CITY OF WOLVERHAMPTON COUNCIL

# Health Scrutiny Panel

16 January 2020

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

**Venue** Committee Room 3 - Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

## Membership

**Chair** Cllr Phil Page (Lab)
**Vice-chair** Cllr Paul Singh (Con)

Cllr Obaida Ahmed
Cllr Bhupinder Gakhal
Cllr Milkinderpal Jaspal
Cllr Lynne Moran
Cllr Susan Roberts MBE
Cllr Wendy Thompson
Tracy Creswell (Healthwatch)
Sheila Gill (Healthwatch)
Dana Tooby (Healthwatch)

Quorum for this meeting is three voting members.

## 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**
[To receive any apologies for absence].

2 **Declarations of Interest**

3 **Minutes of previous meeting** (Pages 3 - 22)
[To approve the minutes of the previous meeting as a correct record.]

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

**DISCUSSION ITEMS**

5 **Accident and Emergency Department - New Cross Hospital (Royal Wolverhampton NHS Trust)**
[To receive a report on the Accident and Emergency Department at New Cross Hospital]. [Report is marked to Follow].

In attendance for this specific item from the Royal Wolverhampton NHS Trust will be:-

Andy Morgan – ED Consultant and Divisional Director Division 2
Bev Morgan – Head of Nursing Division 2
Tim Powell – Deputy Chief Operating Officer Division 2

6 **STP (Sustainability and Transformation Partnership) Update** (Pages 23 - 40)
[To receive an update presentation on the STP (Sustainability and Transformation Partnership). Steven Marshall (Director of Strategy and Transformation CCG) will give the initial update and then there will be a wider discussion with Health Partners and the Panel].

7 **Work Plan** (Pages 41 - 44)
[To consider the Health Scrutiny Work Programme].

CITY OF WOLVERHAMPTON COUNCIL

# Health Scrutiny Panel

Agenda Item No: 3

Minutes - 7 November 2019

## Attendance

**Members of the Health Scrutiny Panel**

Cllr Obaida Ahmed
Tracy Cresswell
Sheila Gill
Cllr Milkinderpal Jaspal
Cllr Lynne Moran
Cllr Phil Page (Chair)
Cllr Susan Roberts MBE
Cllr Paul Singh (Vice-Chair)
Cllr Wendy Thompson
Dana Tooby

**Witnesses**
Steven Marshall (Director of Strategy and Transformation – CCG)
Dr Jonathan Odum (Medical Director – RWT)
Dr Mike Norell (Lead Medical Examiner – RWT)
Jo Reynolds (Primary Care Transformation Manager – CCG)

**Employees**
Martin Stevens (Scrutiny Officer) (Minutes)
John Denley (Director of Public Health)
David Watts (Director of Adult Services)
Dr. Ankush Mittal (Consultant in Public Health)

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# Part 1 – items open to the press and public

*Item No.* *Title*

1 **Apologies**
An apology for absence was received from Panel Member, Cllr Bhupinder Gakhal.

David Loughton, Chief Executive of the Royal Wolverhampton NHS Trust and Professor Steve Field, Chairman of the Royal Wolverhampton NHS Trust sent their apologies to the Panel.

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

3 **Minutes of previous meeting**
The minutes from the meeting held on 12 September 2019 were confirmed as a correct record.

4 **Matters Arising**

The Chair took the opportunity to thank most sincerely the CCG Clinical Accountable Officer, Dr Helen Hibbs MBE for her public service to the CCG. She would be stepping down from the role at the end of November. She did however intend to continue in her role at the Black Country and West Birmingham Sustainability Transformation Partnership, until April of next year. The STP was on the workplan for the first meeting in the New Year and so he hoped the Panel could thank her in person. He sought the Panel's approval to send a letter on behalf of the Health Scrutiny Panel thanking her for her contribution to Wolverhampton CCG. Members of the Panel paid tribute to the work of Dr Hibbs.

The Chair commented that he was very pleased how the last Health Scrutiny Panel had gone at Linden House, where the first part of the meeting had been on the Tettenhall Wood Road GP Surgery consultation. The Panel had received a wide range of evidence from interested parties and he felt the matter had been handled appropriately by the Health Scrutiny Panel. It had been a good example of Local Government Scrutiny out in the heart of the community.

The Chair stated that earlier in the day he had been formally notified of the formal decision of the Primary Care Commissioning Committee. At the meeting a paper had been presented by the Tettenhall Medical Practice withdrawing their previous application to close their branch surgery, but asking to reduce the number of clinical sessions provided from 7 to 4. The committee had considered the proposals and took views from local residents. They agreed to support the proposals as set out in the paper having considered all the options, the outcome of the consultation and the equality impact assessment.

The surgery was currently open for three and a half days a week. From January 2020, this would reduce to two half days and one full day. More appointments would be offered at the main site in Lower Green to ensure the same number of appointments were available to patients. Local patients who were unable to travel to Lower Green surgery would be offered pre-bookable appointments a month in advance and a number of 'on the day' appointments would also be ring fenced for patients local to Wood Road. Meanwhile, the CCG would be supporting the practice to explore other models for the future including using alternative clinicians.

A Member of the Panel commented that it was good and bad news. It was clearly good news that the surgery was being saved but bad news that there would be a reduction in service hours at the Tettenhall Wood Road surgery. They hoped that the hours would be increased again in the future should circumstances allow.

A Member of the Panel commented that they thought the wrong approach had been taken. They believed it was a recruitment issue, which needed to be solved. The overall overhead costs would increase on the Tettenhall Wood Road surgery with the reduction in service hours. They believed the Panel would be looking at the issue again in 12-18 months.

**Resolved:** That the Chairman of the Health Scrutiny Panel write to Dr Helen Hibbs MBE on behalf of the Panel thanking her for her contribution to Wolverhampton CCG.

5 **Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024 - Health Scrutiny Panel**

The Finance Business Partner presented a report on the Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024. He commented that there weren't any specific saving proposals which fell within the remit of the Panel. They were seeking feedback on the budget relevant to the remit of the Panel and how it was aligned to the priorities of the Council. In addition they were asking for feedback on the Draft Budget and Medium Term Financial Strategy 2020-2021 to 2023-2024, including budget proposals that were relevant to the remit of the Panel. In October 2019, Cabinet had been informed that after taking into account projected changes to corporate resources and emerging pressures, the projected remaining budget deficit for 2020-2021 would be in the region of £3.9 million, rising to £20 million over the medium term period to 2023-2024.

The Finance Business Partner stated that the report also made reference to the Medium Term Financial Strategy including provision for a real terms increase to the Public Health Grant budget in 2020-2021. This had been announced by the Government in the Spending Round 2019 to ensure local authorities could continue to provide prevention and Public Health interventions.

The Director for Public Health remarked that the £20 million grant from Government to Public Health did come with some mandatory requirements, which included having to provide the Healthy Child Programme, Sexual Health Services and NHS Health checks. Despite the Public Health Grant being reduced year on year, it was refreshing to be able to list the successes detailed in paragraph 5.3 of the report. This had included increasing the number of health checks offered to the eligible population. The City had moved from one of the lowest performing areas to top quartile within the year.

The Director for Public Health commented that the number of rough sleepers had reduced, which was pleasingly in contrast to the national trend. Substance misuse treatment had significantly improved meaning recovery rates were better with more people finding employment. They had moved from a treatment to recovery focus. The performance of the Healthy Child Programme was at its best since Public Health had transferred to the Council in 2013. He believed the most important check to be at 2 -2.5 years old as this was to try and ensure every child was ready for school. Performance was currently at 72.6%. They were working closely in partnership with the Royal Wolverhampton NHS Trust on the Healthy Child Programme. Public Health also provided the drug and alcohol services for the City, which was not a mandatory requirement, but a requirement locally.

The Chair referred to the budget risks in appendix 1 to the report detailed on pages 26 and 27 of the agenda pack. As some of the risks were out of the authority's control, he asked what the Council was doing to mitigate them. He noted that four items were currently listed as red risks. The Financial Business Partner commented that the fact that the risks had been identified enabled the Council to better prepare. They were always addressing whether the risk was appropriate and constantly reviewing emerging pressures. The Director for Adult Services stated that the Council would continue to look for proposals to help contribute towards the savings gap.

A Member of the Panel stated that it would be helpful for a footnote on the risk register to identify whether it was external funding or resources and therefore outside of the Council's control.

**Resolved:** That the Scrutiny Panel response be finalised by the Chair and Vice Chair of the Scrutiny Panel and forwarded to Scrutiny Board for consideration.

6 **Public Health Annual Report 2018-19**

The Director for Public Health presented the Public Health Annual Report 2018-2019. He had a statutory duty to deliver an Annual report. He stressed it was important to get the basics right in life to ensure people remained in good health this included good housing and living in a good community. The Annual report included a section at the back of the report on individual ward profiles. He was particularly pleased with the work Public Health had completed in partnership with health partners on health checks. Organisation had been the key to success in both the increased uptake of health checks and flu vaccinations.

A Member of the Panel commented that she felt the ultimate strapline from the report was that if you wanted to live longer it was important not to be poor. They stressed the importance of living in good quality housing and the value of the enforcement work the Council carried out in private sector housing. They believed the enforcement team had halved in strength in recent years.

The Panel discussed the ward profiles and the differences in life expectancy. Comments were made about breaking the cycle of deprivation within families. A Panel Member asked about the amount of alcohol related hospital admissions in Wolverhampton and what action could be taken to bring the level down. The Director for Public Health responded that alcohol abuse was a key problem for the City to address. It was important to promote sensible drinking practices and have an effective intervention service. The Wolverhampton alcohol intervention services were well respected nationally.

A Panel Member asked about the homeless figures for Wolverhampton. The Director for Public Health offered to write to her with the formal definitions of rough sleeping and homelessness as they were different.

The Chair remarked that it was most concerning that nearly a third of local children aged 0-15 years old were living in poverty (31.3%). He asked what definition of poverty Public Health were using in the report and what they were trying to do to change the situation. The Consultant in Public Health responded that Public Health were using a well-established national indicator for child poverty in their report. Nationally there was a database of all the families in receipt of child tax credits. A child was deemed to be living in poverty if they lived in a household in receipt of child tax credits and the household was receiving income support or job seeker supporter, or if they were living in a family receiving child tax credit and were deemed to be in the bottom 60%. Wolverhampton did not compare well to the rest of the country and that was largely down to the deprivation rate in Wolverhampton. The child poverty figure in Wolverhampton was similar to Dudley, Sandwell and Walsall. The only way to improve the figure was to increase the employment rate and improve household incomes. Jobs, skills, strong and stable homes and opportunity were key.

The Chair asked what the contributing factors were that meant there were more children in the care of the Council in the City (110.6 per 10,000) than in England (62.0). He commented that this was a significant difference to the national average and asked how the Wolverhampton figures compared to the rest of the Black Country. He was particularly keen to know if there were any children at unregistered providers. The Consultant in Public Health responded that the Wolverhampton figures were in line with those for Walsall, Sandwell and Dudley. The figure had come down for Wolverhampton but was still high compared to the national figure. He believed the level of deprivation in Wolverhampton was the key reason why the figure was high in Wolverhampton. The Director for Public Health commented that he would provide a written response to the Chairman on the matter of unregistered providers.

The Chair asked for some information on the work Public Health were doing with health partners to combat loneliness including the use of any technological solutions. The Consultant in Public Health responded that relationships and systems was the key point to address when addressing loneliness. In an aging population you would see increasingly elderly women living on their own because of their higher average life expectancy to men. Men were increasingly marrying at a later age and therefore some were living on their own at an early stage in adulthood. Pregnant women also sometimes fell into social isolation after giving birth. Social isolation was therefore a life course issue. The Public Health Team were supporting the NHS in some of the work they were undertaking in social prescribing. The NHS were putting significant financial resources into social prescribing. Public Health's role he saw as bridging systems together. They were looking to redesign the Wolverhampton Information Network which was a key directory of local opportunities at a place based level.

The Director for Adult Services commented that they were undertaking significant work from a social care perspective in combatting social isolation. They had introduced new ways of working for social workers over the last 18 months to free up time from bureaucratic process, so they could spend more time in communities working to support people in social isolation. The Healthwatch Manager commented that they had just completed a two-year project on loneliness and social isolation and expressed a desire to feed the findings of this work into Public Health.

7 **Wolverhampton CCG Annual Report 2018-19**

The Chair read out an initial statement which praised the CCG for receiving an outstanding rating in July 2018 and also this year. It had also been a great achievement for the CCG to receive the Clinical Commissioning Award for 2018. He was very pleased to see the increased uptake in health checks. He was also pleased to see the CCG using innovative technology in primary care to improve services which included being one of the first areas to implement online triage and GP online video consultation. He also welcomed the extended GP opening hours.

The Chair had submitted a number of questions on behalf of the Health Scrutiny Panel in advance of the meeting. The questions and written answers provided were as follows: -

**Mental Health**

1) The report makes reference to you working to minimise your Out of Area Placements in Mental Health. What steps are being taken to ensure we have enough beds in Wolverhampton to avoid out of area adult placements and how many more do you think would be sufficient for now and in the future? Crucially it also refers to this not being able to be zero, as you have no female Psychiatric Intensive Care Unit in the Black Country (p.18).

**CCG Written Response :-**

In this contracting round we are working with BCPFT and DWMHPT to increase the beds we purchase locally – if possible by as many as 8 – from April 1st 2020 (this will involve reducing the access of BSOL CCG to BC&WB STP wide bed stock) we are working with BCPFT to develop an STP wide female PIC Ward – we expect to have this by April 2021.

Across both our business intelligence teams (i.e. provider and commissioner) we are working with data to understand the increase in activity and what community models are required to prevent admission and relapse and ensure access to evidence based community care in line with NICE and the constitutional and transformational standards of the NHS Plan.

We have raised concerns with PH alcohol and substance misuse commissioners regarding the impact of high levels drug use in Wolverhampton upon mental ill health and have requested a public health comms campaign.

We have agreed a service model for primary and secondary mental health and a service specification is in draft. Additional investment is available however recruitment to required workforce is likely to be an on-going risk for at least 2-3 years while we work with HHE to grow the required workforce and trainees.
We i.e. the CCG have set a sum aside to invest in promoting emotional health and well-being to mitigate against the impact of Public Health and Social Care cuts in these services and to mitigate against the impact of very high levels unemployment deprivation and substance misuse in Wolverhampton. We have also identified sums of money for Sec 117 MHA care packages – again to mitigate against social care financial pressures.

2) Can you inform us about how the new online counselling service (p.5) for 11-18 years olds is working? It seems like this has great potential to really help. Is there any capacity or is it fully subscribed? How do young people get referred to this Service and are GPs using it consistently? What are the overall costs for the service and how long is the contract with the provider “Kooth” set to last?

**CCG Written Response:-**

In 2018/19 there were 1,237 CYP registered to access the online digital platform – this included counselling sessions, moderated chatrooms and access to articles & self-help resources and a messaging service. It is an anonymous service where the CYP have to report what area of the city they

live in, their age, gender and ethnicity. Issues and concerns are broken down by gender and ethnicity. It is already working in excess of the hours commissioned which is for 110 hours per month. Currently we are possibly using up twice as many hours. Young people are mainly being signposted through from schools or school teachers – over 600 referrals that way but only 81 through GP. The current costs are £63,500 for the year and the contract is for 3 years initially, which is the same amount of time as the emotional mental health and wellbeing service. However, there have been requests from Kooth to increase the contract due to the hours being used. Only 135 contacts went through the MHSDS for last year – 2 contacts or more and this year 122 contacts have already gone through up until end of September 2019.

3) The Improving Access to Psychological Therapies end of year figure was not available at the publication of the report. Can you please inform us of the final figure? Can you give the Panel your views on how well the service is working and where it could be improved?

**CCG Written Response:-**

The final figure was 18.53 %.

We are on track to achieve 22% by March 2020 having invested an additional 700,000K including digital IAPT

The service is meeting all KPIs and is working closely with GPs and colleagues in Primary Care to embed the service within with PCNs with very good progress

4) There were six instances of mental health patients waiting more than 12 hours in A&E in 2018/19 (p.23). What lessons were learnt? How are you ensuring with health partners that the mistakes are not repeated?

**CCG Written Response:-**

The delays related to the unavailability of AMHPs and delays accessing a MH bed. We have supported CWC for 3 years now with additional funding for AMHPs and are awaiting an update regarding the AMHPs gaps at weekends especially.

5) The report refers to people with mental health problems such as schizophrenia or bipolar dying on average 16-25 years sooner than the general population (p.29). What are you doing to help improve this figure and how much of a factor are the prescription drugs administered, in the early death? How are we ensuring that people are not on drugs longer than they need to be and at the appropriate dosage? What are the other known factors in the earlier death?

**CCG Written Response:-**

We have commissioned and enhanced service from primary care colleagues to increase health checks for people with SMI in primary care and are

monitoring access to health checks in secondary mental health care – building on a CQUIN scheme from last year. We have invested in BCPFT so that they are able to implement Graph Net allowing primary and secondary care to share EPRS (this is now on line).

We will train BCPFT IAPT staff in IAPT LTC and implement these models as soon as training complete working with RWT.

**Cancer**

6) With reference to the national target of 93% for the percentage of Service Users referred urgently with breast cancer symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment), the performance is only listed at 6.7% (p.21). Can you provide us with the latest position and what steps you are, and have taken with health partners to rectify this performance gap and ensure continuous improvement?

**CCG Written Response:-**

At the time of the performance being measured at 6.7%, patients were booking at approximately day 50 and we had a backlog in Wolverhampton of over 500 patients. We have been working collaboratively with Walsall and Dudley providers and have implemented a dynamic process which informs the patient upon referral of the current waiting times across the area, so that the patient is more informed about how they can be seen more quickly. We are now being measured on performance as a system, rather than as individual providers. This has resulted in a more even share across the three providers and Wolverhampton patients are now being seen at day 15 with the backlog down to a manageable position. We will see performance figures improve as we receive validated cancer data.

7) With reference to the national target of 94% for the percentage of Service Users waiting no more than 31 days for subsequent treatment, where the treatment is surgery, the performance is only listed at 66.7% (p.21). Can you provide us with the latest position and what steps you have taken and are taking with health partners to rectify this performance gap?

**CCG Written Response :-**

An improving position, currently 75.76% (August). Delays for performance figures are due to validation of patient outcomes. Breast pathway improvements will have a positive effect with capacity released. Recent actions taken to help with overall performance are:

- Capacity in August was affected by the summer period (higher DNA's, clinical A/l)
- The backlog of patients waiting over 62 day is remaining relatively steady with the largest cohorts of patients being on the Urology and Colorectal pathways followed by Breast.

- The Trust has successfully recruited 8 additional radiographers, 6 of which have commenced in post with the remaining 2 due to start before the end of the year.
- The Trust is running monthly “super clinics” in Breast and Gynaecology.
- The first biopsy list took place in August, the effect of which should be a reduction in the prostate cancer pathway by a minimum of 7 days by moving Template Biopsy to an outpatient procedure.
- Current waiting time for an outpatient Hysteroscopy is down to 13 days in August from 19 in June.

**GPs**

8) Can we have some more details on the outcomes of the GP Home Visiting Service Pilot (P.5), which aims to free up more GP time in surgeries for more preventative work with patients?

**CCG Written response:-**

The GP Home Visiting service was piloted across 6 practices from November 2018 – October 2019. The GP Home Visiting Service was developed to improve access to Primary Care and prevent/ reduce the need for patients to attend Urgent and Emergency care services such as A&E, Urgent Treatment Centre’s and GP Out of Hours.

Improving access to General Practice and other primary care services is a priority for reforming the NHS. The national driver of seeking accessible Primary Care services 8am to 8pm, seven days a week is one of the underlying policy drivers behind the GP Home Visiting scheme.

The implementation of the GP Home Visiting Service pilot was intended to provide an extension of available primary care appointments and give patients improved local access and support. Home visits are a significant call on GP’s time, and there is a view that in many cases patients can be seen and treated by an alternative suitably qualified health professional.

The GP Home Visiting Service Pilot provided 6 varied case studies that demonstrated that the provider has delivered a high quality; safe service; supported by competent clinical decision making and good clinical intervention. The service is responsive, patient focused; delivering positive outcomes for patients and their families.

The service was able to provide patients with a timely response; patients were able to receive a visit on the same day (where clinically appropriate/required). Patients with complex needs benefitted from a smooth, seamless access/ escalation to the Rapid Intervention Team whom were able to meet their needs and prevent further deterioration and admission.

The overall feedback from GP’s was that the service met the needs of patients, released GP time; allowing them to focus on patients who have complex needs and take part in additional strategic planning/clinical initiatives. Utilisation by practices was varied during the pilot and during this

time the additional workforce being introduced in PCNs has prompted a review of the delivery model. Whilst the pilot has now ended some of the positive benefits mentioned above will be used to influence a revised delivery model for the future, using PCN workforce

9) On the matter of learning disabilities, you refer to quality audits (p.19) of the resulting Health Action Plans and providing feedback to GPs. What were the main themes of the feedback given?

**CCG Response:-**

Two practices were audited. The main learnings were:

- GPs and PNs valued the holistic assessment offered
- It was recognised that Practices were working flexibly addressing needs, making reasonable adjustments and involving families
- It was recognised that there is a need to support more practices in offering health checks
- Continue to support practices with Health action plans to ensure they are reasonably adjustable and accessible
- Raise awareness amongst GPs that they can receive support from the LD team

10) NICE TAG Audits (p.27) – What is the outcome of the audits within Primary Care? There are particular national concerns around opioids, antidepressants and benzodiazepines.

**CCG Response:-**

## Audits

**Valproate & women of child bearing age (12 - 55 years)** – audit to show prevalence and highlight patients that have not had a review with their specialist. Lists of patients sent to RWT & BCPFT – to undertake reviews asap (Ensure women of childbearing potential have been made aware of the risks to the foetus associated with taking valproate).

The PCMT identified 230 females of child bearing potential who were prescribed valproate; **the records of 161 patients indicated that they had received information about effective contraception**
**Nitrofurantoin audit.**

The Specialist Pharmacy Service (SPS) has issued updated guidance regarding drug monitoring in adults in primary care, stating that liver and kidney function should be checked regularly in long-term prescribing. The guidance recommended to advise patients to report any signs/symptoms suggestive of pulmonary toxicity (e.g. cough; chest pain; dyspnoea), hepatotoxicity, peripheral neuropathy (sensory as well as motor involvement) or haemolysis.

An audit was developed to establish if Wolverhampton GPs were currently managing patients prescribed long-term nitrofurantoin in accordance with the

SPS guidance. The audit was conducted across Wolverhampton GP practices to review nitrofurantoin prescribing; **168 patients were identified** who had been prescribed **nitrofurantoin for 6 months or more**. 39% (65) patients had liver or kidney function results recorded in previous 6 months and 9 patients' records contained a note that respiratory symptoms had been checked or discussed in the last 6 months. Each practice was given a copy of their practice audit for review at a practice meeting; it is anticipated that all practices will repeat this audit within the next 6-12 months.

**Morphine Dosage safety work**
Following incidents related to the prescribing of morphine liquid elsewhere in the UK; the question was raised "how safe is Wolverhampton GP prescribing of morphine liquid?" The PCMT reviewed every morphine liquid prescription issued in the previous 3 months. For the purpose of this audit prescriptions were assigned to one of 3 categories; potentially unsafe, safer and safest. Potentially unsafe prescriptions represented **8% of all prescriptions**; prescriptions were generally placed in this category because the instructions were unclear or open to interpretation. **All potentially unsafe prescriptions were identified immediately to prescribers for information and action, to ensure patient safety**.

**Bisphosphonate review audit**
Bisphosphonates have been widely used in the treatment of osteoporosis for many years. There is robust data demonstrating efficacy in fracture risk reduction over three to 5 years of treatment. As these agents accumulate in bone with some persistent anti-fracture efficacy after therapy is stopped. The British National Formulary and Summary of Product Characteristics for oral bisphosphonates contain advice that duration of treatment should be reviewed periodically and the benefit and potential risk should be re-evaluated for each patient particularly after 5 years of use. An audit was designed to check if patients under 75 years who have been prescribed oral bisphosphonates (alendronate, ibandronate, risedronate) for 5 years or more have been reviewed. A copy of the audit report template is attached to this report.

| | |
|---|---|
| **Number of patients on bisphosphonates <75years for over 5 years included in the audit** | **373** |
| **Number of patients <75y prescribed oral bisphosphonate for over 5 years with documented review** | **81** |
| **Number of patients <75y prescribed oral bisphosphonate for over 5 years who have been reviewed with a date set for next review of bisphosphonate treatment** | **5** |

Each practice has been given a copy of their practice audit for review at a practice meeting; all patients were booked in for a review and the audit will be repeated in 12 months. The PCMT has advised the use of the bisphosphonate review read code (8BT4 or XacFU) and the use of diary dates to facilitate re-audit.

| ***Audit title and purpose*** | ***Action identified to practices*** |
|---|---|
| ***NICE- Gestational diabetes and no HbA1c or fasting blood glucose***<br>***NICE guideline [NG3] - offer an annual HbA1c test to women who were diagnosed with gestational diabetes who have a negative postnatal test for diabetes*** | ***819 patients required HbA1c blood test*** |
| ***SGLT2 with eGFR <60ml/min/1.73m$^2$***<br>***SGLT2s (canagliflozin, dapagliflozin and empagliflozin) require regular renal function blood tests and appropriate dosage to ensure safe prescribing.*** | ***1419 patients prescribed SGLT2; 121 patients (8.5%) required a renal function blood test and 42 patients (3%) required a dosage review*** |
| ***MHRA - metformin and GFR <30ml/min/1.73m$^2$***<br>**Manufacturer advises avoid if eGFR is less than 30 mL/minute/1.73m$^2$** | ***31 patients identified for review*** |
| ***MHRA - mirabegron & uncontrolled hypertension***<br>***Mirabegron contraindicated in uncontrolled hypertension (systolic blood pressure ≥180 mmHg or diastolic blood pressure ≥110 mmHg).*** | ***60 patients required blood pressure check; 1 patient required a review*** |

***Hydrochlorothiazide: risk of non-melanoma skin cancer, particularly in long-term use***

An MHRA Drug Safety Update (DSU) on 14 November, advised that patients taking hydrochlorothiazide-containing products should be informed about the cumulative, dose-dependent risk of non-melanoma skin cancer, particularly in long-term use, and the need to regularly check for (and report) any suspicious skin lesions or moles. It was further advised that patients should be counselled to limit exposure to sunlight and UV rays and to use adequate sun protection. The PST ran searches to identify all patients taking the product and issued letters 414 patients advising them of the risks, 24 of which were advised to see a GP due to a history of skin cancer.

***Esmya® (ulipristal acetate) and risk of serious liver injury: new restrictions to use and requirements for liver function monitoring before, during, and after treatment***

On 7 August 2018, an MHRA alert was issued to UK healthcare professionals to inform them of the new measures to minimise the risk of serious liver damage. In light of the safety advice the decision was taken to repatriate prescribing for patients on Esmya® back to RWT gynaecology. During the current work plan a search was completed in all practices, resulting in the identification of 2 patients for whom prescribing was repatriated.

**Prophylactic Antibiotics for UTI**

There is good evidence to show that prophylactic use of antibiotics for up to six months is effective for preventing UTIs in patients with recurrent infections.

However there is a lack of evidence that this is an effective treatment strategy beyond six months. The PCMT ran searches in practices to identify patients for whom prescribing was for longer than six months and took appropriate action.

| | |
|---|---|
| No. patients prescribed antibiotic for >6 months for UTI | 179 |
| No. patients with documented review in last 6 months | 11 |
| No. patients referred to GP for review | 168 |
| No. patients for whom antibiotic stopped (latest information) | 61 |

**C.Diff Medication Reviews**
Clostridium difficile work has continued to involve medication reviews for CDI patients, completed by the practice based pharmacist or the patient's GP. A total of 50 patients have had a full medication review post CDI with the majority of the changes being made around laxative and PPI use.

**Controlled Drugs**
The PST worked to identify to practices patients prescribed a quantity of controlled drugs exceeding a 30 days' supply in order that the quantity could be reduced or the patient record annotated if greater than a 30 day supply was clinically required for patient care. The number of patients where the quantity was reduced as result of the intervention during the last quarter was 1003.

Work planned for Q4:-

- Focus on Pain medicines especially Opioids
- NOAC – improve monitoring and dosing based on renal function
- Hypnotics work conducted in 17/18 – to bring back in 20/21

11) Please can you give us the latest position on Medicines of Limited Clinical Value (p.38)?

**CCG Response:-**

18/19 – implementation started in October
Prescribing of Medicines of Limited Clinical Value reduced by 44K

19/20 – Medicines of Limited Clinical Value reduced by 33k in first 5 months – against an annual target of 60K

18/19 – OTC meds – implementation from November
Prescribing reduced on OTC products by 22K

19/20 – OTC – fall of 22K based on first 5 months – against a target of 100K for the year

12) How are you ensuring that the GP surgeries are located in the correct areas and with the right staffing across Wolverhampton. How are you planning for the future demographic changes of the City?

**CCG Response:-**

Practice locations and ensuring population health needs are met is largely covered by the CCG in partnership with our PCNs who focus on sections of the community and changes / challenges presented in those neighbourhoods whether this be additional housing, health needs/changes in demographic etc. In addition, we are sighted on any housing developments through the Black Country and Health Liaison Strategic planning meeting which meets every quarter. This is considered and any new practice development then form part of the Primary Care strategic planning discussions

**Risks on Maternity Services**

13) The report refers to managing risks (p.10) associated with a number of service areas including maternity services. Do you look at other CCG areas such as Shropshire, which has had significant issues in this area and how do you learn from their mistakes?

**CCG Response:-**

Through working at the Black Country and West Bham LMS level, we take a whole system approach to managing risks, regularly reviewing demand and capacity across all Trusts in the footprint, as well as working closely with the Local Maternity Systems on our borders to understand any potential impact on the Black Country of any current issues and their future plans. We conduct regular quality, safety and performance monitoring and implement such measures as timely patient diverts to neighbouring trusts when needed, by working collaboratively with all stakeholders to ensure consensus and consistency of approach.

We have seen this at work recently in maternity services where a cap on births, implemented in 2007 in RWT was lifted, following assurance that sufficient medical workforce/capacity now exists, in line with national standards regarding midwife to birth levels. Similarly, a cap on births in Walsall was also recently lifted.

**Health Inequalities**

14) The report refers to reducing health inequalities in Wolverhampton (p.10). Can you give some examples where this has taken place? Some case studies in future would be ideal, to give a human element, making it relatable.

**CCG Response:-**

To be discussed.

There were a number of supplementary questions asked in response to the written responses which had been tabled at the meeting. A Member of the Panel asked for some more information on the GP Home Pilot. The Director for Strategy and Transformation responded that the pilot had been initially for six months and had been extended by a further six months to allow a full evaluation to take place. Some practices had made extensive use of the resource available, whilst one practice had only used it on two occasions during the twelve months of the Pilot. The Pilot had been underutilised by approximately 40% of the resource available, which meant the intervention for a home visit was costing an average of £163.00 per intervention.

The Director for Strategy and Transformation stated that the average cost of an intervention was not deemed an appropriate use of public funding. The decision was consequently made to cease the pilot but not to cease the principle. They were in discussions with West Midlands Ambulance Service about the opportunity of having paramedics operating a home visiting service, which would hopefully be less expensive in terms of delivery costs. The intention was therefore not to stop a home visiting service, but to find a more financially sustainable delivery model.

A Member of the Panel asked about GP requirements for home visits when specifically requested by a patient. The Director for Strategy and Transformation responded that GPs in their contract had to undertake home visits during in-hours, provided that the individual was bed bound and of a certain age. The out of hours home visiting service was contracted through Vocare, who were the urgent treatment care provider. The Member of the Panel asked if there were any statistics for GPs providing in-hours home visits. The Director for Strategy and Transformation responded that he didn't believe there were any statistics on this question. He suspected the amount of home visits undertaken would be variable across practices. The Member of the Panel asked if consideration could be given in the future to collecting data on GP home visits. The Director for Strategy and Transformation responded that it was something which could be looked into.

The Panel asked supplementary questions on the finances relating to community services and on Improving Access to Psychological Therapy (IAPT). The Director for Strategy and Transformation confirmed that IAPT was a CBT (Cognitive Behavioural Therapy) model. IAPT was the lowest level of mental health intervention. He detailed the cluster model and how the IAPT referral system worked and the waiting times for the service. They did recognise that the community mental health service was not performing as well as it should, which was causing them serious concern.

There was a discussion about health inequalities. The Director for Strategy and Transformation of the CCG commented that health inequalities was a very complex issue. The historical headline indicator for health inequality had been longevity. There were other indicators which he thought needed to be considered, such as years of healthy life. Another indicator could be access to services, but this indicator had problems. Attendance at urgent care appointments, referral rates for conditions and conversion into an outpatient first appointment and subsequent procedure lacked consistency across Wolverhampton. He made reference to the fact that in some areas in Wolverhampton the GP ratio to number of patients varied considerably. Other indicators for the determinants of health could be the natural and built environment, income, poverty, crime, and education. It was the CCG's role

to ensure they worked with Public Health to ensure all people had the right access to health services.

With reference to the response that had been given on the waiting time for a breast cancer appointment, a Panel Member asked what was meant by the term “a more manageable position.” In response the Director for Strategy and Transformation commented that by using the scanning services of Dudley and Walsall the waiting time had reduced in Wolverhampton to less than 14 days, that had of course had an adverse effect on the waiting times in Dudley and Walsall.

The Medical Director of the Royal Wolverhampton NHS Trust commented that the Trust’s Cancer Services had been under intense pressure to deliver the 14 day initial breast assessment. There had been a significant rise in the number of women presenting with symptomatic breast lumps. The conversion of those referrals into a cancer diagnosis had remained the same and so there had been a true increase in the number of breast cancer patients presenting to the service, which reflected the national position. There had been some problems with radiographers and radiologists undertaking some of the images and biopsies. The situation had reached an unacceptable position, but what had helped was other Trusts in the Black Country and in particular Walsall and Dudley, being able to accommodate women from Wolverhampton. The waiting time figures in Wolverhampton were now much better. The whole pathway problem was not solved, as it was much more complex than the 14 and 28 day target position, but significant work was ongoing to address the problems. CT scanning and MRI scanning was in great demand.

A Member of the Panel asked for some information on how long people were kept waiting for cancer scan results. This was in reference to different types of cancer and not just breast cancer. Their personal experience was that people were waiting a long time for the results of scans. The Medical Director of the Royal Wolverhampton NHS Trust agreed to provide a written response and commented that the times would vary depending on the organisation undertaking the scan on behalf of the Trust (there were now 3) the type of scan and cancer.

The Consultant in Public Health on the subject of cancer care commented that early diagnosis and prevention was important to reduce the burden on cancer services. He remarked that it was clear there was inequality in relation to cancer screening. South Asian women were much less likely to undertake cervical screening compared to white women, there was a 1 to 10 disparity. There were other issues relating to age and deprivation in terms of access to bowel screening. Equalities information was important to consider alongside targets. The Panel agreed that health inequalities could be an item for them to consider in the future.

**Resolved:** That health inequalities be added as a future item for the Panel to consider in the future.

8 **GP Appointment Waiting Times**

The Wolverhampton CCG Primary Care Transformation Manager presented a report on GP appointment waiting times. There were two forms of data available, National data was collected by NHS Digital and local data was collected for Primary Care Networks Hub access through a Local Enhanced Service. The waiting time statistics for Wolverhampton were similar to other areas in the STP (Sustainability and

Transformation Partnership). They were also comparable to regional and national statistics. There were no performance targets for waiting times for either core services or hub appointments. The contractual requirements for Extended Access Hubs were that both pre-bookable and on the day appointments needed to be available.

The CCG Primary Care Transformation Manager commented that all practices had same day provision with different models of managing demand. Practices had reported that the majority of their appointments were available on an urgent basis in order to manage patient expectations. All practices had systems in place to manage demand and flow of patients, by releasing appointments at different times.

A Panel Member asked how the CCG informed patients that out of hours appointments were available. The CCG Primary Care Transformation Manager responded that there had been a bus and metro advertising campaign, in addition to radio advertising. The STP were undertaking some communication work and developing this with the local community.

9 **GP Communication Report - Healthwatch**

The Healthwatch Manager introduced the GP Communication report. Healthwatch Wolverhampton had carried out a short survey to gain an understanding of the communication that was taking place across Wolverhampton from the GP's to the patients. There had been over 500 responses. 73% of patients had indicated that they did not receive any communication from their practice. The communication that was received by 27% was mainly around appointment and prescription reminders. Healthwatch had been informed that communication was shared through the Patient Participation Groups. However, when Healthwatch asked the public the question, 76% were not aware of PPGs but 51% would be interested in attending one at their practice. She understood there had been some changes since the survey had been completed and shared with health partners.

**Resolved:** That the Health Scrutiny Panel notes the report and thanks Healthwatch for its compilation.

10 **Healthwatch Wolverhampton Annual Report 2018-19**

The Healthwatch Manager introduced the Healthwatch Annual Report 2018-19.

The Chair asked how Healthwatch promoted to the general public their ability to inform Healthwatch of issues they had been experiencing. The Healthwatch Manager responded that they used a variety of different methods. They tried to get out into the community, which had included having a take over shop in the Wulfrun Centre. They would be happy to hold something in the Civic Centre should the appropriate approval be given.

The Chair commented that he had read in the Annual Report that Healthwatch had identified interpreter services at Patient Participation Groups as an area requiring improvement. The Panel would be reviewing Patient Participation Groups as an item next year.

The Chair asked the Trust and the CCG to comment on the statement in the Section in the Annual Report entitled, "Spotlight on Mental Health." The relevant section he read out as follows: -

"Due to the times that GP's and mental health services can be accessed; people are often forced to go to the Emergency Department with challenging behaviour because of their mental health condition, they are often treated by security in the same way that someone who is causing a problem. This often makes the situation worse and has a negative impact on the mental health of the person."

The Director for Strategy and Transformation of the CCG responded that it was clearly a failure of the system if someone was going to A&E in crisis for a mental health condition. The key was to try and ensure that this did not happen, but whilst this was an admirable ambition, it was inevitable that there would be some cases of people going to A&E in a mental health crisis. It was important that they be treated with dignity.

The Medical Director of the Royal Wolverhampton Health Trust responded that it was difficult for security staff to sometimes to be able to distinguish between someone in a mental health crisis and someone intent to cause a difficulty. Someone in an acute mental health crisis could have very challenging behaviour and A&E was clearly not a suitable place for them. Security staff were trained to deal with various situations and did their best to try and manage them. Sometimes the perception of how a person felt they had been dealt with could differ to the security staff.

The Director for Adult Services commented that it was not a unique local challenge as it was a national problem. There was a general discussion about the matter.

**Resolved:** That the Health Scrutiny Panel formally note the Healthwatch Annual Report 2018-2019 and that Healthwatch be thanked for its excellent content.

11 **Development of the Medical Examiner Role and on site Registrar**

The Medical Director from the Royal Wolverhampton NHS Trust introduced a report on the development of the Medical Examiner Role and on-site Registrar. He stated that the introduction of the Medical Examiner Role was very welcome and was at least ten years too late. There had been discussions about introducing the role since the Shipman Inquiry. Earlier this year the Trust had opened up a Bereavement Centre in a vacant area of the Urgent and Emergency Care Centre. The Centre was staffed by administrative officers, medical examiners, a bereavement nurse and a City Council Registrar.

The Lead Medical Examiner stated that there were 8 consultants classed as Medical Examiners. The process was an independent one and they discussed the care of the deceased with the medical team and the family of the deceased. They were able to refer matters to the Coroner. They completed checks to ensure that the Medical Certificate of Cause of Death was correctly completed. This helped to prevent delays when a family took the certificate to the Registrar to register the death. They were aiming to scrutinise 97% of all cases. The feedback they had received from families had largely been of an informal nature and the most common reaction was to say that they couldn't speak highly of the care received.

Panel Members praised the introduction of the new Bereavement Centre and thanked the Medical Examiners for their work.

12 **Health Scrutiny Work Programme**

The Scrutiny Officer reported that the Chair and Vice-Chair of the Panel had met Officers from Public Health the previous day and it had been recommended to defer the item on cancer screening to the March 2020 meeting. Members of the Panel agreed to make the change to the work plan.

**Resolved:** That the Health Scrutiny Work Programme be agreed.

The meeting closed at 4:05pm.

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Healthier Futures
Black Country and West Birmingham

# STP Overview and Long Term Plan

Steven Marshall
Deputy AO & Director of Strategy& Transformation – Wolverhampton CCG

Building Healthier, Happier Communities

# Our health and care partnership

- **1.4 million population** across the Black Country and West Birmingham
- **19 partners** (4 Hospitals, 3 Mental Health Trusts, 5 Local Authorities, 4 Clinical Commissioning Groups, Community Trust, Ambulance Service, NHS Midlands)
- **Five localities**
- **216 GP Practices** (34 Primary Care Networks)
- **Shared vision** for improving health and care.

# Our vision



**Working together to improve the health and wellbeing of local people.**

# Leadership

Over the last three years, the STP has provided us with a framework to transform our local health and care system in the Black Country and West Birmingham. It has enabled us to act systematically and together - to agree and address common challenges in a way that we could not as individual organisations.

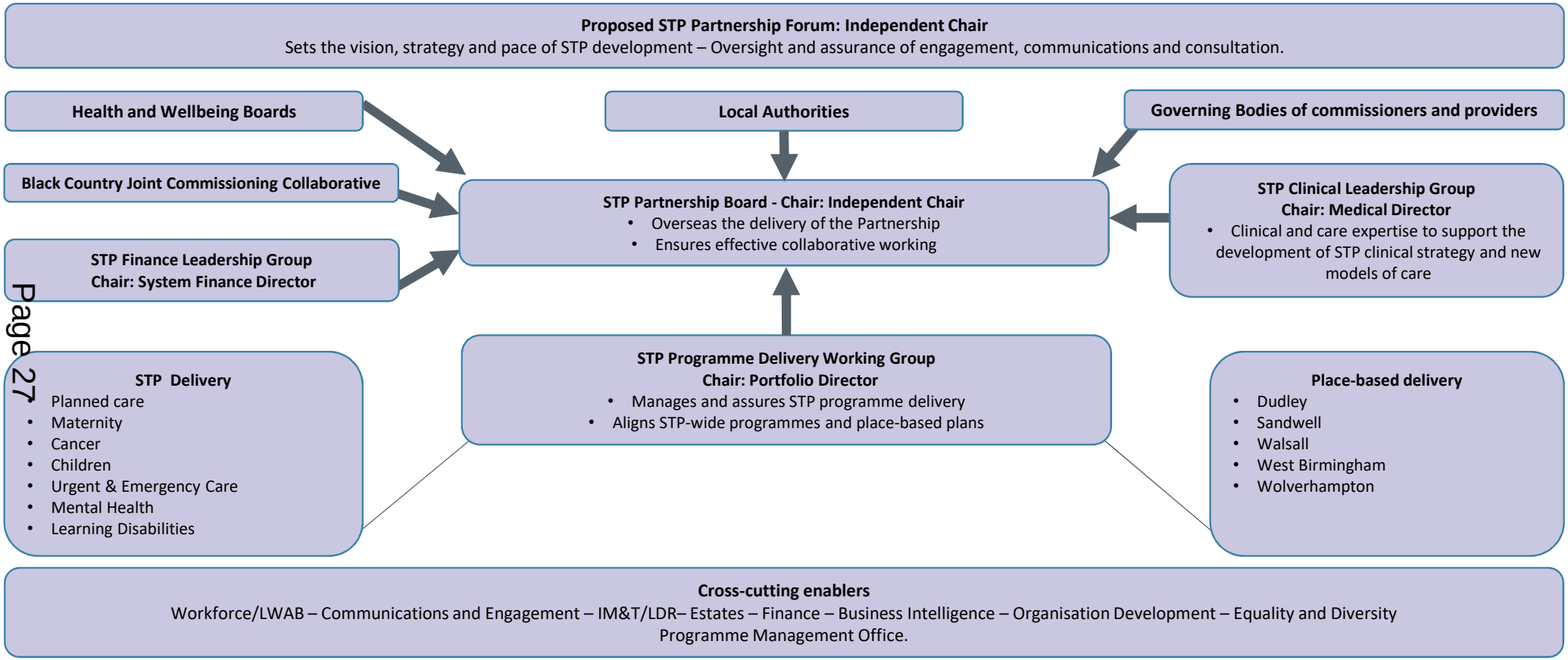
- **Senior Responsible Officer, Dr Helen Hibbs**
- **Independent Chair, Jonathan Fellows**
- **Portfolio Director, Alastair McIntyre**
- **Clinical Leadership Group (CLG) Chair – Dr Jonathan Odum**
- **STP Programme Management Office**

**STP Clinical Leadership Group – monthly meetings**
Establishing clear, robust and manageable processes to provide clinical leadership and assurance across work programmes

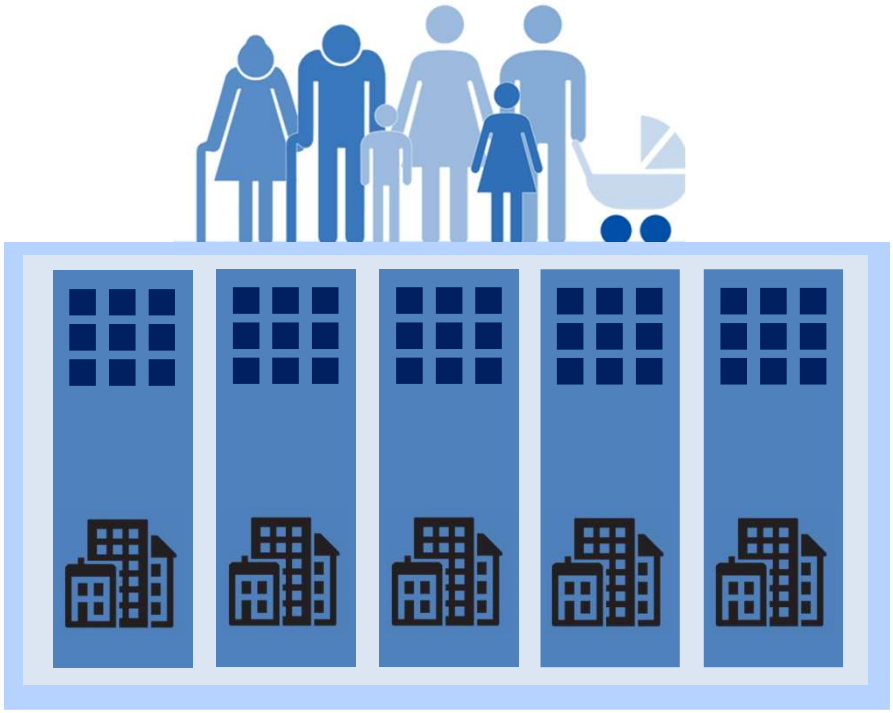
**STP Partnership Board - quarterly meetings**
Sets the vision, strategy and pace of STP development
Overseas the delivery of the Partnership
Ensures effective collaborative working



# Our STP governance



# Future model for delivering integrated care



| | |
|---|---|
| **People** | People empowered to look after their own health and each other. |
| **Neighbourhood** | Services wrapped around 30-50,000 GP neighbourhoods |
| **Place** | Our five places support the integration of health and care services focussed around the patient. This includes: acute, community mental health, local authority and voluntary sector services. |
| **System** | Partnership sets the vision, strategy and pace of system wide development. It will oversea the delivery of the Partnership and ensures effective collaborative working.<br><br>Working as a system to tackle the health, quality and experience gaps. |
| **Region** | NHS England & NHS Improvement working together to directly commission some services at a national and regional level, including most specialised services. (Midlands) |

# What are we already collaborating on

Action plan to **transform maternity** services in place

Maternity Voice Partnerships in each locality

**General Practice Nurse** Strategy

Black Country and West Birmingham named **GP retention intensive** support site

Black Country and West Birmingham **Primary Care Strategy**

**Frailty collaborative**

**Primary Care Network** Development

**New** Perinatal Mental Health Community Service launching

Walsall and Wolverhampton **Stroke Service Reconfiguration**

**Individual Placement Support** (IPS) service in all localities

**Pharmacy** collaboration

Black Country and West Birmingham **COPD guidelines**

Demonstrator site for **personalised care**

**Transforming Care Partnership**

For people with learning disabilities and/or autism

**New** Black Country Pathology Service

# Shaping our long term plan

**Patients and public**

During April and May last year, each Local Healthwatch across the Black Country and Birmingham engaged with the public to understand their experiences of health and care services. Over 1500 surveys were completed and over 200 people took part in focus groups to share their views. The key themes were:

- improved access to information, signposting and health education
- timely access to Services
- increased support in local communities
- ongoing engagement and involvement.

**Staff**

Following the launch of the NHS Long Term Plan, health and social care staff from across the STP were asked to complete a survey to share their views on what is important to local people. 165 people responded from a range of organisations. When asked about the challenges facing the NHS in the Black Country and West Birmingham, the top three answers from staff were:

- increasing demand
- not enough resources
- people with more complex needs.



Healthier Futures
Black Country and West Birmingham

# Developing a Long Term Plan for the Black Country and West Birmingham

- Opportunity to work with local people, our health and care partners and staff to develop a plan that is locally owned and delivers the national ambitions
- Making health and care in the Black Country and West Birmingham sustainable
- To support a workforce that is fit for the future and create a system of health and care organisations that are seen as employers of choice
- To support local people with the knowledge and skills to have more choice and control over their own health and care
- Recognising our collective strength in working together to resolve our common challenges.



# Our long term plan priorities

## 1. Working together to improve health and wellbeing of local people

This is about how we help everyone have better health and wellbeing at every stage of their lives, from birth through their old age. We will work to develop approaches to population health to focus on areas where we can make a bigger difference to people's lives and reducing variation.

## 2. Making the Black Country and West Birmingham the best place to work

All STP partners are committed to working closer together to make this the best place to live and work.

## 3. A system that is fit for the future

In the Black Country and West Birmingham we believe that our system needs to evolve to keep up with changes in technology, digital, people's expectations and the way they live their lives and want to access services. We are working at system, place and PCN levels to identify areas have the greatest potential to deliver improvements to the way the NHS and our partners provide heath and care. We also need to develop models of care that are financially sustainable within the resources we receive.

## Our Vision

# Working together to improve the health and wellbeing of local people

## Healthier people

**We will:**

- reduce the inequalities in health outcomes
- improve the quality of services
- deliver on clinical priorities
- prevent ill-health
- ask 'what matters to you?'
- have services provided in a consistent way

**What will be different**

- People will live healthier for longer
- People who are most vulnerable will get the support they need to stay healthy
- There will be more opportunities for healthy life choices
- There will be more investment in mental, primary and community health care
- Your care will be personalised
- There will be more digital options available to you


## Making Black Country and West Birmingham the best place to work

**We will:**

- attract more staff to work in health and care in this area
- retain our existing workforce
- develop a new workforce

**What will be different**

- Our workforce will know that we care about what is important to them
- There will be more opportunity for workforce to develop
- There will be more options to support workforce to balance their work and home lives
- There will be more ways for workforce to move around the system of health and care
- There will be new roles created to support new ways of working
- Our workforce will get the support they need to do the best job they can

## A system that is fit for the future

**We will:**

- have new integrated models of care
- make the best of the money we have
- work together to share risks and create opportunities
- invest in our facilities

**What will be different**

- Localised teams of health and care will work together to support your social, physical and mental health
- You will be supported to self-care, including options for digital technology
- Local hospitals will work together to deliver accessible and safe care
- Buildings will be fit-for-purpose
- A new, dedicated mental health service provider
- Investing more in your local front-line services

# Delivering integrated care – Clinical Strategy

Building on our strong place-based integration and financial performance, we have developed a clinical strategy.

The strategy highlights 12 priority areas:

- Cancer
- Mental Health
- Learning Disability Services
- Maternity and Neonates
- Children and Young People
- Urgent and Emergency Care
- Cardiovascular Disease
- Clinical Support Services
- Pathology
- Musculoskeletal conditions
- Respiratory Disorders
- Frailty



# Delivering integrated care – Primary Care

Primary care is at the heart of place based plans and integral to integrated care delivery.

- Clinical champions in our four place based areas
- GPs shaping and developing primary care networks
- New roles being developed in primary care
- Community services wrapped around Primary Care
- Multidisciplinary Team approach
- GPs working together with secondary care to improve clinical pathways.



# Delivering integrated care – Strategic Commissioning

We will move towards strategic commissioning by:

- Commissioners working together across the STP
- Developing population health management
- Over-arching common outcomes framework
- Developing a model to enable both place and STP-wide commissioning and service delivery
- Commissioners and providers will work together to make services more clinically effective, keeping the patient at the centre of everything we do



# Enablers

We will

- develop an STP workforce strategy to support the STP clinical strategy
- develop common IT enablers (e.g. shared information governance) and estates enablers
- develop a shared view of system finances and performance
- deliver care through place based alliances
- deliver on our STP estates strategy.



# Benefits of integrated health and care

**Delivering financial sustainability and living within our financial envelope**

- Meeting our control total
- Increasing investment in mental health services
- Increasing investment in primary and community care

**Improving the health and wellbeing of the population**

- Improved life expectancy
- Reducing the number of people living with poor health
- Reducing infant mortality
- Reduce unwarranted variation

**Improving the patients experience of health and care services**

- Better access to services
- Streamlined urgent and emergency care
- Improved patient experience measures.



# Challenges

- Developing and maintaining new relationships with health and care partners across the system.
- Changing relationships with external bodies
- Moving from an STP to an Integrated Care System (ICS)
- How we continue to engage with local people use their views and experiences to shape services and plan in the BCWB
- Increasing collaboration with local government, Voluntary and Community sector, and Social Enterprises
- Working with clinicians to ensure transformation is clinically led
- Moving from competition to collaboration.



# Thank you.



# Scrutiny Work Programme

## Health Scrutiny Panel

The Panel will have responsibility for Scrutiny functions as they relate to: -

All functions of the Council contained in the National Health Service Act 2006, the Local Authority (Public Heath, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 ("the Regulations") - which came into force on 1st April 2013, the Health and Social Care Act 2012 and related regulations.

- The Health and Social Care Act 2012 and related regulations.
- Reports and recommendations to relevant NHS bodies, relevant health service providers, the Secretary of State or Regulators.
- Initiating the response to any formal consultation undertaken by relevant NHS Trusts and Clinical Commissioning Groups or other health providers or commissioners on any substantial development or variation in services.
- Participating with other relevant neighbouring local authorities in any joint scrutiny arrangements of NHS Trusts providing cross border services.
- Decisions made by or actions of the Health and Wellbeing Board.
- Public Health – Intelligence and Evidence
- Public Health – Health Protection and NHS Facing
- Public Health - Transformation
- Public Health – Commissioning
- Healthier City
- Mental Health
- Commissioning Mental Health and Disability
- HeadStart Programme

| Date of Meeting | Item Description | Lead Report Author | Notes |
|---|---|---|---|
| 16 January 2020 | • Accident and Emergency<br><br>• STP (Sustainability and Transformation Partnership) | Royal Wolverhampton NHS Trust / CCG<br><br>CCG – Stephen Marshall | Head of Nursing, Consultant and Director of Operations to be invited. |
| 5 March 2020 | • Mortality Statistics<br><br>• Patient Participation Groups<br><br>• Cancer Screening<br><br>• Maternity Services – Quality Assurance | Royal Wolverhampton NHS Trust<br><br>Royal Wolverhampton NHS Trust / Public Health<br><br>Royal Wolverhampton NHS Trust | Non-Executive Director to be invited.<br><br>Invite two or three PPG groups to the Panel.<br><br>Invite Midwives. Show DVD. |

| | | | |
|---|---|---|---|
| | • Blakenhall Dementia Day Services (Provisional)<br><br>• Reconfiguration of hyper acute and acute stroke services | Tom Denham<br><br>CCG / Royal Wolverhampton NHS Trust | |

**Potential Future Items: -**

1. Black Country Partnership NHS Foundation Trust Merger – Possible an informal meeting will be arranged
2. June 2020 – Review of the new Patient Experience, Engagement and Public Involvement Strategy.
3. Healthy Child Programme
4. Independent Reconfiguration Panel – Briefing Note about the process
5. West Midlands Ambulance - To address priorities identified in the Quality accounts and in particularly those on Maternity Care in the pre-hospital environment.
6. Unions – On particular matters
7. CQC Report on RWT
8. Pharmaceutical Ordering



**Work Plan Version: 08/01/20 15:03**

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