mortality from chronic liver disease rate per 100,000 population aged under 75 2008-10	132	19.3	10.1	31.0		0.0
	2	Children in Poverty 2010	17365	30.8	20.9	57.0		3.9
	3	Proportion of Reception children classified as obese 2011-12	n/a	13.0	9.5	14.5		4.6
	4	Proportion of Year 6 children classified as obese 2011-12	n/a	24.2	19.2	28.5		10.3
	5	Prevalence of obese adults 2006-08 (estimated)	n/a	27.5	24.2	30.7		13.7
	6	Employment of people with long term conditions, mental illness and learning difficulties (placeholder)						
	7	Incidents of domestic abuse (Placeholder)						
	8	Circulatory disease mortality rate per 100,000 population aged under 75 2008-10	641	85.0	67.2	123.2		38.8
Group 2	9	Prevalence of diabetes 2010-11 (by PCT)	14846	7.1	5.5	7.7		3.5
	10	Infant mortality rate per 1,000 live births 2009-11	n/a	7.3	4.4	8.0		0.0
	11	Improved quality of life for those with dementia (Placeholder)						
	12	Child development at 2 years (Placeholder)						
	13	Mortality rate for people with serious mental illness (Placeholder)						
	14	An indicator on recovery from stroke (Placeholder)						
	15	Permanent admissions rate per 100,000 aged 65+ to residential and nursing care homes 2011-12	285	696.7	691.6	1239.3		170.6
Group 3	16	% Cancer diagnosed in stages 1 and 2 (Placeholder)						
	17	Under 18 conception rates Sept '11 (Yearly rate rolled forward a quarter at a time)	n/a	46.7	32.0	57.6		13.2
	18	Hip fracture emergency admission rate per 100,000 for persons aged 65+ 2010-11	307	535.7	451.9	654.6		324.0
	19	Households that are in fuel poverty 2010	23836	24.3	16.4	27.1		4.6
	20	Incidence of harm to children due to failure to monitor (Placeholder)						
Group 4	21	Homeless households 2010-11	324	3.3	2.0	10.4		0.1
	22	% of women smoking at delivery Q1 2012-13	144	16.9	12.9	30.2		2.1
	23	Emergency admissions for children with asthma under 19 April 2009 to March 2010	208	372.5	230.2	586.2		91.1
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	25	Emergency admissions for children with diabetes under 19 April 2009 to March 2010	52	93.1	65.7	123.5		14.9
	26	Social connectedness (Placeholder)						
	27	% self reported wellbeing-people with low happiness 2011-12	n/a	33.5	29.0	36.6		19.2
	28	Work sickness absence rates (Placeholder)						
Group 5	29	Children's and young peoples experience of healthcare (Placeholder)						
	30	Flu immunisation uptake 65 and over 2011-12 (by PCT)	30141	70.6	74.0	64.8		81.5
	31	Flu immunisation uptake at risk groups 2011-12 (by PCT)	13553	50.0	51.6	43.4		66.3
	32	Accident admissions rate per 10,000 population for 0-17 year olds due to injury 2010-11	559	106.0	124.3	235.1		73.2
	33	Prevalence of depression 2010-11 (by PCT)	23028	8.9	11.1	20.3		4.6
Group 6	34	Admission of full-term babies to neonatal care (Placeholder)						
	35	Older peoples perception of safety (Placeholder)						

Appendix 13 – Health and Wellbeing Board Prioritisation Framework

	Prioritisation Question	**Weighting**
1	Is there evidence of an intervention that can change this outcome?	x3
2	What is the anticipated benefit? (including Quality of Life)	x2
3	How many people will benefit?	x2
4	How much will it cost/save?	x2
5	Is it acceptable to the public?	x2
6	Do we have to do this e.g. national requirement?	x1
7	Does it reduce inequalities?	x2
8	Are there wider benefits to society?	x2
9	How strong is local feeling about this?	x2
10	Does it contribute to other priorities? (e.g. City Strategy)	x2

DRAFT

Dear colleague

Addressing Health and Wellbeing in Wolverhampton
The Joint Strategic Needs Assessment : "Focussing on Outcomes"

Wolverhampton Health and Wellbeing Board has produced its 2013 Joint Strategic Needs Assessment which is a statutory responsibility of the board. The JSNA is an integral tool to support local commissioning organisations and should be a key component of local commissioning strategies where the aim is to improve outcomes and services for the people of Wolverhampton in order to improve their health and wellbeing.

For the Health and Wellbeing Board it provides a common understanding of needs within the city of Wolverhampton and enables partners to come together to focus on where joint actions can make a difference – which will be agreed in our Joint Health and Wellbeing Strategy.

Health and Wellbeing Boards represent a real opportunity for health, local government and public health and local Healthwatch to work together to agree shared priorities and to make a real difference to our residents. To do this we need to develop a joint understanding of the health and wellbeing needs of the local population using the most reliable and robust information and to make the most of scarce resources. Therefore, we have agreed that our particular emphasis is to focus on what matters and what makes a difference – on outcomes.

As well as understanding Wolverhanpton's needs, we have made measuring the needs and the changes that the Board makes in addressing those needs at the heart of our JSNA. We are providing an additional evidence base where the JSNA has highlighted specific health issues as needing attention and have produced a series of 15 further detailed briefings on key health topics.

Needs do change over time and therefore the JSNA will be updated on a yearly basis to make sure that our priorities continue to be the right ones which to enable us to monitor the progress .

We hope you find the JSNA a useful and informative document.

Councillor Sandra Samuels
Chair, Wolverhampton Health and Wellbeing Board

Dr Helen Hibbs
Chief Officer
Wolverhampton Clinical Commissioning Group

Wolverhampton City Council **OPEN DECISION ITEM**

Health and Well Being Board **Date 4 SEPTEMBER 2013**

Originating Service Group(s) **COMMUNITY**

Contact Officer(s)/ Telephone Number(s) **V GRIFFIN (55)5370**

Title **DRAFT JOINT HEALTH AND WELLBEING STRATEGY**

RECOMMENDATIONS

- That the Board notes and comments on the draft Health and Wellbeing Strategy Mark 2 and approves its publication.

1. BACKGROUND

1.1 At its meeting on 1 May 2013 the Health and Wellbeing Board agreed the priorities for the Board and its sub-groups for 2013/14 and noted progress on the JSNA / Health and Wellbeing Strategy (Mark 2). The updating of the Health and Wellbeing Strategy (Mark 2) has been coordinated by the Task and Finish Group and is now complete. The updated Strategy needs to been considered alongside the refreshed JSNA which is also on the agenda for receipt at this meeting.

2. HEALTH AND WELLBEING STRATEGY

2.1 The updated Health and Wellbeing Strategy is based on the five key priorities for the board:

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

For each of these areas it commences a brief implementation plan and outlines key outcomes targets against which the plans can be performance managed.

3. FINANCIAL IMPLICATIONS

3.1 There are no financial implications associated with this report.

[MK/22082013/Y]

4. LEGAL IMPLICATIONS

4.1 There are no legal implications associated with this report.

[FD/21082013/B]

5. EQUAL OPPORTUNITIES IMPLICATIONS

5.1 An equal opportunities impact statement has been completed for the Joint Health and Well Being Strategy.

6. ENVIRONMENTAL IMPLICATIONS

6.1 There are no environmental implications associated with this report.

7. SCHEDULE OF BACKGROUND PAPERS

Wolverhampton Joint Health and Wellbeing Strategy – 2013-2018

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:

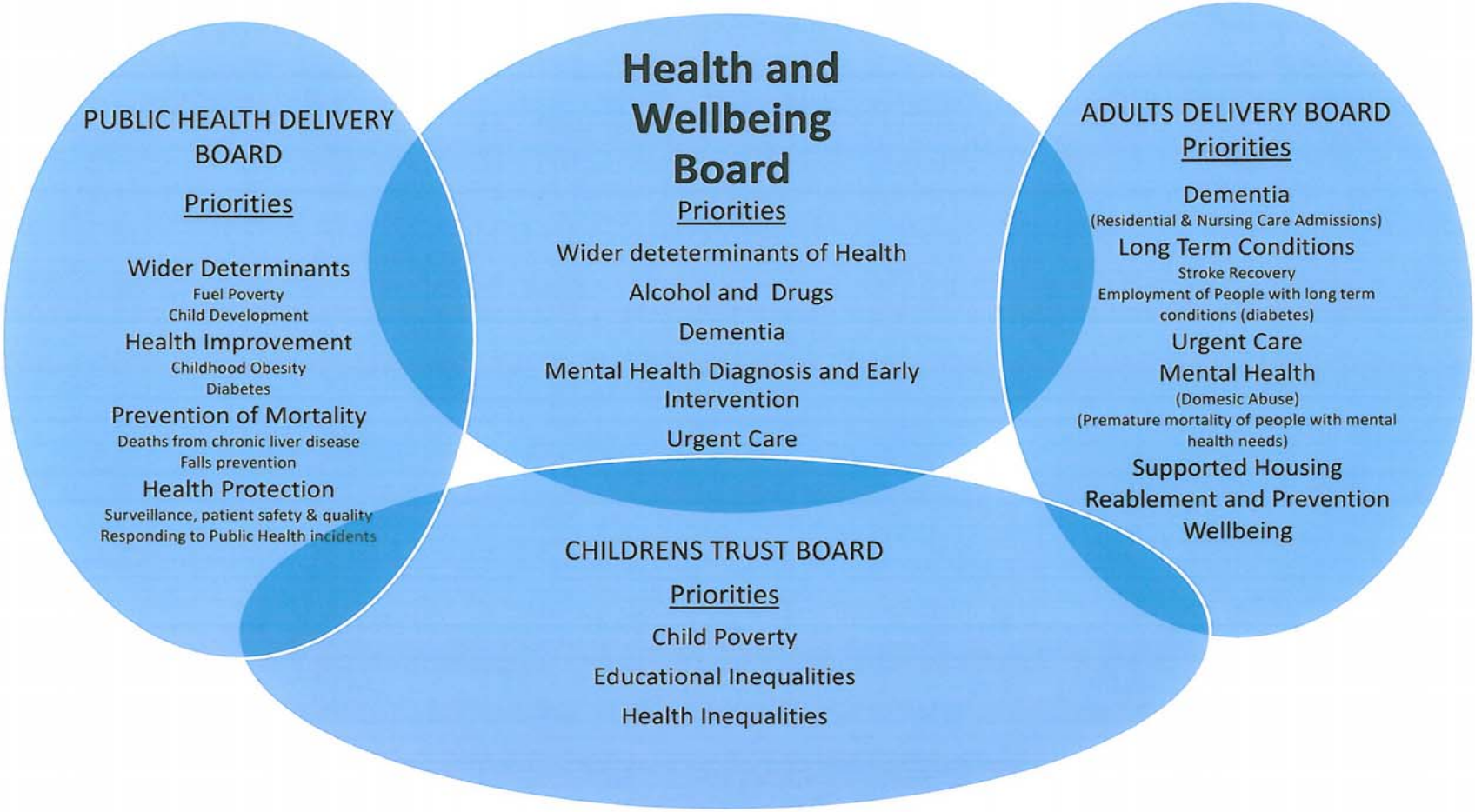
- **Wider Determinants of Health**
- **Alcohol and Drugs**
- **Dementia (early diagnosis)**
- **Mental Health (Diagnosis and Early Intervention)**
- **Urgent Care (Improving and Simplifying)**

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.

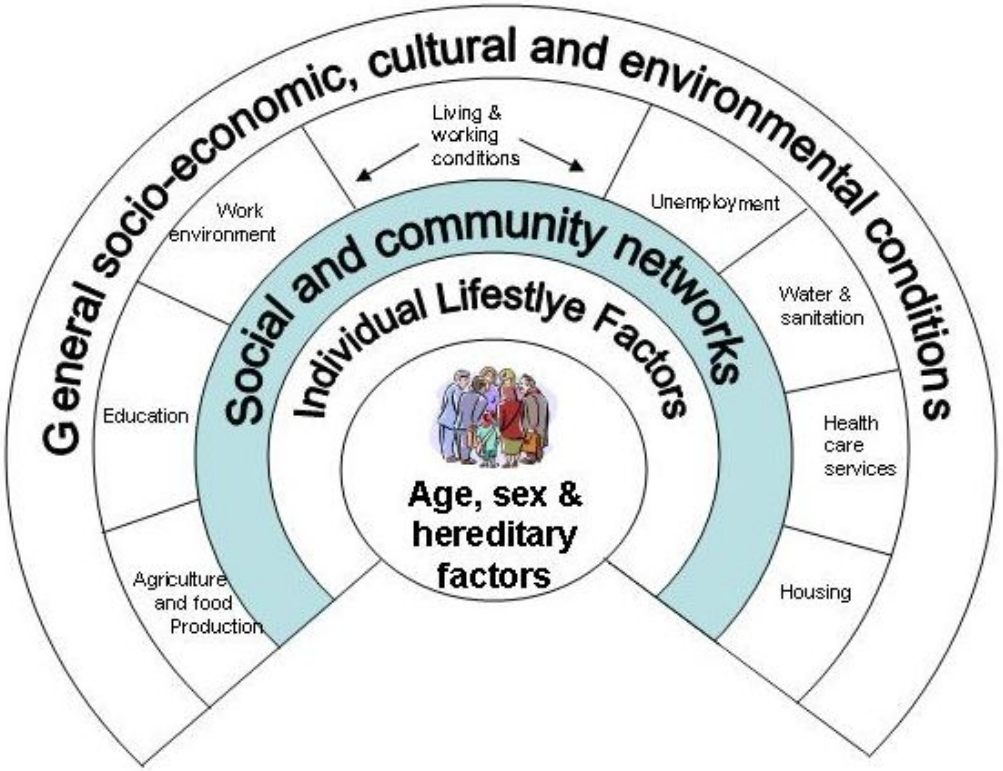
Why is it important

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

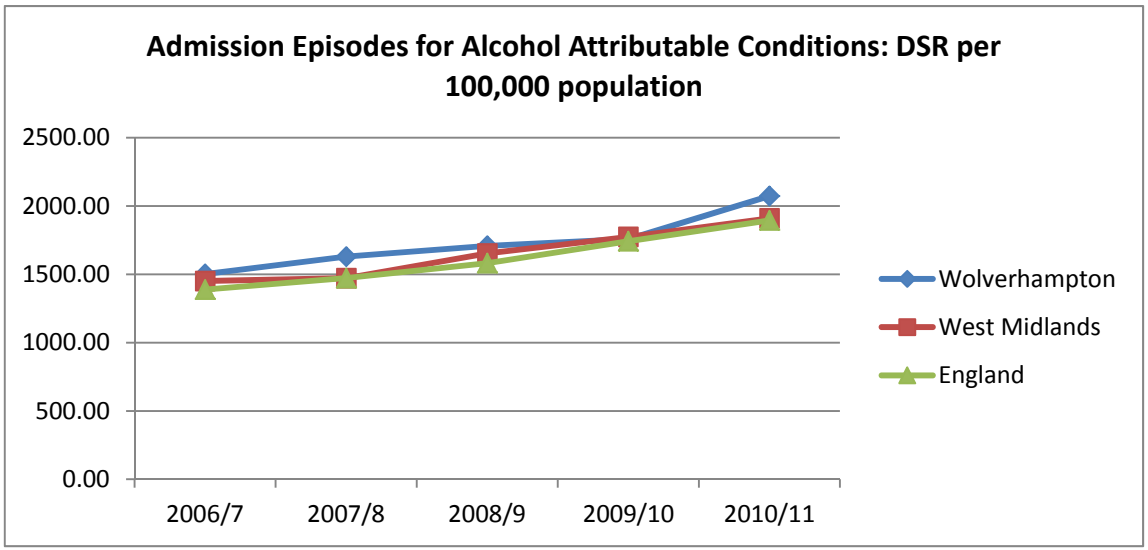
Source: Primary care mortality file

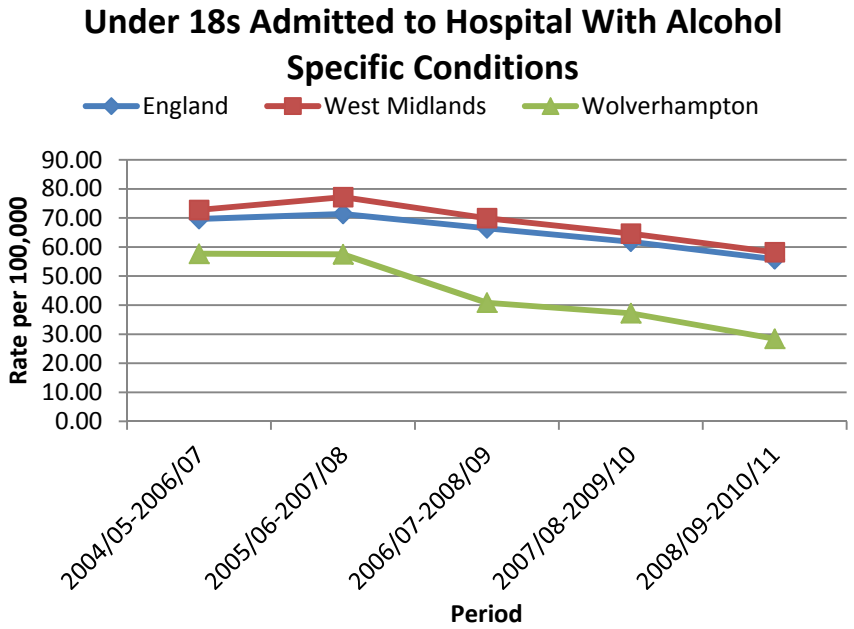
- The years of life lost annual potential for improvement shows the gap between the local value and the national average and gives an indication of the number of years of life lost that could be saved if the local value decreased to the national level.
- After infant mortality, alcohol has the biggest 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.

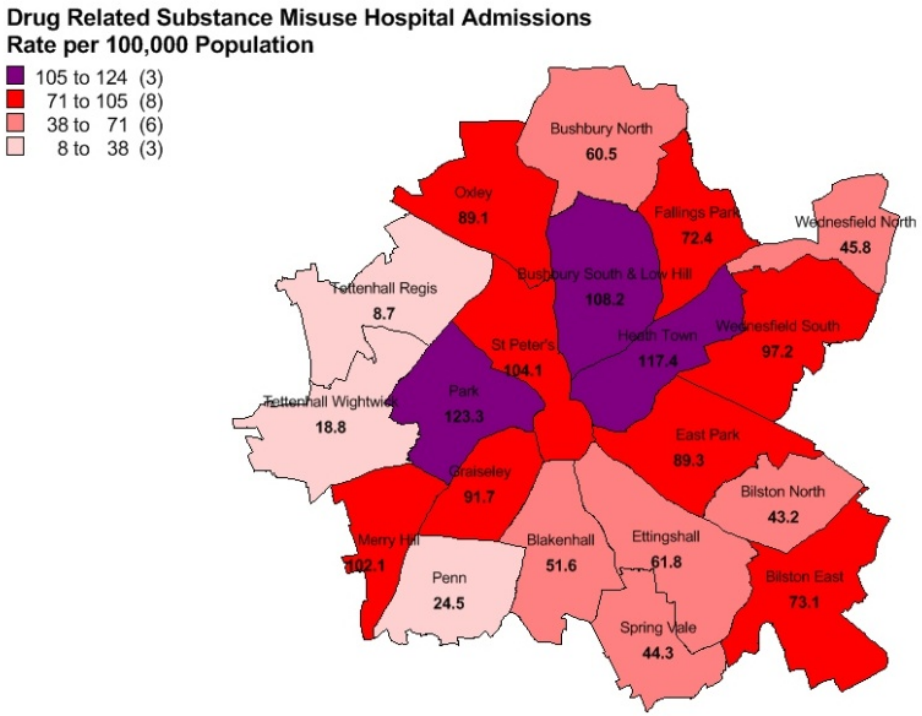
- In 2010/11, there were 2073 hospital admission episodes for alcohol-attributable hospital admissions per 100,000 population in Wolverhampton; nearly an 18% increase on the previous year.
- The rate of alcohol-attributable hospital admission episodes has seen a slow but steady increase over the past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

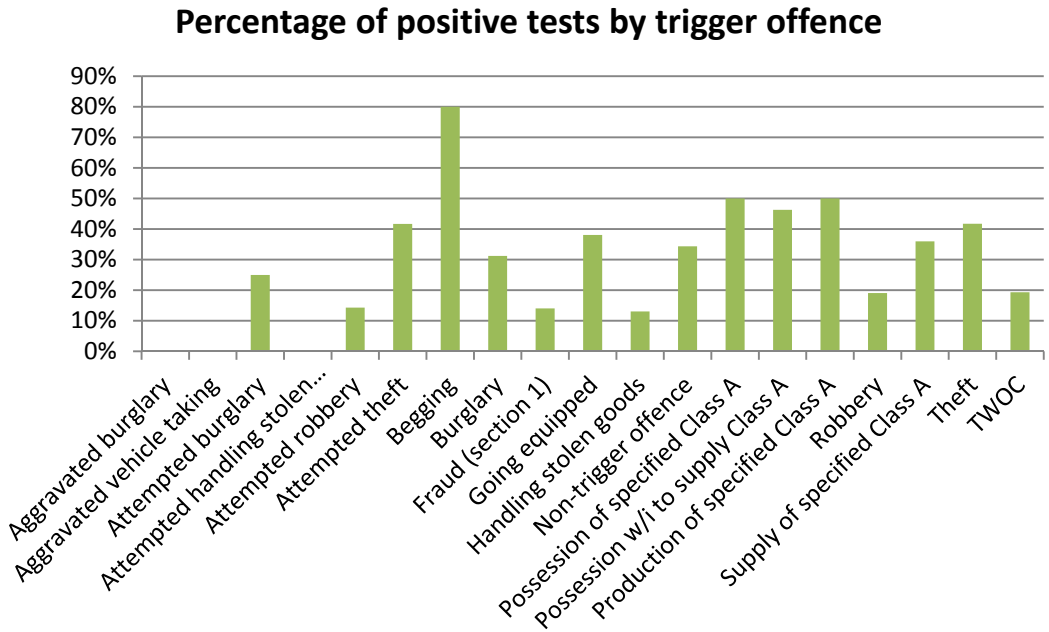
Rates of drug related hospital admissions during 2009-12 where highest in wards in the north east of the city and parts of the south west. Heath Town, Park and Bushbury South and Low Hill had the highest rates of admissions.

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

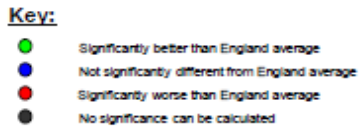
Wolverhampton Surge Planning Group –
The Surge Planning Group provides resilience support to the current Urgent & Emergency Care system by advising on tactical changes to manage surges in activity across Wolverhampton. The primary focus is on the urgent care system, the impact of pressure on those services 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.

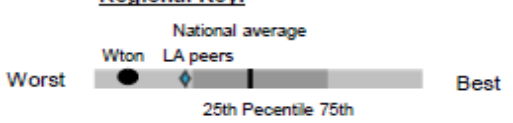
What is the evidence of effective interventions?

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





	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

Wolverhampton City Council **OPEN INFORMATION ITEM**

Health and Wellbeing Board

Date **4 September 2013**

Originating Service Group(s)	**Community – Health, Wellbeing and Disability & Delivery – Central Services**
Contact Officer(s)	**Viv Griffin / Carl Craney**
Telephone Number(s)	**555370 / 555046**
Title	**Health and Wellbeing Board "Away Day" – Response to the Francis Inquiry - Feedback**

SUMMARY

That the report be received and noted and that a further report including the diagrammatic representation of the roles, responsibilities and inter-relationships between the various bodies in the Wolverhampton health and social care economy be submitted to a future meeting.

1. PURPOSE

1.1 The purpose of this report is to inform the Board of the outcome of the "Away Day" held on 31 July 2013 to consider a City wide response to the Francis Inquiry into the failings at the Mid Staffordshire Hospital NHS Foundation Trust.

2. BACKGROUND

2.1 At the meeting of the Board held on 3 May 2013 it was agreed that a Development Day be held with a view to formulating a response to the Francis Report in relation to the Mid Staffordshire Hospital NHS Foundation Trust. At the meeting of the Board held on 3 July 2013 the arrangements for the event together with the invitation list were approved.

2.2 The event was held on the morning of 31 July 2013 at the Civic Centre and was attended by representatives of the Board, the Council's Health Scrutiny Panel, West Midlands Police, Wolverhampton Healthwatch, the University of Wolverhampton and the Director of the Wolverhampton Branch of the West Midlands Care Association; representing residential and nursing care providers and voluntary sector providers in the city.

2.3 Presentations were received from:

- Sarah Norman, Strategic Director for Community;
- Cheryl Etches, Chief Nursing Officer, Royal Wolverhampton NHS Trust;
- Doctor Helen Hibbs, Chief Officer of the Wolverhampton Clinical Commissioning Group;
- Susan Claire Marshall, Director of Nursing and Professional Practice, Black Country Partnership NHS Foundation Trust and
- John Cade, Visiting Lecturer, Institute of Local Government Studies, University of Birmingham.

2.4 Following the presentations there was an opportunity for "Break Out" sessions which were used to consider the first steps to be taken in producing a joint city wide action plan and response to the Francis Inquiry.

2.5 The results of the "Break Out" sessions are detailed below:

- The need to represent in diagrammatic form the key roles of the respective bodies including Healthwatch / the Health Scrutiny Panel / the various Safeguarding Boards / the commissioners of services and the Health and Wellbeing Board in order to ensure that the organisations can work jointly to investigate and respond to areas of concern, namely any alleged emerging failings in the Wolverhampton health and social care economy;
- The need to clarify the respective roles and responsibilities of the various bodies. Also the need for a calm and objective response to any identified problems with a reliance on evidence and facts rather than anecdotes and assumptions;
- A programme of complimentary scrutiny and inspections in order to support the delivery of care;
- The requirement of a whole system approach and the desirability of role and responsibility clarification. The remit also to be widened to include social care and the independent sector;
- An assurance framework to guarantee that any areas of concern are investigated and addressed as appropriate.

3. WAY FORWARD

3.1 It is suggested that a task and finish group be established as a sub committee of the Health and Wellbeing Board to develop the action plan and the whole systems response.

3.2 The group would be led and chaired by the CCG and include representation from Social Care / Health Providers / Health Scrutiny / Healthwatch. The aim would be to present the action plan to the November meeting of the Board.

4. FINANCIAL IMPLICATIONS

4.1 The costs of the event were met from the Democratic Services budget. [AS/22082013/C]

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from this report. [FD/12082013/E]

6. EQUAL OPPORTUNITIES IMPLICATIONS

6.1 The planned city wide response will improve the service to all sectors of the community.

7. ENVIRONMENTAL IMPLICATIONS

7.1 There are no direct environmental implications from this report.

8. SCHEDULE OF BACKGROUND PAPERS

8.1 None.

Wolverhampton City Council **OPEN INFORMATION ITEM**

Health and Wellbeing Board **Date** **4 SEPTEMBER 2013**

Originating Service Group(s) **COMMUNITY**

Contact Officer(s) **WENDY EWINS**
Telephone Number(s) **(55)5302**

Title **WINTERBOURNE REVIEW - IMPLICATIONS FOR WOLVERHAMPTON**

RECOMMENDATION

That the Health and Wellbeing Board receives this report regarding Winterbourne View Hospital and Wolverhampton's response to Transforming Care: A National Response to Winterbourne View Hospital.

1. PURPOSE

1.1 To describe the findings of the investigations into the abuse of patients with learning disabilities at Winterbourne View Hospital and to summarise local work to date to respond to the National report Transforming Care: A National Response to Winterbourne View Hospital.

2. BACKGROUND

2.1 Winterbourne View, an independent hospital provided by Castlebeck Care, was featured in a Panorama documentary in 2011 and showed adults with learning disabilities and autism being assaulted and mistreated by staff. Initially brought to the attention of the TV programme makers by a whistle blower, an undercover reporter spent five weeks at Winterbourne View as a paid care worker and filmed his observations of systematic bullying, ill treatment and abuse of patients by staff.

2.2 Eleven members of staff identified in the programme were subject to criminal investigations and were subsequently convicted. Six staff members were given custodial sentences.

2.3 South Gloucestershire Safeguarding Adults Board commissioned a Serious Case Review which was undertaken by Margaret Flynn and published in August 2012. In addition to this the Government asked the Care Quality Commission (CQC) to implement an immediate programme of unannounced inspections of hospitals providing assessment and treatment for people with learning disabilities and behaviours that challenge. CQC carried out 150 inspections and an initial report was produced in June 2012. The Department of Health also facilitated and co-ordinated a number of other work streams leading to a final report and partnership wide Concordat, published in December 2012. The Executive Summary from the final report is contained with Appendix 1.

2.4 Between now and June 2014 all Local Authorities and PCTs/CCGs must take action to transform the way services are commissioned and delivered to stop people being placed in hospital inappropriately, provide the right model of care, and drive up the quality of care and support for all people with behaviour that challenges. It is envisaged that significantly fewer inpatient and institutional-type beds (e.g. residential and nursing) will be purchased in the future.

The Concordat: Programme of Action which accompanies the report sets out the requirements for each local area. The key actions are to:

- Develop and maintain a local register of all people with learning disabilities or autism who have mental health conditions or behaviour that challenges in NHS-funded care (including hospital placements) no later than 1 April 2013

- Review all current hospital placements (inpatient learning disability and/or autism), ensuring that there is a first point of contact for each person. These reviews should include agreeing a personal care plan for each individual based around their and their families' needs and agreed outcomes, and must be completed by 1 June 2013. Independent advocacy must be provided where appropriate to enable people to express their views

- Support everyone inappropriately placed in hospital to move to community-based support no later than 1 June 2014

- Develop a locally agreed joint strategic plan for high quality care and support services for people of all ages with behaviour that challenges, that accords with the model of good care put forward in the DH final report. These plans should include children's services, mainstream mental health services, police and offender management teams and housing to ensure that a new generation of inpatients does not take the place of people currently in hospital. This joint plan must be produced by April 2014 and will include plans to develop a range of local and responsive services to prevent admission and enable current inpatients to be supported positively in community placements

- The DH report also expects each local area to review people with behaviour that challenges who are placed in large-scale residential care, particularly those who are placed away from their home area. This group should be identified and reviewed in the same way as people in hospital settings.

2.5 We have established a Winterbourne Action Group which meets monthly and oversees the Concordat and local programme of action and includes representation from across services and represents the all-age responsibility to agree a joint plan.

2.6 The review of the abuse of patients at Winterbourne underpins the need to ensure that we are committed to co-produced, co-developed, co-evaluated services for people with learning disabilities and their families. We have therefore arranged for Changing Our Lives (an independent self-advocacy organisation which facilitates the People's Parliament in Wolverhampton) to join the steering group as a critical friend and to support us to co-produce work going forwards.

3. LOCAL RESPONSE TO DATE

3.1 Wolverhampton currently commissions 5 Assessment and Treatment places for people with learning disabilities, these all being provided by Black Country Partnership Foundation Trust (BCPFT) as part of the mental health contract. They are all at Pond Lane, in Parkfields, Wolverhampton. We have rarely purchased out-of-city Assessment and Treatment services for people with learning disabilities.

3.2 We know of all the adults with a learning disability placed outside of the City in residential, nursing and hospital environments and recognise the need to ensure timely and robust reviews.

3.3 The Joint Commissioning Unit (JCU) have been working with Black Country Commissioners and colleagues across the West Midlands region to ensure that we have robust ways of monitoring and safeguarding people placed in Assessment and Treatment facilities.

3.4 The JCU has worked with the Provider (BCPFT) to ensure that we have rigorous Safeguards in place for people with learning disabilities who use their services. This work is on-going but has taken into account the learning from the serious case review, the CQC inspections of 150 Assessment and Treatment hospitals and our own internal monitoring and review processes. It has included:-

- Monthly meetings with the Provider to monitor delivery of the contract and to include monitoring of the delivery of their Action Plan post their CQC inspection. This Action plan is updated and reported to the Commissioner on a monthly basis and is now reporting Green on all areas

- Re-negotiation of the Key Performance Indicators to include bi-annual patient-led audits (facilitated by Changing Our Lives, an independent advocacy organisation) and annual satisfaction questionnaire to be sent to people who have used the service and family carers. We have also agreed CQUINS and a programme of service development for 2013/4

- Monthly monitoring meetings with the Provider to discuss complaints, compliments, serious incidents, safeguarding referrals, use of restraint (physical interventions), service reviews/visits from CQC, delayed discharges, the use of the MCA and DOLS. These meetings are then reported into the Clinical Quality Review and Contracts meetings as appropriate

- A report was taken to the Wolverhampton Safeguarding Vulnerable Adults Board in September 2012 following the publication of the serious case review. Following this, a Joint workshop of the Wolverhampton Safeguarding Vulnerable Adults Board and the Wolverhampton Learning Disability Partnership Board took place in January 2013 to progress the findings of the serious case review and to ensure a joined up approach is continued to ensure safety and quality for people with learning disabilities in care settings

- A commitment has been expressed through our commissioning intentions to reduce the number of inpatient beds we commission in favour of developing an intensive support team which will be able to offer intensive assessment and treatment within a person's usual living environment, if this is appropriate

- Funding has been identified to develop a mental health liaison post within mainstream mental health services, to ensure that wherever possible people with learning disabilities can access the same services as the general population whenever this is appropriate and with reasonable adjustments being made to ensure that their care is effective

- All of the Concordat actions to be delivered by June 2013 have been delivered within the timescales set. This has included developing the register of people with learning disabilities and/or autism who are in NHS funded care. This register is being maintained within the Joint Commissioning Unit. All of the people on this register have been reviewed jointly and in a manner which reflects best practice - there were 7 people on this register

- Wolverhampton has responsibility for 14 adults who are in secure hospitals. The responsibility for reviewing these people is with the NHS Local Area Teams. These reviews have all also been completed, and regular meetings are held between commissioners, the NHS Local Area Team and the community Learning Disability Team to ensure that discharge to the least restrictive settings is proactively sought

- Wolverhampton has also developed a register of people who are in large-scale accommodation in order to review them and ensure that they are appropriately placed and to consider community-based alternatives - these reviews are being staggered throughout the year in line with guidance

- Wolverhampton has responsibility for one young person who has autism and behaviour that challenges and is placed in a CAMHS hospital service. The NHS Local Area Team are responsible for reviewing this young man in the same way as other patients in secure care

- Information from all of the reviews is being collated such that it can be used to develop the Joint Plan and future commissioning intentions. It is anticipated that we will develop the joint plan from September 2013, as most of this information will be available by then.

4. FINANCIAL IMPLICATIONS

4.1 The Concordat is set to be delivered within current resources. A small amount of extra financial support (£70,000) has been awarded via the CCG to enable the Provider Trust (BCPFT) to increase its community support as a short-term measure whilst services are redeveloped. [MK/23082013/K]

5. LEGAL IMPLICATIONS

5.1 Services for persons with learning disability are provided in accordance with the Council's statutory duties as a Social Services Authority under Section 7 of the Local Authority Social Services Act 1970 which also provides for Social Services functions to be exercised in accordance with guidance issued by the Secretary of State. [FD/23082013/N]

6. EQUAL OPPORTUNITIES IMPLICATIONS

6.1 There are equalities implications in this programme of work as the activity will support some of the most vulnerable adults in Wolverhampton. An Equality Analysis will be undertaken to reflect the work required by the Concordat and the outcomes achieved. Current drivers emphasis the need for to promote well-being, and in order to achieve this to we need to focus more systematically on the potential for developing services which effectively prevent and intervene earlier. A range of good quality local support services should reduce the need for people to be moving to out-of-city placements, into hospital settings or into Secure Services.

7. ENVIRONMENTAL IMPLICATIONS

7.1 There are no environmental implications arising out of this report.

8. SCHEDULE OF BACKGROUND PAPERS

Appendix 1 Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report

Appendix 1

Transforming care: A national response to Winterbourne View Hospital Department of Health Review: Final Report

Executive summary

1. The abuse revealed at Winterbourne View hospital was criminal. Staff whose job was to care for and help people instead routinely mistreated and abused them. Its management allowed a culture of abuse to flourish. Warning signs were not picked up or acted on by health or local authorities, and concerns raised by a whistle blower went unheeded. The fact that it took a television documentary to raise the alarm was itself a mark of failings in the system.

2. This report sets out steps to respond to those failings, including tightening up the accountability of management and corporate boards for what goes on in their organisations. Though individual members of staff at Winterbourne View have been convicted, this case has revealed weaknesses in the system's ability to hold the leaders of care organisations to account. This is a gap in the care regulatory framework which the Government is committed to address.

3. The abuse in Winterbourne View is only part of the story. Many of the actions in this report cover the wider issue of how we care for children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging.

4. CQC's inspections of nearly 150 other hospitals and care homes have not found abuse and neglect like that at Winterbourne View. However, many of the people in Winterbourne View should not have been there in the first place, and in this regard the story is the same across England. Many people are in hospital who don't need to be there, and many stay there for far too long - sometimes for years.

5. The review has highlighted a widespread failure to design commission and provide services which give people the support they need close to home, and which are in line with well-established best practice. Equally, there was a failure to assess the quality of care or outcomes being delivered for the very high cost of places at Winterbourne View and other hospitals.

6. For many people however, even the best hospital care will not be appropriate care. People with learning disabilities or autism may sometimes need hospital care but hospitals are not where people should live. Too many people with learning disabilities or autism are doing just that.

7. This is the wider scandal that Winterbourne View revealed. We should no more tolerate people with learning disabilities or autism being given the wrong care than we would accept the wrong treatment being given for cancer.

8. Children, young people and adults with learning disabilities or autism, who also have mental health conditions or behaviours described as challenging can be, and have a right to be, given the support and care they need in a community-based setting, near to family and friends. Closed institutions, with people far from home and family, deny people the right care and present the risk of poor care and abuse.

9. The Department of Health review drew on:

- A criminal investigation with 11 individuals prosecuted and sentenced
- The Care Quality Commission review of all services operated by Castlebeck Care, the owners of Winterbourne View, and the programme of inspections of 150 learning disability hospitals and homes
- The NHS South of England reviews of serious untoward incident reports and the commissioning of places at Winterbourne View hospital
- An independent Serious Case Review commissioned by the South Gloucestershire Safeguarding Adults Board, published on 7 August 2012; and
- The experiences and views of people with learning disabilities or autism and mental health conditions or behaviours described as challenging, their families and carers, care staff, commissioners and care providers.

10. An interim report was published on 25 June 2012. This final report of the review can be published now that the criminal proceedings have concluded.

Programme of Action

11. This report sets out a programme of action to transform services so that people no longer live inappropriately in hospitals but are cared for in line with best practice, based on their individual needs, and that their wishes and those of their families are listened to and are at the heart of planning and delivering their care.

12. The Government's Mandate to the NHS Commissioning Board1 says:
"The NHS Commissioning Board's objective is to ensure that CCGs work with local authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people." (para 4.5)

13. We expect to see a fundamental change. This requires actions by many organisations including government. In summary, this means:

- All current placements will be reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible, and no later than 1 June 2014
- By April 2014 each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning

1 http://www.dh.gov.uk/health/2012/11/nhs-mandate/

14. Disabilities or autism and mental health conditions or behaviour described as challenging, in line with the model of good care set out at Annex A

- As a consequence, there will be a dramatic reduction in hospital placements for this group of people and the closure of large hospitals
- A new NHS and local government-led joint improvement team, with funding from the Department of Health, will be targeted to lead and support this transformation

- We will strengthen accountability of Boards of Directors and Managers for the safety and quality of care which their organisations provide, setting out proposals during Spring 2013 to close this gap

- CQC will strengthen inspections and regulation of hospitals and care homes for this group of people. This will include unannounced inspections involving people who use services and their families, and steps to ensure that services are in line with the agreed model of care; and

- With the improvement team we will monitor and report on progress nationally.

15. A full account of these actions, together with a range of further actions to support improvement of services - including, for instance, steps to improve workforce skills, and strengthening safeguarding arrangements - is set out in Parts 4-8. A timeline of the detailed actions is at Annex B.

16. Alongside this report, we are publishing a Concordat agreed with key external partners. It sets out a shared commitment to transform services, and specific actions which individual partners will deliver to make real change in the care and support for people with learning disabilities or autism with mental health conditions or behaviour that challenges.

17. This report focuses on the need for change, but there are places which already get this right. This shows that the change we intend to make is achievable. Alongside this report, we are publishing examples of good practice which demonstrate what can - and should be - done for all.

Wolverhampton Task and Finish Group
Project Highlight Report

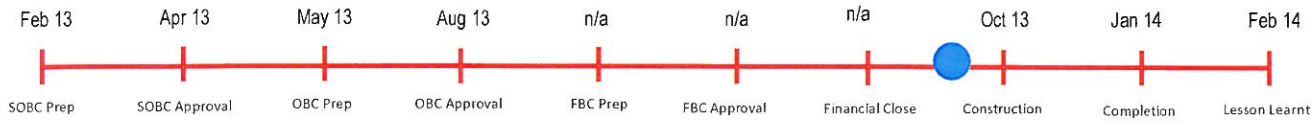
NHS Property Services

Project Name	Heath Town	Report No	3	Date	22nd August 2013

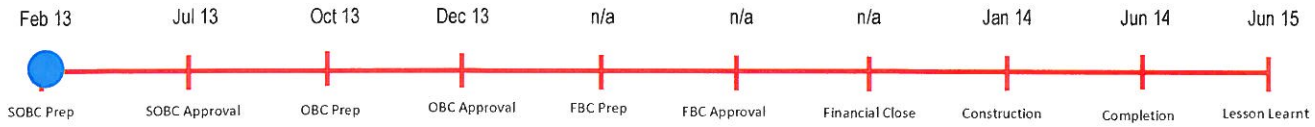
General Update

- A recent site visit has identified serious shortfalls in the quality and scope of accommodation. The space used is not fit for purpose and poses IPC and H&S risks to staff and patients. All aspects of the prioritisation criteria are affected, resulting in this project achieving the highest score amongst the BBC area.
- A recent IPC inspection by RWHT has rated the building as failing to achieve minimum standards.
- NHSPS have asked NHSE for funding to commence a wider ranging project to review alternative arrangements for this practice. This will include a range of short and long term options.
- WCC have notified NHS PS that ideally a maximum of 3 months tenure remains on the unit with a longstop of 15 months.
- WCC have offered the adventure playground building for use for a medium term solution, an initial site visit is planned for the 26th August 2013, initial considerations look positive for this option.

Programme - Planned Status



Programme - Current Status



Wolverhampton Task and Finish Group
Project Highlight Report

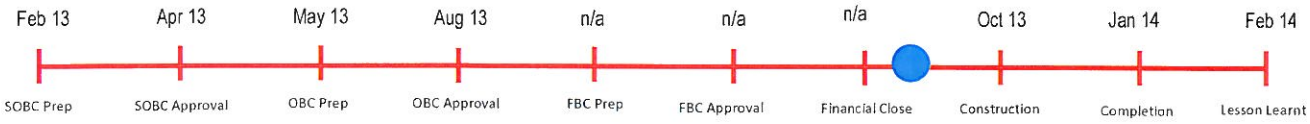
NHS Property Services

Project Name	Scotlands – Dr Hickman	Report No	3	Date	22nd August 2013

General Update

- The progression of this scheme is service critical. Dr Hickman has received official confirmation that he must leave his existing premises March 2014.
- The prioritisation process has concluded that this is the second most important project in the BBC area.
- NHSE have asked that NHS PS review all options available for the short and medium term only. This must involve alternative sites to those reviewed to date and also alternative provision on the current planned site.
- NHS PS are concerned that all options now result in severe risk to continuous service provision for Dr Hickman.
- An option is being considered for a partial refurbishment of the Underhill House site alongside a fit out of St Gregory's church hall. The Area Team Investment Committee will be meeting on the 29th August to decide the best value option for the NHS.

Programme - Planned Status



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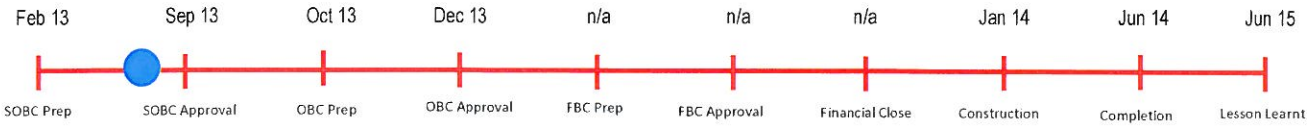


Wolverhampton Task and Finish Group
Project Highlight Report

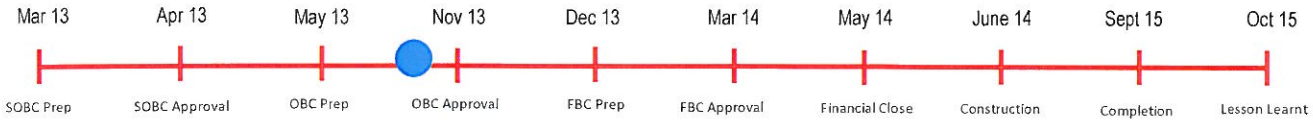
NHS Property Services

Project Name	Bilston Urban Village	Report No	3	Date	22nd August 2013

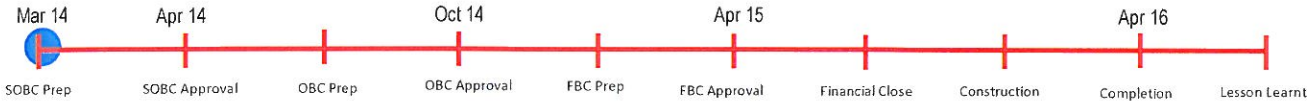
General Update

- Following extension of the primary land lease NHS PS have now placed this scheme on hold for twelve months or until other factors require action.
- NHSE have still to clarify the long term plans for EAPC practices.
- Ongoing communication is required with WCC to discuss integration with the community hubs programme.

Programme - Planned Status



Programme - Current Status



Wolverhampton Task and Finish Group
Project Highlight Report

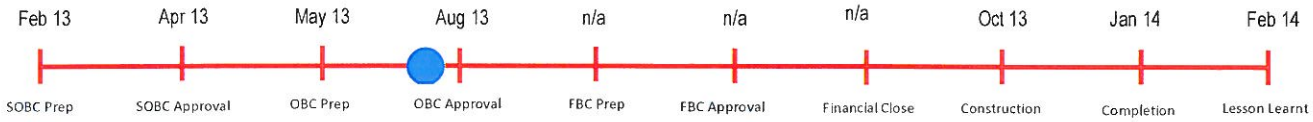
NHS Property Services

Project Name	Bradley	Report No	3	Date	22nd August 2013

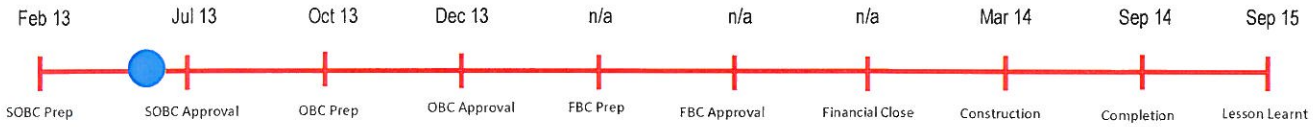
General Update

- A Project Scoping Document (internal business case) has been submitted within NHS PS governance structure requesting funding for a capital refurbishment of the existing space.
- A capital application of approx £1.3m has been made for 2013/14 and 14/15. We are awaiting clarification of the final allocations.
- Formal discussions with the council's property team relating to the lease and necessary adjustments therein are still outstanding. These will be progressed once confirmation of capital allocation has been received.

Programme - Planned Status



Programme - Current Status



Wolverhampton City Council **OPEN DECISION ITEM**

Health & Wellbeing Board **Date 4 September 2013**

Originating Service Group(s) Communities Directorate

Contact Officer(s)/ Sarah Norman
Telephone Number(s)55 5300

Title Children's Trust Board- progress report

RECOMMENDATION

That the Health & Wellbeing Board notes the recent activity at the Children's Trust Board.

1. PURPOSE

1.1 To keep members of the Health & Wellbeing Board informed of the work of the Children's Trust Board (CTB).

2. BACKGROUND

2.1 The Children's Trust Board is a partnership of agencies from all sectors working together to ensure the alignment of strategic priorities for children and young people in the city. It meets on a bi-monthly basis.

2.2 The Children's Trust Board most recently met on 25th July and at this meeting received a summary update from the Children's Trust Delivery Board to inform members of decisions made at the Delivery Board and to communicate business from the sub structure of the Early Intervention and Wellbeing & Resilience Board.

2.3 It was reported that the Children's Trust Delivery Board have endorsed the proposal for the new Children Young People and Families Plan to focus on four priorities.

2.4 It was reported that performance measures have now been incorporated into the revised Child Poverty Strategy and agreed that a multi-agency group supports the development of the Implementation Plan.

2.5 The Early Intervention Board and Wellbeing & Resilience Board, both of which are part of the sub-structure for the Children's Trust, continue to have concerns reported regarding the capacity and ability of services to effectively support the growing numbers of New Arrival families in the city; a multi-agency group is meeting to consider the most integrated way to work. The Children's Trust Board has asked for background information from the New Arrivals group, in order that these issues can be considered strategically.

2.6 Public Health presented a report which outlined the process which had been used to produce the Joint Strategic Needs Assessment. This will be used to form the basis for the Health & Wellbeing Strategy and be used by Commissioners to determine future service provision. This was noted by the Children's Trust Board.

2.7 Progress to date with the development of the Children, Young People and Families Plan was reported. It was highlighted that the Plan is being widely consulted on with stakeholders and this will continue throughout its development, including with children, young people and families.

2.8 The Children's Trust Board supported the Children's Trust Delivery Board in its endorsement of the following four key priorities for the Plan; i) Reducing the impact of Child Poverty; ii) Improving educational outcomes; iii) Improving Family Resilience (Making families stronger); iv) improving the health of children, young people and their families.

2.9 The Board received an update report on the key considerations from the Peer Challenge of Looked After Children's services with Lambeth LBC. The final report from the Peer Challenge will become available for consideration at a later date and the Children's Trust requested that they receive that report at a later meeting.

3.0 West Midlands Police presented information reports to inform the Board of changes to Police Resourcing of Child Protection Conferences and also changes to procedures for dealing with missing and vulnerable people including children.

3.1 A report was noted which updated on the outcome and recommendations from the recent Ofsted Thematic Inspection on Neglect which took place in June 2013. This was part of a nationwide initiative, with a final national report identifying common themes and highlighting good practice due to be published in October 2013.

3.2 The Board were presented with the revised Mental Health and Psychological Wellbeing Strategy for Children and Young People and advised of a workshop taking place on 11 September which will consider the Delivery Plan along with 3 bids for external funding. The Board received and endorsed the revised strategy.

3.3 The Board received an item on work taking place to reduce numbers of looked after children. It outlined findings from a multi-agency stakeholder event which took place following the Dartington Social Research work to audit looked after children's files. The item also made recommendations about ways in which the implementation of the New Operating Model could be supported through the Children's Trust Board, which the Board endorsed.

4. FINANCIAL IMPLICATIONS

4.1 There are no direct financial implications to this report.

NM/22082013/R

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications to this report.

FD/21082013/X

6. EQUAL OPPORTUNITIES IMPLICATIONS

6.1 There are no direct equal opportunity implications to this report

7. ENVIRONMENTAL IMPLICATIONS

7.1 There are no direct environmental implications to this report

8. SCHEDULE OF BACKGROUND PAPERS

8.1 None attached.

Wolverhampton City Council **OPEN INFORMATION ITEM**

Health & Wellbeing Board **Date 4 SEPTEMBER 2013**

Originating Service Group(s)	**COMMUNITY**
Contact Officer(s)/ Telephone Number(s)	**VIVIENNE GRIFFIN (55) 5370**
Title	**ADULT DELIVERY BOARD – PROGRESS REPORT**

RECOMMENDATION

That the Health and Well Being Board note the progress of the Adult Delivery Board's work plan for 2013/14.

1. **PURPOSE**

1.1 To keep members of the Health and Well Being Board abreast of the work of the Adult Delivery Board in regard to the board's work plan for 2013/14.

2. BACKGROUND

2.1 The Board received updates in relation to the work being progressed around the development of the following strategies:

- Dementia
- Urgent Care
- Mental Health
- Supported Housing

2.2 The Board were also updated on the submission of the 'Integration Pioneer Expression of Interest' bid to the Department of Health which had been developed in consultation with representatives from all key stakeholders, to drive forward innovative ideas for integrated working. It had been agreed that the key focus of the integration work would be centred around Dementia, justified because of the growing needs and drivers across health and social care albeit, lessons learned from this work would be applied across the whole economy.

2.3 The outcome of the integration pioneer bid is expected to be announced by the end of August 2013. However, it was felt that, regardless of the result of the bid, the health and care economy would continue to keep the momentum started by the expression of interest discussions and as such, presented the Adult Delivery Board with a number of quick win 30, 60 and 90 day actions that would enable the principle of the integration work to be delivered. The Board approved the quick win action plan and in doing so identified lead persons from the main stakeholders group to progress the actions, in order to take these initiatives forward. A further update on the outcome of the expression of interest would be reported to a future meeting.

2.4 The Board were also presented with the latest iteration of the draft Urgent and Emergency Care Strategy, which had been updated to take account of feedback received from the Health and Well Being Board in May 2013. Whilst there was a general consensus of agreement on the direction of travel, there were some areas of the strategy that needed further enhancement by way of being more explicit about what is going to be done and how, against a backdrop of more rigorous data. It was confirmed that the re-draft of the strategy would aim to respond to the above.

2.5 It was noted that the revised draft Urgent and Emergency Care Strategy would be presented to the November Health and Well Being Board with a view to beginning the formal three month consultation period with the wider community.

2.6 The Board were informed of the work currently being undertaken to refresh the Mental Health Strategy with a view to a draft being presented towards the end of the year, following an independent review of services.

2.7 The Board also endorsed the Mental Health and Psychological Wellbeing Services Strategy for Children and Young People 2013-2016, which had been developed following a period of consultation with key stakeholders, which will now go on to be presented to the Children's Trust. In broad terms the Strategy serves to provide a strategic direction of travel for Children and Young People's Services within the City.

2.8 The Board also considered options to retender the current Housing Related Support for Ex-Offenders Service and agree to the proposed new service model. The service supports adults to become or remain as independent as possible. A review of the current provision identified that a new service with greater capacity needed to be designed to address gaps and current trends. The new contract would come into force June 2014.

2.9 The Board also endorsed the proposed action plan for the refresh of the Reablement Forward Plan, which had been developed in consultation with representatives from the Council, the Clinical Commissioning Group, Black Country Partnership Foundation Trust and The Royal Wolverhampton Trust.

3. FINANCIAL IMPLICATIONS

3.1 There are no direct financial implications to this report.

MK/22082013/B]

4. LEGAL IMPLICATIONS

4.1 There are no direct legal implications to this report.

[FD/16082013/R]

5. EQUAL OPPORTUNITIES IMPLICATIONS

5.1 There are no direct equal opportunity implications to this report.

6. ENVIRONMENTAL IMPLICATIONS

6.1 There are no direct environmental implications to this report.

Wolverhampton City Council **OPEN DECISION ITEM**

Health and Wellbeing Board **Date 4 September 2013**

Originating Service Group(s)	**COMMUNITY – PUBLIC HEALTH**
Contact Officer(s)/ Telephone Number(s)	**ROS JERVIS- DIRECTOR OF PUBLIC HEALTH 551372**
Title	**PUBLIC HEALTH DELIVERY BOARD – PROGRESS REPORT**

RECOMMENDATION

That the Health and Wellbeing Board notes the progress of the Public Health Delivery Board's work plan for 2013/14, in particular the progress on the Public Health Transformational Fund and endorses the process, the criteria and the Board's role in approving/ratifying recommended projects.

1. PURPOSE

1.1 To keep members of the Health and Wellbeing Board abreast of the work of the Public Health Delivery Board in regard to the development of a work plan, however highlighting in-particular the latest developments in relation to the Public Health Transformational Fund, namely the:

- Eligibility criteria
- The process for submission of bids
- The process for assessing bids and making decisions on allocations

2. BACKGROUND

2.1 The Public Health Delivery Board is currently meeting monthly in attempt to speed up the forming process and from October 2013 the Board will meet bi-monthly. These initial meetings have focussed on purpose and process including the terms of reference, membership, its sub-structure, its priorities, work programme and performance framework. Over the last couple of meetings it has also been a high priority for the PHDB to consider the effective use of the transformational budget as a means of integration to tackle health inequalities.

2.2 To ensure that the four pillars of public health are appropriately covered by the business of the PHDB a standing agenda has been developed. This agenda and an updated sub-structure to the PHDB have been attached at appendix 1a & b.

3. THE PUBLIC HEALTH TRANSFORMATIONAL BUDGET

3.1 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.

3.2 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. An additional aim is to encourage creativity and partnership working.

3.3 The Process

3.3.1 Bids of up to £250,000 per annum are invited from Council Directorates in partnership with other external agencies such as the voluntary sector, public or private sector organisations.

3.3.2 The eligibility criteria, as well as the processes for submission, appraisal, decision-making and sign-off have been developed by the Public Health Delivery Board with support from the Big Lottery (see appendix 2a & b).

3.3.3 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.

3.3.4 The Health and Well-Being Board is the final place where recommendations for funding are to be received and ratified or approved. Should there be a long gap between the closing date and a Health and Well-Being Board meeting, it is requested that the Board identify a representative(s) or panel with delegated authority for approval.

4. FINANCIAL IMPLICATIONS

4.1 All successful bids will be funded from the Public Health Transformational Fund of £1 million. Funding for Public Health is being provided to the Council from the Department of Health in the form of a ring-fenced grant. The total funding settlement for Public Health for 2013/14 is £18.770 million.

[AS/19082013/Q]

5. LEGAL IMPLICATIONS

5.1 There are no direct legal implications arising from this report.

5.2 Governance arrangements for health and wellbeing are regulated by statute and secondary legislation. Under the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 the Health and Wellbeing Board is constituted as a Committee under section 101 of the Local Government Act 1972 with power to appoint sub-committees.

[FD/19082013/E]

6. EQUAL OPPORTUNITIES IMPLICATIONS

6.1 The Public Health Service seeks to ensure equality of opportunity as it delivers its core functions and aims to reduce health inequalities.

6.2 The broad aims and objectives of the Transformational Fund are to improve the health of the population, particularly the health of the more vulnerable in our society.

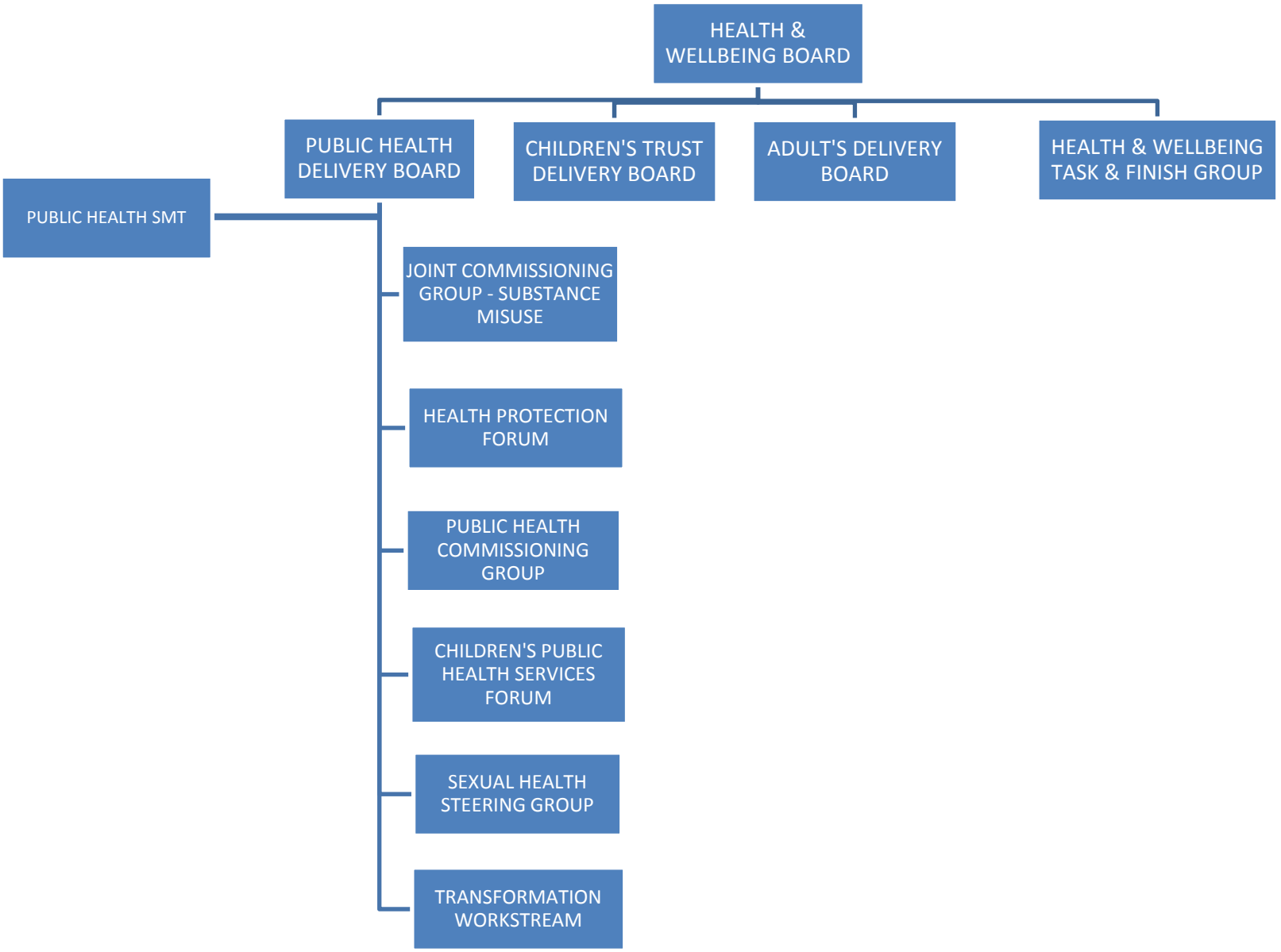
7. ENVIRONMENTAL IMPLICATIONS

7.1 There could be environmental implications arising from decisions to fund initiatives that seek to improve environmental conditions.

8. SCHEDULE OF BACKGROUND PAPERS

Health & wellbeing Board 3 July 2013 PUBLIC HEALTH DELIVERY BOARD – PROGRESS REPORT

Appendix 1a


HEALTH & WELLBEING BOARD
PUBLIC HEALTH DELIVERY BOARD
CHILDREN'S TRUST DELIVERY BOARD
ADULT'S DELIVERY BOARD
HEALTH & WELLBEING TASK & FINISH GROUP
PUBLIC HEALTH SMT
JOINT COMMISSIONING GROUP - SUBSTANCE MISUSE
HEALTH PROTECTION FORUM
PUBLIC HEALTH COMMISSIONING GROUP
CHILDREN'S PUBLIC HEALTH SERVICES FORUM
SEXUAL HEALTH STEERING GROUP
TRANSFORMATION WORKSTREAM

Appendix 1b

AGENDA

PUBLIC HEALTH DELIVERY BOARD

DATE

VENUE AND TIME (2 hours)

No.	Agenda Item	Who	Time
1.	Welcome/introductions/apologies	Chair	10 minutes
2.	Minutes of the last meeting and matters arising	Chair/all	
3.	Performance: highlight reports relating to:- a. Public Health Business Plan b. Health and Well-Being Strategy	Chair/all	20 minutes
4.	Work Programme: summary reports from:- a. Transformational workstream b. Health Protection workstream including HPF c. Public Health Commissioning workstream including the PHCG & JCG d. Sexual Health Review e. Children's Public Health f. CCG Work programme	 NM KS JG NM KS KS	60 minutes
5.	Partnership and wider links: summary reports (ad-hoc basis):- a. b.	Various	20 minutes
6.	AOB		10 minutes
7.	Date and time of next meeting		

*Denotes papers attached

PUBLIC HEALTH TRANSFORMATIONAL FUND 2013/14

Please read this eligibility document carefully before completing and signing the Proposal Form.

Public Health is inviting Council Directorates and partners to submit proposals to its Transformational Fund. The key aim of this time limited fund is to discover new ways for Public Health to work with Council colleagues and partners, and where successful, for this to become "usual practice". This way, Public Health is transformed into routine Council business.

Your submission will be assessed against the funding criteria AND compared against other submissions in this round for a spread across the range of Public Health outcomes required.

(1) What is the fund about?

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 our physical and mental health, such as our sense of connectedness, our income, education, employment and housing.

The Public Health Transformational fund is a 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 is everyone's business within the Council. An additional aim is to encourage creativity and partnership working.

There are 4 key domains to public health work:

1) **Wider determinants of health**, such as child poverty, good child development, education, accidents, employability and good quality housing
2) **Health Improvement**, such as smoking cessation, healthy living
3) **Health protection**, such as immunisation work
4) **Preventing early mortality**, such as from cancer or liver damage.

Our work is represented diagrammatically below and the full list of our targets in the Public Health Outcomes Framework is in appendix 1. Your work should aim to improve at least one of the targets in the Public Health Outcomes Framework as indicated on the spine chart by a red dot.

What is Public Health and the Public Health Outcomes Framework?

Public Health Outcomes

Outcomes

Vision: To Improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest

Outcome 1: **Increased healthy life expectancy**
Taking account of the health quality as well as the length of life

Outcome 2: **Reduced differences in life expectancy and healthy life expectancy between communities**
Through greater improvements in more disadvantaged communities

DOMAINS

Domain 1:

Improving the wider determinants of health

Objective:
Improvements against wider factors that affect health and wellbeing and health inequalities, **such as education, skills, employment and housing.**

Indicators Indicators Indicators } *Across the life course*

Domain 2:

Health improvement

Objective:
People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators Indicators Indicators } *Across the life course*

Domain 3:

Health protection

Objective:
The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators Indicators Indicators } *Across the life course*

Domain 4:

Healthcare public health preventing premature mortality

Objective:
Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

Indicators Indicators Indicators } *Across the life course*

(2) How much is available and what is the area of benefit?

Each project can apply for a maximum of £250,000 per year for two years. You must demonstrate how the money will be spent and explain how this represents good value for money.

These grants are solely for the benefit of Wolverhampton-based organisations and the City's residents, so all funded project activity must take place within the City boundaries.

There is a different process for applications up to £100,000 and for those between £100,000 and £250,000. All applications should use the form attached, but for those of £100,000 and over some additional information will be required. The approval process is slightly different too, please see chart in point (7) below.

(3) What are we looking for?

- Proposals which support improvement to areas in the Public Health Outcomes Framework, particularly the areas where Wolverhampton is 'in the red' (see appendix 1).
- Proposals that result in savings to health and social care whilst improving client outcomes
- Proposals that clearly show how they represent a development in the current service and can be predicted to become embedded as "usual practice".
- Proposals which represent good value for money.
- Projects will be assessed against other bids in that funding round to ensure a range of public health targets are being addressed in each round.
- Assessment criteria are presented in appendix 3.

(4) Who is Eligible?

This fund is available to Council Directorates in partnership with external partners. These external partners can be third sector organisations, private or public organisations and can include more than one partner.

(5) What doesn't this fund support?

- Proposals that duplicate existing activity or projects - continuation funding for existing activity or salaries will *only* be approved where there is a clear plan for innovative change or development

- Organisational core costs unless on a proportionate basis that is a direct result of the funded project.
- Social events, social trips, outings, visits
- Political or religious activity or contributions towards public appeals
- Expenditure outside the grant period or use of funds not authorised by the City Council
- Purchase of land or vehicles and special needs equipment for individuals
- Building repairs or maintenance or replacement or purchase of non-essential equipment
- IT equipment is low priority; should fit-for-purpose recycled equipment be available through the City Council, it will be approved instead of new equipment and project funding adjusted accordingly, so we can make the best use of available resources.

(6) What are the conditions of funding?

Funds are subject to availability and governed by a Grant Agreement with the City Council. This agreement will include delivering against your specified outcomes and evaluation plan.

Release of funding will be in parts, negotiated with projects individually. However, continued payment will be based on successful project delivery and satisfactory monitoring.

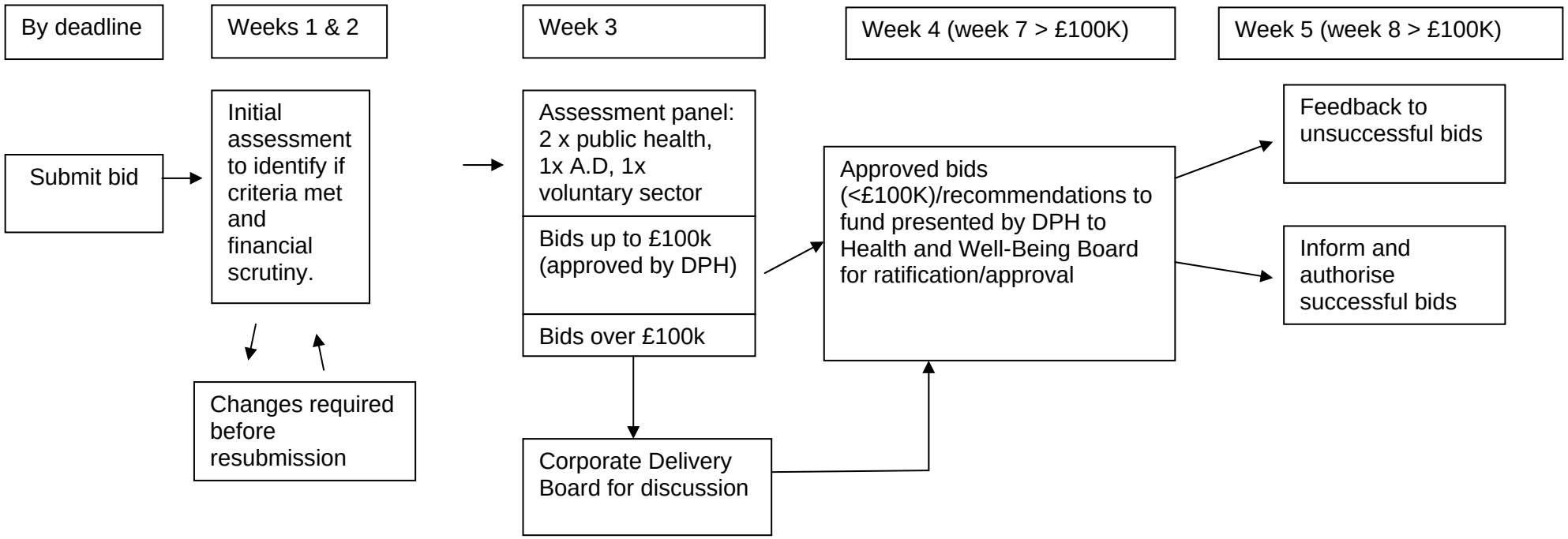
(7) What is the process for receiving and processing submissions?

Invitations to apply to the fund will be made on a quarterly basis and in each quarter there will be a closing date for receiving applications. First, applications will be assessed against the eligibility criteria and either accepted, accepted with minor changes which can be done in 1 week, or returned with feedback on more changes required and asked to resubmit in the next quarter, or rejected. Two weeks after the closing date, all accepted projects will be forwarded to the assessment panel for consideration. Recommendations from the panel will then be put forward for acceptance. For projects under £100,000 each year, they will be presented by the Director of Public Health to the Health and Well-Being Board for ratification. For projects of £100,000 up to £250,000, projects will be forwarded to Corporate Delivery Board for discussion before being presented by the Director of Public Health to the Health and Well-Being Board for approval. Should there be a long gap before the Health and Well-Being Board meets, the Board will identify representatives with delegated authority to approve projects. This will reduce delays in getting started. Projects worthy of approval submitted by Public Health

will be counter-signed by the Strategic Director for Community to ensure a transparent process at all stages.

The process and governance for receiving and processing submissions is depicted below. Due to the need to move rapidly, there will be no appeals process, but feedback will be given on unsuccessful projects.

PUBLIC HEALTH TRANSFORMATIONAL FUND 2013/14



PUBLIC HEALTH TRANSFORMATIONAL FUND 2013/14

There will be 3 rounds of applications in 2013/14, which are currently thought to be:

	Open advert:	Close date	Decision:
Round 1	Early Sep 2013	Mid Oct	< £100k w/b 25th November >£100k + 3 weeks
Round 2	Early Dec	Mid Jan 2014	< £100k end Feb 2014 >£100k + 3 weeks
Round 3	Early Feb 2014	Early March	< £100k mid April 2014 ➢ £100k + 3 weeks

The possibility of further rounds during 2014/15 will be assessed at the end of round 3.

If you would like some advice about your proposal, please contact

Neeraj Malhotra
Consultant in Public Health – Transformational Lead
Wolverhampton City Council

Tel: 01902 558673

email address: phtransformation@wolverhampton.gov.uk

(Proposal form available @ http://wolvesnet/grants)

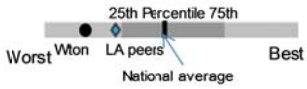
Wolverhampton City Council

Appendix 1: Public Health Outcomes Framework spine chart

Key:

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

Spine chart explanation:



Completed by Wolverhampton Public Health Intelligence Team-December 2012

Domain		Indicator	Local Number	Local Value	Nat Avg	Nat Worst	National Range	Nat Best
Vision	v1	Male life expectancy at birth 2008-10	n/a	76.7	78.6	75.5		80.6
	v2	Female life expectancy at birth 2008-10	n/a	80.8	82.6	80.2		83.8
	v3	Male inequality in life expectancy 2006-10	n/a	9.7	9.4	16.9		3.1
	v4	Female inequality in life expectancy 2006-10	n/a	5.8	6.5	11.6		1.2
	v5	Male disability free life expectancy 1999-2003	n/a	58.3	61.7	50.4		71.5
	v6	Female disability free life expectancy 1999-2003	n/a	60.8	64.1	54.0		71.3
	v7	Male inequality in DFLE 1999-2003	n/a	11.3	10.9	20.0		1.8
	v8	Female inequality in DFLE 1999-2003	n/a	10.6	9.2	17.1		1.3
1. Wider determinants	1.1	Children in Poverty 2009	17365	30.8	20.9	57.0		3.9
	1.2	Good development at age 5 2011	1514	52.0	59.0	48.0		74.0
	1.3	School absentees, % half days lost to unauthorised absence 2010-11	67	1.5	1.1	2.4		0.2
	1.4	First time entrants to the justice system, young people 2011	187	830.8	748.8	953.6		450.5
	1.5	NEET's at 16-19 years as at 2010-11	n/a	7.6	6.7	8.9		4.9
	1.6	% of Secondary mental health service users in settled accommodation 2010-11	850	83.7	66.8	33.3		83.8
	1.7	*People in prison who have a mental illness*						
	1.8	*% employed with long term conditions*						
	1.9	*Work sickness absence rates*						
	1.1	Road injuries and deaths 2008-2010	226	31.6	44.3	128.8		14.1
	1.11	*Incidents of domestic abuse*						
	1.12	Rate of violent crime 2010-11	4190	17.6	14.8	35.1		6.4
	1.13	% of reoffenders Q2 2009-Q1 2010	966	25.0	26.4	35.9		0.0
	1.14	Rate per 1,000 population affected by noise 2010-11	3795	15.9	7.8	66.7		1.3
	1.15	Homeless households 2010-11	324	3.3	2.0	10.4		0.1
	1.16	Utilisation of outdoor space for exercise/health reasons 2009-12	n/a	11.7	14.0	2.2		29.1
	1.17	Households that are in fuel poverty 2010	23836	24.3	16.4	27.1		4.6
	1.18	*Social connectedness*						
	1.19	*Older peoples perception of safety*						
2. Health improvement	2.1	% low birthweight babies, under 2500g 2010	267	7.7	7.0	11.5		4.3
	2.2i	Breast feeding initiation Q4 2011-12	2097	65.2	74.5	39.0		94.7
	2.2ii	Breastfed at 6-8 weeks Q4 2011-12	386	41.6	46.1	19.0		83.2
	2.3	% of women smoking at delivery Q1 12-13	148	18.3	12.7	28.0		1.0
	2.4	Under 18 conception rate 2010	760	55.5	38.1	64.9		10.8
	2.5	*Child development at 2 years*						
	2.6i	Proportion of Reception children classified as obese 2010-11	348	12.6	9.4	14.6		6.0
	2.6ii	Proportion of Year 6 children classified as obese 2010-11	595	23.8	19.0	26.5		10.7
	2.7	Accident admissions rate per 10,000 population for 0-17 year olds due to injury 2010-11	559	106.0	124.3	235.1		73.2
	2.8	Emotional wellbeing of looked after children 2010-11	n/a	13.8	13.9	10.1		22.8
	2.9	Children and young people smoking 2009	n/a	4.0	4.0	9.0		1.0
	2.10	Hospital admission as a result of self-harm, rate per 100,000 population 2010-11	360	158.4	212.0	509.8		49.6
	2.11	Health eating adults 2006-2008	n/a	22.5	28.7	19.3		47.8
	2.12	Prevalence of obese adults 2006-08 (estimated)	n/a	27.5	24.2	30.7		13.7
	2.13	% of adults physically active Oct 2009-Oct 2011	n/a	9.8	11.2	5.7		17.3
	2.14	Smoking prevalence in adults Q3 10/11- Q2 11/12	n/a	21.3	20.3	29.0		14.1
	2.15	% successful completion of drug treatment 2010	159	11.0	12.3	5.1		33.6
	2.16	*Prisoners with substance dependance not know to services*						
	2.17	Prevalence of diabetes 2010-11 (by PCT)	14846	7.1	5.5	7.7		3.5
	2.18	Alcohol related hospital admissions rate per 100,000 2010-11	5707	2073.0	1895.0	3276.0		910.0
	2.19	*% Cancer diagnosed in stages 1 and 2*						
	2.20i	Cervical screening uptake 2010-11 (by PCT)	47335	76.5	78.6	67.2		84.3
	2.20ii	Breast screening uptake 2010-11 (by PCT)	11987	73.4	77.4	59.8		85.1
	2.21i	*Non cancer screening programmes-HIV in pregnancy*						
	2.21ii	*Non cancer screening programmes-Syphilis, hepatitis B and susceptability to rubella in p*						
	2.21iii	*Non cancer screening programmes-Sickle cell in pregnancy*						
	2.21iv	*Non cancer screening programmes-Newborn blood spot*						
	2.21v	Non cancer screening programmes-Newborn hearing (by PCT) 2009/10	3211	96.4	92.3	64.2		98.3
	2.21vi	*Non cancer screening programmes-Newborn physical examination*						
	2.21vii	Non cancer screening programmes-Diabetic retinopathy 2010-11 (by PCT)	12542	88.6	91.6	81.0		95.8
	2.22	Uptake of the NHS health checks programme 2011-12 (by PCT)	9926	12.8	7.2	0.0		28.9
	2.23iii	% self reported wellbeing-people with low happiness 2011-12	n/a	33.5	29.0	36.6		19.2
	2.24	Hospital admissions due to falls in persons over 65 2010-11	786	1452.8	2475.0	4844.4		1259.0

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3. Health protection	3.1	% of mortality attributable to air pollution 2010	n/a	5.8	5.6	8.3		3.6
	3.2	Chlamydia diagnosis rate per 100,000 15-24 year olds 2011	900	2733.5	1979.2	5995.0		464.0
	3.3i	Hep B vaccine coverage 2 year olds Jan-Mar 2012 (PCT's, note small numbers)	<5	50.0	69.0	0.0		100.0
	3.3ii	*BCG vaccine coverage 1 to 16 years*						
	3.3iii	DTaP/IPV/Hib uptake at 2 years at Jan-Mar 2012 (by PCT)	824	95.7	96.3	85.5		99.5
	3.3iv	Men C coverage at 2 years at Jan-Mar 2012 (by PCT)	807	93.7	95.3	82.0		99.5
	3.3v	PCV coverage at 2 years at Jan-Mar 2012 (by PCT)	766	89.0	92.5	72.7		100.0
	3.3vi	Hib/Men C booster at 5 years at Jan-Mar 2012 (by PCT)	751	90.9	91.4	70.1		99.0
	3.3vii	PCV booster at 5 years at Jan-Mar 2012 (by PCT)	724	87.7	91.4	68.4		96.8
	3.3viii	MMR uptake at 2 years at Jan-Mar 2012 (by PCT)	775	90.0	92.0	73.1		97.7
	3.3ix	MMR 1 dose coverage at 5 years at Jan-Mar 2012 (by PCT)	768	93.0	95.8	83.0		98.8
	3.3x	MMR 2nd dose uptake at 5 years at Jan-Mar 2012 (by PCT)	668	80.9	91.2	68.7		95.2
	3.3xi	TD/IPV booster at 13-18 years 2010-11 (by PCT, of those where data was available)	2744	17.4	18.6	0.3		100.0
	3.3xii	HPV vaccine uptake complete course at June 2012 (Provisional-by PCT)	828	61.8	82.6	45.2		97.6
	3.3xiii	PPV vaccination coverage 65+ 2010-11	26750	63.8	70.5	46.8		76.0
	3.3xiv	Flu immunisation uptake 65 and over 2011-12 (by PCT)	30141	70.6	74.0	64.8		81.5
	3.3xv	Flu immunisation uptake at risk groups 2011-12 (by PCT)	13553	50.0	51.6	43.4		66.3
	3.4	People presenting with HIV at a late stage 2008-2010	44	58.7	52.3	89.0		14.3
	3.5i	% treatment completion rates for TB 2011	n/a	74.1	84.3	0.0		0.0
4. Public health and preventing mortality	4.1	Infant mortality 2008-10	79	7.7	4.6	19.2		2.2
	4.2	Rate of tooth decay in children aged 5 years 2007-08 (completed every four years)	n/a	0.7	1.1	2.5		0.5
	4.3	Mortality rate per 100,000 population from causes amenable to health care 2008-10	892	121.6	92.3	160.2		42.2
	4.4	Circulatory disease mortality rate per 100,000 population aged under 75 2008-10	641	85.0	67.2	123.2		38.8
	4.5	Cancer mortality rate per 100,000 population aged under 75 2008-10	935	125.2	110.1	159.1		30.3
	4.6	Mortality from chronic liver disease rate per 100,000 population aged under 75 2008-10	132	19.3	10.1	31.0		0.0
	4.7	Mortality from chronic respiratory disease rate per 100,000 population aged under 75 200	106	13.8	11.7	28.5		4.4
	4.8	Mortality from infectious diseases, rate per 100,000 population 2008-10	95	8.3	6.7	14.0		2.0
	4.9	*Mortality rate for people with serious mental illness*						
	4.10	Suicide mortality rate per 100,000 population for persons all ages 2008-10	60	8.4	7.9	14.2		3.8
	4.11	% of emergency hospital readmissions within 28 days of discharge 2009-10	2408	10.3	11.2	13.1		7.5
	4.12iv	Preventable sight loss-sight loss certifications, rate per 100,000 population 2010-11	132	55.1	43.1	85.7		2.9
	4.13	*Health related quality of life for older people*						
	4.14	Hip fracture emergency admission rate per 100,000 for persons aged 65+ 2010-11	307	535.7	451.9	654.6		324.0
	4.15	Excess winter mortality ratio for persons aged all ages 2007-10	147	19.0	18.7	35.0		7.2
	4.16	*Dementia and its impacts*						

In addition to the targets in the PH outcomes framework, we would welcome projects which directly address the following:

Education (all ages),
Skills,
Employment
Housing
Community Self Reliance and Resilience

An example of how to read the spine chart:

The red dots are our priorities and show where Wolverhampton is significantly worse than the national average. For the first target, V1- Male life expectancy at birth in 2008-10, shows that a boy born in Wolverhampton between 2008-10 has a life expectancy of 76.7 years compared to a national expectation of 78.6 years: that is nearly a 2 year difference. “Nat worst” means the local authority area with the poorest performance and “nat best”- the local authority area with the best performance. (NB it’s 7/10 out of 12 months, but don’t get too bogged down with the detail!).

Concentrate on the red dots and the 5 areas highlighted above, at the bottom of the spine chart.

Appendix 2

PH Nice guidance name & number	Link	Date published Review date	
Brief interventions and referral for smoking cessation (PH1)	View guidance	Mar 2006 Jun 2013	
Four commonly used methods to increase physical activity (PH2) (partially updated by PH41 and PH44)	View guidance	Mar 2006 TBC	
Prevention of sexually transmitted infections and under 18 conceptions (PH3)	View guidance	Feb 2007 Jun 2013	
Interventions to reduce substance misuse among vulnerable young people (PH4)	View guidance	Mar 2007 Jun 2013	
Workplace interventions to promote smoking cessation (PH5)	View guidance	Apr 2007 May 2014	
Behaviour change (PH6)	View guidance	Oct 2007 TBC	
School-based interventions on alcohol (PH7)	View guidance	Nov 2007 Mar 2014	
Physical activity and the environment (PH8)	View guidance	Jan 2008 Feb 2014	
Community engagement (PH9)	View guidance	Feb 2008 TBC	
Smoking cessation services (PH10)	View guidance	Feb 2008 TBC	
Maternal and child nutrition (PH11)	View guidance	Mar 2008 Jul 2014	
Social and emotional wellbeing in primary education (PH12)	View guidance	Mar 2008	
Promoting physical activity in the workplace (PH13)	View guidance	May 2008 Jul 2014	

PH Nice guidance name & number	Link	Date published Review date	
Preventing the uptake of smoking by children and young people (PH14)	View guidance	Jul 2008 Sep 2014	
Identifying and supporting people most at risk of dying prematurely (PH15)	View guidance	Sep 2008 Oct 2013	
Mental wellbeing and older people (PH16)	View guidance	Oct 2008 Nov 2014	
Promoting physical activity for children and young people (PH17)	View guidance	Jan 2009 Apr 2015	
Needle and syringe programmes (PH18)	View guidance	Feb 2009 TBC	
Management of long-term sickness and incapacity for work (PH19)	View guidance	Mar 2009 TBC	
Social and emotional wellbeing in secondary education (PH20)	View guidance	Sep 2009 Jan 2016	
Reducing differences in the uptake of immunisations (PH21)	View guidance	Sep 2009 Feb 2015	
Promoting mental wellbeing at work (PH22)	View guidance	Nov 2009 TBC	
School-based interventions to prevent smoking (PH23)	View guidance	Feb 2010 Apr 2016	
Alcohol-use disorders - preventing harmful drinking (PH24)	View guidance	Jun 2010 Nov 2013	
Prevention of cardiovascular disease (PH25)	View guidance	Jun 2010 Jun 2013	
Quitting smoking in pregnancy and following childbirth (PH26)	View guidance	Jun 2010 Jul 2013	
Weight management before, during and after pregnancy (PH27)	View guidance	Jul 2010 Jul 2013	
Looked-after children and young people (PH28)	View guidance	Oct 2010 Oct 2013	
Strategies to prevent unintentional injuries among under-15s (PH29)	View guidance	Nov 2010 Nov 2013	
Preventing unintentional injuries among under-15s in the home (PH30)	View guidance	Nov 2010 Nov 2013	
Preventing unintentional road injuries among under-15s: road design (PH31)	View guidance	Nov 2010 Nov 2013	
Skin cancer prevention:	View guidance	Jan 2011	

information, resources and environmental changes (PH32)		Oct 2013	

PH Nice guidance name & number	Link	Date published Review date	
Increasing the uptake of HIV testing among black Africans in England (PH33)	View guidance	Mar 2011 Jul 2014	
Increasing the uptake of HIV testing among men who have sex with men (PH34)	View guidance	Mar 2011 Jul 2014	
Preventing type 2 diabetes - population and community interventions (PH35)	View guidance	May 2011 May 2014	
Prevention and control of healthcare-associated infections (PH36)	View guidance	Nov 2011 Nov 2014	
Tuberculosis - hard-to-reach groups (PH37)	View guidance	Mar 2012 Mar 2015	
Preventing type 2 diabetes - risk identification and interventions for individuals at high risk (PH38)	View guidance	Jul 2012 Jul 2015	
Smokeless tobacco cessation - South Asian communities (PH39)	View guidance	Sep 2012 Sep 2015	
Social and emotional wellbeing - early years (PH40)	View guidance	Oct 2012 Oct 2015	
Walking and cycling (PH41)	View guidance	Nov 2012 Nov 2015	
Obesity - working with local communities (PH42)	View guidance	Nov 2012 Nov 2015	
Hepatitis B and C - ways to promote and offer testing (PH43)	View guidance	Dec 2012 Dec 2015	
Physical activity: brief advice for adults in primary care (PH44)	View guidance	May 2013 May 2015	
Tobacco harm reduction (PH45)	View guidance	Jun 2013 Jun 2016	
BMI and waist circumference - black, Asian and minority ethnic groups (PH46)	View guidance	Jul 2013 TBC	

Appendix 3: Assessment criteria

Project Title

Criteria	weighting	scoring
Council Department		
Partner organisation		
Population served		5
Transformational in future way of working	X 3	5
PH outcome and/or PH domain		5
Range of projects in this round		5
Clear aim	X 2	5
Clear objectives		5
Clear milestones		5
Clear outcomes (SMART)	X 3	5
Number of people affected/ targets	X2 (ambitious)	5
Clear evidence of need for the work	X 2	5
Evaluation plan, including data available and required	X 2	5
Evidence of stakeholder involvement in planning		5
Evidence of client involvement in planning		5
Evidence of on-going engagement		5
Good value		5
Savings expected: when?	X 2	5
Social Value act		5
Health inequalities		5
Risks identified		
Total		135

PROPOSAL FORM

PUBLIC HEALTH TRANSFORMATIONAL FUND 2013/14

Please read the eligibility criteria carefully before completing and signing the proposal form. If you need advice about your proposal, you can email us at phtransformation@wolverhampton.gov.uk or call us on 01902 558673.

PLEASE COMPLETE EACH SECTION BY WRITING IN THE SILVER BOX

Section 1: First details

1. Council Department and Directorate
2. Partner Organisation
3. Service Area
4. Project title
5. Summary of current provision in the council and partner organisation
6. Summary of project *(Please use bullet points and no more than 100 words)*
7. Contact name and number to hear outcome of this application

Section 2: Your project in partnership

1. When are you planning to start and finish your project?
2. Is this a new project?
3. If this is an existing project, how long has it been running?
4. If this is an existing project, does this represent a development of the service?
5. Has this project been funded before? If yes, when and by whom?

6. Briefly describe the main business of your partner organisation

7. Have you worked with them before?

Please complete the details for your Partner/s

Name of main contact
Telephone number/s
Email address/es

8. Which organisation (of the partners) is to be responsible for managing and administering the project finances?

Section 3: About your project

1. Brief background to your project, including rationale and need (*no more than 150 words*)

2. Who is the population you will be working with e.g. children, older age, vulnerable and are they local to Wolverhampton?

3. What is the aim of your project? (what you are going to achieve) *(in no more than 30 words)*

4. What are your objectives? (services/activities you'll provide to achieve your aim) (*Please use bullet points and no more than 100 words)*

5. What milestones (short, medium and long term) are you proposing to monitor progress? *(Please use bullet points and no more than 200 words)*

6. Please describe the outcomes you expect your project to achieve (what will be different and for whom) (*Please use bullet points and no more than 200 words)*

7. Please explain how these relate to either the PH outcomes framework or PH domains *(Please use bullet points and no more than 200 words)*

8. Please describe what your project involves i.e. what you will do? *(Please use bullet points and no more than 200 words)*

9. Is there an evidence base behind your proposal or is it experimental? Explain briefly. (appendix 2 of criteria document has all Public Health NICE guidance for reference)

10. Please explain how this project will shape the way you work to continue delivering against the PH framework or domains in the future *(Up to 200 words)*

11. How has your partner organisation been involved in your project planning, including setting the aim, objectives and outcomes? *(Please use bullet points and no more than 200 words)*

12. How have your target audience/clients/service users/ beneficiaries been involved in your project planning, including setting the aim, objectives and outcomes? *(Please use bullet points and no more than 200 words)*

13. How will you continue to engage with key stakeholders and clients?

14. How many people are you expecting your project/activity to impact on?

15. Equalities – Please state how this will contribute to reducing health inequalities

16. Savings – Please state how this will contribute to savings across health and/or social care

17. In the spirit of the social value act, please describe any benefits we should consider? For reference see http://wolvesnet/grants/social_value_act

18. Please indicate if your service area is contributing towards the cost of the project either in cash or in kind and if so, how much and in what way?

19. What if any, are the risks with your project?

20. Budget: Please explain what you need the money for and explain how it represents good value.

Item	£
	£
	£
	£
	£
	£
	£
Total Cost for 1 year	£
Total Cost for 2 year	£

Section 4: Evaluation Plan

Above, you have described your project aims, objectives, milestones and outcomes. Your evaluation plan needs to demonstrate how you will know when you have achieved these, what will be different and for whom. The following questions should help to achieve this.

1. Please describe the data you have and the data you will need and how (and who) will collect it (will you need a baseline or to benchmark, collect new data or have routine data available, qualitative vs quantitative data?) against the following;

    a. Project aim (what you are going to achieve)

    b. Objectives (services/activities you'll provide to achieve this)

    c. Milestones (the steps along the way to achieve your objectives)

    d. Outcomes (what will be different and for whom)

2. Identify what support, if any, you may need to develop/achieve your evaluation plan

Section 5: Your contact details

1. Who is the main contact for your project for us to communicate with?

Title

Forenames in full

Surname

Position in the organisation/job title

Contact address

Landline Mobile Number

Email address

2. Verification of Proposal Form

We confirm that we are authorised to sign this proposal on behalf of our Directorate/ service area or organisation and that the information in the proposal is true and approved by our organisations.

Signature 1 Name (in capitals please) Position Organisation

Signature 2 Name (in capitals please) Position Organisation

Please note:

To be accepted, proposals must be signed by an Assistant Director from the City Council and the responsible person from the partner organisation. Public Health proposals will need to be signed by the Strategic Director for Communities. You can scan in signatures. Please ensure all questions are answered and that your signed proposal is submitted by the closing date. Incomplete or late submissions will not be considered.

We hope this will not occur, but should a proposal be completed untruthfully, the City Council reserves the right to withdraw the proposal from the assessment process, withdraw any funding offer, or cease funding where a grant is being paid.

Section 5. How to submit your application

Please email your signed proposals to **phtransformation@wolverhampton.gov.uk**

Closing Date:

Wolverhampton City Council **OPEN INFORMATION ITEM**

Health and Wellbeing Board Date 4 September 2013

Originating Service Group(s) **TRANSPORTATION**

Contact Officer(s)/ **MARIANNE PAGE**
Telephone Number(s) **1798**

Title **NEW CROSS HOSPITAL PUBLIC TRANSPORT FACILITIES**

RECOMMENDATION

That the details of the report be received by the Health and Wellbeing Board.

1. PURPOSE

1.1 Following an initial report received by the Board on the 3rd July 2013, this report is to provide a further update on the continuing work to improve public transport accessibility to New Cross Hospital.

2. BACKGROUND

2.1 There are already a significant number of bus services to the hospital site; the report and attachments received by the board on the 3rd July 2013 outlined the existing public transport facilities serving New Cross Hospital.

2.2 Centro is continuing to work with partners to ensure good access to New Cross Hospital. All bus services that run in the West Midlands are provided by private companies and therefore are required to run on a profit making basis. Centro has no powers to force operators to run to specific routes and timetables, but they do work in partnership with the bus companies to try and ensure a level of service across the conurbation that meets passenger needs. Two years ago, through partnership working, Centro secured a number of additional links to the hospital from residential areas, both commercial and subsidised by Centro. Centro continues to contribute £457,125 per annum towards the operation of these bus services to New Cross Hospital.

2.3 New Cross Hospital continues to have direct public transport links from a wide area. Twelve buses an hour access the hospital grounds during the day and there are four bus stops within the site which provide excellent access to the various services and departments. Along Wolverhampton Road to the front of the hospital, which is within 400m of all the hospital services, an additional 17 buses an hour stop in each direction. Many of these provide direct links from Wolverhampton City Centre.

2.4 Wolverhampton City Council and National Express West Midlands have held meetings with representatives from New Cross Hospital to look at a strategy for improving public transport access to the site and enhancing the provision of information and publicity about available services for passengers. No further meetings have been held since the last report on the 3rd July.

2.5 Wolverhampton City Council is also working with Centro, the hospital and bus companies to identify any highway improvements which could help buses access. One bus stop has already been relocated to benefit pedestrians and passengers and the hospital has now removed all parking spaces on the hospital road, helping buses to get around the grounds more easily. No further infrastructure works have been undertaken since the last report.

2.6 New Cross Hospital has recently commenced construction of a new multi storey parking facility, which will provide approximately 695 spaces when complete. This forms part of their master plan for redevelopment and should help to ease congestion on site, reducing delays to existing public transport services.

2.7 Representatives on site at New Cross Hospital have been working with the City Council for some years to develop and implement their Travel Plan to promote sustainable transport use to staff and reduce single occupancy car use. As part of this on-going process, and during phases of future redevelopment on site, enhancements to bus services, information availability and methods of promoting public transport use will continue to be identified and implemented wherever possible.

2.8 On 10th July 2013 a letter from Wolverhampton City Councils Cabinet Member for Health and Wellbeing was sent to the Chair of the Integrated Transport Authority on behalf of the Board. The letter outlined how essential the continued improvement of public transport accessibility is to such an important facility, and registered the support of the Board for the continued pursuit of Bus Rapid Transit or Metro proposals to provide a direct, convenient and appealing public transport service to the hospital. A copy of the letter is attached to this report

3. FINANCIAL IMPLICATIONS

3.1 There are no financial implications arising from this report. [JR/14082013/L]

4. LEGAL IMPLICATIONS

4.1 There are no legal implications arising from this report. [FD/19082013/L]

5. EQUAL OPPORTUNITIES IMPLICATIONS

5.1 Ensuring the hospital access site is fully accessible to all people by all modes of transport is a vital equal opportunities issue.

6. ENVIRONMENTAL IMPLICATIONS

6.1 There are no environmental implications arising from this report.

7. SCHEDULE OF BACKGROUND PAPERS

7.1 Letter to Chair of the ITA (dated 10th July 2013)

Please Ask For
Direct Line
Facsimile
E-mail sandra.samuels@wolverhampton.gov.uk
Minicom

Wolverhampton City Council

Labour Councillor for Ettingshall Ward
Cabinet Member for Health & Wellbeing

Sandra Samuels

Civic Centre St Peter's Square
Wolverhampton WV1 1SH
Main Switchboard (01902) 556556

Your Ref.
My Ref.

SS/LA

10 July 2013

Councillor John McNicholas,
Chairman of the Integrated Transport Authority,
Centro House,
16 Summer Lane
Birmingham
B19 3SD

Dear Councillor McNicholas

New Cross Hospital Public Transport Facilities

I write to you as Chair of Wolverhampton City Council's Health and Wellbeing Board, which has been considering the issue of public transport access to New Cross Hospital. It has received recently a report detailing the on-going efforts from Wolverhampton City Council Officers, Centro, public transport operators and New Cross Hospital representatives, to work in partnership to promote and improve public transport accessibility to the site. These are efforts which the Board fully supports and expects to continue.

In order for the hospital facility to be utilised to its full potential by patients, visitors and employees from all areas, the site needs to be accessible by all modes of transportation, particularly public transport. We would take this opportunity to highlight how essential the continued improvement of public transport accessibility is to such an important facility, and would like to register our support for the continued pursuit of Bus Rapid Transit or Metro proposals to provide a direct, convenient and appealing public transport service to the hospital.

Public Transport access to New Cross is clearly a critical issue for the residents of Wolverhampton, and will remain an issue that the Health and Well Being Board are committed to improving.

Yours sincerely

Councillor Sandra Samuels
Cabinet Member for Health and Wellbeing

Home Address:
"Sunnybank" Needwood Close Wolverhampton WV2 4PP
Telephone (01902) 341009
Mobile 07775 007991

Report to: **Wolverhampton Health and Well Being Board**

Report from: **Les Williams, Director of Operations and Delivery, Birmingham, Solihull and the Black Country, NHS England**

Subject: **The NHS belongs to the people: A Call to Action**

1 Background

The document 'The NHS belongs to the people: A Call to Action' was published by NHS England on 11th July. The full paper is attached as Appendix 1.

The document sets out the case for transformational change across the NHS. It describes the future challenges both on the growing demand for NHS services through;

- the growth in the elderly population
- the rise in the incidence of people with long term conditions
- the rising expectations that patients have on the standards of care that they receive

and the pressures on the supply of NHS services through:

- the increasing costs of providing care
- the limited scope for further productivity gains
- the constraints on public resources

The document states that continuing with the current model of care will result in the NHS facing a funding gap of around £30bn between 2013/14 and 2020/21 (although it should be noted that this estimate does not take into account productivity improvements and assumes the health budget will remain protected in real terms).

The document, having identified the pressures for change, also describes some of the future opportunities including:

- working with Public Health England to improve prevention
- enabling patients to gain greater control of their own health
- harnessing new technologies

Call to Action is a programme of engagement with staff, stakeholders, patients and the public in a debate about healthcare provision in England. It is intended to be the broadest, deepest and most meaningful public discussion that the service has ever undertaken. Its aims are to:

- build a common understanding about the need to renew our vision of health and care services particularly to meet the challenges of the future
- give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures

- gather ideas and potential solutions that inform and enable CCGs to develop 3 to 5 year commissioning plans
- gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 to 10 years.

Call to Action will offer a number of ways for people to engage including:

- A digital call to action via an on line interactive platform on NHS Choices, to share ideas and receive feedback
- Local engagement events led by clinical commissioning groups and if agreed, Health and Well Being Boards
- Regional events in major cities across the NHS engaging local government, regional partners, business and the public
- National engagement events

2 Themes for Debate

Consideration is being given to having themed months commencing in September/October which would focus on:

- Putting patients first
- Prevention and early diagnosis
- Achieving parity of esteem between mental and physical health
- Collaboration of care
- Sharing success (including adoption and spread)

This is not a formal consultation and as such will be an iterative process with no absolute end point. It is, however anticipated that the bulk of the engagement will run from September to December. This is intended to allow some of the outputs to be captured in the 2013/14 planning round.

3 Communications to Date

Call to Action was launched on 11th July and attracted significant media interest. It is featured both on the NHS England website and on the NHS Choices website.

CCGs have been informed through communication from the Commissioning Assembly and by the CCG bulletin and are now organising events

Area Teams from NHS England are working with and advising and supporting CCGs on local engagement and 3 to 5 year strategy development. We also want to work with partners to build momentum and will support local engagement to ensure population coverage. In terms of our direct commissioning of services, it is important that we hear from patients, the public and stakeholders about their views on the future of primary care, Specialised Services and the public health services which we directly commission.

We will also be offering engagement and presentations to local Healthwatch organisations.

4 Improving General Practice

In the context of General Practice, on Wednesday 14th August, NHS England published its intention to engage with local communities, clinicians and stakeholders, about the best possible way to develop general practice for the future. As part of NHS England's 10 year strategy to transform the NHS, it is reviewing the current primary care system and engaging with key partners, including frontline clinicians, to develop a long term, effective solution. The main purpose is to stimulate debate in local communities, among GP practices, CCGs, area teams, health and wellbeing boards and other community partners, on the best way to develop general practice services. NHS England is inviting comments about how it can best support local changes, for example through the way national contractual frameworks are developed. NHS England is also developing its strategic approach to commissioning primary dental, pharmacy and eye care services and will carry out separate engagement exercises at a later stage.
A date for an engagement event on Improving General Practice has been agreed as 6pm on Thursday 26th September 2013, at St Chad's Court in Birmingham.

5 Role of Health and Well Being Boards

Health and Well Being Boards are seen as critical partners in the design and delivery of a Call to Action and particularly in supporting the alignment of plans and encouraging the wider participation of local stakeholders. In addition, the Call to Action needs to inform the development of plans for the use of the integrated health and social care budgets during 2014/15, ready for 2015/16.

6 Recommendations

The Health and well Being Board is recommended to:

- Note the publication of 'The NHS belongs to the people: A Call to Action'
- Comment on its content and intention
- Discuss and agree how to participate in the process of engagement

NHS England

The NHS belongs to the people

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Foreword: NHS Call to Action

The NHS is 65 this year: a time to celebrate, but also to reflect. Every day the NHS helps people stay healthy, recover from illness and live independent and fulfilling lives. It is far more than just a public service; the NHS has come to embody values of fairness compassion and equality. The NHS is fortunate in having a budget that has been protected in recent times, but even protecting the budget will not address the financial challenges that lie ahead.

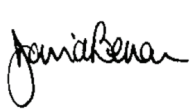
If the NHS is to survive another 65 years, it must change. We know there is too much unwarranted variation in the quality of care across the country. We know that at times the NHS fails to live up to the high expectations we have of it. We must urgently address these failures, raise performance across the board, and ensure we always deliver a safe, high quality, value-for-money service. We must place far greater emphasis on keeping people healthy and well in order to lead longer, more illness-free lives: preventing rather than treating illness. We also need to do far more to help those with mental illness.

There are a number of future pressures that threaten to overwhelm the NHS. The population is ageing and we are seeing a significant increase in the number of people with long-term conditions - for example, heart disease, diabetes and hypertension. The resulting increase in demand combined with rising costs threatens the financial stability and sustainability of the NHS. Preserving the values that underpin a universal health service, free at the point of use, will mean fundamental changes to how we deliver and use health and care services.

This is not about unnecessary structural change; it is about finding ways of doing things differently: harnessing technology to fundamentally improve productivity; putting people in charge of their own health and care; integrating more heath and care services; and much more besides. It's about changing the physiology of the NHS, not its anatomy.

For these reasons, this new approach cannot be developed by any organisation standing alone and we are committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, National Institute for Health and Care Excellence (NICE), the Health and Social Care Information Centre, the Local Government Association, the NHS Commissioning Assembly, Health Education England, the Care Quality Commission (CQC) and NHS England want to work together alongside patients, the public and other stakeholders to improve standards, outcomes and value.

We are all committed to preserving the values that underpin the NHS and we know this new future cannot be developed from the top down. A national vision that will deliver change will be realised locally by clinical commissioning groups, Health & Wellbeing Boards and other partners working with patients and the public. That is why we are supporting a national 'Call to Action' that will engage staff, stakeholders and most importantly patients and the public in the process of designing a renewed, revitalised NHS. This is all about neighbourhoods and communities saying what they need from their NHS; it is about individuals and families saying what they want from their NHS. Above all, this is about ensuring the NHS serves current and future generations as well as it has served those in the past.



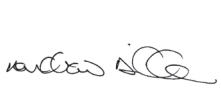
David Behan,
Chief Executive
Care Quality Commission

Alan Perkins,
Chief Executive
Health and Social Care Information Centre

Ian Cumming,
Chief Executive
Health Education England

Zoe Patrick,
Chair of the LGA Community Wellbeing Board
Local Government Association

David Bennett,
Chief Executive
Monitor



Andrew Dillon,
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National Institute for Health and Care Excellence

Peter Melton,
Chief Clinical Officer, North East Lincolnshire CCG, Co-chair of NHS Commissioning Assembly steering group

David Nicholson,
Chief Executive
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David Flory,
Chief Executive
NHS Trust Development Authority

Duncan Selbie,
Chief Executive
Public Health England

The NHS belongs to the people: a call to action

Executive Summary

Every day the NHS saves lives and helps people stay well. It is easy to forget that only 65 years ago many people faced choosing between poverty if they fell seriously ill or forgoing care altogether. Over the decades since its inception the improvements in diagnosis and treatment that have occurred in the NHS have been nothing short of remarkable. The NHS is more than a system; it is an expression of British values of fairness, solidarity and compassion.

However, the United Kingdom still lags behind internationally in some important areas, such as cancer survival rates.[1] There is still too much unwarranted variation in care across the country, exacerbating health inequalities.[2] As the Mid-Staffordshire and Winterbourne View tragedies demonstrated, in some places the NHS is badly letting patients down and this must urgently be put right.

But improving the current system will not be enough. Future trends threaten the sustainability of our health and care system: an ageing population, an epidemic of long-term conditions, lifestyle risk factors in the young and greater public expectations. Combined with rising costs and constrained financial resources, these trends pose the greatest challenge in the NHS's 65-year history.

The NHS has already implemented changes to make savings and improve productivity. The service is on track to find £20 billion of efficiency savings by 2015. But these alone are not enough to meet the challenges ahead. Without bold and transformative change to how services are delivered, a high quality yet free at

[1] Christopher Murray et al. (March 2013), "UK health performance: findings of the Global Burden of Disease Study 2010", The Lancet.

[2] For example, unwarranted variation in common procedures and in expenditure. See John Appleby et al. (2011), "Variations in health care: the good, the bad and the inexplicable", King's Fund and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".

the point of use health service will not be available to future generations. Not only will the NHS become financially unsustainable, the safety and quality of patient care will decline.

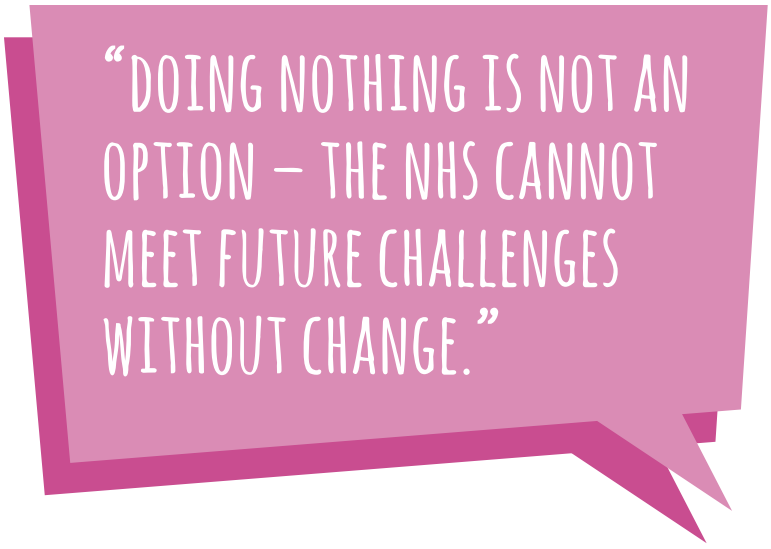
In order to preserve the values that underpin it, the NHS must change to survive. Change does not mean top-down reorganisation. It means a reshaping of services to put patients at the centre and to better meet the health needs of the future. There are opportunities to improve the quality of services for patients whilst also improving efficiency, lowering costs, and providing more care outside of hospitals. These include refocusing on prevention, putting people in charge of their own health and healthcare, and matching services more closely to individuals' risks and specific characteristics. To do so, the NHS must harness new, transformational technology and exploit the potential of transparent data as other industries have. We must be ready and able to share these data and analyses with the public and to work together with them to design and make the changes that meet their ambitions for the NHS.

So this document is a 'Call to Action' – a call to those who own the NHS, to all who use and depend on the NHS, and to all who work for and with it. Building a common understanding of the challenges ahead will be vital in order to find sustainable solutions for the future. NHS England, working with its partners, will shortly launch a sustained programme of engagement with NHS users, staff and the public to debate the big issues and give a voice to all who care about the future of our National Health Service. This programme will be the broadest, deepest and most meaningful public discussion that we have ever undertaken.

Bold ideas are needed, but there are some options we will not consider. First, doing nothing is not an option – the NHS cannot meet future challenges without change. Second, NHS funding is unlikely to increase; it would be unrealistic to expect anything more than flat funding (adjusted for inflation) in the coming years. Third, we will not contemplate cutting or charging for core NHS services – NHS England is governed by the NHS Constitution which rightly protects the principles of a comprehensive service providing high quality healthcare, free at the point of need for everyone.

The Call to Action will not stifle the work that clinical commissioning groups and their partners have already accomplished. It is intended to complement this work and lead to five-year commissioning plans owned by each CCG. The Call to Action will also shape the national vision, identifying what NHS England should do to drive service change. This programme of engagement will provide a long-term approach to achieve goals at both levels.

The NHS belongs to all of us. This Call to Action is the opportunity for everyone who uses or works in the NHS to have their say on its future.



How is the NHS currently performing?

Quality at the core

Over recent years, the quality of NHS services has improved and, as a result, so has the nation's health. However, there is still too much unwarranted variation across the country. In England the Government measures the quality of care in five areas, collected together in the NHS Outcomes Framework. Each of these areas is discussed below.

Preventing people from dying early

As a nation we are living longer than ever before. Between 1990 and 2010, life expectancy in England increased by 4.2 years.[3] The NHS has made significant improvements in reducing premature deaths from heart and circulatory diseases but the UK is still not performing as well as other European countries for other conditions.[4]

Preventing disease in the first place would significantly reduce premature death rates. Early diagnosis and appropriate treatment of disease can also reduce premature deaths.

Around 80% of deaths from the major diseases, such as cancer, are attributable to lifestyle risk factors such as excess alcohol, smoking, lack of physical activity and poor diet.[5]

[3] Office for National Statistics (2011) http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-227587
[4] World Health Organisation (2013) http://data.euro.who.int/hfadb/
[5] World Health Organisation (2011) "Global Status Report on Non-communicable Diseases"

Enhanced quality of life for people with long-term conditions

Long-term conditions (LTC) or chronic diseases cannot currently be cured, but can be controlled or managed by medication, treatment and/or lifestyle changes. Examples of long-term conditions include high blood pressure, depression, dementia and arthritis.

Over 15 million people in England have an LTC. They make up a quarter of the population yet they use a disproportionate amount of NHS resources: 50% of all GP appointments, 70% of all hospital bed days and 70% of the total health and care spend in England.[6] People living at higher levels of deprivation are more likely to live with a debilitating condition, more likely to live with more than one condition, and for more of their lives.[7]

The NHS, working with local authorities and the new health and wellbeing boards, needs to be much better at providing a service that appropriately supports these patients' needs and helps them to manage their own conditions. Better management of their own conditions by patients themselves will mean fewer hospital visits and lower costs to the NHS overall, and more community-based care, including care delivered in people's homes

"BETTER MANAGEMENT BY PATIENTS WILL MEAN FEWER HOSPITAL VISITS & LOWER COSTS TO THE NHS OVERALL."

Helping people recover following episodes of ill health or following illness

Demand on NHS hospital resources has increased dramatically over the past 10 years: a 35% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75.[8] A combination of factors, such as an ageing population, out-dated management of long term conditions, and poorly joined-up care between adult social care, community services and hospitals accounts for this increase in demand.

Compounding the problem of rising emergency admissions to hospital is the rise in urgent readmissions within 30 days of discharge from hospital. There has been a continuous increase in these readmissions since 2001/02 of 2.6% per year.[9]

New thinking about how to provide integrated services in the future is needed in order to give individuals the care and support they require in the most efficient and appropriate care settings, across health and social care, and in a safe timescale. For example, the limited availability of some hospital services at weekends has a negative impact on all five domains of the NHS Outcomes Framework: preventing people from dying prematurely; enhancing the quality of life for people with long-term conditions; helping people to recover from ill health and injury; ensuring people have a positive experience of care; and caring for people in a safe environment and protecting them from avoidable harm.

[6] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).
[7] The Marmot Review (2010), "Fair Society Healthy Lives".
[8] Royal College of Physicians (2012), "Hospitals on the edge? The time for action".
[9] Health and Social Care Information Centre
http://www.hscic.gov.uk/searchcatalogue?q=title%3A%22Hospital+Episode+Statistics%2C+Admitted+patient+care+-+England%22&area=&size=10&sort=Relevance]

This is why the first offer in *Everyone Counts: Planning for Patients*, is to support the NHS in moving towards more routine services being available seven days a week. The National Medical Director has established a forum to identify how to improve access to more comprehensive services seven days a week which will report in the autumn of 2013.

NHS England recently announced a review of urgent and emergency services in England, which will also recommend ways to meet the objective of a seven-days-a-week service. Not only will this offer improved convenience for patients, full-week services will also improve quality and safety.

Patient experience

The UK rates highly on patient experience compared to other countries. A 2011 Commonwealth Fund study[10] of eleven leading health services reported that 88% of patients in the UK described the quality of care they had received in the last year as excellent or very good, ranking the UK as the best performing country. However, the data also show that the UK has improvements to make in the coordination of care and patient-centred care.

Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS. People from disadvantaged groups including the frail older population, some black and minority ethnic groups, younger people and vulnerable children, generally access poorer quality services and have a poorer experience of care (some also have lower life expectancies). This can be made worse by these groups having lower expectations of the experience of care and being less likely to seek redress. We must act to improve access and the quality of services for these less advantaged groups.

> "Everyone working in the NHS must strive to maintain and improve on this high level of patient satisfaction and extend it to everyone who uses the NHS."

[10] Commonwealth Fund (2011), "International Health Policy Survey".

Patient safety

Although great improvements in patient safety have been made, the findings from the Mid-Staffordshire public inquiry set out starkly what can happen when safety is not at the heart of everything the NHS does. The NHS must work to ensure that all patients experience the safe treatment they deserve. Global healthcare expert Professor Don Berwick was recently asked by the Prime Minister to look into improving safety in the NHS and will report back with his findings later this year.

In addition to reducing harmful events, we must make it easier for staff to report incidents. In 2011, 1,325,360 patient safety incidents were reported to the National Reporting and Learning System,[12] of which 10,916 or less than 1% were serious. Despite this large number of reports we know we have not captured everything, and are working to make it easier for staff and patients to report incidents or near-misses. Learning from even largely minor incidents is important as it helps the NHS to avoid more serious incidents in the future.

Over the past 15 years, international studies have suggested that around 9 in 10 patients admitted to hospital experience safe treatment without any adverse events and our NHS is no different. But even these relatively low levels of adverse events are far too high. Of those people who do experience adverse events a third of them experienced greater disability or death.[11]

Health inequalities

Health inequalities is the term that describes the unjust differences in health, illness and life expectancy experienced by people from different groups of society. In England, as elsewhere, there is a so-called 'social gradient' in health: the more socially deprived people are, the higher their chance of premature mortality, even though this mortality is also more avoidable. People living in the poorest areas of England and Wales, will, on average, die seven years earlier than people living in the richest areas.[13] The average difference in disability-free life expectancy is even worse: fully 17 years between the richest and poorest neighbourhoods.[14] Health inequalities stem from more than differences in just income - education, geography, and gender can all play a role.

The NHS cannot address all the inequalities in health alone. Factors such as housing, income, educational attainment and access to green space are also important (the "wider social determinants of health"). In fact, it is estimated that only 15-20% of inequalities in mortality rates can be directly influenced by health interventions that prevent or reduce risk. If the NHS is to help tackle these inequalities we must work closely with Government departments, Public Health England, local authorities and other local partners to ensure the effective coordination of healthcare, social care and public health services.

[11] Charles Vincent, Graham Neale and Maria Woloshynowych (2001) "Adverse events in British hospitals: preliminary retrospective record review", British Medical Journal.

[12] National Patient Safety Agency (2012), "National Reporting and Learning System Quarterly Data Workbook" http://www.nrls.npsa.nhs.uk/resources/collections/quarterly-data-summaries/?entryid45=135153

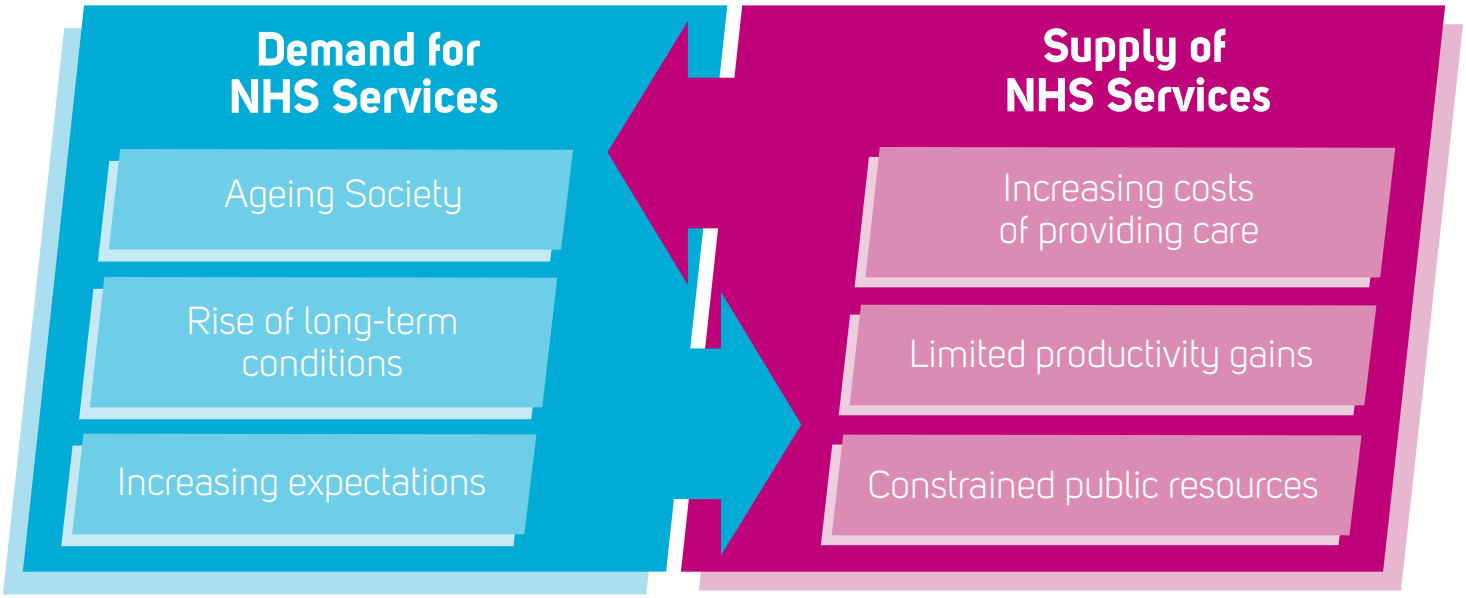
[13] The Marmot Review (2010), "Fair Society Healthy Lives"

[14] The Marmot Review (2010), "Fair Society Healthy Lives"

What challenges will the health and care service face in the future?

As the NHS strives to improve the quality and performance of current NHS services and to live up to the high expectations of patients and the public, we must anticipate the challenges of the future - trends that threaten the sustainability of a high-quality health service, free at the point of use. It is the potential impact of these trends that means that while a new approach is urgently needed, we must take a longer-term view when developing it.

Future pressures on the health service



Ageing society

People are living longer and while this is good news an ageing population also presents a number of serious challenges for the health and social care system:

- Nearly two-thirds of people admitted to hospital are over 65 years old.
- There are more than 2 million unplanned admissions per year for people over 65, accounting for nearly 70% of hospital emergency bed days.[15]
- When they are admitted to hospital, older people stay longer and are more likely to be readmitted.[16]
- Both the proportion and absolute numbers of older people are expected to grow markedly in the coming decades. The greatest growth is expected in the number of people aged 85 or older - the most intensive users of health and social care.[17]

Studies suggest that older patients account for the majority of health expenditure. One analysis found that health and care expenditure on people over 75 was 13-times greater than on the rest of the adult population.[18]

"STUDIES SUGGEST THAT OLDER PATIENTS ACCOUNT FOR THE MAJORITY OF HEALTH EXPENDITURE."

Extra care housing: supporting older people to stay independent

Extra care housing is sometimes referred to as very sheltered housing or housing with care. It is social or private housing that has been modified to suit people with long-term conditions or disabilities that make living in their own home difficult, but who don't want to move into a residential care home.

This 'retirement village' type of housing offers an alternative to traditional nursing homes, providing a range of community and care services on site. Compared with residence in institutional settings, extra care housing is associated with better quality of life and lower levels of hospitalisation, suggesting the potential for overall cost savings.[19]

[15] Candice Imison et al. (2011), "Older people and emergency bed use: exploring variation", King's Fund.
[16] Jocelyn Cornwell et al. (2012), "Continuity of care for older hospital patients: A call for action", King's Fund.
[17] Commission on Funding of Care and Support (2011), "Fairer Care Funding: The Report of the Commission on Funding of Care and Support".
[18] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[19] A Netten et al. (2011), "Improving housing with care choices for older people: an evaluation of extra care housing", Personal Social Services Research Unit.

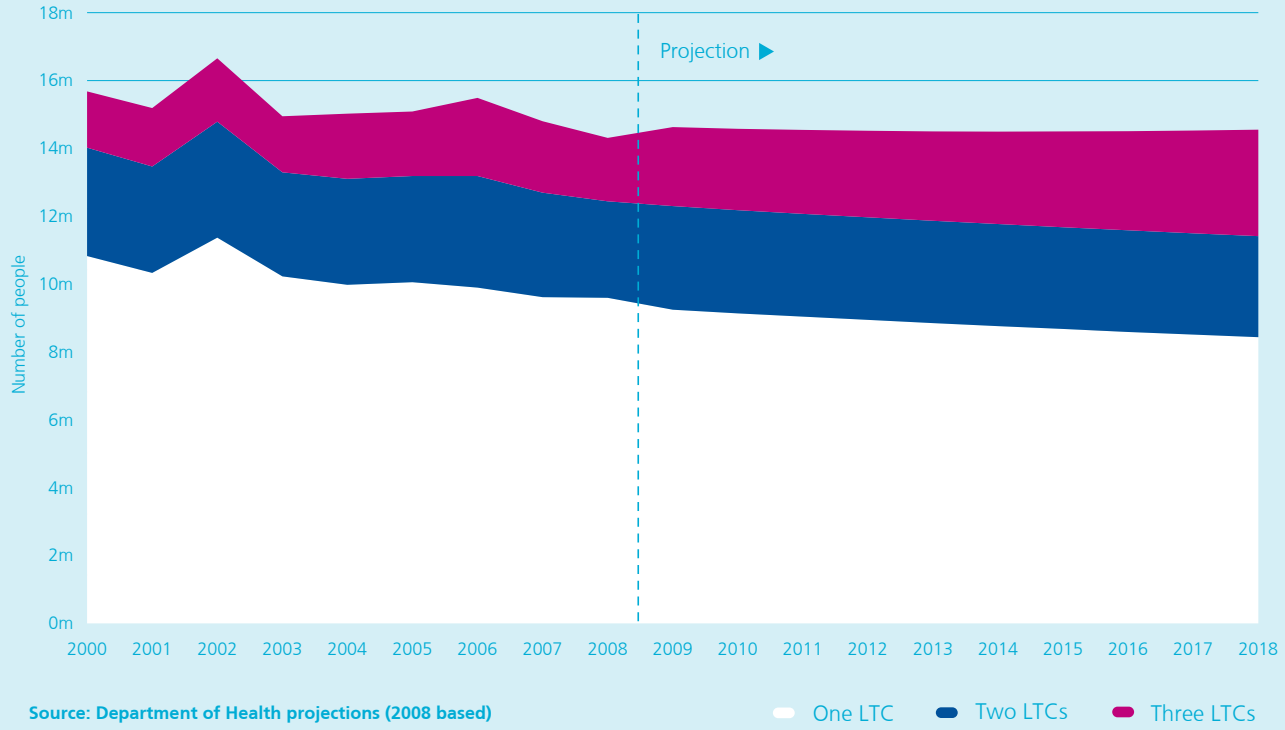
Changing burden of disease

People with one or more long-term conditions are already the most important source of demand for NHS services: the 30% who have one or more of these conditions account for £7 out of every £10 spent on health and care in England. Those with more than one long-term condition have the greatest needs and absorb more healthcare resources; for example, patients with a single long-term condition cost about £3,000 per year whilst those with three or more conditions cost nearly £8,000 per year. These multi-morbid, high-cost patients are projected to grow from 1.9 million in 2008 to 2.9 million in 2018.[20]

Patients with multiple long-term conditions must be managed differently. A hospital-centred delivery system made sense for the diseases of the 20th century, but today patients could be providing much more of their own care, facilitated by technology, and supported by a range of professionals including clinicians, dieticians, pharmacists and lifestyle coaches. They also need close coordination amongst these different professionals.

"THE 30% WHO HAVE ONE OR MORE LONG-TERM CONDITION ACCOUNT FOR £7 OUT OF EVERY £10 SPENT ON HEALTH AND CARE IN ENGLAND"

Actual/projected numbers with one or more long-term conditions by year and number of conditions



Source: Department of Health projections (2008 based)

[20] Department of Health (2012), "Long Term Conditions Compendium" (3rd edition).

Meeting the dementia challenge: rapid diagnosis and referral

There are now 800,000 people living with dementia in the UK. By 2021, the number of sufferers is projected to exceed one million and dementia is estimated to cost the NHS, local authorities and families £23 billion a year. As the Prime Minister's 2012 Challenge on Dementia noted, diagnosis comes too late for many dementia patients and they and their families don't always get the care and support they need. This is in part because too little is known about the causes of this disease and how to prevent it, but some areas are leading the way in offering better care. In Stockport, Greater Manchester, local GPs are working with the Alzheimer's Society to increase diagnosis rates and provide post-diagnosis support. GPs have agreed a 'fast-track' referral process for suspected dementia patients that will also trigger support from Alzheimer's Society staff and volunteers. The scheme also sets out to improve the skills of clinicians to better recognise the early signs of dementia and increase early detection.[21]

Lifestyle risk factors in the young

We know that the risk of developing debilitating diseases is greatly increased by personal circumstances and unhealthy behaviours such as drinking, smoking, poor diet and lack of exercise, all of which contribute to premature mortality. If predictions are correct, and 46% of men and 40% of women are obese by 2035, the result is likely to be 550,000 additional cases of diabetes, and 400,000 additional cases of stroke and heart disease.[22] Although we understand the problem, we do not yet have enough evidence to be sure about what will facilitate sustainable weight loss and other associated behaviours. Working together with individuals, their families, employers and communities to develop effective approaches will be an extremely important task for the next generation NHS.

Rising expectations

Patients and the public rightly have high expectations for the standards of care they receive - increasingly demanding access to the latest therapies, more information and more involvement in decisions about their care.[23] If the convenience and quality of NHS services is compared to those in other sectors, many people will wonder why the NHS cannot offer more services online or enable patients to receive more information on their mobile telephones. Patients want seven-day access to primary care provided near their homes, places of work, or even their local shop or pharmacy. They also want co-ordinated health and social care services, tailored to their own needs. To provide this level of convenience and access, we need to rethink where and how services are provided.

[21] Alzheimer's Society (2012), "Dementia 2012".
[22] Y.C. Wang et al (August 2011), "Health and economic burden of the projected obesity trends in the USA and the UK," The Lancet.
[23] See for example Economist Intelligence Unit (2009), "Fixing Healthcare: The Professionals Perspective".

Increasing costs

The cost of providing care is getting more expensive. The NHS now provides a much more extensive and sophisticated range of treatments and procedures than could ever have been envisaged at its inception. New drugs, technologies and therapies have made a major contribution to curing disease and extending the length and quality of people's lives. The NHS can now treat conditions that previously went undiagnosed or were simply untreatable. It is of course a good thing that the NHS has more therapies at its disposal and can now diagnose and treat previously neglected illnesses. However, many healthcare innovations are more expensive than the old technologies they replace - for example, the latest cancer therapies[24] - which raises affordability questions. We must ensure that we invest in the technology and drugs that demonstrate the best value and this rigour must be extended throughout the system, evaluating not just therapies and technologies, but also different models of delivering health and care services.

Limited financial resources

The NHS is facing these challenges at the same time that the UK is experiencing the most challenging economic crisis since the 1930s and adjusting to an era of much tighter public finances. The broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best. This represents a dramatic slow-down in spending growth.

Since it began in 1948, the share of national income that the NHS receives has more than doubled, an average rise of about 4% a year in real terms. As part of its deficit reduction programme the Government has severely constrained funding growth.

In addition, recent spending settlements for local government have not kept pace with demand for social care services. Unlike healthcare funding, social care funding is not ring-fenced; councils decide how much of their budget to spend on services based on local need. As a result, financially challenged local authorities have, in some locations, reduced spend on social care to shore up their finances. Reduced social care funding can drive up demand for health services, with cost implications for the NHS.[26] We therefore need to consider how health and care spending is best allocated in the round rather than separately in order to provide integrated services.

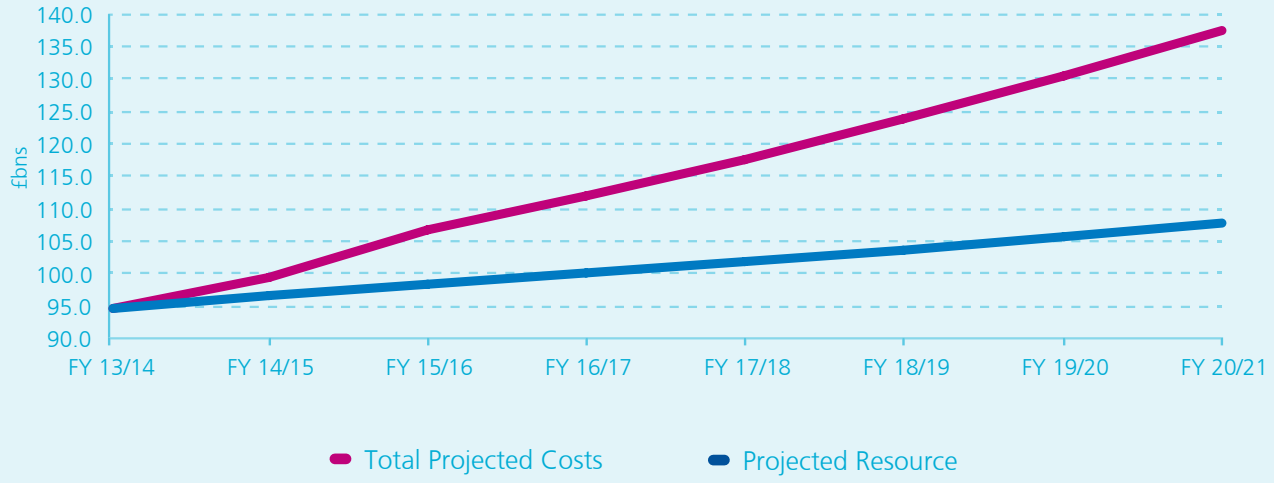
In England, continuing with the current model of care will result in the NHS facing a funding gap between projected spending requirements and resources available of around £30bn between 2013/14 and 2020/21 (approximately 22% of projected costs in 2020/21). This estimate is before taking into account any productivity improvements and assumes that the health budget will remain protected in real terms.[25]

[24] Richard Sullivan et al (September 2011), "Delivering affordable cancer care in high-income countries", The Lancet Oncology.

[25] NHS England analysis.

[26] Research has found that spending on social care could generate savings in both primary and secondary healthcare and that increased social care provision is related to reductions in delayed hospital discharges and readmission rates. See Richard Humphries (2011), "Social Care Funding and the NHS: An Impending Crisis?," King's Fund and J Forder and JL Fernández (2010), "The Impact of a Tightening Fiscal Situation on Social Care for Older People", PSSRU Discussion Paper 2723, London, Kent and Manchester, Personal Social Services Research Unit.

Projected resource vs. Projected spending requirements



Source: NHS England

Limited productivity improvements

Measuring the productivity[27] of the NHS is methodologically difficult and hotly debated. The Office of National Statistics suggests that between 1995 and 2010 average productivity in the NHS grew at 0.4%, whilst in the economy as a whole it grew at a much faster rate of 2% over the same period.[28] Beneath this, NHS labour productivity levels have increased faster than equivalent rates in the wider economy by an average of 2.5% per year between 2007 and 2010.[29] This suggests that the NHS may not be using its capacity as efficiently as it could.

NHS productivity remains an unresolved debate. However, traditional productivity improvements will not be enough to plug the future funding gap. NHS England's analysis suggests that the overall efficiency challenge could be as high as 5-6% in 2015/16 compared to the current 4% required efficiency in 2013/14.[30] Improvements such as better performance management, reducing length of stay, wage freezes or better procurement practices all have a role to play in keeping health spending at affordable levels. However, these measures have been employed to deliver the so-called "Nicholson Challenge" of 4% productivity improvements each year, amounting to some £20bn in savings, and there is a limit to how much more can be achieved without damaging quality or safety. A fundamentally more productive health service is now needed, one capable of meeting modern health needs with broadly the same resources.

> "THE OVERALL EFFICIENCY CHALLENGE COULD BE AS HIGH AS 5-6% IN 2015/16 COMPARED TO THE CURRENT 4% REQUIRED EFFICIENCY IN 2013/14."

[27] At its most basic productivity is the rate at which inputs (like labour, capital and supplies), are converted into outputs (like consultations or operations) and outcomes (such as good health) in order to improve quality of life.

[28] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[29] Office for National Statistics (2010), "Public Service Productivity Estimates: Healthcare, 2010".

[30] This is the challenge for the NHS after national action to constrain wages and other input costs. In recent years these have typically delivered c.1% per annum in savings which over the period modelled would equate to c.£8bn.

Seizing future opportunities

The future doesn't just pose challenges, it also presents opportunities. Technological, social and other innovations – many of which are already at work in other industries or sectors – can and should be harnessed to transform the NHS. These exciting opportunities have the potential to deliver better patient care more efficiently to achieve the transformation that is required, some of which are discussed below. These are not exhaustive and it is crucial that as a service we become better able to spot other trends and innovations with the potential to reshape health services.

A health service, not just an illness service

We must get better at preventing disease. In the future this means working increasingly closely with partners such as Public Health England, health and wellbeing boards and local authorities to identify effective ways of influencing people's behaviours and encouraging healthier lifestyles. The NHS has helped many people quit smoking (although there are still about 8m smokers in England), but has yet to develop similarly sophisticated methods for assisting people to improve their diet, take more exercise or drink less alcohol.

About 4% of the total health budget in England is spent on prevention and public health, which is above the Organisation for Economic Co-operation and Development (OECD) average,[31] but this will strike many as too little. We need to look at our health spending and how investment in prevention may be scaled up over time. It is not just about investment; partnering with Public Health England, working with health and wellbeing boards and local authorities and refocusing the NHS workforce on prevention will shape a service that is better prepared to support individuals in primary and community care settings.

[31] Department of Health (2009), "Public Health and Prevention Expenditure in England".

Giving patients greater control over their health

Developing effective preventative approaches means helping people take more control of their own health, particularly the 15 million people with long-term conditions. The evidence shows that support for self-management, personalised care planning and shared decision making are highly effective ways that the health system can give patients greater control of their health. When patients are involved in managing and deciding about their own care and treatment, they have better outcomes, are less likely to be hospitalised,[32] follow appropriate drug treatments[33] and avoid over-treatment.[34] Personalised care planning is also highly effective.[35] A major trial of Personal Health Budgets, a tool for personalised care planning, has shown improved quality of life and cost-effectiveness, particularly for higher needs patients and mental health service users.[36]

Manchester Royal Infirmary: home dialysis

Manchester Royal Infirmary has developed an innovative dialysis provision pathway, which allows patients to perform extended haemodialysis at home, rather than in hospital. This has delivered improved health and longevity, empowering patients through greater involvement, freedom and flexibility, and offers wider benefits of fewer medications and hospital visits resulting in substantial reductions in healthcare costs.[37]

Harnessing transformational technologies

The digital revolution can give patients control over their own care. Patients should have the same level of access, information and control over their healthcare matters as they do in the rest of their lives. The NHS must learn from the way online services help people to take control over other important parts of their lives, whether financial or social, such as online banking or travel services. First introduced to the UK in 1998, now more than 55% of internet users use online banking services.[38] A comparable model in health would offer online access to individual medical records, online test results and appointment booking, and email consultations with individual clinicians. Some of the best international providers already do this.[39] This approach could extend to keeping people healthy and independent through at-home monitoring, for example. These innovations would not only give patients more control, they would also make the NHS more efficient and effective in the way that it serves the public.

[32] JH Hibbard and J Green (February 2013), "What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs," Health Affairs.

[33] Expert Patients Programme (2010), "Self-care reduces costs and improves health: the evidence".

[34] D Stacey et al. (May 2011), "Decision aids to help people who are facing health treatment or screening decisions", Cochrane Summaries and Department of Health (2011), "NHS Atlas of Variation in Healthcare: Reducing unwarranted variation to increase value an improve quality".

[35] "RCGP Clinical Innovation and Research Centre (2011), "Care Planning: improving the lives of people with long term conditions".

[36] https://www.phbe.org.uk/

[37] NHS England (2013), "Catalogue of Potential Innovation".

[38] Office for National Statistics (2009), "e-society" (Social Trends 41).

[39] For example Kaiser Permanente and the Veterans Administration, both in the USA

e-Intensive Care: a second pair of eyes

Guy's and St Thomas' NHS Foundation Trust, in London, has recently deployed a new e-Intensive Care Unit (ICU) to keep a 'second pair of eyes' on critically ill patients. Used in about 300 hospitals in the US, where studies have shown the system has reduced mortality rates and hospital stays, the eICU allows critical care specialists to remotely monitor patients using high-definition cameras, two-way audio and other instruments that keep track of vital signs. Not only does the system facilitate provision of 24/7 care, it also enables the most experienced specialists to spread their skills more widely and to help more patients with the greatest need.[40]

"THE NEW FRIENDS AND FAMILY TEST ASKS PATIENTS WHETHER THEY WOULD RECOMMEND THEIR HOSPITAL TO THEIR FRIENDS & FAMILY AND THE FIRST RESULTS WILL BE PUBLISHED ON NHS CHOICES IN JULY 2013"

Digital inclusion will have a direct impact on the health of the nation, and so innovation must be accessible to all, not just the fortunate. From April 2013, 50 existing UK online centres in local settings, such as libraries, community centres, cafes and pubs, are receiving additional funding to develop as digital health hubs where people will be able to find support to go online for the first time and use technology and information services such as NHS Choices to improve their health and wellbeing.

Exploiting the potential of transparent data

To support active patients the best quality data must be collected and made available. Dramatic improvements need to be made in the supply of timely and accurate information to citizens, clinicians and commissioners. Commissioners can use improved data to better understand how effectively money is being invested. For patients, more and better data will enable them to make informed decisions about their health and healthcare.

The new Friends and Family Test asks patients whether they would recommend their hospital wards or A&E department to their friends and family should they need similar care or treatment. Beginning in July 2013, the results will be published on the NHS Choices website. This is just one example of transparency which will for the first time allow citizens to compare NHS performance based on the opinions of the patients.

[40] Guy's and St. Thomas' NHS Foundation Trust, www.guysandstthomas.nhs.uk/news-and-events/2013-news/20130703-eICU.aspx

Moving away from a 'one-size fits all' model of care

A relatively small minority of patients accounts for a high proportion of health service utilisation and expenditure. This suggests an opportunity to manage patients, and help them manage themselves, more intelligently, based on an understanding of individual risk.

Healthcare is becoming more personal in other ways too. Recent biomedical advances suggest a revolution in medicine itself may be afoot that could enable clinicians to tailor treatment to individuals' specific characteristics. For instance, it has been proven that mutations in two genes called BRCA1 and BRCA2 significantly increase a person's risk of developing breast cancer. Individuals can now be tested for these mutations, allowing early detection and targeted use of therapeutic interventions. Similar progress is being made in understanding the biological basis of other common diseases. The health service needs to consider how to invest in this work and how it can most effectively be translated into everyday practice.

Risk-stratification in North West London

As part of the Inner North West London Integrated Care Pilot, patient information was combined across primary, secondary and social care providers to understand the impact of high-risk patients on services and expenditure. The data showed that the 20% of the population most at risk of an emergency admission to hospital accounted for 86% of hospital and 87% of social care expenditure. Yet despite this high concentration in expensive downstream services, only 36% of primary care resources were expended on these same patients.[41] This suggests that through better management of these patients in primary care many hospital admissions could be prevented and intensive social care support reduced, resulting in improved care with reduced costs.

Unlocking healthcare as a key source of future economic growth

All too often we think of health expenditure as solely a cost, but investment in individuals' wellbeing and productivity delivers vast benefits to society and the economy. Conversely, illness costs the UK economy dearly: in 2011, 131 million work days were lost due to sickness.[42] This translates into an annual economic cost estimated to be over £100bn whilst the cost to the taxpayer, including benefits, additional health costs and forgone taxes, is estimated to be over £60bn.[43]

In addition to preventing and relieving illness, the NHS has a central role in contributing to economic growth. The NHS is the largest single customer for the UK health and life sciences industries including pharmaceutical, biotechnology, medical devices and other sectors,[44] and Britain is recognised as a leader in biomedical research. We must consider how the NHS can work with industry partners to make sure that the health and life sciences continue to be a growing part of the UK economy.

[41] McKinsey & Co. (2013), "Understanding patients' needs and risk: a key to a better NHS".
[42] Office of National Statistics (2012), "Sickness absence in the labour market".
[43] Department of Health (2011), "Innovation, Health and Wealth".
[44] Department of Health (2011), "Innovation, Health and Wealth"

What's next?

This document discusses the key problems and opportunities that a renewed vision for the health service must address. In the next phase of work, we will analyse, with our key partners, the causes of these trends and challenges and share these more widely in order to begin to generate potential solutions. Some of these solutions may come from reviews that are already underway such as the Urgent and Emergency Care Review and the Berwick Review on improving safety in the NHS. Some solutions may be adapted from small-scale pilots or international models that can demonstrate success, but there is no doubt that new ideas are needed.

We cannot generate these new ideas alone. NHS England is committed to working collectively to improve services. This is why Monitor, the NHS Trust Development Authority, Public Health England, NICE, the Health and Social Care Information Centre, the Local Government Association,the steering group of the NHS Commissioning Assembly, Health Education England and the Care Quality Commission want to work in partnership with NHS England to understand the pressures that the NHS faces and to work together alongside patients, the public and other stakeholders to identify new and better ways to deliver health and care.

The NHS constitution stipulates that the NHS belongs to the people and so does its future. In keeping with this principle we will be working together with staff, patients and the public to develop new local approaches for the NHS. We need your help to ensure that the ideas identified are sustainable and respect the values that underpin the health service. To enlist your help, we are launching a nationwide campaign called *'The NHS belongs to the people: a Call to Action'*.

A call to action

A call to action is a programme of engagement that will allow everyone to contribute to the debate about the future of health and care provision in England. This programme will be the broadest, deepest and most meaningful public discussion that the service has ever undertaken. The engagement will be patient - and public-centred through hundreds of local, regional and national events, as well as through online and digital resources. It will produce meaningful views, data and information that CCGs can use to develop 3-5 year commissioning plans setting out their commitments to patients and how services will improve.

The call to action aims to:

- Build a common understanding about the need to renew our vision of the health and care service, particularly to meet the challenges of the future.
- Give people an opportunity to tell us how the values that underpin the health service can be maintained in the face of future pressures.
- Gather ideas and potential solutions that inform and enable CCGs to develop 3-5 year commissioning plans.
- Gather ideas and potential solutions to inform and develop national plans, including levers and incentives, for the next 5 – 10 years.

What will happen with the data and views that are collected?

All data, views and information will be collected by CCGs and NHS England. This information will then be used by CCGs to develop 3-5 year commissioning plans, setting out commitments to patients about how services will be improved.

This information will also be used by NHS England to shape its direct commissioning responsibilities in primary care and specialised commissioning.

Information gathered in this way will drive real future decision making. This will be evident in the business plans submitted for both 2014/15 and 2015/16. These plans will signal service transformation intentions at both local and national level.

There is no set of predetermined solutions or options about which we are consulting. Bold, new thinking is needed and we will consider a wide range of potential options. However, there are three options that we will not be considering:

1. **Do nothing.** The evidence is clear that doing nothing is not a realistic option nor one that is consistent with our duties. We cannot meet future challenges, seize potential opportunities and keep the NHS on a sustainable path without change.

2. **Assume increased NHS funding.** In the 2010 spending review, the Government reduced spending on almost all most public services, although health spending was maintained. We do not believe it would be realistic or responsible to expect anything more than flat funding (adjusting for inflation) in the coming years.

3. **Cut or charge for fundamental services, or 'privatise' the NHS.** We firmly believe that fundamentally reducing the scope of services the NHS offers would be unconstitutional, contravene the values that underpin the NHS and - most importantly - harm the interests of patients. Similarly, we do not think more charges for users or co-payments are consistent with NHS principles.

How will the call to action engage people?

The call to action will offer a number of ways for everyone to engage with the development of a renewed vision for the health service including:

A digital call to action

Staff, patients and the public will be able contribute via an online platform hosted by NHS Choices. This platform will enable people to submit their ideas, hold their own local conversations about the future of the NHS and search for engagement events and other interactive forums.

'Future of the NHS' surgeries with NHS staff, patients and the public

Local engagement events will be led by clinical commissioning groups, health and wellbeing boards, local authorities and other local partners such as charities and patient groups. These workshop-style meetings will be designed to gather views from patients and carers, local partner groups and the public. We will also be holding events designed to capture the views of NHS staff, for instance, through clinical senates.

Town hall meetings

Held in major cities across the NHS, these events will engage local government, regional partners, business and the public. These regional events will give people who have not contributed locally a chance to participate in regional discussions.

National engagement events

A number of national events focusing on national level partner organisations to the NHS will be held. These will include Royal Colleges, patient groups and charities, the private sector and other stakeholders.

Conclusion

The NHS is one of our most precious institutions. We need to cherish it, but we also need to transform it. Future trends threaten its sustainability, and that means taking some tough decisions now to ensure that its future is guaranteed. We believe that by working together as a nation, we have a unique opportunity to transform the NHS into a health service that is both safe and fit for the future.

The NHS needs your help. Have your say.