Health and Wellbeing Board

6 November 2013

Time 2.00pm **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

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1. **Apologies for Absence**

2. **Notification of Substitute Members**

3. **Declarations of interest**

4. **Minutes of the previous meeting (4 September 2013)**
[For approval]

5. **Summary of outstanding matters [Viv Griffin]**

6. **Chair's update [Councillor Mrs Sandra Samuels]**

7. **A joint strategy for the provision of urgent and emergency care for patients using services in Wolverhampton [Richard Young]**

8. **Health and Wellbeing Board Forward Plan 2013/14 [Viv Griffin]**

9. **Care Quality Commission – inspection of New Cross Hospital (Royal Wolverhampton NHS Trust) – initial feedback – Verbal Report [Cheryl Etches OBE]**

10. **Mental Health Strategy – refresh and update on Mental Health Detection and Early Prevention – progress report [Viv Griffin / Sarah Fellows]**

11. **Progress report on joint Health and Wellbeing Strategy Priority: Alcohol and Drugs [Ros Jervis]**

12. **NHS Wolverhampton (Wolverhampton Clinical Commissioning Group) – Commissioning Intentions [Richard Young]**

13. **Funding Transfer from NHS England to Social Care 2013/14 [Anthony Ivko]**

14. **Feedback from Sub Groups**
- **Children's Trust Board [Emma Bennett]**
- **Adults Delivery Board [Viv Griffin]**
- **Public Health Delivery Board [Ros Jervis]**

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

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

Health and Wellbeing Board
Minutes – 4 September 2013

Attendance

Cllr Sandra Samuels (Chair) – Cabinet Member for Health and Wellbeing
Dr David Bush – NHS Wolverhampton
Carol Lamyman – Healthwatch Wolverhampton (substitute for Maxine Bygrave)
Chief Superintendent Neil Evans – West Midlands Police
Cllr Steve Evans – Cabinet Member for Adult Services
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
Professor Linda Lang – University of Wolverhampton
Sarah Norman – Strategic Director for Community
Councillor Paul Singh – Shadow Cabinet Member for Health and Wellbeing

Staff

Viv Griffin	Assistant Director, Health, Wellbeing & Disability, Community Directorate
Andrew Lawley	NHS Property Services
Marianne Page	Section Leader, Transportation, Education and Enterprise Directorate
Sue Wardle	Consultant in Public Health, Community Directorate
Les Williams	Operations & Delivery Director, Local Area Team, NHS England
Richard Young	Director of Strategy and Solutions, NHS Wolverhampton
Carl Craney	Democratic Support Officer, Delivery Directorate

By Invitation

Alan Coe	Independent Chair, Wolverhampton Safeguarding Adults Board

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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 Maxine Bygrave (Chair, Wolverhampton Healthwatch), Guy Carson (Capital Projects Programme Manager, NHS Property Services and Councillor Val Gibson (Cabinet Member for Children and Families).

2. **Notification of Substitute Members**
Carol Lamyman for Maxine Bygrave (Wolverhampton Healthwatch).

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

4. **Minutes of the previous meetings (3 and 31 July 2013)**
Resolved:
That the minutes of the meetings held on 3 and 31 July 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**

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

The Chair, Councillor Sandra Samuels reported that a report in connection with the above would be presented by Les Williams, Operations and Delivery Director, Local Area Team, NHS England later in the meeting. The report had been admitted as an urgent item in accordance with Section 100B(4)(b) of the Local Government Act 1972.

- **Public Health Funding Allocation**

The Chair, Councillor Sandra Samuels reported receipt of a letter from Duncan Selby, Chief Executive, NHS England that the Public Health Funding Allocation would be ring-fenced for a third year to 2015/16.

Resolved:
That the Chair's Update be received and noted.

7. **Health and Wellbeing Forward Plan**
Viv Griffin presented the Health and Wellbeing Board Forward Plan for 2013/14.
Resolved:
That the Forward Plan be received and noted and that any additional items be notified to Carl Craney, Democratic Support Officer.

8, **Draft Recommendations on the Future of Services for Local People using Stafford and Cannock Hospitals – Consultation**
Dr Helen Hibbs presented a report in connection with the Trust Special Administrators' draft recommendations on the future of services for local

people using Stafford and Cannock Chase hospitals. The recommendations were currently the subject of a public consultation exercise primarily aimed at those patients who currently used those hospitals and advised the Board that any changes to service provision at New Cross Hospital would be the subject of a separate consultation exercise. She reported that the proposals contained within the recommendations included the Cannock Chase Hospital being managed by the Royal Wolverhampton NHS Trust and some services transferring from Cannock to New Cross Hospital. She advised that from the perspective of NHS Wolverhampton the proposals were to be welcomed as they presented an opportunity for more patients to utilise New Cross Hospital which, in turn, would serve to "future proof" the New Cross facility.

Carol Lamyman advised that Healthwatch Wolverhampton would be responding separately to the Trust Special Administrators' recommendations and that she had also been contacted by the BBC who was proposing to film an article in relation to the current position at the Accident and Emergency Department at New Cross Hospital.

Sarah Norman commented on the implications for the City Council with the likelihood of Wolverhampton residents being treated at Cannock Hospital and the effect on the Social Work Team. She reported that discussions were underway with Staffordshire County Council with regard to the mirrored position of Staffordshire residents being treated at New Cross Hospital.

Dr Helen Hibbs repeated her earlier comments that no firm decision had yet been made and that any proposed changes to services provided at New Cross Hospital would be subject to a separate consultation exercise. Les Williams confirmed this to be the case with any proposed major variation to existing services. Sarah Norman acknowledged the point but reminded the Board of the needs of the City Council to be prepared for the consequential effects of any changes.

Resolved:

That the proposals contained within the consultation document be noted.

9. **Report of the Chair of the Adults' Safeguarding Board**

Alan Coe, Independent Chair of the Wolverhampton Adults' Safeguarding Board presented a report which outlined the work undertaken by the Safeguarding Board to support adults at risk remain safe as summarised in the 2012/13 Annual Report. An Executive Summary of the Annual Report was circulated at the meeting.

Resolved:

1. That the contents of the report and the priorities set for 2013/15 be noted and supported both collectively and individually;

2. That the respective agencies be requested to ensure that the work of the Board is supported actively to ensure:

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

3. That the various bodies ensure that their representatives on the Board and relevant sub groups and task and finish groups of the various bodies are enabled to make a full contribution to the safeguarding agenda

10. **Joint Strategic Needs Assessment for Wolverhampton**

Ros Jervis and Sue Wardle presented a report on the process that had been used to produce the Joint Strategic Needs Assessment (JSNA) for Wolverhampton and invited the Board to approve the JSNA for publication at the earliest opportunity.

Sue Wardle advised that once approved, the JSNA would be published in a loose leaf format to aid with regular updating. She reported on the robust process which had been followed in the production of the document.

Bob Jones referred to the quantitative and qualitative information contained within the document but expressed concern that in Appendix 9 it appeared that none of the views of the City Councillors had been received. He questioned as to whether this was correct and, if so, whether the methodology behind the production of the document needed to be reviewed. Viv Griffin assured the Board that this gap had been noted but that the views of City Councillors had been sought and of their contributions through the various “Away Days” held leading to the production of the document.

Resolved:

1. That 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 Health and Wellbeing Strategy be noted;
2. That the JSNA be approved for publication by the Joint Health and Wellbeing Strategy Task and Finish Group in conjunction with Wolverhampton City Council Communications Team.

11. **Health and Wellbeing Strategy**

Viv Griffin reminded the Board that at the meeting held on 1 May 2013 the priorities for the Board and its sub-groups had been agreed for 2013/14 and the progress on the JSNA/ Health and Wellbeing Strategy (Mark 2) had been noted. The updating of the Health and Wellbeing Strategy (Mark 2) had been coordinated by the Task and Finish Group and was now complete. The updated Strategy needed to be considered alongside the refreshed JSNA (see above). She invited the Board to consider the updated Strategy.

Viv Griffin reported on her intention to produce and present a “Balanced Scorecard to future meetings of the Board to enable progress with the implementation of the refreshed Strategy to be monitored.

Carol Lamyman commented on her keenness to be involved in those aspects of the Strategy relating to Mental Health and undertook to arrange to meet with Viv Griffin to discuss this matter further.

Richard Young reported on the current position with regard to Urgent Care and that following the meeting of the Board held on 31 July 2013 the Strategy document was being re-drafted to take into account the views expressed at that meeting. The revised document would be presented to the meeting of the Board scheduled to be held on 6 November 2013 and would include a communication and engagement plan. The revised document would be presented to the Adults Delivery Board for consideration prior to its consideration by this Board.

He reported on the work which was underway in relation to a revised procurement methodology for the “Out of Hours” service including various alternative methods of delivering this service with a view to ensuring that patients received the right care in the right place at the right time. He also reported on attempts that were being made by NHS Wolverhampton in conjunction with the Royal Wolverhampton NHS Trust and the Local Area Team of NHS England to address a number of common misconceptions surrounding access to General Practitioners in Wolverhampton.

Professor Linda Lang drew to the attention of the Board a number of initiatives which had been discussed at a forum on Emergency Care which had been held in Birmingham in July and enquired as to whether any consideration was being given to these types of initiatives. Richard Young responded that NHS Wolverhampton had been represented at this particular forum and that the initiatives discussed were being considered actively for inclusion in the Wolverhampton Urgent Care Strategy.
Resolved:

1. That the draft Health and Wellbeing Strategy (Mark 2) be approved for publication;
2. That the best thanks of the Board be extended to the Task and Finish Group for its work on the production of both the JSNA and the Health and Wellbeing Strategy (Mark 2).
3. That the report on the current position in relation to Urgent Care be noted and that a further report on this matter be considered at the meeting of the Board scheduled for 6 November 2013.

12. **Feedback from Health and Wellbeing Board “Away Day” – Response to the Francis Inquiry**

Viv Griffin presented a report which informed 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 NHS Foundation Trust. It was 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 system response. The Group would be led and chaired by NHS Wolverhampton and include representation from social Care / Health Providers / Health Scrutiny / Healthwatch. Dr Helen Hibbs advised that NHS Wolverhampton would be willing to lead and chair the Group.
Resolved:

1.That the report be received and noted;
2. That the suggested Task and Finish Group be established and led and chaired by NHS Wolverhampton.

13. **Winterbourne Review – Implications for Wolverhampton**

Viv Griffin presented a report which described the findings of the investigations into the abuse of patients with learning disabilities at Winterbourne View Hospital and which summarised local work to date to respond to the National report Transforming Care: A National Response to Winterbourne Hospital. She drew to the attention of the Board proposals to go further in Wolverhampton in terms of inspections than required nationally and on the intention to use this inspection regime as an example of best practice.

Carol Lamyman commented on her keenness to be involved in those aspects of the revised working practices and undertook to arrange to meet with Viv Griffin to discuss this matter further.

Resolved:

That the report be received and noted.

14. **NHS Capital Programme**

Andrew Lawley reported on the current position with the following schemes in Wolverhampton:

- Bradley;
- Bilston Urban Village;
- The Scotlands; and
- Heath Town.

On behalf of the Board the Chair, Councillor Sandra Samuels expressed her concern and displeasure with the manner in which the progress or lack of progress on these schemes had come to the attention of the Board, inasmuch as it had been reported in the local press without first having been drawn to the attention of the constituent members. She advised that an apology had, however, been received from NHS England with regard to this matter.

Andrew Lawley explained that the precise responsibilities between NHS England and NHS Property Services with regard to informing partners of the position on schemes remained unclear between the 2 branches of the newly reconfigured NHS. Les Williams repeated his previous apology for the handling of this matter but assured the Board that where security of tenure of medical facilities was a primary cause of concern; this was being addressed as a priority issue.

Sarah Norman welcomed the comments now made by Les Williams but enquired as to whether, in the case of premises where security of tenure was an issue but the need for improvement works or possible re-location was of

equal importance, whether both components were being treated as priority matters, given the need to identify long term solutions rather than short term fixes.

Andrew Lawley advised on the need to re-visit the now outdated former Capital Strategies of the Primary Care Trust and of the intention of both NHS England and NHS Property Services to work with NHS Wolverhampton and partners to identify long term solutions to the current issues. Sarah Norman enquired as to when NHS England would be in a position to respond on the possible future use of Underhill House.

Councillor Steve Evans opined that the current position was a result of the transformation of the NHS and that under the current process he had felt, as the Cabinet Member for Adults, side-lined during the various discussions within the NHS, particularly with regard to the possible future use of Underhill House. He enquired as to the responsible body for the Capital Programme approval process, who that body was accountable to and how the Board could seek to influence the decision making process. Les Williams advised that this process was managed by NHS England, of the financial position of that body and offered an assurance that the Local Area Team of NHS England was endeavouring to secure satisfactory outcomes for the Birmingham, Solihull and Black Country area despite the competition for funding from a finite pot across the country.

Bob Jones sought clarification on the current budgetary position and as to whether the Local Area Team had a ring-fenced budget for use in its area. Les Williams and Andrew Lawley explained the division of responsibilities for the allocation of resources within the current NHS Operating Model. Andrew Lawley drew to the attention of the Board the specific issues which needed to be addressed at the Lower Bradley premises and the options available in the short term together with the steps which could be taken to affect a medium term solution to these particular issues.

Following a question from the Chair, Councillor Sandra Samuels, Les Williams advised that the Board could seek to influence the process via correspondence with either the Regional Director of NHS England (Paul Watson) or the Chief Executive of NHS England Dame Barbara Hakin).

Ros Jervis reported on the outcome of a visit to the Heath Town premises to conduct an inspection for Infection Prevention and Control purposes and of the outcome of the inspection. Andrew Lawley thanked the City Council for the proposals it had put forward with regard to the identification of suitable alternative premises.
Resolved:

> That the Regional Director of NHS England be requested to explain the apparent current impasse on improvements to Primary Care facilities in Wolverhampton and to attend a future meeting of the Board to respond to questions on a number of outstanding issues.

14. **Feedback from Sub Groups**

- **Children's Trust Board**

Sarah Norman presented a report which informed the Board of the work of the Children's Trust Board. She drew particular attention to the following issues which had been considered at the last meeting of the Children's' Trust Board:

- Work on new arrivals in the City;
- The 4 priorities identified in the new Children, Young People and Families Plan;
- The revised Mental Health and Psychological Wellbeing Strategy for Children and Young People;
- Challenges faced by the City Council with the increasing number of Looked After Children.

Sarah Norman responded to a number of questions regarding the latter issue and reported on plans to recruit additional Social workers to assist with this matter.

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 and drew to the attention of the Board the strong correlation between the work of the Adults Delivery Board and the contents of the Health and Wellbeing Strategy.

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 with regard to the development of a work plan and highlighted the latest developments in relation to the Public Health Transformational Fund, namely the:

- Eligibility criteria;
- The process for submitting bids; and
- The process for assessing bids and making decisions on allocations.

Resolved:

That the report be received and noted, in particular the progress on the Public Health Transformational Fund and that the process, criteria and the Board's role in approving / ratifying recommended projects be endorsed.

16. **Bus Service Connections to New Cross Hospital**

Marianne Page presented an updated report on the continuing work to improve public transport accessibility to New Cross Hospital.

Resolved:

That the report be received and noted and that a copy of any response received from the letter to the Integrated Transport Authority agreed at the meeting held on 3 July 2013 be circulated to all members of the Board.

Urgent Item

The NHS belongs to the people: A Call to Action

(In accordance with Section 100B(4) (b) of the Local Government Act 1972 this item was admitted for consideration)

Les Williams presented a report in relation to the document "The NHS belongs to the people: A Call to Action" which had been published by NHS England on 11 July 2013. He explained the contents and purposes of the document.

Viv Griffin enquired as to when comments on the document needed to be submitted. Les Williams advised that the closing date was December 2013. Sarah Norman suggested that given the current transformation programme both locally and nationally the contents of the document needed to be amended and integrated to reflect the work being undertaken locally to be meaningful to the local health economy. She advised that there would be a reluctance to adopt nationally dictated templates and communication plans which did not accurately reflect the current local position. Dr Helen Hibbs commented that many of the issues which were contained in the document were day to day matters for NHS Wolverhampton which would be undertaken as a matter of course. She suggested that there was an urgent need to align national and local pieces of work.

Les Williams advised that, from the NHS England perspective, the concentration on outcomes rather than the form of engagement would be paramount. He outlined the range of publicity material which could be made available for the various proposed engagement events.

Resolved:

That the publication of the document now presented be noted.

Agenda Item No. **5**

Health and Wellbeing Board
6 November 2013

Report Title	Summary of outstanding matters	
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards Affected	All	
Accountable Strategic Director	Sarah Norman, Community	
Originating service	Delivery	
Accountable officer(s)	Carl Craney Tel Email	Democratic Services Officer 01902 55(5046) carl.craney@wolverhampton.gov.uk

Recommendations for noting:
The Health and Wellbeing Board is asked to note:

1. The current position.

1.0 Purpose

1.1 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 Background

2.1 At previous meetings of the Shadow Board /Board the following matters were considered and details of the current position is set out in the fourth 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	CLINICAL COMMISSIONING GROUP – COMMISSIONING INTENTIONS	RICHARD YOUNG	Report to January meeting.
1 MAY 2013	CHILD POVERTY – TIMELINES, SIX TARGET WARDS AND MEMBERSHIP	KEREN JONES	Report to a future meeting

	OF STAKEHOLDER WORKSHOP		
31 JULY 2013	DRAFT URGENT AND EMERGENCY CARE STRATEGY	RICHARD YOUNG	Report to November meeting

4.0 Financial / Legal / Equalities/ Environmental / Human resources / implications

4.1 None arising directly from this report.

5.0 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

Agenda Item No: **7**

Health and Wellbeing Board

6 November 2013

Report Title	A Joint Strategy for the Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17	
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards Affected	All	
Accountable Strategic Director	Sarah Norman, Community	
Originating service	Wolverhampton Clinical Commissioning Group and the Royal Wolverhampton NHS Trust	
Accountable officer(s)	Dr Morgans	WCCG Governing Body Member, GP lead
	Dr Odum	RWT Medical Director
	Tel	01902 444878
	Email	r.modiri@nhs.net
		Media enquiries are handled for Wolverhampton CCG by the Central Midlands CSU Media Team - telephone: 0121 612 3888 email: mediacsu@nhs.net

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Approve the proposals as set out in the Strategy document;
2. Supports the consultation document and engagement plan.

Recommendations for noting:

The Health and Wellbeing Board is asked to note:

1. The limitations for the consultation process.

1.0 Purpose

1.1 To provide the Health and Well Being Board with the draft Urgent and Emergency Care Strategy for Wolverhampton for approval. The recommendations from the Health and Well Being Board in July 2013 have been incorporated within the draft strategy document.

1.2 The Urgent and Emergency Care Strategy has been developed for the city of Wolverhampton and for patients who reside elsewhere but who use our services. The strategy describes a cohesive response to the significant pressures seen within the urgent and emergency care system to ensure that the future system can flex to manage surges in activity, is high quality and affordable for the local health economy. The existing system was not designed to cope with the levels of activity being seen at urgent and emergency care services across the city and can be confusing and complex for patients to navigate. Doing nothing is not an option.

1.3 In anticipation of the Health and Well Being Board’s support for the strategy and the limitations on possible dates for consultation, a Communication Plan has been developed together with a Consultation Document to prepare for the consultation process. Patients have helped us to develop these documents.

2.0 Background

2.1 Wolverhampton Clinical Commissioning Group (WCCG) and the Royal Wolverhampton NHS Trust (RWT) are wholly committed to improving the health and wellbeing of our population. We have worked with our health and social care partners to develop a joint urgent and emergency care strategy for patients from Wolverhampton and for those who use our services.

2.2 The pressure seen by the urgent and emergency care system in Wolverhampton is unsustainable. Performance on a number of important indicators has worsened over the winter period in 2012 and has continued into 2013. Indicators including how quickly patients are seen, discharged or admitted at the Emergency Department are particularly affected. This deterioration is also reflected in the experience and quality of care patients receive.

2.3 This strategy is centred on improving service provision by examining the whole urgent and emergency care system and describing the proposed arrangements for the future system in Wolverhampton until 2016/17. The strategy focuses on urgent and emergency care however it is interlinked with other strategies being developed for the city such as primary care, long term conditions, mental health, end of life care, health inequalities and intermediate care amongst others. Short to medium term solutions are being developed alongside the strategy and will be delivered in 2013/14.

2.4 This strategy intends to improve quality and translates local and national policy into action, outlines the local context, current activity and defines how the vision for urgent

and emergency care will be delivered through a simplified, proactive and flexible system that directs patients to the right service in the right place at the right time.

2.5 There are 4 phases to the delivery of the strategy including:

Phase 1 – Consult (Dec 13-Dec 14)

- Publish strategy & consult to understand patient & stakeholder views
- Work with patients & local partners to develop regular & consistent communication methods & promotional campaigns
- Work with Equality leads to undertake an equality impact assessment
- Include the outcomes of the consultation to develop an implementation plan

Phase 2 – IMPROVING PRIMARY CARE (Nov 13 -Dec 16)

- Work with our patients and partners to make changes in Primary Care including a GP home visiting scheme and improving timely access to GP practices
- Improve the quality and integration of out of hours services into the new Urgent Care Centre in 2016
- Develop the required primary care provision required at the front door of ED, test and embed the model working towards 2016
- Develop improved high quality, integrated pathways of care across primary and secondary care supported by telephone access through NHS 111 and WUCTAS
- Undertake focused work on over 65 years (including care homes) and 0-5 years

Phase 3 – IMPROVING SECONDARY CARE (Nov 13-Dec 16)

- Work with our patients and partners to make changes in Secondary Care including service provision and improving timely access
- Work together to develop the new Emergency Department
- Develop standards of care including senior decision makers at the start of the patients journey from ED
- Work with local authority partners to improve rapid access to social care and seamless service provision across health and social care including care homes
- Work with Mental Health partners to improve urgent and emergency care provision and response times for patients in crisis

Phase 4 – REVIEW & AMEND (On-going)

- On-going review of system capacity during changes in phases 1-3 & identify additional changes required to respond to surges in activity
- On-going review of efficiencies and reinvest finances to manage future growth
- Continually develop the IT systems and information sharing required ensuring data is accurate, timely & routinely used
- Monitor activity to identify negative impacts on services further to changes being implemented
- Work with other commissioning areas to develop the urgent care elements of strategies (mental health, social care, end of life, public health, etc) to prevent ED attendance and emergency admissions
- Continue to work with partners and providers such as public health and WMAS to deliver improvements in the quality of service provision for patients

2.6 A consultation plan and supporting patient consultation document has been developed with patients, for patients. The timescales for the Consultation are not yet confirmed however are expected to start in December 2013. The consultation process must end before the 'Purdah' period begins (dates are not yet known). It is envisaged that once the public consultation is complete, a feedback report will be available to update the public on any changes to our plans.

2.7 The Health and Well Being Board's support is vital in taking the strategy work forward.

2.8 The draft strategy will be presented to the Health Scrutiny Panel on Thursday 7th November 2013 together with feedback from the Health and Well Being Board.

3.0 Progress, options, discussion, etc.

3.1 Further to the Health and Well Being Board in July 2013, the Joint Urgent and Emergency Care Board have considered the valued feedback from members and work has been undertaken to further develop the joint Urgent and Emergency Care Strategy to incorporate the required changes.

4.0 Financial implications

4.1 The strategy provides the strategic direction for urgent and emergency care in Wolverhampton. Any savings and financial implications of the strategy will be developed within the implementation plan for strategy delivery.

5.0 Legal implications

5.1 Procurement and legal implications will be incorporated as part of the programme planning work and will included within the implementation plan.

6.0 Equalities implications

6.1 The Urgent and Emergency Care Board is fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity, so that we can remove or minimise disadvantages between people who share a protected characteristic and those who do not. All Urgent and Emergency Care services will ensure that services are appropriate and do not discriminate on the basis of the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or beliefs, sex and sexual orientation. Where services are required based on age, the reason will be on the grounds of service provision such as children's services or services aimed specifically at older adults due to the nature of their conditions. Further details can be found in Appendix 1 of the strategy document. The rights and pledges contained in the NHS Constitution will be upheld at all stages of the patient journey through Urgent and Emergency Care.

7.0 Environmental implications

7.1 Procurement and legal implications will be incorporated as part of the programme planning work and will included within the implementation plan. The new Emergency Department building will be required as part of the strategy work to support the system changes required.

8.0 Human resources implications

8.1 Workforce planning will be part of the individual service changes.

9.0 Schedule of background papers

9.1 Version 10 of the Joint Urgent and Emergency Care Strategy was presented to the Health and Well Being Board in July 2013.

10.0 Key Risks

10.1 Key risks relating to the strategy process

10.1.1 The consultation period must start in December due to the limitations on consulting during the Purdah period (dates not yet known);

10.1.2 The development of the business case for the new Urgent and Emergency Centre is required by March 2014 due to the enabling and building works to facilitate the new Urgent and Emergency Centre opening in early 2016. Any delays in the strategy sign off or the consultation process will cause significant consequences to the business case approval and subsequently the building process;

10.1.3 The existing contracts for services such as the walk in centre at Showell Park and the GP Out of Hours service are due to expire in 2014. Decisions must be made by December 2013 to support the future of commissioning of these services.

10.2 Key risks relating to the Strategy:

10.2.1 If change to the system is not delivered, key quality measures are likely to be missed;

10.2.2 Our patients have told us that they are confused about how and where to access urgent and emergency care and are using ED as a default. Without the changes to simplify the system there will continue to be additional pressure over sustained periods of time – patients using the Emergency Department, walk in centres, GP Practices and the West Midlands Ambulance Service will be particularly affected;

10.2.3 Patients are using the ED in the out of hours period rather than accessing the GP out of hours service due to difficulties with accessibility, location and confusion on operating hours and accepted conditions. Existing contracts are limiting changes being made to service provision – this cannot be sustained;

10.2.4 The existing Emergency Department was not designed to cope with the existing level of patients using the service. A new centre is required to reduce risk to patient care due to limited space. The building will also provide the opportunity to bring services together and deliver the national agenda for services to provide a 24/7 urgent and emergency care response to patients using services;

10.2.5 There are significant financial implications for the health economy resulting from the increases in activity and particularly the Emergency Department. The future system must be affordable for the future;

10.2.6 The implications of changes at Mid Staffordshire NHS Trust are not yet known however there is a risk that the existing system in Wolverhampton will not cope with additional activity from neighbouring CCG's unless change is made;

10.2.7 The increased pressures and the onset of winter will result in a further decline in the quality of patient care.

October 2013

Draft Communications, Engagement and Consultation Plan

Communications to tell the story

A schedule of communications will take place between October and December in order to inform clinicians and staff within our organisations, partner organisations, patient/community groups and the public about the forthcoming consultation. The objective will be AIDA – to get attention, leading to interest, leading to people's desire to take part, and leading to action – i.e. attending an event or completing a feedback form.

Message principles and process

- All messages will be agreed and issued jointly by WCCG and RWT;
- Communications will be shared across 'owned and earned channels' – the free things like internal newsletters and social media, but also through local media and information cascades within community and patient groups.
- All written pieces will include a quote from clinical leads from both organisations.
- All messages will uphold the NHS communications values:
    - Clear and professional: demonstrating pride and authority in what we do.
    - Cost-effective: showing that budgets have been used wisely.
    - Straightforward: avoiding gimmicks and over complicated design or wording.
    - Modern: portraying the NHS in a way that is up to date.
    - Accessible: understood by the target audience and easily obtainable and, where appropriate, available in other languages, symbols or formats.
    - Honest: avoiding misleading information or false promises.
    - Respectful: showing respect for our audience, avoiding unfair stereotypes, acknowledging the different needs of individuals and populations.

Activity

There will be the following communications messaging activity (please note timescales will be determined when the project timeline are confirmed).

Audience	Date	Action	Key message
Public	*Oct 13 – March 14*	*(Part of another strategy)* *Choose well campaign will run across various media – twitter, web, press, radio and phone app.*	• *Encourages residents to choose the right service for their urgent and emergency care.*

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Internal	Late Oct 13	Joint message to GPs and staff within the CCG, social care and public health – this will be run through respective internal communications channels: • Team W (GPs – 23 Oct) • Practice Managers Forum (29 Oct) • CCG intranet	• Explain the review, reasons for undertaking it and set out overarching consultation approach.
Stakeholder /public	Late Oct/early Nov 13	Message to key stakeholders including councillors, providers, neighbouring CCGs and patient groups through the CCG's **Partner News** newsletter	• Explain the pressure we see as we head into winter; • Urge people to 'choose well' and why it's important; • Explain the review, reasons for undertaking it and set out overarching consultation approach.
Public	Late Oct 13	Media release featuring a quote from key clinical leads, linked to pressures or something else seasonal/topical	• Explain the pressure we see as we head into winter; • Urge people to 'choose well' and why it's important; • Explain the review, reasons for undertaking it and set out overarching consultation approach.
CCG staff	13 Nov 13	Team meeting	• Presentation to reiterate the review, share feedback from Health and Wellbeing Board, and explain the consultation process/timescales.
Stakeholder /public	Mid November 13	Filming key clinical leads and members of public	• Ask public about their experiences and pull-out key issues and themes; • Film clinical leads explaining the proposed solutions.
GPs	27 Nov 13	Team W presentation	• Presentation to reiterate the review, share feedback from Health and Wellbeing Board, and explain the consultation process/timescales.
Public	Late Nov 13	Web content	• Main banner on web home page to dedicated to the forthcoming urgent care strategy.

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Public	Early Dec 13	Media release	• Promoting season messages around access; • Trailing the consultation, inviting people to have their say on urgent care through a 12 week public consultation.
Public	Late Dec/Early	Express and Star advertorial in the 'new year, new you' promotion	• We will promote the consultation events and invite people to complete a survey.
Consultation runs 6 January – 6 April			
Public	Jan 14	12 Hours in A&E – live tweeting	• Live tweeting from A&E to highlight the pressures, problems, mis-use and heart-warming stories over a 12 hour period; • Promote opportunities for people to have their say.
Public	w/c 6 Jan 14	Media release	• Promote the start of the consultation. Offer an interview with clinical leads or senior management figures to explain the vision for urgent/emergency care and how people can get involved.

Communications tools

The following communications tools will be developed in order to support understanding of the changes we are proposing and reasons for making them:

- Consultation document that explains the problems, proposals for change and how to take part;
- Single page fact sheet that summarises the consultation document for sharing across staff/stakeholder/public groups;
- FAQ database – this will be added-to when new questions arise;
- Social media including Facebook, Twitter and Netmums – these will offer debating forums where views can be captured;
- Videos – include interview with key clinical leads and patients/members of public (talking heads);
- PowerPoint pack to help PPGs, patient and community groups to cascade information on the consultation;
- Web site (www.wolverhamptonccg.nhs.uk/urgentcare) containing information, all key documents and also survey;
- Blog by clinicians and staff at urgent/emergency care centres allowing feedback and discussion with members of the public;
- Web survey, replicating the survey at the back of the consultation document

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- A6 post cards promoting the consultation in 'light engagement' venues such as school nurseries, libraries and other community venues;
- Advertising in local media, billboards and cinemas will be explored.

Consultation methodology (all to run within the consultation period)

- 3 locality 'round table' meetings – South East, South West and North East – primarily aimed local residents;
- One city-wide event at a central venue – aimed at partners/stakeholders, patients and public;
- Drop-in sessions/a stand at the key urgent and emergency care centres through-out the consultation period;
- Information will be shared throughout all of the CCG's engagement groups (see below), providing advice and the opportunity for people to take part:
    - Joint Engagement Assurance Group (JEAG)
    - GP Practice Partnership
    - Patient and Public Partnership
    - Clinician and Allied Professionals' Forum
    - Community Leaders' Forum
    - GP Locality Groups
    - PPG Locality Groups
    - Patient Partners (members scheme)
- We will consult the Wolverhampton Equality Forum to ensure our consultation is accessible for hard-to-engage groups;
- The consultation will meet the requirements ad principles contained within the One City Community Engagement Strategy.

Key stakeholders

- Service users and public
- Carers Service
- GPs and practice staff
- Staff (broken down to staff group if necessary i.e. frontline, commissioning etc)
- Management: senior managers, Governing Body members
- Other Primary Care colleagues (dentists, pharmacists, opticians)
- Local committees (Medical/Dental/Pharmaceutical/Ophthalmic)
- Wolverhampton Public Health
- City Council including councillors
- Other civic partners such as police, fire and ambulance
- Businesses/employers e.g. Chamber of Commerce
- Overview and Scrutiny Committee (OSC): Carl Craney (Carl.Craney@wolverhampton.gov.uk)
- Health and Wellbeing Board: Earl Piggot-Smith (earl.piggott-smith@wolverhampton.gov.uk)
- Local Councillors and MPs – contact the Communications and Engagement Team for the latest list of these including information on their key areas of interest
- Healthwatch Wolverhampton (Chair: Maxine Bygrave - mbygrave@me.com)
- Other NHS partners (providers, neighbouring CCGs, NHS England)
- Media
- Third and voluntary sector
- Community and social groups (e.g. residents' associations)

DRAFT

- School, college and university students
- Nursery schools

Feedback Requirements

Further to the consultation process, a feedback document will be developed for patients and stakeholders to update them on the outcomes of the consultation process.

NHS
Wolverhampton
Clinical Commissioning Group

Plans for Urgent & Emergency Care in Wolverhampton

Have your say

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Proposals from Wolverhampton Clinical Commissioning Group and Royal Wolverhampton NHS Trust for improving the quality of urgent and emergency care in Wolverhampton – Working in Partnership

Consultation from December 2013 to February 2014

Welcome

Wolverhampton Clinical Commissioning Group (CCG) and the Royal Wolverhampton NHS Trust are working together to improve the quality of the services we deliver.

We'd like to invite you to give us comments on our proposal to improve urgent and emergency care in Wolverhampton.

More and more people are using urgent and emergency care services every year and the system wasn't designed to cope with these numbers. We need to make system-wide changes now to make sure that we can continue to provide high quality services in the future. **Doing nothing is not an option.**

We have already spoken to hundreds of local people to get their views on how our services can be improved to help develop our plans. We want to make sure that our proposals for urgent and emergency care meet the needs of people using the services in Wolverhampton and we'd like to hear from you.

We hope you will read our consultation document and tell us what you think. There will be plenty of opportunities for you to have your say over the next three months. We will then review all your feedback and build this into our plans.

Your views are really important to us. We need your help to build an urgent and emergency care system for the future.

Dr Julian Morgans
GP Clinical Lead
Wolverhampton Clinical Commissioning Group

Dr Jonathan Odum
Medical Director
Royal Wolverhampton NHS Trust

How we plan to improve urgent and emergency care

We aim to simplify and improve urgent and emergency care services so that they are used in the best way by everyone. This is our plan for how we want to improve the city's urgent and emergency care in the future.

At the heart of our plans is the move to bring together some of the city's urgent and emergency care services into one building, which is expected to open in early 2016. This will be a brand new purpose-built centre will be open 24 hours per day and 365 days per year at New Cross Hospital.

We don't have a name for the new building yet but for now we will call it the new **Urgent and Emergency Centre.**

Patients will go through one door and will be directed to the best service to deal with their urgent or emergency care problem – whether that is to see a GP, a nurse or an emergency department doctor.

The new centre will bring the existing Emergency Department (sometimes known as ED, A&E or Casualty), the GP out of hours service and the walk-in service provided at Showell Park into one building at New Cross Hospital. All the other services in the Showell Park building will stay the same.

Wolverhampton CCG also plans to improve the other services that work alongside urgent and emergency care, including access to GP appointments, the management of long term conditions and end of life care, so that everyone gets the right care, in the right place, the first time.

Why do you call it ED and not A&E or Casualty?

ED or Emergency Department is the term that is used in many places across the country to describe the department most of us know as A&E or casualty. Changes to emergency medicine have encouraged the term Emergency Department to be used rather than A&E because it describes what happens when you attend the ED – it is for emergency treatment.

We believe the term more accurately describes the service and makes it easier for people to know where to get help in an emergency.

Right care, right place, first time

We will help patients to understand where to go for their urgent and emergency care needs through regular promotional campaigns. Lots of patients have told us their main reason for choosing to go to ED or a walk-in centre is due to difficulties in getting a GP appointment. Over the next three years, we will aim to make it easier for people to reach their GP practice through telephone, internet or face to face appointments.

We will also bring some of the existing services together into a state-of-the-art centre that will provide higher quality care in more comfortable and pleasant surroundings. It will be able to cope better during busy periods and can be adapted to meet the changing needs of people in the years ahead.

NHS 111 will continue to be available for patients to help them to choose the right place to go for their urgent care need.

Improving quality

Experienced doctors and nurses will be available early on in a patient's care to make decisions on the best service to treat them. Staff will work together so that if a patient needs urgent or emergency care quickly, the right people are available to see and treat them.

Working 24/7

The new centre at New Cross Hospital will be open 24 hours per day, 365 days per year. It will also have a rapid response visiting service that will be available for patients who need urgent care fast, but can't get to the centre. These could be people in residential or nursing homes, for example.

Changes to the system in 2016/17

The Urgent and Emergency Care System **Now**

Open 8am - 6.30pm mostly Mon - Fri	Open 24/7	Open 10am - 7pm Mon - Sun	Open 8am - 8pm Mon - Sun	Open Mon-Fri 6.30pm-8am Open Sat-Sun 24 hours	Open 24/7
GP Practices	NHS 111	Walk-in Centre at the Phoenix Centre	Walk-in Centre at Showell Park	Phoenix Centre Out of Hours	Emergency Department

The Urgent and Emergency Care System in the **Future**

Open 8am - 6.30pm mostly Mon - Fri	Open 24/7	Open 10am - 7pm Mon - Sun	Open 24/7
GP Practices	NHS 111	Walk-in Centre at the Phoenix Centre	Emergency Department

What is urgent and emergency care?

The terms urgent and emergency can mean different things to different people. With so many services available, it's no wonder that our patients have told us they are unsure about the different options available to them.

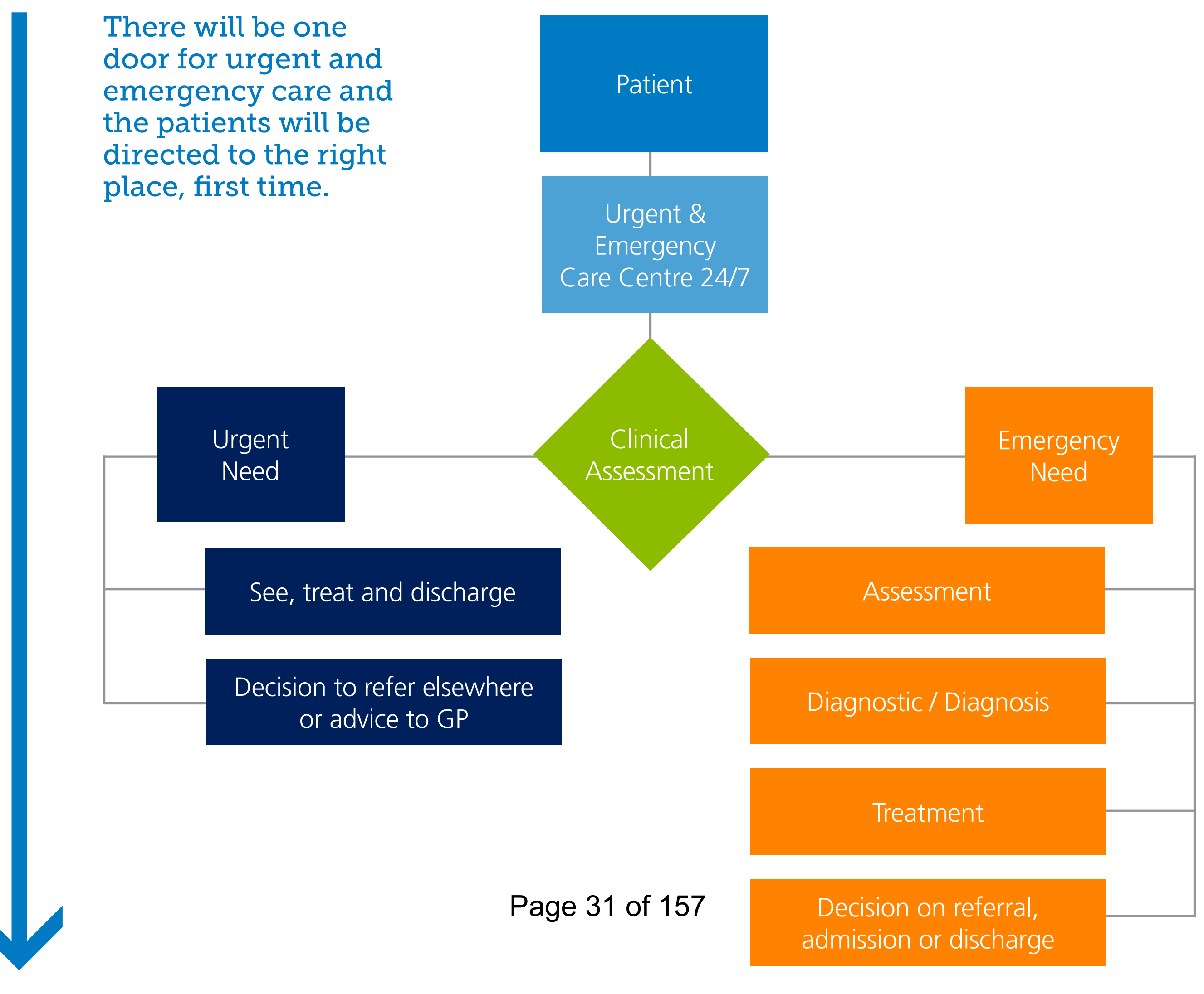
Urgent care

For minor illnesses or injuries where you can't wait for a routine appointment to see a doctor or nurse. These could include ear pain, rash, headache, minor burns and scalds, sprains and wounds. You can get urgent advice or treatment from a pharmacist (a chemist), NHS 111, a GP or a walk-in centre and, when your GP practice is closed, the GP out of hours service.

Emergency care

For life-threatening illnesses or injuries. These could include chest pains, loss of consciousness, severe loss of blood, choking, fits that aren't stopping or breathing difficulties. If you experience any of these symptoms you should dial 999 immediately.

The new Urgent and Emergency Department
the right care, the first time



How did we develop our plans?

Senior doctors have led the process of developing our plans. We know the only way of getting the right urgent and emergency care system is by working with local patients and partner organisations. We have spent almost a year talking to patients, doctors, nurses and the public to develop a strategy, and have considered different ways of changing the system.

December 2012	We talked to a total of 180 users of urgent and emergency care services through surveys and focus groups on how they used services and what they perceived the problems to be.
December 2012 – June 2013	We reviewed information on how people use our services and how much they cost. We also spoke to many organisations that are involved with health and social care to get their views.
March – April 2013	We surveyed doctors and nurses and held a patient and public workshop. Both allowed us to test some of our thoughts about how we might tackle the problems we have identified. We looked at many alternatives – including doing nothing – but there was clear support for changing the urgent and emergency care system as a whole.
12-13 July 2013	We surveyed visitors to our stall at the Wolverhampton City Show in West Park on their general experiences of using urgent and emergency care and how they felt these could be improved.
July 2013	We brought all the feedback and information together to design our urgent and emergency care strategy.
31 July 2013	We presented a draft strategy to the city's Health and Wellbeing Board. Here we received important recommendations on how we should improve the draft strategy.
August – October 2013	We worked with patient representatives to design a public consultation, taking into account the needs of local people such as accessibility, how to keep people updated and involved, and what questions we should ask. We also continued the work to update the strategy.
November 2013	We agreed that the strategy should go out for public consultation.

Visit www.choosewellmidlands.nhs.uk

Choose Well
when you are unwell

There's a range of NHS services on your doorstep...

Symptoms	Service	When to use
Choking Chest pain Blackout Blood loss	**ED or 999**	Life-threatening situations and emergencies
Unwell? Unsure? Confused? Need help?	**NHS 111** (CALL 111 – when it's less urgent than 999)	When you need medical help fast but it's not a 999 emergency
Cuts Strains Itches Sprains	**Walk-in Centre**	Open until late for minor injuries and illnesses
Vomiting Ear pain Sore belly Back ache	**Your GP**	If you have an illness or injury that won't go away, make an appointment with your GP
Diarrhoea Runny nose Painful cough Headache	**Pharmacy**	For advice on common illnesses and medicines to treat them
Hangover Grazed knee Sore throat Cough	**Self-care**	Stock up your medicine cupboard at home

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Why do we need to change?

The pressure in urgent and emergency care is a problem right across England. Whilst we would expect winter to be very busy, this year pressure has continued into the summer, which is causing longer waits and rising costs.

Patients tell us they can't get a GP appointment, or they don't know where to go when they have an urgent need. More and more people are choosing to use the walk-in centres and ED rather than their own GP.

The system wasn't designed to cope with the numbers of patients using the services today. Small fixes have been made to services, but there is a need to make system-wide changes. **Doing nothing is not an option.**

We need to make changes to urgent and emergency care services so that they are sustainable, high quality and work better together.

Services are duplicated and patients find them confusing

Our patients tell us that the current system is confusing. Having so many places to choose from can often result in people going from one service to another before they get the treatment they need. Patients don't know which service to go to at different times of the day or week.

Did you know?

In a survey we conducted almost one third of people said they had to visit two or more services to be treated when needing urgent / emergency care.

Some patients find it hard to get an appointment with their GP

Patients have told us that they find it difficult to get a GP appointment when they want one, or they don't even call their GP in the first place because they don't think they will get an appointment. GPs often are the 'first call' to the NHS but when patients find them difficult to reach, they end up using other services where they know they will be seen. This means some patients attend ED for minor illnesses or injuries. It is far better for these patients to be treated by a local GP or nurse who knows about all their healthcare needs.

Did you know?

In a survey we conducted, 56% of users of urgent / emergency services said they had tried to go to their GP first.

Increased use by patients

More and more people are using urgent and emergency care services. Therefore, we need to make changes now so that all services remain high quality and affordable.

Your local NHS working together

The NHS organisations responsible for buying, monitoring and providing care in Wolverhampton are working together to improve urgent and emergency care.

NHS Wolverhampton Clinical Commissioning Group

Formed in April 2013, Wolverhampton CCG is responsible for buying and monitoring healthcare for the city's 249,000 residents. These services range from routine s[illegible] home visits and learning disability servic[illegible]he ambulance service and emergency care from local hospitals and NHS trusts. We are led by the city's GPs and nurses and spend £326m a year with the aim of providing people with the right care, in the right place, the first time.

NHS Wolverhampton Clinical Commissioning Group

The Royal Wolverhampton NHS Trust

One of the largest NHS providers in the West Midlands, the trust provides hospital and community services for the people of Wolverhampton, the Black Country, South Staffordshire and the wider West Midlands.

With an operating budget of £374m, it employs more than 6,700 people and has more than 800 beds on two sites.

Our health and social care partners

South East Staffordshire and Seisdon Peninsula CCG

Serves a population of approximately 210,000 patients from Tamworth, Lichfield and South Staffordshire ([illegible]sdon). Some of the patients from Seisdon Pe[illegible] in particular use the ED service [illegible]t N[illegible] Cros[illegible] [illegible]spital. Seisdon consists of nine GP [illegible]kin[illegible] after a population of approximately

[illegible] GP practices from across Walsall, [illegible] 270,000 people. Some of Walsall CCG's [illegible] the ED service at New Cross Hospital.

[illegible]ampton City Council

[illegible] that the social care needs of people who live [illegible]ity are met. The council works closely with [illegible]rhampton CCG to help people stay at home [illegible]r than go into hospital wherever possible. Both [illegible]anisations are also working to tackle areas of poor [illegible]alth in Wolverhampton with the aim of helping [illegible]sidents to live longer, healthier lives.

Cannock Chase CCG

Made up of 27 GP practices serving a population of approximately 132,000. Some of Cannock Chase CCG's patients also use the ED service at New Cross Hospital.

Healthwatch

Responsible for making sure the public's voice is included in changes or developments that are made in healthcare and that they are in the best interests of patients.

West Midlands Ambulance Service

Provides the urgent and emergency 999 ambulance service to the West Midlands region, including Wolverhampton.

Black Country Partnership (BCP)

Provides mental health, learning disabilities and community healthcare services for people of all ages in Wolverhampton and the Black Country.

Frequently Asked Questions

How will my views help?

We want to make sure our plans for urgent and emergency care meet the needs of people using services in Wolverhampton. We've already asked some local people how they thought our services could be improved and used this information to help develop our plans. Now we'd like to hear from a wider group to help to build our detailed plans for urgent and emergency care services.

Why are you investing money in urgent care?

People aren't sure where to go. The current system can result in patients going from one service to another before they get the treatment they need. For people who need urgent care, we want to make sure the system is easier to understand and is improved.

Doing nothing is not an option. More and more people are using urgent and emergency care services every year. We want to continue to provide high quality services that we can afford in the future. If we don't make changes now, we will have big problems in the future because existing services won't be able to cope.

We want to improve the quality of urgent and emergency care services in Wolverhampton. By bringing some of the services and GPs, nurses and hospital doctors together, we can offer a better service, which will be available 24/7.

Are you making changes to save money?

This isn't about cost-cutting. We want to make these changes so that our urgent and emergency services remain high quality in the future. Sometimes the current services don't perform well (long waiting times, for example). We would like to improve and simplify urgent and emergency care in the city.

How will the new building at New Cross Hospital make it easier for me to use urgent care services?

It's essential that we direct patients to the best service for them. The new centre will be staffed by highly skilled doctors and nurses who are experienced in assessing and treating patients to give them the right care, in the right place, at the right time.

How will the changes make it easier for me to know where to go in the future?

People have told us that the services available now are confusing. They are open at different times of the day and week and treat different problems. By moving the GP out of hours and Showell Park walk-in services to the front door of the emergency department, we will make it much easier for people to know where to go. We would also like to make it easier for people to go to their GP in an urgent situation.

From 2016/17, where should I go if I need urgent care in normal working hours?

There is a service called NHS 111 that has already started in Wolverhampton to make it easier for people to know where to go for their urgent care. You can call 111 from a telephone when you have a condition that isn't life-threatening. They could advise you to rest at home or to go to a pharmacy, your GP, Phoenix Walk-in Centre or the new Urgent Care Centre at New Cross Hospital.

From 2016/17, where should I go if I need urgent care at night or at weekends?

NHS 111 can help at any time of the day or week. Call 111 if you have a condition that isn't life-threatening and trained advisors will help you choose the service that's best for you.

Will waiting times at New Cross be shorter?

Our plans will bring services and staff together and as a result, we are aiming to reduce the waiting times for patients using the new Urgent and Emergency Centre.

Who will pay for the new centre?

Local Clinical Commissioning Groups pay for the urgent and emergency care treatment that patients registered with GP practices in their area receive. The building of the new Urgent and Emergency Centre at New Cross Hospital is being funded mostly by the Royal Wolverhampton NHS Trust, but the services within it are paid for by local CCGs.

Why do you want to move walk-in services at Showell Park and not from the Phoenix Centre?

Many patients who use Showell Park also use ED, sometimes on the same day. By moving the walk-in service from Showell Park, we can minimise duplication by bringing the services together under one roof.

What will happen to the other services at Showell Park?

All other services, including the GP practice, will stay the same.

How will the proposed plan make it easier for me to get an urgent appointment with my GP?

We want to work with local GPs to improve their booking systems to make it easier for them to give urgent appointments when patients need them. We would also like to work with single- handed GP practices to encourage them to combine into larger groups.

If your plan will make it easier for me to get an urgent appointment with my GP, why does an Urgent and Emergency Centre at New Cross Hospital have to be open 24 hours a day, 365 days a year?

Even if every surgery could meet all its patients' urgent requests during normal opening hours, a large number of people with urgent needs would still go to the hospital. We need to make sure that the right services are available for them.

How will I get to the new centre?

There are buses that go to the New Cross site already, this will stay the same. There is also a new car park being built for people who use the new centre.

How will I get a prescription at the new centre?

There is a pharmacy at New Cross Hospital.

What will happen to urgent eye problems?

The will be no change to the process for patients who attend ED with urgent or emergency eye problems.

I don't live in Wolverhampton but I use ED at New Cross Hospital – what does it mean for me?

Patients living elsewhere in the country who need urgent and emergency care at New Cross Hospital will be treated in the same way as Wolverhampton residents. Patients will go through one front door of the new Urgent and Emergency Centre and will be directed by a clinician to the best place for their treatment (either the Urgent Care Centre or the Emergency Department) 24 hours per day, 365 days per year.

If I don't live in Wolverhampton, who will pay for my urgent and emergency care?

Most users of Wolverhampton's urgent and emergency care services who don't live in the city come from neighbouring CCG areas. CCGs are responsible for paying for treatment for their patients, whether they use services where they live or in another part of the country. For example, if a patient from Walsall uses ED at New Cross Hospital, Walsall CCG will pay for their treatment. We have been working with CCGs who have the highest numbers of patients who attend the New Cross ED to make sure that their patients are considered in these changes.

Get Involved – Have Your Say

We really value your views. From 2 December 2013 to 2 March 2014, we will be asking for your comments.

Please complete this form and send it back to us by 2 March 2014. We will review all your feedback and share our key findings with you in April 2014.

Email us to get involved

email address TBC

Please tick one of the following:

I agree strongly with the plans	
I agree with the plans	
I disagree with the plans	
I disagree strongly with the plans	

Is there anything else you would like to add?

I am responding to these plans as:

An individual	
A representative of an organisation or group	

What is the name and location of the group or organisation that you are representing?

We would like to know a bit more about you. This part is optional:

What is your gender?

Male	
Female	

What is your age group?

Under 18 years	
19-40 years	
41-60 years	
61-80 years	
Over 81 years	

Please provide the first four characters of your postcode.

This will only allow us to see the area you live, but not the house or street.

What is your ethnic group?

British White		British Asian	
Other White		Other Asian	
British Black		British Mixed Race	
Other Black (African or Caribbean)		Other Mixed Race	
		Don't Know	

Please return this form to us by 2 March 2014

Wolverhampton Clinical Commissioning Group
Technology Centre, Wolverhampton Science Park,
Glaisher Drive, Wolverhampton WV10 9RU

Thank you for helping us to shape the future of healthcare in Wolverhampton.

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A Joint Strategy for the Provision of Urgent and Emergency Care for Patients using Services in Wolverhampton to 2016/17

"Improving and Simplifying Arrangements for Urgent and Emergency Care"

'We must do things differently'

October 2013

Document Control

Purpose of this document

The purpose of this document is to provide key information for the future Urgent and Emergency Care System in Wolverhampton.

Version History

Version	*Issue Date*	*Brief Summary of Change*	*Author*
0.1	23/01/13	Initial draft	R Modiri

Document

Version	*Issue Date*	*Brief Summary of Change*	*Author*
0.1	21.02.13	Document Creation	RM
0.2	05.04.13	Include Patient engagement feedback	RM
0.3	17.04.13	Continuation of document content	RM
0.4	26.04.13	Circulation of initial draft	RM
0.5	29.04.13	Additions added to the strategy document	RM
Draft v3	29.04.13	Circulation of strategy document	RM
Draft v4	30.04.13	Circulated to Strategy group	RM
Draftv5.1	02.07.13	Circulated to Strategy Board	LL, DP, ML
Draft 6	10.07.13	Amendments to document	RM
Draft 7	15.07.13	Amendments	JO
Draft 8	16.07.13	Amendments from Strategy Board	RM
Draft 9	19.07.13	Amendments from core revision group	RM
Draft 10	23.07.13	Refinement by Core Revision Group	RM, LL
Draft 11	8.10.13	Amendments including from H&WBB	RM
Draft 12	11.10.13	Minor Amends from U&E Care Board	RM
Draft 13	18.10.13	U&E Care Boards Comments	RM
Draft 13.1	23.10.13	Core Group Comments	RM

Sign Off

Name	*Position*	*Date*	*Signature*
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Contents

1. Foreword 4
2. Statements of Support 5
3. Executive Summary 6
4. Introduction 10
5. What is Urgent and Emergency Care? 10
6. Who Are We? 11
7. Health and Social Care Partners 12
8. Strategic Context 14
9. Urgent and Emergency Care in Wolverhampton 16
10. How Much Do We Spend? 18
11. Challenges / Case for Change 19
12. Case for Change – Through Our Patients Eyes 21
13. Stakeholder Views 22
14. The Urgent and Emergency Care Strategy 22
15. Urgent and Emergency Care and Wider Strategies 27
16. Non Wolverhampton Residents Who Use Our Services 30
17. Delivery of Urgent and Emergency Care 32
18. Expected Benefits of the Strategy 32
19. Engagement with our Patients and Stakeholders 34
20. Conclusion 35
21. Appendix 1 - Equality and Diversity 37
22. Appendix 2 - Demographics 38
23. Appendix 3 - Strategic Context Supporting Information 42
24. Appendix 4 – Addition - Local and National Drivers 43
25. Appendix 5 - Existing Service Descriptions 46
26. Appendix 6 – Finance and Activity 49
27. Appendix 7 - The Case for Change Supporting Information 51
28. Appendix 8 – Glossary of Terms 57
29. Appendix 9 – References 58

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1. Foreword

Wolverhampton Clinical Commissioning Group (WCCG) and the Royal Wolverhampton NHS Trust (RWT) are wholly committed to improving the health and wellbeing of our population. We have worked with our health and social care partners to develop a joint urgent and emergency care strategy for patients from Wolverhampton and for those who use our services. We will place patients at the centre of our decision making and deliver this strategy through the newly established model of clinically led commissioning and collaboration across the health and social care economy. This model will bring about real differences for the health of our population and their experience of services.

The pressure seen by the urgent and emergency care system across the country is unsustainable. Performance on a number of important indicators has worsened over the winter period in 2012 and has continued into 2013. Indicators including how quickly patients are seen, discharged or admitted at the Emergency Department are particularly affected. This deterioration is also reflected in the experience and quality of care patients receive.

"We must do things differently."

Given the complex nature of patient flows across different services, urgent and emergency care cannot be commissioned in isolation and the process requires a multidisciplinary, whole system approach across acute, primary, community-based services, social care and mental health. Collaboration is vital to tackle some of the mounting problems in the city and must be with partners and patients who have and will continue to be at the forefront of the developments and their views integral to the final strategy.

This strategy is centred on improving service provision by examining the whole urgent and emergency care system and describing the proposed arrangements for the future system in Wolverhampton until 2016/17. The strategy focuses on urgent and emergency care however it is interlinked with other strategies being developed for the city such as primary care, planned care, long term conditions, mental health, end of life care, health inequalities and intermediate care amongst others. Short to medium term solutions are being developed alongside the strategy and will be delivered in 2013/14.

This strategy intends to improve quality and translates local and national policy into action, outlines the local context, current activity and defines how the vision for urgent and emergency care will be delivered through a proactive, robust system that directs patients to the right service in the right place at the right time.

This is important work to ensure that we develop an affordable, sustainable and high quality urgent and emergency care system for all of our patients.

Dr Julian Morgans
WCCG Lead – Urgent Care

Dr Jonathan Odum
Medical Director – RWT

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2. Statements of Support

South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group (SES&SP CCG)

South East Staffordshire and Seisdon Peninsula CCG have worked closely with Wolverhampton CCG and the Royal Wolverhampton NHS Trust and agree with the core principles and objectives outlined in this strategy. We will continue to work closely to support the joined up delivery of services across the local geographical boundaries to ensure our local population receives high quality urgent and emergency care.

Tim Dukes
For and on behalf of Seisdon Peninsular CCG

Wolverhampton City Council (WCC)

Wolverhampton City Council welcomes a strategy and is committed to one that works on partnership principles that support modernised ways of working. We share the need to focus on a better quality of outcome for citizens and look forward to taking this strategy forward.

Tony Ivko
For and on behalf of Wolverhampton City Council

West Midlands Ambulance Service NHS Trust (WMAS)

West Midlands Ambulance Service NHS Foundation Trust has worked closely with Wolverhampton CCG and the Royal Wolverhampton Trust and agrees with the core principles and objectives outlined in this strategy. We will continue to work closely to support the joined up delivery of services across the boundaries to ensure people get high quality urgent and emergency care.

Nick Henry
For and on behalf of West Midlands Ambulance Service NHS Foundation Trust

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3. Executive Summary

3.1 The pressures seen within the urgent and emergency care system has been a focus of attention in the press both nationally and locally. It is understood that there is no single cause for the increased pressure nor is there a single solution. The system in Wolverhampton was not designed to cope with the current unpredicted increase in activity which is unsustainable both in terms of quality and finance.

3.2 The focus of attention has been specifically on the Emergency Department and the ambulance service however the entire urgent and emergency care system has experienced increases in demand. Our patients are experiencing long waits and have told us that they are confused on how and where to access appropriate services. Doing nothing is not an option.

3.3 The pressure has prompted the creation of a joint Urgent and Emergency Care Board (U&ECB) with partners from Wolverhampton coming together to develop an Urgent and Emergency Care strategy for the city and to provide a commitment to work with our patients to develop a cohesive and sustainable way forward. The joint U&ECB brings clinicians and managers from health and social care commissioning and provider organisations together with public health and patients representatives. Further details of who we are can be found in sections 6 and 7.

3.4 Urgent and emergency care is a priority in Wolverhampton and this clinically led strategy focuses on the vision of urgent and emergency care for people resident within the city and for those who use our services. Services should be easy to access 24/7 and include urgent GP appointments, Walk in Centres, the Emergency Department, the Ambulance service and Emergency Admissions to hospital. The strategy will be subject to a consultation process further to which an implementation plan will be developed to set out the key deliverables for this work. The strategy outlines the vision and areas of focus however the 'how' will be detailed within the implementation plan.

3.5 It is clear from our extensive work with patients, that people will make choices that they feel are right for them, navigating the system the best way that they can because they don't know what to do or where to go for urgent help. The system has become complicated for patients and their expectations have led to immediate demands to be seen and treated for conditions that are not always urgent, with the default often being the ambulance service or the Emergency Department (ED). These demands on the system may not always be clinically appropriate. This places pressure on different parts of the system and creates wider financial pressures on the local health economy.

3.6 The public in Wolverhampton are becoming more aware that financial sustainability is an important factor in the commissioning and provision of services across the city (and country). It is a core principle within the NHS Constitution that the NHS is committed to providing best value for tax payer's money and the most effective, fair and sustainable use of finite resources. This strategy will improve the quality of urgent and emergency care service provision in Wolverhampton whilst still ensuring its affordability and sustainability. The savings required nationally from the system will be dealt with in the detailed Commissioning Plan for the city and not within this strategy.

3.7 The Department of Health's Vision for urgent and emergency care is of universal, continuous access to high quality urgent and emergency care services. In practice, this will mean that whatever an urgent or emergency care need, patients get the best care from the best person, in the best place at the best time. Urgent and emergency care are broad terms and include anything from a life threatening illness or injury to more minor

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illness or injury that needs urgent attention from health and social care professionals at any time of the day (both in and out of hours). Examples of the distinction between terms are provided in section 5.

3.8 The national landscape for urgent and emergency care is changing with the introduction of services such as NHS 111. National reviews such as that led by Sir Bruce Keogh (due Autumn 2013) are expected to set out principles that outline a system that provides consistently high quality and safe care across all seven days of the week, is simple and guides appropriate choices by patients and clinicians, provides the right care in the right place by those with the right skills, the first time and is efficient in the delivery of care and services. Locally, NHS England announced that its local area teams were drawing up A&E recovery plans. An A&E Recovery Plan has been developed for Wolverhampton to immediately tackle the local issues within the city, the implementation of which will be overseen by the U&ECB.

3.9 Further to the recent Francis Report and Trust Special Administrators (TSA) public consultation on the future of services at Stafford and Cannock Chase Hospitals, it is not yet clear what impact the outcomes will have on services in Wolverhampton. It is imperative that the future urgent and emergency care service provision in Wolverhampton is flexible and adaptable to cope with any fluctuations in activity. See section 8.9 for further detail.

3.10 Taking the views of our patients and stakeholders, and the extreme pressure the system has been 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 and 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."

3.11 The aim of the strategy is to improve and simplify arrangements for urgent and emergency care, to ensure that strong patient centred clinical leadership is available in all access points of the system, to provide better value for money and sustainability, and to provide greater consistency, transparency and openness. It is intended that the strategy will improve quality, safety and standards, provide better patient experience, service integration and be supported by the sharing of information with the regular reporting of outcomes. A no blame culture will be adopted with clinicians, managers and patients working together to improve the services offered to patients.

3.12 The strategic objectives include improved assessment and discharge, managing patient expectation whilst improving quality and timely access to services. Self-care will be encouraged, communication will be improved and patients will be actively identified through the use of risk stratification. The system will be seamless and consistent with the regular exploration and development of alternative solutions to improve quality and patient outcomes.

3.13 It is the intention of the U&ECB to deliver the strategy in phases. The chart below details the phased approach developed to deliver the strategy (further detail can be found in section 14):

2013	2014	2015	2016	2017

Phase 1 – CONSULT (Dec 13 – Dec 14)

- Publish strategy & consult to understand patient & stakeholder views
- Work with patients & local partners to develop regular & consistent communication methods & promotional campaigns
- Work with Equality leads to undertake an equality impact assessment
- Include the outcomes of the consultation to develop an implementation plan

Phase 2 – IMPROVING PRIMARY CARE (Nov 13 -Dec 16)

- Work with our patients and partners to make changes in Primary Care including a GP home visiting scheme and improving timely access to GP practices
- Improve the quality and integration of out of hours services into the new Urgent Care Centre in 2016
- Develop the required primary care provision required at the front door of ED, test and embed the model working towards 2016
- Develop improved high quality, integrated pathways of care across primary and secondary care supported by telephone access through NHS 111 and WUCTAS
- Undertake focused work on over 65 years (including care homes) and 0-5 years

Phase 3 – IMPROVING SECONDARY CARE (Nov 13-Dec 16)

- Work with our patients and partners to make changes in Secondary Care including service provision and improving timely access
- Work together to develop the new Emergency Department
- Develop standards of care including senior decision makers at the start of the patients journey from ED
- Work with local authority partners to improve rapid access to social care and seamless service provision across health and social care including care homes
- Work with Mental Health partners to improve urgent and emergency care provision and response times for patients in crisis

Phase 4 – REVIEW & AMEND (On-going)

- On-going review of system capacity during changes in phases 1-3 & identify additional changes required to respond to surges in activity
- On-going review of efficiencies and reinvest finances to manage future growth
- Continually develop the IT systems and information sharing required ensuring data is accurate, timely & routinely used
- Monitor activity to identify negative impacts on services further to changes being implemented
- Work with other commissioning areas to develop the urgent care elements of strategies (mental health, social care, end of life, public health, etc) to prevent ED attendance and emergency admissions
- Continue to work with partners and providers such as public health and WMAS to deliver improvements in the quality of service provision for patients

3.14 The Urgent and Emergency Care Board is fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity, so that we can remove or minimise disadvantages between people who share a protected characteristic and those who do not. All Urgent and Emergency Care services will ensure that services are appropriate and do not discriminate on the basis of the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or beliefs, sex and sexual orientation. Where services are required based on age, the reason will be on the grounds of service provision such as children's services or services aimed specifically at older adults due to the nature of their conditions. Further details can be found in Appendix 1. The rights and pledges contained in the NHS Constitution will be upheld at all stages of the patient journey through Urgent and Emergency Care.

3.15 This strategy intends to improve urgent and emergency care by providing a seamless, high quality system that communicates with patients and directs them to the right place for their care. The system will be sustainable, flexible and affordable. The new system has been designed to reduce duplication and to enable the system to flex during times of pressure. Primary Care should be accessible for our patients, Ambulances should wait no longer than 15 minutes to be turned around at ED and our patients should wait no longer than 4 hours to be seen, discharged or admitted from the new Emergency Department (and less from the new Urgent Care Centre) 24/7. To support the strategy, work must be undertaken jointly with our partners to ensure the patient journey is as seamless as possible.

3.16 This is important work and it is imperative that we start the process to significantly change the system so that urgent and emergency care provision can respond more effectively to patient's needs, provide high quality care and manage the challenges of activity changes.

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4. Introduction

4.1 The Health and Social Care Act 2012 initiated one of the most radical reforms to the NHS since its creation in 1948. The Act has major implications for the local health system and the relationship between that system and local government (Integrated Commissioning Plan 2013). The Coalition Government has enshrined the definition of quality into the Health and Social Care Act 2012. The Act now places new duties on the Secretary of State for Health, the NHS Commissioning Board, and Clinical Commissioning groups to act with a view to ensuring continuous improvement in the quality of NHS services.

4.2 The government is committed to the idea of a 24/7 urgent care service. This is reiterated in its White Paper, 'Equity and Excellence: Liberating the NHS' that has led to the current health reforms. "The government will develop a coherent 24/7 urgent care service in every area of England that makes sense to patients when they have to make choices about their care. This will incorporate GP Out of Hours services and provide urgent medical care for people registered with a GP elsewhere. It is intended to make care more accessible by introducing, a single telephone number for every kind of urgent and social care need and by using technology to help people communicate with their clinicians".

4.3 Over the years there have been many criticisms and frustrations from local people and healthcare professionals when it comes to having a more responsive urgent and emergency care service. In particular it seems clear that if presented with a responsive, high quality, reliable and accessible primary and community services then our patients would rather use these for many of their needs instead of going to the Emergency Department.

'People act differently when they are anxious' Patient Focus Groups Jan 2013.

4.4 The significant pressure on urgent and emergency care locally, has highlighted real concern about the sustainability of services and has resulted in collaborative and cooperative support from across the health and social care economy to facilitate change. Pressures relating to the announcement of further budget cuts within Wolverhampton City Council (WCC) can only add to these difficulties. The delivery of urgent and emergency care within the context of the model of care described in this strategy has been devolved to the joint Urgent and Emergency Care Board by the respective organisations. Change to the system is a must and doing nothing is not an option.

5. What is Urgent and Emergency Care?

5.1 When people in Wolverhampton are asked what they mean by urgent and emergency care, they talk about the need for an immediate or quick response in a variety of situations:

- When something critical or life threatening happens (a major accident, a deep wound, heavy blood loss or a suspected heart attack);
- When something is serious but not necessarily life threatening, but known by the individual or others to need immediate support (bad falls, initial chest pain);
- When something seems serious but you just don't know what to do (a child with worsening fever or an individual with stomach pains);
- When there is a minor injury which needs immediate attention (cuts, bruises);

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- When you suspect a common illness or condition, but are not sure what to do about it or need urgent help due to personal circumstances (to fit round work or care responsibilities) ***(Source: Patient Engagement January 2013).***

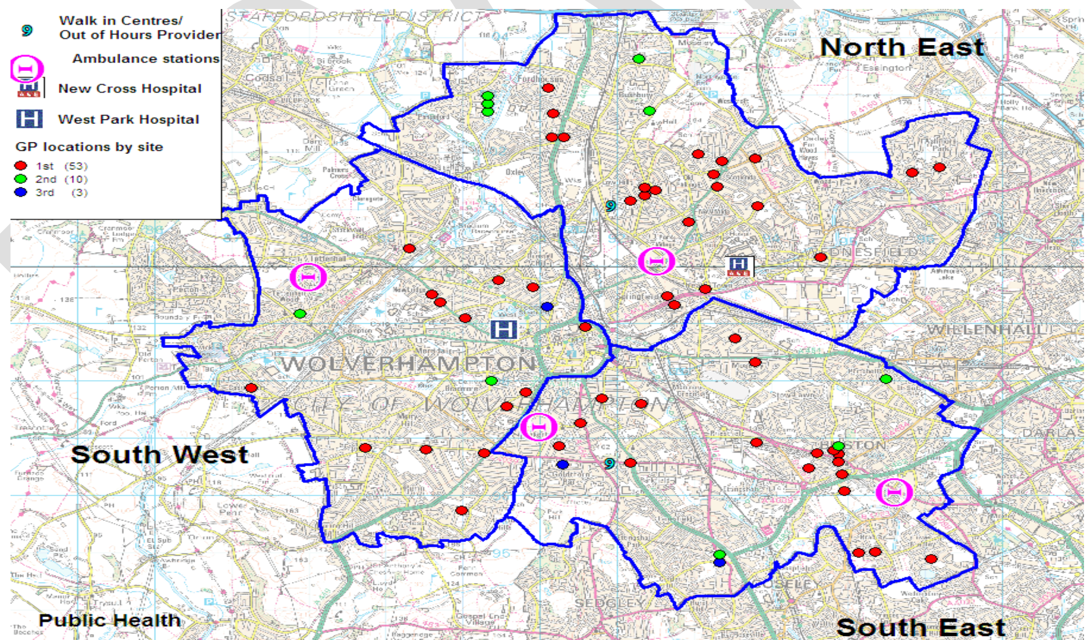
"People have different ideas on what an emergency is. Some people think that a headache is an emergency. They don't always know where to go or what it is" Patient Focus Groups Jan 2013.

5.2 Terms such as unscheduled care, unplanned care, emergency care and urgent care are used interchangeably. The Department of Health's guidance on telephone access to out of hours advice sought to clarify commonly used terms however we must ensure that the terminology used is clear for patients.

- Emergency Care = immediate response to time critical healthcare need
- Urgent Care = a response before the next in–hours or routine (primary care) service is available.

6. Who Are We?

6.1 **Wolverhampton Clinical Commissioning Group (WCCG) -** is a relatively new organisation formed in March 2012 from the amalgamation of two discrete clinical commissioning groups and formerly the Wolverhampton City Primary Care Trust. The CCG is responsible for managing approximately £327 million and is committed to developing an organisation that will deliver modern, high quality, integrated and value for money services for the people of Wolverhampton.



Picture 1. Map of Wolverhampton 2012/13

The Clinical Commissioning Group comprises of all of its 50 (soon to be 49) constituent GP practices however each GP Practice is commissioned individually by NHS England. Every GP practice in the city is aligned with the CCG and this provides the optimal environment to work with our partners and patients to improve outcomes by commissioning high quality, evidence based services. This will be achieved by focussing on health needs, outcomes, sustainability and building effective care

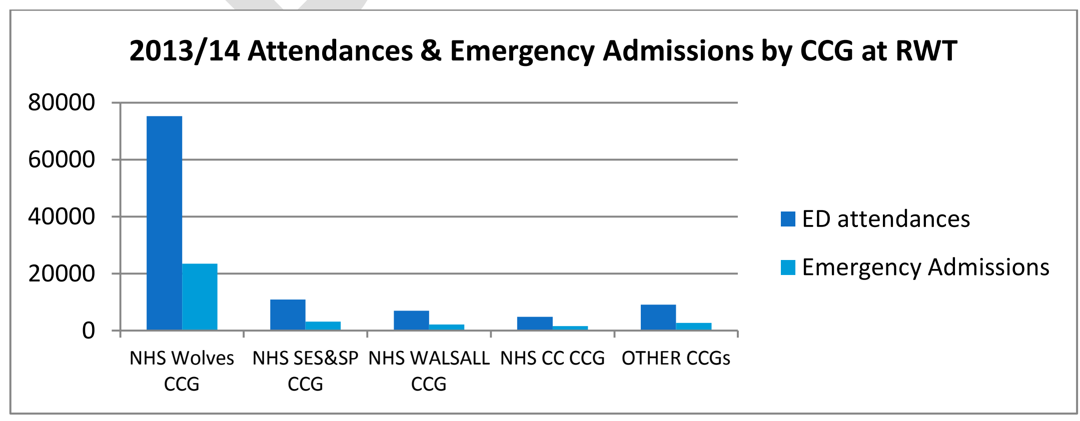
pathways. Wolverhampton ranks amongst the 25 most deprived areas in England and healthcare in the city includes:

- 50 GP practices (reducing to 49 in late 2013)
- One hospital provider (The Royal Wolverhampton NHS Trust - RWT)
- Two walk in centre providers across the city:
  - Phoenix Walk in Centre, provider RWT
  - Showell Park, provider Docs on Call;
- Out of hours provider (Primecare);
- Local Authority (Wolverhampton City Council)
- Mental Health Trust (Black Country Partnership)
- There are also a number of other services including West Park Hospital, Penn Hospital, community healthcare teams, Social Care Provision and Mental Health teams, voluntary services.
- Demographic information for Wolverhampton is available in Appendix 2.

6.2 **The Royal Wolverhampton NHS Trust (RWT) - is an NHS Trust providing** secondary, tertiary and community services for the people of Wolverhampton, the Black Country, South Staffordshire, and the wider West Midlands. It is the largest teaching hospital in the Black Country providing teaching and training to around 130 medical students on rotation from the University of Birmingham Medical School. RWT also provides training for nurses, midwives and allied health professionals though well-established links with the University of Wolverhampton. One of the largest NHS providers in the West Midlands the Trust has an operating budget of £374 million, more than 800 beds on 2 sites, and it employs more than 6,700 staff.

7. Health and Social Care Partners

7.1 **Associate Commissioners.** Wolverhampton patients don't always use the facilities close to where they live, and may use urgent and emergency care services in other parts of the country. When they do, it is still the responsibility of Wolverhampton commissioners to pay for their care. Similarly people from outside Wolverhampton using local urgent and emergency care services are paid for by the commissioners where they live. In 2013/14, Wolverhampton residents are expected to account for 70% of Emergency Department attendances and 71% of emergency admissions at New Cross Hospital. The remaining 30% of attendances are expected to come from Walsall (10%), South East Staffordshire and Seisdon Peninsula CCG (7%), Cannock Chase CCG (5%) and the remaining patients coming from other local and national areas.



7.1.1 **South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group (SES & SP CCG)** - residents are expected to account for approximately 7% of ED attendances and 10% of emergency admissions at New Cross Hospital in 2013/14. The CCG is responsible for the healthcare of 210,000 patients within 3 locality areas; Tamworth, Lichfield and South Staffs (Seisdon) and the population utilise services from 4 hospital providers, three of which are classed as out of the area (i.e. out of Staffordshire). Many of the patients from Seisdon Peninsula Locality in particular use the ED service at New Cross Hospital. Seisdon consists of 9 GP Practices which cover Codsall, Bilbrook, Perton, Wombourne, Claverley, Kinver and Featherstone and their surrounding areas looking after a population of approximately 55,000.

7.1.2 **Walsall Clinical Commissioning Group (WCCG)** – Walsall residents are expected to account for 10% of ED attendances and 7% of emergency admissions at New Cross Hospital in 2013/14. There are 63 GP Member practices from across Walsall which are divided into four locality commissioning groups serving a total population of approx. 270,000.

7.1.3 **Cannock Chase CCG (CC CCG)** is made up of 27 member practices within the boundaries of Cannock Chase District Council and the Huntington, Great Wyrley and Cheslyn Hay wards of South Staffordshire District Council serving a population of approximately 132,000. CC CCG residents are expected to account for approximately 5% of ED attendances and 5% of emergency admissions at New Cross Hospital in 2013/14.

7.2 **Wolverhampton City Council (WCC) -** Wolverhampton City Council exercises responsibility for meeting the Social Care needs of Wolverhampton residents through a range of universal and specific services. For vulnerable adults across all client groups, these are commissioned externally, some through joint commissioning with the CCG and others provided through services directly controlled by the Council. Preventative services are also available e.g. to support Carers, to maintain an individual in their home. The Department of Public Health has a focus on tackling health inequalities through addressing the social determinants of health, commissioning and developing prevention services and programmes, and the optimal management of long term conditions. Work is targeted across the whole of the life course. To improve the quality of the discharge pathway and reduce pressures within Royal Wolverhampton Hospital Trust, WCC have developed an Integrated Discharge team that is already reducing lengths of stay and Delayed Discharges.

7.3 **Black Country Partnership (BCP) -** The Black Country Partnership is a major provider of mental health, learning disabilities and community healthcare services for people of all ages in the Black Country. It provides mental health and specialist learning disabilities services to people of all ages in Sandwell and Wolverhampton, and specialist learning disability services in Walsall, Wolverhampton and Dudley community healthcare services for children, young people and families.

7.4 **Health and Well Being Board (H&WBB) -** Wolverhampton has a Health and Well Being Board consisting of senior decision makers from across the city including health, social care and police amongst others. This board will help give communities a greater say in understanding and addressing their local health and social care needs. Urgent care is one of their key priorities and the board is fundamental in agreeing the way forward for urgent and emergency care service provision for the city. In addition, the Adult Delivery Board has identified Urgent Care as one of their priorities and will be over seeing the work of the Urgent and Emergency Care Board.

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7.5 **Healthwatch England** was established in October 2012 and took over full responsibility of the patient voice from 1st April 2013 in place of LiNk. Healthwatch England leads and supports the Healthwatch network, made up of 152 community-focused local Healthwatch organisations. It is the intention of the Urgent and Emergency Care Board to work closely with Wolverhampton's Healthwatch to ensure that high quality care is delivered across the city for our patients.

7.6 **West Midlands Ambulance Service NHS Foundation Trust (WMAS)** - The Trust is commissioned to deliver an emergency and urgent ambulance service to the West Midlands region. It was authorised as a Foundation Trust in January 2013 and continues to be a significant provider of urgent and emergency care services across Birmingham and the Black Country including Wolverhampton.

8. Strategic Context

8.1 The NHS Constitution sets out the principles and values that underpin the NHS in England. It sets out the rights to which patients, the public and staff are entitled, and pledges to which the NHS is committed to achieve together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The core principles of the NHS Constitution are fundamental to the development and delivery of the Urgent and Emergency Care strategy and are embedded within the strategy's aims and objectives. The seven principles include:

1. The NHS Provides a comprehensive service to all irrespective of sex, race, disability, age, sexual orientation, religion or belief, gender reassignment, belief, pregnancy and maternity or marriage or civil partnership status.
2. Access to NHS services is based on clinical need, not an individual's ability to pay (except in limited circumstances sanctioned by parliament).
3. The NHS aspires to the highest standards of excellence and professionalism
4. The NHS aspires to put patients at the heart of everything it does
5. The NHS works across organisational boundaries and in partnership with other organisations in the interests of patients, local communities and the wider population
6. The NHS is committed to providing best value for tax payers money and the effective, fair and sustainable use of finite resources
7. The NHS is accountable to the public, communities and patients that it serves.

8.2 The Government has set out a clear vision for a modernised NHS driven by a new commissioning system focused relentlessly on improving outcomes for patients. The cornerstone of the proposed system will be local clinical commissioning groups, which will put GPs – using their knowledge and understanding of patients' needs – at the heart of the commissioning process (www.gov.uk).

8.3 The NHS Outcomes Framework 2013/14 – Everyone Counts has a number of principles supporting the new approach to clinically led commissioning from 1st April 2013 including: **empowered local clinicians delivering better outcomes; increased information for patients to make choices; greater accountability to the communities the NHS serves.** The key measures covered within the Outcome Framework include: **listening to patients; focusing on outcomes; rewarding excellence; improving knowledge and data.** All these domains will impact upon the work of the urgent and emergency care services across the city and will be underpinned by the use of NICE guidance. The key measures highlighted above are also included within this strategy.

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8.4 The Department of Health's (DoH) vision for urgent and emergency care is of universal, continuous access to high quality urgent and emergency care services. In practice, this will mean that whatever our urgent or emergency care need, whatever our location, we get the best care from the best person, in the best place and at the best time (DoH, 2012). The 24/7 vision of a coherent Urgent Care Service should aim to provide **Greater consistency, Improved quality and safety, Improved patient experience, Greater integration** and **Better value.**

8.5 The RCGP (Royal College of General Practitioners) suggests that 'good urgent and emergency care is patient-focussed, based on good clinical outcomes (survival, recovery, lack of adverse events and complications, a good patient experience, ease of access and convenience, timely, right the first time) and available 24/7 to the same high standards. They have also developed a Commissioners Guide to Urgent and Emergency Care (Urgent and Emergency Care – A Whole System Approach). The document suggests that 'the urgent and emergency care system still appears fragmented and needs to be more joined-up to make the care provided seamless, more efficient and effective, and offering greater value to commissioners'.

8.6 Given the high profile nature of the pressures, a national review of emergency care is underway led by the NHS England Medical Director, Professor Sir Bruce Keogh, and an inquiry by the Health Select Committee, the outcomes of which are expected in the autumn of 2013. The outcomes of the review are expected to impact the delivery of urgent and emergency care in the future. The emerging principles from the review include a system that provides consistently high quality and safe care across all seven days of the week, is simple and guides appropriate choices by patients and clinicians, provides the right care in the right place by those with the right skills, the first time and is efficient in the delivery of care and services. The emerging principles have been included within this strategy.

8.7 Following the NHS Next Stage Review, the launch of the Equitable Access Programme in 2008/9 led to the opening of new primary care services across England. As part of the Programme, all primary care trusts (PCTs) were required to commission at least one GP-led health centre to provide primary care services to both registered and unregistered patients requiring routine or urgent primary care without an appointment (walk-in patients). These health centres had to be open between 8am and 8pm, 7 days a week. There is much speculation about the walk in centres resulting in an additional layer and confusion for patients on where and how to access services in an urgent situation. Monitor, the sector regulator for healthcare in England, is undertaking a review of the provision of walk in centres across England, the findings of which will be available in December 2013.

8.8 The King's Fund report "Managing Emergency Activity – Urgent Care" May 2011, summarised some of the key reasons why urgent and emergency care is important. The report describes how walk in centres do not appear to have led to shorter waits in general practice or lower admission rates at other health care providers. There are currently two walk in centres in Wolverhampton, one GP led walk in centre located at Showell Park (open 8am-8pm, 7 days) and a nurse led walk in centre located at the Phoenix Centre which is open from 10am-7pm, 7 days.

8.9 Mid Staffordshire NHS Trust has been subject to a full public inquiry, led by Sir Robert Francis QC, following reports of failings to provide adequate care to patients using services at the hospital during 2005 and 2008. Following the Inquiry, the Trust Special Administrators (TSA) have undertaken a 40 day consultation exercise about the future of

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services at Stafford and Cannock Chase Hospitals. The implications of the findings are not yet known and it is therefore imperative that the future urgent and emergency care system is sufficiently flexible to cope with any changes in activity. During a 12 month period with the ED at Stafford Hospital being closed overnight, RWT saw an additional 135 patients per month.

8.10 The national agenda for urgent and emergency care services highlights the need to ensure services are more responsive to people, use resources more efficiently and use developments in medical and technological advances to deliver better care and support to people.

8.11 In establishing the drivers impacting on the model of urgent and emergency care delivery, there are a number of significant areas of relevance to the Wolverhampton Urgent Care Strategy including NHS England's National Commissioning Board, the development of NHS 111 and the new Emergency Department at New Cross Hospital, and potentially RWT being approved as having Hyper Acute Stroke Unit (HASU) Status. The Urgent and Emergency Care Board recognises that these drivers will have varying levels of influence on the strategy, however it is difficult to predict to what extent and timescales. Further details are outlined at Appendix 3 & 4.

9. Urgent and Emergency Care in Wolverhampton

9.1 WCCG has considered a range of evidence and indicators over the past 12 months including the Joint Strategic Needs Assessment (JSNA) information which is developed locally by the Local Authority (including Public Health), social care and the CCG, data from Public Health England and information provided by our GP's, our key providers and engagement with patients and the wider public. The results of the engagement and the analysis of the data has enabled WCCG to identify three key clinical priorities of which Urgent Care is one. The WCCG plans to **"Improve and simplify arrangements for Urgent Care".**

9.2 RWT has also set out Urgent and Emergency Care as one of its strategic priorities. This reflects the importance of ensuring patients access the correct urgent and emergency care facility and only attend the Emergency Department when appropriate and necessary. As the front door of the hospital, the Trust recognises the importance of the EDs emergency and urgent care delivery on other services and the impact that the growth in urgent care has on the hospital as a whole.

9.3 The scope of Urgent and Emergency care is broad and services vary nationally. In Wolverhampton the existing urgent and emergency care system includes a range of services (further details can be found in appendix 5) including:

Self-care & NHS Choices	West Midlands Ambulance Service NHS Foundation Trust (WMAS)
Community Nursing Teams including Hospital at Home, Community Matrons, Tele Healthcare, CICT	Wolverhampton Urgent Care Telephone Access Service (WUCTAS)
Pharmacists	Care Homes (Residential and Nursing Homes
General Practice (GP) practices	Out of Hours Primary Care Service
Walk in Centres (WiC)	Emergency Department (ED)
NHS 111	Emergency Hospital Admissions including Paediatrics, Acute Medical Unit and Surgical Assessment Unit.
Urgent Social Care	Urgent Mental Health

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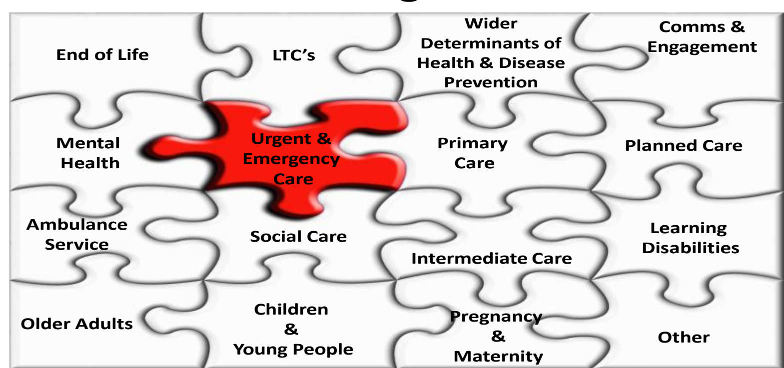
9.4 Urgent and emergency care cannot be commissioned in isolation. The 'jigsaw diagram' below attempts to show visually how pathways and strategies for other areas such as Long Term Conditions, Mental Health and Social Care all impact urgent and emergency care and vice versa. Detailed descriptions of the work being undertaken to improve the wider system and how they will support the urgent and emergency care system are detailed in section 15.

The Urgent & Emergency Care Strategic Fit



9.5 There have been many changes to the Urgent and Emergency Care system over the past few years with the introduction of urgent care provision at the walk in centres at Showell Park and the Phoenix Centre; new out of hours provision by Primecare and new pathway developments for conditions which more recently have been managed in the community including DVT, COPD exacerbations and Cellulitis amongst others. In addition, ways of navigating the system for both patients and healthcare professionals have been streamlined with services such as the Wolverhampton Urgent Care Telephone Service (WUCTAS) and more recently NHS 111. The ambulance service continues to deliver 999 ambulance responses for patients in Birmingham, the Black Country, Staffordshire, West Mercia and Coventry and Warwickshire (West Midlands region) including Wolverhampton and have been making changes to improve their response times particularly in the winter period with the introduction of falls cars and GP rapid response vehicles (when commissioned).

9.6 To ensure our patient's views are integral to the strategy development, the Urgent and Emergency Care Board commissioned an engagement project in December 2012 with patients who were using the urgent and emergency services within Wolverhampton. Our public health, patient engagement and commissioning colleagues worked together with an external organisation to undertake a project where patients completed surveys and attended focus groups to explore their use and thoughts of urgent and emergency care service provision. In addition to the initial project, further engagement work has been undertaken during February-April 2013 with stakeholders and patients to understand their views on different ways the urgent and emergency care system could progress and what the key issues are. Further details can be found in Section 12.

'Your GP knows your family history and you trust your doctor, he knows your case history' Patient Focus Groups Jan 2013.

9.7 There is recognition that patients want to see their own GP but are often confused about which services are available for them to access for their urgent care needs, and how quickly they can be seen, particularly at different times of the day. GPs from across the city also believe that Primary Care could help to reduce Emergency Department activity if the system were to change both in and out of hours. Patients say that anxiety is a key

factor in their choice of where to go for urgent and emergency care. It is the view of the Urgent and Emergency Care Board that access to primary care and the provision of services in the out of hours period must be improved to ensure patients can see a GP when their GP surgery is either open or closed. We must also improve communication across the system for both health and social care professionals and also for our patients.

'Make them aware what is and isn't an emergency' Patient Focus Groups Jan 2013.

9.8 Pathways of care across health and social care are fundamental to the delivery of urgent and emergency care. A patients journey from the start of their urgent care episode right through to their recovery must be considered. Work with our partners to ensure that the social care and mental health requirements for attendance, admission and discharge should be a focus to improve the quality of the journey for patients. Improving timely and appropriate discharge of patients from hospital beds is also a contributing factor to a lack of flow through the hospital with detrimental effects on other patients requiring urgent and emergency care.

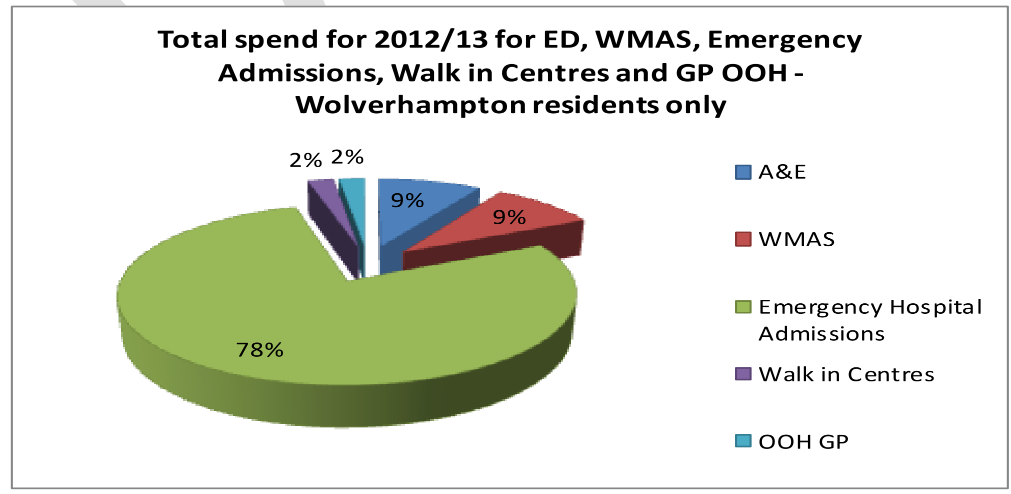
'Present the care pathway visually to people' Patient Focus Groups Jan 2013.

10. How Much Do We Spend?

10.1 In 2013/14, WCCG is responsible for a total operating budget of £327m however this covers the commissioning and monitoring of all of its responsible services.

10.2 Quantifying how much is spent in total on urgent and emergency care in Wolverhampton is difficult due to the complexities of many of the contracts held for health and social care. Areas such as mental health and social care have urgent and emergency elements to services but it may not be their sole purpose. In addition, complex contracts for community services, medicines management and GP contracts make splitting the urgent element of services difficult.

10.3 The chart below shows the % of the total spend for Wolverhampton residents for walk in centres, GP out of hours service, Emergency Department attendances, emergency hospital admissions and the ambulance service only – a total of £90m in 2012/13. This is only a small element of the total urgent and emergency spend if GP urgent care support, NHS 111, community services, mental health and social care are considered.



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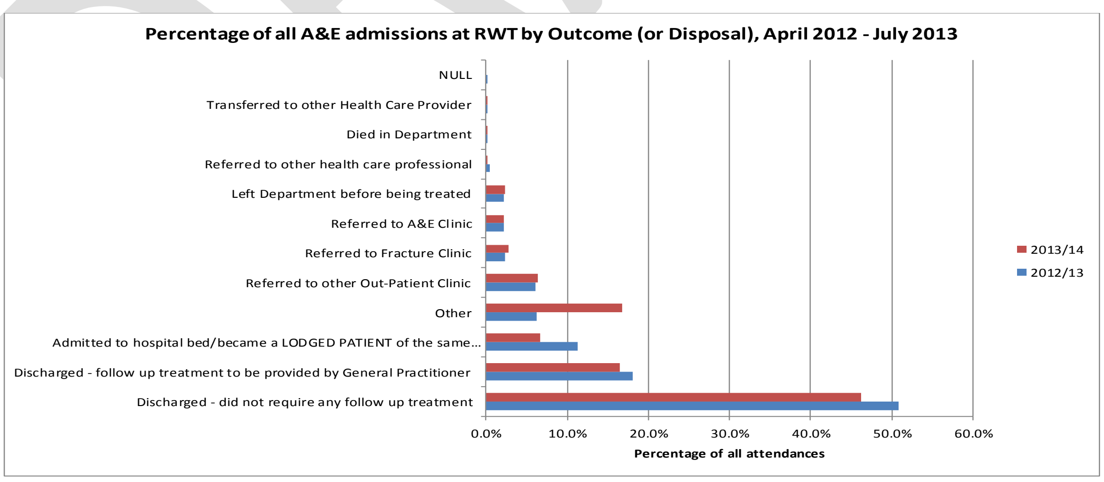
11. Challenges / Case for Change

11.1 Pressure within urgent and emergency care has grown year on year. More recently however, the Wolverhampton local health economy has seen unprecedented surges in activity. Significant numbers of patients attended the Emergency Department in 2013 with the ED seeing its highest number of patients in one day (n. 392) compared to an average of 300 per day between 1/5/13 to 15/7/13.

11.2 Performance against national targets is becoming increasingly difficult to achieve. Historically, RWT has not failed the annual 95% quality indicator for patients being seen, discharged or admitted at ED. The overall target for 2012/13 was achieved however only narrowly during Q4 of 2012/13.

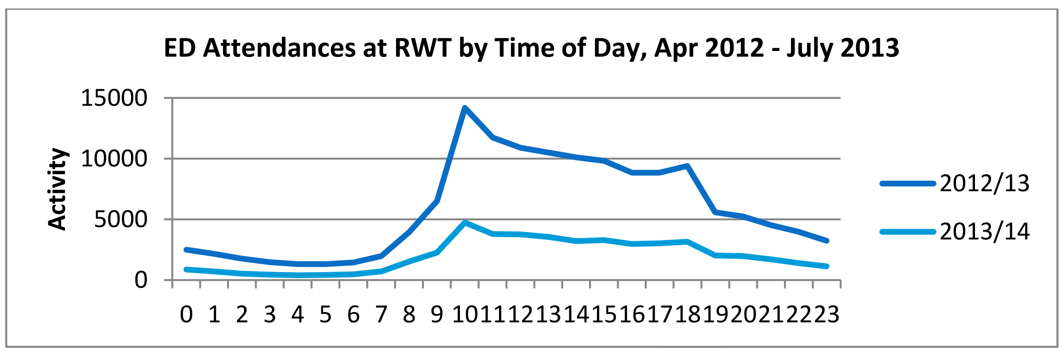
11.3 There were 106,838 attendances at Emergency Department in Wolverhampton in the year 2012/13 compared to 101,298 in 2011/12, an increase of 5.19%. There were also 44518 non electives admissions, an estimated 2,188,866 GP consultations, over 60,000 attendances at both Walk in Centres and approximately 23,923 contacts with the out of hours service. There were 44,936 patients in contact with the ambulance service and ambulance conveyance to RWT increased by 5.4% compared to the previous year's data. An average increase of 56 ambulances per week attending RWT compared to 2011/12 based on Q4 average (A&E Recovery Plan).

11.4 Wolverhampton has one of the lowest attendance to admission ratios. This means that there are a high number of people attending ED, however there are a low number of attendances that turn into an admission. This would suggest that the needs of some of these patients could be met by other services, such as primary care, should those services be available. The chart below shows the outcomes for patients who have used the ED. Patients who have left without being treated, those who do not require follow up or have been discharged with follow up by a GP could possibly be seen in an alternative setting such as primary care. The quality of ED diagnosis data is limited therefore it is not possible without a full audit to confirm the number of primary care patients attending ED.



11.5 Our patients have expressed their concerns at difficulties accessing primary care and the significant impact this has on increasing Emergency Department (ED) attendances. A recent review of Access to Primary Care and Visits to Emergency Departments in England (Thomas E. Cowling et al) has shown a direct correlation between General Practice providing more timely access to primary care and having fewer self-referred discharged Emergency Department visits per registered patients. The chart below

shows the peaks in ED attendances during the opening hours of general practice and immediately when General Practice closes (around 6pm).



11.6 Ambulances are waiting for more than 15 minutes to turnaround at the Emergency Department, hospital bed capacity has been seriously challenged and ‘winter’ wards remained open throughout the summer of 2013/14. Primary Care has also seen significant increases in demand with many of the primary care and community based urgent and emergency care services seeing equivalent pressure across the city.

11.7 Finance and activity modelling has been used to support the redesign of the urgent and emergency care system. A reference group has been developed and the Commissioning Support Unit (CSU) invited to undertake the exercise to understand the potential increases in activity and finance. The CSU support clinical commissioning groups by providing system modelling and business intelligence, amongst other support services. To highlight the current pressures, the modelling predicted an increase in activity from 2012/13 to 2016/17 of 4.3% if no changes were made to the system. However existing pressures have already shown a 5.19% increase at the ED. Further detail can be found in Appendix 6.

11.8 There has been a regular focus on the existing Emergency Department and the limitations of the current service provision due to the building’s current geographic layout and design. The current Emergency Department opened in the mid 1990’s and is not designed for service provision in 2013 resulting in safety concerns due to the lack of space being documented in the local press. RWT is currently making a number of interim improvements to increase capacity but they do not provide suitable long term solutions.

11.9 The emergency attendance and admission departments including the ED, Acute Medical Unit (AMU), Surgical Assessment Unit (SAU) and Paediatric Assessment Unit (PAU) are separated across the hospital site making the physical transfer of patients and economies of scale/ shared staffing resources impractical. Work is underway to develop the case for a new ED building that will house the urgent and emergency care services together with an out of hours primary care resource offering 24/7 urgent and emergency care on the New Cross site. It is imperative that the wider system improves in addition to the proposed new build to ensure that patients are seen in the right place at the right time.

11.10 Through our research it is clear that there is duplication across the system with a small percentage of patients using two or more services for one episode (1591 attendances in 2011 and 1847 in 2012 at the Phoenix Centre and Showell Park which also had an ED attendance within 24 hours). There is significant duplication between the users of the ED and Showell Park given the close proximity of the services. Further detail can be found in Appendix 7.

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11.11 Wolverhampton City Council has invested in supporting alternatives for inappropriate admissions as well as investing in a new Integrated Discharge team. However, the Council faces unprecedented cuts to its budget that will inevitably impact on its' ability to maintain all of the existing services. As a community, partnership working with the social care and NHS partners is paramount to develop a future framework that will deliver greater integration of activity and closer working around the patient.

12. Case for Change – Through Our Patients Eyes

12.1 To understand the patient perspective a research project has been undertaken to engage with patients and to get their views on urgent and emergency care. Approximately 180 patients were involved at urgent and emergency care services across the city including GP Practices, the Emergency Department and walk in centres. Patients were also invited to focus groups where they were able to discuss their thoughts in more detail.

- Participants displayed uncertainty as to when they should be accessing the different parts of the urgent care system;
- The majority of respondents reported that the following factors would influence their decision on which service to access when they had an urgent need:

1. The ability to book a GP appointment
2. The severity of their condition
3. Time of day (if the surgery closed/Out of Hours)
4. Consideration of busy periods/time of year
5. Waiting times
6. Limited availability of appointments/access (GPs)
7. Panic and anxiety influence the use of ED.

12.2 Patients report that they are familiar with their GP and the service that their practice provides. They were confident that they would get the answers and treatment that they need quickly. The overall findings of the report include:

- Urgent Care is confusing for patients and professionals (our patients say that they are unsure where to go for an urgent care need quickly and services are hard to navigate);
- Too many access points (our patients say that they are not always sure which service to go to for different needs – there are additional layers in the system);
- GP appointments are not always available when patients have an urgent need (our patients say that they are using the walk in centres and ED because they cannot get an appointment at their own GP);
- There is significant variability in patient experience;
- Patients want to see their own GP but cannot always get an appointment when it is urgent;
- Patients want to know where to go and what for when they have an urgent need (we need to communicate with patients better);
- There is a recognition that services have to be sustainable;
- There is a strong appetite for patients to be involved in the commissioning of services;
- Access to urgent care should be fast especially for the vulnerable e.g. elderly, young people;

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- Accessible services such as Walk in Centres receive differing views/criticism e.g. Positives: easy access, superb, positive treatment vs. Negatives: just end up in ED anyway, poor response times.

12.3 The groups that patients identified as the most in need were parents with young children, students who are rarely registered with GPs in the area that they are studying in, the elderly population who would rather see their own GP than access ED or the ambulance service and middle aged people who are likely to have to fit their care with full time work.

12.4 The current system is confusing for all of the groups identified above. Patients feel that they have a right to access care and when they are anxious they do not always make the best decision for the system but it is generally the best decision for them. The time of day and personal circumstances have a lot to do with the choices that are made particularly including free prescriptions, fitting around work commitments and also when parents collect their children after school or nursery. Service opening times are not always clear and therefore ED can become the default service by guaranteeing that patients will be seen and treated.

12.5 Anxious parents will take their children to whichever service will resolve their problem and patients feel that the system should communicate better with patients to inform them of the costs involved, the services that are available and to consider charging/fining patients for inappropriate use of services. Patients feel that there are too many options for them to go to and if their own GP is closed or they cannot get an appointment, ED is often the default.

13. Stakeholder Views

13.1 A system wide engagement process was undertaken in early 2013 to understand the views of stakeholders. Engaging with primary care was a priority to ensure that GPs and practice staff were given the opportunity to put their views across. A survey was circulated to all GP's in Wolverhampton and in the Seisdon locality. Wolverhampton GPs agreed with patients suggesting that improvements could be made in primary care together with a total system change including a new ED and Urgent Care Centre at the front door of ED. Seisdon GPs suggested that total system change was their most preferred way forward although improvements in primary care were also a high priority.

14. The Urgent and Emergency Care Strategy

14.1 Our Vision

"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 and 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."

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14.2 System Change Through our Patients Eyes

The new urgent and emergency care system will be improved and simplified for patients with access to general practice, community teams, a walk in centre at the Phoenix Centre, the ambulance service and a new Urgent Care Centre and ED at New Cross Hospital. Patients will be encouraged to self-care or seek advice from pharmacy services or to be guided to the right place for their care through telephone access with NHS 111. The out of hours service and the Showell Park Walk in Centre (only the service, the building and GP practice will remain) will be relocated to become a fundamental part of the new Urgent Care Centre which will offer care to primary care patients 24 hours a day, 7 days per week whether they walk in or are directed there by a healthcare professional.

Patients will be able to access their GP practice in a timely way, they will be clear on the opening times of services and what services are available at what time of the day. Communication will be improved and services will be simplified to ensure the confusion and duplication is reduced. Healthcare professionals will continue to access alternatives to a hospital admission for patients through the use of WUCTAS and this will be opened up to use by care homes, ED, social care and discharging hospital wards to make sure patients are treated as close to home as possible.

Patients with mental health needs and long term conditions will be included in decision making, they will be cared for earlier in their condition with plans in place and developed with them for when their conditions deteriorates. Pathways of care that are agreed across primary and secondary care will be developed for patients with a particular focus on children and older adults. All patients will have a responsive primary care service with a GP in a car responding to urgent calls to general practice, whether patients live in their own home or a care home.

Care homes will be offered advice and guidance, and patients who are at the end of their life and their families and carers will be part of the decision making and planning for their end of life care. Services will work together to keep patients in their place of residence where possible whether they are at the beginning, middle or end of their life and services will be more responsive when patients do experience a crisis.

Emergency Services will continue to be responsive to the needs of patients who are in a life threatening situation. Patients will have access to senior decision makers early on in their care when they do need emergency care. The new emergency department at New Cross Hospital will ensure all urgent and emergency care attendance and admission services are located in one place making the decision on which service patients should access much simpler. Patients will go through one door for new Urgent and Emergency Care Department at New Cross Hospital and will be directed to the right care (the right clinician), at the right place (Urgent Care Centre, ED or emergency admission) at the right time (24/7) whether their need is a minor illness, minor injury or major illness or injury.

The new Urgent Care Centre will see and treat patients and will offer advice to general practice, for patients who have attended, for onward referral where health inequalities, disease prevention or on-going support is required. Patients will be offered guidance on the most appropriate service to access for their care in the future if they have attended a service inappropriately. Frequent service users will be part of a multidisciplinary team review where services will come together to help them to find a resolution to their continued needs.

Patients who are not registered with a GP in Wolverhampton but who use Wolverhampton services in an urgent or emergency situation will not be treated any differently than those who are resident in the city. Patients will be treated at the walk in centre at the Phoenix Centre or at the new Urgent and Emergency Care Department and referred back to their own GP practice for onward care closer to their own place of residence. Services will make sure that where patients from other areas need help to go back home, the necessary arrangements are made in a timely and efficient way.

Resources will be reinvested to improve the timeliness of services, improve the quality and outcomes for patients and to improve communication across the system.

14.3 The Urgent and Emergency Care Strategy for 2013-2017 aims to:

a) **Ensure improved and simplified arrangements for urgent and emergency care** – by developing a simply designed and rationalised system supported by easy telephone and web access - by reducing the confusion in the system by making the entry points more efficient to reflect a new and sustainable 24/7 system.

b) **Ensure strong patient-centred clinical leadership in all access points of the urgent and emergency care system** - Senior clinical decision makers will be a fundamental part of the system and their decisions will be made early and regularly in a patients care pathway.

c) **Provide better value for money and sustainability – Improving appropriate use of urgent care facilities and services.** Reducing inappropriate use of NHS services, to deliver better value for the taxpayer, for local organisations and to provide a financially sustainable system for the future. A reduction in unnecessary ED, ambulance and emergency admissions are a focus of the strategy.

d) **Provide greater consistency and openness, transparency and candour –** by providing consistently high quality, integrated care led by our Clinical Commissioning Group delivering the best outcomes and experience 24/7, with no noticeable differences out of normal office hours. A culture of openness and insight will be developed and action taken where honest concerns about the standards or safety of services are made.

e) **Ensure improved quality, safety and standards -** Deliver up-to-date, high quality services which are clearly focused on meeting the clinical needs of the patient and putting the patient's needs first, with less variation across the city and ingrained in a culture of continuous improvement. NHS standards will be applied.

f) **Ensure improved patient experience** - Ensuring a greater focus on the patient journey through compassionate, caring and continuous improvement in response to patient and carer feedback. We will include our patients in our work;

g) **Provide greater integration and information** - Services working together to provide a seamless service, irrespective of the provider organisations which operate them. Sharing of information and regular reporting of the outcomes of the patient pathway will be ingrained in the system using the latest IT facilities where possible;

h) **No blame culture** - The strategy will support a 'No Blame Culture' with clinicians, managers and services working together to improve the services offered to patients.

14.4 The Urgent and Emergency Care Strategic Objectives include:

a) Improved Assessment and Discharge in all access points;
b) Managing Patient Expectation by clinicians working together;
c) Standardising and Improving Quality in Urgent Care by ensuring services are high quality and clinically robust;
d) Improve Timely Access to Services by improving access and operating hours;
e) Encourage Self-Care (where ever possible) by communicating with our patients;
f) Use of Risk Stratification by managing patients who are at high risk of admission into hospital;
g) Improved Communication by using technology and promotional campaigns;
h) Seamless and consistent urgent and emergency care services by ensuring all providers are managed through a whole system approach;
i) Explore and develop alternative solutions by ensuring new solutions to improve quality within the system are identified, considered and delivered.

14.5 A Phased Approach to delivery

14.5.1 It is the intention of the U&ECB that the Urgent and Emergency Care Strategy is delivered in phases:

14.5.2 **PHASE 1, CONSULT (deliverable December 2013 – December 2014).** A consultation process will be undertaken in phase 1 to understand areas of concern our patients and stakeholders identify with the draft Urgent and Emergency Care Strategy and how they want us to continue to involve them through the development of communication and promotional campaigns in 2014. The consultation process will include a feedback report that will provide patients with an update on how their views have helped us to shape the future. The exercise will inform the implementation plan to deliver real and sustainable change across the system. We will also undertake an Equality Analysis to assess how well existing services are meeting diverse needs, and how any future proposals for change may impact different groups.

14.5.3 **PHASE 2, IMPROVING PRIMARY CARE (deliverable November 2013 – December 2016) -** There is evidence from the literature, and a view from our patients that changes in

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primary care will help the urgent and emergency care system and therefore the board will focus in **phase 2** on delivering real change in Primary Care. This will include improved access to general practice. The out of hours service and the walk in centre at Showell Park will both relocate to be part of a new integrated 24/7 Urgent Care Centre at New Cross Hospital. The NHS Constitution outlines the principle that Access to NHS services is based on clinical need and that our patients have a right to access NHS services. The NHS commits to provide convenient, easy access to services and the Wolverhampton Urgent and Emergency Care Strategy intends to deliver improvements in access to services for all patients using our services by providing the Urgent and Emergency Department 24/7.

Partnership working and involving our patients will be a theme that runs throughout. We will work together to develop pathways of care, to undertake focused work (particularly for 0-5's and over 65's).

PHASE 3, IMPROVING SECONDARY CARE (deliverable November 2013 – December 2016) will include work across the local health economy together with secondary care and patients to develop and implement the proposals for a new Emergency Department at New Cross Hospital with a view to opening its doors in early 2016. It is well documented that the existing Emergency Department at the Royal Wolverhampton Trust is not adequate for current service requirements with concerns about the sustained rise in activity and the resulting pressures, together with safety issues, particularly where patients are waiting in corridors due to the lack of space. This has focussed the urgent need for a new ED facility to address these concerns. The proposed Urgent and Emergency Department will provide high quality services for patients 24/7. Patients will receive assessment by senior clinicians early on in their care with assessment, treatment and discharge taking place as efficiently as possible. The outcomes for patients will be improved and links will be made back to GP practices when additional health support for onward referral is required (e.g. alcohol, mental health, social care support). There will be a fundamental improvement in communication across clinical and other health care services, to improve health inequalities, and to ensure that the urgent and emergency care system improves health outcomes for patients. Partnership working with social care and mental health partners will strengthen responses for patients who have mental health or social urgent and emergency care needs. Patients will be seen and treated regardless if their place of residence is in Wolverhampton or from other places across the country. In particular, partnership working with South East Staffordshire and Seisdon Peninsula CCG, Walsall CCG and Cannock Chase CCG will be important to manage the flows in and out of the hospital; further details can be found in section 16.

14.5.4 **Phase 4, REVIEW AND AMEND** (ongoing) will include a continuous cycle of improvement with a commitment to on-going system capacity reviews to ensure that surges in activity can be managed effectively and where efficiencies are made, they can be reinvested in the system to manage future growth. IT systems will be developed to provide robust, accurate and timely data to support patient care, manage activity surges and to report concerns in the system from patients and staff. We will continue our work with commissioning leads for mental health, public health, end of life, social care, primary care and intermediate care to improve the preventative work undertaken to reduce hospital attendances and emergency admissions. Work with partners, providers and patients will continue to deliver improvements in the quality of services that we provide.

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15. Urgent and Emergency Care and Wider Strategies

15.1 **Addressing the Demand for Urgent and Emergency Care Services -** Prevention, self-management and primary care are areas that will provide the foundation for reducing demand in urgent care services.

15.2 **Understanding the needs –** Public Health are leading on a detailed understanding of the users of urgent care services, such as demographic characteristics which will highlight the appropriateness of attendance and assist in the development of prevention, self-management and primary care pathways to address inappropriate usage. Demographic profiling of service users and the associated diagnosis will enable implementation of targeted approaches to ensure effective and efficient use of urgent care services in the medium and long term. This will entail an audit of urgent care usage and mapping the reason for attendance against the urgent care specification. This will enable the identification of where individuals could have been more appropriately seen outside the urgent care system or highlight areas for prevention.

15.3 **Disease Prevention -** There are a number of existing strategies and services that address preventing disease, including the Healthy Eating and Physical Activity Strategy, infection prevention and control services, healthy lifestyles service, healthy schools programme, the work in early years and children's services. It is imperative that we build on what works well, and employ the evidence base to ensure we are doing as much as possible to address preventable illness and disease. The detailed urgent care profiling that Public Health are undertaking will identify specific areas for targeted approaches to preventing disease progression. In addition, the profiling will highlight 'quick wins' in the system, for example, ensuring all health and social care staff and residents in care homes have the influenza vaccine, or a system change to prevent patients requiring prescription renewals at the weekend.

15.4 **Improving Health and Wellbeing -** Whilst this strategy is focused on addressing the needs and demands in the urgent care system, it is important to acknowledge that reducing demand will require the organisations to consider their role in tackling the wider determinants of health. In order to effectively improve the health of the people of Wolverhampton, and reduce demand on health services, it is important to recognise the biggest gains will be made through improving the social and economic circumstances of residents, improving housing, educational attainment, employment and working conditions. Therefore success in tackling the wider determinants will only be achieved by all key organisations supporting the strategic direction for addressing these determinants of health in Wolverhampton, set by the Health and Well Being Board.

15.5 **Primary Care** - Effective, efficient and high quality primary care is essential in supporting the Urgent and Emergency Care system. A Primary and Community Care Strategy is currently in development and is aiming to provide greater capability, capacity and flexibility in primary and community care to increase the responsiveness to patients. Accessibility to general practice for urgent care needs has been highlighted by patients as an area that, if working effectively, would negate the need for patients to use services such as the ambulance service and ED, and will therefore be a priority for the new Primary and Community Strategy. Other likely priorities within the strategy will be to improve the integration of primary and community teams, based out of the hospital, to serve the current and future healthcare needs of the local health economy. Teams will have the necessary skills, capability, capacity and flexibility to respond to changing demands and will use agreed clinical pathways of care across a range of clinical conditions.

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Patients and the public will be key contributors to the development of the local strategy in terms of being involved in the delivery of their own care, the types of intervention they might receive, the feedback they could provide regarding the quality of services and the contribution that they can make to their own health and well-being. Primary and secondary prevention strategies will be a priority in order to prevent ill-health in the whole population and improve the quality of life and management of patients who have long term and/ or complex conditions.

The development of the Primary and Community Care Strategy and the delivery of such changes is a positive step forward for Wolverhampton. Key components of the strategy and mechanisms for delivery will be heavily influenced by the work undertaken in areas such as urgent and emergency care and long term conditions, and vice versa. The links to prevention, the development of clinical pathways of care and the responsiveness and accessibility for patients will ensure that health is managed in a more robust way and therefore reducing the need for urgent and emergency care. Effective, efficient and high quality primary care is essential in supporting urgent and emergency care.

15.6 **Long Term Conditions Management -** According to national evidence, over 17 million people in the UK report living with a long term condition (LTC). Currently, LTC's account for 70% of health and social care spend, 70% of unplanned admissions and 55% of all GP consultations. National evidence suggests that 1 in 3 people in England suffer from at least one LTC. In Wolverhampton for 2011, those with a Long-term activity-limiting illness (or long term condition) was recorded at 20.6% or 51,391 of the total population of 249,470. The England average was 18% in 2011.

The WCCG Long Term Conditions strategy is currently being developed, and will ensure that there is alignment with a number of other strategies such as the Health and Wellbeing Strategic Priorities, Urgent and Emergency Care, Intermediate Care, Local Authority Older People's strategy, and a continuation of close collaboration with Public Health colleagues in terms of early diagnosis, prevention and wellbeing. A core element of the strategy will be to improve pathways of care for disease areas (such as Diabetes), to understand and improve the impact of respiratory ailments on patients and to introduce Personalised Management Plans for patients with a confirmed long term condition. The intention of these tailor made plans is to ensure that patients are involved in the management of their condition but also to describe what they should do if their condition worsens.

The effective management of long term conditions will have a significant impact on urgent and emergency care, with patients using condition specialists aligned to their care rather than the reactive use of services such as ED and the ambulance service for when their conditions worsens. The emerging strategy is expected in mid-2014.

15.7 **Intermediate Care -** Intermediate care is defined as a range of services to promote faster recovery from illness, provide effective alternatives to hospital admission, support timely discharge from hospital, prevent premature admission to long term care and maximise independent living. Wolverhampton CCG has expanded the remit of the Intermediate Care programme to include residents of nursing and residential homes.

The programme of work has a number of work streams relating to Intermediate Care, Community Services and Nursing Homes. The following schemes, linked to reducing demand and freeing capacity in urgent care, are currently being developed:

- Improved step down provision for people after a period of acute care
- Development of a bed based intermediate care unit for step down provision for people after a period of acute care and step up provision for people to avoid an acute admission

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- Review of current Community Intermediate Care Team to develop a new service specification to include more focus on admissions avoidance
- Improved clinical support to nursing homes and their residents to prevent avoidable hospital admissions
- Review of the current falls service with a view to redesigning the provision to meet the needs of the local population. Reducing falls will reduce the number of ED attendances and hospital admissions.
- Investigate the possibility of all community services providing support and care for residents of residential and nursing homes
- Investigate the possibility of nursing homes and residential homes being able to access telephone support and diagnostics for residents via a single point of access

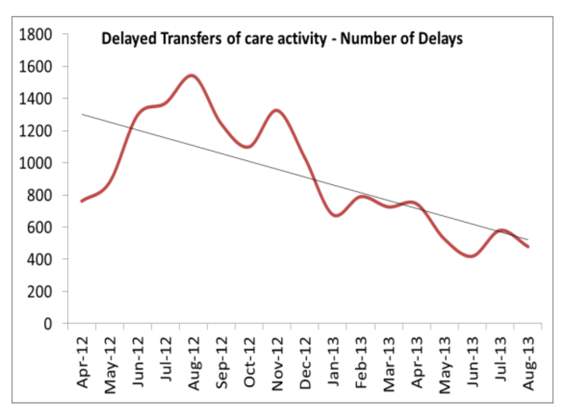
A CCG Intermediate Care and Community Services strategy is planned for production during 2013/14. The strategy will be aligned with other local strategies including the Health and Wellbeing strategic priorities, Urgent and Emergency Care, Long Term Conditions and the Local Authorities Older Peoples strategy.

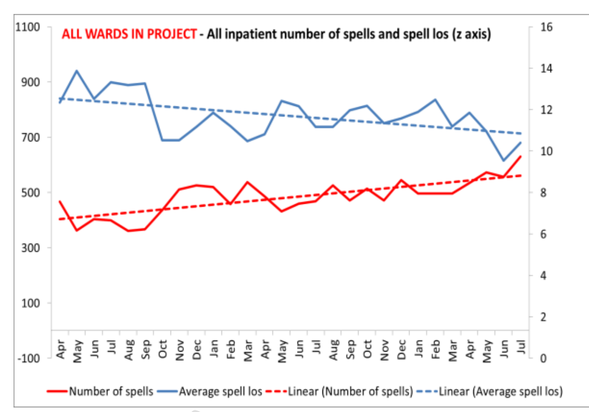
15.8 **Mental Health Management -** If a person's mental or emotional state gets worse quickly, this can be called a mental health emergency or mental health crisis. In this situation, it is important for them to get help quickly to stop the person harming themselves or others. The overall ambition of the revised Mental Health Strategy is to provide proactive and responsive services within primary and secondary care services to ensure patients know what to do in a crisis. By working with patients to improve their longer term care and to plan for urgent situations, there will be improved patient experience, health outcomes and a resulting reduction in the need for ED and in-patient services within the city. Work will also be undertaken to ensure that when a crisis does occur, the responsiveness of Mental Health teams is improved.

Targeted schemes of mental health promotion, early intervention and wellbeing initiatives will also be undertaken with a focus on children and young people, at risks groups such as carers, people from BME groups, people who misuse substances and the unemployed. Partnership working with Mental Health Commissioners and providers of care will continue.

15.9 **Social Care –** WCC provide social work support in community settings and within the acute trust to support vulnerable adults. These teams have access to a range of provision with a focus on maintaining support within the individuals own community through short term reablement residential and community teams. Social care is a significant factor in the needs of patients who access urgent and emergency care services and as a result social care support to the Emergency Department will continue to prevent hospital admissions.

WCC have worked with the Royal Wolverhampton NHS Trust to develop an integrated hospital team that is already improving the quality of discharge for individuals and decreasing both lengths of stay and Delayed Transfers of Care. The team have control over resources outside of the hospital to ensure that appropriate placements are made with the aim of helping people back to their own homes. The chart below shows the impact of this work with 4166 bed days saved to July 2013.





15.10 **End of Life Care -** A new End of Life Care Strategy for Wolverhampton is currently in development with the aim of further developing the service offered to patients considered to be within the last year of their life to support them to die in their place of choice. There are some key areas of focus within the new strategy, one of which includes the facilitation of Preferred Priorities for Care/ Advance Care Plans. The care plans will be developed with the patients, their families, carers and professionals involved in their care to ensure everyone is aware of the wishes and feelings of those at the end of life. The plans will ensure clarity on what should happen when a patient's condition deteriorates, what should be expected and what to do if there is an urgent need or crisis.

The plans will be used to improve communication between agencies, including the ambulance service, through the development of a shared record which will detail an individual's preferences, particularly where the patient wishes to die in their usual place of residence. Workforce development will also be undertaken to ensure they have the necessary skills to deliver individualised end of life care, in accordance with Preferred Priorities for Care/ Advance Care Plans such as effective symptom management. The first draft of the strategy will be available in late 2013.

15.11 **West Midlands Ambulance Service -** Work is being undertaken to upgrade paramedic skills to enable further diagnostic skills to treat patients in the right setting first time with Community Paramedic schemes, (a hub model for efficiencies) and Hospital Ambulance Liaison Officers (HALOs) are being established to better support the acute and community services. WMAS is continuing to develop the Directory of Services (DoS) that supports the identification of alternative services for appropriate patients who call 999, the new 111 number and for utilisation by health care professionals with patients. Work is also underway to identify frequent service users with the intention of reducing the number of 999 calls to WMAS through a multi-disciplinary approach. It is the intention of the Urgent and Emergency Care Board that this work continues.

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16. Non Wolverhampton Residents Who Use Our Services

16.1 South East Staffordshire and Seisdon Peninsula CCG

16.1.1 **Prevention -** Within south Staffordshire there is a focus on increasing access in primary care through additional urgent care appointments and prevention of hospital admission, through the introduction of a falls team, care home education and a focus on holistic case management across an integrated health and social care community team. These teams are undertaking risk stratification and working with high volume users of services to avoid them attending a hospital setting in an urgent situation.

16.1.2 **Supporting Early Discharge -** Once a Staffordshire patient has been admitted to New Cross Hospital, there is an integrated South Staffordshire Hospital Discharge Team located within the hospital to support patients to return to their usual place of residence. The team is based with the hospitals capacity team and work with support from reablement teams and case mangers within the community linked directly to GP practice. If the patient requires longer rehabilitation the team can source community beds via the Urgent Care Support Service.

16.2 **Walsall CCG**

16.2.1 **Prevention** - Walsall has been working with GP's, Walsall Healthcare Trust and Social Care & Inclusion to develop a model of care which is more integrated and delivers a rapid response to those elderly patients who are unwell, but can be maintained safely and appropriately in their own home, thus avoiding a hospital admission. More recent changes in District Nursing will support the implementation of risk stratification and the work undertaken with WMAS for high users of their services.

16.2.2 **Supporting Early Discharge** – Walsall Council's reablement services have been redesigned to put a greater emphasis upon supporting earlier discharge and maximising patient's independence and well-being. There is also a single point of contact for patients who require intermediate care services to facilitate early discharge.

16.3 **Cannock Chase CCG**

16.3.1 **Prevention** - The focus within CC CCG is to have an emergency and urgent care system which meets the needs of the local population and ensures that people are treated in the right place by the right health care professional. The aim is to increase primary management through increased emergency capacity and the development of an acute visiting service. There is a commitment to reducing emergency hospital admissions through the use of the falls team, case management and integrated pathways of care. The CC CCG is currently working with Mid Staffordshire Foundation Trust to develop an ambulatory care unit which will provide rapid assessment, diagnosis and treatment without hospital admission.

16.3.2 **Supporting Early Discharge** - Cannock Chase CCG have commissioned a range of services to support discharge from acute hospitals. These include a bed based service at Cannock Chase Hospital and a large range of community Services including the Support Discharge Service, Community Intervention Service, and Community Matrons. They have also commissioned a range of specialist services which include the Community Stroke Team, the Respiratory Care Service and Heart Failure Team.

16.4 **Trust Special Administrators (TSA) - Changes to Cannock and Stafford Hospitals (taken from public documents) –** the TSA have suggested a number of changes to the existing system in Stafford and Cannock however they have suggested that the Accident and Emergency services remain open during the current opening hours of 8am and 10pm at Stafford Hospital and for Cannock Chase Hospital to continue to provide a Minor Injuries Unit from 8am to midnight daily rather than a full Emergency Department. It is unclear at this stage what the expected impact of the proposals for changes to the system in Stafford and Cannock will have in Wolverhampton or exactly what will be agreed, however the Urgent and Emergency Care Strategy outlines the changes at the front door of ED which will allow the system to flex to cater for patients from other CCG areas through the UCC or ED. The ability to flex resources and refer back into the community teams will be vital to managing fluctuations in activity, particularly for those patients from other areas who attend or have had an emergency admission at New Cross Hospital.

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17. Delivery of Urgent and Emergency Care

17.1 The **Joint Urgent and Emergency Care Board** will provide the leadership and governance to oversee the delivery of the urgent and emergency care strategy and implementation plan together with having the responsibility for overseeing the delivery of the short to medium term A&E Recovery Plan. Workstreams will be developed to deliver the implementation plan and workstream leads will report to the Urgent and Emergency Care Board. The following groups will also feed into the Board:

a) Black Country Urgent Care Group - This group manages urgent and emergency care across the Black Country and regularly considers models of care that have been tested elsewhere and which have been seen to work. It also reviews the existing system and the impact of current pressures, the impact of schemes such as NHS111, WMAS, discussion of fines and targets, out of hours contracts and cluster opinion of implementing guidance. It is imperative that the work of this group is considered as there are clear links to developments that can support the growing surges in activity. Collaborative commissioning can be undertaken where economies of scale will provide benefit to the wider urgent and emergency care system.

b) Wolverhampton Surge Planning Group - The Surge Planning Group provides resilience support to the current urgent and 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 but the work will be overseen by the Urgent and Emergency Care Board. The groups chair is a member of the Urgent and Emergency Care Board.

c) Emergency Portal Board - The Emergency Portal Board has been created to develop the outline and full business case for the new Emergency Department at the New Cross site and the Urgent Care Centre. This development links directly to the strategy.

18. Expected Benefits of the Strategy

18.1 The strategy has been developed to set out the challenges to the system, the improvements that have been identified, and a phased approach to delivery. The strategy intends to make the system easier for patients to navigate to the right place for assessment and treatment and for services to respond in a timely way to reduce the burden on ED and emergency hospital admissions. The implementation plan will describe the service changes in detail.

18.2 The Equality Delivery System Goals and Outcomes will specifically achieved in the following areas:

18.2.1 **Better Health Outcomes for all – achieving improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results:**

- Services will be commissioned, designed and procured to meet the health needs of local communities, promote well-being and reduce health inequalities particularly in Urgent and Emergency Care. Extensive work has been undertaken to understand the views of our patients and to ensure the development of the strategy and the

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future changes to the Urgent and Emergency Care system meet the local needs of pour patients.

- Individual patients health needs will be assessed and resulting services provided in appropriate and effective ways.
- Changes across services for individual patients will be discussed with them and transitions made smoothly particularly for the out of hours service and new walk in centre service. A 12 week consultation exercise will take place to ensure patients are clear of the proposed changes and how they will affect them.
- The safety of patients will be prioritised and assured. By bringing services together, the safety of patients will be assured through the optimal clinical model, safety standards and quality measures.

18.2.2 **Improved patient access and experience – improve accessibility and information, and deliver the right services that are targeted, useful, useable, and used in order to improve patient experience:**

- Patients, carers and communities will be able to readily access services and will not be denied access on unreasonable grounds. The new Urgent Care Centre will provide a service for patients 24 hours per day and will ensure that unregistered patients are supported to register with a GP practice for their on-going care.
- Patients will be informed and supported to be as involved as they wish to be in their diagnoses and decisions about their care and to exercise choice about the treatments and places of treatments. Through improved communication patients will understand which service is most appropriate for their care and they will be supported through their diagnosis and will be referred back to their own GP for onward referral if required.
- Patients and carers will report positive experiences of their treatment, care outcomes, of being listened to and respected and of how their privacy and dignity is prioritised. New pathways of care, improved communication and a supportive system for patients where clinicians can work together to ensure patients experiences of their treatment is improved.
- Patients and carers complaints about services and subsequent claims for redress should be handled respectfully and efficiently. There is a continual need to listen to patients and take action on their concerns. Ongoing changes should be made where complaints about services highlight safety concerns or service improvements.

18.2.3 **Empowered engaged and well supported staff - increase the diversity and quality of the working lives of the paid and non-paid workforce supporting all staff to better respond to patients and community's needs:**

- Through support training, personal development and performance appraisal staff will be confident and competent to do their work so that services are commissioned and provided appropriately;
- Staff should be free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues with redress being open and fair to all. Transparency and the 'no blame' culture will be supportive of staff and patients.

18.2.4 **Inclusive leadership at all levels –ensure that equality is everyone's business and everyone is expected to take an active part supported by the work of specialist equality leaders and champions.**

18.3 The true benefits of this work will emerge over time however the initial aspirations include:

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1. 20% of current ED attendances to be diverted to the new UCC by 2016;
2. The sustainable delivery of the 95% ED target will be achieved 98% of the time;
3. Reduced Emergency Admissions by 2016;
4. Patients who arrive at ED by ambulance will be assessed by a clinician within 15 minutes;
5. An increase in GP appointments for urgent requests by 2016/17;
6. Improved mental health response times within the ED to improve urgent care provision for patients in crisis by 2016/17.

18.4 Success will result in a reconfigured urgent and emergency care system that is organised, effective and efficient and where our patients can find the right care, at the right time, first time. Communication will be improved and our patients will be empowered to know the right service available for their needs.

18.5 The Equality Analysis we conduct will ensure that we can identify where there may be gaps in provision for protected characteristic groups, and that proposed changes to the Urgent and Emergency Care system are assessed for their potential impact and are consistent with the Public Sector Equality Act duties of all the NHS and social care organisations involved in this strategy.

19. Engagement with our Patients and Stakeholders

19.1 Patient and stakeholders views have been fundamental to the development of the strategy. It is the intention of the Joint Urgent and Emergency Care Board to consult on the strategy to ensure that our patients, partners and stakeholders are able to help us to shape the future. It is also our intention to understand how our patients and stakeholders want to continue to be involved to ensure the future developments are inclusive.

19.2 The timescales for the consultation are not yet available however we are planning from it to run from December 2013 through to February 2014. The consultation will be dependent upon agreement by the Health and Well Being Board, the Health Scrutiny Panel and the WCCG and RWT boards prior to the consultation process beginning.

19.3 The Joint Urgent and Emergency Care Board will provide the governance structure required to oversee the consultation and the delivery of the strategy through the implementation plan and workstreams.

19.4 A separate public facing consultation document has been developed with patients, together with a Communications and Engagement plan to ensure that we reach as many people who use our services as possible.

19.5 Once the consultation process has taken place, it is important that feedback is given to the public on the outcomes of the consultation process and furthermore, any changes made to the system. Regular updates will be required to continue to keep patients and wider stakeholders engaged and to communicate the achievement of milestones.

20. Conclusion

20.1 This strategy describes the importance of changing the delivery of urgent and emergency care within Wolverhampton to improve the quality and affordability of services for people using our services. The importance of delivering a streamlined and efficient system must not be taken lightly. The current system is not sustainable given the levels of pressure that it has been experiencing and we must do things differently.

20.2 The Urgent and Emergency Care Strategy has been developed to improve quality across the system and to respond to the changing landscape of the local and national health economy. The system has seen extreme pressure in 2012 which has continued into 2013/14. It is imperative that the urgent and emergency care system sees improvements prior to winter 2013/14 when further pressure is expected but that we also plan for the future.

20.3 Our patients have suggested that the system is confusing and they are not sure where to go for their urgent and emergency care need particularly at different times of the day. Healthcare professionals confirm that the ED is "not fit for purpose", service provision can be confusing and timeliness is a factor causing delays across the system.

20.4 Our patient's voice is vital in ensuring that services provide high quality and appropriate pathways across organisational boundaries. Our links with Wolverhampton's Healthwatch will become increasingly important to deliver such an ambitious strategy.

20.5 The draft strategy will be amended in late 2013 further to comments from the Health and Well Being Board and Health Scrutiny prior to the consultation process. Further amendments to the strategy may be made, if required, further to the consultation process.

20.6 It is our intention that our patients receive the right care, right place, first time. To achieve this, the existing urgent and emergency care system must change.

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Appendices

21. Appendix 1 - Equality and Diversity

21.1 All Urgent and Emergency Care services will ensure that services are appropriate and do not discriminate on the basis of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or beliefs, sex or sexual orientation.

21.2 NHS Wolverhampton Clinical Commissioning Group (WCCG) is fully committed to promoting equality of opportunity, eliminating unlawful and unfair discrimination and valuing diversity. As a result the Urgent and Emergency Care Strategy will ensure:

- Urgent care services that will be accessible, high quality health services on the basis of clinical need, tailored appropriately to the different healthcare needs of the various groups in the community we serve;
- That barriers to accessing services are identified and removed or reduced. No person will be treated less favourably on the grounds of their protected characteristics or any other factor that it would be inequitable to take in to account;
- That our premises do not create barriers, physical or social for service users or employees;
- Communicate effectively and ensure that the information we provide is accessible easy to understand, relevant and appropriate.

21.3 The protected characteristics covered by the public sector equality duty (Section 149 of the Equality Act 2010) are:

a. Age: This refers to a person having a particular age (eg 32 years old) or being within an age band (21-25, 46-50 years old)
b. Disability: A person has a disability if s/he has a physical or mental impairment that has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities
c. Gender reassignment: This is the process of transitioning from one gender to another. A person who is Transgender is someone who expresses themselves in a different gender to the gender they were assigned at both. Although the legislation covers gender reassignment, we recognise the term 'trans' better encompasses the wider community.
d. Marriage and civil partnership: A union between a man and a woman or the legal recognition of a same-sex couple's relationship
e. Pregnancy and maternity: The condition of being pregnant or the period after giving birth. It is linked to maternity leave in the employment context. In the non-work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding.
f. Race: This refers to a group of people defined by their skin colour, nationality (including citizenship), ethnic or national origins
g. Religion or belief: Religion means the religion a person belongs to and a belief includes religious and philosophical beliefs including a lack of belief (e.g. Atheism). Generally a belief should affect your life choices or the way you live for it to be included in the definition (political views are not included)
h. Sex: Being either a man or a woman
i. Sexual orientation: Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes.

Where services are required based on age, the reason will be on the grounds of service provision such as children's services or services aimed specifically at older adults due to the nature of their conditions.

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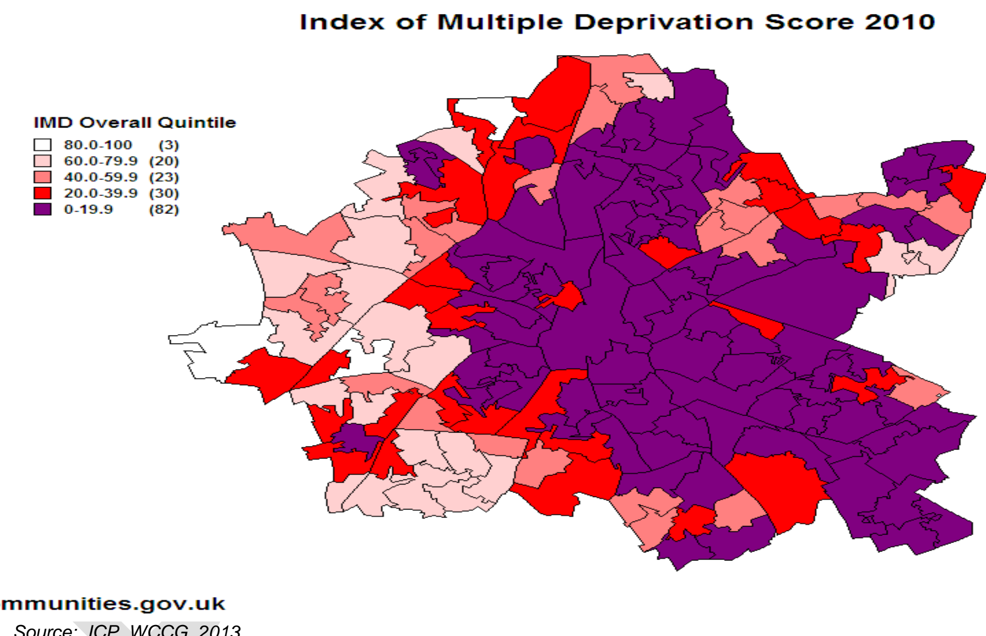
22. Appendix 2 - Demographics

22.1 Wolverhampton's resident population is approximately 249,500, although the registered population is reported as 236,000. It is one of the most densely populated places in the country, with nearly 9,000 residents per square mile.

22.2 About a quarter of the population is of black and minority ethnic (BME) origin. The biggest growth in the population is likely to be in this group with BME communities constituting around one third of the city's population by 2026.

22.3 Births have increased in the last 8 years leading to an increase in the 0-19 age group. 75% of these births are in the most deprived areas. This contributes to increased child poverty and intergenerational cycles of ill-health.

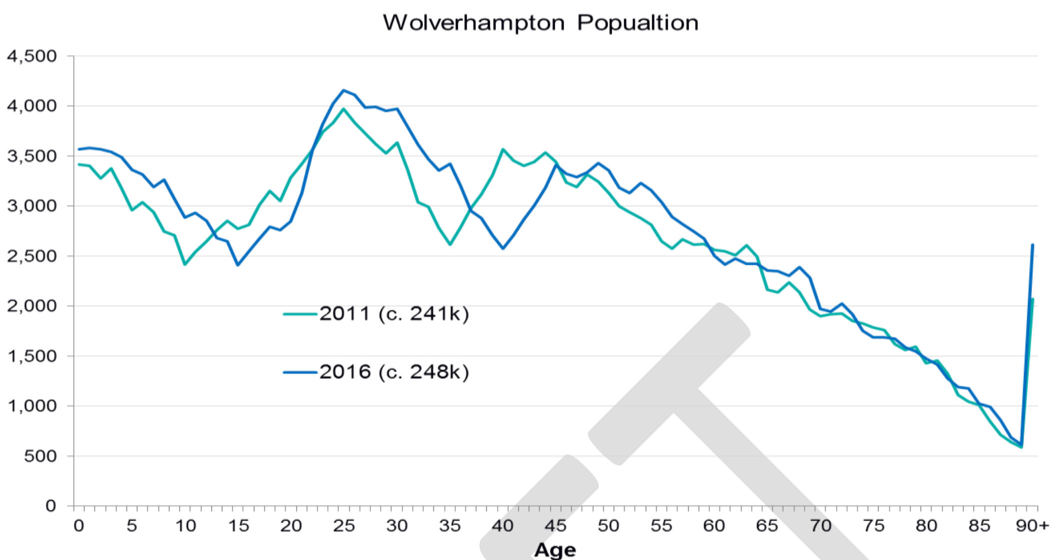
- Wolverhampton is ranked 21st most deprived out of 354 local authorities. Deprivation is not concentrated in a few areas – almost half of the city's neighbourhoods are amongst the 20% most deprived in the country. Deprivation is focussed in the North East and South East.
- Social marketing tools demonstrate distinct groups that will respond to services and health promotion in different ways.
- Deprivation is correlated with poor lifestyles, high morbidity and high mortality.



Source: ICP, WCCG, 2013

22.4 Population Size and Age Profile in Urgent and Emergency Care - The chart below shows the changes in population size and age profile from 2012 to 2016.

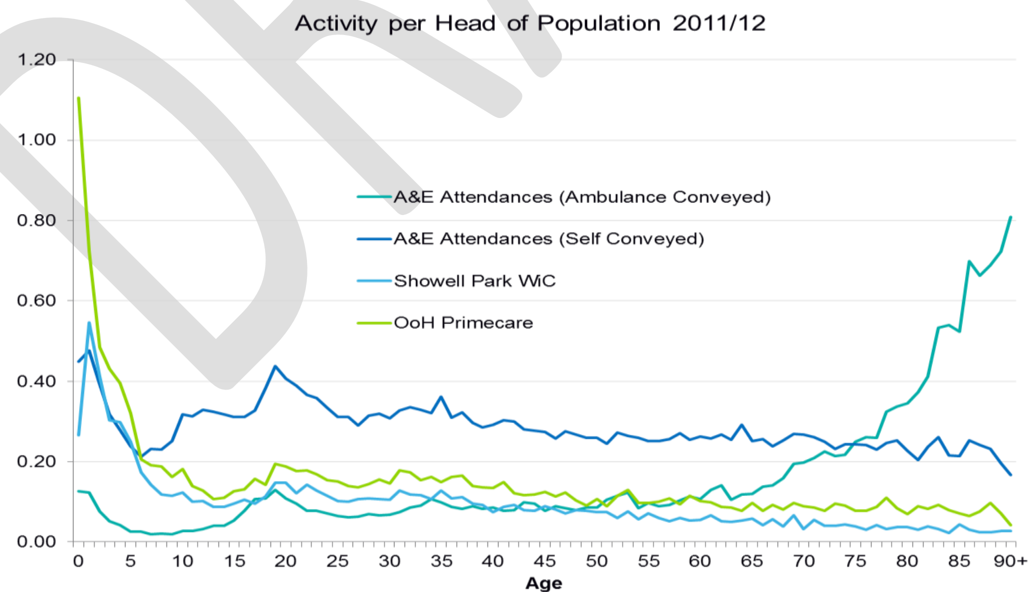
3a&b – Population Size and Age Profile (2)



Source : ONS 2010 based sub-national population projections

22.5 The chart below shows the activity levels at the ED, the Out of Hours service and one of the walk in centres in Wolverhampton (Showell Park) during the year 2011/12. There is a significant peak in activity for children 0-5 years in the out of hours period but also for ED attendances (both ambulance and self conveyed) together with a peak in older adults that are conveyed via an ambulance.

3a&b – Population Size and Age Profile (1)



Source : SUS A&E, Showell Park MDS, Primecare MDS 2011/12

22.6 Risk Factors **-** There are a number of significant risk factors for the population of Wolverhampton including:

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- Obesity, smoking, physical inactivity and high alcohol consumption are all risk factors for circulatory disease mortality
- Obesity, smoking, physical inactivity and high alcohol consumption are all risk factors for cancer mortality
- High alcohol consumption is a precursor to alcohol related mortality
- Smoking in pregnancy and high rates of teenage conceptions increases the risk of infant mortality
- Smoking in pregnancy and high rates of teenage conceptions increases the risk of infant mortality.
- A bout of flu will reduce quality of life for people with long term conditions and increase unplanned hospitalisation for chronic ambulatory care sensitive conditions.
- Parental smoking are risk factors for emergency admissions for children (particularly around asthma and lower respiratory tract infections)
- Obesity and smoking impacts on effective recovery following any health event. Obesity can particularly effect recovery following hip or knee replacement

Source: ICP, WCCG, 2013

22.7 The Big Six - The gap **between** life expectancy in Wolverhampton and England and Wales is driven by six causes of death – infant mortality, coronary heart disease, alcohol related mortality, suicide, lung cancer and stroke. Further to the review of our demographics, the following areas require addressing:

- High attendance rates at ED
- Prevalence of epilepsy – hospital admissions as a result of epilepsy for children
- Stroke admissions
- Asthma for adults and children
- Emergency admissions for lower respiratory tract infections for children
- Need to transfer care from emergency care to primary care. This should be focused on high need groups.
- Close work with social care to support recovery following discharge from hospital.
- More detailed data on emergency hospital admissions.

22.8 Wolverhampton has one of the highest ED attendance rates in the country however one of the lowest attendance to admission ratios. This means that there are a high number of people attending ED however there are a low number of attendances that turn into an admission.

22.9 NHS Atlas of Variation in Healthcare 2011 - The NHS Atlas of Variation in Healthcare shows the prevalence rates for a number of different areas, mostly planned or Long Term Conditions. However there are a number of areas that relate to Urgent and Emergency Care.

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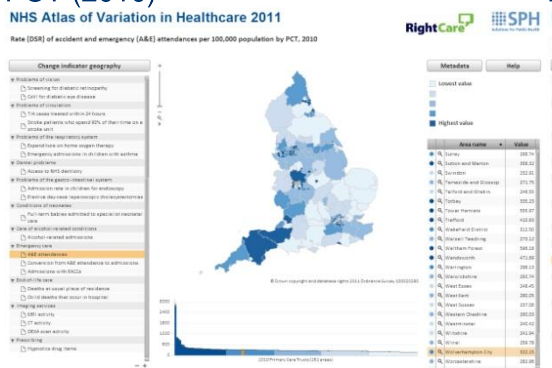
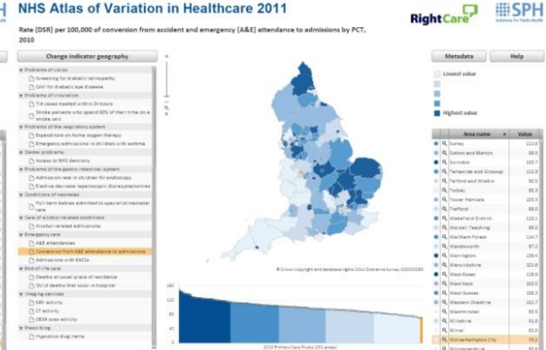
Rate of Accident and Emergency Attendances per 100,000 population by PCT (2010)



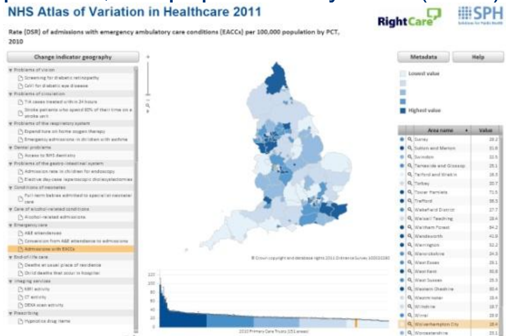
Wolverhampton has one of the highest rates

Rate per 100,000 of conversion from Accident and Emergency to admission by PCT (2010)



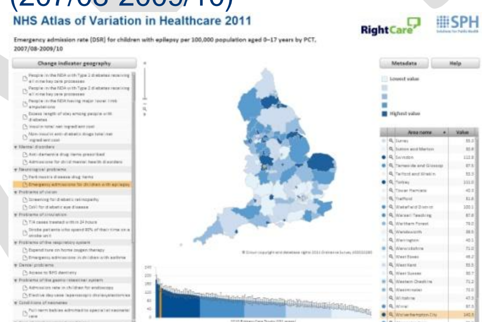
Wolverhampton has one of the lowest A and E attendances to admission rates

Rate of admission with emergency ambulatory care conditions (EACC's) per 100,000 population by PCT (2010)



Wolverhampton has one of the lowest rates

Emergency admission rate (DSR) for children with Epilepsy per 100,000 population aged 0-17 years by PCT (207/08-2009/10)



Wolverhampton has one of the highest rates

Source: NHS Atlas of Variation in Healthcare 2011 (http://www.sepho.org.uk/extras/maps/NHSatlas2011/atlas.html)

23. Appendix 3 - Strategic Context Supporting Information

23.1 Urgent and Emergency care has particular significance to commissioners due to:

- Clinical safety issues
- The changing expectations and experience of patients as a result of a 24/7 culture
- The unacceptable variation in quality and availability in some services
- The volume of the work and high visibility to all
- The increasing demand for some services
- The duplication in the system
- The complexity of service provision, including primary care, acute hospitals, ambulance services, mental health services, pharmacies, social services and third sector
- Escalating costs
- The challenge to make efficiency savings in the NHS
- High profile and press and media interest
- The changing political context.

23.2 It is important to ensure that the urgent and emergency care system is 'integrated'. One service affects the other therefore it is imperative that they are commissioned as part of a system.

23.3 The King's Fund report "Managing Emergency Activity – Urgent Care" May 2011, summarised some of the key reasons why urgent and emergency care is important:

- Urgent care services are currently often highly fragmented and generate confusion among patients about how and where to access care
- Poor sharing of information as patients move between different providers of care in an emergency is a cause of many significant failures of care
- The quality of out-of-hours care is highly variable, particularly in terms of continuity of care, leading to variable patient experiences
- The growth of new forms of urgent care has failed to reduce A and E attendances. For example, emergency attendances in England rose by 46% between 2003/04 and 2009/10 (however, from 2004 the data also included Walk In Centres and Minor Injury Centres with ED attendances increasing around 6% per annum and Emergency 999 calls over 8 million in 2010/11 with demand rising at 4% per annum)
- Walk-in centres do not appear to have led to shorter waits in general practice or lower admission rates at other health care providers
- Emergency admissions have also grown rapidly. The number of emergency admissions in England rose by 11.8% between 2004/05 to 2008/09 – resulting in around 1.35 million extra admissions.

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24. Appendix 4 – Addition - Local and National Drivers

- NHS England – National Commissioning Board
- Emergency Department Development
- NHS 111
- Achievement of Hyper Acute Stroke Unit Status (HASU) at The Royal Wolverhampton NHS Trust

24.1 NHS England (National Commissioning Board)

24.1.1 NHS England supports NHS services nationally and ensures that money spent on NHS services provides the best possible care for patients. It funds local clinical commissioning groups to commission services for their communities and ensures that they do this effectively.

24.1.2 Some specialist services will continue to be commissioned by NHS England centrally where this is most efficient. Working with leading health specialists, NHS England brings together expertise to ensure national standards are consistently in place across the country. Throughout its work it promotes the NHS Constitution and the Constitution's values and commitments. Formally established as the NHS Commissioning Board on 1 October 2012, NHS England an independent body, at arm's length to the Government. The area team will ensure the development and delivery of A&E Recovery plans regionally.

24.2 The Emergency Department Development

24.2.1 The Emergency Portal Board is developing an outline business case for the new Emergency Department which is scheduled to open its doors in early 2016. A Planning Application for the redevelopment of the New Cross site was submitted to Wolverhampton City Council and received approval in 2010. This included outline planning approval for a new Emergency Centre.

24.2.2 The Outline Business Case will focus on the provision of redesigned services within a new facility which will support operational benefits for Emergency Services with the Trust. It will also afford the opportunity for the development of the required system changes within the existing urgent and emergency care system and the introduction of a new Primary Care Centre which will be open 24 hours per day, 7 days per week, 365 days per year.

24.2.3 It is proposed that the new facility will be provided on a phased basis. Phase 1 is proposed to include a new Emergency Department and supporting ambulatory and diagnostic facilities and the PCC. Subsequent phases of the development are proposed and include a second and third floor housing Emergency Admissions Units for Children (PAU), Medical Patients (AMU), Surgical Patients (SAU) and a proposed Clinical decisions Unit (CDU). The new ED Business case is tightly linked to the emerging Urgent and Emergency Care Strategy and work has been undertaken to provide assurance to the CCG's that the new ED will improve quality.

24.3 NHS 111

24.3.1 NHS111 has been introduced to Wolverhampton in 2013 and is a new service to make it easier for patients to access local NHS healthcare services. Patients can call

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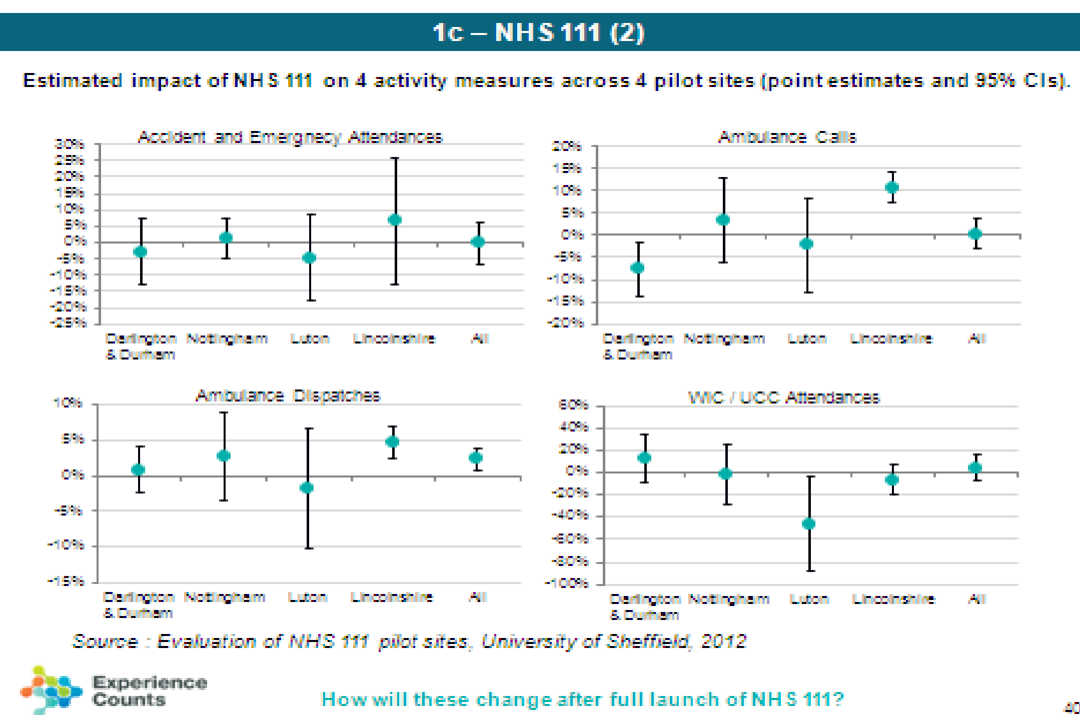
111 when they need medical help fast but when it is not a 999 emergency. The intention is that through access to a directory of services, NHS111 will be able to direct patients to the most appropriate service such as pharmacies, GP practices and walk in centres as an alternative to ED when they are unsure where to go.

24.3.2 As this is a new service, it is unclear of the impact of NHS111 on activity and costs. Pilot sites have shown varying results but as the chart below shows, the overall impact was limited with the exception of Ambulance dispatches. It should be noted that the impact of NHS111 may be very different to the pilots once the national service embeds.

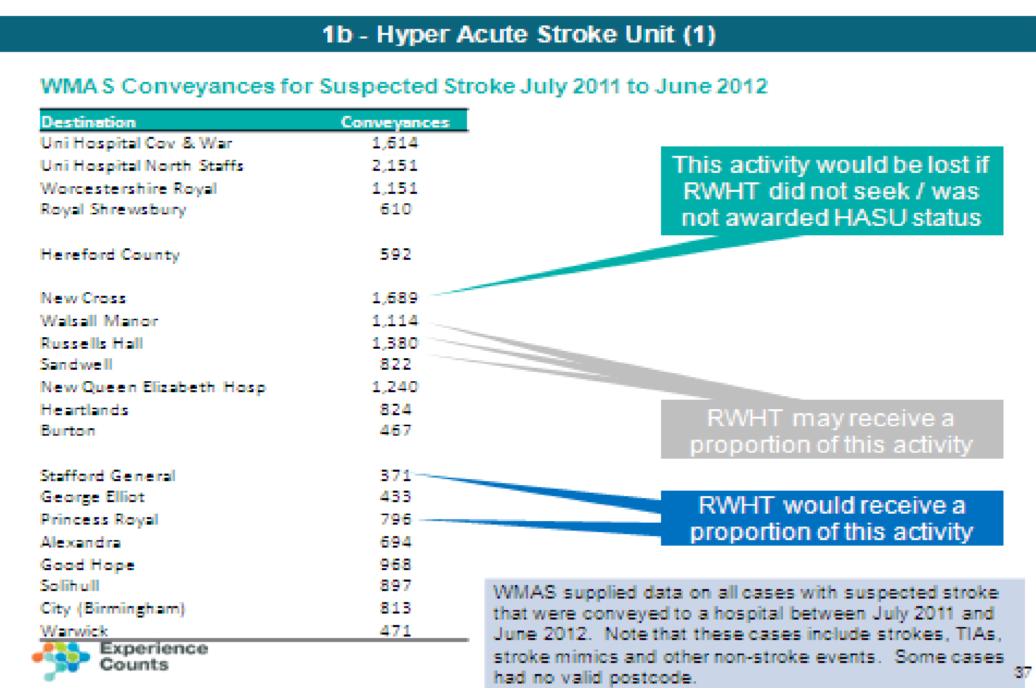


24.3.3 It is important that work is undertaken to focus on activity to ensure that 111 sends Wolverhampton patients to the right services at the right time and that gaps in services are identified

24.4 Regional Review of Stroke Services

24.4.1 In May 2012, it was announced that the NHS Midlands and East will be undertaking a review of stroke services, including the provision of Hyper Acute Stroke Services. The purpose of the review is to achieve a step change improvement in the quality of stroke services and stroke outcomes. The Royal Wolverhampton Trust is engaging in this review process to develop a proposal to deliver stroke services across the whole pathway including hyper acute services.

24.4.2 The Hyper Acute Service has been established in Wolverhampton for a number of years and provides a service to 600+ stroke patients. In 2009, the Trust doubled its stroke catchment area to provide hyper acute and acute stroke services to a wider catchment area, which increased the number of stroke patients attending the Trust.
Source: Emergency Portal Outline Business Case



1b - Hyper Acute Stroke Unit (1)

WMAS Conveyances for Suspected Stroke July 2011 to June 2012

Destination	Conveyances
Uni Hospital Cov & War	1,614
Uni Hospital North Staffs	2,151
Worcestershire Royal	1,151
Royal Shrewsbury	610
Hereford County	592
New Cross	1,689
Walsall Manor	1,114
Russells Hall	1,380
Sandwell	822
New Queen Elizabeth Hosp	1,240
Heartlands	824
Burton	467
Stafford General	371
George Elliot	433
Princess Royal	796
Alexandra	694
Good Hope	968
Solihull	897
City (Birmingham)	813
Warwick	471

24.4.3 The chart above shows the activity that is attributed for suspected Stroke between July 2011 and June 2012.

24.4.4 The decision on HASU status remains unclear and the outcome of RWT achieving Hyper Acute Stroke Unit Status will certainly impact the activity levels and service provision at RWT particularly within the Emergency Department.

24.4.5 If HASU is not awarded to RWT, almost 1700 patients annually will attend surrounding Hospital Trusts for suspected strokes. This will reduce the activity and service provision required at RWT and will divert the ambulance activity away from the hospital site.

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25. Appendix 5 - Existing Service Descriptions

25.1 In Wolverhampton the existing urgent and emergency care system includes the following, and these services should therefore be considered as within the scope of this strategy.

Service Name	Description
Self-Care & NHS Choices	Where appropriate, Patients are encouraged to look after themselves by self-caring. This may include resting or reviewing websites such as NHS Choices to review the symptom checker for the best course of action. This can now link into the new 111 service.
Pharmacists	Patients self-caring (or looking after themselves) by using over the counter medicines and/or advice and support from Pharmacists at Pharmacy shops based across the city. Pharmacists and chemists play a key role in providing quality healthcare to patients.
General Practice (GP) Practices	There are currently 51 General Practices within Wolverhampton and 9 within Seisdon Peninsula. Usually open from 8am-6.30 pm Mon-Fri with some practices undertaking Saturday morning opening.
Walk in Centres (WiC)	There are currently 2 walk in centres across the city including at the Phoenix Centre (nurse led) and Showell Park (GP led), both providing 'walk in' primary care services.
Urgent Social Care	The rapid response required by social services where patients are in crisis or require urgent support both in the community and within a hospital setting.
Urgent Mental Health	The rapid response required by mental health services where patients are in crisis or require urgent support both in the community and within a hospital setting. If a person's mental or emotional state quickly worsens, this can be treated as a mental health emergency or mental health crisis.
Urgent Community Nursing Teams	The rapid response required by community teams where patients are in crisis or require urgent support both in the community and within a hospital setting and includes:
➢ **CICT**	A rapid response service providing nursing and rehabilitation care in the community, patients own homes and a hospital setting to facilitate discharge.
➢ **Hospital at Home**	Community Hospital at Home focuses on specific conditions that are amenable to care in the community preventing a hospital admission from primary care or Emergency Department or facilitating reduced LOS from AMU or the wards. Conditions such as IV antibacterials for Cellulitis, ESBL, IV steroids for MS patients, domiciallry management of patients with DVT, management of exacerbations of COPD.
➢ **Communit y Matrons**	The Community Matron Team delivers comprehensive, evidence-based holistic clinical assessments and interventions with the primary aim of reducing inappropriate/avoidable hospital admissions and where possible facilitating reduction in length of hospital stay for individuals with long term conditions.
➢ **Tele Healthcare**	Tele healthcare to support people with long term conditions, to enable them to understand their illness and manage it themselves, minimising the medical and social impact of the illness, avoiding unnecessary admissions to hospital, avoid unnecessary exacerbations and deteriorations, supporting patients who live at home, reducing the need for care in residential and nursing homes.

SPAR	SPAR accepts referrals from within the Trust, GPs and other health professionals to District Nursing Service, CICT, Hospital at Home, Night Visiting Service, Tissue Viability and End of Life/Palliative Care. SPAR has a single contact number, with specific referral criteria for each service; it is a single access process for community services, run by a dedicated trained team that also provides WUCTAS.
West Midlands Ambulance Service NHS Foundation Trust (WMAS) - 999	Urgent and Emergency Ambulance services providing 'Hear and Treat', 'See and Treat' and 'See and Convey'. 999 should be used for life-threatening emergencies.
The New 111 Number (replacing NHS Direct)	Providing a telephone service to support less urgent responses required by patients. The service has access to a directory of services that allows 111 to navigate patients to the most appropriate place for their care.
Wolverhampton Urgent Care Telephone Access Service (WUCTAS)	A single point of access telephone service for Healthcare professionals only. Providing a range of alternatives to hospital attendance or admission including to a range of urgent diagnostic tests and clinical and community pathways/services. Open 10am to 7pm seven days a week. In addition to the SPAR element accepting referrals into community services
Out of Hours Primary Care Service	Providing an urgent general practice service for patients requiring a doctor in the out of hours period. A GP is always available from 6.30pm to 8am weekdays and all day weekends and bank holidays.
Care Homes (Residential & Nursing)	Since April 2002 all homes in England, Scotland and Wales are known as 'care homes', but are registered to provide different levels of care. A home registered simply as a care home providing personal care will provide personal care only - help with washing, dressing and giving medication. A home registered as a care home providing nursing care will provide the same personal care but also have a qualified nurse on duty twenty-four hours a day to carry out nursing tasks. These homes are for people who are physically or mentally frail or people who need regular attention from a nurse.
Emergency Department (ED)	ED (formerly A&E) departments assess and treat patients with serious injuries or illnesses. The Emergency Department offer access 24 hours a day, 365 days a year. The Accident and Emergency Department at New Cross Hospital has many services. In the main, it provides services for minor injury and illnesses, acute medical/surgical/paediatric emergencies, out of hours stroke thrombolysis, in patient head injury management, emergency hand surgery, elective minor surgical operations, an emergency medicine follow up clinic, eye casualty and a physiotherapy service.
Emergency Admissions including:	Emergency admissions – that is, admissions that are not predicted and happen at short notice because of perceived clinical need (NHS Connecting for Health 2010)
➢ **PAU (Paediatric Assessment Unit)**	Emergency hospital admissions unit for children (under 18 years). Admissions methods are via the GP, ED or other parts of the hospital including consultant referrals.
➢ **AMU**	Emergency admissions for patients who require an admission for general

(Acute Medical Unit)	medical needs. The Emergency Assessment Unit is based at New Cross Hospital, it provides timely and accurate initial care for all emergency attendances with onsite senior decision making, 24 hours per day, 7 days per week. The service is open to all self-referrals, GP referrals and ambulance/paramedic delivered patients. Patients are seen, treated and discharged when appropriate, or resuscitated and referred on to the appropriate sub specialty medical/surgical team for further management.
➢ **SAU (Surgical Assessment Unit)**	Emergency admissions for patients requiring surgical assessment needs. The Unit receives patients who are over the age of 16 referred via Accident and Emergency, a General Practitioner or as a direct admission from a Consultant Clinic. The ward is for patients who present with acute general surgical or urological problems. On arrival patients undergo rapid assessment, diagnosis, stabilization and/or treatment of their condition, prior to transfer to an appropriate area or discharge. Patients who require <48 hours in hospital will remain on the unit whilst patients who require admission for a period of greater than 48 hours will be transferred to the appropriate ward. This service is provided 24 hours, 7 days per week.

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26. Appendix 6 – Finance and Activity

26.1 To understand the financial implications of any proposed way forward, activity and finance modelling has been undertaken for all descriptions. A reference group was developed to ensure that the modelling was developed by primary and secondary care.

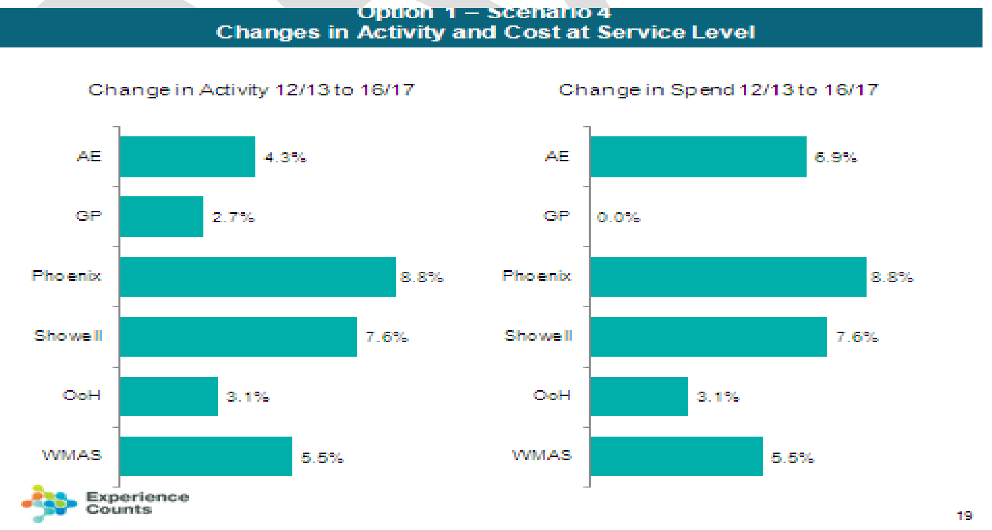
26.2 The reference group identified two imminent service configuration decisions that are likely to impact on future urgent care activity levels in Wolverhampton.

- the award of HASU status to a subset of acute hospitals
- the potential downgrade of the A&E service at Stafford Hospital

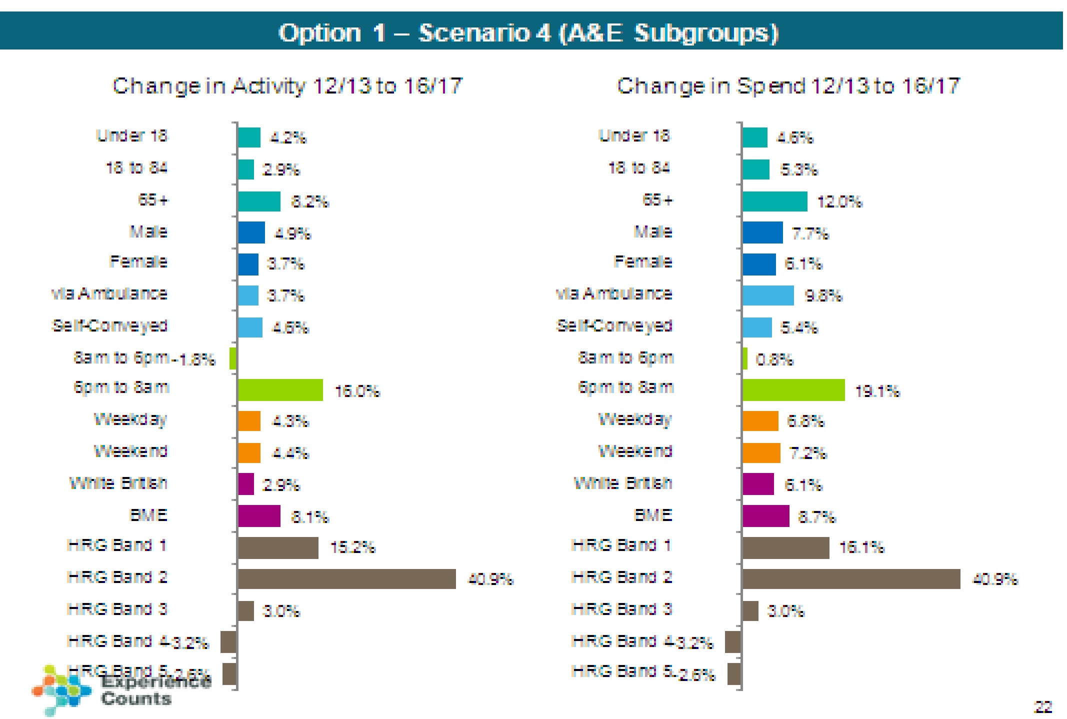
26.3 As a result, 6 scenarios were developed including if RWT was/was not awarded HASU status (or Dudley/Sandwell are) and if the ED department at Mid Staffs was/was not downgraded to an MIU.

Scenario	HASU	Mid Staffs A&E
1	× RWHT	no change
2	× RWHT	↓MIU
3	✓ RWHT & Sandwell	no change
4	✓ RWHT & Sandwell	↓MIU
5	✓ RWHT & Dudley	no change
6	✓ RWHT & Dudley	↓MIU

26.4 The system is complicated and modelling can never be exact however, the chart below shows the breakdown of the expected changes if 'no change' is made, RWT achieve HASU status and Mid Staffs is downgraded to an MIU.



26.5 The chart below details the breakdown of predicted activity from 2012/13 to 2016/17 if no changes are made.



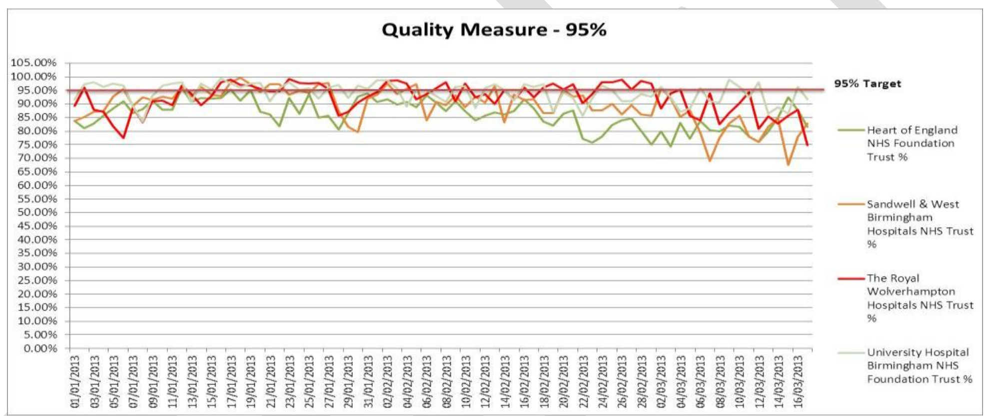
26.6 There is a significant increase in activity for older people (65+) together with more patients being seen in the out of hours period. Band's 1 and 2 are the more complex tariffs and see the most significant increase.

27. Appendix 7 - The Case for Change Supporting Information

27.1 The existing system has improved and changed over recent years with investment in walk in centres, enhancements to general practice, a new out of hours GP service, changes to the Emergency Department amongst a whole host of other improvements. There are a number of significant reasons why it is imperative that we develop a future urgent and emergency care system that is sustainable:

27.2 **Quality measures are difficult to achieve (inc. waiting times, time in ED, ambulance turnaround):**

27.2.1 The chart below shows the number of patients being seen and discharged within 4 hours at ED at the Royal Wolverhampton Trust, Sandwell and West Bromwich Hospitals NHS Trust, Heart of England NHS Trust and University Hospitals Birmingham from 1st January 2013 to 16th March 2013. Although RWT does well to try and meet this target, it is becoming increasingly more difficult to ensure that patients are seen and discharged within a 4 hour period.



27.3 **Confusion and duplication across the system (too many access points);**

27.3.1 The chart below shows the Activity vs Proximity to services for the Emergency Portals across the city. The activity in the deepest 'purple' is where is the most concentrated activity is for that portal. There is significant duplication in the following maps:

- Maps for ED and Showell Park – patients are using the walk in centre at Showell Park and also the ED department
- Maps for the walk in centre at the Phoenix Centre and Primecare – both services are based from the same building.

Activity vs Proximity to Services

ED, Showell Park and Phoenix combined 2011/12

ED attendance 2011/12

Showell Park 2011/12

Phoenix 2011/12

Primecare Activity 2011/12 – Primecare is based at the Phoenix Walk in Centre

ED average cost 2011/12

27.3.2 In addition to the duplication of services from patients living in the same areas, the opening hours of the services are different:

- Pharmacies – variable but mostly 9am to 5.30/6pm (Mon to Sat);
- GP practices – variable but mostly 8am to 6.30pm with some afternoon closures Wed/Thurs;
- Walk in Centre - Showell Park - 8am to 8pm, 7 days per week
- Walk in Centre – Phoenix – Mon to Friday 10am to 7pm and 10am to 4pm on Saturdays, Sundays and bank holidays;
- Ambulance Service – 24/7
- Out of hours service – 6.30-pm to 8am Mon- Friday and all day at the weekend
- ED – 24/7.

27.4 Patient's health seeking between services (using several services in one episode).

27.4.1 Further to analysis of the walk in centre activity it appears that there are a number of patients who are using the walk in centres for their primary care requirements rather than using their own GP.

27.4.2 In total there were 1591 attendances in 2011 and 1847 in 2012 at the Phoenix Centre and Showell Park which also had an ED attendance within 1 day. Some of this activity will be for conditions that have worsened however this does suggest that some patients are bouncing between services for the same condition.

27.4.3 Very few patients attend all three services within a 24 hour period. There were only 19 attendances over an 18 month period who had attended all three centres in 1 day.

27.5 Too many people getting the right care , but not necessarily in the right part of the system;

27.5.1 The analysis also highlighted that activity is localised around the physical location of the Urgent Care Portal. When looking at the usage of the centres by patient based on their registered GP practice, it is clear that the proximity of the service to a patients home or GP practice has a significant impact on their use i.e. the closer they are based to the walk in centre, the more significant their usage. This might not always be appropriate as much of this activity could be resolved through self-care, through discussions with a Pharmacist or through visiting their own GP.

27.6 **GP access is variable (our patients are saying that they cannot get a GP appointment);**

27.6.1 GP access is difficult to measure and there are no routine ways of understanding our GP availability through data systems. However we have done much work with our patients to understand the barriers to our existing services and they say:

- GP appointments are not always available when patients have an urgent need (our patients say that they are using the walk in centres and ED because they cannot get an appointment at their own GP);
- There is significant variability in patient experience;
- Patients want to see their own GP but cannot always get an appointment when it is urgent.

27.7 **Services are stretched due to increased activity and increased complexity;**

27.7.1 GP practices, both walk in centres, ED and the ambulance service have all seen increased activity or increases in the complexity of patients arriving at services. The out of hours service is the exception, having seen **a reduction** in activity.

27.8 **Increasing costs in the system - funding is a challenge, there is no new money;**

27.8.1 It is no secret that funding is a challenge in the public sector and will continue to be so over the next few years. To ensure that services are sustainable, Clinical Commissioning Groups must ensure that savings are made and that a continuous cycle of improvement is undertaken to improve quality for patients.

27.8.2 The chart below shows the activity and finance changes expected from 2012/13 to 2016/17 if 'no change' is made

27.8.3 The scenario relates to a number of potential changes that could impact activity levels over the next few years. Scenario 4 includes the potential for RWT to achieve Hyper Acute Stroke Unit status and the potential for Mid-Staffs to be downgraded to an MIU, both of which would significantly change the activity levels across the system.

27.8.4 Activity and finance usually move inline for services that are on a block contract as the activity levels have a financial cap. Walk in Centre (primary care) activity appears to increase at the fastest rate however have only a 'like for like' increase in cost. The most significant change is the ED activity and finance changes. The ED was predicted to see an increase of 4.3% over the 4 year period however the associated cost of this activity increases at a far greater rate (6.9%). It must be noted that the activity for 2012/13 was already an increase of 5.19% more than 2011/12.

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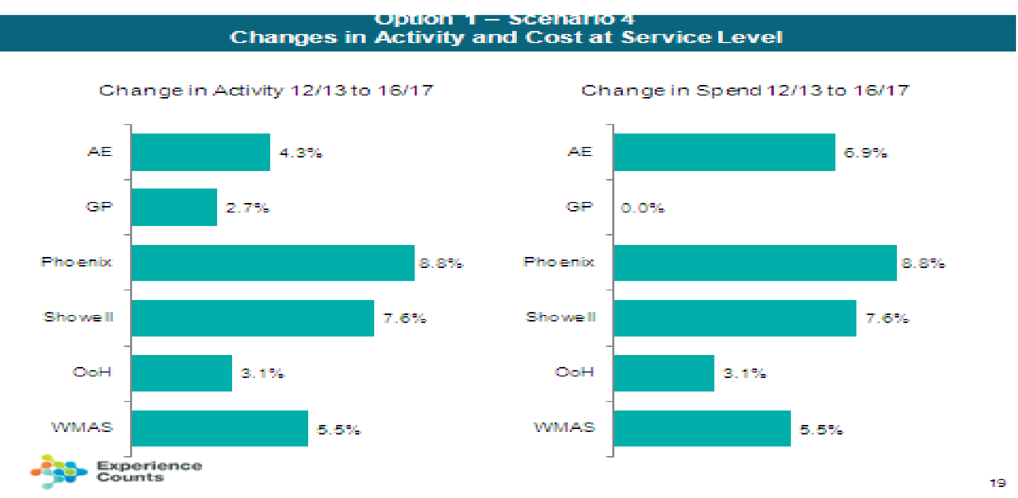
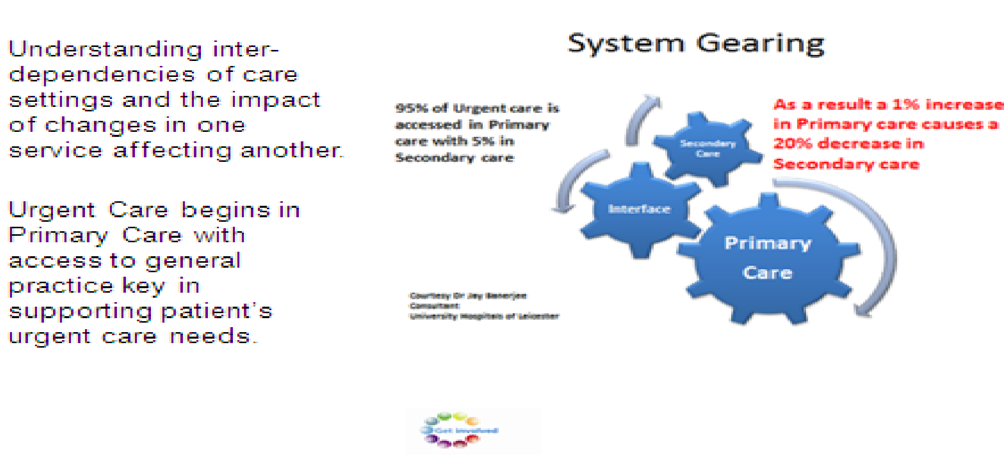


27.9 **An uncoordinated approach to Urgent Care (Urgent Care is a system);**

27.9.1 The existing services are commissioned individually and therefore one service might not compliment another. For example, the existing out of hours service has been commissioned in isolation of the wider urgent and emergency care services. As a result patients are confused about where the service is, if they can 'walk in' or the hours of opening.



27.9.2 'As a result of "system gearing" small changes in primary care, which includes general practice, can give rise to a much greater effect on the activity in hospitals (secondary care).

27.9.3 General practice provides the majority of urgent care and small changes to improve overall access and a consistent approach to urgent care requests, especially to older people, is likely to have a significant effect both on ED attendance and hospital admissions.

27.9.4 Improved access to timely integrated health and social care services in the community is also likely to have a significant impact on hospital admissions, length of stay, discharge and re-admission rates.' (RCGP, 2011).

27.10 **Walk in Centres offer an additional layer to the system**

27.10.1 'Each year around 290 million consultations take place with GPs and practice nurses, many of which are of an urgent nature. Between 1995 and 2006, the number of consultations grew at the rate of 3% each year. Over this same period, there was also an increase in the proportion of telephone consultations (up from 3% to 10% of contacts) and a decrease in the proportion of home visits (from 10% to 4% of contacts, although this is largely linked to the reorganisation of out of hours GP services)' (RCGP, 2011).

27.10.2 General Practitioners offer a service for minor health problems, illness, ailments and injuries. They look after the health of people in their local community and deal with a whole range of health problems including those requiring urgent treatment or advice. They also provide health education, offer advice on smoking and diet, run clinics, give vaccinations and carry out simple surgical operations. In addition to routine medical care and the management of long term conditions, GP's offer treatment for:

Minor cuts, bruises, burns, scalds insect bites, head injuries	Muscle and joint injuries such as strains and sprains, back pain
Coughs, colds, flu type symptoms and hay fever	High temperature
Skin complaints including rashes, minor allergic reactions, scabies, head lice, sun burn, nappy rash	Eye problems such as conjunctivitis
Ear, nose and throat problems including minor infections, sore throats, ear ache	Pregnancy testing/advice and appropriate referral
Sexual health/lifestyle advice	

27.10.3 Primary Care commissioning is the responsibility of NHS England, However CCG's will need to work closely with the local NHS England Birmingham, Solihull and the Black Country Area Team (the AT) to ensure that GP's and their practices are providing an acceptable standard of care as a minimum.

27.10.4 GP practices provide the same services (and more) than walk in centres. In Wolverhampton there are two walk in centres offering slightly differing services:

- The Phoenix Centre is nurse led seeing patients excluding under 1 years;
- Showell Park Walk in Centre is GP led with no age exclusions.

27.10.5 Both services were developed due to limitation in access to general practice and offer walk in facilities rather than the booked appointment systems that many GP services offer. If access to general practice is improved, there will be a correlating reduction in walk in centre and ED activity.

27.10.6 As described earlier in the strategy, Monitor is currently undertaking a review of the effectiveness of Walk in Centre provision and will publish its findings in the Autumn of 2013.

27.11 **The current activity and finances cannot be sustained in the future – we must do things differently.**

27.11.1 The existing system has seen significant pressure in recent months with patients attending the **Emergency** Department taking longer than 4 hours to be seen and

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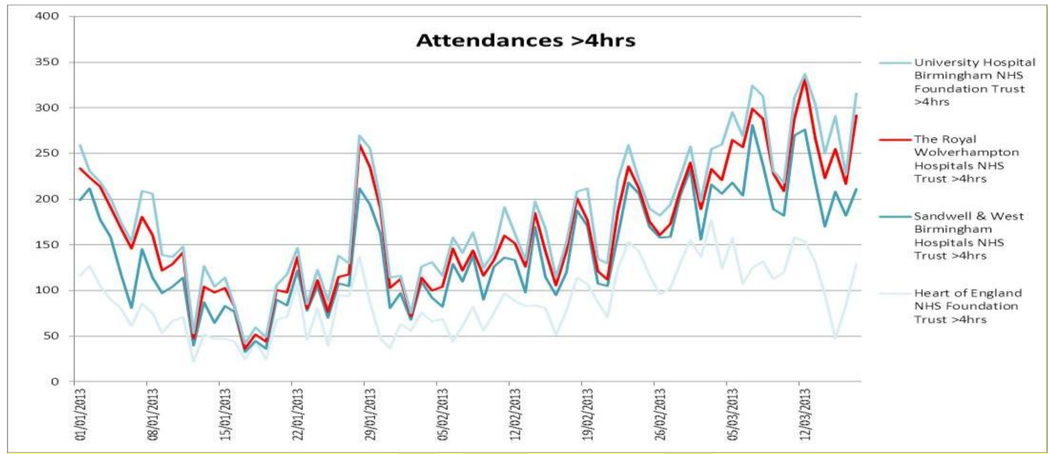
treated. The chart below shows the number of patients who have had to wait for more than 4 hours to be seen and treated from 1st January 2013 to 16th March 2013 for four acute trusts including RWT.

27.11.2 Three of the four trusts have similar activity patterns showing the current pressures within the system.

27.11.3 In more recent weeks the Emergency Department has seen the highest number of attendances within one day ever experienced (n392).



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28. Appendix 8 – Glossary of Terms

Glossary of Terms	
A&E	Accident and Emergency
AMU	Acute Medical Unit
BCP	Black Country Partnership
BME	Black Minority Ethnic
CDU	Clinical decisions Unit
CICT	Community Integrated Care Team
CIP	Cost Improvement Programme
COPD	Chronic Obstructive Pulmonary Disorder
DNAR	Do Not Attempt Resuscitation
DOH	Department of Health
EACC	Emergency Ambulatory Care Conditions
ED	Emergency Department
FSU	Frequent Service User
GP	General Practitioner
HASU	Hyper Acute Stroke Unit Status
HRG	Healthcare Resource Group
HWB	Health and Wellbeing Board
ICP	Integrated Commissioning Plan
IEP	Image Exchange Portal
LA	Local Authority
LINk	Local Improvement Network
LiNKS	Local Improvement Network
LMC	Local Medical Council
MIU	Minor Injuries Unit
ONS	Office of National Statistics
OOH	Out of Hours
PAU	Paediatric Assessment Unit
PC	Primary Care
PCC	Primary Care Centre
QIPP	Quality, Innovation, Productivity, Prevention
RWT	The Royal Wolverhampton NHS Trust
SAU	Surgical Assessment Unit
SES & SPCCG	Staffordshire and Seisdon Peninsula Clinical Commissioning Group
SPAR	Single Point of Access and Referral
WCC	Wolverhampton City Council
WCCG	Wolverhampton Clinical Commissioning Group
WiC	Walk in Centre
WMAS	West Midlands Ambulance Service NHS Foundation Trust
WUCTAS	Wolverhampton Urgent Care Triage Access Service

29. Appendix 9 – References

- *NHS Atlas of Variation in Healthcare 2011 (http://www.sepho.org.uk/extras/maps/NHSatlas2011/atlas.html)*
- *Effective Approaches in Urgent and Emergency Care'* created by the Intensive Support Team (Nov 2011)
- *Primary Care and Emergency Departments*, Primary Care Foundation (March 2010)
- Project Initiation Document (PID) *GP Alongside A&E*, Wolverhampton City Primary Care Trust (May 2012)
- *GP Alongside A&E Service Specification*, Wolverhampton City PCT (May 2012)
- *Making Sure health and social care services work together:* Gov.uk *https://www.gov.uk/government/policies/making-sure-health-and-social-care-services-work-together*
- *Urgent and Emergency Care*: Department of Health, http://www.dh.gov.uk/health/category/policy-areas/nhs/urgent-and-emergency-care (viewed: 13th December, 2011).
- *QIPP Workstreams*: Department of Health, http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/QIPPworkstreams/DH_115468 (viewed 13th December 2011).
- *RCGP Urgent & Emergency Care Commissioning Guide*: RCGP http://commissioning.rcgp.org.uk/wp-content/uploads/2011/09/RCGP-Urgent-Emergency-Commissioning-Guide-v2.pdf#
- *RCGP Urgent & Emergency Care Commissioning Guide* RCGP http://commissioning.rcgp.org.uk/wp-content/uploads/2011/08/RCGP-Urgent-Emergency-Commissioning-Guide-Chapter-8-p43-48.pdf
- *Integrated Commissioning Plan, WCCG, 2013*
- *Urgent Care for Children & Young People:* RCGP *http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z%20policy/Urgent_care_young_people.ashx*
- Kingsfund: *http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf*
- *System Plan: http://www.blackcountry.nhs.uk/wp-content/uploads/2012/04/System_Plan_Summary_2-11.pdf*
- *Urgent & Emergency Care Whole System Approach:* RCGP *http://www.rcgp.org.uk/revalidation-and-cpd/~/media/Files/CIRC/Audit/Urgent_emergency_care_whole_system_approach.ashx*
- *Developing the NHS Commissioning Board*, *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/152154/dh_128196.pdf.pdf*
- *Press Release*: Mid Staffs Enquiry http://www.midstaffsinquiry.com/pressrelease.html
- *Health care service standards in caring for neonates, children and young people* RCN 2011 http://www.rcn.org.uk/__data/assets/pdf_file/0010/378091/003823.pdf
- *Facing the Future*: Standards for Paediatric Services, RCPCH, Dec 2010 http://www.rcpch.ac.uk/facingthefuture
- *Not just a matter of time: a review of urgent & emergency services in England, Healthcare Commission*, September 2008 http://www.cqc.org.uk/publications.cfm?fde_id=10575
- *Children and Young People Emergency and Urgent Care Pathway*, NHS Institute for Innovation and Improvement, 2008 http://www.institute.nhs.uk/quality_and_value/high_volume_care/focus_on%3A_emergency_and_urgent_care_pathway.html

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- The Way Ahead College of Emergency Medicine 2008 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/147789/dh_117198.pdf.pdf
- Single handed GP Practices http://careers.bmj.com/careers/advice/view-article.html?id=20011803
- Digital by Default, 'The delivery Choice for England's Population Innovation Health & Wealth' by Transform Innovation Ltd.
- Health and Well Being Board Guide: http://healthandcare.dh.gov.uk/hwb-guide
- The Kingsfund,Urgent and Emergency Care May 2013: http://www.kingsfund.org.uk/projects/urgent-emergency-care?gclid=CJu1IKGTlrgCFeXItAod230AGg
- High quality care for all, now and for future generations: transforming urgent and emergency care services in England. Emerging Principles from the Urgent and Emergency Care Review June 2013
- Children and Young Peoples Plan 2011-2014, WCC, wolverhampton.gov.uk/childrensplan
- July A&E Recovery Plan, WCCG, Version 2
- NHS Constitution, http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf viewed 1/10/13
- TSA Public Consultation, http://tsa-msft.org.uk/wp-content/uploads/2013/07/Consultation-document.pdf viewed 2/10/13
- http://www.monitor.gov.uk/sites/default/files/publications/ToPublishReviewWalkinCentreServicesMay2013.pdf

Agenda Item No. 8

HEALTH AND WELLBEING BOARD – FORWARD PLAN 2013/14

MEETING	TOPIC	LEAD OFFICER
6 NOVEMBER 2013 (14:00 HOURS)	Reports from Sub Groups	Viv Griffin / Sarah Norman / Ros Jervis (WCC)
	Urgent and Emergency Care Strategy	Richard Young (CCG)
	Alcohol and Drugs – Progress Report	Ros Jervis (WCC)
	Draft Urgent and Emergency Care Strategy	Richard Young (CCG)
	Integration Transition Fund – Update on outcome of expression of interest	Anthony Ivko (WCC)
	Mental Health Strategy – Refresh and update on Mental Health Detection and Early Prevention	Viv Griffin / Sarah Fellows (WCC)
	Care Quality Commission – Inspection of New Cross Hospital (Royal Wolverhampton NHS Trust) – Initial Feedback	Cheryl Etches OBE (RWT)
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)

	Children and Young People's Plan – Refresh	John Welsby / Fiona Ellis (WCC)
	Autism Self - Assessment	Kathy Roper (WCC)
	Child Poverty Strategy	John Welsby (WCC)
5 MARCH 2014 (14:30 HOURS)	Reports from Sub Groups	Viv Griffin / Sarah Norman / Ros Jervis (WCC)
	Alcohol Strategy Update	Ros Jervis (WCC)

Agenda Item No: **10**

Health and Wellbeing Board

6 November 2013

Report Title	Mental Health Strategy Update	
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards Affected	All	
Accountable Strategic Director	Sarah Norman, Community	
Originating service	Health, Wellbeing and Disability	
Accountable officer(s)	Sarah Fellows Tel Email	Joint Head of Service Mental Health 01902 55(5304) Sarah.Fellows@wolverhampton.gov.uk

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Recommendation(s) for action or decision:
The Health and Wellbeing Board is recommended to:

1. Receive a detailed report regarding the outcomes of the Mental Health Strategy review at its January 2014 meeting, including detail regarding proposed commissioning intentions and next steps.

Recommendation(s) for noting:
The Health and Wellbeing Board is asked to note:

1. The action regarding the procurement and initiation of an independent review / stocktake of the Adult Mental Health Strategy.

2. The progress to date regarding the implementation of the Mental Health Strategy pending the outcome of the independent review.

3. The progress to date regarding the planned actions for the Health and Wellbeing Board Strategy Priority 4 Mental Health (early diagnosis and prevention).

1.0 Purpose

1.1 The purpose of this report is to provide an update regarding the Health and Wellbeing Board Strategy Priority 4 Mental Health (early diagnosis and prevention) and to inform members of the Health and Wellbeing Board of the progress regarding the implementation and review of the Wolverhampton City Council and Wolverhampton Clinical Commissioning Group Adult Mental Health Strategy (CCG) 2010 – 2015.

2.0 Background

2.1 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, with significant personal, social and economic costs attached. For this reason Mental Health (early diagnosis and prevention) is a key strategic priority within the Wolverhampton Joint Health and Wellbeing Strategy 2013-2018.

2.2 The refreshed Joint Mental Health Strategy will be pivotal in delivering one of the key priorities of the Health and Wellbeing Strategy – Mental Health Early Diagnosis and Prevention. It will specifically respond to the Department of Health (2011) report 'No Health Without Mental Health'.

2.3 The Joint Mental Health Commissioning Strategy outlines the transformation of Mental Health Service delivery in Wolverhampton for the period 2010 – 2015. The strategy development was informed by local data collection and analysis – which included a population needs assessment, bench marked quantitative activity and qualitative data from stakeholder engagement (including service users, carers, referrers and providers).

2.4 The strategy implementation has involved the transition of service users into new secondary care services and out of secondary services into primary care and primary care facing services. The commissioned health service model - provided by the Black Country Partnership Foundation Trust (BCPFT) - is aligned with the Yorkshire Care Pathways 'care cluster model'. The transition of service users into the appropriate service areas has been monitored by the Accelerated Transitions Group within BCPFT and via the quality, performance and contract monitoring mechanisms of the CCG.

2.5 New services initiated within the health elements of the model include the Wellbeing Service (incorporating Wolverhampton Healthy Minds), the Referral and Assessment Service and the Complex Care Team.

2.6 Following the end of the Section 75 agreement between Wolverhampton City Council and the Black Country Partnership Trust, mental health social care services have been re-modelled to include the Intake Team, the Complex Care Service and the Community Inclusion Team. Partnership working across health and social care and the independent sector is facilitated and co-ordinated by the Mental Health Partnership Meeting and the Mental Health Stakeholder Forum.

2.7 From the early stages of the strategy initiation commissioners and providers have worked together closely regarding the implementation of key service developments. Unanticipated levels of referrals into some secondary mental health services and feedback from service users and carers has suggested that some aspects of the service model require review. A 'stock take' of the strategy has been undertaken by the commissioner working closely with the provider. This included a 'whole systems' stakeholder event to focus upon pathways into and out of health services within social care and the independent sector to identify potential / actual gaps or pathway difficulties across the whole system.

2.8 As part of the CCG / BCPFT Local Delivery Plan process it has been agreed that an independent review of the implementation of the Mental Health Strategy will be jointly commissioned by BCPFT and the CCG. A revised Mental Health Strategy will be developed by the commissioner following completion of the independent review. This will be available in draft form in January 2014 and will respond to key strategic priorities for the City, and the local and national developments that have affected the health and social care landscape following the initiation of the Strategy such as the economic downturn, changing and emerging patterns regarding levels of need and demographics across the City and NHS and social care reform.

2.9 The revised Mental Health Strategy will be wholly aligned / co-terminus with the recently initiated Emotional and Psychological Health and Well-being Commissioning Strategy for Children and Young People 2013-16. This is to ensure a focus upon early diagnosis and prevention, families and to provide a 'life course' approach in keeping with the principles and priorities of 'No Health without Mental Health' (Department of Health 2011).

2.10 Overall the development of the revised strategy will provide an opportunity to re-focus commissioning upon a 'whole systems' model to deliver prevention, early diagnosis and intervention and recovery and target areas of in-equality, vulnerability and risk. There will be an emphasis upon commissioning to deliver integrated pathways across education, health and social care. This will include utilising new approaches and solutions including those regarding innovative technologies, and therefore be aligned with and support the delivery of Quality, Innovation, Productivity and Prevention (QIPP).

3.0 Progress to date

3.1 The commissioner has developed a Delivery Plan for the period July 2013 – January 2014 which is described in Appendices 1 and 2, as well as a Project Plan regarding the key mental health (early diagnosis and prevention) outputs of the Joint Health and Wellbeing Strategy, which is described in Appendix 3. In addition to the high level information provided within Appendices 1, 2 and 3 it is requested that the following developments are noted.

3.2 The commissioner is liaising with public health colleagues in WCC regarding the re-fresh of the mental health data intelligence within the Joint Strategic Needs Assessment (JNSA), to ensure that this exercise will provide the detail required to provide a comprehensive current and future picture of the mental health needs of the population

and an analysis of local risk and protective factors to inform 'whole systems' commissioning, including a comprehensive and targeted package of mental health promotion initiatives across the lifespan. The commissioner is working with public health colleagues in WCC regarding an application for Local Authority transformation funds to support delivery to this initiative.

3.3 The procurement processes regarding the strategy independent review has commenced. It is anticipated that the review will commence by the end of October. In the interim outline commissioning intentions have been communicated with BCPFT pending the outcomes of the strategy independent review.

3.4 The commissioner has provided additional non-recurrent financial resource ('winter pressures money') and substantive uncommitted strategy money to the provider to support the care pathway of people presenting with mental health needs in the Accident and Emergency Department of the Royal Wolverhampton Trust (RWT). This pilot remains on-going and the outcomes of this initiative are being jointly evaluated currently by both providers to ensure optimal benefit for the urgent and unplanned care pathway, and to inform the development of a Rapid, Assessment, Interface and Discharge (RAID) style model pilot at RWT. In addition substantive uncommitted strategy funds have been allocated to the provider to increase capacity within the Referral and Assessment Service (RAS) pending review of commissioning intentions post the Mental Health Strategy review. .

3.5 Further uncommitted strategy funds have been allocated to the provider to increase capacity within the Complex Care Service to maintain the care and treatment of people who are moving to recovery but require longer term care and support as an alternative model to discharge to Primary Care. The Well-Being Service model has also been reviewed to increase the capacity of the service to meet the needs of people requiring intensive support. Strategy funds have been provided to support the capacity of this service, to improve waiting times for those receiving psychological therapies and to increase the numbers of those service users moving to recovery within the service. On-line Cognitive Behaviour Therapy (CBT) is also available for people referred to the service and up take of this initiative is being closely monitored by commissioner and provider.

3.6 Commissioner and provider are working with the Birmingham, Black Country and Solihull NHS England Area Team to deliver a Simple Tele-health pilot project within BCPFT. Pilot areas have been identified as CAMHS and Well-Being. Potentially this initiative may be extended to other Mental Health Service Providers in Wolverhampton in 2014/15.

3.7 Commissioner and provider mental health leads within the Local Authority are jointly reviewing the current social care elements of the mental health service model. A bid is in preparation for Local Authority Public Health transformation funds to support re-commissioning of elements of the day service model, following feedback from service users and carers and Health Watch regarding components of the pathway and to support delivery of the key priorities of the Reablement Plan.

3.8 Some mental health community support services are currently in a tender process; this includes two community/day services and the service user empowerment service, and some supported accommodation services, which form part of the accommodation Reablement Pathway.

3.9 Commissioner and provider/s are working together to deliver the Emotional and Psychological Health and Well-being Commissioning Strategy for Children and Young People 2013-16, and to develop pathways with Adult Mental Health services and initiate the services changes within Adult Mental Health services within BCPFT to deliver the Young Persons’ Service for those aged 14-25 years.

3.10 The Commissioner continues to explore opportunities to collaboratively commission some service components with Black Country commissioning colleagues, including Sandwell and West Birmingham CCG.

4.0 Financial implications

4.1 The Mental Health Strategy will be delivered within the existing financial contract quantums with QIPP / cost efficiency savings applied as per CCG and WCC plans. New initiatives / service models will be funded by remodelling / re-commissioning of existing services and collaborative commissioning arrangements e.g. with Sandwell and West Birmingham CCG colleagues where / if possible. Applications are in progress for Local Authority transformation funds and non-recurrent funds from the CCG as discussed, to support early diagnosis and prevention initiatives and to increase capacity within the Referral and Assessment Service to support the urgent and unplanned care pathway at RWT. This is pending any re-commissioning / re-modelling of any aspects of the current service model post the development of the revised Mental Health Strategy.

[NM/28102013/U]

5.0 Legal implications

5.1 There will be a statutory duty to engage in a formal consultation process regarding any proposed service changes in the revised / refreshed Mental Health Strategy.

[RB/18102013/B]

6.0 Equalities implications

6.1 An Equality Impact Assessment will be conducted on the revised / refreshed Mental Health Strategy.

7.0 Environmental implications

7.1 No environmental implications regarding the implementation and review of the Mental Health Strategy have been identified to date.

8.0 Human resources implications

8.1 No environmental implications regarding the implementation and review of the Mental Health Strategy has been identified to date.

9.0 Schedule of background papers

9.1 Appendix 1 Mental Health Commissioning Delivery Plan – July ‘13 – January ‘14
Appendix 2 Dashboard Report - Reviewed: October 2013
Appendix 3 Mental Health (Early Diagnosis and Prevention) Project Plan

Service Area / Care Pathway or Initiative	Action Required	Lead/s	Action Required	Finance	Key Service User Outcomes / Activity /Outputs
	Overview of service model change / development or initiative to be delivered.		**Process and Key Milestones** **Completion date**		**KPIs, Vital Signs, NICE, MHPbR Outcomes, Project Plans etc.**
1. All- Age Mental Health Strategy Delivery	Deliver CAMHS Strategy and re-freshed Adult Mental Health Strategy. Ensure focus on: • MHPbR • QIPP • Gap analysis from stakeholder event • CAMHS Consultation • Collaborative Commissioning • Resilience Strategy • Early diagnosis and prevention • Care pathways • Care Programme Approach	SF, MG and SE.	Complete Commissioning Intentions. **September 2013**. Appoint to Independent Review re AMH Strategy. **September 2013**. Develop / Deliver Draft Strategy. **January 2014**.	Within contract quantum/s with QIPP target/s.	No Health Without Mental Health NICE CGs Five Ways to Well-Being Children's Act Outcomes

Service Area / Care Pathway or Initiative	Action Required	Lead/s	Action Required	Finance	Key Service User Outcomes / Activity /Outputs
	Overview of service model change / development or initiative to be delivered.		**Process and Key Milestones** **Completion date**		**KPIs, Vital Signs, NICE, MHPbR Outcomes, Project Plans etc.**
2. Engagement with Universal Services, Schools, Colleges, Universities, Community and Faith Groups, Places of Employment Primary Care	Programme of targeted MH Promotion initiatives to be delivered across Universal Services, Schools, Colleges, Universities, Community and Faith Groups, Places of Employment Primary Care, etc to include: • Self-harm and suicide prevention tool kit for Schools, Colleges, and Universities. • Beat Bullying / Cyber bullying • Time to Change • Focus on Looked After Children. • Parenting Programme. • Substance Misuse. • Simple Tele-Health. • Resilience Strategy • Early diagnosis and prevention • Care pathways	MG and CDWs working with Public Health.	MH Strategy Task and Finish Group to agree programme of deliverables / initiatives and timescales for delivery by **December 2013**. Bid to Public Health Funds to initiate key deliverables **September 2013.** Work with Mending Minds re bid to Lottery Funding – **October 2013**. Re-fresh attendance at and engage Stakeholder Forum by **October 2013**.	Bid applications **September & October 2013**.	No Health Without Public Mental Health Five Ways to Well-Being Children's Act Outcomes

Service Area / Care Pathway or Initiative	Action Required	Lead/s	Action Required	Finance	Key Service User Outcomes / Activity /Outputs
	Overview of service model change / development or initiative to be delivered.		**Process and Key Milestones** **Completion date**		**KPIs, Vital Signs, NICE, MHPbR Outcomes, Project Plans etc.**
3. Early Interventio n (14- 35 years).	Review service specification to ensure alignment with new CAMHS model. Ensure focus upon: • Pathway to HTT • Looked After Children. • Pathway to Substance Misuse • Consultant Psychiatry sessions • Pathways to Tier 4 (Children and Adult). • Collaborative Commissioning / cross Trust model	MG working with Provider	Liase with West B'ham and Sandwell CCG re Trust wide model. **September 2013**. Reviewed service specification to be agreed by **January 2014**.	Baseline and MH Grant.	NICE Guidance Vital Signs Five Ways to Well-Being Children's Act Outcomes

Service Area / Care Pathway or Initiative	Action Required	Lead/s	Action Required	Finance	Key Service User Outcomes / Activity /Outputs
	Overview of service model change / development or initiative to be delivered.		**Process and Key Milestones** **Completion date**		**KPIs, Vital Signs, NICE, MHPbR Outcomes, Project Plans etc.**
4. RAS / Home Treatment (Adults)	Re-model Crisis / RAS and review HTT service specification. Ensure alignment with draft service specification for RAID Model. Ensure focus upon: • Crisis Contacts • Gate keeping Function • All age function out of hours • Section 136 MHA 1983 • Consultant Psychiatry sessions • Pathways to Tier 4 (Children and Adult). • Out of hours	SE working with Provider	Review Service Specification **January 2014**. Detail of non-recurrent outputs reviewed BCPFT / RWT **October 2013.**	Contract Baseline. Strategy monies. Non-recurrent funds 2012/13. Bid to CCG for Reablement Funds to pump prime service change (Interim Model). September 2013 Additional Non-recurrent funds 2012/13 (transition)	NICE Guidance Vital Signs Five Ways to Well-Being Children's Act Outcomes

Service Area / Care Pathway or Initiative	Action Required	Lead/s	Action Required	Finance	Key Service User Outcomes / Activity /Outputs
	Overview of service model change / development or initiative to be delivered.		**Process and Key Milestones** **Completion date**		**KPIs, Vital Signs, NICE, MHPbR Outcomes, Project Plans etc.**
5. Psychiatric Liaison	Re-model RAS and Older Adults Liaison Psychiatry. Develop revised service specification for new psychiatric liaison model. Ensure focus upon: • Response times • Gate keeping Function • All age function • CAMHS function out of hours • Section 136 MHA 1983 • Consultant Psychiatry sessions • Substance Misuse Pathways • Pathways to Tier 4 (Children and Adult). • Collaborative Commissioning	SF working with Provider	Review good practice model/s and NICE CG. **September 2013** Review of Dr Hardy activity and MH Breeches. **October 2013**. Develop RAID Type Model via Urgent Care Sub-group. **October 2013**. Liase with West B'ham and Sandwell CCG re Trust wide model. **September 2013**. Service Specification to CCG finance by **October 2013.**	Contract Baseline. Bid to CCG for Reablement Funds to pump prime service change (Interim Model) September 2013.	NICE Guidance Vital Signs Five Ways to Well-Being Children's Act Outcomes

Service Area / Care Pathway or Initiative	Action Required	Lead/s	Action Required	Finance	Key Service User Outcomes / Activity /Outputs
	Overview of service model change / development or initiative to be delivered.		**Process and Key Milestones** **Completion date**		**KPIs, Vital Signs, NICE, MHPbR Outcomes, Project Plans etc.**
6. Well-Being	Review current model and develop revised service specification. Ensure focus upon: • Response times • Waiting times • Numbers moving to recovery • Numbers moving to employment / off sick pay • CPA / Case Management • Consultant Psychiatry sessions • Clusters 0-3 • Clusters 4-7 • Pathways into Big White Wall • Ticket to Recovery	SE working with Provider	Review good practice model/s and NICE CG. **October 2013**. Review of waiting list initiative. **September 2013**. Review of BCPFT action plan. **September 2013**. Review of Big White Wall activity. **September 2013**. Review of Consultant Psychiatry in-put. **December 2013.** Reviewed service specification to be agreed by **January 2014**.	Contract Baseline. Waiting List initiative 2012/13. Bid to CCG for Reablement Funds to continue waiting list initiative. September 2013 Additional Non-recurrent funds 2012/13 (transition)	NICE Guidance Vital Signs IAPT KPIs Five Ways to Well-Being

Service Area / Care Pathway or Initiative	Action Required	Lead/s	Action Required	Finance	Key Service User Outcomes / Activity /Outputs
	Overview of service model change / development or initiative to be delivered.		**Process and Key Milestones** **Completion date**		**KPIs, Vital Signs, NICE, MHPbR Outcomes, Project Plans etc.**
7. Recovery (Complex Care)	Review service specification to ensure alignment with revised Adult MH pathways (end of single point of access). Ensure focus upon: • Pathway to HTT • Dual Diagnosis Pathway • PD Hub • Pathway to EIS • Assertive Outreach contacts • Criminal Justice Pathway (see below) • Consultant Psychiatry sessions • Transition of patients Cluster 0-7 into other services.	SF working with Provider	Reviewed service specification to be agreed by **January 2014**.	BCPFT Contract Baseline. Additional Non-recurrent funds 2012/13 (transition)	NICE Guidance Vital Signs Five Ways to Well-Being

Service Area / Care Pathway or Initiative	Action Required	Lead/s	Action Required	Finance	Key Service User Outcomes / Activity /Outputs
	Overview of service model change / development or initiative to be delivered.		**Process and Key Milestones** **Completion date**		**KPIs, Vital Signs, NICE, MHPbR Outcomes, Project Plans etc.**
8. Day Support	Re-model and re-commission Day Support model. Ensure focus upon: • Outcomes Framework • Recovery Model • CPA • Alignment with BCPFT service model • Clusters 0-3 • Clusters 4-7 • Clusters 8 - 17 • People aged 18-25 • Culturally sensitive services	SE working with Providers	Report outcome of Day Service review to DDG. **September 2013**. Plan and design new service model. **October 2013**. Report new service model to DDG with financial plan. **October 2013**. Instigate procurement of interim transition model. **November 2013**. Plan procurement of new service model **December 2013**.	Bid to CCG for Reablement Funds to pump prime service change. September 2013. Existing Community contracts baselines.	NICE Guidance Five Ways to Well-Being

Service Area / Care Pathway or Initiative	Action Required	Lead/s	Action Required	Finance	Key Service User Outcomes / Activity /Outputs
	Overview of service model change / development or initiative to be delivered.		**Process and Key Milestones** **Completion date**		**KPIs, Vital Signs, NICE, MHPbR Outcomes, Project Plans etc.**
9. In-Patients including Older Adults & PIC	Develop commissioning intentions re female PIC and review provision in placements / cost and volume contracts. Review service specifications to ensure alignment with revised MH pathways. Ensure focus upon: • Pathway to HTT / Intermediate Care • OBDYs • Dual Diagnosis Pathway • Consultant Psychiatry sessions • Delayed Discharges • Repatriations from placements • Step down to Recovery House • Step down to Victoria Court	SF and JVD working with Provider	Liase with Black Country commissioners re collaborative approach for male and female PIC **September 2013**. Report to CCG Finance re QIPP update (Individual Cases). **August & October 2013.** Agree QIPP target BCPFT 2014/15. **January 2014**. Reviewed service specifications to be agreed by **January 2014**.	BCPFT contract service lines QIPP target/s 2013/14 and 2014/15	NICE Guidance Vital Signs Five Ways to Well-Being

Service Area / Care Pathway or Initiative	**Action Required**	**Lead/s**	**Action Required**	**Finance**	**Key Service User Outcomes / Activity /Outputs**
	Overview of service model change / development or initiative to be delivered.		**Process and Key Milestones** **Completion date**		**KPIs, Vital Signs, NICE, MHPbR Outcomes, Project Plans etc.**
10. Social Care Model (Adult Mental Health)	Review model to ensure alignment with revised Adult and CAMHS MH pathways. Ensure focus upon: • Integrated Pathways with BCPFT • EDT and In-take Team support to A&E • Reablement • Revised Day Services model provision • Step-down from Penn and Nursing / Residential Care • Pathways to supported accommodation • Referral response times	SF & MG working with Provider.	Reviewed service model to be agreed by **December 2013**. Plan next steps accordingly.	Baseline	NICE Guidance Five Ways to Well-Being

Service Area / Care Pathway or Initiative	**Action Required**	**Lead/s**	**Action Required**	**Finance**	**Key Service User Outcomes / Activity /Outputs**
	Overview of service model change / development or initiative to be delivered.		**Process and Key Milestones** **Completion date**		**KPIs, Vital Signs, NICE, MHPbR Outcomes, Project Plans etc.**
11. Older Adults MH Services	Review service specifications to ensure alignment with revised Adult MH pathways. Ensure focus upon: • Pathway to In-patients • Dual Diagnosis Pathway • MHPbR Cluster outcomes • Pathway to in-patients • Assertive Outreach contacts • Consultant Psychiatry sessions • Psychiatric Liaison / RAID	SF working with Provider and SB	Review good practice model/s and NICE CG. **October 2013**. Agree delayed discharges policy health / social care. **October 2013**. Reviewed service specification with reviewed KPIs to be agreed by **January 2014**.	Contract Baseline	NICE Guidance Five Ways to Well-Being

Appendix 2

Mental Health Commissioning Delivery Plan July 2013 – January 2014 Dashboard Report - Reviewed: October 2013

Service area / pathway initiative	Red	Amber	Green	Comments / Risks / Corrective Action Plan	Lead	Updated (Date)
1. All-Age Mental Health Strategy Delivery		Y		Appoint to MH Strategy stocktake	SF	10/13
2. Engagement with Universal Services etc.		Y		Bid Application to Transformation Funds	MG	10/13
3. Referral and Assessment Service			Y	Service specification review in progress	SE	10/13
4. Psychiatric Liaison / RAID	Y			Service specification development in progress.	SF	10/13
5. Well-Being		Y		Review of Waiting List Initiative and Service specification in progress.	SE	10/13
6. Complex Care			Y	Service specification development in progress.	SF	10/13
7. Criminal Justice		Y		Meeting scheduled SWB CCG.	SF	10/13
8. Day Support		Y		Bid application in progress.	SE	10/13
9. In-patients		Y		Meeting scheduled SWB CCG / QIPP in progress	SF	10/13
10. Social Care Model			Y	Review in progress	SF	10/13
11. Older Adults				Service Specification reviews in progress	SF	10/13
Total:	1	6	3			

	Red	Amber	Green	Total
Projects	1	6	3	9
No. of completed projects	None			

Mental Health (Early Diagnosis and Prevention) Project Plan

This document is designed as a standardised project plan. The plan will be subject to monthly update and monitoring. This will be reported by exception to the relevant Committees etc. as requested.

Project Key and name:	**The Mental Health (Early Diagnosis and Prevention) Plan**	**Cross Cutting Initiatives** (If applicable)	**Joint Health and Well-being Strategy** **Emotional and Psychological Health and Well-Being Strategy** **Commissioning Strategy for Children and Young People 2013/16** **Mental Health Strategy** **Mental Health Commissioning Delivery Plan** **Joint Strategic Needs Assessment** **CCG Integrated Commissioning Pan** **No Health without Mental Health** **No Health without Public Mental Health** **Five Ways to Wellbeing** **What about the Children?** **Quality, Innovation, Productivity and Prevention (QIPP)**

Project Description:	**Project Description:** • The purpose of the project is to deliver to each of the priority areas of the planned high level out puts of the Mental Health (Early Diagnosis and Prevention) Plan, which is a component of the Joint Health and Wellbeing Strategy. • This project is aligned with the Adult Mental Health Strategy re-fresh / review and the delivery of the CAMHS Strategy. • This project will deliver a series of initiatives that will provide a focus and emphasis upon mental health early diagnosis and prevention across health, education and social care. • This Project will deliver detailed needs analysis of the current and future mental health and wellbeing needs of the population of our City, including an analysis of local risk and protective factors. • This project will deliver a Resilience Strategy as an integral component of the re-freshed Mental Health Strategy.	
Scope of Project:	The project will consider all universal, primary care and mental health services across the lifespan, promoting prevention, early diagnosis and recovery and targeting areas of inequality, vulnerability and risk.	
Project Lead:	Sarah Fellows– Joint Commissioning Mental Health	
Project Members:	1. Sarah Fellows – Joint Commissioning Mental Health	
	2. Mai Gibbons – Senior Commissioning Officer	
	3. Susan Eagle – Senior Commissioning Officer	
Timescales:	**Expected Start Date:**	September 2013
	Expected lifespan:	Review Monthly End: August 2014
Planned Outputs:	1. To re-fresh / revisit the mental health data within the Joint Strategic Needs Assessment (JNSA).	
	2. To promote good / positive mental health and wellbeing.	
	3. To address health risk behaviour in people with mental health difficulties and / or people at risk of developing mental health difficulties.	
	4. To describe early intervention care pathways from universal to primary and secondary care services for all care clusters in Adult Mental Health and all diagnostic groups in CAMHS.	
	5. To re-fresh / review the Care Programme Approach policy across all agencies to promote recovery and reablement across all care clusters / service areas, to prevent relapse / re-admissions where possible.	

	6. Within all of the above describe pathways for hard to reach groups.		
	7. To develop the utilisation of the Recovery Star as a set of outcome measures across all care clusters / service areas and as a mechanism to support the commissioning and delivery of a greater and more cohesive 'whole systems' approach to mental health.		
Existing External Action:	**The action below has been identified against your project within an existing external action plan:**		
	Joint Health and Wellbeing Strategy		
Expected Milestones:	**Describe milestone:**	**Due date**	**Achieved date**
	1. To provide strong data 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.	End January 2014	January 2014
	2. To develop programme of universal proportionality i.e. targeted wellbeing promotion to facilitate recovery of people at risk of developing mental difficulties and people with mental health difficulties. Sign up to 'Time to Change campaign to tackle stigma locally. 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'.	End January 2014	January 2014
	3. Work with Public Health England to co-ordinate approaches for identified target audiences regarding: ▪ Alcohol ▪ Cannabis (skunk) ▪ Tobacco ▪ Obesity	End January 2014	January 2014

	4. As part of CAMHS and Adult Mental Health Strategy development re-fresh / develop early intervention care pathways for all care clusters / service areas. • Work with GPs and Provider Leads • Align with NICE Guidance • Identify pathways for key target groups	Drafts by April 2014	April 2014
	5. Re-fresh / review the Care Programme Approach policy across all agencies to promote recovery and reablement across all care clusters / service areas, to prevent relapse / re-admissions where possible. • Align with Strategy development and delivery • Work with GPs and Provider Leads • Align with NICE Guidance	Drafts by April 2014	April 2014
	6. As part of CAMHS Strategy and Adult Strategy development and delivery 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, who are at risk due to issues regarding their gender identity and / or sexuality and people who are Disabled and /or have a Learning Difficulty.	End January 2014	January 2014

	7. To develop the utilisation of the Recovery Star as a set of outcome measures across all care clusters / service areas and as a mechanism to support the commissioning and delivery of a greater and more cohesive 'whole systems' approach to mental health. • Align with Strategy development and delivery • Work with Provider Leads • Develop through Mental Health Strategy Steering Group and Stakeholder Forum	End April 2014	April 2014
Outcomes to give assurance that project is completed:	**How will the progress against outcomes be measured?**	**Evidence**	**Sign off date**
	1. Re-fresh JNSA	Via MH Steering Group	
	2. Mental Health Promotion	As above	
	3. Health Risk Behaviour	As above	
	4. Early Intervention / Diagnosis Pathways	As above	
	5. Re-fresh CPA Policy	As above	
	6. Pathways for targeted / hard to reach groups	As above	
	7. Recovery Star	As above	

Reporting Process:	**Which group will the project report into?**	**How often?**
	Mental Health Strategy Steering Group Joint Commissioning Development and Delivery Group Adult Delivery Board Health and Well-Being Board	Bi-Monthly / as required

Risk Profile

In this section describe any risks or barriers to the successful delivery of the project.

Risk Matrix

	Likelihood	Unlikely to occur	May occur at some time	Is likely to occur
Consequence	**Score**	**1**	**2**	**3**
Minimal effect on project delivery	**1**	1	2	3
Will affect some parts of project delivery	**2**	2	4	6
Significant impact on the delivery of project	**3**	3	6	9

Project Inter-dependencies	**Is the success of this project dependent on any other project or process?** (describe below)	**Yes/No**
	[e.g. project cannot commence until another project concludes] No, the project can commence / continue.	
Risk Assessment: Describe any risks that are likely to affect the delivery of the Project		
Risk:	**How is this risk likely to affect the project?:** (include any risk mitigation)	**Risk Score:** (see matrix below)
	All project outputs have cross cutting initiatives and will rely upon strong multi-disciplinary working with health colleagues and other stakeholders.	3x2= 6 Red

Review Dates of this plan

Review Date	Reviewer	Comments/ Alterations etc
October 2013	SF	

Agenda Item No: **11**

Health and Wellbeing Board

6 November 2013

Report Title	**Progress Update on Joint Health and Wellbeing Strategy Priority: Alcohol and Drugs**	
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards Affected	All	
Accountable Strategic Director	Sarah Norman, Community	
Originating service	Community/Public Health	
Accountable officer(s)	Ros Jervis	Director of Public Health
	Tel	01902 55(1372)
	Email	Ros.jervis@wolverhampton.gov.uk

Recommendation

That the Health and Wellbeing Board:

- Notes the update in relation to the implementation of the key performance indicators in the Joint Health and Wellbeing Strategy 2013 – 18.
- Notes the plan by the Alcohol Strategy Strategic Leads group to develop a highlight reporting system (dashboard) to streamline the reporting of indicators to monitor progress with the Wolverhampton Alcohol Strategy 2011-2015. This will make reporting more meaningful by reporting by exception those areas that are off track, those areas that are on track and those areas doing very well.
- To agree the proposal that the Wolverhampton Alcohol Strategy is the key implementation plan for the alcohol strand of the Joint Health and Wellbeing Strategy priority area for drugs and alcohol and that the implementation plan for drugs will be through the NACRO contract overseen by a multiagency Joint Commissioning Board

1.0 Purpose

1.1 Alcohol and drugs is one of the key priorities in Wolverhampton's Joint Health and Wellbeing Strategy (JHWBS) 2013-18, approved by the Health and Wellbeing Board at its September 2013 meeting. This report is to:-

- Provide members of the Board with regular updates regarding the key performance indicators used in the JHWBS to monitor performance for this priority and to outline plans to provide more meaningful reporting of the Wolverhampton Alcohol Strategy.

- Proposals are made to clarify the relationship between Wolverhampton's Alcohol Strategy and the Joint Health and Wellbeing Strategy Alcohol priority, which is that the Alcohol Strategy is the implementation plan for the alcohol element of the Health and Wellbeing Strategy Alcohol and drugs priority.

- Arrangements for monitoring the drugs strand of the priority are also outlined.

2.0 Background

2.1 Wolverhampton Joint Health and Wellbeing Strategy 2013 -2018
The Joint Health and Wellbeing Board approved Wolverhampton's Joint Health and Wellbeing Strategy at its board meeting on 4th September 2013. One of the top five priorities identified by the Board was Alcohol and Drugs, with the following key high level targets to monitor progress:

- 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 users in treatment who complete treatment and do not represent within 6 months (non-opiates)

2.2 Wolverhampton Alcohol Strategy 2011 - 2015
The Shadow Health & Wellbeing Board endorsed the Wolverhampton Alcohol Strategy 2011 – 2015, associated action plan and performance management framework on 5th September 2012 and agreed to receive periodic progress reports.

The Board received a comprehensive update on the progress of the strategy at its meeting on 3rd July 2013 which considered performance outturn against action plan for 2012/13 and presented a revised action plan for 2013/14.

2.3 Joint Commissioning Group – NACRO contract for substance misuse
Following a 10 month procurement programme Wolverhampton City Council commenced an initial three-year contract with substance misuse and crime reduction charity NACRO to deliver a new, consolidated drug and alcohol treatment service for young people and

adults on 1st April 2013. The contract is delivered by NACRO in partnership with Birmingham and Solihull Mental Health NHS Foundation Trust and Aquarius.

NACRO provides a culturally sensitive whole person and recovery focussed integrated system of care and treatment for: adult drug users, adult alcohol users, young substance users and those affected by familial misuse.

Operational delivery is being met through the NACRO contract and performance framework, which has a payment by results (PBR) element, within the contract. A multiagency Joint Commissioning group has oversight of the NACRO contact and oversees the performance of the contract and outcomes as determined by the needs assessment completed by public health.

3.0 Progress Against Delivery

3.1 Performance Update - Wolverhampton Joint Health and Wellbeing Strategy 2013 -2018
Public Health England (PHE) estimates show that there are 2,135 opiate/crack users and 5,264 dependant drinkers in Wolverhampton. Currently there are 1,393 adults in effective drug treatment, 61 young people receiving treatment for addiction and 553 adults in alcohol treatment in Wolverhampton. The performance indicators used in the Health and Wellbeing Strategy outlined in section 2.1, mirror national benchmarks set around achieving successful outcomes for those in treatment.

Nationally validated performance feedback on drug and alcohol treatment from PHE is received quarterly and the summary from the latest release shows that:

Indicator	Current performance
Reduction in 3 year average alcohol related mortality rates per 100,000 all ages population from a baseline of 19.6 in 2008 – 2010	Latest annual reporting for 2010-2012 shows a 3 year average mortality rate of 15.9 per 100,000 all ages population. This reduction is to be cautiously welcomed, and continued monitoring will establish if this downward trend is sustained
Improvement to the top quintile nationally for the percentage of drug users in treatment who complete treatment and do not represent within 6 months (opiates)	When considered as a percentage of the whole treatment population, the overall figure for Wolverhampton for successful completion rate of opiate (and alcohol users) has remained static. Clients being treated for non-opiate use have decreased. The partnership needs only to increase by an additional 10 clients to meet the cluster top performers but an additional 50 non-opiates would be required. The re-presentation rate needs some focussed attention to ensure clients are not being pushed out of the system too quickly.
Improvement to the top quintile nationally for the percentage of drug users in treatment who complete treatment and do not represent within 6 months (non-opiates)	

In future updates, reporting will be by exception.

3.2 Performance Update - Wolverhampton Alcohol Strategy 2011 - 2015
In future updates, reporting will continue to be by exception as in previous Board updates, however, the Alcohol Strategy Strategic Leads group is developing a highlight reporting system via a dashboard to streamline the reporting of indicators to monitor progress with the Wolverhampton Alcohol Strategy 2011-2015. This will consist of fewer, but more meaningful indicators which will highlight those areas that are off track, those areas that are on track and those areas doing very well. However, in order to do this effectively, the 4 goal leads for the key strategy areas will need time to collect and incorporate the data – which is not available until some weeks after each quarter end. It is anticipated that the next Board update due in March 2014 will report on data available to end of December 2014 (i.e. up to Quarter 3, 2013/14).

3.3 Implementation of the Drug and Alcohol Priority
In order to clarify the relationship between these work streams, it is proposed that the Wolverhampton Alcohol Strategy is the key implementation plan for the alcohol strand of the Joint Health and Wellbeing Strategy priority area for drugs and alcohol and that the implementation plan for drugs will be through the NACRO contract overseen by a multiagency Joint Commissioning Board

4.0 Financial implications

4.1 There are no direct financial implications arising from this report.

4.2 Any actions arising from both Strategies will be delivered within the approved budgets held under Public Health, other mainstream budgets held by services and external agencies that are responsible for delivery of specific actions.

4.3 The NACRO contract value is £5.5 million which is funded from Public Health grant.

[AS/18102013/K]

5.0 Legal implications

4.1 There are no direct legal implications arising from this report. However, a number of the actions contained within the Wolverhampton Alcohol Strategy Action Plan will require specific legal involvement on an individual, case by case, basis.

[JH/181013/I].

6.0 Equalities implications

6.1 The broad aims and objectives of the Joint Health and Wellbeing Strategy and Wolverhampton Alcohol Strategy are intended to reduce the harmful impact of alcohol (and drugs) on health & wellbeing and reduce health inequalities.

7.0 Environmental implications

7.1 There are direct environmental implications arising from this report as several actions contained within the Alcohol Strategy and action plan seek to improve environmental conditions, particularly within the City Centre.

8.0 Human resources implications

8.1 There are no direct HR implications of this performance update report.

9.0 Schedule of background papers

9.1 Papers to Health and Wellbeing Board
REPORT TO THE SHADOW HEALTH AND WELLBEING BOARD – Wolverhampton Alcohol Strategy 2011 – 2015. 5TH September 2012

REPORT TO THE HEALTH AND WELLBEING BOARD – Joint Health and Wellbeing Strategy Update. 1st May 2013

REPORT TO THE HEALTH AND WELLBEING BOARD – Alcohol Strategy – Progress Update. 3rd July 2013

REPORT TO THE HEALTH AND WELLBEING BOARD - Wolverhampton Joint Health and Wellbeing Strategy 2013 – 2018 and JSNA. 4th September 2013

9.2 Papers to Licensing Committee
REPORT TO LICENSING COMMITTEE – Wolverhampton Alcohol Strategy 2011 – 2015. 27th June 2012

REPORT TO LICENSING COMMITTEE - Wolverhampton Alcohol Strategy 2011 – 2015. 27th June 2012- Update Report. 13th February 2013

REPORT TO LICENSING COMMITTEE – Alcohol Strategy: Progress Update. 22nd May 2013

9.3 Papers to Cabinet
REPORT TO THE CABINET (RESOURCES) PANEL – Substance Misuse Procurement Programme. Tuesday 21st February 2012

REPORT TO CABINET – Section 75 Agreement With Wolverhampton City PCT. Wednesday 11th April 2012

REPORT TO THE CABINET (RESOURCES) PANEL – Substance Misuse Procurement Programme. Tuesday 27th November 2012

9.4 Papers to Health Scrutiny Panel

REPORT TO HEALTH SCRUTINY PANEL – Wolverhampton Substance Misuse Services Consultation Findings. Thursday 12th April 2012

REPORT TO HEALTH SCRUTINY PANEL – Wolverhampton Substance Misuse Service Contract Award and Mobilisation. Thursday 7th February 2013

Agenda Item No: **12**

Health and Wellbeing Board

6 November 2013

Report Title	Wolverhampton CCG Commissioning Intentions 2014/15
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Strategic Director	Richard Young – Director of Strategy & Solutions - WCCG
Originating service	Wolverhampton Clinical Commissioning Group
Accountable officer	Richard Young Director of Strategy & Solutions - WCCG

Recommendations for action or decision:

The Health and Wellbeing Board is recommended to:

1. Considers the first draft of the list of CCG commissioning intentions
2. Notes the timeline and methodology for prioritisation / refinement.
3. Provides feedback to CCG on identifying priorities for 2014/15.

1.0 Purpose

1.1 To advise the Health & well-Being Board of the first draft of commissioning intentions from the Wolverhampton CCG for the financial year 2014/15 and the timeline for engagement with key stakeholders, including clinicians, partner organisations and patients and the public.

2.0 Background

2.1 The CCG is required to share commissioning intentions with providers at the beginning of October each year for the subsequent financial year. The attached schedule identifies the first draft of commissioning intentions for the contract year 2014/15. This is a 'long list' of possible commissioning intentions for 2014/15

3.0 Progress, options, discussion, etc.

3.1 The CCG is in the process of undertaking the first round of engagement and prioritisation discussions with key stakeholders, including patients and the public, clinicians and partner organisations. As a result of such discussions, this list will be refined in to a final set of commissioning intentions for presentation at the CCG Commissioning Committee.

3.4 The prioritisation will be undertaken using the framework that has been previously agreed by the Commissioning Committee, incorporating amendments in order to take account of public and patient feedback.

4.0 Financial implications

4.1 There are no direct financial implications relating to the development of the CCG commissioning intentions and their prioritisation.

5.0 Legal implications

5.1 There are no direct legal implications relating to the development of the CCG commissioning intentions and their prioritisation.

6.0 Equalities implications

6.1 There are no direct equalities implications relating to the development of the CCG commissioning intentions and their prioritisation.

7.0 Schedule of background papers

The proposed timelines for the engagement process is outlined in the table below.

Key Meetings	Month	Key Milestones
GP Locality meetings Practice Manager Meeting 12/9 Commissioning Committee 25/9	**September 2013**	
GP Partnership meeting (General meeting) 10/10 JEAG 17/10 Commissioning Committee 23/10 Public Event/AGM – TBA QIPP Board 18/10 (provider wish list) DDGs (provider wish list)	**October 2013**	Long List of Commissioning Intentions to Provider (inc. contract notices) Provider wish list expected (finance and activity modelling)
GP Locality Meetings – TBA Commissioning Committee 27/11 (final recommendation and provider wish list) Health and Well Being Board 6/11 DDDs (provider wish list)	**November 2013**	(finance and activity modelling)
Governing Body 10/12 (sign off)	**December 2013**	Short List of Commissioning Intentions to Provider (finance and activity modelling)
GP Locality meetings – TBA General Meeting – TBA Health and Well Being Board 8/01	**January 2014**	Finalise Negotiations (finance and activity modelling)
	February 2014	14/15 Finance plan to F&P
	March 2014	Governing body budget sign off Contract Sign off

CI Ref No:	Lead Manager	Contract Area:	Specific Contract:	Intention Type:	Service Area:	Speciality Area:	Description:
CI001	Mike Hastings	All	All	Contract	n/a	n/a	Data sharing into a longitudinal patient record – Acute, Primary Care, Mental Health, Social Services and Community data in one record
CI002	Sarah Southall	Community Services	RWT	Contract	Community	Continence	Review Continence Service specification to include and put in place realistic performance measures i.e. time to assessment, time to treatment. Urinary/faecal incontinence pathways to be revised against current NICE guidance.
CI003	Sarah Southall	Community Services	RWT	Contract	Community	District Nursing	Review District Nursing specifcation and working practices between community and primary care services to avoid gaps in service.
CI004	Maxine Danks	Mental Health	BCP	Contract	All	All	Current service provision from both RWT and BCFPT with regard to completion of checklists/Decision Support Tools which are integral to the process when considering individuals for NHS Continuing Healthcare are at present, of poor quality and do not adhere to the National Framework for NHS Continuing Healthcare (revised 2012).It has historically proved extremely difficult to engage the trusts with training that has been offered by the PCT/CCG to address this.Therefore following completion of a training programme that will have been completed 13/14 by the CCG it is imperative that in future attendance at training relating to this process is mandatory.This will be required of all nurses working within the acute trust at RWT, BCFPT and nurses band 6 or above working in district nursing services. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: At present there is no specific training plan. This will be developed and delivered on a rolling programme by clinical members of the CHC team. Will ensure compliance with national process and reduce potential complaints regards process
CI005	Sarah Fellows	Mental Health	BCP	Contract	All	All	Service models and specifications - Commissioner and provider will work together to agree and sign off comprehensive service specifications in line with the contract sign off timetable.
CI006	Sarah Fellows	Mental Health	BCP	Contract	n/a	n/a	Review existing key Performance Indicators and develop more robust key performance measures for 2014/2015. This will include the introduction of financial penalities linked to local KPI's equivalent to a maximum of 1% of the total contract value.
CI007	Sarah Fellows	Mental Health	BCP	Contract	n/a	n/a	Contract Costing - Commissioners will agree with the provoder appropriate contract currencies and financial monitoring schedules for 2014/15. This will take into consideration, the current contract rebasing exercise together with national guidance for Mental health Payment by result. It should be noted however that commissioners will wish to contract within the current financial envelope (2013-14)
CI008	Dr Sinha	Mental Health	BCP	Development	n/a	n/a	To re-model / re-commission the Referral and Assessment Service to provide an all age Liaison Psychiatry service, with a RAID type model, and a separate / succinct all age Home Treatment / Crisis Resolution Service. To enable GPs to refer directly into all other components of secondary Mental Health Services, ending the single point of access. To commission Consultant Psychiatry sessions within all components of these services. To commission a Liaison Psychiatry Service that will respond to A&E within the 4 hour RWT target. This is to include staff resource for Section 136 MHA suite within the in-patient or Crisis / Home treatment Service Model. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: There are existing service pathways for all of the above which will require re-modelling. Added value will concern speed of patient access / egress, improve compliance with national good practice models / implementation guides, more effective use of resources to meet KPIs and Vital Signs.
CI009	Dr Sinha	Mental Health	BCP	Development	n/a	n/a	Commission a more flexible approach and greater governance regarding the use of the cluster model as entry to services and care pathways, following the MH Strategy stocktake / review. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: There are existing service pathways for all of the above which will require re-modelling. Added value will concern speed of patient access / egress, improve compliance with national good practice models / implementation guides, more effective use of resources to meet KPIs and Vital Signs.
CI010	Dr Sinha	Mental Health	BCP	Development	n/a	n/a	To agree a revised care pathway for Cluster 11 patients receiving depot medication within the Complex Care Team, within BCPFT, such as greater and more cost effective use of community depot clinics. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: There are existing service pathways for all of the above which will require re-modelling. Added value will concern speed of patient access / egress, improve compliance with national good practice models / implementation guides, more effective use of resources to meet KPIs and Vital Signs.

CI Ref No:	Lead Manager	Contract Area:	Specific Contract:	Intention Type:	Service Area:	Speciality Area:	Description:
CI011	Dr Sinha	Mental Health	BCP	Development	n/a	n/a	To review the Well-Being Service specification / model to re-specify the succinct elements of the service, i.e. Wolverhampton Healthy Minds (IAPT) and Well-Being to ensure succinct pathways for clusters 0-3 and 4-7 and to ensure best use of the initiation of Consultant Psychiatry sessions within this service as a priority. To review the IAPT element of the service to ensure that the service meets all KPIs. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: There are existing service pathways for all of the above which will require re-modelling. Added value will concern speed of patient access / egress, improve compliance with national good practice models / implementation guides, more effective use of resources to meet KPIs and Vital Signs.
CI012	Dr Sinha	Mental Health	BCP	Development	n/a	n/a	To work with BCPFT to develop the service model / draft specification for the Young Person's Service (ages 14-25) and scope the impact and pathways regarding Adult Services, including the Early Intervention Service. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: There are existing service pathways for all of the above which will require re-modelling. Added value will concern speed of patient access / egress, improve compliance with national good practice models / implementation guides, more effective use of resources to meet KPIs and Vital Signs.
CI013	Dr Sinha	Mental Health	BCP	Development	n/a	n/a	To work with BCPFT to develop the service model / draft specification for the 'traditional CAMHS Service' (ages 0-14) and scope pathways with other services including the Early Intervention Service. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: There are existing service pathways for all of the above which will require re-modelling. Added value will concern speed of patient access / egress, improve compliance with national good practice models / implementation guides, more effective use of resources to meet KPIs and Vital Signs.
CI014	Dr Sinha	Mental Health	BCP	Development	n/a	n/a	Review Consultant Psychiatry input / sessions across the whole service model. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: There are existing service pathways for all of the above which will require re-modelling. Added value will concern speed of patient access / egress, improve compliance with national good practice models / implementation guides, more effective use of resources to meet KPIs and Vital Signs.
CI015	Dr Sinha	Mental Health	BCP	Development	n/a	n/a	Review all Older Adults service provision/ service specifications. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: There are existing service pathways for all of the above which will require re-modelling. Added value will concern speed of patient access / egress, improve compliance with national good practice models / implementation guides, more effective use of resources to meet KPIs and Vital Signs.
CI016	Dr Sinha	Mental Health	BCP	Development	n/a	n/a	Liaise with Commissioning Colleagues in Sandwell and West Birmingham CCG to identify opportunities for collaborative commissioning regarding all of the above. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: There are existing service pathways for all of the above which will require re-modelling. Added value will concern speed of patient access / egress, improve compliance with national good practice models / implementation guides, more effective use of resources to meet KPIs and Vital Signs.
CI017	Maxine Danks	Mental Health	BCP	Dis-investment	n/a	CHC Assessment Team	Historically Wolverhampton PCT/CCG have commissioned provider services to deliver the assessment element of the NHS Continuing Healthcare process.The new model within the CCG for delivery of NHS CHC includes an in-house assessment team; this will enable case management to be completed by the CCG.In order for this model to be adopted the current service must be decommissioned and the allocated costs utilised to implement the changes required for an in- house service. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: There is no specific pathway within the current contract. However, the current service allocation is for 1.5 WTE posts at Band 6 and the monies for these will need to be removed from the contract. Additionally case management is at present procured from the Local Authority at additional cost to CCG, an in-house service will allow this aspect to be delivered at no additional cost. Will reduce delays in delivering service and improve process
CI018	Dr Sinha	Mental Health	BCP	Dis-investment	n/a	n/a	Implement a QIPP target regarding the provision of in-patient services at Penn Hospital and the reduced bed numbers. Macarthur Unit and to use this resource to collaboratively commission female PIC with other Black Country commissioning colleagues and to commission the Section 136 MHA suite within the in-patient or Crisis / Home treatment Service Model. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: There are existing service pathways for all of the above which will require re-modelling. Added value will concern speed of patient access / egress, improve compliance with national good practice models / implementation guides, more effective use of resources to meet KPIs and Vital Signs.

CI Ref No:	Lead Manager	Contract Area:	Specific Contract:	Intention Type:	Service Area:	Speciality Area:	Description:
CI019	Mark Lane	Primary care	GP LES	Investment	Elective	All	Introduction and development of a primary care incentive scheme to support better utilisation of primary care and community pathways prior to referral to a secondary care provider.
CI020	Mark Lane	Primary care	GP LES	Investment	n/a	n/a	To review all existing LES arrangements within Primary Care Contracts and to incorporate within Primary care Incentive Scheme.
CI021	David Birch	Primary care	GP LES	Investment	Out-patient	Medicine Management	NICE has issued single Technology Appraisals (TA's) for dabigatran, rivaroxaban and for apixaban (referred collectively as NOACs), for the prevention of stroke and systemic embolism in atrial fibrillation (AF). These medicines have the potential advantage over warfarin of not requiring INR blood monitoring. In order to ensure patients have access to these medicines a proposed pathway and guidance has been produced. Local data suggests only half of those eligible for anticoagulants are on warfarin. There are three groups of patients, 1) Newly diagnosed AF patients, 2) Patients currently taking warfarin who require a NOAC & 3) Patients that have declined or are intolerant to warfarin. It is proposed GPs providing the anticoagulation enhanced service can initiate patients on a NOAC where competent to do so and when in the interest of the patient, this will require the GP to:- • deliver induction counselling & • carry out required blood tests • prescribe the NOAC & • Monitor effects of the medicine Uplift in funding to the present enhanced service for anticoagulation will be required to cover the costs of this work and preventing referrals to RWT to prescribe these new medicines. Relation to existing Service/Community pathways, existing usage & how proposal shall add value Patients prescribed warfarin can get their INR blood monitoring carried out by RWT community service or at their GP practice if their GP practice offers the enhanced service for INR monitoring. GPs could prescribe NOACs for :- 1) Newly diagnosed AF patients, 2) A percentage of the 735 patients currently taking warfarin and have their INR monitored in primary care, who require a NOAC & 3) Patients that have declined or are intolerant to warfarin Uplift in funding to the present enhanced service for anticoagulation will allow GPs to prescribe NOACs for the patient groups as noted above, without the need to referring patients to RWT to carry out this task. This should result in a net reduction In spend, (based on the assumption enhanced fee is less than referring to RWT)
CI022	Clare Barrat/Sharon Sidhu	Secondary Care	MFS	Re-Procurement	Elective	IVF	Formal procurement of Assisted Conception Services to offer further choice for patients for the provision of fertility investigations / treatment.
CI023	Maxine Danks	Secondary Care	RWT	Contract	All	All	Current service provision from both RWT and BCFPT with regard to completion of checklists/Decision Support Tools which are integral to the process when considering individuals for NHS Continuing Healthcare are at present, of poor quality and do not adhere to the National Framework for NHS Continuing Healthcare (revised 2012).It has historically proved extremely difficult to engage the trusts with training that has been offered by the PCT/CCG to address this.Therefore following completion of a training programme that will have been completed 13/14 by the CCG it is imperative that in future attendance at training relating to this process is mandatory.This will be required of all nurses working within the acute trust at RWT, BCFPT and nurses band 6 or above working in district nursing services. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: At present there is no specific training plan. This will be developed and delivered on a rolling programme by clinical members of the CHC team. Will ensure compliance with national process and reduce potential complaints regards process
CI024	Steve Phillips	Secondary Care	RWT	Contract	Community	All	To agree and implement the Community Contract Rebase Exercise
CI025	Steve Phillips	Secondary Care	RWT	Contract	Elective	Maternity	To operate and apply PBR rules regarding the maternity pathway to bring them inline with all other providers who are submitting via SUS on Non PBR Variable.
CI026	Mike Hastings	Secondary Care	RWT	Contract	n/a	n/a	Joint Data Quality Group – setup and meet regularly
CI027	Mike Hastings	Secondary Care	RWT	Contract	n/a	n/a	Access to 'Ward-level' data for activity to patient level (pseudonymised) where requested
CI028	Mike Hastings	Secondary Care	RWT	Contract	n/a	n/a	Joint DoS review on a 6 monthly basis
CI029	Mike Hastings	Secondary Care	RWT	Contract	n/a	n/a	Sharing access of primary and secondary care Choose and Book hosted reports
CI030	Mike Hastings	Secondary Care	RWT	Contract	n/a	n/a	A Spine compliant PAS (or at least representation/updates from the project)
CI031	Mike Hastings	Secondary Care	RWT	Contract	n/a	n/a	Commitment from secondary care to work with primary care in the development of a referral information system which identifies clinical pathways
CI032	Mike Hastings	Secondary Care	RWT	Contract	n/a	n/a	Ability to link OP/attendances and interventions to spells – also by clinician

CI Ref No:	Lead Manager	Contract Area:	Specific Contract:	Intention Type:	Service Area:	Speciality Area:	Description:
CI033	Steve Phillips	Secondary Care	RWT	Contract	n/a	n/a	CCG to move to using reconciliation statements to adjust payments. Intention to still use monthly mandate but to recover overpayments as a result of data issues identified by the rs process.
CI034	Steve Phillips	Secondary Care	RWT	Contract	n/a	n/a	The commissioner requires the provider to ensure a greater use of appropriate coding to support a better understanding of activity for example greater use of sub-speciality codes as well as a reduced usage of "other" within all datasets.
CI035	Steve Phillips	Secondary Care	RWT	Contract	n/a	n/a	Review existing key Performance Indicators and develop more robust key performance measures for 2014/2015. This will include the continued use of financial penalities linked to local KPI's equivalent to a maximum of 1% of the total contract value.
CI036	Sarah Southall	Secondary Care	RWT	Development - Quality	All	All	Personalised Care Planning: Issues that are evident need to be highlighted using information from Quality Matters. This is a 2013/14 CQUIN – by quarter four 85% of identified patients with multiple morbidities to have an individual care plan developed through engagement with an MDT. Work is on-going on development of detailed project plan/availability of electronic system by end of quarter 4.
CI037	Dee Harris	Secondary Care	RWT	Development - Quality	Emergency	A&E	Development and implemetation of Urgent Care Strategy
CI038	Claire Morrissey	Secondary Care	RWT	Development	Elective	Neurology	Review following work undertaken and identified through WMQRS
CI039	Claire Morrissey	Secondary Care	RWT	Development	In-patient	EOLC	Review and implementation of the EOLC Strategy including a review of the Palliative Care pathways
CI040	Maxine Danks	Secondary Care	RWT	Dis-investment	Community	CHC Assessment Team	Historically Wolverhampton PCT/CCG have commissioned provider services to deliver the assessment element of the NHS Continuing Healthcare process.There have been significant issues with regard to service delivery for at least 3 years and this necessitated the CHC commissioning department employing additional nurse capacity to maintain service continuity.The new model within the CCG for delivery of NHS CHC includes an in-house assessment team; this will enable case management to be completed by the CCG.In order for this model to be adopted the current service must be decommissioned and the allocated costs utilised to implement the changes required for an in- house service. Relation to existing Service/Community pathways, existing usage & how proposal shall add value: There is no specific pathway within the current contract. However, the current service is not fit for purpose and results in delays completing assessments. The hospital discharge liaison team who provide elements of the service within New Cross Hospital are not able to prioritise this aspect of their role and it needs to be removed from the acute hospital setting. Additionally case management is at present procured from the Local Authority at additional cost to CCG, an in-house service will allow this aspect to be delivered at no additional cost. Will reduce delays in delivering service.
CI041	Mark Lane	Secondary Care	RWT	Dis-investment	Elective	Ophthalmology	Review and development of more appropriate care pathways for patients within Opthalmology, including areas of Emergency Care Eye Pathway, PEARS Scheme, Community Ocular Hypertension pathway.
CI042	Mark Lane	Secondary Care	RWT	Dis-investment	Elective	Surgery	Development of Surgical Threshold Management
CI043	Mark Lane	Secondary Care	RWT	Dis-investment	Elective	T&O	Review and development of more appropriate care pathways for patients within Trauma & Orthopaedic Services
CI044	Dee Harris	Secondary Care	RWT	Dis-investment	Emergency	A&E	To commission Primary Care alongside A&E also incorporating community services e.g Matons for Ambulatory conditions to better manage and facilitate patient flows accessing emergency services.
CI045	Dee Harris	Secondary Care	RWT	Dis-investment	Emergency	A&E	To commission Urgent Care Hot Clinics to provide alternative pathways for patients accessing emergency services.
CI046	Dee Harris	Secondary Care	RWT	Dis-investment	Emergency	A&E	To review existing WUCTAS service to either extend or cease current arrangements.
CI047	Claire Morrissey	Secondary Care	RWT	Dis-investment	In-patient	All	Building on existing work through the development of a Vitual ward to reduce emergency admissions.
CI048	Steve Phillips	Secondary Care	RWT	Dis-investment	In-patient	Dementia	To cease top up support for dementia services of £600k as this will now form part of PbR tariff going forward.
CI049	Anglea Parkes	Secondary Care	RWT	Dis-investment	In-patient	Eldlerly / General Medicine	As part of the Frail / Elderley Strategy commission Elderly Care Nurses to be linked Nursing Homes, to support impact on reduced admissions and LOS.
CI050	Anglea Parkes	Secondary Care	RWT	Dis-investment	In-patient	Eldlerly / General Medicine	To commission Intermediate care beds at Warstones Community Hub to provide step up / step down facility to support reduced LOS and prevent admissions.
CI051	David Birch	Secondary Care	RWT	Dis-investment	Out-patient	? INR Clinics	Uplift in funding to the present enhanced service for anticoagulation will allow GPs to prescribe NOACs for the patient groups as noted above, without the need to referring patients to RWT to carry out this task. This should result in a net reduction In spend, (based on the assumption enhanced fee is less than referring to RWT)
CI052	Mark Lane	Secondary Care	RWT	Dis-investment	Out-patient	All	Reduction in referrals following use of more appropriate primary and community management pathways.
CI053	Mike Hastings	Secondary Care	RWT	Dis-investment	Out-patient	All	Implement Choose and Book Advice and Guidance across services to reduce first outpatient appointments.
CI054	Steve Phillips	Secondary Care	RWT	Dis-investment	Out-patient	All	Agree a local price to reflect a clinic attendance is Nurse led or AHP led rather than be Consultant charge. The approach would bring RWT in line with other acute contracts.
CI055	Steve Phillips / Sharon Sidhu	Secondary Care	RWT	Dis-investment	Out-patient	All	To only commission and pay for Out-Patient activity to national average new to review ratio's, including implementation of local targets and information reporting to support meeting national averages at a speciality level.

CI Ref No:	Lead Manager	Contract Area:	Specific Contract:	Intention Type:	Service Area:	Speciality Area:	Description:
CI056	Steve Phillips / Sharon Sidhu	Secondary Care	RWT	Dis-investment	Out-patient	All	To only commission and pay for referrals from consultants not in the same speciality.
CI057	Steve Phillips / Sharon Sidhu	Secondary Care	RWT	Dis-investment	Out-patient	All	To review and expand existing policy for POLCV.
CI058	Anglea Parkes	Secondary Care	RWT	Dis-investment	Out-patient	Chiropody / Podiatry	Commission Nail Cutting under existing AQP providers
CI059	Claire Morrissey	Secondary Care	RWT	Development	Out-patient	COPD	LTC Management 2 (Respiratory) - Review, Development and implementation of strategy including community services.
CI060	Sharon Sidhu	Secondary Care	RWT	Dis-investment	Out-patient	Dermatology	To remove 60% of current out-patient activity to be provided within the Community Dermatology Service being procured during 2014/15, with the new service commencing on 1st April 2015.
CI061	Claire Morrissey	Secondary Care	RWT	Development	Out-patient	Diabetes	LTC management 1 (Diabetes) - Review, Development and implementation of strategy including community services.
CI062	Sharon Sidhu	Secondary Care	RWT	Dis-investment	Out-patient	Gastro	To review and implement a new pathway for Gastro - Calprotectin diarrhea pathway
CI063	Andrea Smith	Secondary Care	RWT	Dis-investment	Out-patient	TBC	To continue to develop and commission more specialities under a Clinical Assessment Service
CI064	Sharon Sidhu	Secondary Care	RWT	Dis-investment	Pathology	Pathology	To explore options with surrounding CCG's for a local procurement for Pathology services.
CI065	Dee Harris	Secondary Care	RWT	Investment	Emergency	A&E	To review and where appropriate commission full implementation of individual developments indentified within the CCG's Surge Plan to support Winter Pressures.
CI066	David Birch	Secondary Care	RWT	Investment	Reduce Hospitals Admissions and length of stay	General Medicine	Under nutrition is a cause and consequence of disease, leading to poor health and social outcomes. Malnutrition affects 5% of the population. Fully implementing NICE guidance on nutrition support suggests significant savings can be made due to reduced hospital admissions and reduced length of stay for admitted patients, reduced demand for GP and outpatient appointments. Residents in Care Homes have a higher prevalence of malnutrition 30-42%. Locally, use of oral nutritional supplements (ONS) to treat under nutrition cost the CCG more than £1.4M in 2012-13 Proposal is to build on the work done by Registered Dieticians (RD) as part of an 18 month QIPP project that suggests effective nutritional screening and management is patchy, and that 60% of ONS in Care Homes could be stopped or reduced by taking a 'Food First' approach to nutritional management, and using recent data, this would represent a cost saving of £380,000 per year. This would require an investment of £95,000 p/a to allow RWT RD's to fully implement this project. Relation to existing Service/Community pathways, existing usage & how proposal shall add value RDs have been working on aspects of the proposed project as part of a QIPP project which has begun to engage with local GPs, Care Homes and Prescribing Advisors to promote appropriate nutritional screening and management using a 'Food First' approach. Although this project has already delivered savings, evidence shows that similar projects have produced the majority of savings in years 2 &3. To change the nutrition culture across the whole CCG area will take longer than the 18 month QIPP project. ONS have been used in increasing quantities over many years, and are seen as the mainstay of nutritional management by care homes, healthcare professionals, patients and their families. Work has started to change the culture, but more needs to be done. The proposed project would :- 1. To promote effective nutrition screening in care homes (including when not to screen 2. Continue to promote food as 'the norm' in nutritional management and build on work already done with care homes, GPs and community HCPs. 3. Monthly visits to the 'big 6' care homes. 4. Continue to work with the acute service on appropriate use of ONS in hospital. 5. Offering education sessions and a 'Good Nutritional Management' award scheme for care homes to link with CQC outcomes, thus providing an incentive for them. 6. Further education for GPs, GP registrars and community HCPs on appropriate nutritional screening and management. 7. Revising the Nutrition Screening and Management Guidelines to promote ONS prescribing only when assessed by a RD.
CI067	Clare Barrat/Sharon Sidhu	Secondary Care	RWT	Re-Procurement	Elective	TOPS	Formal procurement of Termination of Pregnancy Services currently contracted via RWT.
CI068	Mark Lane	Third Sector	Age Concern	Dis-investment	n/a	n/a	To not roll forward existing contract with Age Concern for supportive services.

Agenda Item No: **13**

Health and Wellbeing Board

6 November 2013

Report Title	Funding Transfer from NHS England to Social Care – 2013/14	
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards Affected	All	
Accountable Strategic Director	Sarah Norman, Community	
Originating service	Joint Commissioning	
Accountable officer(s)	Steve Brotherton Tel Email	Head of Older People Commissioning 01902 55(5318) steve.brotherton@wolverhampton.gov.uk

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Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1, Approve this report; and

2, Approve the Council entering into an agreement under Section 256 of the NHS Act 2006 with the relevant NHS body setting out that the relevant NHS body will provide the sum of £4.922 million to the Council which will be ring fenced for the provision of adult social care.

1.0 Purpose

1.1 To seek approval for this report

1.2 To seek approval for the Council entering into an agreement under Section 256 of the NHS Act 2006 with the relevant NHS body setting out that the relevant NHS body will provide the sum of £4.922 million to the Council which will be ring fenced for the provision of adult social care.

2.0 Background

2.1 For the last two financial years, NHS Support for social care funding has been transferred from the Wolverhampton Primary Care Trust to the Council in order to support adult social care services, delivering health benefits in the process. Both of these funding transfers had been agreed under Section 256 of the National Health Service Act 2006.

2.2 For 2013/14 this funding transfer for Wolverhampton will be £4.922 M and will be transferred from NHS England to the local authority again via an agreement under Section 256.

2.3 NHS England requires a number of criteria to be clearly addressed and demonstrated within the 256 agreement:

- The funding must be used to support adult social care whilst at the same time delivering a health benefit
- There must be a local agreement between health and social care partners about the use of the funding and the outcomes to be delivered – this will be mandated through the Health and Well Being Board
- The funding must make a positive difference to social care services and outcomes for service users, compared to plans in the absence of the funding
- The funding can be used to support existing services or transformation programmes, assuming the above criteria is met and they would be under threat without this funding

2.4 The advice from NHS England on approval route for report is as follows:

- A draft report to be send to the area team prior to being submitted to the Health and Well Being Board
- Health and Well Being Board to receive and approve the report with the S 256 agreement
- Local authority to secure Councillor approval through Cabinet (Resources) Panel

- A copy of approved report; S 256 agreement; the minutes of the Health and Well Being Board meeting that approved the report; Council contact name and an analysis of how the funding will be spent to be sent to NHS England
- Area team will then raise the purchase order and confirm invoicing detail
- Local authority to supply an invoice
- NHS England to transfer the funding

2.5 The governance arrangements for this funding will be through the Adult Delivery Board – see appendix 1.

2.6 This funding will focus on the delivery of an integrated approach to Reablement; Prevention and Early Intervention, ensuring a joined up all-encompassing philosophy and approach, which delivers greater independence and choice for all customers.

2.7 This funding will deliver the following short, medium and long term priorities:

- The further development of an integrated hospital discharge team
- The development and delivery of a single point of access
- The further development and delivery of bed based intermediate care, including rehabilitation and step-down
- The development and delivery of an integrated approach to domiciliary reablement
- The further development and delivery of an integrated approach to Tele-healthcare and community equipment

2.8 This funding will contribute towards the delivery of the outcomes detailed in appendix 2 of this report.

2.9 The outcomes achieved through this funding will be monitored through a balanced scorecard, developed and agreed by all partners, that takes into account all appropriate local and national frameworks – see appendix 2.

2.10 Once the broad outcomes outlined in the appendices of this report are agreed, the Clinical Commissioning Group and the City Council will work together in order to quantify both the baseline and performance improvement measures against a number of these outcomes. This work will be completed by 30 November 2013 and will not delay the overarching agreement or transfer of the funding.

3.0 Financial implications

3.1 NHS Support for social care funding for this year will focus on an integrated approach to the on-going development of reablement and rehabilitation, better preparing the health and social care market to deliver a value for money response to the increasing demographic pressures that have already emerged. This means a focus for 2013/14 on re-shaping the model for existing in-house services.

3.2 The expenditure plan for this funding is categorised in the following table:

Area	***Amount of Funding***
Continuation of Local Authority Bed Based Intermediate Care	1.200 M
Continuation of Domiciliary Based Intermediate Care	1.100 M
Commissioning & Financial Support	0.250 M
Telecare/Community Equipment & Adaptations	0.900 M
Integrated Hospital Discharge Team	0.372 M
Carer Support – Continuation of Dementia Residential Respite	0.500 M
Carer Support – Continuation of external market block contract day services across the City	0.600 M
TOTAL	**4.922 M**

[MA/06112013/J]

4.0 Legal implications

4.1 In order for the relevant NHS body to provide the Council with the sum of £4.922 million the Council will need to enter in to an Agreement under s.256 of the NHS Act 2006 with the relevant NHS body. The agreement will oblige the Council to ring fence the funds for the provision of social care services. The Council will also be obliged to provide evidence that funds have been used for social care and may be subject to audit.;

[TS/28102013]

5.0 Equalities implications

5.1 A detailed equality analysis will be completed to inform the on-going development and implementation of this programme.

5.2 The Reablement Forward Plan for Wolverhampton employs an all-encompassing definition, including all adult services users.

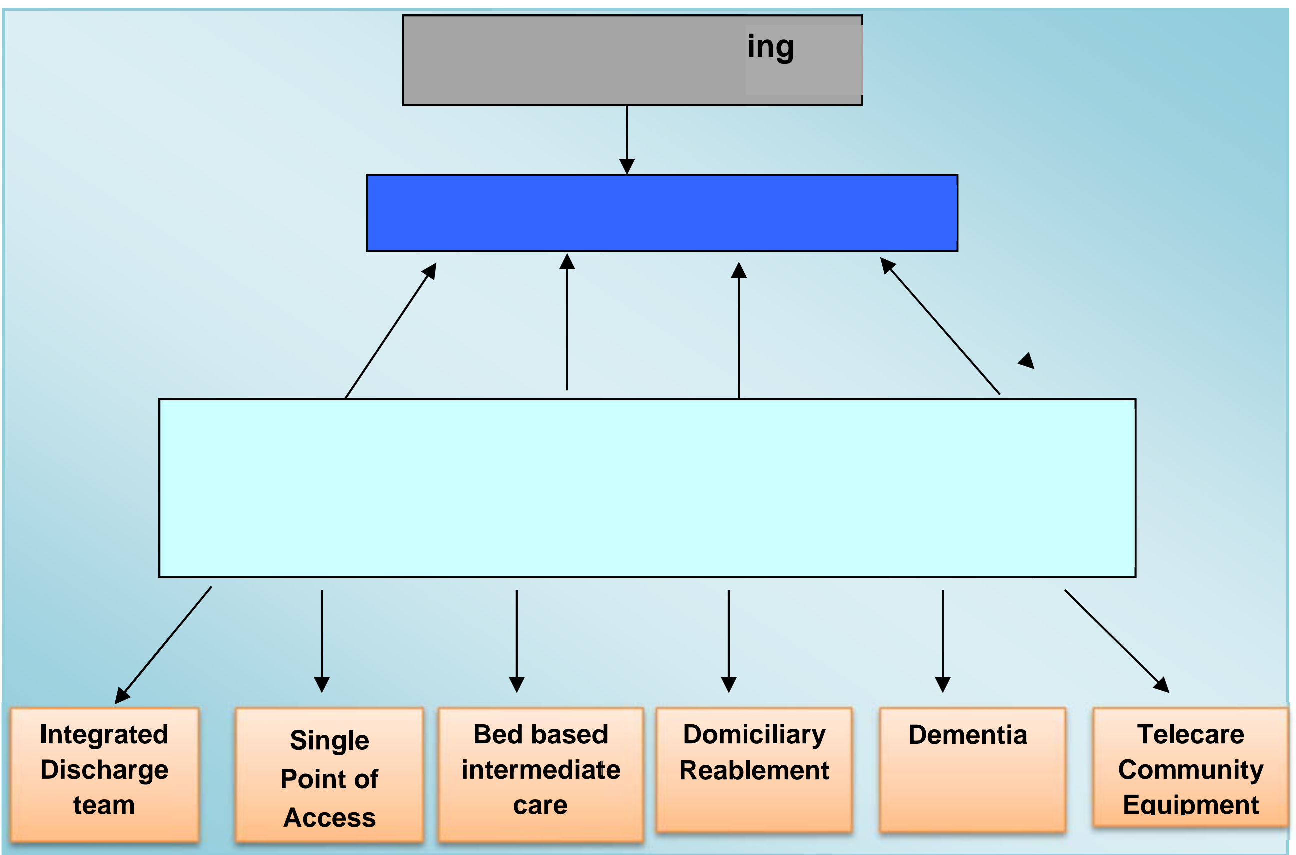
6.0 Environmental implications

6.1 There are no obvious environmental implications that arise from this report.

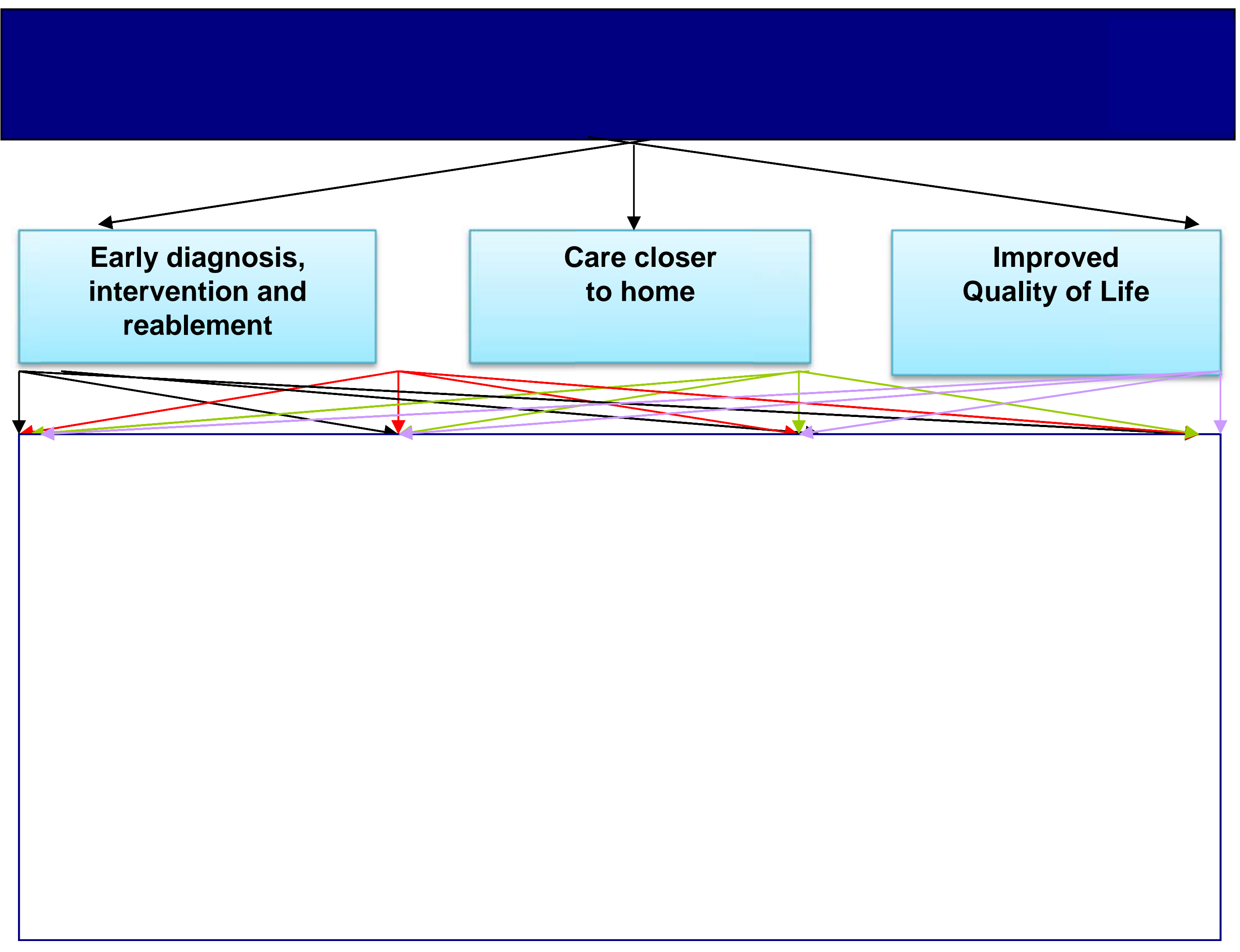
7.0 Appendices

1. Proposed Governance
2. Hierarchy of Outcomes

Appendix One – Governance



Appendix Two – Hierarchy of Outcomes



Agenda Item No: **14a**

Health and Wellbeing Board

6 November 2013

Report Title	Children's Trust Board Progress Report
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing
Wards Affected	All
Accountable Strategic Director	Sarah Norman, Community
Originating service	Community/Safeguarding, Business Support and Children's Early Help Services

Accountable officer(s)	Emma Bennett	Interim Assistant Director Safeguarding, Business Support & Children's Earl Help Services
	Tel	01902 55(6101)
	Email	Emma.Bennett@wolverhampton.gov.uk

Recommendations for noting:
The Health and Wellbeing Board is asked to note:

1. Recent activity at the Children's Trust Board.

1.0 Purpose

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

2.0 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.

3.0 Progress, options, discussion, etc.

3.1 The Children's Trust Board most recently met on 26th September and at this meeting received an update on the Children's Services Performance profile. The report was noted and it was agreed that two of the areas which are currently rated as red should provide reports to a future meeting.

3.2 It was therefore agreed that the Improvement Plans for City of Wolverhampton College and Local Authority Care Homes should be received at a future meeting.

3.3 The Board agreed that the Children's Services Profile reports be considered in September and June going forward.

3.4 An update was received on the Families in Focus programme being developed in the city. It was agreed that further discussion take place with Learning Communities, to ensure wide engagement of schools with the Troubled Families agenda.

3.5 The CTB requested that progress reports which include the outcomes for families engaged in the programme to date come to the Board and that case studies be received which include feedback from families.

3.6 A report was presented to inform the Board of the work of the New Arrivals Group. Currently, the group is reviewing its role and objectives and governance arrangements are being considered. The CTB felt that the Community Cohesion Forum, may be the best place for this group to report to.

3.7 It was reported under any other business, that a review of the function, terms of reference and membership of the Children's Trust is to take place. Comments to be submitted to Assistant Director for Safeguarding, Business Support & Children's Early Help Services.

4.0 Financial implications

4.1 There are no direct financial implications to this report.

[NM/29102013/G]

5.0 Legal implications

5.1 There are no direct legal implications to this report.

[JH/291013/S]

6.0 Equalities implications

6.1 There are no direct equal opportunity implications to this report, as it is an update on progress at the Children's Trust Board, rather than with specific programmes of work in relation to delivery of Children's Services.

7.0 Environmental implications

7.1 There are no direct environmental implications to this report

8.0 Human resources implications

8.1 There are no direct Human resources implications to this report.

9.0 Schedule of background papers

9.1 None attached.

This report is PUBLIC
[NOT PROTECTIVELY MARKED]

Agenda Item No: **14(b)**

Health and Wellbeing Board

6 November 2013

Report Title	Adult Delivery Board – Progress Report	
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards Affected	All	
Accountable Strategic Director	Sarah Norman, Community	
Originating service	Community / Health, Wellbeing and Disability	
Accountable officer(s)	Viv Griffin Tel Email	Assistant Director 01902 55(5370) Vivienne.Griffin@wolverhampton.gov.uk

Recommendations for noting:

The Health and Wellbeing Board is asked to note the progress of the Adult Delivery Board's work plan for 2013/14, in particular:

I. The progress being made in co-producing key partnership strategies which look to address strategic issues such as Urgent and Emergency Care, Long Term Conditions, Reablement and Dementia which cut across partner organisations; and

II. The engagement of providers and key stakeholders from across the city in developing these strategies ensuring they are reflective of the needs of its service users.

1.0 Purpose

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

2.0 Background

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

- Urgent Care
- Long Term Conditions
- Reablement

as well as, considering the Mental Health and Psychological Well Being Strategy Implementation Plan; discussing the development of the Board's performance management framework; and receiving an update on the outcome of Wolverhampton's Integration Pioneer expression of interest.

3.0 Progress

3.1 The Draft Urgent and Emergency Care Strategy was considered by the Board before its final presentation to the HWBB on the 6th November 2013. The Board agreed there was more work to be done to include reference to social care and the needs of children. The next iteration of the draft strategy would look to incorporate both of these areas in more detail.

3.2 The Board received an update on the development of the Long Term Condition Strategy which was currently being progressed by Wolverhampton City Clinical Commissioning Group (WCCCG) centred on the following key workstreams:

- Proactive management of long term conditions,
- Improving delivery of service, and
- Early diagnosis and lifestyle management.

The first iteration of the draft strategy would be presented to the next meeting of the Adult Delivery Board.

3.3 The Board were informed of the progress of the Reablement Forward Plan refresh and the proposals surrounding the development of corresponding:

- Governance Structures,
- Hierarchy of outcomes and metrics, and
- Short/medium/long term priorities.

Senior Responsible Officers had now been identified to lead on various aspects of this work with a view to presenting the draft Forward Plan to the December Board meeting.

3.4 The Board were presented with an overview of the proposed changes to the National Probation Services and the likely impact on future provision of service and continued support to Boards at both local and regional level. With effect from the 1st April 2014, Wolverhampton, Dudley and Walsall will form a single senior manager role as part of the National Probation Service. A new Provider will take over the delivery of the service in October 2014 following a process of tendering.

3.5 The Board received a summary overview of the Mental Health & Psychological Well-Being Strategy Implementation Plan and the work being undertaken by the Black Country Partnership Foundation Trust's Children and Young Peoples Transformation Team to develop the next steps of the plan. It was reported that a number of key priorities would be actioned as part of the next steps which will be coordinated via Task and Finish groups.

3.6 The Board noted that whilst the Wolverhampton Integration Pioneer Expression had been unsuccessful, the Health and Care economy in Wolverhampton had agreed to keep the momentum going in terms of delivering the objectives of the bid. A 90 day quick wins action plan would be presented to the next Board meeting.

3.7 The Board also discussed the development of a performance management framework, which would enable them to be kept abreast of any slippage/difficulties in delivering the strategic implementation plans and allow for issues to be escalated and managed in a controlled environment. More detailed proposals would be presented to the next Board meeting.

4.0 Financial implications

4.1 There are no direct financial implications to this report.

[NM/25102013/S]

5.0 Legal implications

5.1 There are no direct legal implications to this report.

[RB/18102013/A]

6.0 Equalities implications

6.1 There are no direct equalities implications to this report.

7.0 Environmental implications

7.1 There are no direct environmental implications to this report.

8.0 Human resources implications

8.1 There are no direct human resource implications to this report.

Agenda Item No: **14(c)**

Health and Wellbeing Board

6 November 2013

Report Title	Public Health Delivery Board	
Cabinet Member with Lead Responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards Affected	All	
Accountable Strategic Director	Sarah Norman, Community	
Originating service	Community / Public Health	
Accountable officer(s)	Ros Jervis Tel Email	Director of Public Health 01902 551372 ros.jervis@wolverhampton.gov.uk

Recommendation(s) for action or decision:

That the Health & Wellbeing Board notes the progress of the six key work streams of the Public Health Delivery Board's work programme for 2013/14.

1.0 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 an effective work programme.

2.0 Background

2.1 From October the Public Health Delivery Board will be meeting bi-monthly. Initial meetings have focussed on purpose and process including the terms of reference, membership, its sub-structure, its priorities, work programme and performance framework. The main focus of the October meeting was a thorough review of the six key work streams and the work of the relevant sub-groups.

3. The Public Health Delivery Board Work Programme

3.1 Transformational work stream

3.1.1 The first round of the transformational fund was opened on 11th September and closes on 18th October. The application form and eligibility criteria was widely circulated both internally and with external partners. Although the team received many enquiries from teams interested in submitting a proposal, at the time of writing this paper the final response was unknown.

3.1.2 The update paper also discussed other transformational projects either underway or development, for example LAC transformation and a process for the development of concepts and ideas including the appraisal of the evidence base and cost benefits.

3.2 Health Protection work stream

3.2.1 An update paper was received that detailed progress in relation to the establishment of the multi-agency Health Protection Forum. The Health Protection Forum has held two meetings with good attendance from a wide range of partners, including CCG, NHS England, Public Health England, RWT and LA Resilience Team. The meeting held on 17th September 2013 focussed on assurance frameworks and the development of a Health Protection JSNA. The Public Health England Screening and Immunisations Team for Birmingham, Black Country and Solihull were asked to complete and present an assurance framework on the new immunisations programmes. A number of risks were identified in these programmes, and therefore Public Health England Screening and Immunisation Team have been asked to update and resubmit the framework for the DPH.

3.2.2 It was noted that a number of issues regarding Emergency Planning, Resilience and Response (EPRR) are to be clarified, including the roles, responsibilities and processes for seeking assurance from local NHS providers that they have robust and tested plans in place, the need to clarify escalation and communication pathways for incidents, outbreaks and emergencies, and clarity on the role of Director of Public Health in EPRR. The Wolverhampton Director of Public Health (DPH) has written to Les Williams, Director of Operations at NHS England Area Team, requesting that he hold a meeting with Directors of Public Health and CCG Accountable Officers from across Birmingham,

Solihull and the Black Country to discuss these issues as a matter of urgency. This meeting is due to take place on 25th October 2013.

3.2.3 A scenario testing day was held on 4th October at Himley Hall for Public Health, CCGs, Public Health England and NHS England for those in the West Midlands West Health Protection Unit footprint. This is intended to test a draft CONOPS that has been developed by West Midlands West Health Protection Unit and Walsall and Wolverhampton Public Health. This highlighted several key issues and themes for local resolution.

3.3 **The Public Health Commissioning work stream**

A comprehensive update paper was received regarding the public health commissioning programme:

3.3.1 **Public Health Contracts**

There are around 50 public health contracts, the majority of which transferred to the Local Authority from the PCT in April 2013. A number of additional contracts or transactional budgets have also had to be set up to cover subsequently identified gaps in aligned goods and support services as well as resourcing a small number of Local Authority corporate priorities identified within the public health remit. A draft procurement timetable is in place to comply with transfer of (NHS) services under public health and the Councils procurement and contracting guidelines as well as standing financial instructions. Procurement activity will commence following:

- A comprehensive audit of the contracts, themed by public health delivery and outcome areas.
- GP and Pharmacy contract reviews. Local Authority contracts have now been issued and electronic monitoring processes established that link to the Councils finance system. Technical issues around data submission and the payment system are also still being worked through.

3.3.2 **Commissioning Priorities**

- A large contract award for substance misuse services was made during the period of transition for public health from PCT to the Council. A considerable amount of the commissioning team’s time and resource continues to be taken up with mobilisation and implementation. In addition the scope of this has increased to include management of assurance work streams on request through the Directorate and Local Police and Crime Board. Comprehensive monitoring and reporting is currently being undertaken on a bi weekly programme board basis, monthly data submission and clinical governance meetings as well as quarterly contract review.
- A sexual health review is currently underway covering all CASH and GUM services particularly targeted at vulnerable groups.
- Child Weight Management (Healthy Lifestyles). Following evaluation of the previous child weight management service and a number of pilot interventions, commissioning intentions were discussed and agreed at the HEPA steering group in July. Around 15 stakeholders interviews have now been undertaken with the intention that this feeds into the specification for tender planned for Q4. Further work may however be required to support pathways around the new child weight management service prior

to tender, and to maximise a range of current PH investment in projects and services around healthy lifestyles.

3.3.3 A draft Memorandum of Understanding (Collaborative Commissioning between PH and Wolverhampton CCG (JCU) has been produced for consultation with the CCG. Key areas identified as priorities for collaboration are; mental health, maternity, sexual health, tuberculosis and infection prevention as well as the deep dive, intelligence support around CCG priority areas.

3.3.4 Establishment of a clinical governance framework and incident reporting process is required now that PH is no longer part of an NHS infrastructure. Initial discussions have been had with PHE in relation to accessing clinical reporting systems such as STEIS and the CCGs Quality and Risk Team who are offering support to PH in developing our contracts and assurance processes.

3.3.5 **Commissioning Intentions**
The CCG have requested PH engagement in the development of commissioning intentions and RWT have also requested that PH align with CCG process and discussions in relation to their contracts. Areas of responsibility outside of NHS/health facing service areas will also require consideration in relation to commissioning intentions taking all of the current contractual and transitional work streams

3.4 **Sexual Health Review**

A sexual health review is currently underway covering all CASH and GUM services particularly targeted at vulnerable groups. A steering group are overseeing the project plan. This work stream is currently covering individual service reviews, gap analysis, focus groups and consultation. Commissioning intentions and plans will be drawn up on completion of the review.

3.5 **Children's Public Health**

An update paper was received regarding the establishment of the Children's' Public Health Commissioning Group with representatives across the full range of responsible commissioning organisations, hosted by Wolverhampton Public Health. Key issues from the first meeting were:

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

Next steps include the development of a robust plan to promote collaboration and effective joint working, including the development of a joint work programme. The second meeting, on 1st October 2013 agreed the Terms of reference for this group and clarified roles and responsibilities. A comprehensive mapping exercise for all Wolverhampton services for 0-5 year olds has been commenced.

3.6 CCG Work Programme

3.6.1 Overview of the Core Offer and work programme

The range of matters covered by the core offer include:

- Assessments of the health needs of groups of individuals within the local authority area with particular conditions of diseases
- Providing summary profiles of the overall health of people in the local authority area with the aim of supporting the CCGs commissioning of appropriate health services.
- Advice on the development of plans for the anticipated care needs of persons for who a CCG is responsible

In addition the Public Health Team has agreed to provide an analysis of data for each of the outcomes included in the NHS Outcomes Framework, a demographic profile of the population of Wolverhampton, and detailed needs assessments of a minimum of two areas, to be agreed on an annual basis. These reports feed into the JSNA.

A joint workshop between Public Health and the CCG was help to develop a more detailed work plan to deliver against the core offer in 2013/14 it was agreed that public health would provide needs assessments on three areas rather than two these being Diabetes, Urgent Care and Maternity Services. This has very recently been amended replacing Maternity Services with Dementia.

3.6.2 Progress

- The Diabetes Needs Assessment is near completion and the Urgent Care Needs Assessment is now being scoped and work is due to commence on this imminently. Due to the recent request from the CCG to undertake a Dementia Needs Assessment scoping of this work is yet to be clarified.

- Public Health have agreed to develop locality based profiles to support the development of the CCG Primary Care Development Strategy. This will involve looking at the existing QOF tool and populating it, if access to data can be agreed. Discussions are also taking place on the development of practice profiles and locality JSNAs in 2014/15.

- The CCG have asked for other, additional work to be undertaken since the workplan for the year was agreed. Therefore an ad hoc requests process was agreed and put in place. The CCG is required to complete a request form and submit it to the Evidence and Intelligence Team for consideration. A formal response will then be made.

- An MOU on access to data has been completed and additional MOUs on EPRR, Collaborative Commissioning are being developed.

4.0 Financial implications

4.1 There are no direct implications arising from this report.

4.2 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 £18.77 million.

[AS/18102013/R]

5.0 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.

[RB/18102013/E]

6.0 Equalities 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.

7.0 Environmental implications

7.1 There are no direct environmental implications arising from this report.

8.0 Human resources implications

8.1 There are no direct human resources implications arising from this report.

9.0 Schedule of background papers

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

Health & wellbeing Board 4 September 2013 PUBLIC HEALTH DELIVERY BOARD – PROGRESS REPORT