# Health and Wellbeing Board

5 November 2014

**Time** 2.00 pm **Public Meeting?** YES **Type of meeting** Oversight

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

## Information for the Public

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# Agenda

## Part 1 – items open to the press and public

*Item No.* *Title*

**MEETING BUSINESS ITEMS - PART 1**

1 **Apologies for absence (if any)**

2 **Notification of substitute members (if any)**

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

4 **Minutes of the previous meeting** (Pages 1 - 10)
[To approve the minutes of the previous meeting held on 3 September 2014 as a correct record]

5 **Matters arising**
[To consider any matters arising from the minutes of the meeting held on 3 September 2014]

6 **Summary of outstanding matters and Chair's update** (Pages 11 - 14)
[To consider and comment on the summary of outstanding matters and to receive remarks from the Chair including feedback from the "Away Day" held on 15 October 2014]

[Viv Griffin]

7 **Health and Wellbeing Board Forward Plan 2014/15** (Pages 15 - 18)
[To consider and comment on the items listed on the Forward Plan]

[Viv Griffin]

8 **Proposals to deliver planned care at Cannock Chase Hospital for Wolverhampton patients - Outcome of Consultation Exercise**
[To receive a report on the outcome of the public consultation exercise]**[To be circulated]**

[Maxine Espley]

9 **Implementation of Action Plans following Francis Report - Update**
[To receive an update on the progress in implementing the Action Plans produced following the Francis Report] **[To be circulated]**

[Noreen Dowd]

10 **Wolverhampton Safeguarding Adults Board - Annual Report -2013 - 14** (Pages 19 - 86)
[To consider the Wolverhampton Safeguarding Adults Board Annual Report 2013 – 14]

[Alan Coe]

11 **Child Poverty Strategy** (Pages 87 - 94)

[To consider a report on governance arrangements, performance measures, responsibility for priority actions and how a "call for action" could be delivered]

[Keren Jones]

12 **Joint Strategic Needs Assessment (JSNA) - Refresh** (Pages 95 - 124)
[To consider the JSNA Refresh]

[Ros Jervis]

13 **Pharmaceutical Needs Assessment: Update** (Pages 125 - 198)
[To inform the Board of the findings of the Wolverhampton Pharmaceutical Needs Assessment and seek endorsement of the draft document for statutory 60 day consultation]

[Ros Jervis]

14 **Wolverhampton Healthwatch - Annual Report** (Pages 199 - 234)
[To consider the Wolverhampton Healthwatch Annual Report 2013 – 14]

[Maxine Bygrave]

15 **Better Care Fund - Update** (Pages 235 - 244)
[To receive a position report on the Better Care Fund]

[Sarah Carter]

16 **Feedback from Sub Groups** (Pages 245 - 268)
[To receive feedback from the following Sub Groups]

**(i) Children's Trust Board (Emma Bennett)**
**(ii) Transformation Commissioning Board (Viv Griffin)[Verbal report]**
**(iii) Public Health Delivery Board (Ros Jervis)**

17 **NHS Capital Programme** (Pages 269 - 272)
[To receive an update on the current position]

[David Johnson]

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# Meeting of the Health and Wellbeing Board

## Minutes - 3 September 2014

**Members in attendance:**

Cllr Mrs Sandra Samuels (Chair) – Cabinet Member for Health and Wellbeing
Maxine Bygrave – Chair, Wolverhampton Healthwatch
Dr Helen Hibbs – Chief Officer, Wolverhampton Clinical Commissioning Group
Ros Jervis – Director of Public Health, Community Directorate
Sarah Norman – Strategic Director, Community Directorate
Dr Narinder Sahota – Local Area Team, NHS England (Substitute for Dr Kiran Patel)
Cllr Paul Singh – Shadow Cabinet Member for Health and Wellbeing

**In attendance**

Steve Brotherton – Head of Older People Commissioning, Community Directorate
Sarah Carter – Programme Director, Better Care Fund, Wolverhampton Clinical Commissioning Group
Steve Corton – Senior Equality and Diversity Manager, Midlands and Lancashire Commissioning Support Unit
Stephen Dodd - Independent Vice Chair, Wolverhampton Safeguarding Children's Board
Noreen Dowd – Interim Chief Operating Officer, Wolverhampton Clinical Commissioning Group
Fiona Ellis – Commissioning Manager, Children, Young People and Families, Community Directorate
Maxine Espley – Director of Planning and Contracting, Royal Wolverhampton NHS Trust
Grace Forrester – Commissioning Project Officer, Community Directorate
Viv Griffin – Assistant Director, Health, Wellbeing and Disability, Community Directorate
Tony Ivko – Assistant Director, Older People and Personalisation, Community Directorate
Chris Irvine – Wolverhampton Voluntary Sector Council
Keren Jones – Assistant Director, Partnerships, Economy and Culture, Education and Enterprise Directorate
Richard Welch – Team Leader, Healthier Places Team, Community Directorate
Carl Craney – Democratic Support Officer, Delivery Directorate

*Item No.* *Title*

1 **Apologies for absence (if any)**

Apologies for absence had been received from Cllr Val Gibson (Cabinet Member for Adults), Ch. Sup. Simon Hyde (West Midlands Police), Tim Johnson (strategic Director, Education and Enterprise, Wolverhampton City Council), Prof. Linda Lang (University of Wolverhampton) and Dr Kiran Patel (Medical Director, Local Area Team, NHS England).

2 **Notification of substitute members (if any)**

Dr Narinder Sahota attended the meeting as a substitute for Dr Kiran Patel.

**Chair's announcement**

The Chair, Cllr Mrs Sandra Samuels welcomed attendees to the meeting. She advised that Item 17 (Proposals to deliver planned care at Cannock Chase Hospital for Wolverhampton patients) would be considered in the "Open Session" of the meeting and that, accordingly, the press and public could remain for the item.

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

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

4 **Minutes of the previous meeting**

Resolved:

That the minutes of the meeting held on 9 July 2014 be confirmed as a correct record and signed by the Chair subject to the following amendments:
i) Maxine Bygrave (Chair, Wolverhampton Healthwatch) being included in the list of Members present at the meeting;
ii) Chris Irvine (Wolverhampton Voluntary Sector Partnership) to be listed as in attendance but not under the "Employees" column.

5 **Matters arising**

There were no matters arising from the minutes of the meeting held on 9 July 2014.

6 **Summary of outstanding matters**

Resolved:

That the summary of outstanding matters be received and noted including that the issue of governance arrangements in respect of the Better Care Fund, raised at the meeting held on 7 May 2014 had now been addressed.

7 **Health and Wellbeing Board Forward Plan 2014/15**

Viv Griffin presented the Health and Wellbeing Board Forward Plan for 2014/15 and advised the Board that a report in connection with Special Needs and Disability Reform would be submitted to the meeting scheduled for 5 November 2014. She also reminded the Board that the "Away Day" was scheduled to be held on 15 October 2014 at the Molineux Hotel, Wolverhampton and that the papers for the event would be circulated shortly.

The Chair, Cllr Mrs Sandra Samuels, stressed the importance of the event and encouraged all members of the Board to attend or to nominate a substitute to attend on their behalf.

Resolved:

That the Forward Plan be received and noted.

8 **Safeguarding Children's Board Annual Report 2012-13 - Report of the Independent Chair**

Stephen Dodd, Vice Chair of the Wolverhampton Safeguarding Children's Board (WSCB) presented the Annual Report for 2012 -13. He referred to the review of governance arrangements, including Board membership, the attempts to clarify agency roles and responsibilities in the climate of significant change, the revised branding and the review of Committees. He reported that the Board now met quarterly rather than bi-monthly, that the roles of Board members had now been defined, that there was more work undertaken jointly with the Adults Safeguarding Board and of the work undertaken to monitor serious case reviews. He advised that the Annual Report for 2013 – 14 was due to be considered at the meeting of the WSCB during week commencing 8 September 2014 and would be presented to a future meeting of this Board.

Chris Irvine questioned as to whether, in the face of budget reductions, safeguarding remained a priority for the various agencies. Stephen Dodd assured the Board that safeguarding remained a core priority for all agencies but acknowledged the effects of the increased case load with a reduced workforce. The Chair, Cllr Mrs Sandra Samuels, enquired as to whether all members of this Board had received the appropriate training on safeguarding matters.

Resolved:

1. That an assurance be provided to the Wolverhampton Safeguarding Children's Board that the respective agencies represented on this Board report annually to their respective boards on children's safeguarding;
2. That all agencies represented on the Board be required to ensure that the internal assurance mechanisms that demonstrate their role and performance in relation to safeguarding arrangements for children and young people were in place;
3. That the Annual Report of the Wolverhampton Safeguarding Children's Board for 2012 – 13 be received and noted;
4. That the Independent Chair (or his nominee) be co-opted onto this Board;
5. That arrangements be made for Cllr Paul Singh and Ros Jervis to receive the appropriate training in respect of safeguarding matters;

6. That the Wolverhampton Safeguarding Children's Board Annual Report 2013 – 14 be submitted to a future meeting for consideration.

9 **Better Care Fund - progress report**

The Board considered a report and received a PowerPoint presentation from Sarah Carter in connection with the latest position on progress made in relation to the development of the Better Care Fund Programme Plan in Wolverhampton which was due to be submitted on 19 September 2014. Following a question from the Chair, Cllr Mrs Sandra Samuels, Sarah Carter explained and gave examples of the Primary and Community Care work stream.

Ros Jervis enquired as to when the re-design of community and primary care would be undertaken in order to have an impact on emergency admissions. Sarah Carter explained that preparatory work would commence in year one of the programme (2015/16) with implementation in year two (2016/17) and also gave an example of a "quick win" inasmuch as GP's would work closely with the top ten residential homes in the City for emergency admissions to hospital. She also explained the "Eclipse Strategy" whereby risk stratification at residential homes would be undertaken by GP's. Dr Helen Hibbs advised that simple steps could make a big difference with GP's working with the staff at residential homes to identify those residents most likely to succumb to infection or illness.

Noreen Dowd advised the Board that the Programme Plan had been prepared having regard to the QUIPP savings (efficiency savings) required at the Clinical Commissioning Group and the financial constraints faced by the local authority thus ensuring that double counting had not occurred.

Maxine Bygrave referred to the current period of constant change and enquired as to what assurances were being provided to the local population that the revised methods of working did not represent a reduction in the standard and quality from that provided previously. Sarah Carter reported on the proposals for a Quality Impact Assessment to be undertaken and on the benchmark data available on which comparisons between services could be made. Maxine Bygrave referred to the reliance on the whole system approach adopted in the Plan and whether regard had been had to the capacity issues especially within the voluntary sector. Sarah Carter reported that arrangements had been made to meet with representatives of the Third Sector Partnership on 18 September 2014 to discuss this issue and stressed that some services could be delivered better by the Voluntary Sector. The Chair, Cllr Mrs Sandra Samuels, emphasised the importance of ensuring that the necessary capacity and resources were in place. Dr Helen Hibbs referred to the quality monitoring arrangements at the Clinical Commissioning Group which would monitor the delivery of services and opined that services being delivered differently did not necessarily mean that the standard or quality was worse than previously provided. Dr Narinder Sahota drew to the attention of the Board those areas which were currently rated as "Amber" in the Plan, the importance of quantity and quality and the need for the whole system approach to be followed. Sarah Norman stressed the need to demonstrate that the health and social care providers and commissioners were working together.

Resolved:

1. That authority be delegated to the portfolio holders for Adults, Health and Well Being and Resources, in consultation with the Director for Community and the Assistant Director Finance, to approve the Better Care Fund Programme Plan on behalf of the council, to be submitted by 19 September 2014.
2. That the council services and associated budgets for 2015/16 are agreed as part of the Better Care Fund Programme Plan under the delegation detailed above; be pooled in the Better Care Fund, subject to the conclusion of a pooling agreement with Wolverhampton Clinical Commissioning Group (CCG) under Section 75 of the National Health Service Act 2006.
3. That a further report be provided to Health and Wellbeing Board following the submission by 19 September 2014, to provide an update on the final Better Care Fund Programme Plan, and seek approval for the finalised Section 75 agreement

10 **Joint Strategy for Urgent Care - Equality Analysis**

Noreen Dowd introduced Steve Corton to the Board. She explained that the report to be presented would concentrate on two main areas, those areas to be addressed by agencies and those areas falling under the remit of this Board. Steve Corton presented the Equality Analysis for the Joint Urgent Care Strategy and sought the Board's agreement to adopt specific recommendations in the equality analysis.

Sarah Norman welcomed the report but questioned how the Board could be satisfied that the six recommendations pertaining specifically to the Board could be delivered and sought clarity on the actions to be taken. Steve Corton explained that he would be meeting with the individual agencies, that the Board could, as the strategic lead, require its partners to action the recommendations and that he would be responsible for monitoring the adoption and action on the recommendations. Noreen Dowd suggested that the Board task Steve Corton with taking the necessary steps to ensure that the appropriate steps were taken to implement the recommendations and to submit a further report to a future meeting of the Board on progress.

In response to a question from Chris Irvine in relation to hard to reach groups Steve Corton assured the Board that he endeavoured to ensure that the steps and actions required from each group were proportionate to the size and resources available.

Resolved:

1. That Steve Corton (Midlands and Lancashire Commissioning Support Unit, NHS England) be tasked, on behalf of the Board, with taking the necessary steps to ensure that the appropriate steps were taken to implement recommendations 8, 10, 11, 19, 20 and 21 in the equality analysis document and to submit a further report to a future meeting of the Board on progress;
2. That the Equality Analysis, particularly the 21 recommendations set out on pages 40 – 42 of the document be noted.

11 **Child Poverty Strategy**

Keren Jones presented a report which updated the Board on progress in delivering Wolverhampton's Child Poverty Strategy and the future governance arrangements. She advised the Board that responsibility for resolving the issues associated with Child Poverty sat with the Children's Trust Board but this would transfer shortly to the Early Help Board. The Social and Economic Inclusion Board would be charged with the lead role in prevention of and breaking the cycle of Child Poverty. The Children's Trust Board would commission an annual review and from the information received make recommendations on future actions to both the Early Help Board and the Social and Economic Inclusion Board.

The Chair, Cllr Mrs Sandra Samuels, questioned as to whether a strong working relationship existed between the Child Poverty Strategy Group and the Wolverhampton Children's Safeguarding Board. Keren Jones undertook to look into this matter and to ensure that linkages between the two Groups were strengthened. Sarah Norman commented that prevention of poverty and neglect could be achieved through working together through the Early Help Board.

Chris Irvine commented that an analysis of the figures in respect of child poverty in the City made disappointing reading and that while the topic had been a priority for many years little progress had been made in addressing the problem. Keren Jones reminded the Board that the current Strategy had only been in place for 12 months, had been refreshed and needed time before any results were identifiable.

The Chair, Cllr Mrs Sandra Samuels suggested that there was a need for a governance framework together with a performance monitoring mechanism in order to identify the progress being made. Dr Helen Hibbs commented that Child Poverty could only be reduced if overall poverty in the City was reduced and reminded the Board of steps which had been taken with regeneration, increasing employment opportunities, enhancing employability together with providing support those children living in poverty. She suggested that the Strategy, as written, made insufficient reference to the need to improve educational opportunities. Ros Jervis suggested that a whole system approach was required given that the contributions of all service areas could have an impact.

Noreen Dowd suggested that the approach adopted with the "Obesity Call to Action" should be followed. Chris Irvine reminded the Board of the important role Schools had to play in resolving the issue and of the opportunities which existed in making use of the Pupil Premium. The Chair, Cllr Mrs Sandra Samuels, commented on the important role that health also played in this issue.

Resolved:

1. That the revised governance arrangements be noted;
2. That consideration of the report be deferred to the next meeting of the Board and that further consideration be given to the use of the approach followed with the "Obesity Call to Action" together with the preparation of a governance framework and a performance monitoring mechanism.

12 **Progress update - Joint Health and Wellbeing Board Strategy Priority - Drugs and Alcohol**

Ros Jervis presented a report which provided an update on key performance indicators used in the Joint Health and Wellbeing Strategy (JHWBS) to monitor performance on alcohol and drugs. The report also presented the Alcohol Strategy reporting dashboard for comment albeit that it was still in development and provided an update on other issues of relevance to this JHWBS priority area.

She drew attention to the current performance and informed the Board of discussions which had taken place with the current contractor and of the possible application of financial penalties in the contract. She reminded the Board that the contract was for a three year period with an option to extend for a further two years. A Recovery Plan was now in place but unless significant improvements were achieved consideration would need to be given to re-tendering the contract.

Resolved:

1. That the update on the key performance indicators and other issues in relation to the alcohol and drugs priority in the Joint Health and Wellbeing Strategy 2013-2018 be noted.
2. That the new reporting dashboard, agreed at the November 2013 meeting of the Health and Wellbeing Board, which summarised progress with the Wolverhampton Alcohol Strategy 2011- 2015 be noted and any comments be passed to Ros Jervis, Director of Public Health.
3. That the Alcohol Strategy strategic leads undertaking a review and refresh of the strategy as it nears the end of its term be noted.
4. That the Director of Public Health be requested to send a letter to the Government on behalf of the Board requesting that a sensible approach be taken in relation to “minimum pricing” guidance on the sale of super strength cider and that the issue of duty be clarified immediately on sparking ciders to include those that are causing most harm to individuals, families and communities.

13 **Children, Young People and Families Plan - 2014 - 2024**

Fiona Ellis presented the draft Children Young People and Families Plan 2014 – 24 for consideration and comment.

Resolved:

That the draft Children, Young People and Families Plan 2014 – 24 be endorsed.

14 **Refreshed Joint Dementia Care Strategy and Implementation Plan - 2014 - 2016**

Tony Ivko reported that work was ongoing on the refresh of the Joint Dementia Strategy and Implementation Plan 2014 – 2024 alongside the associated Better Care Fund work stream and undertook to ensure it was circulated to members of the Board for comment. Comments were required by 30 September 2014. The Strategy and Implementation Plan would also be considered by the Clinical Commissioning Group Board during September 2014.

Resolved:

That the report be noted and that comments be submitted by Board members by the deadline of 30 September 2014.

15 **Feedback from Sub Groups**

**(i) Adults Delivery Board**

Viv Griffin reported that no meetings of the Adults Delivery Board had been held since the last meeting.

**(ii) Public Health Delivery Board**

Ros Jervis presented a report on the new work streams of the Public Health Delivery Board, as agreed through the Business Planning cycle and matters arising from the meeting held on 31 July 2014. With regard to Priority Three – Integrating the healthier places team into Public Health, she advised that Richard Welch had been appointed as Team Leader of the Healthier Places Team. With regard to Priority Seven – Health Protection and Emergency Preparedness Resilience and Response (EPRR), she reported that Steve Barlow had been appointed to the Health Practitioner Lead Practitioner post.

Resolved:

That the report be received and noted.

16 **Exclusion of the press and public**

Resolved:

That the public and press be not excluded from the meeting.

17 **Proposals to deliver planned care at Cannock Chase Hospital for Wolverhampton patients**

Maxine Espley reported on the background to and the proposals for the delivery of planned care at Cannock Chase Hospital to Wolverhampton patients. A public consultation exercise had been launched in July 2014 with a closing date which had been extended to 17 October 2014. A hand-out which explained the proposals and the formal consultation document was circulated at the meeting. Currently, 314 survey responses had been received; over 100 people had attended or were due to attend public events and 1315 hits recorded on the consultation website. A report on the results of the consultation exercise was to be submitted to the Health Scrutiny Panel meeting scheduled to be held on 20 November 2014.

Following a question from the Chair, Cllr Mrs Sandra Samuels, Maxine Espley confirmed that there would be one team operating across the two sites with staff assigned on a rotational basis and that an on-site Manager was now in place. With regard to concerns which had been raised in connection with transport between the two sites, Maxine Espley outlined the arrangements which were now proposed and which had addressed many of the issues. Dialogue was continuing with user groups.

Maxine Bygrave welcomed the extension to the public consultation period but questioned the availability of the supplement to the original consultation document including details as to why the “do nothing” option was not viable. Also, she enquired as to the availability of the draft travel analysis. Maxine Espley assured the Board that the supplementary documents now referred to were available on the consultation website. An initial travel analysis had been undertaken, colleagues at the Commissioning Support Unit were preparing a full equalities assessment and the Equalities Impact Assessment would be made available to the Board in due course. She reminded the Board that the proposals would, once implemented, lead to a reduction in the number of cancelled operations due to emergency pressures.

Resolved:

That the report be received and noted and a verbal report on the outcome of the public consultation exercise be made to the next meeting of the Board.

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**Agenda Item No. 6**

# Health and Wellbeing Board

5 November 2014

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

**Recommendations for noting:**
The Health and Wellbeing Board is asked to consider and comment on the summary of outstanding matters

## 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 previous meetings of the Health and Wellbeing Board.

## 2.0 Background

2.1 At previous meetings of the 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 |
|---|---|---|---|
| 1 May 2013 | Child Poverty Strategy – Timelines, Six Target Wards And Membership Of Stakeholder Workshop | Keren Jones (WCC) | Progress report to this meeting |
| 8 January 2014 | Certification of Deaths | Ros Jervis (WCC) | Report to a future meeting (Government guidance awaited) |
| 8 January 2014 | Children's Safeguarding Action Plan – New approach | Emma Bennett (WCC) | Report to a future meeting (via Children's Trust Board report) |
| 8 January 2014 | Better Care Fund | Sarah Carter (WCCCG) | Report to this meeting |
| 8 January 2014 | Report back from SEND Sub Group | Viv Griffin (WCC) | Report to 07/01/15 meeting |
| 31 March 2014 | Health and Well Being Strategy – Performance Monitoring | Helena Kucharczyk (WCC) | Quarterly reports |
| 31 March 2014 | NHS Capital Programme – NHS England – GP practices in Wolverhampton | Les Williams / Dr Kiran Patel (NHS England) | Quarterly reports |

| | | | |
|---|---|---|---|
| 3 September 2014 | Joint Strategy for Urgent Care – Equality Analysis | Delivery Plan | Report to this meeting |
| 3 September 2014 | Child Poverty Strategy | Delivery Plan | Report to this meeting |
| 3 September 2014 | Proposals to deliver planned care at Cannock Chase Hospital for Wolverhampton patients | Outcome of public consultation exercise | Report to this meeting |

## 3.0 Financial implications

3.1 None arising directly from this report. The financial implications of each matter will be detailed in the report submitted to the Board.

## 4.0 Legal implications

4.1 None arising directly from this report. The legal implications of each matter will be detailed in the report submitted to the Board.

## 5.0 Equalities implications

5.1 None arising directly from this report. The equalities implications of each matter will be detailed in the reports submitted to the Board

## 6.0 Environmental implications

6.1 None arising directly from this report. The environmental implications of each matter will be detailed in the report submitted to the Board.

## 7.0 Human resources implications

7.1 None arising directly from this report. The human resources implications of each matter will be detailed in the report submitted to the Board.

## 8.0 Corporate landlord implications

8.1 None arising directly from this report. The corporate landlord implications of each matter will be detailed in the report submitted to the Board.

## 9.0 Schedule of background papers

9.1 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

5 November 2014

| | |
|---|---|
| **Report Title** | Health And Wellbeing Board – Forward Plan 2014/15 |
| **Cabinet Member with Lead Responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing |
| **Wards Affected** | All |
| **Accountable Strategic Director** | Sarah Norman, Community |
| **Originating service** | Communities/Health, Wellbeing and Disability |
| **Accountable officer(s)** | Viv Griffin — Assistant Director<br>Tel 01902 55(5370)<br>Email Vivienne.Griffin@wolverhampton.gov.uk |

**Recommendation**

That the Board considers and comments on the items listed in the Forward Plan

| MEETING | TOPIC | LEAD OFFICER |
|---|---|---|
| **5 NOVEMBER 2014 (1400 HOURS)** | **YOUNGER ADULTS THEMED MEETING** | |
| | Proposals to deliver planned care at Cannock Chase Hospital for Wolverhampton patients | Maxine Espley (RWNHST) |
| | Implementation of Action Plans following Francis Report – Update | WCCCG / RWHNHST |
| | Wolverhampton Safeguarding Adults Board Annual Report – 2013 – 14 | Alan Coe (WSAB) |
| | Child Poverty Strategy | Keren Jones (WCC) |
| | Joint Strategic Needs Assessment (JSNA) – Refresh | Ros Jervis (WCC) |
| | Pharmacy Needs Analysis | Ros Jervis (WCC) |
| | Healthwatch Annual Report | Maxine Bygrave (W'ton Healthwatch) |
| | Better Care Fund – Update | Sarah Carter (WCCCG) |
| | Better Care Fund – Transfer of funding from NHS England to Social Care | Anthony Ivko (WCC) |
| | Report from Sub Groups | Viv Griffin / Emma Bennett / Ros Jervis (WCC) |
| | NHS Capital Programme | Dr Kiran Patel |

| | | |
|---|---|---|
| **7 JANUARY 2015 (1230 HOURS)** | Report from Sub Groups | Viv Griffin / Emma Bennett / Ros Jervis (WCC) |
| | Wolverhampton Safeguarding Children's Board Annual Report 2013 -14 | Alan Coe (WSCB) |
| | Health and Wellbeing Board – Governance arrangements including updated Terms of Reference and amendments to membership | Viv Griffin (WCC) |
| | Mental Health Strategy | Sarah Fellows (WCC) |
| **4 MARCH 2015 (1400 HOURS)** | Report from Sub Groups | Viv Griffin / Emma Bennett / Ros Jervis (WCC) |
| | Joint Strategy for Urgent Care – Equality Analysis | Steve Corton (M&LCSU) |

**To be added at some appropriate point: YOT input JSNA**

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**Agenda Item No. 10**

# Health and Wellbeing Board

5 November 2014

| | | |
|---|---|---|
| **Report title** | Safeguarding Adults' Board Report 2013-14<br>Report of the Independent Chair | |
| **Cabinet member with lead responsibility** | Councillor S Evans<br>Adults | |
| **Wards affected** | All | |
| **Accountable director** | Sarah Norman, Community | |
| **Originating service** | Adults' Safeguarding | |
| **Report to be/has been considered by** | Wolverhampton Safeguarding Adults Board | 12 June 2014<br>11 September 2014 |

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**Recommendation(s) for action or decision:**

The Health and Wellbeing Board is recommended to:

1. Provide assurance to Wolverhampton Safeguarding Adults Board that the respective agencies represented on the Health and Wellbeing Committee report annually to their respective boards on children's safeguarding;

2. Ensure all agencies represented at the Board have internal assurance mechanisms that can demonstrate their role and performance in relation to safeguarding arrangements for adults at risk.

3. That Board members representing the key agencies mentioned in Statutory Guidance dated October 23 2014 agree to ensure that the new statutory Board is in place and properly constituted and funded by 1 April 2015

4. To note the report

## 1.0 Purpose

1.1 The purpose of this report is to provide the Health and Wellbeing Board with a copy of the Wolverhampton Safeguarding Adult Board's (SAB) Annual Report and Executive Summary (**Appendix 1 & Appendix 2**), to inform the Board of safeguarding activity 2013/2014 and to present the Safeguarding Board with progress made against the priorities for 2013-16.

1.2 The report reminds members of the requirement for the Board to become a statutory body by 1 April 2015

## 2.0 Background

2.1 The Safeguarding Manager - Adults is responsible for producing an Annual Report on behalf of the Wolverhampton Safeguarding Adults Board. The Annual Report contains contributions from the partner agencies who are members of the Board.

2.2 The report provides information regarding local safeguarding initiatives, the work and structure of the Safeguarding Board, progress against previous year priorities, partner achievements, and safeguarding data performance. An Executive Summary has also been produced, this summarises the key headlines from the full report and has been developed in recognition of the needs of the potential audience.

2.3 Each year a first draft of the Annual Report and Executive Summary is presented to the June Safeguarding Board and a final draft is presented at the September Board, once agreed it has previously then been presented to the Health and Wellbeing Board. Last year, it was agreed that the Annual Report would be presented to Adult and Community Scrutiny Panel prior to presentation to the Health and Wellbeing Board , thus enabling Members to familiarise themselves with the report contents and to provide opportunity for challenge.

## 3.0 Progress, options, discussion, etc.

3.1 The Annual Report reflects the complex and wide ranging agenda that the Board, its working groups and partner organisations have been working on throughout the year. The Board has started to make good progress in the first year against its 2013-2016 priorities:

**Priority One - Better Outcomes**

- Collecting better information from people who have been at risk and gathering information as to whether our intervention has made them feel safer.

**Priority Two - Quality Assurance**

- Review of both national and local serious case reviews were undertaken to identify key trends and themes and to identify key actions required.
- Set of performance measures agreed enabling the collation of safeguarding information from all partners on the Board and not just from the council.

**Priority Three - Information Sharing**

- A specific Safeguarding Adults Information Sharing Protocol has been developed, following consultation with Board members it is on track to be formerly adopted at September Board.
- Established Housing Providers Safeguarding forum across all social housing providers operating in Wolverhampton.

**Priority Four- Prevention and early intervention**

- An audit across partners is being undertaken to identify current prevention and early intervention provision across the city.

**Priority Five – Communication and engagement**

- Delivered safeguarding in faith sessions- listening to faith groups and learning how we can all keep vulnerable people safe.
- Delivered workshops on the changes to the Disclosure & Barring Service (DBS) to faith groups and small voluntary organisations**.**

**Priority Six – Workforce Development**

- The roles and responsibilities and lines of accountability of organisations are clear so that staff understand what is expected of them and others.

3.3 For each of the Board's Priorities there is a lead who is responsible for driving the priority forward, the leads are all Board members and they report regularly to the Board on both the progress made and challenges faced. The Priority Leads make up the Board's Executive Group.

3.4 The number of safeguarding alerts received increased significantly from 1172 in 2012/13 to 1,305 in 2013/14. This could be attributed to increased public awareness through activities organised by the Safeguarding Board and partner agencies and increased media coverage, particularly in the area of abuse in residential care settings. The Annual Report shows that the type of abuse with highest number of referrals is neglect and also provides a breakdown of safeguarding alerts by geographical Ward area for information.

3.5 For 2013/14 a new question was included in the safeguarding documentation to capture the expected outcomes of the adult at risk of harm and also whether the expected outcomes were achieved. The data shows that where the question was asked, the expectations of the adult at risk were fully achieved in 86%

3.6 Under the Care Act 2014 the safeguarding of adults is placed on a statutory footing from the 1 April next year. This brings it into line with the safeguarding children board. Final guidance was published on 23 October 2014. Much of it confirms what is already standard practice both locally and nationally. However work is underway to ensure current practice and processes reflect the guidance. The membership of all safeguarding adults' boards must include:

- the local authority which set it up;
- the CCG in the local authority's area; and
- the chief officer of police in the local authority's area

The guidance provides a longer list of other potential members including representatives of the community and the voluntary sector as well as a range of other statutory agencies. It is recommended but it is not essential that each board has an independent chair.

## 4.0 Financial implications

4.1 The Care Act guidance states that: 'It is in all core partners' interests to have an effective SAB that is resourced adequately to carry out its functions.' The oversight of present safeguarding arrangements is underpinned by funding of £67039. The three main contributors are:

- Wolverhampton Council - £40889
- West Midlands Police – £11150
- Wolverhampton CCG - £15000

The West Midlands Police Force calculate their contribution on a regional formula. The level of support from the local authority and CCG is not underpinned by any specific calculation. As part of the work in preparation for becoming a statutory Board discussions are taking place to determine what support is required to deliver a safe service. This will include comparisons with our neighbouring safeguarding boards..

## 5.0 Legal implications

5.1 There are no direct legal implications arising from this report

## 6.0 Equalities implications

6.1 Safeguarding adults at risk is a concern for all communities. Improving public engagement – which includes raising public awareness about what safeguarding is and what people should do if they recognise it - is a joint priority for both the Safeguarding Children and the Safeguarding Adults' Boards. Work is currently underway to improve our links with all local communities both directly and also in part through improved links with faith groups.

## 7.0 Environmental implications

7.1 Comment briefly on the environmental implications of the report/proposals.

## 8.0 Human resources implications

8.1 There are no environmental implications arising from this report.

## 9.0 Corporate landlord implications

9.1 There are no corporate landlord implications arising from this report at this stage

## 10.0 Schedule of background papers

10.1 Department of Health: Care and Support Statutory Guidance – October 2014

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## Safeguarding Activity

The total number of alerts received this year was 1350, a marked increase from last year which totalled 1173.

It is unclear why there has been such an increase in the number of alerts, although there has been an increase every year for the last three years. It may be attributed to the increased public awareness through media coverage and locally through safeguarding awareness raising sessions delivered by the Safeguarding Team and partner organisations.

## Alerts and Referrals

| | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Alerts | 989 | 1173 | 1305 |
| Referrals | 586 | 495 | 519 |
| Referrals as a % of Alerts | 59% | 42% | 40% |



This year a new question has been included to capture the expected outcomes of the adult at risk of harm, and whether the expected outcomes have been achieved. The results show that, where deemed applicable, the expectations of the client are fully achieved in 86% of safeguarding investigations and at least partly achieved in a further 7% of cases.

| | Number | % |
|---|---|---|
| Yes, expectations were achieved | 233 | 86 % |
| Expectations were partly achieved | 18 | 7% |
| No, expectations were not achieved | 20 | 7% |
| Not applicable | 213 | - |
| Overall Total | 495 | |

**An example of the positive impact that Safeguarding can have on a person's life :**

***Case Study***

*A safeguarding referral was raised in respect of a young woman with a profound learning disability who lived at home with her sister and her sister's family.*

*The allegation was that the sister roughly handled her using excessive and inappropriate restraint, that she was not properly clothed and that the food she was provided was second rate. It was also suggested that she was excluded from family life and was made to feel that she was not a full and valuable member of the family.*

*The sister was a person who did not want to engage with agencies and presented many obstacles and challenges. Intensive multi-agency work was undertaken within the safeguarding process. The patience and skill of the social worker, combined with the full commitment and dedication of the care agency and the input of occupational therapy and community nursing have ensured that there is a detailed and comprehensive Protection Plan and Health Plan and that the young woman is safeguarded and closely monitored. She has been able to remain in her family environment which was felt by all, including an independent advocate, to be in her best interests.*

**WHO CAN I TELL MY CONCERNS TO?**
**To make a Safeguarding Alert ring Adults Social Care Services on 01902 551199.**

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

**In an emergency, ring 999.**

# Wolverhampton Safeguarding Adult Board Annual Report 2013/14

## *Executive Summary*

SEE Abuse STOP Abuse CALL 01902 551199

Wolverhampton Safeguarding Adults Board

## Introduction

This executive summary highlights some of the work undertaken by the Safeguarding Adults Board during 2013/14. The Board ensures all partner organisations work together to prevent abuse and to protect people if they are harmed or exploited.

Alan Coe is the independent Chair of both the Wolverhampton Safeguarding Adults Board and the Children Board. A joint Chair helps improve ways of preventative working as many issues are common to both adults and children such as domestic violence, and we have seen a greater emphasis on developing joint approaches to recognising and tackling abuse. 15 agencies are represented on the Board and there are four meetings a year.

## Developments and Achievements

There have been many developments and achievements in the last year and details can be found in the full Annual Report. To view the full Annual Report please see link below:
http://www.wolverhampton.gov.uk/article/2959/Safeguarding-Adults-Board-SAB

## Risk Register

In September 2013 the Board developed its first Risk Register; the Register identifies potential risks to the effective functioning of the Board and possible mitigating actions. This is reviewed at each Board meeting and updated.



## Board Priorities 2013-16

**We have made some good progress against the Priorities in Year 1**

**Priority One: Better Outcomes** –

Service User experience and involvement in safeguarding enquiries directs improved practice

*Our highest priority is to get better information from people who have been at risk and who can tell us whether our intervention has made them feel safer, whether they feel they have been given choice and control and whether people have confidence that they are listened to.*

**Priority Two: Quality Assurance** –

Ensure there are effective Multi-Agency Quality Assurance and Performance Management processes in place

*We are about to introduce a set of performance measures and will collate information for all partners on the board rather than just the Council.*

**Priority Three: Information Sharing**-

Improvements are made to how agencies can share personal information legally and ethically to enable adults to be protected from harm or unwarranted risk

*Draft Safeguarding Adults Information Sharing Protocol developed to be presented at September 2014 Board.*

**Priority Four: Prevention**-

There is a coherent inclusive approach by both Safeguarding Boards to community initiatives which protect disadvantaged groups

*An audit across partners is being undertaken to identify current prevention and early intervention provision across the city. Information from the annual assurance statement is being used to inform this picture.*

**Priority Five: Communication and Engagement**-

There is a consistent and co-ordinated approach to how the safeguarding message for adults, young people and children is disseminated to all groups and communities.

*Delivered "Safeguarding in Faith" sessions, listening to faith groups and learning how we can all keep vulnerable people safe.*

**Priority Six: Workforce Development**-

The workforce of all partner agencies have undergone safe and robust recruitment processes and understand safeguarding issues as they relate to their role.

*Safeguarding Awareness training delivered to emplyees and volunteers and opportunities are available to develop enhanced skills for those with specific role/responsibilities.*

# Wolverhampton Safeguarding Adults Board

# Annual Report 2013/2014

Wolverhampton Safeguarding Adults Board

# Board Partners

YOW! Youth Organisations Wolverhampton

Wolverhampton Homes

West Midlands Police

Wolverhampton
A Safe City
operating as Wolverhampton's Local Police & Crime Board

Staffordshire and West Midlands Probation Trust

Wolverhampton City Council

West Midlands Fire Service

The Royal Wolverhampton Hospitals NHS
NHS Trust

Our Community
you matter, we care

West Midlands Ambulance Service NHS
NHS Foundation Trust

Black Country Partnership NHS
NHS Foundation Trust

NHS
Wolverhampton
Clinical Commissioning Group

WDVF
Wolverhampton
Domestic Violence Forum

## Contents Page


| | |
|---|---|
| Introduction | 4 |
| Safeguarding Adults- Peer Review | 5-6 |
| The Structure and Work of the Board | 7-8 |
| Risk Register | 8-9 |
| Response to Winterbourne View | 9 |
| The Board's Priorities 13-16 | 10 |
| Summary of Board Progress Against 13-16 Board Priorities | 11-16 |
| Case Study | 17 |
| Partner Achievements including Case Study | 18-36 |
| Making Safeguarding Personal | 36 |
| Wolverhampton Safeguarding Adult Budget | 36-37 |
| Training/Workforce Development | 37-38 |
| Safeguarding Adult Activity 13/14 | 39-54 |
| Case Study | 55 |
| Feedback Form | 56 |
| Appendices | 57 |

# Introduction

Welcome to the 2013/14 annual report of the Wolverhampton Safeguarding Adults Board. This report is produced on behalf of the multi-agency Wolverhampton Safeguarding Adults Board and contains contributions from the wide range of agencies who are its members.

Although the stories of abuse and neglect that we see on our screens or read in the newspapers are depressing I believe that safeguarding adults is something the public are more aware of now than previously. The casual neglect and indifference of residents was for many years a hidden feature of institutional care. I suspect there is far less of it happening now but it is reported upon more.

It remains the job of Wolverhampton's Adult Safeguarding Board to make sure all the partner organisations work together to prevent abuse and also to protect people if they are harmed or exploited. The annual report tells you what has been achieved and what the plans are for the next 12 months.

In the past twelve months there have been substantial pressures on partnership working brought about in most instances by the contraction of public spending. There have been organisational changes affecting many agencies with a responsibility for adult safeguarding. Board membership has changed significantly which affects the continuity of our work as new managers take on new roles. Despite this I am delighted to say there are continuing signs of progress. There has been significant additional expenditure within West Midlands Police Service on adult safeguarding. Their new service with more trained experts in adult protection means that people at risk of significant harm will be supported by highly trained investigators who work in partnership with Council Social Care Services and the NHS. Finally, a major inspection of the Royal Wolverhampton Trust by the Care Quality Commission confirms generally high levels of care for the many patients of New Cross. All of this gives cause for some optimism but the challenges lead me to feel that we have not made as much progress as we all would have wished.

Nationally there continue to be scandals concerning the care of disabled and older people. There is more to do on staff training and picking up the early warning signs of poor care. Similarly there is more to do to protect the rights of those people who are so disabled and dependent that they cannot freely give informed consent to where and how they live. In the following pages you can learn more about what we are doing both separately and together to protect those people most at risk of being harmed. I welcome feedback and advice about what more we can do and how we can do it better.

Alan Coe - Independent Chair

# Safeguarding Adults - Peer Review

In order to assess the effectiveness of the safeguarding adults arrangements in Wolverhampton and as part of a national programme of sector led improvement activity, the City Council invited the Local Government Association (LGA) to conduct a peer review of its safeguarding adults practices. The peer review team was made up of a number of experts from a variety of organisations from different parts of the country including an Elected Council Member, Senior Police Officer, Local Authority Adult Social Care Director and Health representative. The review which took place the week commencing 16th September 2013 highlighted a number of key strengths. The following are quotes from the feedback report which reflected positively on safeguarding arrangements;

- *Generally a positive picture with a key aspect being the strong partnership working arrangements in place based on good personal relationships;*
- *The Safeguarding Board is well led, the right partners are around the table and represented at the most appropriate level of seniority;*
- *The Safeguarding Board has a good understanding of its strengths and weaknesses and a well worked up action plan with clear priorities;*
- *Overall frontline practice seems to be good and is improving; and*
- *Wolverhampton Adults and Community's Directorate is well placed through its foundation on strong partnership working to make significant progress in the next 12 months.*

The review also provided some extremely helpful challenge and feedback in relation to **areas for development**; Detailed below are just a few of the headline recommendations from across the thematic areas:

### Outcomes

- *Continue to move towards a change in focus from being process driven to being outcomes focused; and*
- *Review and evaluate the steps you have taken to include and respond to the voice of the user and carer in adult safeguarding*.

### People's experience of safeguarding

- *Wolverhampton City Council website should be made more user friendly with regard to adult safeguarding; and*
- *Improve the timeliness of feedback and information to users and carers involved in safeguarding processes*.

**Leadership**

- *There is a need for development in members awareness, understanding and ownership of adult safeguarding;*
- *Review the political governance and scrutiny arrangements for adult safeguarding; and*
- *Ensure adult safeguarding is owned corporately.*

**Service delivery & effective practice**

- *The Safeguarding Board recognise training provision, delivery and evaluation is a priority for improvement; and*
- *Ensure effective information sharing across all areas.*

**Working together – Safeguarding Adults Board**

- *Focus on prevention and early intervention could be strengthened; and*
- *Maximise the opportunity for multi-agency training.*

An action plan was drawn up to help drive the areas identified as requiring development forward. The areas in the action plan were divided into 6 themes and these mirror closely the Priorities that the Board had already identified for the coming three years.

- Political and Corporate Governance
- Service User/Carers Voice and Experience
- Learning and development
- Think Family and Domestic Abuse Safeguarding
- Prevention and Early Intervention
- Social care and Health

The action plan was assigned to the respective leads/groups following its adoption by the Wolverhampton Safeguarding Adults Board. It was agreed that Community Directorate Management Team (CDMT) would own the action plan and receive quarterly updates on progress, which would also be shared with the Safeguarding Board. All actions have now been accepted by the respective leads/groups and progressed within respective work plans. The action plan continues to be scrutinised and evidence will be sought to ensure that activity of the plan has an impact on the outcome for service users.

## The Structure and Work of the Board

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

The Board also oversees the effectiveness of the arrangements made by individual agencies and the wider partnership to safeguard adults from abuse. The remit of the Board is not operational but one of co-ordination, quality assurance, planning, policy and development. It contributes to the partnership's wider goals of improving the well-being of adults in the City.

Alan Coe has been the Board's independent Chair since 2011. In February 2013, Alan also became the independent chair of the Wolverhampton Safeguarding Children Board. There are many advantages of having the same chairperson for the two Boards. A joint chair helps improve ways of preventative working as many issues are common to both adults and children such as domestic violence, and we have seen a greater emphasis on developing joint approaches to recognising and tackling abuse.

In October, the Children and Adult Safeguarding Boards had a joint awareness raising stand in the Wulfrun shopping centre, offering advice and information to members of the public, there have also been joint Domestic Violence and Forced Marriage Training sessions for both adult and children's services social workers, and two joint events for Faith groups and small voluntary organisations.

Currently, fifteen agencies are represented on the Board see Appendix 1 for list of Board members. It is agreed that the Care Quality Commission will attend and report on their activity at one Board meeting each year. The Board also has the support of an elected Council Member who attends meetings whenever he is able to do so and has participated in various adult safeguarding events. Previously, the Board endorsed five observers from governing bodies of member organisations to attend the open part of the Board meeting. This year due to organisational change in a number of partner agencies, we have said goodbye to several members and welcomed new people on to the Board.

The Board has four meetings per year; it also has one development event which usually takes place in March. This year there was also an extraordinary meeting to review the Board's priorities.

The development event this year focussed on reviewing and developing the Board's risk register aligning the risks to the new Board Priorities. The minutes of all the open part of the meetings can be found on the Councils' Safeguarding Adults webpage:
http://www2.wolverhampton.gov.uk/health_social_care_2/adult_social_care/protecting_vulnerable_adults/

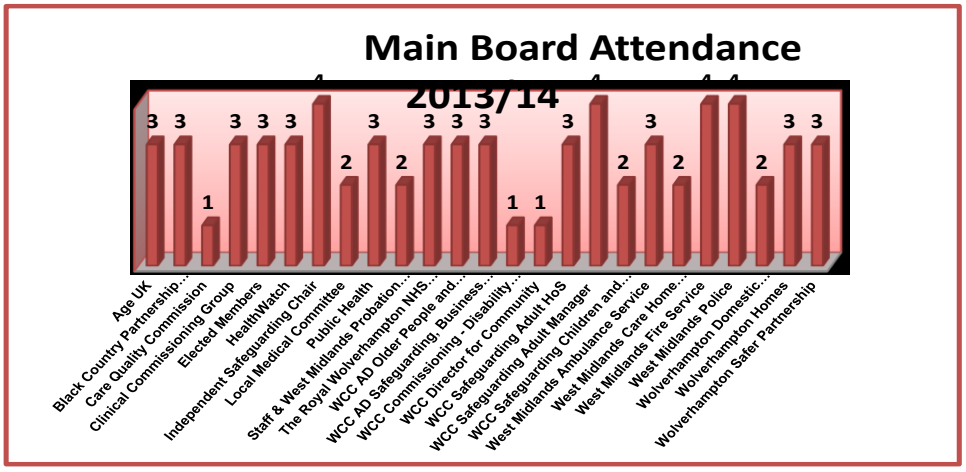
It is expected that the work of the Board is reported back by members to their organisations using their internal governance structures.

During the year the Government published the draft Care Bill. The Bill built on the finding of the Law Commission report and recommendations into the legal framework for adult social care

(including safeguarding). The Care Bill proposes, amongst other things, that Safeguarding Adults Boards (SAB) should be put on a statutory basis and to require Local Authorities to make (or cause to be made) enquires where an adult at risk in its area is or may be being subjected to abuse.
The new legislation will be implemented April 2015 but preparations are being made now on the main contents relating to adult safeguarding in order for us to be ready for the changes.

No Serious Case Reviews were requested or undertaken during 2013/14.

Attendance at Board meetings is detailed below.




## Risk Register

In September 2013 the Board developed its first Risk Register; the Register identifies potential risks to the effective functioning of the Board and possible mitigating actions. Representatives of the Board attended a regional event to look at developing an agreed regional Board Risk Register, our model was felt to be an effective tool, it was adapted slightly and circulated across the West Midlands region as the suggested regional risk register tool.

At the Board development event in March, Board members looked at each of the Board's priorities and refreshed the Risk Register, this will be presented at the June 2014 Board and will then become a regular Board agenda item as the Risk Register needs to be a live document that is reviewed and updated on a regular basis. If you would like to view the Risk Register this is available on the following link:
http://www.wolverhampton.gov.uk/article/2959/Safeguarding-Adults-Board-SAB

### How do we know if the Board is effective?

In 2013/14 the West Midlands adult safeguarding regional network developed an Annual Assurance document template. The Board adopted this Annual Assurance Tool in 2013 and agreed to use it in order for partners to undertake a self- audit to enable the Board to assess the effectiveness of local safeguarding arrangements.

This Partnership Annual Assurance document was developed based on the Department of Health's 6 key safeguarding principles (2011):-

- **Empowerment** - Presumption of person led decisions and informed consent
- **Protection** - Support and representation for those in greatest need
- **Prevention** - It is better to take action before harm occurs
- **Proportionality** – Proportionate and least intrusive response appropriate to the risk presented
- **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse
- **Accountability** - Accountability and transparency in delivering safeguarding.

This was the first time that the Partnership Self Audit tool was used in Wolverhampton. It provided partner agencies the opportunity to report on aspects of their safeguarding activity and also gave the Board opportunity for comment on areas of development

## Response to Winterbourne View

The Safeguarding Board has received regular updates on progress made with regards to the local progress in relation to Transforming Care: A National Response to Winterbourne View Hospital

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

All Local Authorities and Clinical Commissioning Groups were required to take action to transform the way services are commissioned and delivered to stop people being placed in hospital inappropriately, provide the right model of care, and drive up the quality of care and support for all people with behaviour that challenges.
This has included developing the register of people with learning disabilities and/or autism who are in NHS funded care. This register is being maintained within the Joint Commissioning Unit.

All of the people on this register have been reviewed jointly and in a manner which reflects best practice.

Further reviews were undertaken by the Community Learning Disability Team to ensure best practice with regards to the wider messages from Winterbourne - i.e. keeping people safe in services, particularly people in large-scale accommodation and people placed out of area. A

number of work streams have been developed out of this to ensure quality, to move people closer to home or into different environments where this has been appropriate.

## The Board's Priorities 2013-16

In last year's Annual Report it was acknowledged that that the working group structure was not as effective as the Board would like, attendance at the working groups had been inconsistent and at times problematic therefore early in this reporting year an extraordinary meeting was arranged to look at the Board's priorities and to consider possible alternative ways in which the Priorities could be delivered and who would be the most appropriate person to lead on each of the priorities. The meeting reviewed the progress made against the previous priorities and reviewed whether the priorities remained the same.

We recognised that the Board needed to support more innovative ways of implementing its priorities. This was due to the inconsistent attendance at working group meetings, in part caused by the reduction in capacity of many partner agencies as they struggle to do more with fewer resources, this includes doing more in partnership with other local Boards on a regional basis, getting more work done through time-limited Task and Finish groups, arranging virtual meetings and ensuring greater board leadership and oversight of the Board's work programme. It was agreed that each priority lead would report back to the Board during the coming year.

**The Priorities for 2013-16 are**: -

- **Priority One: Better Outcomes** –

  Service User experience and involvement in safeguarding enquiries directs improved practice

- **Priority Two: Quality Assurance** –

  Ensure there are effective Multi-Agency Quality Assurance and Performance Management processes in place

- **Priority Three: Information Sharing**-

  Improvements are made to how agencies can share personal information legally and ethically to enable adults to be protected from harm or unwarranted risk

- **Priority Four: Prevention**-

  There is a coherent inclusive approach by both Safeguarding Boards to community initiatives which protect disadvantaged groups

- **Priority Five: Communication and Engagement**-

  There is a consistent and co-ordinated approach to how the safeguarding message for adults, young people and children is disseminated to all groups and communities

- **Priority Six: Workforce Development**-

  The workforce of all partner agencies have undergone safe and robust recruitment processes and understand safeguarding issues as they relate to their role.

# Summary of Board Progress against 2013-16 Board Priorities (Year 1)

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


(Priority Lead - Maxine Bygrave- Healthwatch)

Purpose:

- Ensure that the feedback and experiences of local people, who have had contact or been involved in safeguarding processes, influence and improve the way safeguarding is delivered and received
- Ensure there are effective mechanisms for collating, analysing and responding to user feedback
- Ensure that we 'close the loop' by sharing how user feedback and experience has improved the way we work.

Achievements:

- We have clarified what needs to be done and agreed how it will be achieved. Our highest priority is to get better information from people who have been at risk and who can tell us whether our intervention has made them feel safer, whether they feel they have been given choice and control and whether people have confidence that they are listened to. We are well on the way to getting that and we can make improvements based on the feedback we receive.

Challenges:

- There was an initial challenge in gathering the level of information that partners collate following a review of the existing priority goals.
- WSAB partners hold a significant amount of information collated using existing user feedback mechanisms and there needs to be agreement on how this data can be used measure outcomes.

**Priority Two**: Quality Assurance- Ensure there are effective Multi-Agency Quality Assurance and Performance Management processes in place (Priority Lead- Susan C Marshall -Black Country Partnership Foundation Trust).

The Board agreed that this priority would be addressed on a regional basis by forming a Regional Black Country Quality Improvement Group; membership of the group was made up of safeguarding leads from Sandwell, Walsall, Wolverhampton and Dudley, police, health colleagues and chaired by representative from BCPFT.

Purpose:

- Develop multi-agency quality assurance process, including audits of shared cases, to ensure safeguarding practice is proportionate, effective and timely
- Explore feasibility of identifying adults whose circumstances may make them vulnerable to abuse
- Make sure that agency learning from the Domestic Homicide Review action plan is disseminated within WSAB Partner agencies
- Collate performance measures agreed by WSAB partner agencies, including those relating to service users' experiences, which gives it assurance that safeguarding processes are robust and make people feel safer.

Achievements:

- Review of both national and local serious case reviews; including domestic homicide reviews and the confidential Inquiry into the deaths of individuals with learning disabilities was undertaken to identify key trends and themes and identify any key actions for taking forward
- We are about to introduce a set of performance measures and will collate information for all partners on the board rather than just the Council.

Challenges:

- At the last meeting held at the end of January representatives were present from each of the four Local Authority areas and the police, concerns were raised about the lack of representation from other agencies invited, who span all four areas and who should be represented on the group
- Due to poor attendance at the group and the departure of the Chair it was decided that the regional group would no longer meet and this priority will be addressed locally from 2014. A new local Quality and Performance group has now been set up.

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

 (Priority Lead- Mark Henderson – Wolverhampton Homes).

Purpose:

- Develop a robust Wolverhampton Safeguarding Adult Board Information Sharing Protocol that all Partner Agencies are signed up to.
- Agencies will have clear governance of information sharing around safeguarding

- Support the implementation of the 'Trigger Points' protocol and processes for adults who make frequent calls upon multiple services.

Achievements:

- Draft Safeguarding Adults Information Sharing Protocol developed to be adopted at June 2014 Board
- Discussion with partners held to gauge and gather support for an early safeguarding alert system. A system will be developed during 2014/15 which will minimise the risk of partner agencies being unaware of others concerns i.e. removes the surprise factor
- Established Housing Providers forum across all social housing providers operating in city. Includes social media 'yammer' site. This may prove to be a model for other agencies to follow i.e. children's board, schools etc.

Challenges:

- Dissemination of systems to frontline officers within large agencies and buy in from senior executives in driving forward

More widely

- Continues impact of welfare reforms
- Increasing levels of vulnerability.

**Priority 4** – Prevention and Early Intervention **-**There is a coherent inclusive approach by both Safeguarding Boards to community initiatives which protect disadvantaged groups.


(Priority Lead Karen Samuel – Wolverhampton Safety Partnership)

Purpose:

- The focus for this priority is to develop a strategic approach to earlier intervention and prevention to adult safeguarding to reduce risk of safeguarding activity. This will include arrangements to progress 'trigger thresholds' work across agencies to identify vulnerable adults at risk before safeguarding adults risk threshold is met. It will also involve strengthening links to Public Health and extend use of the Joint Strategic Needs Assessment to inform strategic planning for adult safeguarding.

Achievements:

- An audit across partners is being undertaken to identify current prevention and early intervention provision across the city. Information from the annual assurance statement is being used to inform this picture.
- Potential indicators to monitor progress have been identified – these will be finalised following completion of the plan.

- Triggers work is being progressed through Priority 3 of the Priorities Action Plan with Mark Henderson as Lead; an update on the progress of this has been obtained.
- Information from the Joint Strategic Needs Assessment (JSNA) has been identified which could assist with safeguarding Prevention work. Public Health has been asked to assist with development and implementation of the resulting action plan.

Challenges:

- The shifting local infrastructure is likely to present some challenges in understanding what provision is in place and how services fit together; as many services are in the middle of significant change, it's unlikely the audit, when completed, will provide the clarity needed to shape our action plan.
- Taking account of the point above, the action plan will need to be subject to regular review to ensure it remains reflective of changing services and practice.
- Increasing demands placed on partners may result in some difficulties drawing together this initial picture and with securing and maintaining the required involvement of partners with shaping the action plan.
- The triggers threshold work will require an agreed IT platform through which partner data can be cross-referenced; there are likely to be some barriers across organisations about the introduction of an 'additional' system over and above those already in use.

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


(Priority Lead- Stephen Dodd - Youth Organisations Wolverhampton (YOW).

Purpose:

- Public/community groups are more aware of how to raise a concern
- Public/community groups are more aware of help and support available
- Public/community groups have more confidence in support available
- Public/community groups are more aware of safeguarding issues publicised
- Public/community groups are more engaged with safeguarding adults and children
- Information is more accessible and accessed more
- Safeguarding messages are more evidence - / need-based.

Achievements:

- Established a committed task and finish group with good representation
- Partnership working across both Adult and Children Boards
- Present at a Multi- Faith "Forgiveness" event raising awareness of safeguarding

- Delivered "Safeguarding in Faith" sessions, listening to faith groups and how we can all keep vulnerable people safe
- Delivered session on the changes to Disclosure & Barring Service (DBS) to faith groups and small voluntary organisations.

Challenges:

- It has been a challenge adapting to change and fewer resources within organisations
- Recognising that the focus needs to be realistic and not overly ambitious.

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


(Priority Lead- Lynne Fieldhouse- Royal Wolverhampton Trust).

Purpose:

- Adults can have confidence that processes have been followed to ensure where possible staff and volunteers pose no risk of harm
- Adults can have confidence that staff and volunteers are appropriately trained and skilled.

Achievements:

- Safeguarding Awareness training delivered to all staff and volunteers and opportunities are available to develop enhanced skills for those with specific role/responsibilities
- The organisations are assured that staff and volunteers have the required safeguarding competencies for their role
- Employers have robust procedures in place to ensure that all staff and volunteers are safely recruited so that unsuitable people are prevented from working with adults at risk
- The roles, responsibilities and lines of accountability of Organisations are clear so that staff understand what is expected of them and others.

This 3 year planned approach will on completion ensure the Board's workforce development framework is fully implemented by partner agencies and ensure the workforce of all partner agencies have undergone safe and robust recruitment processes and understand safeguarding issues as they relate to their role.

Drivers for this priority include:

- Statement of government policy on adult safeguarding 16/5/11 Principles Protection, Prevention, Accountability
- Care Quality Commission Outcome 7 - Safeguarding people who use services from abuse
- Care Quality Commission Outcome 12 – Suitability of staffing
- WSAB Workforce Development Adult Safeguarding Framework
- Helping employers make safer recruiting decisions. Govt. doc 2013.

Year 1 - 2013 Progress:

- Partner organisations/employers have a training plan/strategy/framework for their staff and volunteers
- Compliance to local training plans is monitored
- Training activity/risks are reported to Board via performance dashboard/exception reporting.

**Case Study**

Mrs X is an 80 year old woman who lives with her son Z in rented accommodation. Mrs X and Z are joint tenants. Mrs X is frail, has some mobility issues but independently manages her own personal care needs. Z has mental health needs and has some dependency on alcohol.

Mrs X presented at her GP surgery with facial injuries and alleged that her son had physically assaulted her. The GP was aware that there had been previous history of domestic abuse.

The GP raised a safeguarding alert and Mrs X also agreed to make a complaint to the Police. Mrs X agreed to emergency respite as a place of safety whilst she considered her longer term options. Halfway through the 2 week respite, Mrs X decided that she wanted to return home as she was missing her son. She also decided to withdraw her witness statement to the Police. All options available such as a Non-Molestation Order were explained and refused by Mrs X.

Mrs X was deemed to have the mental capacity to make decisions around her accommodation and keeping herself safe. She was able to identify and weigh up the risks to her safety in returning home. She did agree to a Protection Plan being put in place in order to minimise the risks of future harm.

The case was referred to Multi Agency Risk Assessment Conference and an urgent safeguarding case conference was arranged, Mrs X attended. The meeting was also attended by representatives from the Police, Mental Health Trust, Community Psychiatric Nurse and social workers from the Community Mental Health Team and the older person's team.

At the Case Conference, a Protection Plan was agreed and consisted of Police reassurance visits three times weekly, a SIG marker on the address so further calls to the Police would be treated as priority, weekly social work visits, telephone calls and opportunities to explore alternative accommodation. Z agreed to a forensic risk assessment and support in respect of his mental health needs and alcohol dependency. Z stated that at times he wanted to kill his mother. Z was referred for Anger Management. A Carelink alarm was put in place, and there was further exploration of day centre opportunities and further discussion regarding change of accommodation. Both parties agreed that one of them needed to move out but neither of them wanted it to be them.

Mrs X has been supported in viewing alternative accommodation types; sheltered and very sheltered housing and 24 hour residential accommodation. She has declined all these and also day care opportunities.

With the support and collaborative joint working of the two teams (Community Mental Health Team under 65 and Adult Care Team) Z's mental health is now stable and there have been less altercations. The level of risk of harm has now been reassessed as medium and some of the safeguards such as the Police visits have ceased.

The risks remain but they are balanced with Mrs X's capacitated desire to remain at home in the company of her son. The case remains open with a live Protection Plan and on-going case management.

# Partner Achievements 2013/14

## Wolverhampton Homes

**Mark Henderson**

**: -** What outcomes were set for the past year?

- To review adult safeguarding procedure by Quarter 4, 2014
- To provide awareness-raising sessions regarding safeguarding to all front line staff by Quarter 3 2013
- To develop a Housing Provider Safeguarding Group by Quarter 4, 2014
- Recruitment to Mental Health Support Officer (as part of Families in Focus Programme)
- Review of Tackling Domestic Violence procedure by Q3 2013
- Embed new working arrangements for Anti -Social Behaviour Team (WCC/ WH)
- Ensure Domestic Homicide Review/Serious Case Review reports are carried out efficiently and the opportunity to learn from such cases is not lost
- Attendance at Multi Agency Risk Assessment Conference.

To what extent were these outcomes achieved?

- Procedure reviewed Q3, 2013/14
- Awareness-raising safeguarding sessions rolled out (see below) Q3, 2013/14
- Meetings held to discuss the development of the Housing Provider Safeguarding Group – currently looking at the format of meetings to decide on best way to develop this initiative
- Recruitment to Mental Health Support Officer pending (Q2, 2014/15)
- Review of Domestic Violence procedure completed Q3, 2013/14.

What are the priorities going forward?

- Further promotion / awareness raising among staff of procedures. To this end we are holding a Focus Group on 11 June with staff from across the company to discuss their perception of the current arrangements and how we can make sure that where issues are identified they are responded to appropriately
- Further work around the development of the Housing Providers Safeguarding Group
- Review of Anti -Social Behaviour Team

- Awareness of issues for Lesbian Gay Transgender Bisexual (LGTB) community / staff
- Information for tenants around staff responsibility to identify and report any safeguarding issues they may come across as part of their work.

**Training:**

What training has been provided to staff?

Staff who have face to face contact with the public are trained to recognise abuse and how to report it. Dementia awareness raising sessions 2013 was also delivered to frontline staff.

281 front line staff attended the safeguarding awareness training 2013/14.

Is Safeguarding Adults training included as part of the new staff induction?

Reference is made to safeguarding during the induction programme for all new staff. It is not what could be called 'training' but it does highlight the responsibility staff have in this matter.

Is Domestic Violence, Forced Marriage and Honour Based Violence training delivered to staff?

How many people received this training during 2013/14?

Wolverhampton Homes delivered domestic violence training to staff in 2012/13.

How is this training audited to ensure awareness and understanding of staff?

- Number of referrals made and number reported on a regular basis in the equalities section of the Business Improvement Committee
- Training needs identified with each member of staff via 1-2-1's and yearly appraisal.

**Service User Experience:**

What information is available to service users regarding the safeguarding process?

There is a Web page outlining what anyone should do if they have concerns around safeguarding of adults. Following recent discussions had about safeguarding and raising the profile of this issue it has been agreed that we need to put information out to tenants about how we deal with issues and what staff have a responsibility to do. This has arisen due to a specific case we have dealt with recently what has given us the opportunity to look at the information we currently put out and led us to deciding it was not sufficient.

How do service users give feedback regarding safeguarding processes?

Generally, service users haven't given any feedback. However, the case referred to above has highlighted a gap in information we give to tenants about what we ask staff to do in terms of safeguarding. This has led to us deciding we need to do more awareness raising. This may lead to service users giving more feedback.

# West Midlands Police

**Tess Beckett**

West Midlands Police are committed to engaging with our partners, providing a joint approach to safeguarding.

**Achievements regarding Safeguarding Adults**:

What outcomes were set for the past year?

- Development of a Vulnerable Adult Hub as a more effective way or receiving information about adults who may be at risk and acting upon it.

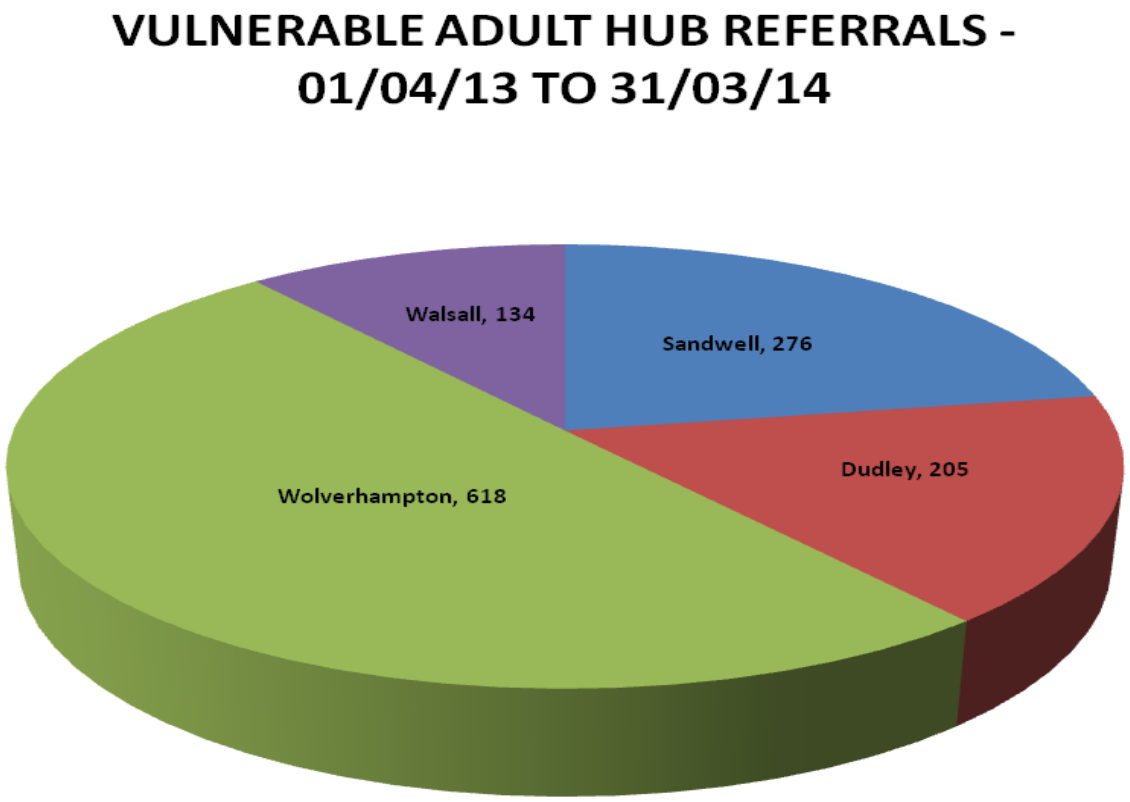
To what extent were these outcomes achieved?

- In January 2013 West Midlands Police responded to the National concern of vulnerable adult abuse by piloting a six month Vulnerable Adult hub a dedicated team of officers covering the Black Country. The pilot was continually reviewed; West Midlands Police and partners deemed the hub to be best practice. The hub offered a single point of contact to respond to referrals from our partners, primary investigations were completed. Due to staffing issues investigations were then passed to Local public protection teams to develop
- The hub has grown over the past 12 months; in September 2013 Birmingham local authority joined the workings of the hub with Solihull and Coventry joining in February 2014. The Vulnerable adult hub is now a force hub based at Sandwell. The team consist of 14 experienced Police Officers and four members of business support supervised by Detective Inspector Tess Beckett
- Service transformation review has been completed across the Force over the past 11 months. The staffing levels for public protection has almost doubled from 480 to 800. This change process will begin on 2/6/14 with experienced Police officers moving into public protection. The team will work 7 days a week 0800 – 2000 proving an excellent service to our most vulnerable members of the community
- The team have responsibility for all Vulnerable Adult Abuse and will retain all investigations under the public protection remit; incidents were previously passed to local officers once the primary investigations were completed. West Midlands Police can now provide continuity for victims with experienced vulnerable abuse officers responding to calls for service
- West Midlands Police are the only force in the country to have a dedicated vulnerable adult team; we have been approached by a number of other forces to see our best practice.

**Training**:

- West Midlands Police have completed the following training during this review period, all Sergeants and Inspectors across the force regardless of role have received a full days training in Vulnerable Adult Abuse, Honour Based Violence, Female Genital Mutilation, Human Trafficking, Child Sexual Exploitation, Child Protection
- All West Midlands Police officers have received mandatory training in Victims code, Child Sexual Exploitation, human trafficking, child protection, and new domestic violence procedures
- All frontline officers have received information about the hub, how to signpost and minimum standards of guidance training surrounding Vulnerable adult abuse
- In addition all vulnerable adult team officers have received training from the office of public guardian, The crown prosecution service, coroner's officers and have attended multi agency training on Domestic violence, Serious case reviews, Child Sexual Exploitation, Female Genital Mutilation, financial abuse and Winterbourne view
- During the past 12 months West Midlands Police have also completed Operation Sentinel, which focused on a different Public protection issue each month, offering training to partners and focusing on the victim's perspective
- Magistrates in the borough have been trained on the new domestic violence policy, bail offender management implications, domestic homicide review procedures and domestic violence protection orders
- West Midlands Police supervisors are required to dip sample incidents to seek the views of victims in how their incident was investigated and how we could improve with our service.

There have been 618 referrals that have been received from Wolverhampton that passed the threshold to be sent to the Police. The types of abuse being referred are physical, financial, sexual emotional and include S44 offences. The high level of referrals are evidence of increased awareness of adult safeguarding in the city.




## Royal Wolverhampton NHS Trust (RWT)

**Lynne Fieldhouse**

**Achievements regarding safeguarding adults:**

What outcomes were set for the past year?

1) The post of an independent domestic violence advisor (IDVA) which is externally funded was filled in October 2012 for a period of one year. The post holder is based in the Emergency Department receives Trust -wide referrals and undertakes an educational/awareness raising role across the Trust. The service has been well received.
2) Adult safeguarding training has been delivered by an independent training provider to staff. Staff have also received PREVENT training which is part of the Government's counter terrorism strategy. (PREVENT is 1 of the 4 elements of CONTEST, the government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism.)

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

To what extent were these outcomes achieved?

1) Having an Independent Domestic Violence Advisor (IDVA) was a 1 year pilot and this concluded October 2013, due to its success temporary funding was extended to end of May 2014.

The main aims of the project have been;

- To provide a main point of contact for domestic violence victims for crisis intervention and signposting
- To develop a referral system
- To raise awareness with healthcare staff and represent the Trust at Multi Agency Risk Assessment Conference (MARAC).

The success of the pilot and the perceived benefit to patients, families and staff has resulted in the Trust investing and recruiting to a substantive Independent Domestic Violence Advisor post.

2) The Trust has 7 accredited PREVENT trainers and has delivered training to 1,200 staff since May 2013. The training is mandated for new starters to the Trust.
   Safeguarding Adults training as of March 2014:
   - 99% compliance for 6,500 staff for basic awareness [level 1] training
   - 78% compliance for 46 staff requiring level 2 training
   - 70% compliance for the 13 staff requiring level 3 training
   - An independent trainer was commissioned to deliver the level 2 & 3 training.

3) This has progressed with over 40 Champions identified who meet monthly. They present to communication forums and the Dignity agenda will form part of the Trust's service improvement agenda through a creating best practice work stream.

What are the priorities going forward?

1. To implement the training toolkit for PREVENT as outlined in the NHS Standard contract for 2013/14

2. To improve the care given in acute and community general settings to Learning Disability patients through education and clinical referral system

3. To improve the governance of data capture for safeguarding incidents in respect of compliance to the West Midlands Strategy and thematic analysis to influence care delivery

4. To incorporate the pertinent remedial actions identified by the Peer Challenge in September 2013 into the work schedule of the RWT Safeguarding Adult Group.

**Training:**

What training has been provided to staff?

- 99% compliance for 6,500 staff for awareness [level 1] training
- 78% compliance for 46 staff requiring level 2 training
- 70% compliance for the 13 staff requiring level 3 training.

Safeguarding Adults training is included as part of the new staff induction and 500 people have received Domestic Violence, Forced Marriage and Honour Based Violence.

Measures of success equal a reduction in inappropriate alerts for adult safeguarding, an increase in referrals to the Independent Domestic Violence advisor.

**Service User experience:**

What information is available to service users regarding the safeguarding process?
Leaflets including easy read available at clinic /ward level and at our patient information centres.
How do service users give feedback regarding safeguarding processes?
Non-specifically for the organisation but would be part of multi-agency feedback/user experience.

## Black Country Partnership Foundation Trust

**Achievements regarding safeguarding adults:**

What outcomes were set for the past year?

- Review delivery of adult safeguarding training
- Ensure appropriate and additional resources within Adult safeguarding team
- Improve systems for recording Adult Safeguarding alerts
- Review policies and procedures
- Establish a Safeguarding Adults Committee
- Report Quarterly to Executive Board
- Develop methods to capture service user's experience of adult safeguarding.

To what extent were these outcomes achieved?

- Training plan in place. Adult safeguarding awareness at Induction. Mandatory training for all staff annually. Adult Safeguarding Training is delivered on a 3 year cycle to frontline staff
- Head of Adult Safeguarding recruited June 2013 and Lead Practitioner post recruited July 2013. Adult Safeguarding team now has 3 Whole Time Equivalent posts
- Incident Reporting System (DATIX) now used to capture Adult Safeguarding alerts. On-going development including staff training on system in place
- Policies and procedures for, Domestic Violence, Did Not Attend and Adult Safeguarding reviewed. West Midlands Policy and Procedures adopted as overarching policy for Adult Safeguarding
- Adult Safeguarding Forum terms of reference reviewed. Meets bi –monthly and reports to newly established Joint Children's and Adults safeguarding Committee
- Quarterly reports to Executive Committee now in place with first report in Quarter 4
- Capturing service user's experience of Adult Safeguarding remains an area for development internally though BCPFT has contributed through partnership working.

What are the priorities going forward?

- Development of workforce through training and awareness raising
- Building on Prevention strategy
- Capturing service user experience of Adult Safeguarding
- Deprivation of Liberty Supreme Court Judgement

- Improve partnership working local, regional and nationally
- Impact of Social Care Bill.

**Training:**

What training has been provided to staff?

- Adult Safeguarding awareness at Staff induction
- Adult Safeguarding level 1, Mandatory basic awareness training for all staff
- Adult Safeguarding level 2 training for staff who may be involved in raising an alert
- Adult Safeguarding level 3 training for staff who may manage the process
- PREVENT- Counter Terrorism.

Other awareness raising events have been provided by our local authority partners and staffs are encouraged to attend through advertising of events. For example:

- Domestic Violence
- Female Genital Mutilation
- Hate Crime.

Have all public facing staff completed Safeguarding Adults training / refresher training as required? How many people received this training during 2013/14?

All staff attends mandatory training annually and attendance target is 95%.

Safeguarding Adults training is included as part of the new staff induction. Approximately 500 people have received Domestic Violence, Forced Marriage and Honour Based Violence training during 2013/14.

How is this training audited to ensure awareness and understanding of staff?

Measures of success equal a reduction in inappropriate alerts for adult safeguarding, an increase in referrals to the Independent Domestic Violence advisor.

Awareness raising is included in mandatory training and attendance was 88.9% of workforce as of March 2014.

How is this training audited to ensure awareness and understanding of staff?

Attendance records
Training evaluation feedback forms
Clinical supervision.

**Service User experience:**

What information is available to service users regarding the safeguarding process?

Trust website.
Local authority website.

Posters and leaflets in clinical areas.

How do service users give feedback regarding safeguarding processes?

BCPFT takes patient experience very seriously and collects and monitors feedback from service users and carers about their experiences of their care. BCPFT recognises that capturing specific adult safeguarding is a priority for 2014/15
BCPFT is committed to working in partnership with the Adult Board to capturing and evaluating service user experience of Adult Safeguarding.

## Wolverhampton Clinical Commissioning Group (CCG)

**Manjeet Garcha**

**Achievements regarding safeguarding adults:**

What outcomes were set for the past year?

CCG will meet its statutory requirements in

- Executive lead for safeguarding
- Named GP for adults safeguarding
- LMC lead for adults safeguarding
- CCG membership at WSAB
- CCG lead for key work streams to forge engagement, accountability and embed WSAB work into stakeholder core business
- Promote city wide safeguarding policy
- Complete education and training for GPs at Team W events with on- going events planned
- Strengthen safeguarding governance at CCG with clear reporting schedules and align with WSAB priorities
- Increase understanding of CCG role for MCA/DoLS

To what extent were these outcomes achieved?

The CCG has worked hard to achieve all of the above and adults safeguarding remains a key strategic priority for safeguarding all services we commission.

What are the priorities going forward?

Continue to strengthen, work closer with the Local Authority to ensure new responsibilities assigned due to Care Bill 2014 are met.

**Training:**

What training has been provided to staff?

CCG contracted providers have a statutory responsibility to provide training for all staff, these are monitored via the contract meetings and no breach has been reported.

Is Safeguarding Adults training included as part of the new staff induction?

All provider induction training for new staff is inclusive.

CCG funds a domestic violence support officer post, based in A&E. Audits are undertaken to review effectiveness of post. On merit of excellent work undertaken last year, referrals to MARAC and admissions avoidance another one full year has been funded.

**Service User Experience:**

What information is available to service users regarding the safeguarding process?

Safeguarding is now a standing agenda item on all locality and patient participation group meetings. I am awaiting the receipt of the new leaflets to distribute out across the City's practice participation groups, but members of public are sharing GP and safeguarding contact numbers.

## West Midlands Care Association (WMCA)

**Trisha Haywood**

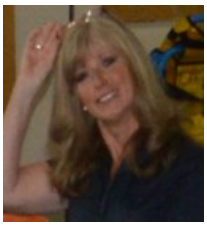
During the past year Adult Safeguarding has been high on the agenda in our Association meetings. Nearly every meeting has had a speaker to address changes in procedures, the responsibility of the individual home, thresholds for referral, procedure for reporting and how to investigate a safeguarding case. Homes feel comfortable communicating with the safeguarding team for advice and guidance.

Training continues to be a key aspect for all staff and we are looking forward to the launch of the new Safeguarding Adults training DVD.

The West Midlands Care Association (WMCA) has a representative on the Board who disseminates all information to the meetings and has attended board training, also took an active role in the Peer Review of Safeguarding arrangements in Wolverhampton.

WMCA is committed to working in partnership with the Safeguarding Board to ensure homes have timely access to all information training and guidance.

# Wolverhampton Domestic Forum



**Kathy Cole-Evans**

Wolverhampton Domestic Violence Forum (WDVF) is an independent company and charity, and a membership organisation that over the last 20 years has brought together around 50-60 partner agencies to develop strategies and action plans to deal effectively with domestic violence in Wolverhampton. More recently, in line with the Government's Violence against Women and Girls Strategy and Action Plan, WDVF's multi-agency Executive Board agreed to extend its area of influence to develop local strategy work around sexual violence, forced marriage, honour based violence, and female genital mutilation, alongside domestic violence.

WDVF's priority areas of work include contributions towards statutory functions and city strategy priorities that are shown in the table below, all of which contribute to Wolverhampton's Violence against Women and Girls Strategy's outcomes which are:

Outcome 1: To reduce serious harm resulting from 'violence against women and girls' subject areas including homicide prevention

Outcome 2: To reduce the prevalence of 'violence against women and girls'

Outcome 3: To reduce the rate of repeat incidents for domestic violence

Outcome 4: To increase the rate of 'violence against women and girls' subject areas offences brought to justice.

| WDVF priority areas of work | Outcomes | Comments |
|---|---|---|
| Developing & performance managing successive Wolverhampton Violence Against Women & Girls Strategy (VAWG) & Action Plans | Outcomes 1 - 4.<br><br>Statutory function that enables multi-agency delivery against VAWG which is one of Safer Wolverhampton Partnership (SWP) Board's priority areas. | WDVF leads on VAWG at SWP Board and structures. |
| Domestic Homicide Reviews (DHR) | Outcome 1<br><br>Statutory function Home Office guidance-DV Forum should provide | WDVF provides independent challenge at DHR panels.<br><br>WDVF is taking the chair for Wolverhampton's Standing DHR Panel.<br><br>WDVF also leads on specific DHR |

| | | |
|---|---|---|
| | independent challenge at DHR panels. | strategic recommendations on behalf of SWP<br>WDVF contributes to DHR research. |
| Contribution to earlier intervention and safeguarding work for children and adults | Outcomes 1, 2 & 3 - City Strategy priorities to prevent serious harm /homicide, and reduction of looked after children. | WDVF's co-located team work jointly screening cases where children and pregnant women are identified, and twice weekly crisis intervention meetings of high risk of serious harm/homicide cases between fortnightly MARAC meetings. |
| VAWG training and awareness raising | Outcomes 1 - 4 | - Delivering 1/4ly Safeguarding Board DV & VAWG training<br>- Training on VAWG and the DASHH risk assessment model, e.g. to Adult & Children Social Workers, Housing Officers, West Midlands Police, Magistrates, etc. |
| Undertaking the governance of Multi-Agency Risk Assessment Conferences (MARAC) | Outcomes 1 & 4 | - WDVF Executive Board has recently picked up MARAC governance to continuously improve MARAC arrangements in line with best practice and our recent self- assessment audit<br>-WDVF has recently had some funding returned from WMP and is recruiting a MARAC Coordinator to focus on these improvements. |
| Awareness raising and institutional advocacy of violence against women and girls' issues and the coordinated community response model. | Outcomes 1-4. | -Institutional advocacy and participation at regional and local boards, scrutiny panels, strategic meetings, e.g. (Stephen Rimmer's) Strategic West Midlands DV Board, West Midlands CPS Scrutiny Panels, West Midlands CJ Board's Victim, Witness & DV Delivery Board and Black Country Area Delivery Group. - Developing and contributing to the development of strategic documents, policies, procedures, e.g. Wolverhampton's Over-arching DV Protocol, Wolverhampton VAWG Strategy & Action Plan, Wolverhampton's Forced Marriage Guidance Protocol - Institutional advocacy through |

| | | |
|---|---|---|
| | | examination of data across systems and organisations, e.g. the attrition rate and outcomes through the criminal justice system. |
| Developing and piloting recognised good practice | Outcomes 1-4 | Egs. - Investing in a pilot Independent Health DV Adviser at A&E, which is now being mainstreamed by the Royal Wolverhampton NHS Trust<br>- Continued employment of an Independent Criminal Justice DV Adviser through SWP funding<br>- Continued employment of an Independent Sexual Violence Adviser through WDVF funding<br>- Development of a pilot community based perpetrator programme through external foundation trust funding and WDVF reserves funding, but which needs sustaining<br>-Chairing Specialist DV Court Steering Group |
| Contributing to developing work | Outcomes 1-4 | Egs. – Participating at West Midlands Police Domestic Abuse Offender Management Group to develop good practice and risk management around prolific and priority DV offenders/perpetrators aligned with MARAC and other arrangements<br>- Families in Focus Board<br>- Families r First Steering Group, etc. |

**Challenges to and Progress with WDVF's work**

The primary challenge to which WDVF is exposed is that the security of its core funding is currently under threat.

Over the last 2 years in addition to WDVF's statutory and city priority work, this mainline core funding has facilitated WDVF attracting a further £251k income from other local partnerships for example the Safer Wolverhampton Partnership, from external foundation trusts, and from other fund-raising activities and donations. This additional funding has enabled WDVF to re-invest in services such as a setting up and providing a community based perpetrator programme over the last 2 years, continuing to employ independent advocacy services through the criminal justice

system for both domestic and sexual violence victims, employing and piloting an independent advocacy and training service at A&E, recruiting a MARAC Coordinator to drive best practice improvements in our safeguarding of victims at highest risk of serious harm and homicide, and other awareness raising activities, amongst a range of additional interventions without the Council's mainline core funding, it is highly likely that WDVF would not survive as an independent organisation, and in addition to the cost-effective work that it coordinates being lost, all the additional funding that WDVF attracts and re-invests would also cease to be in place.

As part of WDVF's management of the current reduced level of core funding, WDVF has recently been offered and accepted accommodation by and alongside Children's Social Care Duty Referral hub in the Civic Centre, and will provide specialist VAWG and DASHH risk assessment training to Social Care staff to assist in developing their new model of working.

Maintaining and marketing WDVF's independent status is acknowledged as an important element of WDVF's ongoing work since although based alongside Children's Social Care, it is imperative that WDVF maintains its independent status and its ability and need to provide challenge.

The Forum also contributes to the city strategy priorities. In particular in relation to domestic violence the most significant aspects of our activity are coordinating support, care, protection and safeguarding of the most vulnerable children and adults to improve their life chances, and providing support that enables people to be independent and seeking work in order to build their resilience and make them economically active. WDVF contributes to this priority area through its continuing development of a co-located multi-agency team that includes the Forum's Strategy Coordinator providing strategy and performance management, criminal justice Independent DV Adviser, Independent Sexual Violence Adviser, and seconded staff including a full time crisis intervention Independent DV Adviser from the Haven, and part time staff including a Senior Housing Officer, Adult Protection Police Officer, Child Protection Police Officer, Children's Social Worker, and Safeguarding Children's Nurse. Similarly for adults at high risk of serious harm and homicide, WDVF hosts twice weekly crisis intervention and safety planning meetings in between fortnightly MARAC meetings where the Independent DV Advisers and SV Adviser meet with Police and Housing staff to take the necessary steps to reduce the risks associated with these cases.

## West Midlands Fire Service

**Andy Proctor**

**<u>Achievements regarding safeguarding adults:</u>**

What outcomes were set for the past year?

Ensure safeguarding of identified people at risk by satisfying statutory responsibilities for safeguarding children, young people and adults.

Personnel will receive safeguarding training for adults and children.

Personnel will receive Extremism and Terrorism awareness training.

Safeguarding alerts initiated by West Midlands Fire Service personnel

Representation on Safeguarding structures.

To what extent were these outcomes achieved?

All staff had awareness training around Adult and Child Safeguarding.
Safeguarding alerts successfully carried out including attendance at Serious Case Reviews.
Invitation and attendance at Safeguarding Boards across Black Country North.

What are the priorities going forward?

*Further in depth awareness training of Adult and Child Safeguarding*.

**Training:**

What training has been provided to staff?

*Basic Awareness* of safeguarding

Have all public facing staff completed Safeguarding Adults training / refresher training as required?
How many people received this training during 2013/14?

All Watches have either received or are booked to receive safeguarding training.
For all employees in the Vulnerable Person Officer Role they must receive this training before undertaking visits.

Safeguarding Adults training is not included as part of the new staff induction?

Domestic Violence, Forced Marriage and Honour Based Violence is not routinely training delivered to staff, certain watches do undertake ad hoc training in these areas. Training audited to ensure awareness and understanding of staff by staff completing a Questionnaire provided post training to test learning?

## Wolverhampton City Council

Many parts of the council contribute towards helping adults who may be at risk of harm keep safe. This includes services as diverse as Trading Standards, the Council's workforce development services through to social work operational teams who undertake direct enquiries sometimes jointly with the Police when a concern about abuse is received. In April 2013 Public Health moved across to the City Council, and the Safeguarding service now sits under Public Health.

# Public Health


**Ros Jervis**

**Achievements regarding safeguarding adults:**

What outcomes were set for the past year?

A priority for review was safeguarding pathways for adult drug and alcohol users. In 2013/ 14 the public health commissioning team worked with the new drug and alcohol provider, Recovery Near You [RNY] to build safeguarding pathways, polices and responses with regards to the new service model.

Recovery Near You report that;

- Staff are delivering a quality service to service users and have an understanding of the needs of vulnerable adults and the need to safeguard them. This is monitored through 1:1 and professionally facilitated group supervision
- Most of the staff within RNY were subject to TUPE from existing services within the city and all had come with experience, training and knowledge of adult safeguarding
- The main priorities for the service have been with pregnant service users; those experiencing mental health issues, dual diagnosis, domestic abuse and other vulnerabilities relating to their substance misuse i.e. homelessness or parenting concerns.

To what extent were these outcomes achieved?

- The focus of the service is such that all of the above issues present on an almost daily basis. The outcomes for RNY are around ensuring robust pathways are developed, implemented and followed. The maternity pathway has been recently amended and is being followed by all services within maternity and RNY. Mental health and dual diagnosis pathways have been drawn up and are there in principle. Additional work is being done with mental health leads.

What are the priorities going forward?

- Priorities for RNY are to ensure pathways within mental health are robust and being followed. Meetings are now set between leads of each service on a weekly basis and sharing information, good practice at team meetings is key.

- RNY has monthly designated safeguarding key worker lead meetings with the interim safeguarding manager and service manager to discuss those service users who have safeguarding, maternity and domestic abuse issues and what action is being taken.

- Priorities are to explore what can be done to achieve better outcomes for families and individuals. Weekly meetings take place with managers and staff to discuss those particular

service users who are high risk. This is so action plans can be set and maintained around risk issues and how other services may need to be involved. As a result multi-disciplinary teams are organised so that staff sit together and plan a joint working process.

**Training:**

What training has been provided to staff?

- Training around adult safeguarding has taken place with the NHS staff team. During their induction to the Birmingham and Solihull Mental Health NHS FT [BSMHFT] staff received this training. The remaining staff will be allocated on to this training either via the local safeguarding or via BSMHFT. This is currently been requested and RNY are awaiting confirmation of dates.

Have all public facing staff completed Safeguarding Adults training / refresher training as required? How many people received this training during 2013/14?

- No, this has not happened. There have been a number of competing priorities for RNY and they have focused on child safeguarding as a service. Adult safeguarding will be a focused piece of work ensuring staff are trained and have refresher training.

Is Safeguarding Adults training included as part of the new staff induction?

- All new staff has access to a range of training for the 3 partnership organisations. Nacro provide a number of on line training which all staff can access, Aquarius has training which all staff can access as does BSMHFT.

Is Domestic Violence, Forced Marriage and Honour Based Violence training delivered to staff? How many people received this training during 2013/14?

- This training has not been delivered to the current team as all of the staff that were part of TUPE had received domestic abuse training. Staff have had workshops regarding domestic abuse, completion of DASH and how to refer to MARAC. Priorities are for the staff team to have 1 day domestic abuse training from the Haven

- This has been approved and dates are pending.

### Trading Standards

Trading Standards officers have provided training to the Adult Social work teams on how to spot victims of scams and rogue traders, what the Trading Standards service can do and how to contact them. They have also worked alongside social workers to undertake safeguarding enquiries this has led to a successful prosecution.

**Case Study**

***"PAIR FINED FOR TARGETING ELDERLY IN MOBILITY CON"***

This was an Express & Star newspaper headline back in April 2013. The owner of a Mobility company and his sales agent were fined **£6,809** in total, for selling unnecessary and overpriced mobility aids to elderly vulnerable people.

The case was heard before Wolverhampton Magistrates Court, where the judge described the sales agent as an 'over-vigorous salesman'. He was working for A K, the sole director of Mobility Healthcare UK Limited on a commission only basis.

The pair had initially tried to sell a Halesowen couple, aged 90 and 91, a stair lift at a grossly inflated price of £4,550. During the sales pitch the salesman lied to Social Services, to prevent the Local Authority carrying out a free assessment. He pretended to be the consumer's son, when the Authority called to arrange an appointment. Unfortunately the consumers did not have a son, only a daughter, who became suspicious

A separate issue was brought to the attention of Wolverhampton Trading Standards via a safeguarding referral, after awareness training had been delivered to front line staff, working in the community.

A concerned domiciliary carer and social worker had initiated a referral regarding potential financial abuse of a service user. A 74 year old Wolverhampton resident had been sold £12,000 worth of mobility equipment over a three month period; none of the equipment met the victim's needs.

The two matters were combined and Wolverhampton Trading Standards took the lead.

The 74 year old Wolverhampton victim, who had a number of health issues and limited mobility, had previously purchased equipment from an unrelated company. 18 months later the victim was re-visited by the sales rep, who was now working for Mobility Healthcare UK Limited. A 'friendship' developed which enabled the salesman to get the victim to spend £12,000 on a range of mobility aids. The victim initially purchased a double mattress for an existing bed; was then persuaded to purchase a new electrical bed base, which required another additional mattress, then a reclining chair and finally it was discovered the victim had placed a deposit on a stair lift, which had not yet been fitted.

a number of agencies working together in innovative ways to gather sufficient evidence to bring a prosecution. The victim was not required to give evidence; the domiciliary carer provided a statement as did colleagues in Social Services. Occupational Health carried out a number of assessments on the victim and the equipment purchased which concluded the chair was the incorrect size, not allowing the victim to sit back fully, the electrical bed base and second mattress were unnecessary and the stair lift was totally unsuitable. The evidence provided by colleagues was sufficient to enable Trading Standards officers to prove the items purchased were unnecessary, which along with further evidence to show the items were overpriced, led to the successful prosecution.

### Quality Assurance & Compliance Team

The Quality Assurance and Compliance team monitors the quality of care and support services accessed by adults and children of Wolverhampton. During the period 1st April 2013 – 31st March 2014 the team has carried out 236 visits to 58 individual adult social care services, including all primary and secondary domiciliary contracted care providers. The team is on course to visit all adult residential social care services in Wolverhampton on a two year rolling cycle. The team also gained responsibility for monitoring Children's residential services both in and out of city, and foster care provider organisations, achieving 54 visits to 43 individual services or providers between August 2013 – March 2014. The team has worked intensively with a smaller number of social care providers to improve their practice or to assist them with emergencies, for example where the registered manager resigns without notice. All registered social care services now have an allocated Quality Assurance & Compliance Officer to advise and support services toward the delivery of good quality care. The team is currently working on a revised risk management plan which will support more effective working with all providers of adult and children's social care in Wolverhampton or with placements made by Wolverhampton City Council.

## Making Safeguarding Personal

In 2013/14 The Community Directorate took part in a national pilot project called '*Making Safeguarding Personal'* (MSP), set up by the Local Government Association and the Association of Directors of Adult Social Services.
The project was run across a number of councils in the UK, and had funding to run until around February 2014.

The purpose of the project was to ensure that where possible we deliver the safeguarding outcomes customers want (working in an outcome focused & person centred way). We need to focus on what the person wants to achieve as a result of our intervention, from the first contact, right through the process, and to look at the end with the person, as to whether they feel their desired outcome has been achieved. This is part of a national drive to make Adult Safeguarding work develop from being very process led to a more personalised approach by keeping vulnerable people safe.

As a first step, work was undertaken to refresh the electronic social care record CareFirst to ensure workers capture, record and monitor customer outcomes from the very outset of a referral to the close of the safeguarding investigation.

Relevant staff guidance was also developed to correspond with the new prompts on Carefirst which were uploaded onto Carefirst to help staff navigate their way through the process.
The introduction of these changes was to move away from the traditional process driven approach to adopting a more person centred approach, which may extend to including the wider family, friends and community network in helping the customer determine their outcomes i.e. *'what do they want to come out of a safeguarding referral/investigation?'*.

## Wolverhampton Safeguarding Adult Budget

For 2013/2014, the financial contributions for the work of the Board came from Wolverhampton City Council, Wolverhampton Clinical Commissioning Group, West Midlands Police and Black

Country Partnership Foundation Trust. Contributions from partner agencies (not including the City Council) amounted to £27,950.

The contributions made by the above agencies have covered the general expenses of Board business, the work of the Independent Chair of the Board and specific pieces of work including:

- The printing of leaflets, Board Annual Report and Executive Summary
- The costs of multi- agency safeguarding training during 2013/14
- Financial contribution to the Safeguarding Peer Review
- Production of new Adult Safeguarding DVD and Workbook (To be launched June 2014).

The Wolverhampton Domestic Violence Forum has delivered Domestic Violence training sessions in lieu of financial contribution.

In preparation of the Board becoming statutory in April 2015, in accordance with the Care Act 2014 a dedicated Safeguarding Board budget will be established and the Board will receive regular updates on the budget position.

## Training/Workforce Development

*Wolverhampton City Council:*

The Council's Workforce Development Team and Adult Safeguarding Unit produced a training plan for 2013/14. Further development activity was commissioned from the specialist providers already working with Wolverhampton City Council. This ensured that there was consistency and continuity based on the evaluation of the programmes previously commissioned.

Below is a summary of the training attended by internal and external workforce in Wolverhampton during 2013/14. All Council workers who may come into contact with adults at risk have learning opportunities to help them understand and recognise what abuse is and how to respond should they come into contact with people that are experiencing abuse. The attendance at some sessions has been very disappointing and will be taken into consideration when finalising the 2014/15 training plan, a time when learning methods must be cost effective for all agencies.

**Safeguarding Adults: Recognising & Reporting x 2 sessions**

1 October 2013 9:30-12:30 x 25 places **20 attended**

1 October 2013 1:30 – 4:30 x 25 places **7 attended**

**Safeguarding Adults: Provider Managers**

11 October 2013 9:30 – 4:30 x 25 places **20 attended**

In addition the following e-learning modules are available:

**Introduction to Adult Safeguarding for Social Workers**

**The Role of the Social Worker in Adult Safeguarding**

**Legislation and Partnership Working**

**Safeguarding for Adult Service Workers**

**Safeguarding for Non-Adult Service Workers**

**Deprivation of Liberty Safeguards**

**Dementia Awareness**

**Domestic Violence (Adults)**

| | |
|---|---|
| **E learning -** | **In total 73 accessed** |
| **Domestic Violence & MARAC** | **40 attended (Full)** |
| **Making Safeguarding Personal** | |
| **10/4/14** | **19 attended** |
| **14/4/14** | **18 attended** |

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

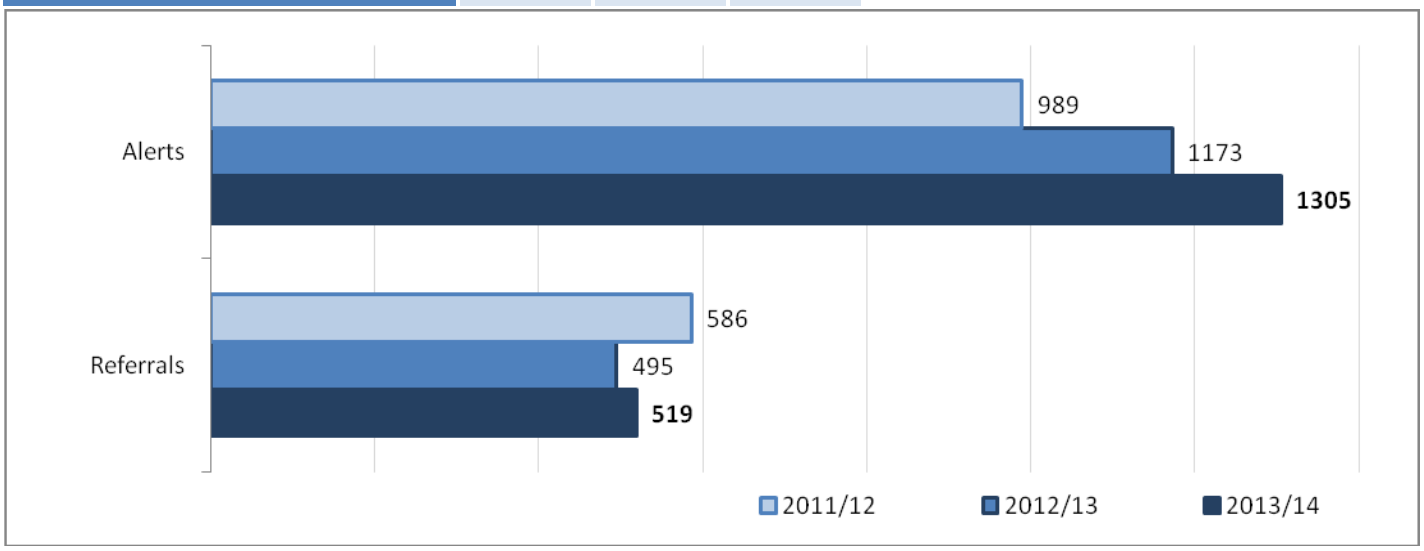
A new Safeguarding DVD and work book has been commissioned this includes scenarios and will be launched at an event in June 2014.

# Safeguarding Adults Activity 13/14

The total number of alerts received this year was 1350, a marked increase from last year which totalled 1173.
It is unclear why there has been such an increase in the number of alerts, although there has been an increase every year for the last three years. It may be attributed to the increased public awareness through media coverage and locally through safeguarding awareness raising sessions delivered by the Safeguarding Team and partner organisations.

**Alerts and Referrals**

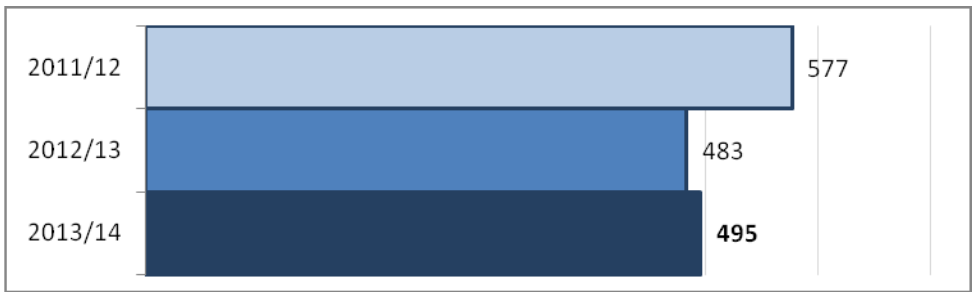
| | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Alerts | 989 | 1173 | 1305 |
| Referrals | 586 | 495 | 519 |
| Referrals as a % of Alerts | 59% | 42% | 40% |




Of the 1350 alerts received, 519 lead to a safeguarding investigation; the others were deemed to be either inappropriate or once further information had been gathered did not require a safeguarding investigation. This decrease can be attributed to the application of the threshold guidance which was implemented in January 2013 and the revised questions on the CareFirst questionnaires which are completed by social care managers on receipt of all alerts.

**Completed Referrals**

| | 2011/12 | 2012/13 | 2013/14 |
|---|---|---|---|
| Completed Referrals | 577 | 483 | 495 |




The number of completed referrals generally follows the number of referrals in the year. This figure does not show any points of concern.

**Alerts and Referrals by Age and Gender**

| | Alerts | | | | Referrals | | | |
|---|---|---|---|---|---|---|---|---|
| | Female | % | Male | % | Female | % | Male | % |
| Age 18-64 | 275 | 51% | 261 | 49% | 89 | 54% | 75 | 46% |
| Age 65+ | 462 | 66% | 242 | 34% | 223 | 66% | 114 | 34% |
| Total | 737 | 59% | 503 | 41% | 312 | 62% | 189 | 38% |

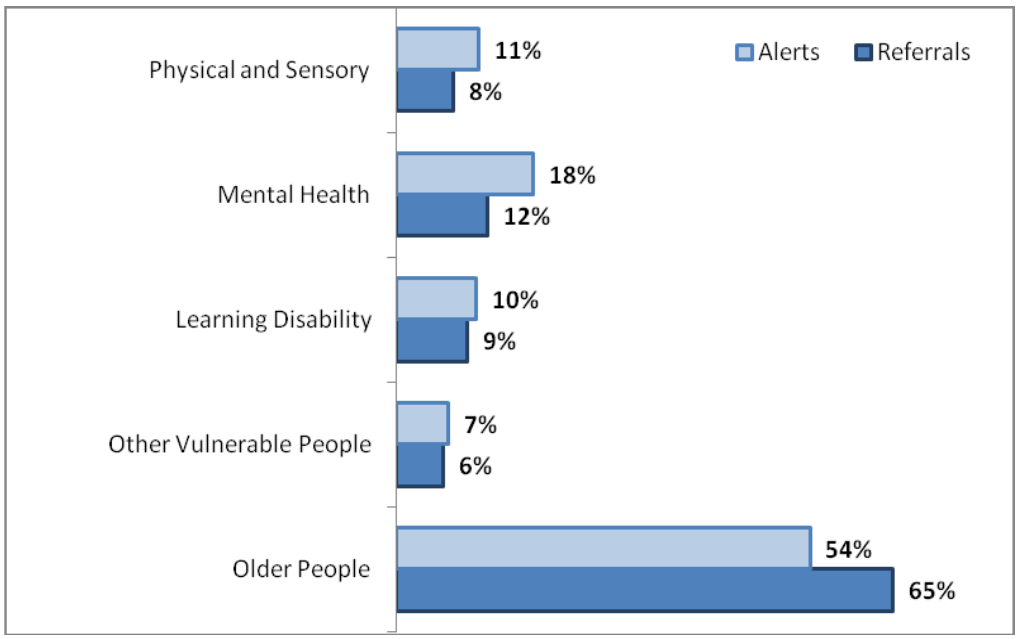
The above graph shows the proportion of alerts and the proportion of referrals

The alerts referrals by gender breakdown does not differ by a significant amount and indicates that gender does not affect the likelihood of investigation.

**Alerts and Referrals by Primary Client Group**

The report has broken down the Primary Client Group to include the category of older people. Of the total number of alerts received, over 57 % were for people aged over 65 years of age regardless of their care needs. This highlights the fact that older people are more at risk of abuse than any other Primary Client Group. Nearly 60% of the total number of alerts were for women, but the highest number of alerts (66%) were for women aged 65+. Therefore women over the aged of 65 years are more at risk of abuse than any other client group

| | Alerts | | Referrals | | % of Alerts that proceed to Referral |
|---|---|---|---|---|---|
| | Number | % | Number | % | |
| Physical and Sensory Disability | 140 | 11% | 39 | 8% | 28% |
| Mental Health | 234 | 18% | 62 | 12% | 27% |
| Learning Disability | 136 | 10% | 48 | 9% | 35% |
| Other Vulnerable People | 89 | 7% | 32 | 6% | 36% |
| Older People | 707 | 54% | 337 | 65% | 48% |




Alerts and referrals by Primary client group does not show any significant causes for concern. As previously noted in the age breakdown the older people category is more likely to proceed to investigation.

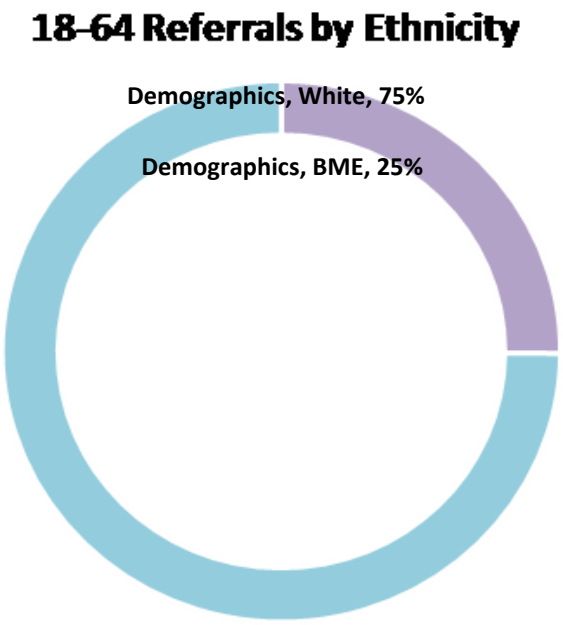
The only point which shows a discrepancy is that of the Mental Health primary client group. Although 18% of alerts relate to Mental Health only 12% of referrals are for Mental Health clients. This again, implies that there is either concerns being raised that are not safeguarding issues relating to Mental Health clients or part of this may be due to the complexity of Mental Health cases.

**Referrals by Ethnicity – 18-64**

| | 2011/12 | | 2012/13 | | 2013/14 | | Demographics |
|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | |
| White | 132 | 74% | 91 | 71% | 117 | 73% | 75% |
| Asian | 20 | 11% | 19 | 15% | 25 | 16% | 15% |
| Black | 19 | 11% | 16 | 12% | 14 | 9% | 6% |
| Mixed | 3 | 2% | 3 | 2% | 1 | 1% | 2% |
| Other | 4 | 2% | 0 | 0% | 3 | 2% | 2% |

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

The breakdown of referrals by ethnicity for the 18-64 age group show that investigations broadly matched the local authority demographic. The biggest anomaly is that there is an over representation of referrals for Black clients. This can be explained by the fact that Black clients are also over-represented in the proportions of service users although this anomaly has decreased from previous years implying that ethnicity is not an influencing factor in safeguarding investigations.

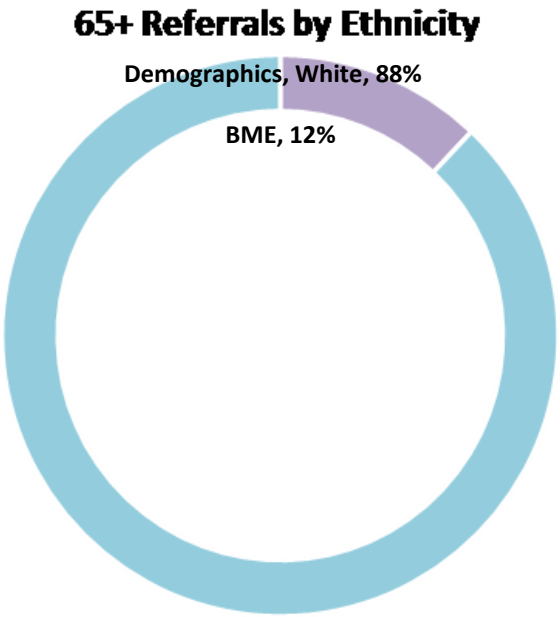


**Referrals by Ethnicity – 65+**

| | 2011/12 | | 2012/13 | | 2013/14 | | Demographics |
|---|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % | |
| White | 340 | 88% | 260 | 82% | 284 | 86% | 88% |
| Asian | 19 | 5% | 23 | 7% | 17 | 5% | 7% |
| Black | 27 | 7% | 31 | 10% | 30 | 9% | 4% |
| Mixed | 0 | 0% | 0 | 0% | 0 | 0% | 0% |
| Other | 0 | 0% | 2 | 1% | 1 | 0% | 0% |

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

The breakdown by ethnicity for 65+ shows that again the figures broadly match the local authority demographic. The biggest anomaly is again that black clients are over represented but as before this is also true of the service users. This discrepancy has decreased marginally from the 2012/13 result.

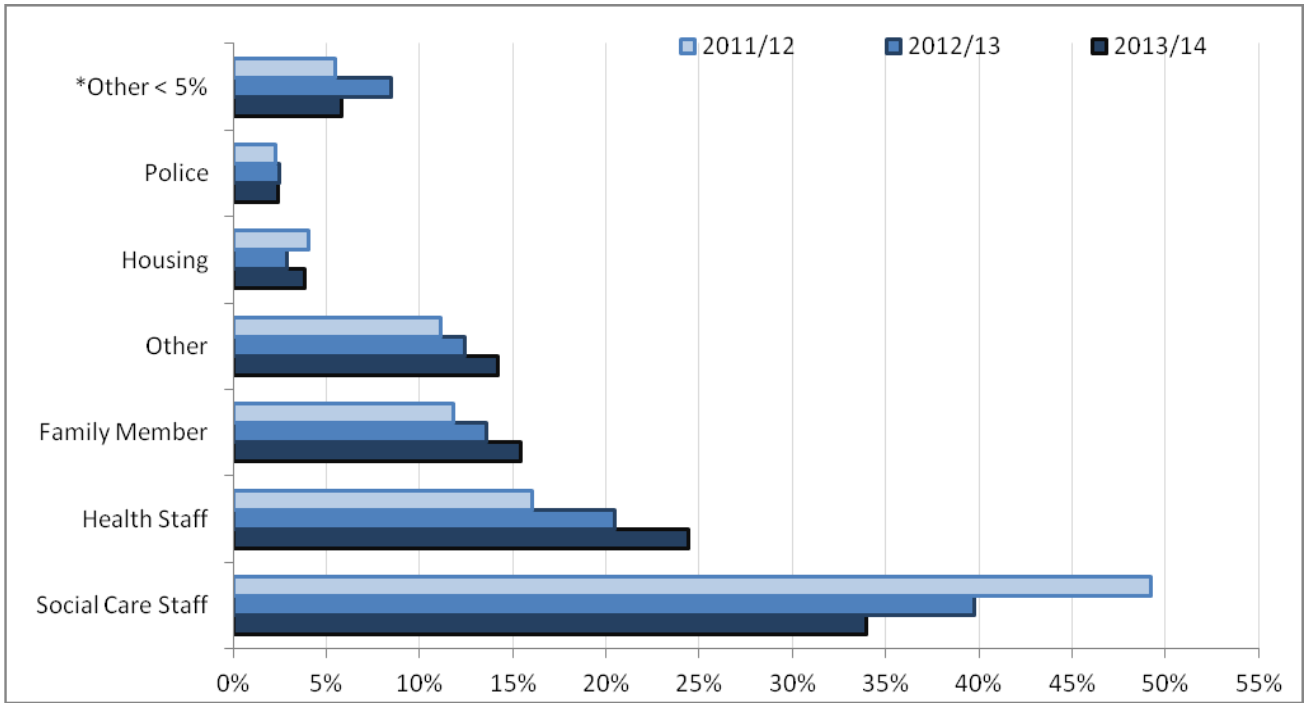


**Sources of Referral**

In 2013/14, as in previous years, the highest percentage of referrals came from Social Care Staff with 34% although this figure continues to fall year-on-year. The fact that this proportion is decreasing but the overall number of referrals is unchanged suggests that more referrals are coming from other sources outside the authority due to an increase in public and professional awareness. This is particularly true of Family Members and Health staff.

The proportion of referrals from 'Other' sources has increased to 14% which suggests that there may be other unlisted sources which could be added to the possible options.

| | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| Social Care Staff | 279 | 49% | 179 | 40% | 170 | 34% |
| Health Staff | 91 | 16% | 92 | 20% | 122 | 24% |
| Self-Referral* | 2 | 0% | 9 | 2% | 3 | 1% |
| Family Member | 67 | 12% | 61 | 14% | 77 | 15% |
| Friend / Neighbour* | 11 | 2% | 9 | 2% | 7 | 1% |
| Other Service User* | 0 | 0% | 0 | 0% | 0 | 0% |
| Care Quality Commission* | 14 | 2% | 17 | 4% | 16 | 3% |
| Housing | 23 | 4% | 13 | 3% | 19 | 4% |
| Education / Training / Workplace Establishment* | 4 | 1% | 3 | 1% | 3 | 1% |
| Police | 13 | 2% | 11 | 2% | 12 | 2% |
| Other | 63 | 11% | 56 | 12% | 71 | 14% |
| Overall Total | 567 | | 450 | | 500 | |

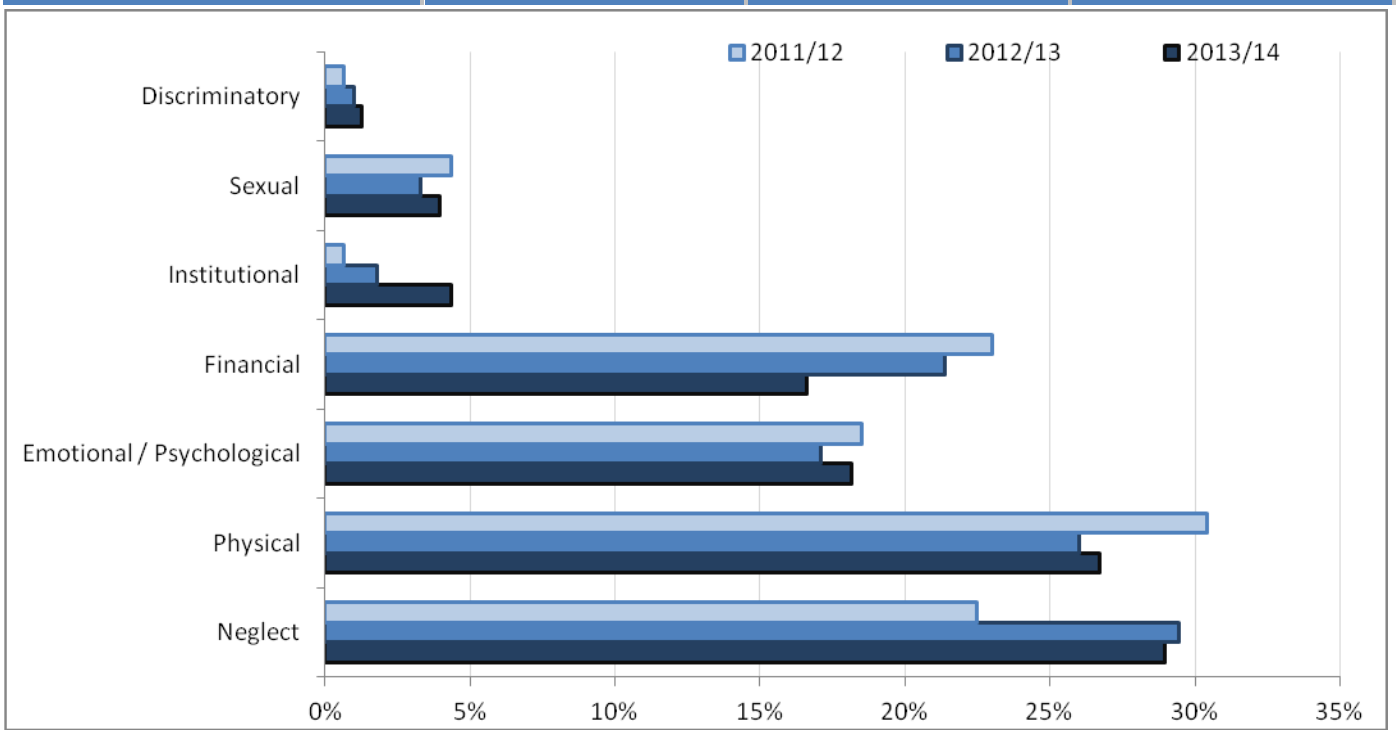


*Sources marked with a * have less than %5 of referrals in all years and have been combined in the bar chart.

**Referrals by type of Alleged Abuse**

For the second year since reporting, neglect has been the highest category of abuse. It may be possible to attribute this increase to the large number of safeguarding investigations regarding institutions where neglect is reported to be the main type of abuse. The main change in the data over the last 3 years is that the proportion of financial abuse has fallen continually from 23% to 17% whilst at the same time institutional abuse has increased from 1% to 4%. The increase in institutional abuse is likely to be due to an increased public awareness of neglect in care homes, due primarily to press coverage.

| | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| Neglect | 176 | 22% | 179 | 29% | 206 | 29% |
| Physical | 238 | 30% | 158 | 26% | 190 | 27% |
| Emotional / Psychological | 145 | 19% | 104 | 17% | 129 | 18% |
| Financial | 180 | 23% | 130 | 21% | 118 | 17% |
| Institutional | 5 | 1% | 11 | 2% | 31 | 4% |
| Sexual | 34 | 4% | 20 | 3% | 28 | 4% |
| Discriminatory | 5 | 1% | 6 | 1% | 9 | 1% |
| Overall Total | 783 | | 608 | | 711 | |

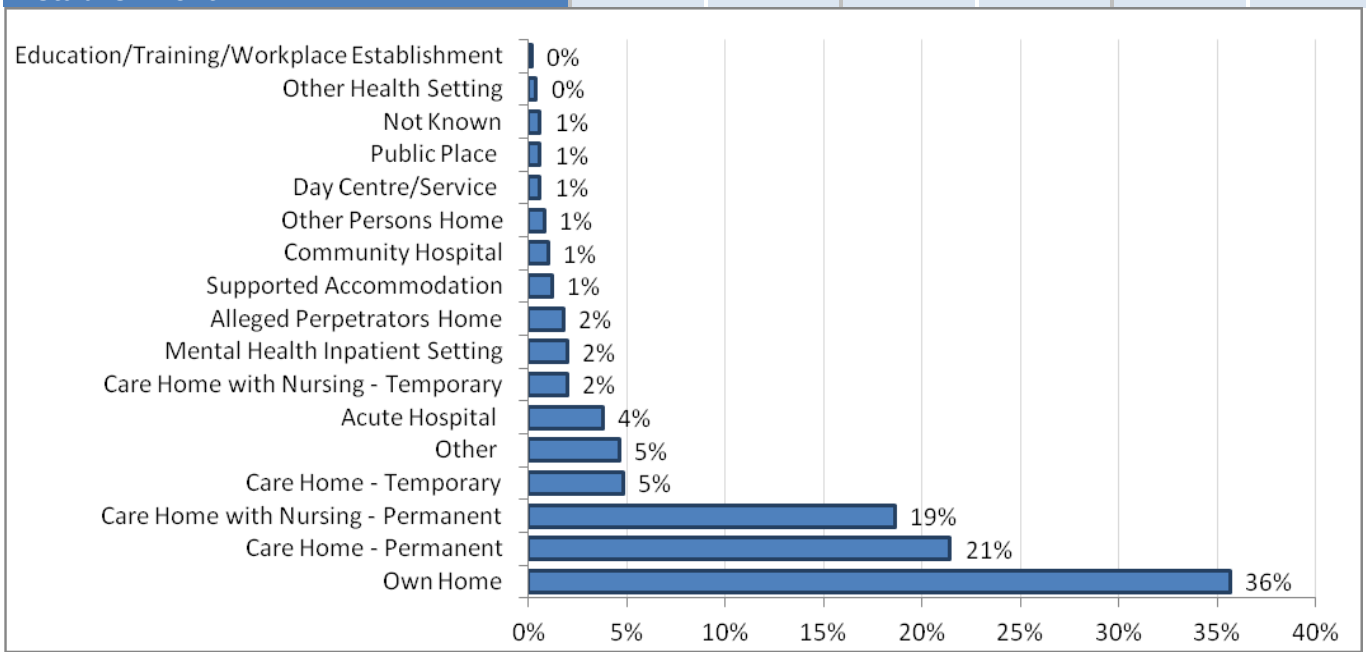



Referrals may contain more than one type of alleged abuse and therefore the numbers are greater than the number of referrals.

**Location of Alleged Abuse**

This year the most common location of alleged abuse is again in the persons own home, whilst at the same time the proportion of alleged abuse in permanent residential and care homes has increased and if allegations of abuse in care homes, nursing homes and temporary placements are combined they are significantly higher than in the persons own home.

| | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| Own Home | 225 | 40% | 168 | 37% | 178 | 36% |
| Care Home - Permanent | 102 | 18% | 86 | 19% | 107 | 21% |
| Care Home with Nursing - Permanent | 89 | 16% | 82 | 18% | 93 | 19% |
| Care Home - Temporary | 18 | 3% | 23 | 5% | 24 | 5% |
| Other | 24 | 4% | 19 | 4% | 23 | 5% |
| Acute Hospital | 13 | 2% | 13 | 3% | 19 | 4% |
| Care Home with Nursing - Temporary | 29 | 5% | 9 | 2% | 10 | 2% |
| Mental Health Inpatient Setting | 3 | 1% | 4 | 1% | 10 | 2% |
| Alleged Perpetrators Home | 7 | 1% | 7 | 2% | 9 | 2% |
| Supported Accommodation | 16 | 3% | 15 | 3% | 6 | 1% |
| Community Hospital | 12 | 2% | 6 | 1% | 5 | 1% |
| Other Persons Home | - | - | - | - | 4 | 1% |
| Day Centre/Service | 3 | 1% | 3 | 1% | 3 | 1% |
| Public Place | 12 | 2% | 4 | 1% | 3 | 1% |
| Not Known | 11 | 2% | 10 | 2% | 3 | 1% |
| Other Health Setting | 1 | 0% | 1 | 0% | 2 | 0% |
| Education/Training/Workplace Establishment | 2 | 0% | 0 | 0% | 1 | 0% |



All other locations of abuse are reported above but the numbers are generally too small to draw any meaningful conclusions.

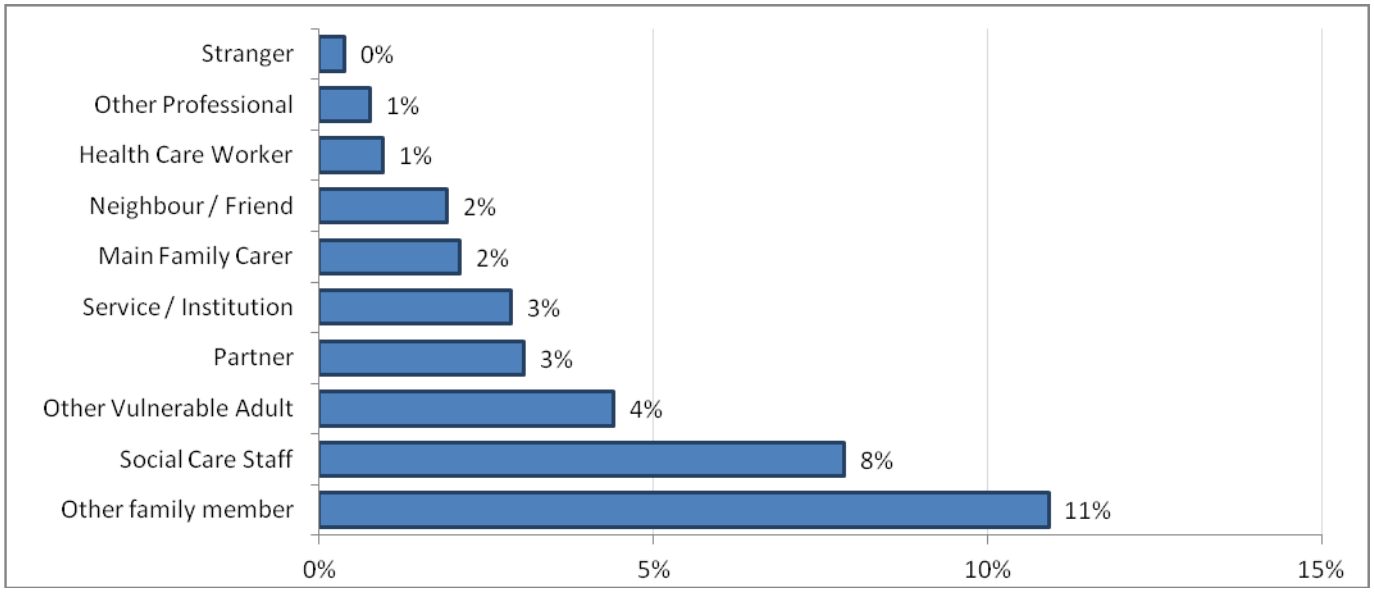
**Relationship with Person Suspected of Causing Harm**

The data shows that the number of referrals where the alleged abuser was not known has increased to 65% from 54%. This may suggest that either more work is required to identify persons suspected to be causing harm or that awareness has increased so that reports of safeguarding concerns are now being made without knowing the identity if the person suspected to be causing harm. The not known category has been excluded from the chart to clearly show the remaining categories.

The largest proportion of known persons suspected to be causing harm is 'Other Family Member' at 11%, followed by 'Social Care Staff' at 8%. This broadly matches previous year's trends and is generally expected as these people are likely to have most contact with the vulnerable adults.

'Service / Institution' and 'Main Family Carer' are new relationship types for 2013/14 and are showing a relatively large proportion of people fall into these categories.

| | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| Not Known | 416 | 73% | 253 | 54% | 338 | 65% |
| Other family member | 57 | 10% | 80 | 17% | 57 | 11% |
| Social Care Staff | 26 | 5% | 55 | 12% | 41 | 8% |
| Other Vulnerable Adult | 28 | 5% | 10 | 2% | 23 | 4% |
| Partner | 16 | 3% | 19 | 4% | 16 | 3% |
| Service / Institution | - | - | - | - | 15 | 3% |
| Main Family Carer | - | - | - | - | 11 | 2% |
| Neighbour / Friend | 10 | 2% | 11 | 2% | 10 | 2% |
| Health Care Worker | 3 | 1% | 17 | 4% | 5 | 1% |
| Other Professional | 3 | 1% | 3 | 1% | 4 | 1% |
| Stranger | 0 | 0% | 2 | 0% | 2 | 0% |
| Overall Total | 568 | | 471 | | 522 | |



**Case Conclusion**

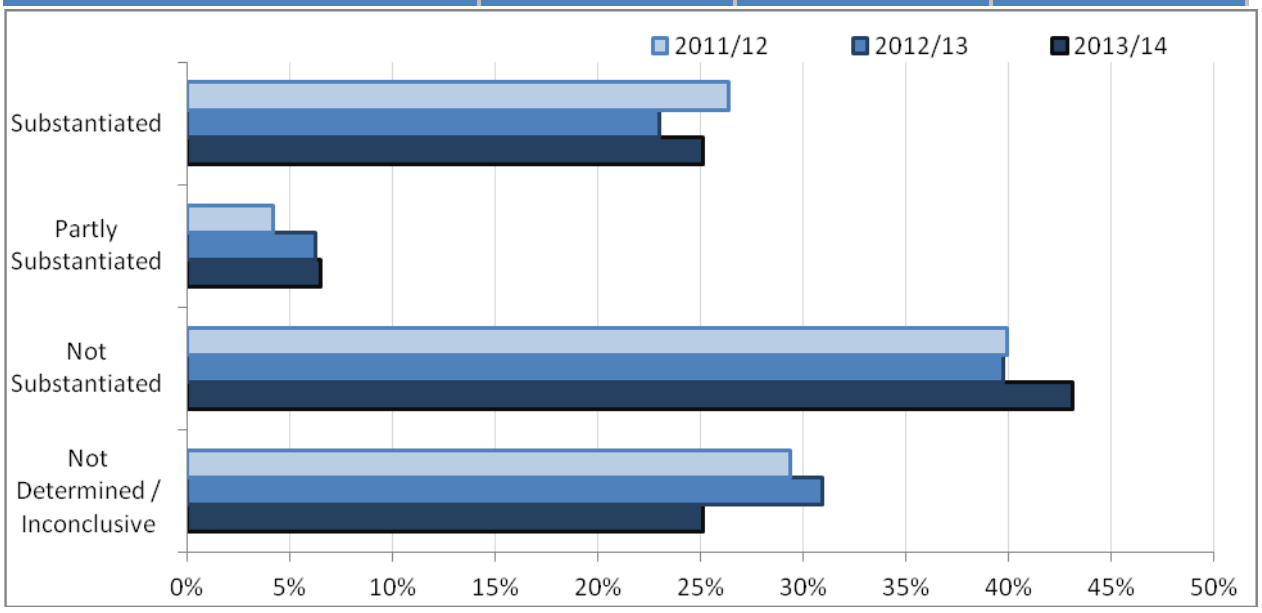
In 2013/14 25% of cases were substantiated and 7% were partly substantiated.

The overall proportion of substantiated or partly substantiated has increased marginally from 2012/13 from 29% to 32%.

The not substantiated figure has also increase from 39% to 43%. This is not necessarily a bad result as the proportion of not determined has decreased at the same time meaning that while less cases are resulting in a safeguarding 'success' in relation to substantiation of claims, there are less cases with an uncertain outcome.

'Ceased at Individuals Request' and 'Inappropriate Referral' are new outcomes recorded in 2013/14 and are not counted towards the results.

| | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| Substantiated | 150 | 26% | 107 | 23% | 123 | 25% |
| Partly Substantiated | 24 | 4% | 29 | 6% | 32 | 7% |
| Not Substantiated | 227 | 40% | 185 | 39% | 211 | 43% |
| Not Determined / Inconclusive | 167 | 29% | 144 | 31% | 123 | 25% |
| Ceased at Individuals Request | - | - | - | - | 4 | - |
| Inappropriate Referral | - | - | - | - | 2 | - |
| Overall Total | 568 | | 465 | | 495 | |

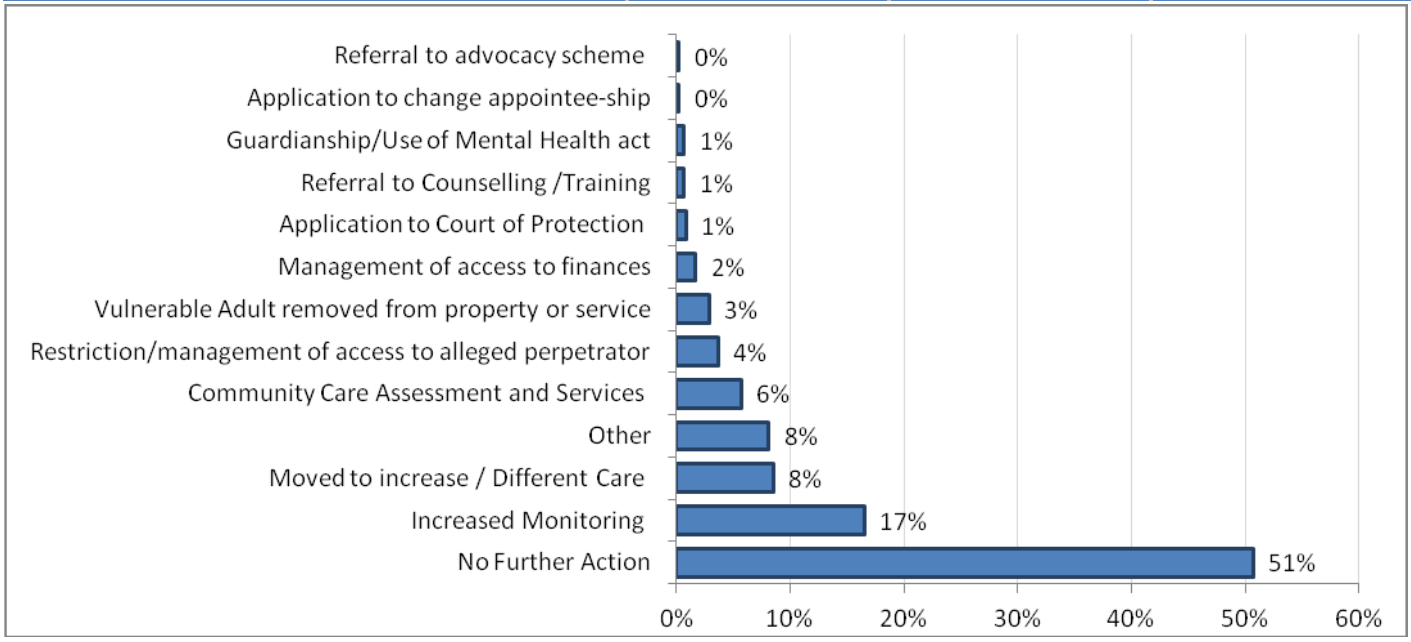


**Outcomes for the Person at Risk of Harm**

The proportion of cases where the outcome was 'No further action' ended at 51% which is only a marginal increase from the 2012/13 result of 50%. This is largely expected due to the high proportion of unsubstantiated cases along with the possibility that the investigation itself is likely to have an impact on reducing or negating the risk of future abuse.

The main outcome after this is 'Increased Monitoring' at 17%. All of the outcomes remain relatively static over all three years.

| | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| No Further Action | 312 | 55% | 234 | 50% | 251 | 51% |
| Increased Monitoring | 99 | 17% | 85 | 18% | 82 | 17% |
| Moved to increase / Different Care | 29 | 5% | 43 | 9% | 42 | 8% |
| Other | 50 | 9% | 37 | 8% | 40 | 8% |
| Community Care Assessment and | 31 | 5% | 22 | 5% | 28 | 6% |
| Restriction/management of access to | 14 | 2% | 11 | 2% | 18 | 4% |
| Vulnerable Adult removed from property | 10 | 2% | 7 | 2% | 14 | 3% |
| Management of access to finances | 9 | 2% | 8 | 2% | 8 | 2% |
| Application to Court of Protection | 3 | 1% | 7 | 2% | 4 | 1% |
| Referral to Counselling /Training | 3 | 1% | 1 | 0% | 3 | 1% |
| Guardianship/Use of Mental Health act | 1 | 0% | 1 | 0% | 3 | 1% |
| Application to change appointee-ship | 6 | 1% | 5 | 1% | 1 | 0% |
| Referral to advocacy scheme | 0 | 0% | 3 | 1% | 1 | 0% |
| Overall Total | 568 | | 465 | | 495 | |

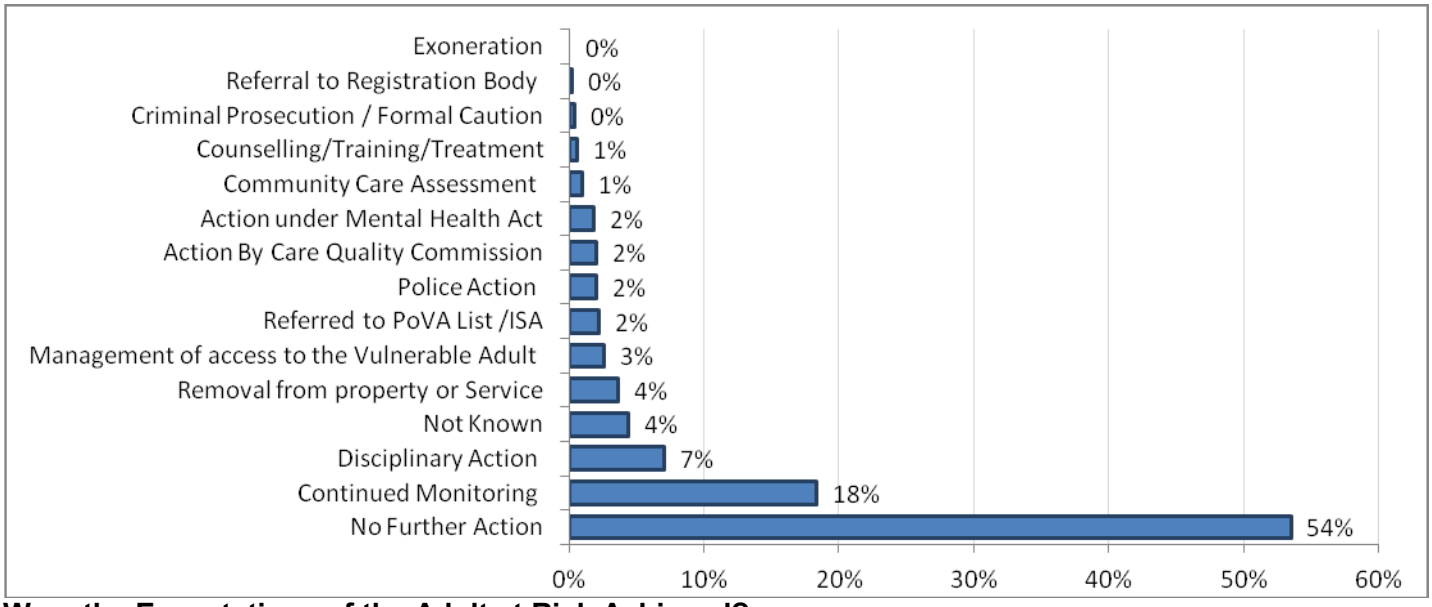


**Outcomes for Person Alleged to be Causing Harm**

The proportion of cases where the outcome for the person alleged to be causing harm was 'No Further Action' remains high at 54% but is an improvement on the 2012/13 result of 59%. This is largely expected due to the high proportion of unsubstantiated cases along with the possibility that the investigation itself is likely to have an impact on reducing or negating the risk of future abuse.

The most common action taken is 'Continued monitoring' with 18% of outcomes in 2012/13. All of the outcomes remain relatively static over all three years.

| | 2011/12 | | 2012/13 | | 2013/14 | |
|---|---|---|---|---|---|---|
| | Number | % | Number | % | Number | % |
| No Further Action | 320 | 56% | 273 | 59% | 265 | 54% |
| Continued Monitoring | 86 | 15% | 84 | 18% | 91 | 18% |
| Disciplinary Action | 15 | 3% | 14 | 3% | 35 | 7% |
| Not Known | 30 | 5% | 23 | 5% | 22 | 4% |
| Removal from property or Service | 32 | 6% | 12 | 3% | 18 | 4% |
| Management of access to the Vulnerable Adult | 17 | 3% | 11 | 2% | 13 | 3% |
| Referred to PoVA List /ISA | 4 | 1% | 12 | 3% | 11 | 2% |
| Police Action | 13 | 2% | 7 | 2% | 10 | 2% |
| Action By Care Quality Commission | 6 | 1% | 0 | 0% | 10 | 2% |
| Action under Mental Health Act | 4 | 1% | 2 | 0% | 9 | 2% |
| Community Care Assessment | 2 | 0% | 6 | 1% | 5 | 1% |
| Counselling/Training/Treatment | 18 | 3% | 4 | 1% | 3 | 1% |
| Criminal Prosecution / Formal Caution | 2 | 0% | 6 | 1% | 2 | 0% |
| Referral to Registration Body | 0 | 0% | 3 | 1% | 1 | 0% |
| Exoneration | 13 | 2% | 7 | 2% | 0 | 0% |
| Action by Contract Compliance | 6 | 1% | 1 | 0% | 0 | 0% |
| Overall Total | 568 | | 465 | | 495 | |




**Were the Expectations of the Adult at Risk Achieved?**

This year a new question has been included throughout the safeguarding documentation which is to capture the expected outcomes of the adult at risk of harm, and whether the expected outcomes have been achieved. The results show that, where deemed applicable, the expectations of the client are fully achieved in 86% of safeguarding investigations and at least partly achieved in a further 7% of cases.

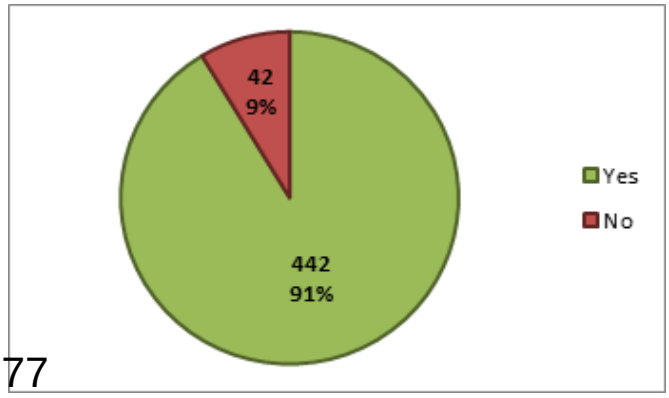
This result appears to be very good and shows that the large majority of safeguarding investigations result in a satisfactory outcome for the adults at risk. However it should be noted that 213 cases (43%) are not measured as the outcome was recorded as not applicable. Much of this is where the client is unaware of the safeguarding issue or unable to comprehend the fact that they were at risk.

| | 2013/14 | |
|---|---|---|
| | Number | % |
| Yes, expectations were achieved | 233 | 86% |
| Expectations were partly achieved | 18 | 7% |
| No, expectations were not achieved | 20 | 7% |
| Not applicable | 213 | - |
| Overall Total | 495 | |

**Feedback given to the Alerter**

This year a new question was introduced at the start of the safeguarding process and at the end to capture whether feedback was given to the person raising the Alert.

| Was feedback given to the Alerter? | | |
|---|---|---|
| Yes | 442 | 91% |



| | | |
|---|---|---|
| **No** | 42 | 9% |

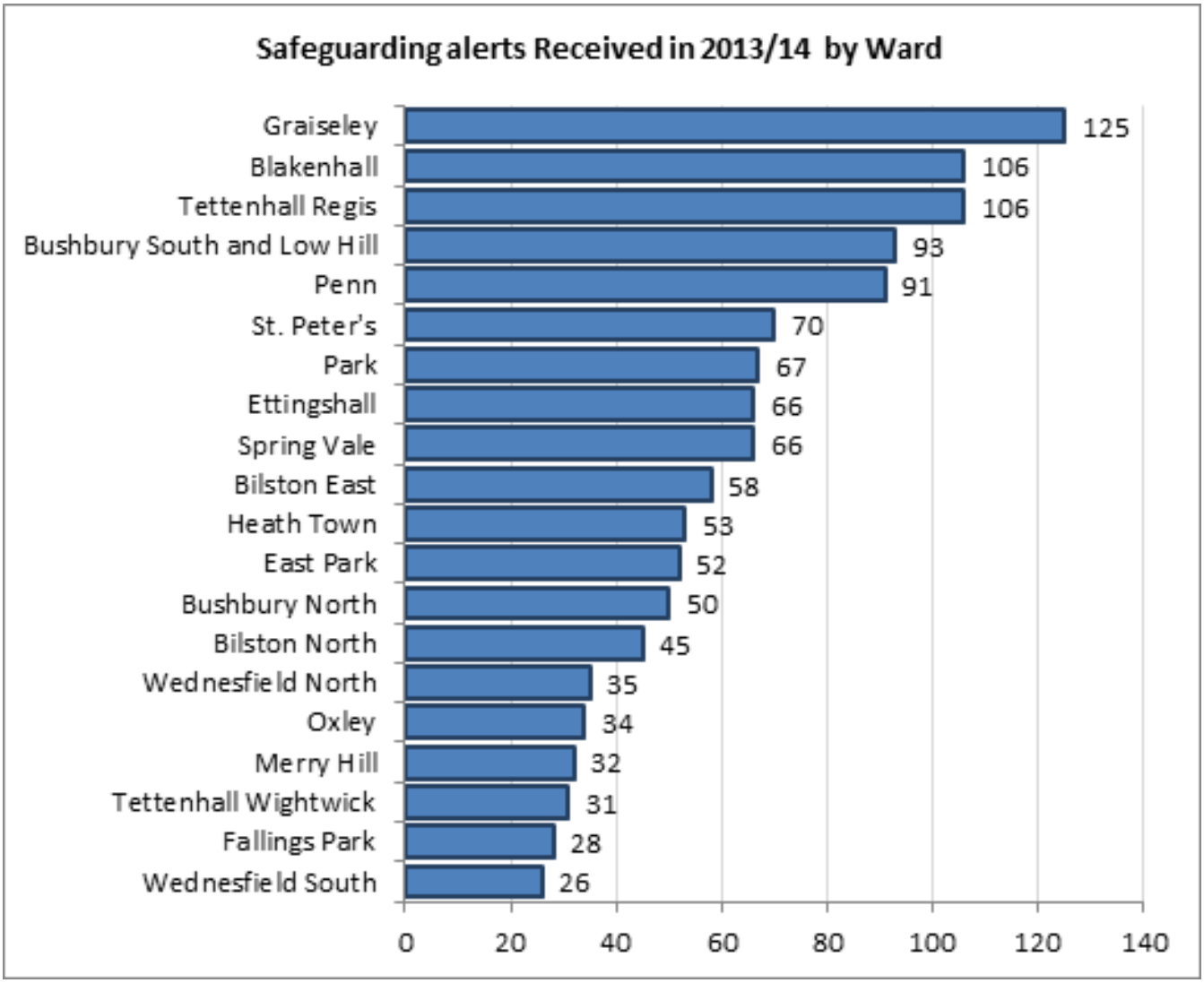
**In 2013/14**
The Safeguarding Team chaired 36 Large Scale Strategy Meetings of which 10 were Initial and 25 were Reviews and 1 was an Outcomes meeting. These meetings are held when there are a number of concerns relating to a care service and there may be implications for a number of service users.

The Safeguarding Team chaired a total of 57 Case Conferences of these 57 22 were Initial and 35 were Reviews.

Service Users attended 12, Family attended 11, and an Independent Mental Capacity Advocate (IMCA) attended 1

**For all alerts received in 2013/14 the breakdown is as follows:**

| Ward | Alerts | % of Alerts |
|---|---|---|
| **Bilston East** | 58 | 4.7% |
| **Bilston North** | 45 | 3.6% |
| **Blakenhall** | 106 | 8.6% |
| **Bushbury North** | 50 | 4.1% |
| **Bushbury South and Low Hill** | 93 | 7.5% |
| **East Park** | 52 | 4.2% |
| **Ettingshall** | 66 | 5.3% |
| **Fallings Park** | 28 | 2.3% |
| **Graiseley** | 125 | 10.1% |
| **Heath Town** | 53 | 4.3% |
| **Merry Hill** | 32 | 2.6% |
| **Oxley** | 34 | 2.8% |
| **Park** | 67 | 5.4% |
| **Penn** | 91 | 7.4% |
| **Spring Vale** | 66 | 5.3% |
| **St. Peter's** | 70 | 5.7% |
| **Tettenhall Regis** | 106 | 8.6% |
| **Tettenhall Wightwick** | 31 | 2.5% |
| **Wednesfield North** | 35 | 2.8% |
| **Wednesfield South** | 26 | 2.1% |
| **Invalid or Out of Area** | 58 | - |
| **Deceased** | 22 | - |

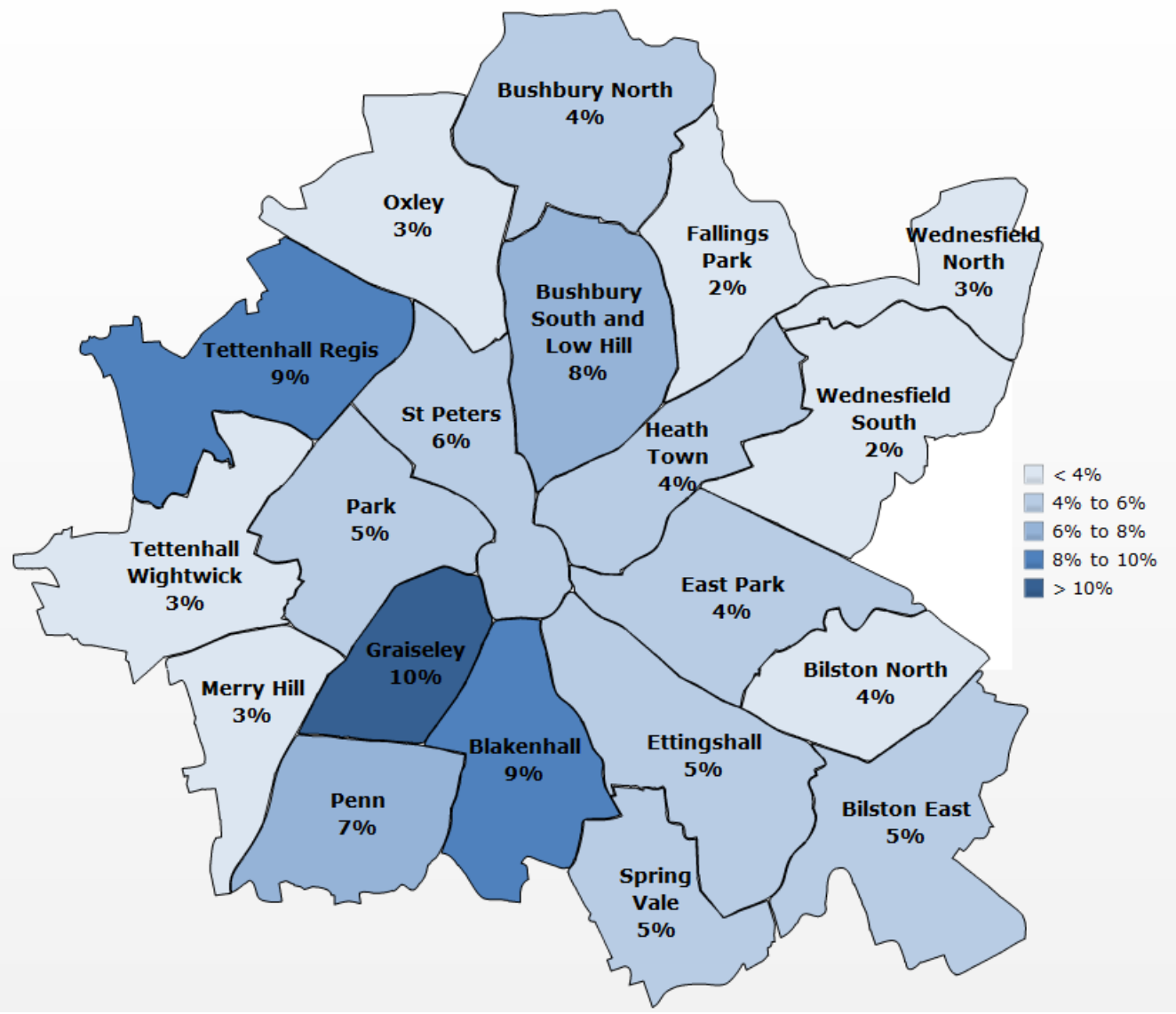



The table below shows the total number of DoLS applications and the number of authorisations granted or not. This is broken down by hospital and care home.

| | Managing Authority | Total No.of DoLS applications from 1st April 2013- 31st March 2014 | Authorisation Granted | Authorisation Not Granted |
|---|---|---|---|---|
| **Wolverhampton** | Care Homes | 63 | 47 | 16 |

| | | | | |
|---|---|---|---|---|
| **Wolverhampton** | Hospitals | 12 | 7 | 5 |

**Map showing the proportion of Alerts by Ward in 2013/14**




**Definitions of terms used in this document:**

Alert: This is when a concern is passed to the Local Authority, also known as an SA1

Referral: This is an alert which goes on to be investigated by the authority in relation to a safeguarding concern, also known as an SA3.

Completed Referral: This is when an investigation is concluded, also known as an SA5.

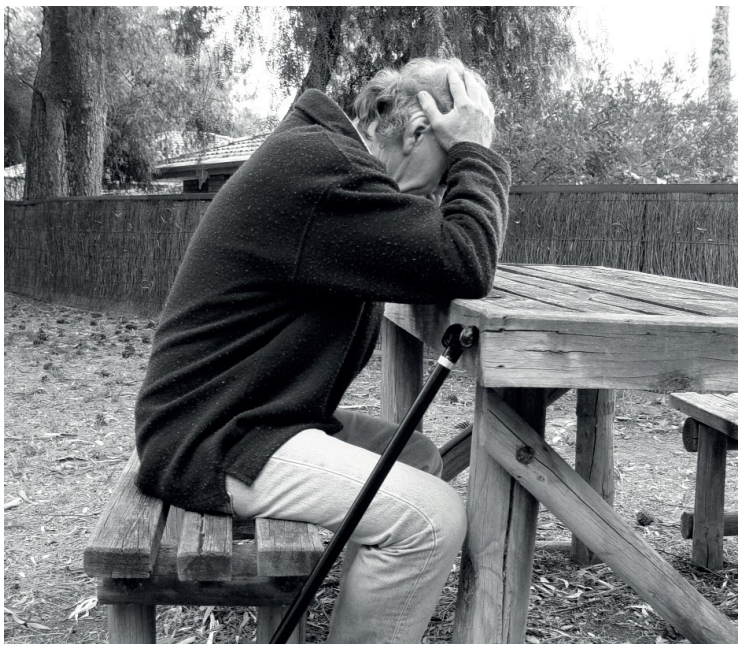
**Case Study**

A safeguarding referral was raised in respect of a young woman with a profound learning disability who lived at home with her sister and her sister's family.

The allegation was that the sister roughly handled her using excessive and inappropriate restraint, that she was not properly clothed and that the food with which she was provided was second rate. It was also suggested that she was excluded from family life and was made to feel that she was not a full and valuable member of the family.

The sister was a person who did not want to engage with agencies and presented many obstacles and challenges.

Intensive multi-agency work was undertaken within the safeguarding process. The patience and skill of the social worker, combined with the full commitment and dedication of the care agency and the input of occupational therapy and community nursing have ensured that there is a detailed and comprehensive Protection Plan and Health Plan and that the young woman is safeguarded and closely monitored. She has been able to remain in her family environment which was felt by all, including an independent advocate, to be in her best interests.



**FEEDBACK FORM**

**Can you please help by providing us with feedback on the content of this report. You may wish to print off this page and return this in the post to:**
Safeguarding Service, Priory Green Building, Whitburn Close, Pendeford, Wolverhampton, WV95NJ

**or alternately contact the Safeguarding Adult Team on 01902 553218/553259 to give verbal feedback.**

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

_____
_____
_____
_____
_____
_____
_____
_____

**WHO CAN I TELL MY CONCERNS TO?**
**To make a referral ring Adults Social Care Services on 01902 551199.**

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

**In an emergency, ring 999.**

# Appendix 1

Wolverhampton Safeguarding Adult Boards Partner Organisations - Members & Their Representatives 2013-14

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

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**Agenda Item No. 11**

# Health and Wellbeing Board

5 November 2014

| | |
|---|---|
| **Report title** | Wolverhampton Child Poverty Strategy Governance, Performance Measures |
| **Cabinet member with lead responsibility** | Councillor Gibson |
| **Wards affected** | All |
| **Accountable director** | Tim Johnson |
| **Originating service** | Strategic Projects and Funding |
| **Accountable employee(s)** | Heather Clark — Strategic Projects and Funding Manager<br>Tel — 01902 555614<br>Email — Heather.clark2@wolverhampton.gov.uk |

**Recommendation(s) for action or decision:**

The Health and Wellbeing Board is recommended to:

1. Feedback on new governance structures for child poverty, split of responsibilities and proposed performance measures.

## 1.0 Purpose

1.1 The report has been produced at the request of the Health and Wellbeing Board following an update report in September 2014 including:

- Confirmation of new governance arrangements;
- Confirmation of the performance measures that each Board will use to measure progress; and
- Confirmation of how the responsibility for priority actions will be split.
- Consider how 'a call for action' might be delivered.

## 2.0 Background

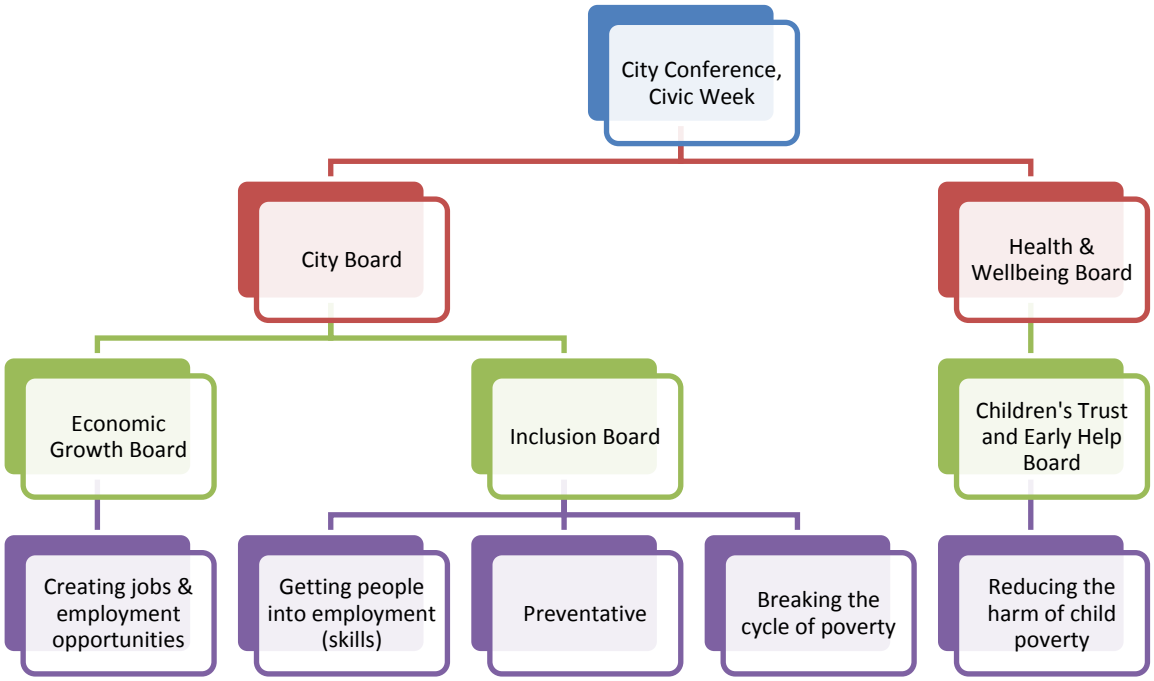
2.1 Wolverhampton's revised Child Poverty Strategy was signed off by Cabinet in June 2013. The strategy outlined actions under four building blocks: financial inclusion; employment and skills; early intervention, health and educational attainment; and housing and neighbourhoods. In addition, it aimed to shift our approach from managing the consequences of child poverty by moving away from crisis interventions (high cost) to preventative (prevent families falling into crisis and support families out of poverty) and to break the cycle of child poverty for future generations.

2.2 An update report on Wolverhampton Child Poverty Strategy was taken to the Health and Wellbeing Board in September 2014. The Board expressed the need for a governance framework together with a performance monitoring mechanism. The Board recognised the link to addressing overall poverty with links to regeneration, increasing employment opportunities, enhancing employability and providing support for children living in poverty. The Health and Wellbeing Board requested that more emphasis be given to improving educational opportunities and a whole system approach was required to recognise the contribution and impact of all service areas. The Board also requested we explore an approach adopted with the "Obesity Call to Action".

## 3.0 Governance

3.1 **Reducing child poverty**: This is a key priority under Wolverhampton's City Strategy 2011-26. Under the new partnership structure, the City Board will replace the Wolverhampton Partnership Executive Board. The Inclusion Board will be responsible for developing and delivering plans and interventions to get more people into work, tackle worklessness and some of the wider determinants of poverty.

3.2 **Reducing the harm of child poverty**: The Children's Trust and its Early Help Board will be responsible for the Children and Young People's Plan priority reducing the harm of child poverty. These will focus on dealing with the symptoms of child poverty (crisis), whereas the Economic and Social Inclusion Board will focus on prevention and breaking the cycle.




3.3 The City Annual Conference will report back on overall performance to stakeholders and residents of the city.

## 4.0 Responsibilities, Performance Measures

4.1 The Government has released the national Child Poverty Strategy 2014-2017 which aims to tackle the root causes of poverty by focusing on three areas which are in line with the building blocks of Wolverhampton's Child Poverty Strategy:

| **National Child Poverty Strands** | **Wolverhampton Building Blocks** |
|---|---|
| Supporting families into work and increasing their earnings | Employment and Skills<br>Financial Inclusion |
| Improving Living Standards | Housing and Neighbourhoods |
| Preventing poor children becoming poor adults through raising their educational attainment | Early Intervention, Health and Education Attainment |

4.2 The tables below outlines the proposed role of each Board in addressing child poverty for discussion ranging from the focus on reducing the harm from child poverty by the Children's Trust Early Help Board to the role of the Inclusion Board around prevention and breaking the cycle of child poverty for future generations. The Boards are currently refining their priorities and work programme, therefore these will evolve.

| | | | | | |
|---|---|---|---|---|---|
| | **Delivery: Wolverhampton's Child Poverty Strategy** | | | | |
| | **THE BOARD: Economic Growth Board** | | | **CHAIR**: Cllr Peter Bilson | |
| | **Summary of role in relation to child poverty**: developing and delivering the Economic Growth Plan to deliver more jobs and addressing barriers to growth | | | | |
| **Building Block** | **Employment and Skills** | **Early Help, Education Attainment and Health** | **Financial Inclusion** | **Housing and Neighbourhoods** | **Reducing the harm of child poverty** |
| Targets/ Indicators | Increased net jobs measured by number of jobs per head of population (job density) | | | | |
| Activities | • Develop priority projects that create new jobs, support growth and regenerate the city for local growth funds.<br>• Market the city more effectively to inward investors, developers and visitors | | | | |
| Trend | ▼ | | | | |

| | | | | | |
|---|---|---|---|---|---|
| | **Delivery: Wolverhampton's Child Poverty Strategy** | | | | |
| | **THE BOARD: Inclusion Board** | | | **CHAIR**: Ian Darch | |
| | **Summary of role in relation to child poverty**: developing and delivering plans to get more people into work, tackle worklessness and some of the wider determinants of poverty | | | | |
| **Building Block** | **Employment and Skills** | **Early Help, Education Attainment and Health** | **Financial Inclusion** | **Housing and Neighbourhoods** | **Reducing the harm of child poverty** |
| Targets/ Indicators | Reduce unemployment, including youth unemployment | | Reduction in rent arrears, eviction rate and homelessness applications | Improve decency in the private rented sector; improve energy efficiency; reduce fuel poverty | |
| Activities | Develop and deliver projects to get more people into work including addressing low skills and tackling barriers | | Support the transition onto Universal Credit through development local support services around triage, digital inclusion and personal budgeting support | Introduce better education, enforcement and standards within private sector housing.<br>Implement decent homes and energy efficiency programmes | |
| Trend | ▼ unemployment | | ▲ possessions<br>▼ homelessness applic | ▲decency and energy efficiency | |

Note: the Inclusion Board are currently developing their work programme going forward, however the areas highlighted above are likely to be

| | | | | | |
|---|---|---|---|---|---|
| | **Delivery: Wolverhampton's Child Poverty Strategy** | | | | |
| | **THE BOARD: Children's Trust Early Help Board** | | | **CHAIR**: Emma Bennett | |
| | **Summary of role in relation to child poverty** – Children and Young People's Plan priorities: Reducing the harm of child poverty; Increase achievement and involvement in education, training and employment; support families to be strong; Improve the health of children, young people and families | | | | |
| **Building Block** | **Employment and Skills** | **Early Help, Education Attainment and Health** | **Financial Inclusion** | **Housing and Neighbourhoods** | **Reducing the harm of child poverty** |
| Targets/ Indicators (Priorities) | • Over 25 unemployment rates<br>• Out of work benefit claimants | • Increased educational participation and attainment<br>• Decreased young people not in education, employment and training (NEET) | | • Reduced number of homeless young people | • Reducing in number of young people known to anti-social behaviour |
| Activities | • Deliver the Troubled Families programme aim get parents into employment | • Deliver the Troubled Families programme aim improve attendance in education and training<br>• Support children and young people to engage and achieve in education, training and employment | | • Support for young people at risk of homelessness through family mediation and joint protocal | • Reduce likelihood of continuing anti-social behaviour and criminal activity<br>• Focusing on young people at risk to help them engage in positive activities and promote engagement |
| Trend | ▼ unemployment | ▲ Educational attainment<br>▲ NEET | | ▲ Homeless young people | |

4.5 The obesity call for action approach included a summit planned in October 2014 supported by organisations pledging their support. This approach has previously occurred with the Growth Pledge, in line with the employment and skills building blocks, which aimed to encourage pledgers to invest more in skills, mentor a budding entrepreneur, build links with education, offer work placements and apprenticeship. Going forward, we could explore this approach as part of the Local Support Services Framework linked to the rollout of Universal Credit. A workshop is planned November 2014 to begin designing the support framework taken forward by a Task and Finish group and partner organisations could be asked to pledge their involvement in supporting those affected through triage and signposting and where appropriate providing access to digital access devices and personal budgeting support.

## 5.0 Financial implications

5.1 There are no financial implications of Wolverhampton's Child Poverty Strategy, however there are gaps in delivery that require additional resources to address. Any additional resource requirements for implementation will be subject to the normal budgetary approval processes. There are also potential consequences of not dealing with preventative aspects of child poverty which could have adverse impacts on service demand in future. [ES/23102014/E]



## 6.0 Legal implications

6.1 The Council as a Responsible Authority has a duty under section 23 of the Child Poverty Act 2010 to prepare a Child Poverty Strategy in conjunction with partner agencies. RB/23102014/X

## 7.0 Equalities implications

7.1 An Equalities Analysis was produced at the time of the development of the strategy and did not foresee any negative impact from the Child Poverty Strategy. The Child Poverty Needs Assessment highlighted that certain groups are most vulnerable to child poverty including lone parents, black minority ethnics (BME's) and people with disabilities, therefore the Strategy itself will actively target those groups most vulnerable to child poverty having a positive impact on equalities.

## 8.0 Environmental implications

8.1 Addressing issues in relation to housing and neighbourhoods is one of the key building blocks in the Child Poverty Strategy. This includes actions to improve quality standards in private sector housing and reduce fuel poverty.

## 9.0 Human resources implications

9.1 There are no human resources implications.

## 10.0 Corporate landlord implications

10.1 There are no corporate landlord implications.

## 11.0 Schedule of background papers

11.1 Wolverhampton Child Poverty Strategy

Agenda Item No. **12**

# Health and Wellbeing Board

5 November 2014

| | | |
|---|---|---|
| **Report title** | Joint Strategic Needs Assessment Refresh 2014 | |
| **Cabinet member with lead responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing | |
| **Wards affected** | All | |
| **Accountable director** | Sarah Norman, Community | |
| **Originating service** | Public Health | |
| **Accountable employee(s)** | Ros Jervis | Director Public Health |
| | Glenda Augustine | Consultant in Public Health |
| | Tel | 01902 554211 |
| | Email | ros.jervis@wolverhampton.gov.uk |
| **Report to be/has been considered by** | Public Health Senior Management Team | 15th October 2014 |

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**Recommendation(s) for action or decision:**

The Health and Wellbeing Board is recommended to:

1.1 Note the annual change in the health and social care indicators that inform the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.

1.2 Approve the publication of the Joint Strategic Needs Assessment Refresh for 2014.

## 1.0 Purpose

**1.1** The purpose of this report is to provide an update on the changes to the health and wellbeing of the residents of Wolverhampton as indicated by a review of the outcomes frameworks that have informed the Joint Strategic Needs Assessment (JSNA).

## 2.0 Background

2.1 The JSNA is a tool to understand the needs of Wolverhampton residents and agree collective action. It is a process that identifies the current and projected health and wellbeing needs of the local population across the life course, and brings together evidence in the form of numerical data, insights from communities and other high quality published evidence.

2.2 The JSNA informs the priorities of the Health and Wellbeing Board's Joint Health and Wellbeing Strategy (JHWBS) and provides a shared evidence base for consensus on the key local priorities.

2.3 The Health and Wellbeing Board agreed that the JSNA and JHWBS should be reviewed annually, as the JSNA is an on-going process that needs to be updated and refreshed so that the intelligence continues to provide the latest information for the population and the JHWBS continues to reflect the right priorities

2.4 This 2014 refresh reviewed the following outcomes frameworks; Public Health, NHS, Adult Social Care and the locally produced Children's framework in comparison to the baseline health and wellbeing data published in 2013. The detail of the individual indicator changes is outlined in appendix one with a graphical portrayal of the rating against the England average.

2.5 It was not possible to compare a number of indicators with previously reported data due to a change in the reporting methodology, so the new figures in this report will provide a baseline for future reporting.

## 3.0 Key Findings of JSNA Refresh

3.1 Wolverhampton is managing the housing needs of homeless individuals, even though there is a high level of homelessness. This indicates that services are effective and this outcome does not impact on the current priorities in the Joint Health and Wellbeing Strategy.

3.2 The rate of teenage pregnancies in Wolverhampton has reduced by almost a quarter over two years and although the rate remains higher than the England average, current

interventions appear to be effective. This finding does not impact on the current priorities in the Joint Health and Wellbeing Strategy.

3.3 The chlamydia screening programme is effectively identifying young people with this condition but may need to consider increasing uptake in young men. However, this issue of young men engaging with this programme is universal and does not impact on the current priorities in the Joint Health and Wellbeing Strategy.

3.4 Whilst uptake of flu immunisation has improved, further work is required to encourage 'at-risk' individuals to participate in the immunisation programme. This is currently being addressed nationally and locally and does not impact on the current priorities in the Joint Health and Wellbeing Strategy.

3.5 There has also been significant improvement in ten indicators across health and social care resulting in better outcomes for individuals and communities, alongside an improved rating in the frameworks. These outcomes do not impact on the current priorities in the Joint Health and Wellbeing Strategy.

3.6 Wolverhampton was reported to have the worst outcomes in the West Midlands for excess weight in children aged 4-5 years and 10-11 years, breast cancer screening and uptake of two doses of the Measles, Mumps and Rubella (MMR) vaccine.

3.7 Infant mortality was the only indicator where Wolverhampton had the worst outcome in England. This work is being addressed by a multi-agency infant mortality working group and there will also be a health scrutiny review. This outcome should not impact on the current priorities in the Joint Health and Wellbeing Strategy.

## 4.0 Additional Indicators Reported in the JSNA Refresh

4.1 Additional indicators from the Public Health Outcomes Framework, not previously listed in the framework report for 2013, have been included in this report. These indicators are excess weight in children age 4-11 years, excess weight in adults and MMR – one dose at 2 years and two doses at age 5 years.

4.2 The indicators on excess weight have been included, supplementary to the already listed indicator on obesity, to provide a complete overview of the proportion of the population that would benefit from weight management programmes.

4.3 The change in the reporting of the MMR vaccine uptake has been amended to provide completeness of vaccine coverage, as two doses of the vaccine are required to provide satisfactory protection against these infectious diseases. Therefore, reporting should reflect initial uptake at age 2 years and total uptake, that is, two doses at age 5 years.

## 5.0 Impact of JSNA Refresh

5.1 The update of the national outcomes framework indicates that there is no significant impact on the current strategic priorities within the Wolverhampton Joint Health and Wellbeing Strategy.

5.2 Whilst the reporting of the majority of the outcomes remains unchanged, there has been some slight improvement over the past year. This is not an unusual finding for an annual review of data as significant changes in population of health and social care outcomes evolve over time, with the true impact of intervention success emerging between three and five years from the baseline.

## 6.0 Financial implications

6.1 This report has no direct financial implications.

[NM/23102014/J]

## 8.0 Legal implications

8.1 There are no anticipated legal implications to this report.

[KR/22102014/G]

## 9.0 Equalities implications

9.1 This report does highlight a gender inequality within the Chlamydia screening programme that is known finding throughout this national programme. This does not directly impact on service delivery or employment.

## 10.0 Environmental implications

10.1 There are no anticipated environmental implications related to this report.

## 11.0 Human resources implications

11.1 There are no anticipated human resource implications related to this report.

## 12.0 Corporate landlord implications

12.1 This report does not have any implications for the Council's property portfolio.

## 13.0 Schedule of background papers

13.1 The outcome frameworks spine charts are included for information.

Appendix One

# Wolverhampton

# Joint Strategic Needs Assessment:

# Refresh 2014

**Public Health Wolverhampton Intelligence and Evidence Team**
**Last Updated: 14th October 2014**

**Introduction**

This paper provides a summary of the changes to the health and wellbeing of the residents of Wolverhampton as suggested by the updated indicators within the following outcomes frameworks:

- Public Health Outcomes Framework
- NHS Outcomes Framework
- Adult Social Care Outcomes Framework
- Children's Outcome framework

Baseline health and wellbeing data from these frameworks was described in Appendix 1 of the Joint Strategic Needs Assessment suite of documents produced in 2013. This 12 month review of the indicators will aim to highlight any significant changes to this baseline information to identify progress on current priorities and depict any areas of increasing local need. The indicators reported in 2013 have been tabulated and compared to the current data available, see Tables 1 to 3. A specific table was not produced for the Children's Outcome Framework as the indicators reported are primarily contained within the Public Health Outcomes Framework. It should be noted that due to a national change in the process of standardisation, some rates may appear artificially inflated as a result of the new methodology used, rather than due to actual occurrences. However, previous data for these indicators has been revised to allow comparison over time[1].

**Key Findings from Outcome Frameworks Update 2014**

1. The rate of statutory homelessness has been recalculated and the new indicator suggests that Wolverhampton (0.5 per 1,000) is better than the England average (2.4 per 1,000) and this has been a consistent trend since 2010/11
   ***What does this mean?***
   Wolverhampton is managing the housing needs of homeless individuals, even though there is a high level of homelessness. This indicates that services are effective and this outcome does not impact on the current priorities in the Joint Health and Wellbeing Strategy.

2. There has been a 24% reduction in the rate of teenage pregnancies between 2010 (55.5 per 1,000) and 2012 (42.2 per 1,000); however, the rate still remains significantly higher than the England average (27.7 per 1,000) as there has also been a similar reduction in the rate across England (27%)
   ***What does this mean?***
   The rate of teenage pregnancies in Wolverhampton has been reduced by almost a quarter over two years and although the rate remains higher than the England average, current interventions appear to be effective. This finding does not impact on the current priorities in the Joint Health and Wellbeing Strategy.

3. Chlamydia diagnoses for 15-24 year olds has improved (2,027 per 100,000) and is now similar to the England average (2,016 per 100,000); conversely, the breakdown of this outcome by gender (not reported) indicates that the diagnosis rate for males is significantly worse than the England average, whilst the diagnosis rate for females is significantly better than the England average. It should be noted that gender inequality for chlamydia diagnosis is a similar finding across the majority of areas in the West Midlands.

[1] The European Standard Population (ESP) is an artificial population structure which is used in the weighting of mortality or incidence data to produce age standardised rates. The population structure of the ESP was updated in 2013 and implemented across all national statistics in 2014. This revision will cause mortality rates and cancer incidents to increase significantly.

***What does this mean?***

The chlamydia screening programme is effectively identifying young people with this condition but may need to consider increasing uptake in young men. However, this issue of young men engaging with this programme is universal and does not impact on the current priorities in the Joint Health and Wellbeing Strategy.

4. Flu immunisation in 'at-risk' groups (51.6%) has shown a marginal increase in uptake since the last report and is now rated similar to the England average (51.3%); however, there is room for further improvement as this outcome indicates that just under 50% of at risk individuals are *not* being immunised against the flu, which could have a significant effect on health and wellbeing.

   ***What does this mean?***

   Whilst uptake of flu immunisation has improved, further work is required to encourage 'at-risk' individuals to participate in the immunisation programme. This is currently being addressed nationally and locally and does not impact on the current priorities in the Joint Health and Wellbeing Strategy.

5. There has also been significant improvement in the following indicators resulting in a change of the rating from worse than the England average to similar to the England average:
   a. Rate of violent crime
   b. Self- reported wellbeing
   c. Human Papillomavirus (HPV) vaccine coverage
   d. Treatment completion for Tuberculosis (TB)
   e. Preventable sight loss certifications
   f. Emergency admissions for hip fractures in 65 year olds and over
   g. Secondary care mental health service users in employment
   h. Incidence of healthcare acquired Clostridium Difficile (C.Diffe)
   i. Permanent admission of younger adults (16-64 years) to residential and nursing care homes
   j. Delayed transfers of care from hospital and due to adult social care

   ***What does this mean?***

   Overall there has been significant improvement in a number of areas across health and social care resulting in better outcomes for individuals and communities. These outcomes do not impact on the current priorities in the Joint Health and Wellbeing Strategy.

6. Wolverhampton was reported to have the worst outcomes in the West Midlands for a small number of indicators:
   a. Excess weight in children aged 4 to 5 years old (27.0% compared to 22.7%)
   b. Excess weight in children aged 10 to 11 years old (40.6% compared to 35.5%)
   c. Breast cancer screening coverage (70.3% compared to 76.9%)
   d. Measles, Mumps and Rubella (MMR) vaccine - 2 doses at 5 years (76.5% compared to 87.9%)

   ***What does this mean?***

   Whilst Wolverhampton does not have the worst outcomes in the country for these indicators, there is room for improvement in these indicators and work is underway to address childhood obesity, screening and immunisation

7. There was only one indicator where Wolverhampton had the worst outcome in England that is the infant mortality rate (7.5% compared to 4.1%)

**What does this mean?**

There is a need to investigate why more babies born in Wolverhampton die before the age of one year, compared to all other areas in England. This work is being addressed by a multi-agency infant mortality working group and there will also be a health scrutiny review. This outcome should not impact on the current priorities in the Joint Health and Wellbeing Strategy.

**Wolverhampton Demographic profile**

The city's resident population is estimated to be 251,557 (mid-year estimates 2013) which is an increase of approximately 2,087 compared to the 2011 census. There is no reported change to the predicted increase in the older population (age 65 years and over) over the next 10 years or to the predicted below regional and national average population growth in Wolverhampton. The ethnic composition of Wolverhampton has not been updated over the last year. The deprivation ranking of the 21st most deprived Local Authority in the country remains as previously reported, with 51.1% of the Wolverhampton population falling amongst the most deprived 20% nationally.

**Joint Health and Wellbeing Board Strategic Priorities**

The Joint Strategic Needs Assessment process has informed the development of the Wolverhampton Joint Health and Wellbeing Strategy, produced by the Health and Wellbeing Board. The health and wellbeing priorities listed below were selected to provide a number of high level evidenced-based priorities that are a local challenge to resolve, and span organisational responsibilities. The strategic outcomes for the strategy are aimed at increasing life expectancy, improving quality of life and reducing child poverty. Therefore, the top five priorities identified to achieve these outcomes are:

- Wider determinants of health
- Alcohol and drugs
- Dementia (early diagnosis)
- Mental Health (diagnosis and early intervention)
- Urgent Care (improving and simplifying)

**Impact of Joint Strategic Needs Assessment Refresh 2014**

The update of the national outcomes framework indicates that there is no significant impact on the current strategic priorities within the Wolverhampton Joint Health and Wellbeing Strategy. The majority of the indicators within the updated outcome frameworks remain unchanged, which is not surprising for an annual update of population level outcomes. It was not possible to compare a number of indicators with previously reported data due to a change in the reporting methodology, so the new figures in this report will provide a baseline for future reporting.

Additional indicators from the Public Health Outcomes Framework, not previously listed in the framework report for 2013, have been included in this report. These indicators are excess weight in children age 4-11 years, excess weight in adults and MMR – 1 dose at 2 years and 2 doses at age 5 years.

The indicators on excess weight have been included, supplementary to the already listed indicator on obesity, to provide a complete overview of the proportion of the population that would benefit

from weight management programmes. Wolverhampton has been reported to have the highest proportion of overweight and obese children aged 4 to 5 years and 10 to 11 years in the West Midlands. This issue is currently being addressed via the Director of Public Health Annual Report, which is a Call to Action on Obesity and the Public Health Business Plan, so will not directly impact on current strategic priorities. Inclusion of these indicators in the future framework reports will provide an update on the improvement in these outcomes.

The change in the reporting of the MMR vaccine uptake has been amended to provide completeness of vaccine coverage, as two doses of the vaccine are required to provide satisfactory protection against these infectious diseases. Therefore, reporting should reflect initial uptake at age 2 years and total uptake, that is, two doses at age 5 years. Current MMR vaccine performance indicates good uptake of the vaccine at age 2 years, but poor uptake of two vaccines at age 5 years. This is not a new finding and a comparison of the trend data for these two indicators highlights the same outcome year on year. However, Wolverhampton is reported to have the worst uptake of MMR at 5 years in the West Midlands, with a decrease in uptake of 4.1% from 80.6% in 2011/12 to 76.5% in 2012/13. National system changes, local resourcing and data reporting have also impacted on this outcome.

Similarly, system changes may have impacted on the outcomes related to breast cancer screening coverage. There appears to be a steady marginal decrease, year on year, in the proportion of women screened for breast cancer in Wolverhampton from the reported 73.4% in 2010/11 to the currently reported 70.3% in 2013. Work is underway with the Public Health England Screening and Immunisation team for Birmingham and the Black Country to improve MMR vaccine uptake at 5 years and address cancer screening coverage, which will include breast cancer screening. This finding does not impact on the current Wolverhampton strategic priorities.

Although there has been improvement in the rating of some indicators, resulting in outcomes similar to the England average, there is still additional work required to ensure continual improvement in these outcomes. An example of where additional work should be encouraged is the uptake of flu immunisation by at risk groups. Just a marginal increase of 1.6% in the uptake of the flu vaccine has resulted in a rating similar to the England average. However, 48.4% of the at risk population remain unimmunised increasing the risk of poor health outcomes. Therefore, there should be an ambition in particular indicators to exceed the England average to achieve an impact at the individual as well as population level.

There appears to be a gender inequality in the Chlamydia screening programme whereby the overall screening outcome indicates a similar detection rate to the England average, but male detection rate is significantly worse than the England average. A number of reasons may account for this apparent inequality, such as poor uptake of screening by males or more screened males are achieving a screen negative result than females. Further work is required to understand the details of this finding, but is does not impact on the overall strategic priorities. It should be noted that there was a similar finding of gender inequality for chlamydia screening across the West Midlands. There were no other gender inequalities highlighted from the reported indicators. The ranking of indicators throughout the West Midlands was possible for the Public Health Outcomes Framework because a national interactive tool is available to provide this level on analysis. Unfortunately this detailed

analysis is not available for the NHS, Adult Social Care and Children's Outcome Frameworks as there is not a similar tool to enable the analysis.

The infant mortality rate in Wolverhampton was reported to be the worst in England in March 2014. A multi-organisational working group led by Public Health was convened in May 2014 and aims to produce a detailed action plan to address this issue by December 2014. Infant mortality is also being reviewed by the Wolverhampton City Council Health Scrutiny Committee, so there is assurance that there is a detailed focus on this issue and it does not need to be a strategic priority for the Health and Wellbeing Board

**Update on Joint Strategic Needs Assessment Briefings**

1. ***Adult obesity*** has increased from 27.3% to 28.5%; this outcome is worse than the England average of 23%.
2. ***Alcohol related mortality*** has decreased 30.4/100,000 to 28.0/100,000; this outcome is significantly worse than the England average of 18.0/100,000
3. ***Childhood development*** at 2 years old still has no national indicator. The school readiness indicator has changed, but the outcomes for Wolverhampton are still worse than the England average.
4. ***Childhood obesity*** has increased marginally; 4-5 year olds (12.6% to 12.7%) and 10-11 year olds (23.8% to 24.4%). These outcomes are worse than the England average
5. ***Childhood poverty*** has decreased by 0.5%
6. ***Circulatory disease mortality*** has improved from 107.3/100,000 to 105.7/100,000. This outcome is worse than the England average of 81.1/100,000.
7. ***Dementia*** diagnosis rate has improved and this outcome is similar to the England average
8. ***Diabetes*** recording by GP has increased from 7.44% to 7.7% allowing effective treatment to reduce complications.
9. ***Domestic abuse*** national indicator has still not been developed and there is no update on 2011/12 data.
10. ***Employment of people with long term conditions*** has decreased from 56.9% to 44.9%; there has not been a similar decrease in England (60.3% to 58.7%)
11. ***Infant mortality*** has increased and the issue is currently being reviewed
12. ***Life expectancy*** has improved slightly for both males and females but both outcomes still remains lower than the England average
13. ***Mortality for people with mental illness*** remains similar to the England average
14. ***Recovery from stroke***
15. ***Residential and nursing care home admissions*** has decreased significantly and is now similar to the England average

**Conclusion**

In summary, there were no additional priorities identified as a result of the update of the outcomes frameworks used to inform the Wolverhampton Joint Health and Wellbeing Strategy. Whilst the reporting of the majority of the outcomes remains unchanged, there has been some slight improvement over the past year. This is not an unusual finding for an annual review of data as significant changes in population health and social care outcomes evolve over time, with the true impact of intervention success emerging between three and five years from the baseline.

**Table 1: Public Health Outcomes Framework**

| Overarching Indicators | | | | | |
|---|---|---|---|---|---|
| **Indicator** | | **2013 Report** | **2014 Update** | **Comment** | **Change in RAG[2] Rating** |
| 0.1ii | Life expectancy at birth - male | 76.7 | 77.4 | • Increase in life expectancy by 0.7 years<br>• 4.7 years difference to the England average of 82.1 years<br>• Remains significantly lower than England average | No |
| | Life expectancy at birth - female | 80.8 | 81.7 | • Increase in life expectancy by 0.9 years<br>• 4.2 years difference to the England average of 82.1 years<br>• Remains significantly lower than England average | No |
| 0.1i | Healthy life expectancy - male | 59.3 | 58.3 | • Baseline measure (2009-11) reported in 2013 | No |
| | Healthy life expectancy - female | 58.0 | 58.1 | • Baseline measure (2009-11) reported in 2013 | No |
| **Wider Determinants of Health** | | | | | |
| **Indicator** | | **2013 Report** | **2014 Update** | **Comment** | **Change in RAG Rating** |
| 1.01ii | Children in poverty (under 16 years) | 32% (30.8%) | 31.5% (30.6%) | • *This indicator has changed since the last report, which previously reported data for under 20 year olds, shown in brackets, now rebased to show comparison for under 16 year olds*<br>• Marginal decrease in the proportion of children in poverty by 0.5%<br>• 10.9% difference between England average of 20.6%<br>• Remains significantly higher than the England average | No |
| 1.02i | School readiness[a] | 52.0% | 44.2% | • *This indicator has changed since the last report so unable to compare outcomes with previous report*<br>• Remains significantly worse than England average of 51.7% | No |
| 1.03i | Pupil absence | 1.5% | 5.94% | • *This indicator has changed since the last report so unable to compare outcomes with previous report*<br>• Previously recorded % half days of unauthorised absence<br>• Now includes the reporting of % half days of authorised absence<br>• Baseline position significantly worse than England average of 5.26% | No |





[2] RAG rating defines a method of coding indicators in relation to the England Average (EA): **R**ed (significantly worse than EA); **A**mber (significantly similar to EA); **G**reen (significantly better than EA)

[a] Also reported in Children's Outcome Framework

| Wider Determinants of Health (cont) | | | | | |
|---|---|---|---|---|---|
| **Indicator** | | **2013 Report** | **2014 Update** | **Comment** | **Change in RAG Rating** |
| 1.05 | 16-18 year olds not in education, training or employment (NEET)[a] | 7.6% | 6.0% | • Decrease in proportion of NEET by 1.6%<br>• Remains significantly higher than the England average | No |
| 1.12ii | Rate of violent crime (per 1,000 population) | 17.6 | 12.0 | • Significant decrease in the rate by approximately 31.8%<br>• Now similar to the England average of 10.6 | Yes |
| 1.14i | Rate of complaints about noise (per 1,000 population) | 15.9 | 13.1 | • Decrease in the rate of complaints by approximately 17.6%<br>• Remains significantly higher than the England average of 7.5 | No |
| 1.15ii | Statutory Homelessness - (temporary accommodation per 1,000 households) | 3.3 | 0.5 | • *This indicator has been recalculated since the last report*<br>• Now recorded as significantly better than the England average of 2.4<br>• The trend indicates that Wolverhampton has been consistent in achieving significantly better than the England average since 2010/11 | Yes |
| 1.17 | Fuel poverty | 24.3 | 18.3 | • Decrease in the proportion of households in fuel poverty by 6%<br>• Remains significantly higher than the England average of 10.4% | No |
| **Health Improvement** | | | | | |
| **Indicator** | | **2013 Report** | **2014 Update** | **Comment** | **Change in RAG Rating** |
| 2.02i | Breastfeeding: initiation[a] | 65.2% | 64.5% | • Slight decrease in the proportion of mothers initiating breast feeding by 0.7%<br>• Remains significantly lower than the England average of 73.9% | No |
| 2.02ii | Breastfeeding: prevalence at 6-8 weeks after birth[a] | 41.6% | 41.6% | • No change in the proportion of mothers breastfeeding at 6-8 weeks after birth<br>• Remains significantly lower than the England average of 47.2% | No |
| 2.03 | Smoking status at time of delivery[a] | 18.3% | 18.6% | • Nominal increase in the smoking at the time of delivery by 0.3%<br>• Remains significantly higher than the England average of | No |
| 2.04 | Under 18 conceptions[a] (per 1,000 females age 15-17 years) | 55.5 | 42.2 | • Decrease in the rate of under 18 conceptions by 24% between 2010 and 2012<br>• Remains significantly higher than the England average of 27.7% | No |

[a] Also reported in Children's Outcome Framework

| Health Improvement (cont) | | | | | |
|---|---|---|---|---|---|
| **Indicator** | | **2013 Report** | **2014 Update** | **Comment** | **Change in RAG Rating** |
| 2.06i | Reception children classified as obese[a] | 12.6% | 12.7% | • Marginal increase in the proportion of reception classified as obese over 2 years (2010/11 – 2012/13)<br>• Remains significantly higher than England average of 18.9% | No |
| 2.06ii | Year 6 children classified as obese[a] (10-11 years) | 23.8% | 24.4% | • Increase in the proportion of Year 6 children classified as obese by 0.6% over 2 years (2010/11 – 2012/13)<br>• Remains significantly higher than England average of 18.9% | No |
| 2.06i | Excess weight in 4-5 year olds | Not reported | 27.0% | • The prevalence of obese children in reception was reported in 2013<br>• The indicator in this report accounts for overweight and obese children in reception and is significantly higher than the England average of 22.2% | No |
| 2.06ii | Excess weight in in 10-11 year olds | Not reported | 40.6% | • The prevalence of obese children in Year 6 was reported in 2013<br>• The indicator in this report accounts for overweight and obese children in Year 6 and is significantly higher England average of 33.3% | No |
| 2.12 | Adults classified as obese | 27.5% | 28.5% | • An increase in the estimated prevalence of obese adults by 1% between 2006-08 and 2012<br>• Remains significantly higher than England average of 23% | No |
| 2.12 | Excess weight in adults | Not reported | 69.8% | • An estimated prevalence of obese adults was reported in 2013<br>• The estimated indicator in this report accounts for overweight and obese adults and is significantly higher than England average of 63.8% | No |
| 2.17 | Recorded diabetes | 7.10% | 7.70% | • This estimated value of the recorded prevalence of diabetes has increased by 0.6% over two years ( 2010/11 and 2012/13)<br>• Estimated to be significantly higher that the England average of 6.01 | Not RAG rated |
| 2.18 | Alcohol related admissions to hospital (per 100,000) | 2073.0 | 782.0 | • *This indicator has been recalculated since the last report*<br>• Trend remains significantly higher than the England average of 637 | No |
| 2.20i | Breast cancer screening coverage | 73.4% | 70.3% | • *This indicator has been recalculated since the last report*<br>• Trend remains significantly lower than the England average of 76.3% | No |
| 2.20ii | Cervical cancer screening coverage | 76.5% | 70.6% | • *This indicator has been recalculated since the last report*<br>• Trend remains significantly lower than the England average of 73.9% | No |
| 2.21vii | Diabetic retinopathy (eye) screening | 88.6% | 74.6% | • *This indicator has been recalculated since the last report*<br>• Trend remains significantly lower than the England average of 80.9% | No |





[a] Also reported in Children's Outcome Framework

| Health Improvement (cont) | | | | | |
|---|---|---|---|---|---|
| **Indicator** | | **2013 Report** | **2014 Update** | **Comment** | **Change in RAG Rating** |
| 2.23ii | Self-reported wellbeing – people with a low happiness score | 33.5% | 8.8% | • *This indicator has been recalculated since the last report*<br>• Trend now appears similar to the England average of 10.4 | Yes to |
| **Health Protection** | | | | | |
| 3.02i | Chlamydia rate[a] (per 100,000 15-24 year olds) | 2733.5 | 2027 | • *The data collection methodology for this indicator has changed since the last report, therefore not comparable*<br>• Current trend shows an improving rate which is similar to the England average of 2016 | Yes to |
| 3.03v | Pneumococcal Conjugate Vaccine (PCV) Booster[a] | 87.7% | 88.1% | • Marginal increase of 0.4% in vaccine coverage<br>• Remains significantly lower than the England average of 92.5% | No |
| 3.03ix | MMR 1[a] (1 dose at age 2 years) | 90.0% | 92.8% | • Increase of 2.8% in vaccine coverage<br>• Remains similar to the England average of 92.3%, | No |
| 3.03x | MMR 2[a] (2 doses at age 5 years) | Not reported | 76.5% | • Inclusion of this indicator will provide data on completeness of MMR immunisation at age 5 years<br>• Remains significantly lower than the England average of 87.9% | No |
| 3.03xii | HPV[a] coverage | 61.8% | 86.7% | • Increase in coverage by 24.9%<br>• Similar to the England average of 86.7% | Yes to |
| 3.03.xiii | Pneumococcal Polysaccharide Vaccine (PPV) coverage at 65+ | 63.8% | 64.6% | • Marginal decrease of 1.1% in vaccine coverage<br>• Remains significantly lower than the England average of 69.1% | No |
| 3.03xiv | Flu immunisation uptake 65+ | 70.6% | 70.5% | • Marginal decrease of 0.1% in vaccine coverage<br>• Remains significantly lower than the England average of 73.4% | No |
| 3.03xv | Flu immunisation uptake at risk | 50% | 51.6% | • Marginal increase of 1.6% in vaccine coverage<br>• Now similar to the England average of 51.3% | Yes to |
| 3.04 | People presenting with Human Immunodeficiency Virus (HIV) at a late stage of infection | 58.7% | 58.2% | • Marginal decrease of 0.5% in the proportion of people presenting at a late stage of infection<br>• Remains significantly higher than the England average of 48.3% | No |
| 3.05i | Treatment completion for TB | 74.1% | 84.4% | • There has been a 10.3% increase in the proportion of treatment completion for TB<br>• Now similar to the England average of 82.8% | Yes to |

[a] Also reported in Children's Outcome Framework

| Healthcare and Premature Mortality | | | | | |
|---|---|---|---|---|---|
| **Indicator** | | **2013 Report** | **2014 Update** | **Comment** | **Change in RAG Rating** |
| 4.01 | Infant mortality[a] (rate per 1,000 live births) | 7.7 | 7.5 | • Marginal change in the rate of infant mortality<br>• Wolverhampton has the worse recorded rate of infant in England – average 4.1 | No |
| 4.04i | Cardiovascular disease mortality[b] (under 75 rate per 100,00 population) | 85.0 | 105.7 | • *Change in standardisation has artificially inflated the rate – cannot compare to previous report*<br>• Recalculated trend shows improvement in rate from 107.3 in 2009-11<br>• Remains significantly higher than the England average of 81.1 | No |
| 4.05i | Cancer mortality[b] (under 75 rate per 100,00 population) | 125.2 | 158.4 | • *Change in standardisation has artificially inflated the rate – cannot compare to previous report*<br>• Recalculated trend shows improvement in rate from 163.7 in 2009-11<br>• Remains significantly higher than the England average of 146.5 | No |
| 4.06i | Chronic liver disease mortality[b] (under 75 rate per 100,00 population) | 19.3 | 28.0 | • *Change in standardisation has artificially inflated the rate – cannot compare to previous report*<br>• Recalculated trend shows improvement in rate from 30.4 in 2009-11<br>• Remains significantly higher than the England average of 18.0 | No |
| 4.12ii | Preventable sight loss certifications (crude rate per 100,000) | 55.1 | 44.6 | • Decrease in rate of certifications by 19%<br>• Rate now similar to England average of 42.3 | Yes<br>to |
| 4.14i | Hip fracture emergency admission rate 65+ (rate per 100,000) | 535.7 | 548.0 | • *Change in standardisation has altered the rate – cannot compare to previous report*<br>• Recalculated trend shows improvement in rate from 652.0 in 2011/12<br>• Now similar to the England average of 568.1 | Yes<br>to |

[a] Also reported in Children's Outcome Framework; [b] Also reported in NHS Outcomes Framework

**Table 2: NHS Outcomes Framework (also see [b] in Public Health Outcomes Framework)**

| Indicator | | 2013 Report | 2014 Update | Comment | Change in RAG Rating |
|---|---|---|---|---|---|
| **Domain 1: Preventing people from dying prematurely** | | | | | |
| 1.4ii | Breast cancer survival at 5 years (rate per 100,000) | 70.4 | Not reported | There is no updated information reported in the outcomes framework | Not calculated |
| **Domain 2: Enhancing quality of life for people with long term conditions** | | | | | |
| 2.3i | Emergency admissions for chronic conditions usually managed in primary care (adults) (rate per 100,00 population) | 249.1 | 1026.0 | • *Change in indicator methodology – cannot compare to previous report*<br>• Remains significantly higher than the England average of 820.5 | No |
| 2.3ii | Emergency admissions for children with asthma - under 19[a] rate per 100,00 population) | 372.5 | 627.5 | • *Change in indicator methodology combining asthma, epilepsy and diabetes – cannot compare to previous report*<br>• Remains significantly higher than the England average of 340.6 | No |
| 2.3ii | Emergency admissions for children with epilepsy - under 19 (rate per 100,00 population) | 112.8 | | | |
| 2.3ii | Emergency admissions for children with diabetes - under 19 (rate per 100,00 population) | 93.1 | | | |
| 2.5 | Secondary care mental health service users in employment | 6.4% | 34.3% | • *Change in indicator definition – unable to compare with previous report*<br>• Now measures percentage difference in employment of people with mental illness to general population<br>• New indicator similar to England average of 37.0 | Yes<br>to |
| **Domain 3: Helping people recover from episodes of ill health or following injury** | | | | | |
| 3a | Emergency hospital admissions for acute condition usually managed in primary care (rate per 100,000 registered patients) | 687.5 | 1320.3 | • *Change in standardisation has artificially inflated the rate – cannot compare to previous report*<br>• Remains significantly higher than the England average of 1204.3 | No |





[a] Also reported in Children's Outcome Framework

| | | | | | |
|---|---|---|---|---|---|
| **Domain 4: Ensuring that people have a positive experience of care** | | | | | |
| 4ai | Patients satisfied with their GP surgery experience | 85% | 84% | • Marginal decrease of 1% in patient satisfaction with GP surgery experience<br>• Remains significantly lower than England average of 86% | No |
| **Domain 5: Treat/care in a safe environment and protect from avoidable harm** | | | | | |
| 5a | Patient safety incidents | 9.3% | 8.2% | • Decrease of 1.1% in proportion of patient safety incidents<br>• Remains significantly higher than England average of 7.2% | No |
| 5.2i | Incidence of healthcare acquired C.Diffe infection (rate per 100,000 bed days) | 39.0 | 14.9 | • Decrease in rate by 62%<br>• Now similar to the England average of 14.6 | Yes to |

**Table 3: Adult Social Care Outcomes Framework**

| **Domain 1: Enhancing quality of life for people with care and support needs** | | | | | |
|---|---|---|---|---|---|
| **Indicator** | | **2013 Report** | **2014 Update** | **Comment** | **Change in RAG Rating** |
| 1E | Adults with learning disabilities in paid employment | 2.4% | 2.2% | • Nominal decrease of 0.2% in the employment of adults with learning disabilities<br>• Remains significantly lower than England average of 6.8% | No |
| **Domain 2: Delaying and reducing the need for care and support** | | | | | |
| 2A | Permanent admission of younger adults (16-64) to residential and nursing care homes (rate per 100,000) | 45.1 | 13.1 | • Decrease in rate of permanent admissions by 70.9%<br>• Rate now similar to England average of 13.5 | Yes to |
| 2C (1) | Delayed transfers of care from hospital (rate per 100,000 population) | 13.9 | 8.3 | • Decrease in rate of delayed transfers of care from hospital by 40.2%<br>• Rate now the same as England average of 8.3 | Yes to |
| 2C (2) | Delayed transfers due to adult social care (rate per 100,000 population) | 8.7 | 4.1 | • Decrease in rate of delayed transfers due to social care by 52.8%<br>• Rate now similar to England average of 2.2 | Yes to |

**Children's Outcomes Framework (see [a] in Public Health and NHS Outcomes Framework)**

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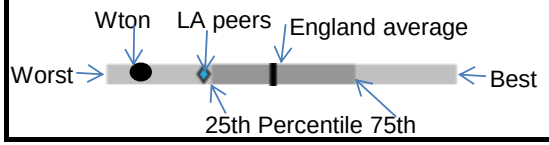
**Significance Key :**

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

**Chart Key:**




| ASCOF all data is for 2012-13 updated at 19/8/2014 | Wton Number | Wton Value | Eng Median Value | Eng Worst | England Range | Eng Best |
|---|---|---|---|---|---|---|
| 1A - Social care-related quality of life (points out of 24) | n/a | 19.4 | 18.9 | 17.7 | | 20.5 |
| 1B - % of people who use services who have control over their daily life | n/a | 77.6 | 76.5 | 64.4 | | 90.9 |
| 1C(1) - % of people using social care who receive self-directed support | 2140 | 73.4 | 66.1 | 25.4 | | 138.1 |
| 1C(2) - % of people using social care who receive direct payments | 970 | 23.3 | 18.6 | 6.1 | | 47.1 |
| *1D Carer-reported quality of life (placeholder)* | | | | | | |
| 1E - % of adults with learning disabilities in paid employment | 40 | 2.2 | 6.6 | 0.9 | | 23.1 |
| 1F - % of adults in contact with secondary mental health services in paid employment | n/a | 3.9 | 5.8 | 1.6 | | 17.5 |
| 1G - % of adults with learning disabilities who live in their own home or with their family | 530 | 69.0 | 75.4 | 47.7 | | 94.5 |
| 1H - % of adults in contact with secondary mental health services who live independently, with or without support | n/a | 78.9 | 67.0 | 12.6 | | 93.3 |
| 1I(1) - % of people who use services who reported that they had as much social contact as they would like | 1080 | 45.8 | 43.9 | 29.7 | | 54.4 |
| *1I(2) - Carers with as much social contact as they would like (placeholder)* | | | | | | |
| 2A(1) - Permanent admissions of younger adults (aged 18 to 64) to residential and nursing care homes, per 100,000 | 10 | 13.1 | 13.5 | 44.8 | | 3.6 |
| 2A(2) - Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 | 215 | 736.0 | 673.0 | 1277.4 | | 207.5 |
| 2B(1) - % 65 and over still at home 91 days after discharge from hospital into reablement/rehabilitation (effectiveness service) | 325 | 85.8 | 85.2 | 58.9 | | 100.0 |
| 2B(2) - % 65 and over still at home 91 days after discharge from hospital into reablement/rehabilitation (offered service) | 430 | 5.6 | 3.1 | 0.6 | | 25.8 |
| 2C(1) - Delayed transfers of care from hospital per 100,000 population | 10 | 8.3 | 8.3 | 27.2 | | 1.3 |
| 2C(2) - Delayed transfers of care from hospital which are attributable to adult social care per 100,000 population | 6 | 4.1 | 2.2 | 13.7 | | 0.3 |
| 3A - % overall satisfaction of people who use services with their care and support | n/a | 62.5 | 64.7 | 45.5 | | 83.7 |
| *3B - Carer satisfaction with social services (placeholder)* | | | | | | |
| *3C - Carers incuded or consulted in decisions (placeholder)* | | | | | | |
| 3D(1) - % of people who use services and carers who find it easy to find information about services | n/a | 74.3 | 74.4 | 65.0 | | 86.4 |
| *3D(2) Carers who find it easy to get information (placeholder)* | | | | | | |
| 4A - % of people who use services who feel safe | n/a | 73.2 | 66.0 | 54.7 | | 81.8 |
| 4B - % of people who use services who say that those services have made them feel safe and secure | n/a | 82.5 | 80.6 | 53.8 | | 94.3 |

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**Key:**

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

**Regional Key:**


**CHOF updated at 19/8/2014**

| | Indicator | Local Number | Local Value | Eng Avg | Eng Worst | England Range | Eng Best |
|---|---|---|---|---|---|---|---|
| Health Improvement | 1 Infant mortality rate per 1,000 2010-2012 | 80 | 7.5 | 4.1 | 7.5 | | 1.1 |
| | 2 Under 18 conceptions rate per 1,000 2012 | 194 | 42.2 | 27.7 | 52.0 | | 14.2 |
| | 3 % mothers aged under 18 2012/13 | 74 | 2.2 | 1.2 | 3.1 | | 0.2 |
| | 4 Rate per 100,000 under 18 year olds for alcohol specific hospital admissions 2010/11-2012/13 | 18 | 32.1 | 42.7 | 113.5 | | 14.6 |
| | 5 % children consumed alcohol in the last week 2012 (no longer available) | | | | | | |
| | 6 % children who had tried drugs 2012 (no longer available) | | | | | | |
| | 7 % children who had tried smoking 2012 (no longer available) | | | | | | |
| | 8 Breastfeeding initiation % 2012/13 | 2055 | 64.5 | 73.9 | 40.8 | | 94.7 |
| | 9 Excess weight in 4-5 year olds % 2012/13 | 776 | 27.0 | 22.2 | 32.2 | | 16.1 |
| | 10 Excess weight in 10-11 year olds % 2012/13 | 1000 | 40.6 | 33.3 | 44.2 | | 24.1 |
| | 11 Mean tooth decay in children aged 5 2011/12 | n/a | 1.0 | 0.9 | 2.1 | | 0.3 |
| | 12 Rate per 100,000 under 18 year olds for substance misuse admissions 2010/11-2012/13 | 17 | 49.5 | 75.2 | 218.4 | | 25.4 |
| | 13 Child mortality rate per 1,000 (1-17) 2010-2012 | 7 | 13.8 | 12.5 | 21.7 | | 4.0 |
| | 14 % low birth weight of term babies 2011 | 115 | 3.5 | 2.8 | 5.3 | | 1.6 |
| | 15 % breastfeeding prevalence at 6-8 weeks after birth 2012/13 | 1472 | 41.6 | 47.2 | 17.5 | | 83.3 |
| | 16 % smoking at time of delivery 2012/13 | 594 | 18.6 | 12.7 | 30.8 | | 2.3 |
| | 17 rate per 100,000 0-17 hospital admissions for mental health conditions 2012/13 | 51 | 90.5 | 87.6 | 434.8 | | 28.7 |
| | 18 rate per 100,000 10-24 hospital admissions for self-harm 2012/13 | 140 | 282.7 | 346.3 | 1152.4 | | 82.4 |
| Health Protection/Stay Safe | 19 Children in care rate per 10,000 under 18 2013 | 660 | 118.0 | 60.0 | 166.0 | | 20.0 |
| | 20 Bullying (no longer available) | | | | | | |
| | 21 Family homelessness per 1,000 households 2012/13 | 280 | 2.8 | 1.7 | 9.5 | | 0.1 |
| | 22 % vaccination coverage - Hepatitis B (1 year old) 2012/13* | | | | | | |
| | 23 % vaccination coverage - Hepatitis B (2 years old) 2012/13* | | | | | | |
| | 24 % vaccination coverage - Dtap / IPV / Hib (1 year old) 2012/13 | 3352 | 94.7 | 94.7 | 79.0 | | 99.0 |
| | 25 % vaccination coverage - Dtap / IPV / Hib (2 years old) 2012/13 | 3243 | 96.7 | 96.3 | 81.9 | | 99.4 |
| | 26 % vaccination coverage - MenC 2012/13 | 3336 | 94.2 | 93.9 | 75.9 | | 98.8 |
| | 27 % vaccination coverage - PCV 2012/13 | 3344 | 94.4 | 94.4 | 78.7 | | 99.0 |
| | 28 % vaccination coverage - Hib / MenC booster (2 years old) 2012/13 | 3118 | 92.9 | 92.7 | 77.0 | | 98.3 |
| | 29 % vaccination coverage - Hib / Men C booster (5 years) 2012/13 | 3040 | 89.9 | 91.5 | 75.7 | | 98.1 |
| | 30 % vaccination coverage - PCV booster 2012/13 | 2957 | 88.1 | 92.5 | 75.1 | | 97.5 |
| | 31 % vaccination coverage - MMR for one dose (2 years old) 2012/13 | 3115 | 92.8 | 92.3 | 77.4 | | 98.4 |
| | 32 % vaccination coverage - MMR for one dose (5 years old) 2012/13 | 3110 | 91.9 | 93.9 | 82.1 | | 98.3 |
| | 33 % vaccination coverage - MMR for two doses (5 years old) 2012/13 | 2587 | 76.5 | 87.7 | 68.9 | | 97.0 |
| | 34 % vaccination coverage - HPV 2012/13 | 1104 | 86.7 | 86.1 | 62.1 | | 96.2 |
| | 35 Children in care immunisations % uptake 2013 | 445 | 95.7 | 83.2 | 0.0 | | 100.0 |
| | 36 Rate per 10,000 (age 0-14 years) for emergency hospital admissions following injury, 2012/13 | 446 | 95.5 | 103.8 | 191.3 | | 61.7 |
| | 37 Rate per 100,000 aged 0-15 killed or seriously injured in road traffic accidents 2010-2012 | 16 | 33.0 | 20.7 | 45.6 | | 6.3 |
| | 38 Chlamydia screening detection rate per 100,000 (15-24 year olds) - CTAD 2013 | 697 | 2026.6 | 2015.6 | 5758.5 | | 840.0 |
| Wellbeing, enjoy & achieve | 39 Physical activity (no longer avaliable) | | | | | | |
| | 40 % of children achieving a good level of development at the end of reception 2012/13 | 1398 | 44.2 | 51.7 | 27.7 | | 69.0 |
| | 41 GCSE % achieved 5 A*-C in. English and Maths 2012/13 | 1618 | 61.0 | 60.8 | 43.7 | | 80.2 |
| | 42 GCSE % achieved 5 A*-G in. English and Maths 2012/13 | 2480 | 93.5 | 90.5 | 87.5 | | 99.4 |
| | 43 GCSE % children in care achieving 5 A*-C in. English and Maths 2013 | 10 | 25.8 | 15.3 | 0.0 | | 41.7 |
| | 44 Children who have someone to talk to (no longer avaliable) | | | | | | |
| | 45 % of children achieving level 2 at key stage 1 2012-13 | n/a | 84.0 | 52.0 | 28.0 | | 100.0 |
| | 46 pupils who voted in school elections (no longer avaliable) | | | | | | |
| | 47 Pupil absence % half days missed 2012/13 | 671504 | 5.9 | 5.3 | 6.3 | | 3.6 |
| | 48 First time entrants to the youth justice system rate per 100,000 10-17 years 2013 | 128 | 531.4 | 440.9 | 846.5 | | 171.0 |
| | 49 % children in poverty (under 16s) 2011 | 15545 | 31.5 | 20.6 | 43.6 | | 6.9 |
| | 50 % 16-18 year olds not in education employment or training 2013 | 530 | 6.0 | 5.3 | 9.8 | | 1.8 |

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**Regional Key:**

National average

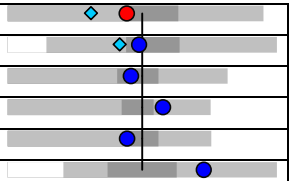
Wton LA peers

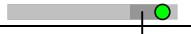
Worst — Best

25th Pecentile 75th

**NHSOF updated at 19/8/2014**

| | Indicator | Local Number | Local Value | Eng Avg | Eng Worst | England Range | Eng Best |
|---|---|---|---|---|---|---|---|
| 1. Preventing people from dying prematurely | 1a Potential years of life lost rate per 100,000 from causes amenable to health care 2012 | n/a | 2810.5 | 2302.7 | 3783.3 | | 1095.6 |
| | 1ai Potential years of life lost rate per 100,000 aged 20+ from causes amenable to health care 2012 | n/a | 3351.1 | 2801.4 | 4758.5 | | 1039.6 |
| | *1aii Potential years of life lost rate per 100,000 aged u20 from causes amenable to health care 2012 (placeholde* | | | | | | |
| | 1b Life expectancy at 75 (Male) 2010-12 | n/a | 11.1 | 11.5 | 10.0 | | 13.6 |
| | 1b Life expectancy at 75 (Female) 2010-12 | n/a | 12.8 | 13.9 | 11.6 | | 15.9 |
| | 1.1 Cardiovascular disease mortality rate per 100,000 population aged under 75 2010-12 | 601 | 105.7 | 96.9 | 144.7 | | 55.7 |
| | 1.2 Mortality from chronic respiratory disease rate per 100,000 population aged under 75 2010-12 | 259 | 46.8 | 33.5 | 81.6 | | 20.5 |
| | 1.3 Mortality from chronic liver disease rate per 100,000 population aged under 75 2010-12 | 166 | 28.0 | 18.0 | 41.6 | | 10.3 |
| | 1.4 Cancer mortality rate per 100,000 population aged under 75 2010-12 | 888 | 158.4 | 146.5 | 207.3 | | 113.5 |
| | 1.4i One year cancer survival from 2011 diagnosis | n/a | 68.6 | 68.2 | 61.8 | | 76.2 |
| | *1.4ii Five year cancer survival (placeholder)* | | | | | | |
| | 1.4iii One year breast, lung and colorectal cancer survival from 2011 diagnosis | n/a | 71.0 | 69.5 | 62.1 | | 76.1 |
| | *1.4iv Five year breast, lung and colorectal cancer survival from 2011 diagnosis (placeholder)* | | | | | | |
| | 1.5 Excess under 75 mortality rate in adults with serious mental illness 2011/12 | n/a | 328.4 | 337.4 | 510.4 | | 124.7 |
| | 1.6i Infant mortality rate per 1,000 live births 2010-2012 | 83 | 7.7 | 4.3 | 7.7 | | 0.0 |
| | 1.6ii Still birth and neonatal mortality rate per 1,000 2012 | 34 | 9.6 | 7.6 | 17.5 | | 0.0 |
| | *1.6iii Five year cancer survival in children (placeholder)* | | | | | | |
| | *1.7 Excess under 60 mortality in people with a learning disability (placeholder)* | | | | | | |
| 2.Enhancing quality of life for people with long term conditions | 2 Health related quality of life for people with long term conditions Jul 12-Mar 13 | 1480 | 0.7 | 0.7 | 0.6 | | 0.8 |
| | 2.1 % of people feeling supported to manage their condition Jul 12-Mar 13 | 1038 | 62.3 | 65.6 | 54.3 | | 78.9 |
| | 2.2 % difference in employment of people with long term conditions compared to the general population Q4 13/1 | 18300 | 18.9 | 13.9 | 0.6 | | 28.6 |
| | 2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions 2012/13 | 2556 | 1026.0 | 820.5 | 1597.0 | | 217.3 |
| | 2.3ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s 2012/13 | 375 | 627.5 | 340.6 | 892.8 | | 0.0 |
| | 2.4 Enhancing quality of life for carers 2012/13 | 589 | 0.8 | 0.8 | 0.8 | | 0.9 |
| | 2.5 % difference in employment of people with mental illness to the general population Q4 13/14 | 2500 | 34.3 | 37.0 | -18.0 | | 51.4 |
| | *2.6i Estimated diagnosis rate for people with dementia (placeholder)* | | | | | | |
| | *2.6ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of* | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. Helping people to recover from episodes of ill health or following injury | 3a Emergency admissions for acute conditions that should not usually require hospital admission 2012/13 | 3627 | 1320.3 | 1204.3 | 2209.1 |  | 299.7 |
| | 3b Emergency readmissions within 30 days of discharge from hospital | n/a | 11.9 | 11.8 | 14.5 | | 7.9 |
| | 3.1i Effective recovery following hip replacement 2011-12 | n/a | 0.4 | 0.4 | 0.3 | | 0.5 |
| | 3.1ii Effective recovery following knee replacement 2011-12 | n/a | 0.3 | 0.3 | 0.2 | | 0.4 |
| | 3.1iii Effective recovery following hernia 2011-12 | n/a | 0.1 | 0.1 | 0.0 | | 0.1 |
| | 3.1iv Effective recovery following varicose veins 2011-12 | n/a | 0.1 | 0.1 | 0.1 | | 0.2 |
| | *3.1v Effective recovery following psychological therapies (placeholder)* | | | | | | |
| | 3.2 Emergency admissions for children with lower respiratory tract infections 2012/13 | 291 | 464.7 | 371.2 | 745.0 | | 115.9 |
| | *3.3 Survival from major trauma (placeholder)* | | | | | | |
| | *3.4 Recovery from stroke (placeholder)* | | | | | | |
| | *3.5i Proportion of patients recovering to their previous levels of mobility at 30 days (placeholder)* | | | | | | |
| | *3.5ii Proportion of patients recovering to their previous levels of mobility at 120 days (placeholder)* | | | | | | |
| | 3.6i Proportion of those aged 65 and over who were still at home 91 days after dicharge from hospital 2012/13 | 130 | 85.6 | 81.4 | 53.7 | | 98.7 |
| | 3.6ii Proportion offered rehab following discharge from hospital 2012/13 | 380 | 5.8 | 3.2 | 0.4 | | 25.4 |
| 4.Ensuring that people have a positive experience of care | 4ai % of patients that rated overall experience of GP's as good or very good Jul-Sep 13 and Jan-Mar 14 | 3448 | 84.0 | 86.0 | 70.0 | | 93.0 |
| | 4aii % of patients that rated out of hours experience of GP's as good or very good Jul-Sep 13 and Jan-Mar 14 | 378 | 64.0 | 66.0 | 49.0 | | 86.0 |
| | 4aiii % of patients that rated experience of NHS dental services as good or very good Jul-Sep 13 and Jan-Mar 1 | 1042 | 86.0 | 84.0 | 70.0 | | 91.0 |
| | 4b Patient experience of NHS inpatient care, overall satisfaction 2013/14* | n/a | 75.7 | 76.9 | 59.0 | | 87.0 |
| | 4c Friends and family test score regarding A&E and inpatient experience* | n/a | 47.0 | 47.0 | 22.0 | | 97.0 |
| | 4.1 Patient experience of outpatient care overall satisfaction 2011* | n/a | 77.9 | 79.5 | 71.0 | | 88.5 |
| | 4.2 Responsiveness to inpatient personal needs 2013/14* | n/a | 66.8 | 68.7 | 54.4 | | 84.2 |
| | 4.3 Patients experience of A&E 2012* | n/a | 74.4 | 79.1 | 71.3 | | 86.6 |
| | 4.4i % of patients that rated overall experience of making an appointment as good or very good Jul-Sep 13 and | 2982 | 74.0 | 75.0 | 55.0 | | 88.0 |
| | 4.4ii % of patients that successfully made an appointment with the dentist Jul-Sep 13 and Jan-Mar 15 | 1138 | 93.0 | 93.0 | 77.0 | | 98.0 |
| | *4.5 Women's experience of maternity services (placeholder)* | | | | | | |
| | *4.6 Bereaved carers views on the quality of care in the last 3 months of life (placeholder)* | | | | | | |
| | 4.7 Patient experience of community mental health services 2013** | n/a | 83.5 | 85.8 | 80.9 | | 90.9 |
| | *4.8 Children and young peoples experience of outpatient services (placeholder)* | | | | | | |
| | *4.9 Peoples experience of integrated care (placeholder)* | | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 5.Treat/care in a safe enviroment & protect from avoidable harm | 5a Patient safety incidents reported per 100 admissions Oct 12-Mar 13* | 4202 | 8.2 | 7.2 | 12.7 |  | 3.0 |
| | 5b Patient safety incidents resulting in severe harm or death reported per 100 admissions Oct 12-Mar 13* | 17 | 0.0 | 0.1 | 0.1 |  | 0.0 |
| | *5c Hospital deaths attributable to problems in care (placeholder)* | | | | | | |
| | *5.1 Incidence of venous thromboembolism related events (placeholder)* | | | | | | |
| | 5.2i Incidence of helthcare associated MRSA infection 2013-14 rate per 100,000 bed days* | <5 | 0.4 | 1.2 | 4.6 |  | 0.0 |
| | 5.2ii Incidence of helthcare associated C.Diff infection 2013-14 rate per 100,000 bed days* | 39 | 14.9 | 14.6 | 37.1 |  | 0.0 |
| | *5.3 Incidence of newly acquired category 2, 3 and 4 pressure ulcers (placeholder)* | | | | | | |
| | 5.4 % of medication error causing a patient safety incident Apr 2013-Sep 2013* | 331 | 7.7 | 10.6 | 29.9 |  | 5.5 |
| | 5.5 Admission of full-term babies to neonatal care 2011*** | 194 | 5.8 | 6.0 | 25.1 |  | 0.9 |
| | *5.6 Incidence of harm to children due to failure to monitor (placeholder)* | | | | | | |
| | * data is for The Royal Wolverhampton NHS Trust | | | | | | |
| | ** data is for Black Country Partnership NHS Foundation Trust | | | | | | |
| | *** data is for Wolverhampton City PCT | | | | | | |

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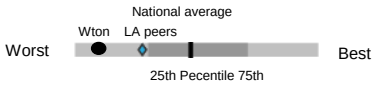
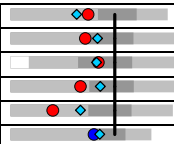
**Regional Key:**




**PHOF updated at 19/8/2014**

| | Indicator | Local Number | Local Value | Eng Avg | Eng Worst | England Range | Eng Best |
|---|---|---|---|---|---|---|---|
| Overarching indicator | 0.1i - Healthy life expectancy at birth 2010 - 12 | n/a | 58.3 | 63.4 | 52.5 | | 70.0 |
| | 0.1i - Healthy life expectancy at birth 2010 - 12 | n/a | 58.1 | 64.1 | 55.5 | | 71.0 |
| | 0.1ii - Life Expectancy at birth 2010 - 12 | n/a | 77.4 | 79.2 | 74.0 | | 82.1 |
| | 0.1ii - Life Expectancy at birth 2010 - 12 | n/a | 81.7 | 83.0 | 79.5 | | 85.9 |
| | 0.1ii - Life Expectancy at 65 2010 - 12 | n/a | 17.7 | 18.6 | 15.8 | | 20.9 |
| | 0.1ii - Life Expectancy at 65 2010 - 12 | n/a | 20.3 | 21.1 | 18.8 | | 23.8 |
| 1. Wider determinants of Health | 1.01i - Children in poverty (all dependent children under 20) 2011 | 17,720 | 30.6 | 20.1 | 46.1 | | 6.6 |
| | 1.01ii - Children in poverty (under 16s) 2011 | 15,545 | 31.5 | 20.6 | 43.6 | | 6.9 |
| | 1.02i - The % of children achieving a good level of development at the end of reception 2012/13 | 1,398 | 44.2 | 51.7 | 27.7 | | 69.0 |
| | 1.02i - The % of children with free school meal status achieving a good level of development at the end of reception 2012/13 | 332 | 34.8 | 36.2 | 17.8 | | 60.0 |
| | 1.02ii - The % of Year 1 pupils achieving the expected level in the phonics screening check 2012/13 | 2,032 | 65.8 | 69.1 | 58.8 | | 79.0 |
| | 1.02ii - The % of Year 1 pupils with free school meal status achieving the expected level in the phonics screening check 2012/13 | 544 | 57.4 | 55.8 | 37.2 | | 70.9 |
| | 1.03 - Pupil absence 2012/13 | 671,504 | 5.9 | 5.3 | 6.3 | | 3.6 |
| | 1.04 - First time entrants to the youth justice system 2013 | 128 | 531.4 | 440.9 | 846.5 | | 171.0 |
| | 1.05 - 16-18 year olds not in education employment or training 2013 | 530 | 6.0 | 5.3 | 9.8 | | 1.8 |
| | 1.06i - Adults with a learning disability who live in stable and appropriate accommodation 2012/13 | 410 | 67.8 | 73.5 | 32.6 | | 96.6 |
| | 1.06ii - % of adults in contact with secondary mental health services who live in stable and appropriate accommodation 2012/13 | 785 | 79.1 | 58.5 | 5.5 | | 94.1 |
| | *1.07 - People in prison who have a mental illness or a significant mental illness (not applicable)* | | | | | | |
| | 1.08i - Gap in the employment rate between those with a long-term health condition and the overall employment rate 2012 | n/a | 12.8 | 7.1 | 21.7 | | -5.3 |
| | 1.08ii - Gap in the employment rate between those with a learning disability and the overall employment rate 2011/12 | n/a | 59.8 | 63.2 | 73.1 | | 40.2 |
| | 1.08iii - Gap in the employment rate for those in contact with secondary mental health services and the overall rate 2012/13 | n/a | 57.1 | 62.3 | 75.1 | | 53.1 |
| | 1.09i - Sickness absence - The percentage of employees who had at least one day off in the previous week 2009 - 11 | n/a | 1.6 | 2.2 | 3.5 | | 0.6 |
| | 1.09ii - Sickness absence - The percent of working days lost due to sickness absence 2009 - 11 | n/a | 1.1 | 1.5 | 2.7 | | 0.3 |
| | *1.09iii - Rate of fit notes issued per quarter (placeholder)* | | | | | | |
| | 1.10 - Killed and seriously injured (KSI) casualties on England's roads 2010 - 12 | 254 | 33.9 | 40.5 | 81.8 | | 16.9 |
| | 1.11 - Domestic Abuse 2012/13 (Police force area level only) | n/a | 13.3 | 18.8 | 30.2 | | 5.6 |
| | 1.12i - Violent crime (including sexual violence) - hospital admissions for violence 2010/11 - 12/13 | 463 | 57.1 | 57.6 | 167.8 | | 9.3 |
| | 1.12ii - Violent crime (including sexual violence) - violence offences per 1,000 population 2012/13 | 2,997 | 12.0 | 10.6 | 27.1 | | 4.1 |
| | 1.12iii- Violent crime (including sexual violence) - rate of sexual offences per 1,000 population 2012/13 | 217 | 0.9 | 0.8 | 2.0 | | 0.3 |
| | 1.13i - Re-offending levels - percentage of offenders who re-offend 2011 | 882 | 28.0 | 26.9 | 36.3 | | 14.4 |
| | 1.13ii - Re-offending levels - average number of re-offences per offender 2011 | 2,589 | 0.8 | 0.8 | 1.3 | | 0.3 |
| | 1.14i - The rate of complaints about noise 2011/12 | 3,274 | 13.1 | 7.5 | 58.4 | | 2.5 |
| | 1.14ii - The % of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime 2011 | 11,880 | 4.8 | 5.2 | 20.8 | | 0.8 |
| | 1.14iii - The % of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time 2011 | 16,820 | 6.7 | 8.0 | 42.4 | | 1.2 |
| | 1.15i - Statutory homelessness - homelessness acceptances 2012/13 | 372 | 3.7 | 2.4 | 11.4 | | 0.2 |
| | 1.15ii - Statutory homelessness - households in temporary accommodation 2012/13 | 54 | 0.5 | 2.4 | 33.2 | | 0.0 |
| | 1.16 - Utilisation of outdoor space for exercise/health reasons Mar 2012 - Feb 2013 | n/a | 9.4 | 15.3 | 0.5 | | 41.2 |
| | 1.17 - Fuel Poverty 2012 | 18,316 | 18.3 | 10.4 | 21.3 | | 4.9 |
| | 1.18i - Social Isolation: % of adult social care users who have as much social contact as they would like 2012/13 | n/a | 46.3 | 43.2 | 31.9 | | 53.5 |
| | 1.18ii - Social Isolation: % of adult carers who have as much social contact as they would like 2012/13 | n/a | 33.2 | 41.3 | 23.9 | | 60.9 |
| | *1.19i - Older peoples perception of community safety - safe in local area during the day (placeholder)* | | | | | | |
| | *1.19ii - Older peoples perception of community safety - safe in local area after dark (placeholder)* | | | | | | |
| | *1.19iii - Older peoples perception of community safety - safe in own home at night (placeholder)* | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 2.01 - Low birth weight of term babies 2011 | 115 | 3.5 | 2.8 | 5.3 |  | 1.6 |
| 2.02i - Breastfeeding - Breastfeeding initiation 2012/13 | 2,055 | 64.5 | 73.9 | 40.8 | | 94.7 |
| 2.02ii - Breastfeeding - Breastfeeding prevalence at 6-8 weeks after birth 2012/13 | 1,472 | 41.6 | 47.2 | 17.5 | | 83.3 |
| 2.03 - Smoking status at time of delivery 2012/13 | 594 | 18.6 | 12.7 | 30.8 | | 2.3 |
| 2.04 - Under 18 conceptions 2012 | 194 | 42.2 | 27.7 | 52.0 | | 14.2 |
| 2.04 - Under 18 conceptions: conceptions in those aged under 16 2012 | 35 | 7.6 | 5.6 | 15.8 | | 2.0 |
| *2.05i - Children aged 2-2½yrs who received a review or an assessment as part of the Healthy Child Programme (placeholder)* | | | | | | |
| *2.05ii - Children aged 2-2½yrs offered ASQ-3 as part of the Healthy Child Programme or integrated review (placeholder)* | | | | | | |
| *2.05 iii - Children aged 2-2½yrs who receive an ASQ-3 score within the expected range (placeholder)* | | | | | | |
| 2.06i - Excess weight in 4-5 and 10-11 year olds - 4-5 year olds 2012/13 | 776 | 27.0 | 22.2 | 32.2 | | 16.1 |
| 2.06ii - Excess weight in 4-5 and 10-11 year olds - 10-11 year olds 2012/13 | 1,000 | 40.6 | 33.3 | 44.2 | | 24.1 |
| 2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) 2012/13 | 446 | 95.5 | 103.8 | 191.3 | | 61.7 |
| 2.07i - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-4 years) 2012/13 | 225 | 129.6 | 134.7 | 282.4 | | 76.0 |
| 2.07ii - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24) 2012/13 | 354 | 102.9 | 130.7 | 277.3 | | 63.8 |
| 2.08 - Emotional well-being of looked after children 2012/13 | n/a | 12.6 | 14.0 | 9.4 | | 21.5 |
| *2.09 - Prevalence of smoking among 15 years olds (placeholder)* | | | | | | |
| *2.10i - Attendances at A&E for self-harm per 100,000 population (placeholder)* | | | | | | |
| *2.10ii - Percentage of attendances at A&E for self-harm that received a psychosocial assessment (placeholder)* | | | | | | |
| *2.11i - Proportion of the population meeting the recommended '5 -A -Day'(placeholder)* | | | | | | |
| *2.11ii - Average number of portions of fruit consumed daily (placeholder)* | | | | | | |
| *2.11iii - Average number of portions of vegetables consumed daily (placeholder)* | | | | | | |
| 2.12 - Excess Weight in Adults 2012 | 437 | 69.8 | 63.8 | 74.4 | | 45.9 |
| 2.13i - Percentage of physically active and inactive adults - active adults 2013 | 238 | 53.3 | 55.6 | 43.4 | | 66.3 |
| 2.13ii - Percentage of active and inactive adults - inactive adults 2013 | 192 | 35.7 | 28.9 | 39.2 | | 16.3 |
| 2.14 - Smoking Prevalence 2012 | n/a | 22.9 | 19.5 | 29.8 | | 12.1 |
| 2.14 - Smoking prevalence - routine & manual 2012 | n/a | 31.7 | 29.7 | 44.3 | | 14.2 |
| 2.15i - Successful completion of drug treatment - opiate users 2012 | 91 | 8.2 | 8.2 | 3.8 | | 17.6 |
| 2.15ii - Successful completion of drug treatment - non-opiate users 2012 | 192 | 45.3 | 40.2 | 17.4 | | 68.4 |
| *2.16 - People assessed for substance dependence issues when entering prison who required treatment (placeholder)* | | | | | | |
| 2.17 - Recorded diabetes 2012/13 | 16,043 | 7.7 | 6.0 | 8.4 | | 3.7 |
| 2.18 - Alcohol related admissions to hospital 2012/13 | 1,782 | 781.9 | 636.9 | 1120.6 | | 365.0 |
| 2.19 - Cancer diagnosed at early stage (Experimental Statistics) 2012 | 350 | 41.4 | 41.6 | 34.4 | | 60.3 |
| 2.20i - Cancer screening coverage - breast cancer 2013 | 16,717 | 70.3 | 76.3 | 58.2 | | 84.5 |
| 2.20ii - Cancer screening coverage - cervical cancer 2013 | 44,602 | 70.6 | 73.9 | 58.6 | | 79.9 |
| *2.21i - % of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result (placeholder)* | | | | | | |
| *2.21ii - % of women booked for antenatal care, who have a screening test for syphilis, hep B and rubella leading to a conclusive result (placeholder)* | | | | | | |
| *2.21iii - % of pregnant women eligible for antenatal sickle cell & thalassaemia screening for whom a result is available (placeholder)* | | | | | | |
| *2.21iv - % of babies registered eligible for newborn blood spot screening with a conclusive result recorded within an effective timeframe (placeholder)* | | | | | | |
| *2.21v - % of babies eligible for newborn hearing screening for whom this process is complete within the appropriate time period (placeholder)* | | | | | | |
| *2.21vi - % of babies eligible for the newborn physical examination who were tested within 72 hours of birth (placeholder)* | | | | | | |
| 2.21vii - Diabetic retinopathy 2011/12 | 10,680 | 74.6 | 80.9 | 66.7 | | 95.0 |
| 2.22i - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check 2013/14 | 26,924 | 39.4 | 18.5 | 0.8 | | 44.4 |
| 2.22ii - Cumulative % of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check 2013/14 | 6,396 | 23.8 | 49.0 | 14.6 | | 100.0 |
| 2.22iii - Cumulative % of the eligible population aged 40-74 who received an NHS Health check 2013/14 | 6,396 | 9.4 | 9.0 | 0.9 | | 29.1 |
| 2.23i - Self-reported well-being - people with a low satisfaction score 2012/13 | n/a | 7.3 | 5.8 | 10.1 | | 3.4 |
| 2.23ii - Self-reported well-being - people with a low worthwhile score 2012/13 | n/a | 4.6 | 4.4 | 8.2 | | 2.9 |
| 2.23iii - Self-reported well-being - people with a low happiness score 2012/13 | n/a | 8.8 | 10.4 | 15.8 | | 5.5 |
| 2.23iv - Self-reported well-being - people with a high anxiety score 2012/13 | n/a | 10.9 | 21.0 | 29.0 | | 10.9 |
| *2.23v - Self-reported well-being - Average Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) score for adults (16+) (placeholder)* | | | | | | |
| 2.24i - Injuries due to falls in people aged 65 and over (Persons) 2012/13 | 592 | 1304.7 | 2011.0 | 3508.0 | | 1177.5 |
| 2.24ii - Injuries due to falls in people aged 65 and over - aged 65-79 2012/13 | 193 | 653.0 | 975.0 | 1826.4 | | 544.3 |
| 2.24iii - Injuries due to falls in people aged 65 and over - aged 80+ 2012/13 | 399 | 3194.5 | 5015.3 | 9118.7 | | 2875.6 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. Health Protection | 3.01 - Fraction of mortality attributable to particulate air pollution 2012 | n/a | 5.3 | 5.1 | 8.3 |  | 3.0 |
| | 3.02i - Chlamydia screening detection rate (15-24 year olds) - Old NCSP data 2011 | 900 | 2591.3 | 2092.3 | 948.0 |  | 4910.5 |
| | 3.02ii - Chlamydia screening detection rate (15-24 year olds) - CTAD 2013 | 697 | 2026.6 | 2015.6 | 840.0 |  | 5758.5 |
| | 3.03i - Population vaccination coverage - Hepatitis B (1 year old) 2012/13 local only | 14 | 93.3 | | | | |
| | 3.03i - Population vaccination coverage - Hepatitis B (2 years old) 2012/13 local only | 9 | 56.5 | | | | |
| | *3.03ii - Population vaccination coverage - BCG (under 1 year old) (placeholder)* | | | | | | |
| | 3.03iii - Population vaccination coverage - Dtap / IPV / Hib (1 year old) 2012/13 | 3,352 | 94.7 | 94.7 | 79.0 |  | 99.0 |
| | 3.03iii - Population vaccination coverage - Dtap / IPV / Hib (2 years old) 2012/13 | 3,243 | 96.7 | 96.3 | 81.9 |  | 99.4 |
| | 3.03iv - Population vaccination coverage - MenC 2012/13 | 3,336 | 94.2 | 93.9 | 75.9 |  | 98.8 |
| | 3.03v - Population vaccination coverage - PCV 2012/13 | 3,344 | 94.4 | 94.4 | 78.7 |  | 99.0 |
| | 3.03vi - Population vaccination coverage - Hib / MenC booster (2 years old) 2012/13 | 3,118 | 92.9 | 92.7 | 77.0 |  | 98.3 |
| | 3.03vi - Population vaccination coverage - Hib / Men C booster (5 years) 2012/13 | 3,040 | 89.9 | 91.5 | 75.7 |  | 98.1 |
| | 3.03vii - Population vaccination coverage - PCV booster 2012/13 | 2,957 | 88.1 | 92.5 | 75.1 |  | 97.5 |
| | 3.03viii - Population vaccination coverage - MMR for one dose (2 years old) 2012/13 | 3,115 | 92.8 | 92.3 | 77.4 |  | 98.4 |
| | 3.03ix - Population vaccination coverage - MMR for one dose (5 years old) 2012/13 | 3,110 | 91.9 | 93.9 | 82.1 |  | 98.3 |
| | 3.03x - Population vaccination coverage - MMR for two doses (5 years old) 2012/13 | 2,587 | 76.5 | 87.7 | 68.9 |  | 97.0 |
| | *3.03xi - Population vaccination coverage - Td/IPV booster vaccination coverage (13-18 year olds) (placeholder)* | | | | | | |
| | 3.03xii - Population vaccination coverage - HPV 2012/13 | 1,104 | 86.7 | 86.1 | 62.1 |  | 96.2 |
| | 3.03xiii - Population vaccination coverage - PPV 2012/13 | 23,899 | 64.6 | 69.1 | 55.3 |  | 77.0 |
| | 3.03xiv - Population vaccination coverage - Flu (aged 65+) 2012/13 | 30,666 | 70.5 | 73.4 | 65.5 |  | 80.8 |
| | 3.03xv - Population vaccination coverage - Flu (at risk individuals) 2012/13 | 14,416 | 51.6 | 51.3 | 44.2 |  | 68.8 |
| | 3.04 - People presenting with HIV at a late stage of infection 2010 - 12 | 32 | 58.2 | 48.3 | 80.0 |  | 0.0 |
| | 3.05i - Treatment completion for TB 2012** | n/a | 84.4 | 82.8 | 0.0 |  | 0.0 |
| | 3.05ii - Incidence of TB 2010 - 12 | 82 | 32.9 | 15.1 | 112.3 |  | 0.0 |
| | 3.06 - NHS organisations with a board approved sustainable development management plan 2012/13 | <5 | 40.0 | 59.0 | 16.7 |  | 100.0 |
| | *3.7 - Comprehensive, agreed inter-agency plans for responding to healthprotection incidents and emergencies (placeholder)* | | | | | | |
| 4. Healthcare and premature mortality | 4.01 - Infant mortality 2010 - 12 | 80 | 7.5 | 4.1 | 7.5 |  | 1.1 |
| | 4.02 - Tooth decay in children aged 5 2011/12 | n/a | 1.0 | 0.9 | 2.1 |  | 0.3 |
| | 4.03 - Mortality rate from causes considered preventable 2010 - 12 | 1,353 | 213.7 | 187.8 | 340.5 |  | 136.2 |
| | 4.04i - Under 75 mortality rate from all cardiovascular diseases 2010 - 12 | 601 | 105.7 | 81.1 | 144.7 |  | 55.7 |
| | 4.04ii - Under 75 mortality rate from cardiovascular diseases considered preventable 2010 - 12 | 377 | 66.7 | 53.5 | 95.2 |  | 29.3 |
| | 4.05i - Under 75 mortality rate from cancer 2010 - 12 | 888 | 158.4 | 146.5 | 207.3 |  | 113.5 |
| | 4.05ii - Under 75 mortality rate from cancer considered preventable 2010 - 12 | 506 | 90.5 | 84.9 | 134.9 |  | 53.8 |
| | 4.06i - Under 75 mortality rate from liver disease 2010 - 12 | 166 | 28.0 | 18.0 | 41.6 |  | 10.3 |
| | 4.06ii - Under 75 mortality rate from liver disease considered preventable 2010 - 12 | 138 | 23.2 | 15.8 | 38.2 |  | 9.0 |
| | 4.07i - Under 75 mortality rate from respiratory disease 2010 - 12 | 259 | 46.8 | 33.5 | 81.6 |  | 20.5 |
| | 4.07ii - Under 75 mortality rate from respiratory disease considered preventable 2010 - 12 | 130 | 23.7 | 17.6 | 45.0 |  | 7.9 |
| | 4.08 - Mortality from communicable diseases 2010 - 12 | 406 | 62.3 | 64.8 | 97.9 |  | 47.0 |
| | 4.09 - Excess under 75 mortality rate in adults with serious mental illness 2011/12 | n/a | 382.4 | 337.4 | 510.4 |  | 124.7 |
| | 4.10 - Suicide rate 2010 - 12 | 56 | 7.7 | 8.5 | 14.5 |  | 4.8 |
| | 4.11 - Emergency readmissions within 30 days of discharge from hospital 2011/12 | 3,376 | 11.9 | 11.8 | 14.5 |  | 8.8 |
| | 4.12i - Preventable sight loss - age related macular degeneration (AMD) 2012/13 | 47 | 113.4 | 104.4 | 221.3 |  | 31.7 |
| | 4.12ii - Preventable sight loss - glaucoma 2012/13 | 14 | 11.8 | 12.5 | 29.3 |  | 2.8 |
| | 4.12iii - Preventable sight loss - diabetic eye disease 2012/13 | 6 | 2.8 | 3.5 | 14.0 |  | 1.1 |
| | 4.12iv - Preventable sight loss - sight loss certifications 2012/13 | 112 | 44.6 | 42.3 | 79.8 |  | 13.5 |
| | *4.13 - Average health status score for adults aged 65 and over (placeholder)* | 263 | 548.0 | 568.1 | 808.4 |  | 403.1 |
| | 4.14i - Hip fractures in people aged 65 and over 2012/13 | 263 | 548.0 | 568.1 | 808.4 |  | 403.1 |
| | 4.14ii - Hip fractures in people aged 65 and over - aged 65-79 2012/13 | 63 | 211.9 | 237.3 | 401.7 |  | 121.8 |
| | 4.14iii - Hip fractures in people aged 65 and over - aged 80+ 2012/13 | 200 | 1522.5 | 1527.6 | 2150.0 |  | 1107.7 |
| | 4.15i - Excess Winter Deaths Index (Single year, all ages) Aug 2011 - Jul 2012 | 114 | 15.7 | 16.1 | 30.7 |  | 2.1 |
| | 4.15ii - Excess Winter Deaths Index (single year, ages 85+) Aug 2011 - Jul 2012 | 43 | 16.0 | 22.9 | 53.1 |  | -7.6 |
| | 4.15iii - Excess Winter Deaths Index (3 years, all ages) Aug 2009 - Jul 2012 | 445 | 19.7 | 16.5 | 27.4 |  | 6.4 |
| | 4.15iv - Excess Winter Deaths Index (3 years, ages 85+) Aug 2009 - Jul 2012 | 180 | 23.2 | 22.6 | 38.5 |  | 11.3 |
| | *4.16 - Estimated diagnosis rate for people with dementia (placeholder)* | | | | | | |

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**Agenda Item No. 13**

# Health and Wellbeing Board

5 November 2014

| | | |
|---|---|---|
| **Report title** | Pharmaceutical Needs Assessment: Update | |
| **Cabinet member with lead responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing | |
| **Wards affected** | All | |
| **Accountable director** | Sarah Norman, Community | |
| **Originating service** | Public Health | |
| **Accountable employee(s)** | Dr Jane Fowles<br>Tel<br>Email | Public Health Specialty Registrar<br>01902 551497<br>Jane.fowles@wolverhampton.gov.uk |
| **Report to be/has been considered by** | N/A | |

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**Recommendation(s) for action or decision:**

The Health and Wellbeing Board is recommended to:

1. Note the findings of the draft Wolverhampton Pharmaceutical Needs Assessment.
2. Endorse the draft Wolverhampton Pharmaceutical Needs Assessment for statutory consultation (Appendix A).
3. Delegate authority to the Chair of the Health and Wellbeing Board to approve the final Pharmaceutical Needs Assessment for publication by 1st April 2015 after consultation and feedback.

## 1.0 Purpose

1.1 To inform the Health and Wellbeing Board of the findings of the Wolverhampton Pharmaceutical Needs Assessment and seek endorsement of the draft document for statutory 60 day consultation. It is recommended that the authority is delegated to the Chair of the Health and Wellbeing Board to receive a summary of the feedback received during consultation and ratify the final Pharmaceutical Needs Assessment for publication by 1st April 2015.

## 2.0 Background

2.1 The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 require Health and Wellbeing Boards to produce and publish a Pharmaceutical Needs Assessment (PNA) by 1 April 2015. A 60 day period of consultation on the draft PNA is required prior to publication. The Health and Wellbeing Board (HWB) is required to publish revised assessments within three years or when significant changes to need for pharmaceutical services are identified.

2.2 The PNA is a structured approach to identifying unmet need for pharmaceutical services. It is a tool to enable the HWB to identify current service provision and inform future commissioning of services from pharmaceutical service providers.

2.3 NHS England has an obligation to ensure that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied by holding pharmaceutical lists controlling market entry to NHS Pharmaceutical services. To be included on a pharmaceutical list, providers must prove they are able to meet a pharmaceutical need as defined by the PNA. Decisions made by NHS England regarding market entry based on the findings of the PNA are open to appeal and legal challenge.

2.4 The Wolverhampton PNA was undertaken in accordance with the requirements set out in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. Development of the PNA has been guided by a steering group with representation from Public Health, Wolverhampton Clinical Commissioning Group (CCG), NHS England Local Area Team (LAT), the Local Pharmaceutical Committee (LPC) and patient groups. Nearly 300 residents responded to a survey on their usage and access to community pharmacies.

2.5 The attached draft PNA outlines key health needs, current provision of pharmaceutical services and identifies key opportunities for community pharmacies to contribute to health and wellbeing in Wolverhampton.

2.6 Community pharmacies provide a range of services defined as:

- Essential – all pharmacies must provide dispensing of medicines and safe disposal of medicines, promotion of healthy lifestyles, participation in health promotion campaigns and support for self-care.

- Advanced – some pharmacies may provide Medicines Use Reviews (MURs), New Medicines Service, Appliance Use Reviews (AURs) and Stoma Customisation Services (SCSs).
- Locally commissioned services – some pharmacies may provide additional services commissioned locally by either NHS England, the CCG or the Public Health department within the council.

2.7 Community pharmacy provision has improved since the last PNA in 2011. At this time there is adequate community pharmacy provision well distributed across the city which is sufficient to meet the needs of residents. There are 27 community pharmacies per 100,000 population which is comparable to Wolverhampton's LAT neighbours. Closing times indicate good evening coverage across the city, and weekend coverage is particularly good on Saturdays. The majority of respondents to the public questionnaire felt that pharmacies are open when they need them. Travel time mapping show most residents can access a pharmacy within a 20 minute walk or six minute car journey.

2.8 Current locally commissioned services include; emergency hormonal contraception, smoking interventions and nicotine replacement therapy, needle exchange and supervised consumption for substance misuse and a minor ailments service. There are opportunities to increase uptake and quality of current services offered through existing commissioning and contracting mechanisms.

2.9 New developments include the introduction of a free flu immunisation service and the Primary Eyecare Assessment and Referral service (PEARs).

2.10 There are wider opportunities to contribute to key local health priorities through community pharmacies, including the delivery of chlamydia testing and treatment, NHS Health Checks and brief interventions and signposting to services for both obesity and alcohol. The evidence base for community pharmacy contribution for these areas should be evaluated and reflected in future commissioning plans.

2.11 The impacts of housing developments and the Urgent and Emergency Care Strategy on community pharmacy provision will need to be monitored. The HWB will need to review developments on a six monthly basis and consider issuing supplementary statements.

## 3.0 Progress

3.1 The draft PNA has been reviewed by the project steering group and now seeks endorsement to begin the statutory 60 day consultation.

3.2 The 2013 NHS Regulations require the HWB to consult with the following groups; the LPC, Local Medical Committee (LMC), persons on pharmaceutical lists and dispensing doctors lists, Healthwatch and other patient, consumer or community groups with an interest in pharmacy provision, NHS Trusts and Foundation Trusts, NHS England and any neighbouring HWBs.

3.3 Draft PNAs are required to be made available to these groups in electronic format. More detailed consultation methodology is in development.

3.4 Consultation is planned to run for 60 days through late November to late January with comments to be incorporated into a final draft for publication by 1 April 2015.

## 4.0 Financial implications

4.1 There are no direct financial implications as a result of this report

4.2 Should any costs arise following the consultation process these will be contained within existing approved budgets under Public Health. [NM/23102014/H]

## 5.0 Legal implications

5.1 The PNA is a statutory requirement outlined in the National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. Decisions made by NHS England regarding market entry based on the findings of the PNA are open to appeal and legal challenge. The purpose of a PNA is to identify the need in a specified area for pharmaceutical services, it should be noted that this is not always the same as an assessment of general health needs in an area. KR/22102014/C.

## 6.0 Equalities implications

6.1 The PNA outlines key health need in relation to community pharmacies and is intended to reduce health inequalities. The PNA explores wider dimensions of access to community pharmacies to ensure equality of access for key vulnerable groups. A public survey on access and usage of community pharmacies received nearly 300 responses and gathered equalities information on respondents to inform analysis. Equalities considerations will continue to inform the wider consultation and future work to develop services delivered in community pharmacies. The equalities toolkit initial analysis has been completed. There are no direct implications for equalities arising from this report.

## 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 Corporate landlord implications

9.1 There are no direct corporate landlord implications arising from this report.

## 10.0 Schedule of background papers

10.1 There are no preceding reports or documents that need to be considered alongside this report.

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# Pharmaceutical Needs Assessment 2015-18

## Wolverhampton Health and Wellbeing Board

## Contents

1. Executive Summary ..... 2
2. Introduction and background ..... 4
3. PNA development process ..... 5
4. PNA Statutory consultation ..... 6
5. Wolverhampton Health Overview ..... 6
6. Local priorities ..... 10
7. Current provision of NHS Pharmaceutical services ..... 11
7.1 Service providers ..... 11
7.2 Accessibility ..... 12
7.3. Essential services ..... 21
7.4. Advanced services ..... 23
7.5. Locally commissioned services ..... 25
7.5.1 Smoking cessation services ..... 25
7.5.2 Unplanned pregnancy and contraception services ..... 27
7.5.3 Drug and alcohol related harms and services ..... 30
7.5.4 Minor ailments ..... 35
7.5.5 Other local services and community pharmacies ..... 36
7.6 Other health needs and opportunities for community pharmacies to contribute ..... 37
7.6.1 Screening and immunisation ..... 37
7.6.2 Cardiovascular health and NHS Health Checks ..... 38
7.6.3 Sexual Health Services ..... 39
7.6.4 Obesity and healthy lifestyles ..... 42
7.6.5 Long term conditions (LTCs) and medicines optimisation ..... 43
8. Future need ..... 44
9. Conclusion ..... 47
10. Appendices ..... 47
Acknowledgements ..... 47
PNA Pharmacy Questionnaire ..... 48
PNA Public Questionnaire ..... 55
Community pharmacies and opening times ..... 60
Pharmacy questionnaire return summary ..... 65

## 1. Executive Summary

The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 require Health and Wellbeing Boards to produce and publish a Pharmaceutical Needs Assessment (PNA) by 1st April 2015. The HWB is required to publish revised assessments within 3 years or when significant changes to need for pharmaceutical services are identified.

The PNA is a structured approach to identifying unmet need for pharmaceutical services. It is a tool to enable the HWB to identify current service provision and inform future commissioning of services from pharmaceutical service providers.

NHS England has an obligation to ensure that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied by holding pharmaceutical lists controlling market entry to NHS Pharmaceutical services. To be included on a pharmaceutical list, providers must prove they are able to meet a pharmaceutical need as defined by the PNA. Decisions made by NHS England regarding market entry based on the findings of the PNA are open to appeal and legal challenge.

The Wolverhampton PNA was undertaken in accordance with the requirements set out in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. Development of the PNA has been guided by a steering group with representation from Public Health, Wolverhampton Clincial Commissioning Group (CCG), NHS England, the Local Pharmaceutical Committee (LPC) and patient groups. Nearly 300 residents responded to a survey on their usage and access to community pharmacies.

Community pharmacies provide a range of services defined as:

- Essential – all pharmacies must provide dispensing of medicines and safe disposal of medicines, promotion of healthy lifestyles, participation in health promotion campaigns and support for self-care.
- Advanced – some pharmacies may provide Medicines Use Reviews (MURs), New Medicines Service, Appliance Use Reviews (AURs) and Stoma Customisation Services (SCSs).
- Locally commissioned services – some pharmacies may provide additional services commissioned locally by either NHS England, CCG or the Public Health department within the council. Current locally commissioned services include; emergency hormonal contraception, smoking interventions and nicotine replacement therapy, needle exchange and supervised consumption for substance misuse and a minor ailments service.

Community pharmacy provision has developed since the last PNA. At this time there is adequate community pharmacy provision well distributed across the city which is sufficient to meet the needs of residents. There are 27 community pharmacies per 100,000 population which is comparable to our Local Area Team (LAT) neighbours. Closing times indicate good evening coverage across the city, and weekend coverage is particularly good on Saturdays. The majority of respondents to the public questionnaire felt that pharmacies are open when they need them. Travel time mapping show most residents can access a pharmacy within a 20 minute walk or 6 minute car journey.

New developments in community pharmacy services include a revised Minor Ailments Service, the introduction of a free flu immunisation service, and the Primary Eyecare Assessment and Referral service (PEARs). These services will need evaluation and review.

There are opportunities to increase uptake and quality of current services offered through commissioning and contracting mechanisms. Commissioners, contractors and the LPC will need to continue to work together to develop and improve these services.

There are potential opportunities for community pharmacies to further contribute to key local health priorities. These could include the delivery of chlamydia testing and treatment, NHS Health Checks and brief interventions and signposting to services for both obesity and alcohol. Further work is needed to assess the evidence for community pharmacy contribution and incorporate this into future service reviews.

## 2. Introduction and background

The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013[1] require Health and Wellbeing Boards (HWBs) to produce and publish a Pharmaceutical Needs Assessment (PNA) by 1st April 2015. HWBs are required to publish revised assessments within 3 years or when significant changes to need for pharmaceutical services are identified. This is the second Pharmaceutical Needs Assessment for Wolverhampton following on from the edition published in 2011.

The PNA is a structured approach to identifying unmet need for pharmaceutical services. It is a tool to enable the HWB to identify current service provision and inform future commissioning of services from pharmaceutical service providers. The Department of Health (DoH) have published an Information Pack for HWBs to guide production of their PNAs[2].

Pharmaceutical services are defined in the NHS (Pharmaceutical Services and Local Pharmaceuticals Services) Regulations 2013:

- Essential services – every community pharmacy providing NHS pharmaceutical services must provide a core list of services including, dispensing of medicines and safe disposal of medicines, promotion of healthy lifestyles, participation in health promotion campaigns and support for self-care.
- Advanced services – some community pharmacy contractors and dispensing appliance contractors subject to accreditation can provide services such as; Medicines Use Reviews (MURs), New Medicines Service, Appliance Use Reviews (AURs) and Stoma Customisation Services (SCSs).
- Locally commissioned services – some community pharmacies offer enhanced services commissioned by NHS England or locally determined services commissioned by local authority Public Health departments or Clinical Commissioning Groups (CCGs). Prior to April 2013 these enhanced services were commissioned by Primary Care Trusts (PCTs).

NHS England has an obligation to ensure that drugs, medicines and listed appliances ordered via NHS prescriptions can be supplied by holding pharmaceutical lists controlling market entry to NHS Pharmaceutical services. Pharmaceutical lists include:

- Pharmacy contractors
- Dispensing appliance contractors – suppliers of prescribed appliances such as dressings, stoma and incontinence aids. They cannot prescribe medicines.
- Dispensing doctors – authorised to provide drugs and appliances in designated rural areas or "controlled localities"
- Local pharmaceutical services (LPS) contractors –hold single negotiated contracts tailored to specific local requirements outside of national pharmacy arrangements

[1] The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013. 2013 No.349. London: TSO. Available from http://www.legislation.gov.uk/uksi/2013/349/pdfs/uksi_20130349_en.pdf. Accessed August 2014.

[2] Department of Health, 2013. *Pharmaceutical needs assessments: Information Pack for local authority Health and Wellbeing Boards.* Available from https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack. Accessed August 2014.

To be included on a pharmaceutical list, providers must prove they are able to meet a pharmaceutical need as defined by the PNA. In 2005 certain exceptions to this requirement were introduced, including pharmacies undertaking more than 100 minimum hours, distance selling pharmacies (mail order or internet), pharmacies in large out of town retail developments and in one stop primary care centres. All applications for new, additional or relocation of pharmacy premises (except distance selling pharmacies), will be assessed against the local PNA. Decisions may be appealed or challenged through the courts. PNAs must therefore comply with the requirements outlined in the 2013 regulations, ensure due process is followed in their development and that they are kept up to date.

## 3. PNA development process

The Wolverhampton PNA was undertaken in accordance with the requirements set out in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. Development of the PNA has been guided by a steering group with representation from Public Health, Wolverhampton Clinical Commissioning Group (WCCG), NHS England, the Local Pharmaceutical Committee (LPC) and patient groups (see Appendix for membership).

A questionnaire was distributed to pharmacies across the city (See Appendices). 67 complete responses were returned, capturing 64 out of 65 community pharmacies (including all four 100 hour pharmacies), two out of three internet pharmacies and one pharmacy located in New Cross Hospital. Key results are presented throughout in relevant sections. Opening times of non-responders and incomplete questionnaires were cross checked through NHS Choices. Information on commissioned services was cross checked with local contracting and activity data.

Throughout the PNA we present data on key health themes highlighting need across the city, mapping and describing three locality areas; north east, south west and south east or electoral wards. This approach to describing localities reflects the approach taken in the Joint Strategic Needs Assessment (JSNA).

A public questionnaire was posted on the LA and CCG website and further promoted through local press and social media (see Appendices). 299 residents responded to the survey. In the last PNA in 2011 no responses were returned to a survey distributed to patient and service user groups, therefore responses this year represent a significant improvement in public engagement. The majority of respondents were from a white ethnic background (89%), 7% were Asian and 3% African Caribbean, which is not reflective of the ethnicity profile of the city with slight under-representation for ethnic minority groups amongst survey respondents. The majority of respondents were women (80%). There was good representation across employed, unemployed, retired and student groups. Respondents were evenly spread from 25-69 years of age, however, 56% had a long term health issue or disability. While this may reflect this group's greater interest in pharmacy provision it is not reflective of the general population as census data suggests 20.5% of Wolverhampton residents have a limiting long term illness or disability.

A key stakeholder event was held in September 2014 to share some initial highlights from the analyses of the community pharmacy and public questionnaires. Stakeholders from GP, CCG, NHS England, Public Health, LPC and patient groups discussed a range of issues from access to services

across the city, currently commissioned local services and potential opportunities for community pharmacy to contribute to health and wellbeing in Wolverhampton.

## 4. PNA Statutory consultation

This draft document will go out for public consultation for a 60 day period through December 2014 and January 2015 in accordance with the requirements set out in the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013.

HWBs must consult with the following bodies in their area during the process of PNA development:

- Local Pharmaceutical Committee (LPC)
- Local Medical Committee (LMC)
- Persons on pharmaceutical lists and dispensing doctors lists
- LPS chemists
- Local Healthwatch organisation for its area and any other patient, consumer or community group which in the opinion of the HWB has an interest in the provision of pharmaceutical services
- NHS Trust or NHS Foundation Trust
- NHS England
- Neighbouring HWBs (who must consult with their respective LPCs and LMCs when compiling a response)

The draft will be made available in electronic form for a 60 day period of consultation.

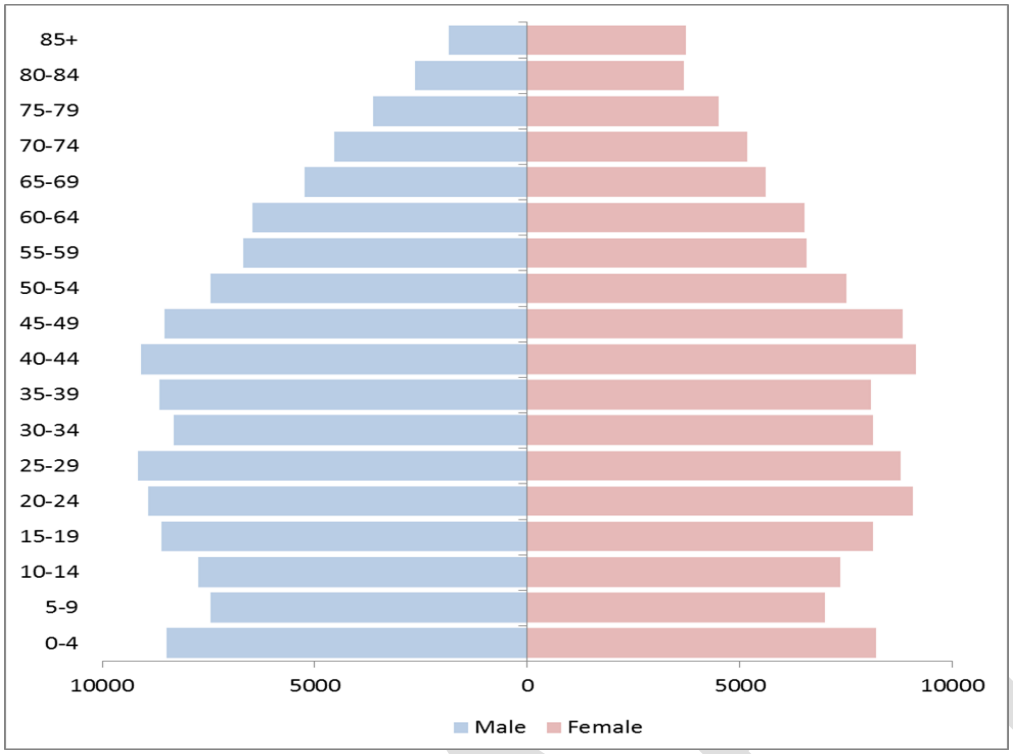
Consultation summary feedback to be added.

## 5. Wolverhampton Health Overview

Population

The city's resident population is estimated to be 251,557 (mid-year estimates 2013) however, the GP registered population is 262,000. The average age of residents in Wolverhampton is 39, which is similar to the national average. However, Wolverhampton has a slightly higher proportion of children aged under 16. There are slightly more females than males living in Wolverhampton.

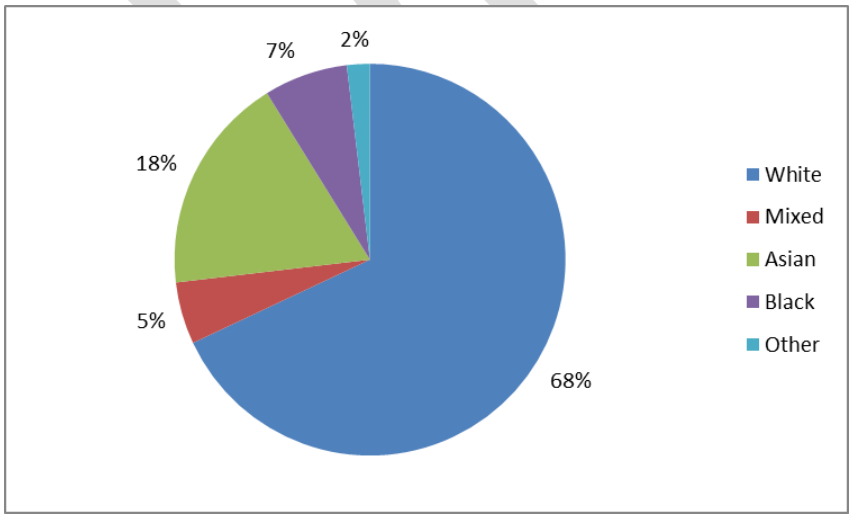
Figure 1: Wolverhampton Age and gender distribution (Census 2011)




Ethnicity and diversity

The majority of residents in the city are from a White ethnic background (68%), with the remaining 32% from Black minority ethnic backgrounds (BME). The proportion of BME residents has slowly increased over time, with the largest of the groups being Asian at 18.8%, followed by Black and Mixed at 6.9% and 5.1% respectively. This is quite different from the national distribution with only 14.3% from a BME background. The south east of the city has the highest proportion of BME residents. Just over 10% of the resident population do not speak English as their main language.

Figure 2: Wolverhampton ethnicity distribution (census 2011)



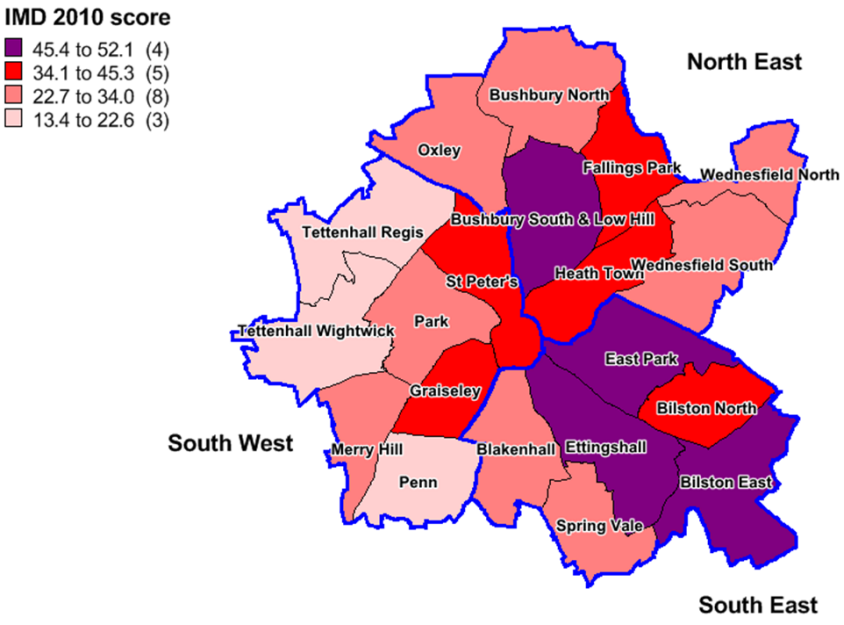

Deprivation

The Index of Multiple Deprivation (2010) is a measure of multiple deprivations at an area level. An overall score is produced based on seven distinct dimensions of deprivation:

- Income
- Employment
- Health deprivation and disability
- Education, skills and training
- Barrier to housing and services
- Crime
- Living environment

Deprivation is a fundamental determinant of poor health and dependence and is generally associated with greater morbidity and mortality. Wolverhampton is the 21st most deprived Local Authority in the country, with 51.1% of its population falling amongst the most deprived 20% nationally. This indicates that over half of Wolverhampton's population live in the poorest areas in England, which impacts on life expectancy and premature mortality rates in the city. The least deprived wards are in the West and the most deprived in the North East and South East of the city.

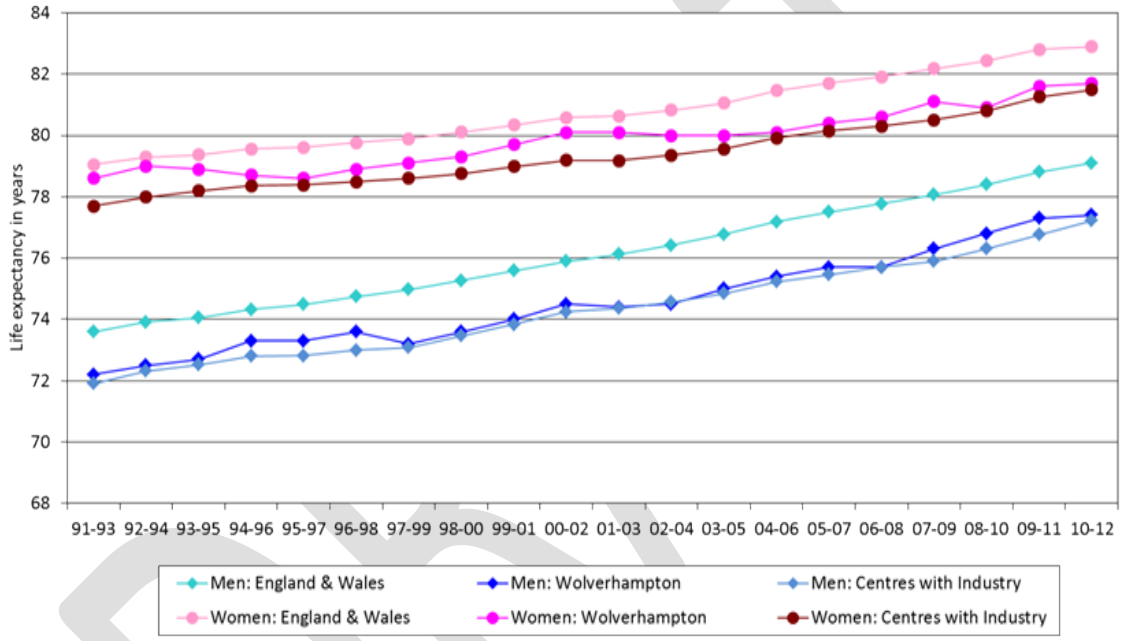
Figure 3 Index of Multiple Deprivation Score 2010, by ward




Life expectancy and mortality

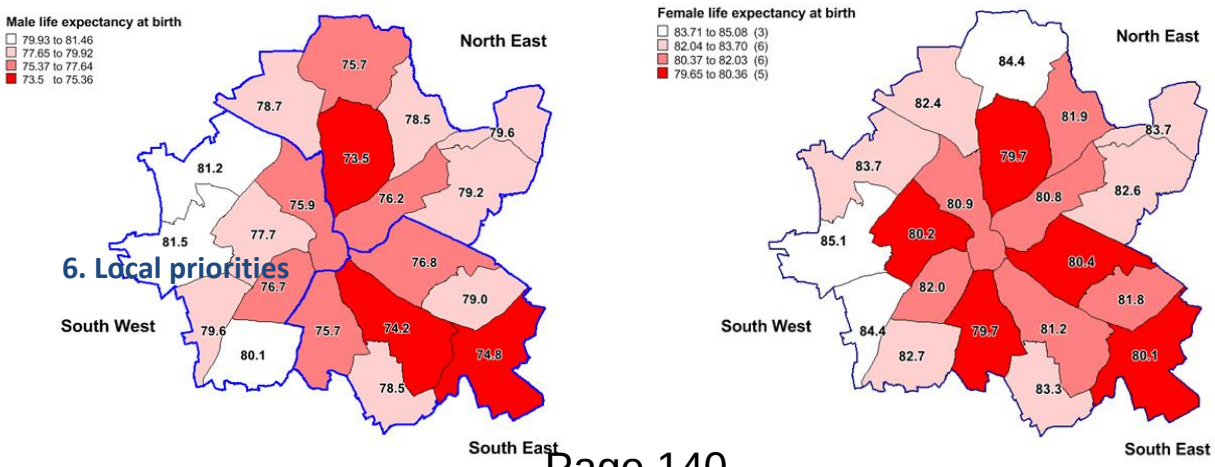
People in Wolverhampton are living longer than ever before, however the gap in life expectancy between the city and the national figure is not closing. Overall life expectancy in 2010-12 was 77.4 years for males and 81.7 years for females. This is almost two years less than the national average for both males and females. In addition, a male in Wolverhampton can expect to live just over 58 years free of any disability which is almost three years less that the national average. Women can expect to live almost 61 years free of any disability which is two years less than the national average. Therefore, not only do Wolverhampton residents live shorter lives but they also spend more of their lives experiencing ill health and disability.

Figure 4: Trend in male and female life expectancy in Wolverhampton




There are considerable inequalities in life expectancy and healthy life expectancy (disability-free life) across Wolverhampton. Local analysis shows that there is a gap of approximately seven years for males and four for females between those who are least and most deprived in Wolverhampton. This gap has remained fairly consistent over time.

Figure 5: Male and female life expectancy by ward 2008-2012




## 6. Local priorities

Wolverhampton's Joint Strategic Needs Assessment (JSNA) has focussed on the outcomes contained in the three national outcome frameworks: Public Health (PHOF), NHS (NHSOF) and Adult Social Care (ASCOF), and an additional locally developed outcomes framework for Children and Young People. The JSNA is currently being updated and preliminary data from the 2014-2015 update has been included in the assessment of health needs.

The HWB drew on evidence from the Joint Strategic Needs Assessment (JSNA) and data from the National Outcomes Frameworks for Health, Adult Social Care and Public Health to identify priorities for joint working to improve life expectancy, quality of life and reduce child poverty. The Health and Wellbeing Strategy for Wolverhampton 2013-2018 centres on five priority areas:

- Wider determinants of health
- Alcohol and drugs
- Dementia (early diagnosis)
- Mental Health (Diagnosis and Early intervention)
- Urgent Care (Improving and Simplifying)

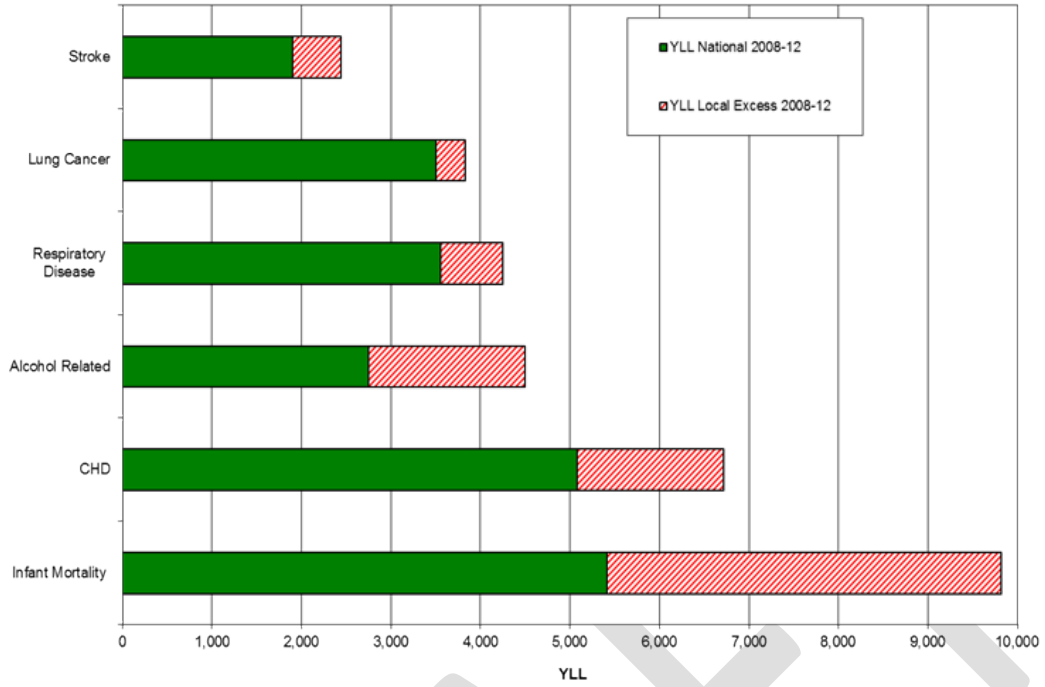
Further priorities of the key sub-groups include; long term conditions (stroke and diabetes), health improvement (childhood obesity and diabetes) and prevention of mortality from chronic liver disease and prevention of falls.

Life expectancy is affected by the number of deaths and the age at which the deaths occur. A small number of early deaths can cause a significant deterioration in life expectancy. The top six conditions accounting for excess years of life lost in Wolverhampton during 2008-2012 are:

- Infant mortality
- Alcohol related mortality <75
- CHD mortality <75
- Respiratory disease mortality <75
- Stroke mortality <75
- Lung cancer mortality <75

These conditions require targeted work to improve life expectancy across the city. The graph below shows the number of life years lost from these causes between 2010 and 2012. The length of the full bar (including green block and red and white striped block) show the total years of life lost in Wolverhampton. The green bar shows the numbers of life years lost if our mortality rates were the same as England. Therefore the red and white striped bar shows the local excess years of life lost and therefore the years of life Wolverhampton could potentially gain if death rates were similar to the national average.

Figure 6: Years of life lost and potential years of life gained




Throughout the PNA we present data on key health themes highlighting need across the city mapping wards and Lower Super Output Areas (LSOAs) where appropriate.

## 7. Current provision of NHS Pharmaceutical services

Community pharmacies offer many additional services other than the dispensing of medicines. They play an important part in contributing to wider health and wellbeing. They are a gateway to accessing a diverse population, some of whom may or may not be known to services and are therefore considered a key stakeholder for meeting joint strategic needs, reducing health inequalities and may be able to alleviate some of the pressure on other services (such as hospital and general practice). The next section will outline current community pharmacy provision highlighting the variety of services offered and describes the role of community pharmacy in key areas of health need.

### 7.1 Service providers

The PNA identifies and maps current provision of pharmaceutical services (information collected in August 2014). A list of pharmacies and opening times can be found in the appendices.

There are a total of 69 pharmacies within Wolverhampton. Of these:

- 65 are community pharmacies including four 100 hour pharmacies
- 3 are distance selling pharmacies
- 1 is located within New Cross Hospital and provides prescriptions for out-patient attendees and hospital discharges, therefore is excluded from further assessment of community pharmacy provision.

Patients can access pharmaceutical services from any community pharmacy including distance selling pharmacy of their choice therefore may access any distance selling pharmacy nationwide. Pharmacy provision has improved since the 2011 PNA, which described 61 community pharmacies including one 100 hour pharmacy and one distance selling pharmacy.

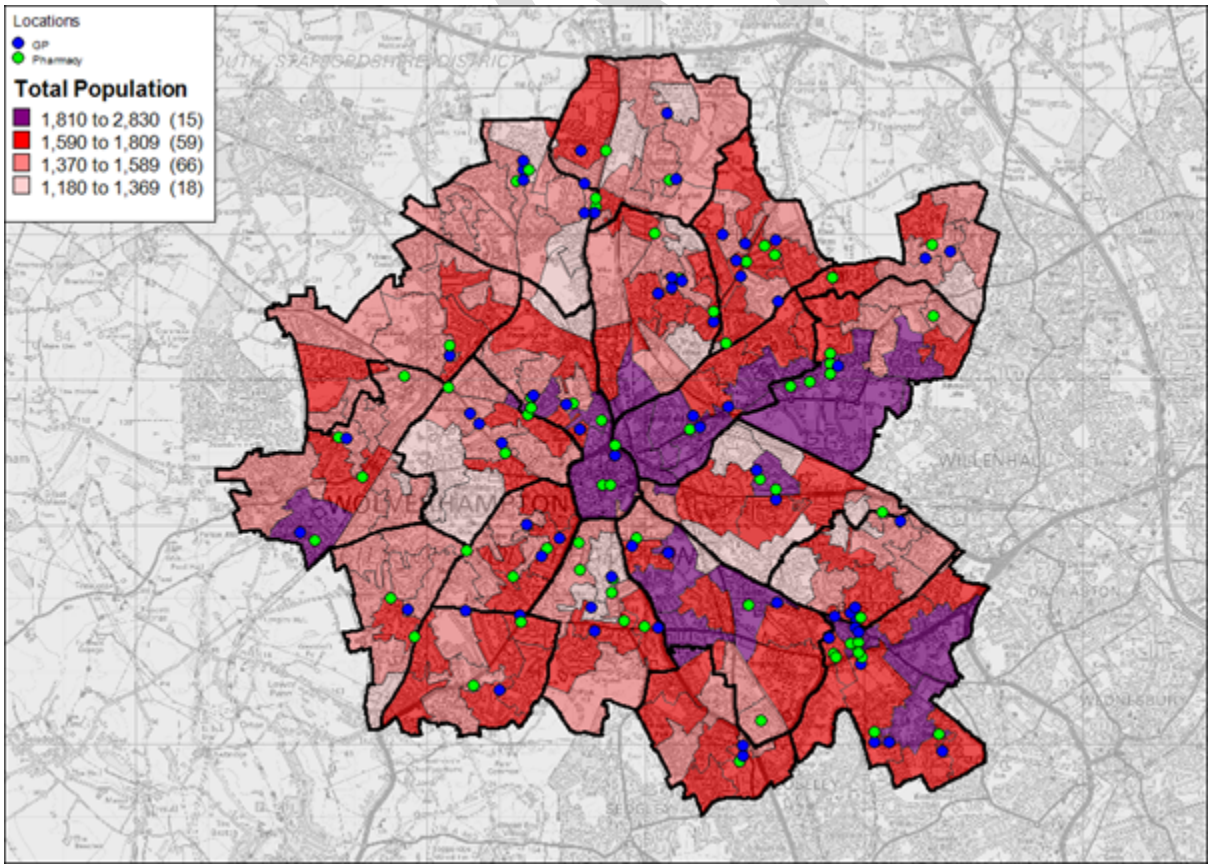
There are no dispensing GP practices, essential small pharmacies, dispensing appliance contractors or LPS contractors in the Wolverhampton area.

### 7.2 Accessibility

Geographical distribution of service providers

The figure below shows the locations of community pharmacies in relation to general practices and population density across the city. Community pharmacies are generally located in close proximity to general practices and concentrated in areas of the city with high population density. Wolverhampton has 27 community pharmacies per 100,000 population, which is comparable to other areas covered by the NHS England Local Area Team (LAT) and higher than the West Midlands and England averages of 23 and 22 respectively[3].

Figure 7: Location of community pharmacies in relation to general practices in Wolverhampton with total population by LSOA

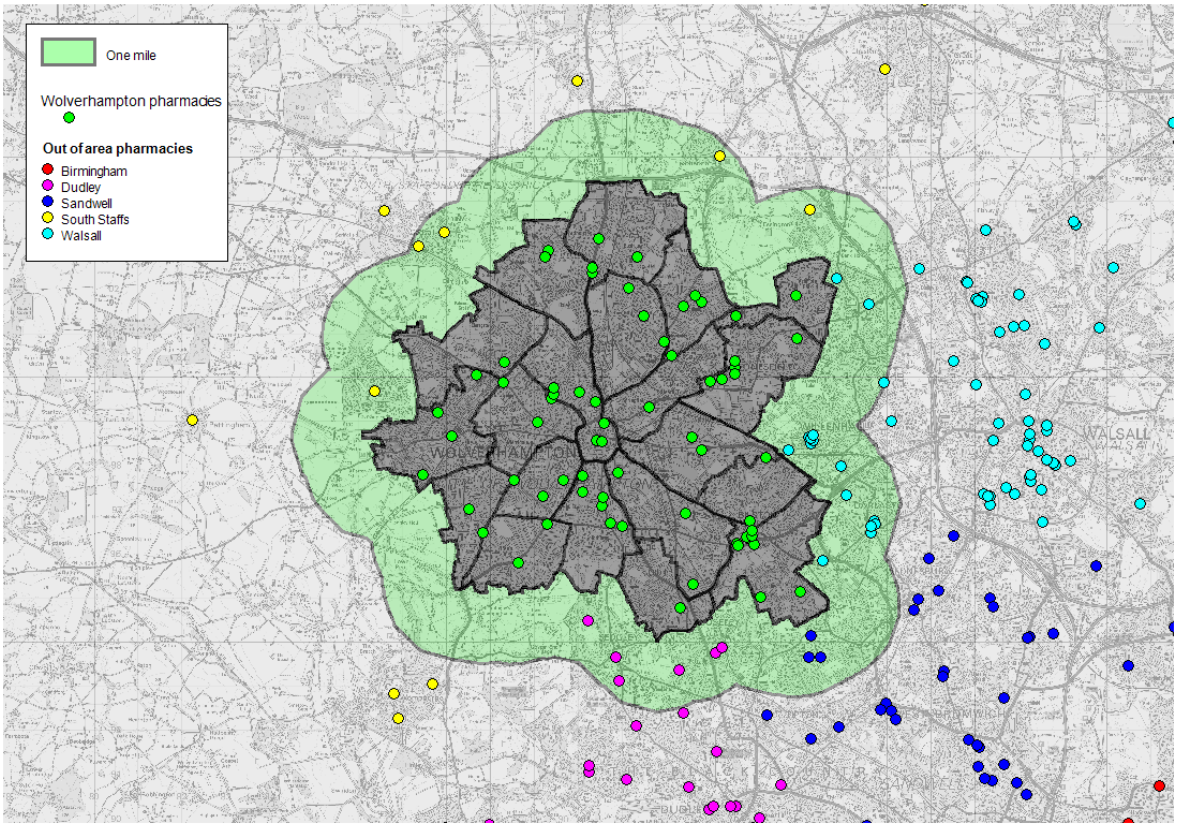



[3] Health & Social Care Information Centre. General Pharmaceutical Services in England 2003-04 to 2012-2013 PCT level tables. Table 2. Available from http://www.hscic.gov.uk/catalogue/PUB12683. Accessed September 2014.

## Wolverhampton border areas

There are four HWBs sharing borders with Wolverhampton; Dudley, Sandwell and Walsall covered by the NHS England Birmingham and the Black Country Local Area Team (LAT) and Staffordshire covered by the Shropshire and Staffordshire LAT. There are 30 pharmacies within one mile of the Wolverhampton border, which are shown on the map below. While there are a number of pharmacies surrounding the borders of Wolverhampton with Sandwell, Walsall and Dudley there are very few pharmacies located around the border of Staffordshire. The north, west and south west of the city is surrounded by South Staffordshire. These are sparsely populated semi- rural areas. The few pharmacies in these areas are located in the most densely populated areas in towns and villages (Perton, Codsall and Essington – populations ranging from 10-11,000). Featherstone with a population of 4,000 has a community pharmacy. Wolverhampton borders with Sandwell, Walsall and Dudley in the east and south east. These are more densely populated, urban areas with larger populations. As a result more pharmacies are located to the east and south east of the Wolverhampton border.

Figure 8: Location of community pharmacies bordering Wolverhampton




## Opening hours

The majority of community pharmacies have 40 core contractual hours. These hours tend to be delivered between 9:00 and 17:00. Pharmacies may apply for less core hours however NHS England can specify when these hours will be. Applications for more than 40 core hours may be agreed by NHS England. Pharmacies cannot amend their core hours without consent from NHS England. Pharmacies may provide supplementary hours outside of their core hour provision, these hours can

be changed with due notice to NHS England. 100 hour pharmacies are an exception to these rules and must provide 100 core contractual hours. The majority of community pharmacies across Wolverhampton open for more than the 40 core hours.

The figures below showing maps of opening times refer to total hours (core and supplementary hours). Figure 9 shows total opening times. The four 100 hour pharmacies are spread across the city. Eight providers report offering over 60 total hours (this is excluding the 100 hour pharmacies already mentioned). All pharmacies offering 60 plus total hours of opening are located in the most deprived areas of the city. The majority of pharmacies (37) report opening for between 50 and 59 total hours, and 18 open for 40 to 49 hours. These services are well distributed across the city.

Figure 9: Community pharmacy total opening hours and deprivation

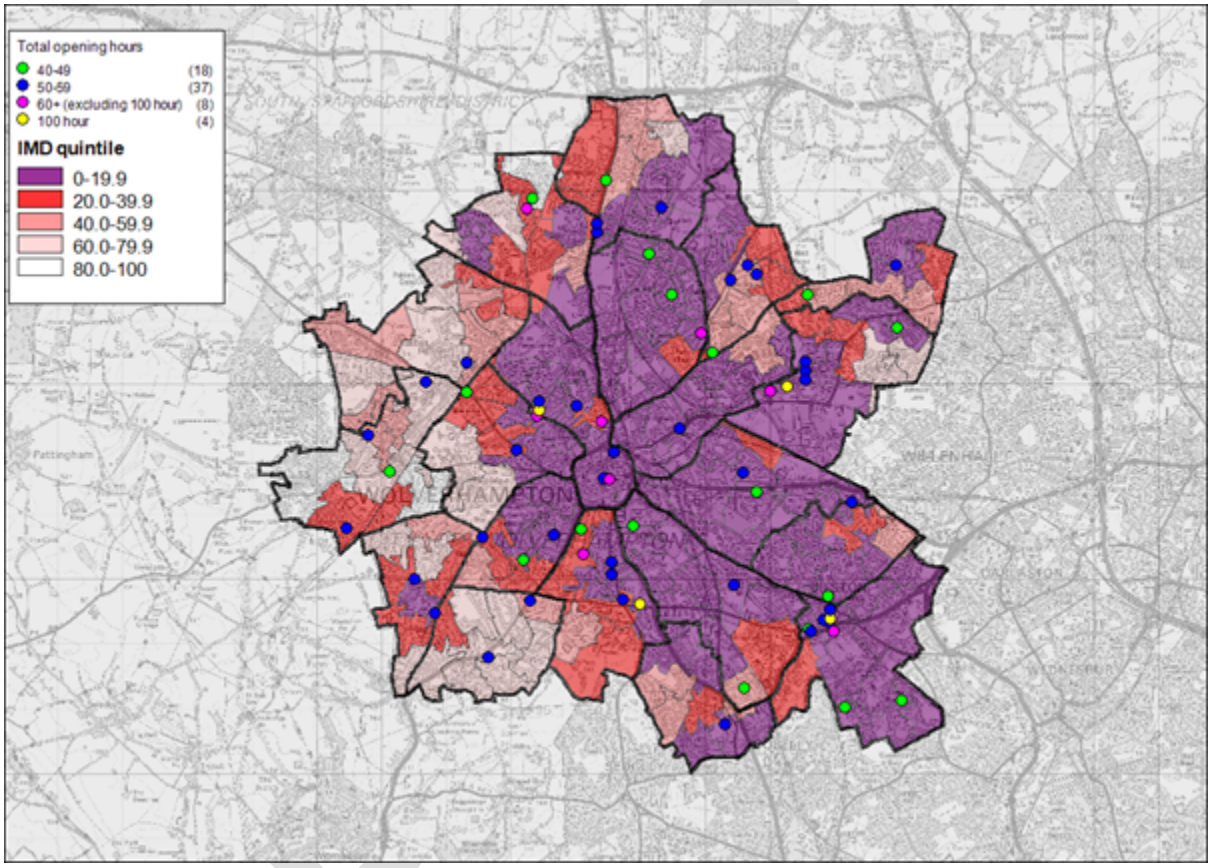


Figure 10: Most common closing times Mon-Fri – taken as an average (mode) across the week.

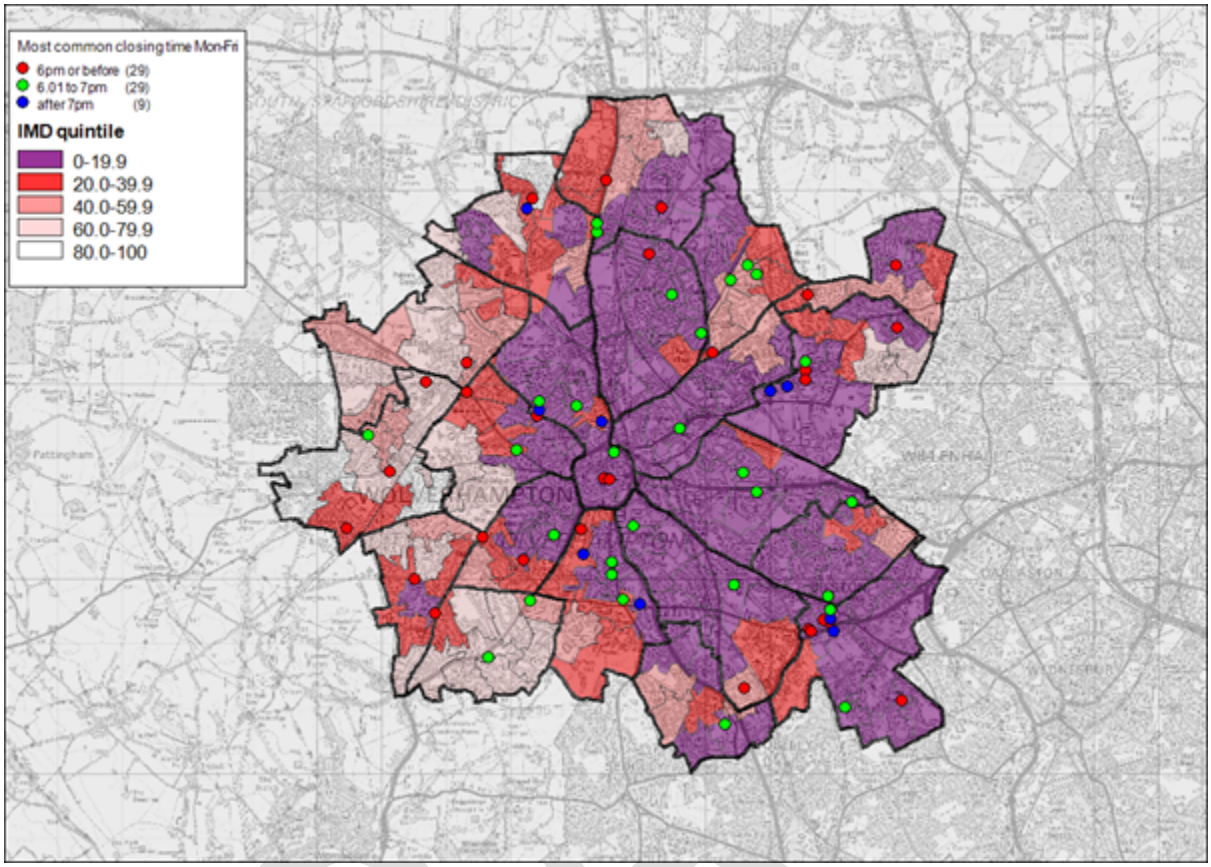
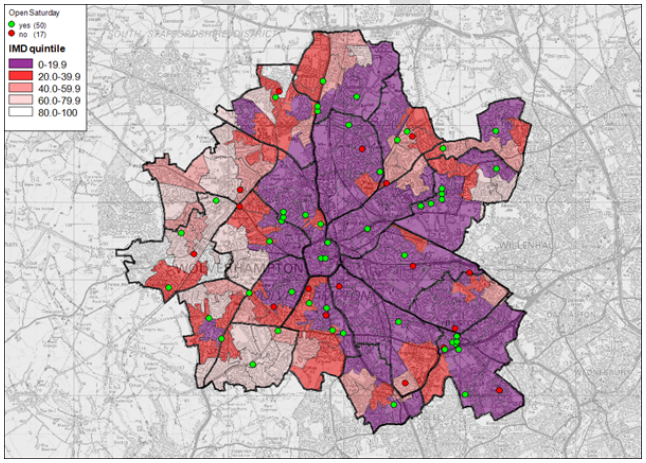


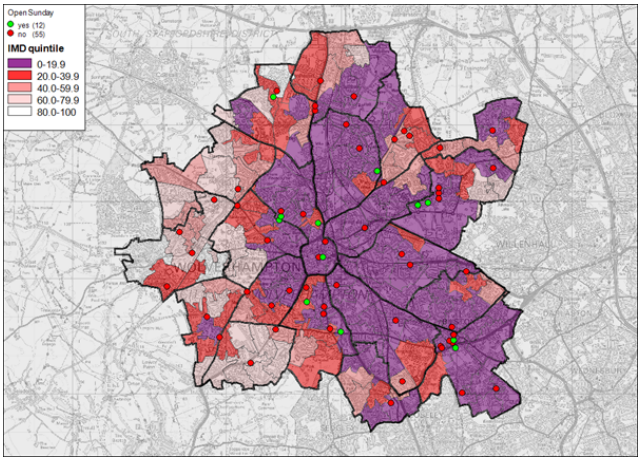

Figure 10 shows most common closing times for community pharmacies. 14% of pharmacies (9) close after 19:00, these pharmacies are located in the most deprived areas of the city. 29 close between 18:00 and 19:00, and 29 between 17:00 and 18:00. These pharmacies are well distributed across the city.

Figures 11 and 12: Weekend opening

Saturday




Sunday




50 pharmacies open on Saturday but only 12 open on Sunday. The pharmacies that open on Sunday also open on Saturdays. Access to community pharmacies at the weekend has improved since the

2011 PNA when 46 pharmacies opened on Saturday and 7 opened on Sunday. Community pharmacies open on Saturday are well distributed across the city, those open on Sunday are concentrated in the most deprived areas of the city.

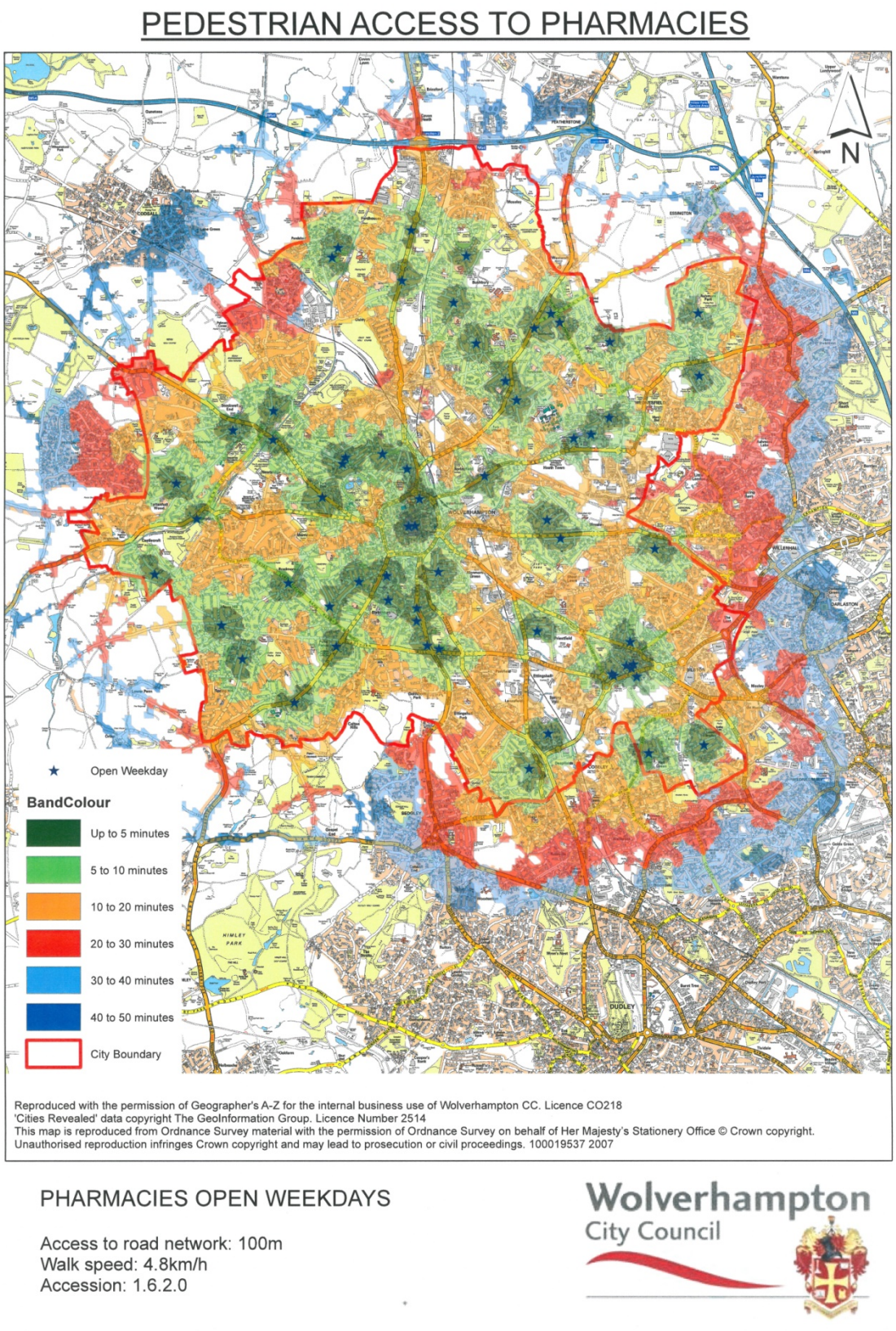
Of those that open on Saturday, nearly half (48%) are open between 17:00 and 19:00, 17 (34%) close at 16:30 or before and eight (16%) are open after 19:00. Of those open on Sunday, opening times are usually between 09:00-10:30 and 16:00-18:00, one pharmacy is open until 22:00 on Sunday.

Respondents to the public questionnaire preferred to visit a pharmacy on Monday to Friday afternoons and early evenings. 95% agreed or strongly agreed that they could find a chemist open on a Saturday whereas 56% said the same for Sundays. 86% of respondents felt that pharmacies were open when they needed them. Of those who disagreed, 21 (7% of all respondents) would prefer later evening opening hours (four mentioned matching hours with those of their GP), seven would like earlier morning opening (2% of all respondents) and four Sunday opening (1% of all respondents). These respondents were more likely to work and use the pharmacy for one off prescriptions.

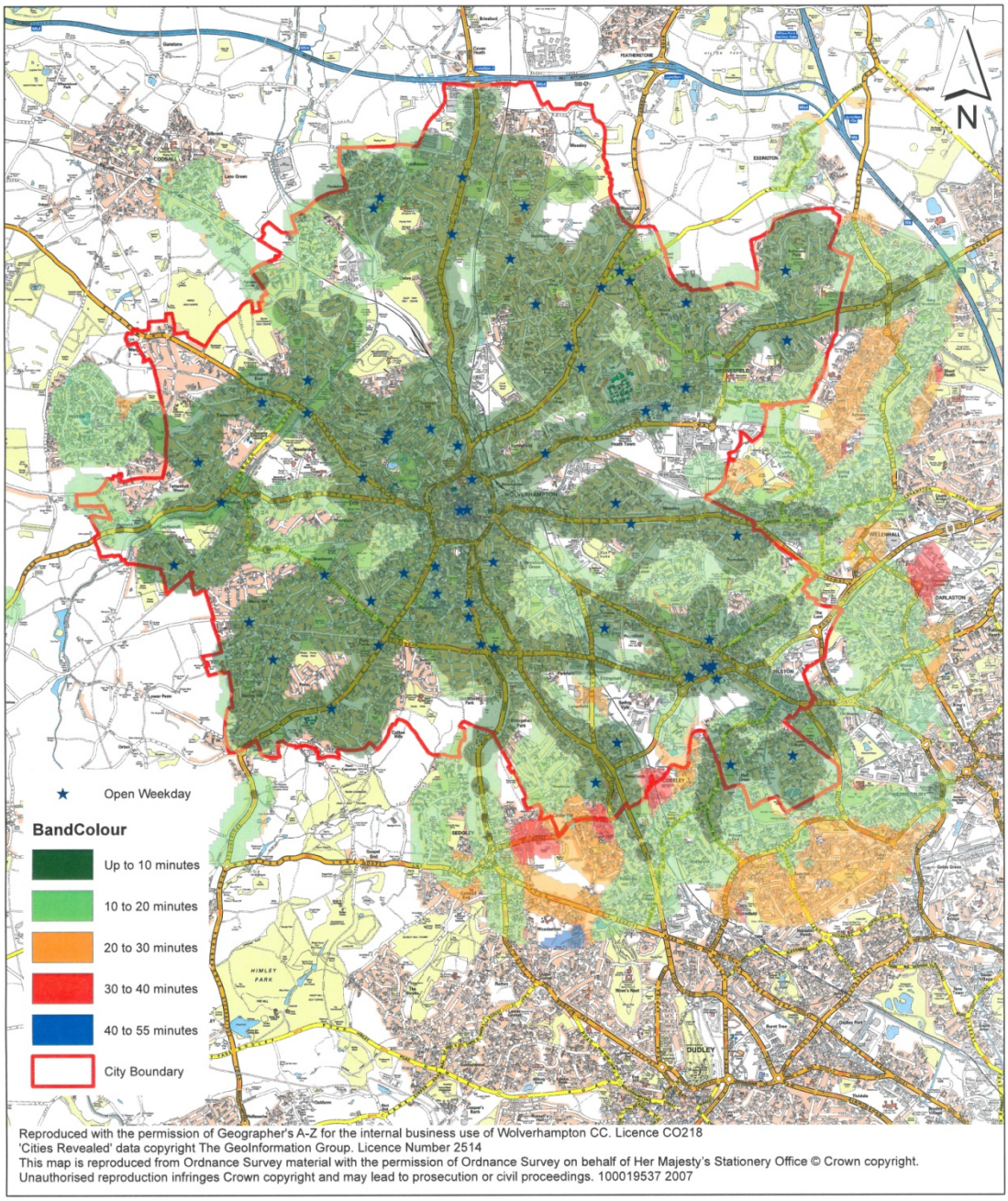
Travel times

To assess travel times to community pharmacies maps were created to look at access on weekdays and weekends, across a range of times by foot, public transport and car travel times. Access to pharmacies across the city is good. Travel time mapping demonstrates that across Wolverhampton, access to a pharmacy by car, even on a Sunday, is no more than six minutes away. Access on foot is good with the majority of journey times taking less than 20 minutes during the week and on Saturdays. On Sunday this increases up to 30-45 minutes. Journeys by public transport on weekdays and Saturdays, regardless of time, are generally up to 20 minutes for most people. On Sundays, travel times by public transport increase to up to 20-30 minutes in some areas of the city. The figures below highlight pedestrian access during the week and public transport access on Monday early evening (17:00-19:00).

Figure 13 and 14: Access mapping for pedestrians – weekdays and access mapping for pedestrians – weekdays 17:00-19:00.



# PUBLIC TRANSPORT ACCESS TO PHARMACIES OPEN WEEKDAY






Monday 5pm to 7pm
Access to stops: 300m
Walk speed: 4.8km/h
Interchange Distance: 0.0m
Produced Accession: 1.6.2.0

PT Data from August 2011

Wolverhampton City Council

Community pharmacy and wider primary care services

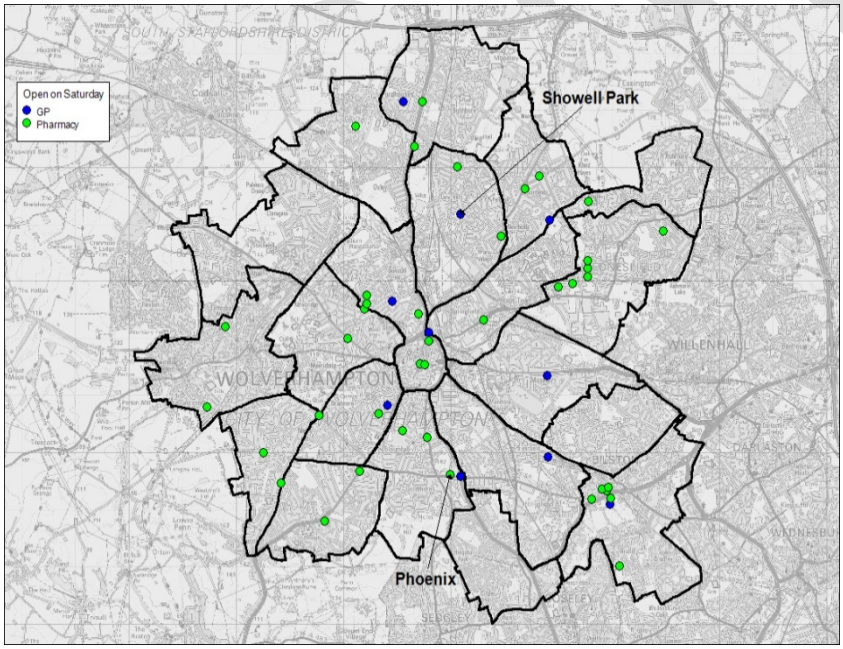
There are 49 GP practices across the city, of which 40 are signed up to the extended hours service. Extended hours provision varies across the week and all practices close by 20:30. Two GP practices offer early morning appointments during the week from 7:00. Nine GP practices provide services on Saturday with most offering morning only appointments, closing between 11:00 and 13:30. One practice remains open until 20:00 and is open from 8:00 to 20:00 on Sunday.

There are two Walk in centres in Wolverhampton offering nurse led advice and treatment for minor health problems (Showell Park and Phoenix). These provide services throughout the week including early evening cover Monday to Friday and weekend or bank holiday cover.

Out of hours cover is provided by Primecare based at the Phoenix Health Centre and accessed through the 111 telephone service.

In general community pharmacies are located in close proximity to general practices and Walk in centres. The map below shows community pharmacy, GP practice and Walk in centres open on Saturdays. Weekend community pharmacy coverage is well matched to GP provision, however community pharmacies in Ettingshall and East Park should consider aligning opening times to that of local GP practices.

Figure 15: Locations of community pharmacies, GP practices and Walk in centres – Saturday opening




Residents usage of community pharmacies

Of the respondents to the public questionnaire 40% visit a pharmacy every month, 26% every 2-3 months and 16% fortnightly. The majority use the same chemist (83%). Most people prefer to visit a pharmacy close to home (69%) or to their GP (40%). Visits are most likely to be for repeat prescriptions (28%), buying over the counter medicines (25%) or collection of one off prescriptions (19%).

Other dimensions of access

*Accommodation*

Of those responding to the pharmacy questionnaire 94% (62) have consultation facilities on site, 58 of these have a closed room on site and 46 have wheelchair access. Provision of private consultation facilities is often mandated in specifications for advanced and locally commissioned services. 62% (41) pharmacies indicated they were willing to consult in a patient's home or another suitable location. 54 provide hand washing facilities and 30 have toilets, usually located in or near the consulting space. These aspects of consultation facilities have improved since the 2011 PNA.

*Languages*

Community pharmacies provide a range of languages in addition to English, the commonest being; 76% (50) Punjabi, 34% (22) Urdu, 31% (20) Hindi and 28% (18) Gujarati.

*Electronic prescription services*

Electronic prescription services allow prescriptions to be sent electronically from a GP practice to a pharmacy and then on to the NHS Prescription Services for payment. There have been two releases of the electronic prescription service. Release 1 maintained the paper prescription as the legal prescription. Release 2 follows on from this and supports electronic transmission of prescriptions, repeat dispensing, cancellation and submission for reimbursement.

64 pharmacies across the city report that they are Release 2 enabled.

*Delivery services*

Many pharmacies offer delivery services, over 40 pharmacies indicated they offer delivery of dispensed medicines free on request to select patient groups and areas.

Assessment of pharmaceutical need

There are 27 community pharmacies per 100,000 population in Wolverhampton, which is comparable to our LAT neighbours, representing good overall community pharmacy provision. There are a range of community pharmacies accessible near the borders with Sandwell, Walsall and Dudley and in key conurbations within South Staffordshire. The majority open for more than 40 hours. Services open for 60 plus hours are concentrated in the most deprived areas of the city targeting areas of likely need. Remaining services are well distributed across the city. Average closing times indicate good evening coverage across the city, with 9 pharmacies open after 19:00. Weekend coverage is particularly good on Saturday. 12 pharmacies are open on Sunday scattered across the city concentrated in the most deprived areas. Community pharmacy locations and opening times are well matched to GP provision. The majority of respondents to the public questionnaire (86%) felt that pharmacies are open when they need them. Travel time mapping demonstrates short journey times throughout the week for all residents with access to a car. By public transport most pharmacies can be reached within 30 minutes even on a Sunday. Most residents can reach a pharmacy within a 20 minute walk during the week and on Saturday. Residents prefer to visit the same pharmacy where possible, either close to home or to their GP. The majority of pharmacies

offer private consultation spaces and many offer services in languages other than English. Most pharmacies can accommodate electronic prescriptions and many offer delivery services.

At this time there is adequate community pharmacy provision, well distributed across the city which is sufficient to meet the needs of residents. Electronic prescribing and delivery services are in place to assist those residents who struggle to reach a pharmacy.

### 7.3. Essential services

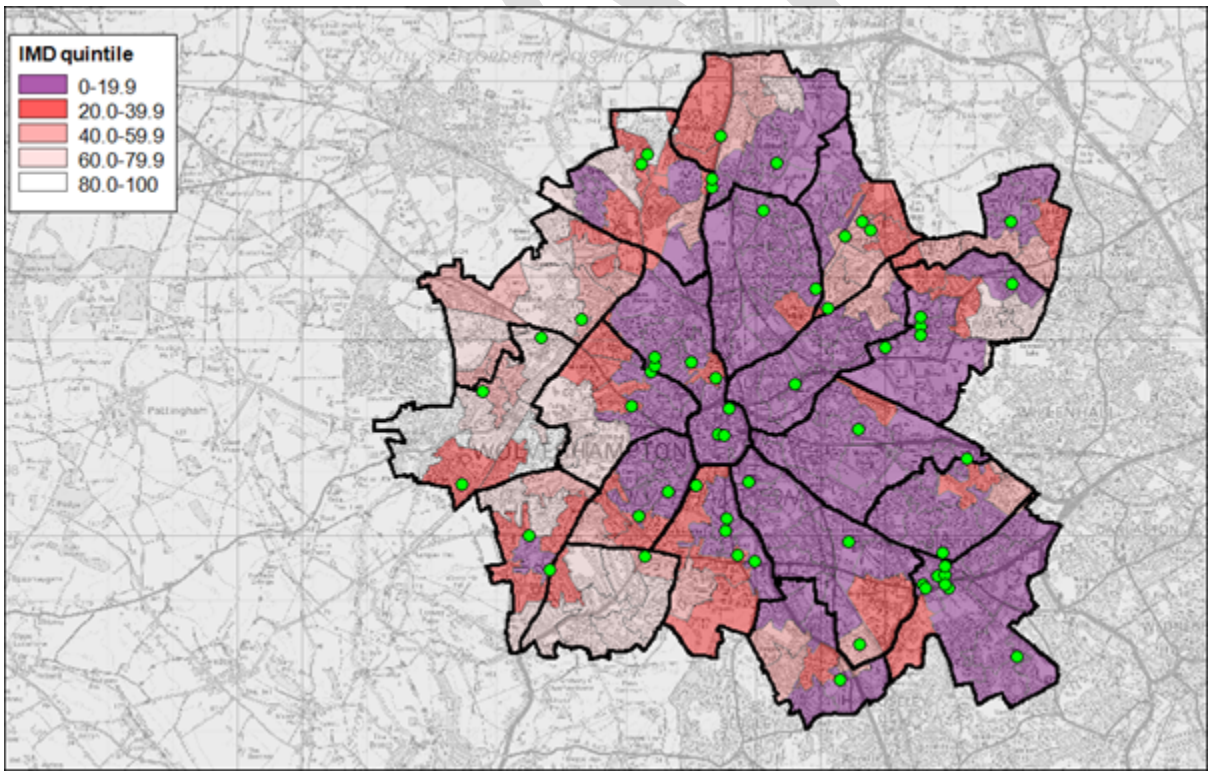
All community pharmacists holding NHS Pharmacy contracts are required to provide the services outlined below.

Dispensing appliances

Pharmacy contractors may regularly dispense appliances, dispense infrequently or decide not to dispense at all. Those choosing to supply must comply with Essential service requirements.

57 pharmacies indicated that they dispense all types of appliances (stoma, incontinence and dressings).

Figure 16: Map of pharmacies that dispense all types of appliances with deprivation




Dispensing medicines

Community pharmacists must ensure supply of medicines ordered on NHS prescriptions, together with information and advice to enable safe and effective use and maintain appropriate records of medicines supplied. In 2012-13 an average of 6,279 items were dispensed per month per pharmacy

across Wolverhampton, compared to averages of 6,359 across the West Midlands and 6,628 in England[4].

Repeat dispensing

In partnership with prescribers, patients can be supplied with repeatable NHS prescriptions through community pharmacies for an agreed period. The service aims to increase choice and convenience for patients, minimise medicines wastage and reduce the workload in General Medical Practices. In Wolverhampton 21% of prescribed items were repeat prescriptions during 2013/14, translating to 4.6% of total prescribing costs.

Disposal of unwanted medicines

Community pharmacies are obliged to accept any unwanted medicines for disposal. NHS England's Local Area Team arranges collection by waste contractors. The service aims to reduce the risks of accidental poisonings and diversion of medicines outside of their prescribed use, whilst ensuring secure disposal and reduction in environmental damage. This service does not extend to sharps disposal and needle waste.

Public Health and the promotion of healthy lifestyles

Community pharmacies are required to participate in up to six campaigns coordinated by NHS England and Public Health England (PHE). This usually involves display of posters and distribution of leaflets or patient literature in support of the campaign. Local arrangements need to be made to align national campaigns with local priorities and knowledge of our population. NHS England, PHE and Wolverhampton Public Health should work closely with the LPC to ensure effective delivery of campaigns.

In addition community pharmacists should offer opportunistic healthy lifestyle advice and public health advice to patients receiving prescriptions for diabetes, hypertension, coronary heart disease or who smoke or are overweight. Verbal advice should be given and may be supported by written information or signposting to other services.

Signposting

Community pharmacists should be provided with information on other health and social care providers and support organisations that they can signpost service users to when they require further support, advice or treatment.

Support for self-care

Pharmacies help to manage minor ailments and common conditions by provision of advice and sales of non-prescription medicines where appropriate. The service aims to support individuals caring for themselves and their families and minimise inappropriate use of health and social care services.

[4] Health & Social Care Information Centre. General Pharmaceutical Services in England 2003-04 to 2012-2013 PCT level tables. Table 2a. Available from http://www.hscic.gov.uk/catalogue/PUB12683. Accessed September 2014.

### 7.4. Advanced services

Some community pharmacies provide the following Advanced Services subject to accreditation under contract with NHS England.

Medicines use reviews (MUR)

The MUR service was introduced in 2005 with significant changes since then. The purpose of the MUR service is with the patient's consent to improve knowledge and use of prescribed medicines by establishing understanding and actual use, identifying and assisting in resolution of ineffective drug use, identifying side effects and interactions thereby improving clinical and cost effectiveness whilst reducing wastage of drugs. MURs are offered to eligible patients taking multiple medicines and patients in three National Target Groups:

- Those taking any high risk drugs (NSAIDs, Anticoagulants, Antiplatelets, Diuretics)
- Patients prescribed certain respiratory drugs
- Patients who have recently been discharged from hospital with changes to medication.

Community pharmacies offering MURs are subject to a cap of 200 in the first financial year of a commissioned service and 400 in subsequent financial years. At least 50% of MURs must be with patients in a National Target Group (NTG). MURs can include brief advice on healthier lifestyles[5].

In September 2014 changes to the 2014/15 Community Pharmacy Contractual Framework agreement introduced a new national target group. Patients prescribed four or more medicines, one of which for a cardiovascular disease or risk condition will be eligible for a MUR. The target for MURs in NTGs will also rise from 50 to 70%.

62 pharmacies indicated in our survey that they provide Medicines Use Reviews and two are intending to provide in the next 12 months. Activity from 2012-13 show an average of approximately 280 MURs took place, with just under 15,000 MURs taking place across 54 community pharmacies in Wolverhampton. This activity seems to be increasing with time and is similar to the West Midlands and England averages (both 267)[6].

New medicines service (NMS)

The NMS was the fourth Advanced Service added to the NHS community pharmacy contract in 2011, initially as a time limited one year service. After positive evaluation NHS England has agreed to continue to commission this service. NMS may only be offered by contractors also offering the MUR service. The NMS is offered to patients with long term conditions who have been started on certain new medicines for the treatment of asthma, COPD, type 2 diabetes, hypertension or antiplatelet or anticoagulant therapy. The NMS is delivered in three stages:

[5] Pharmaceutical Services Negotiating Committee (PSNC) and NHS Employers: Guidance on the Medicines Use Review service, October 2013. Available from http://psnc.org.uk/services-commissioning/advanced-services/murs/ Accessed September 2014.

[6] Health & Social Care Information Centre. General Pharmaceutical Services in England 2003-04 to 2012-2013 PCT level tables. Table 13. Available from http://www.hscic.gov.uk/catalogue/PUB12683. Accessed September 2014.

- First stage services (Patient engagement) – brief advice on new medication, healthy lifestyles and sufficient information on NMS to allow informed consent given to patients presenting prescriptions for new medicines or following referral from another health professional.
- Second stage services (Intervention) – assessment of adherence to treatment, adverse drug reactions and need for further support or referral back to the patient's GP.
- Third stage services (Follow up) – second assessment of adherence to treatment and new or continuing problems with medication or self-management.

Where multiple new medicines are started all should be discussed as part of the NMS. Contractors can claim at the end of a full service intervention as defined in the service specification. Four target payment bands are offered 20, 40, 60 and 80% of maximum number of opportunities (0.5% of prescription volume for practice). Price per intervention increases with target bands and claims cannot exceed the maximum number of opportunities for the practice size[7].

60 pharmacies indicated in our survey that they provide this service and four are intending to begin in the next 12 months. In 2012-13 an average of 59 NMS were provided per pharmacy, equating to a total of around 2,900 NMS across 49 pharmacies. The average number of NMS provided is lower than the West Midlands and England averages of 67 and 68 respectively[8].

Appliance use reviews (AUR)

The AUR was the second Advanced Service added to NHS community pharmacy contract. AURs can take place within pharmacies or at the patient's home and aim to improve knowledge and usage, resolve ineffective usage and provide advice on safe storage and disposal of specified appliances (e.g. incontinence, stoma or catheter appliances and wound drainage pouches). The maximum number of AUR services which can be claimed is not more than 1/35$^{th}$ of the number of appliances dispensed[9].

12 pharmacies indicated that they provide this service and 15 are intending to begin in the next 12 months. Data from 2010-13 show no activity for this service.

Stoma appliance customisation (SAC)

The SAC service can be provided by pharmacies that provide stoma appliances and aims to ensure proper use and comfortable fitting of stoma appliances (listed in Part IXC of the Drug Tariff[10]), improving duration of use and reducing waste via customisation of appliances to patient's measurements.

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[7] Pharmaceutical Services Negotiating Committee (PSNC) and NHS Employers: New Medicine Service guidance, December 2013. Available from http://psnc.org.uk/wp-content/uploads/2013/06/NMS_guidance_Dec_2013.pdf Accessed September 2014.

[8] Health & Social Care Information Centre. General Pharmaceutical Services in England 2003-04 to 2012-2013 PCT level tables. Table 14. Available from http://www.hscic.gov.uk/catalogue/PUB12683. Accessed September 2014.

[9] Department of Health. Pharmaceutical Services (Advanced and Enhanced Services)(England) Directions 2013. April 2013. Available from https://www.gov.uk/government/publications/pharmaceutical-services-advanced-and-enhanced-services-england-directions-2013 Accessed September2014

[10] National Health Service England and Wales. Electronic Drug Tariff, September 2014. Available from http://www.ppa.org.uk/ppa/edt_intro.htm Accessed September 2014.

Eight pharmacies reported that they provide this service and 11 are intending to begin in the next 12 months. Just over 100 SACs were provided during 2012-13 with an average of 16 per contractor across Wolverhampton.

### 7.5. Locally commissioned services

#### 7.5.1 Smoking cessation services

Local health need

The latest data on smoking prevalence in Wolverhampton (2010-12) estimates that 22.9% of individuals, aged 18 years and over, are smokers. This is significantly higher than the England and West Midlands averages of 19.5% and 19.9% respectively. The prevalence of smoking amongst routine and manual workers (31.7%) is similar to the England average of 29.7%.

The proportion of pregnant women smoking at the time of delivery (18.6%) is significantly higher than the England (12.7%) and West Midlands (14.2%) average. Higher rates of smoking at the time of delivery are seen in the north and east of the city, similar to mapped areas of deprivation. Although the inner city areas of St Peter's, Heath Town, Graiseley and Blakenhall have high rates of deprivation there are low levels of smoking in pregnancy. This could be explained by the high levels of Asian and Black residents in these areas who generally have lower smoking rates during pregnancy.

Local services

Public Health commission the Healthy Lifestyles Service (HLS) delivered by the Royal Wolverhampton NHS Trust. This provides a broad range of services aiming to support healthy lifestyles. One aspect of the service is a Smoking Intervention aimed at supporting smoking cessation attempts and a voucher scheme enabling smokers to access two weeks free Nicotine Replacement Therapy (NRT). They offer an individual support service for smokers who want to quit, which includes: One to One Support through GP practices, community pharmacies and a number of drop in clinics in the Wolverhampton area. Workplace groups can be arranged on request so that colleagues who work together can support each other. A specialist pregnancy service is also available for pregnant women and the service has a presence within the Royal Wolverhampton NHS Trust on general wards and the Maternity Unit. Home Visits are available for patients who are housebound and interpreter services are available on request.

The Healthy Lifestyles Service team facilitate other providers such as GPs and community pharmacies in the delivery of Smoking Intervention Services through training and on-going support. The HLS team also lead on the Healthy City Award and deliver Making Every Contact Count (MECC) training to numerous service areas.

The NHS Health Check service includes questions on smoking status and signposting to relevant services

Local services: Community Pharmacy Smoking Intervention

*Responsible commissioner: Wolverhampton City Council Public Health*

Pharmacies providing the smoking intervention service receive training from the Healthy Lifestyles Service, must have a named smoking cessation advisor and provide supportive interventions to achieve four and 12 week quitters. Pharmacy stop smoking services must comply with the standards outlined in the Healthy Lifestyles Service specification. 19 community pharmacies are commissioned to deliver this service, with a large proportion of those offering the service located in the north of the city. In 2013/14 there were 80 claims by pharmacies for four week quits, with an average of three quitters claimed for per pharmacy. The majority of community pharmacies are willing to provide stop smoking services.

Figure 17: Smoking intervention pharmacy provision by number of four week quitters in 2013/14

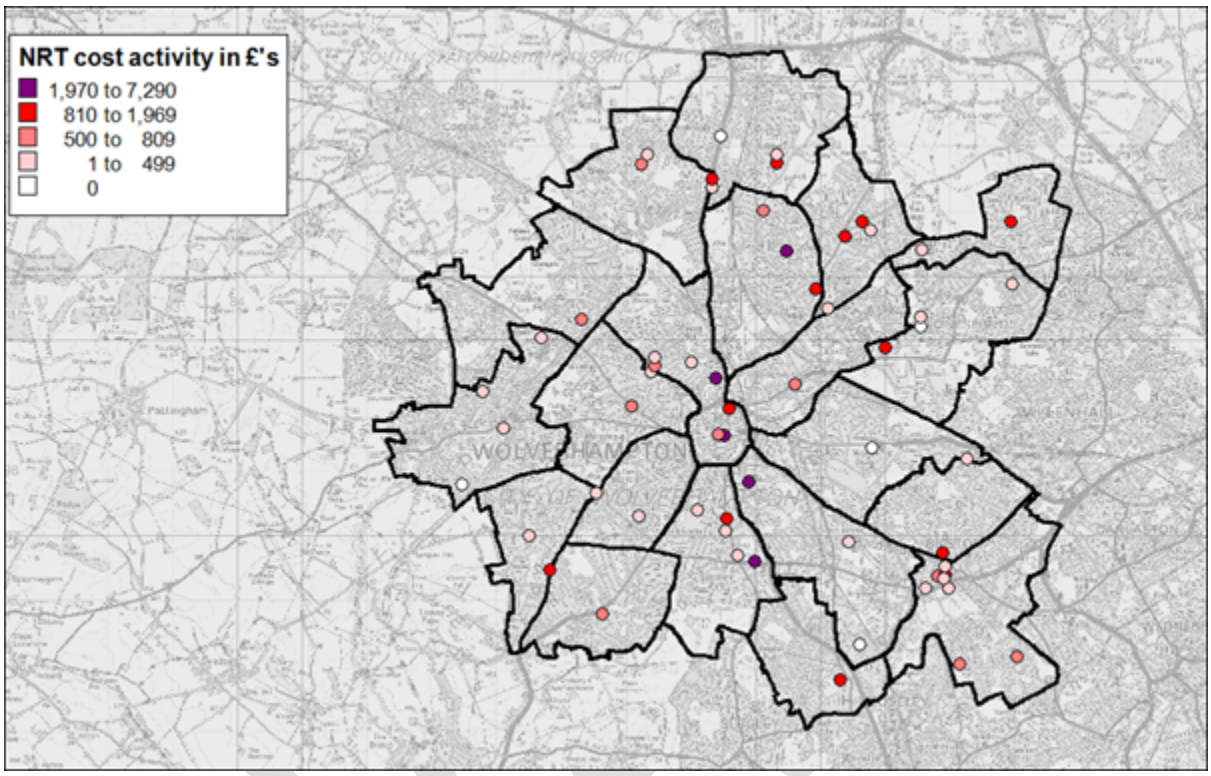

Local services: Community Pharmacy Nicotine Replacement (NRT) Services

In addition Public Health commission a nicotine replacement therapy (NRT) service from community pharmacies. Any smoking cessation advisor accredited by the Healthy Lifestyles Service can provide service users with a voucher for NRT. Vouchers specify the product to be provided and dispensed by pharmacies signed up to the NRT service.

All community pharmacies signed up to the Smoking Intervention service also offer NRT services. In total there are 61 community pharmacies signed up to the NRT service and a further four are willing to sign up. Dispensing activity for 2013/14 by pharmacy suggests that larger pharmacies and/or those located in the north of the city and prominent locations such as the city centre, Bilston High

Street and Wednesfield had the highest activity. Some contractors have no recorded cost activity for 2013/14.

Figure 18: NRT pharmacy provision with spend activity 2013/14




Assessment of pharmaceutical need

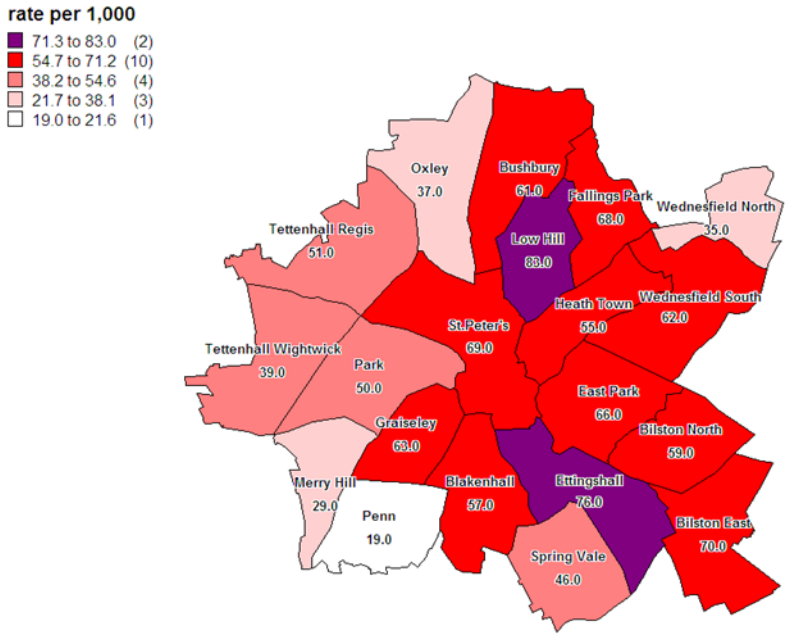
Community pharmacies are well placed to deliver smoking interventions and NRT in the community and provide valuable support to wider services. Current contractors provide good coverage across the city, however smoking intervention services are concentrated in the north of the city. The majority of community pharmacies are willing to provide stop smoking services offering an opportunity to expand the smoking intervention service. Efforts should be made to boost the number of quitters achieved and NRT offered within existing providers.

### 7.5.2 Unplanned pregnancy and contraception services

Local health need

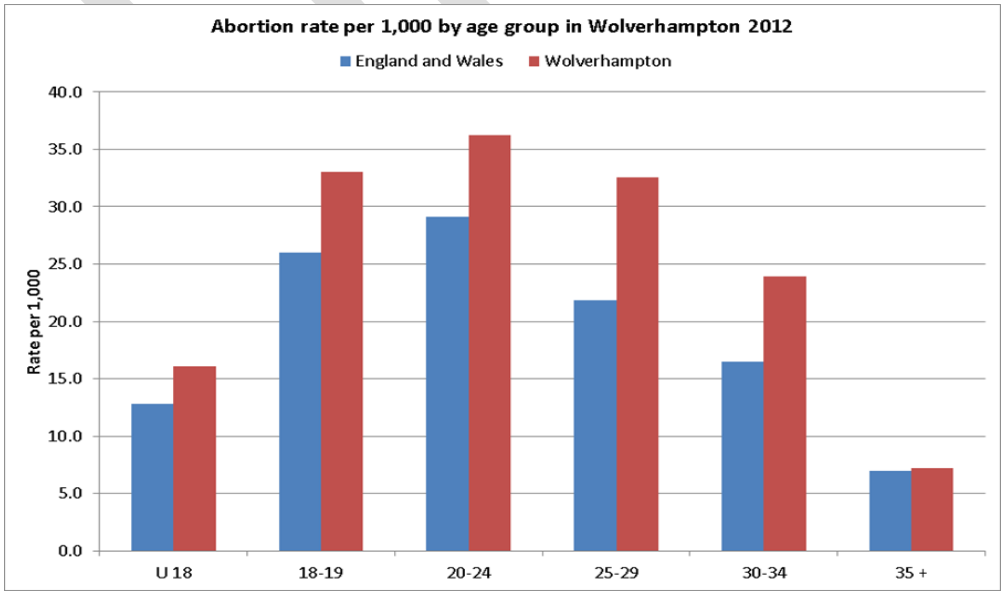
In 2012 the rate of teenage pregnancy in Wolverhampton was 42 per 1,000 population, although significantly improved on recent years the rate remains above the regional (32 per 1,000) and national average (28 per 1,000). The highest rates occur in the more deprived wards in the north, central and east of Wolverhampton. Low Hill and Ettingshall experience the highest rates of teenage pregnancy; 83 and 76 per 1000 respectively. 9.7% of under 18 births between 2004-2012 were not first pregnancies.

Figure 19: Under 18 Conception rates by ward 2008-2010




In Wolverhampton in 2012 there were 1,121 terminations of pregnancy (21.7 per 1,000 women aged 15-44) and rates are consistently higher than the national average. From 2004 to 2012 rates have fallen for women aged 20-24 (22.8 to 16.1) and risen for those aged 30-34 (18.1 to 23.9). 28% of abortions in women under 25 are repeat abortions[11].

Figure 20: Abortion rate in Wolverhampton by age group 2012




[11] Public Health Wolverhampton. Wolverhampton Sexual Health Review 2013/14. July 2014.

Local services

There are a range of services across the city providing contraception and counselling support.

*Schools services* – the school nursing team have 5 CaSH trained nurses who can issue condoms, pregnancy tests and consult for LARC and chlamydia screening. Sex and relationship education (SRE) is coordinated through the Puberty Pack and Secondary Spiral Curriculum resources with support from the Healthy Schools Team. There is inconsistency in delivery of SRE lessons across the city contributing to inequalities in unplanned pregnancy outcomes.

*CaSH (Contraception and Sexual Health) service* – provides a range of contraceptive services, counselling and family planning, including a C Card scheme enabling free access to condoms at 25 sites across the city. There are 54,000 attendances annually with over half being for contraception and family planning.

*GP* - 46 out of 53 GP practices offer fitting and removal of IUDs (Intra uterine device) and 39 offer contraceptive implants. Coverage is well spread across the city.

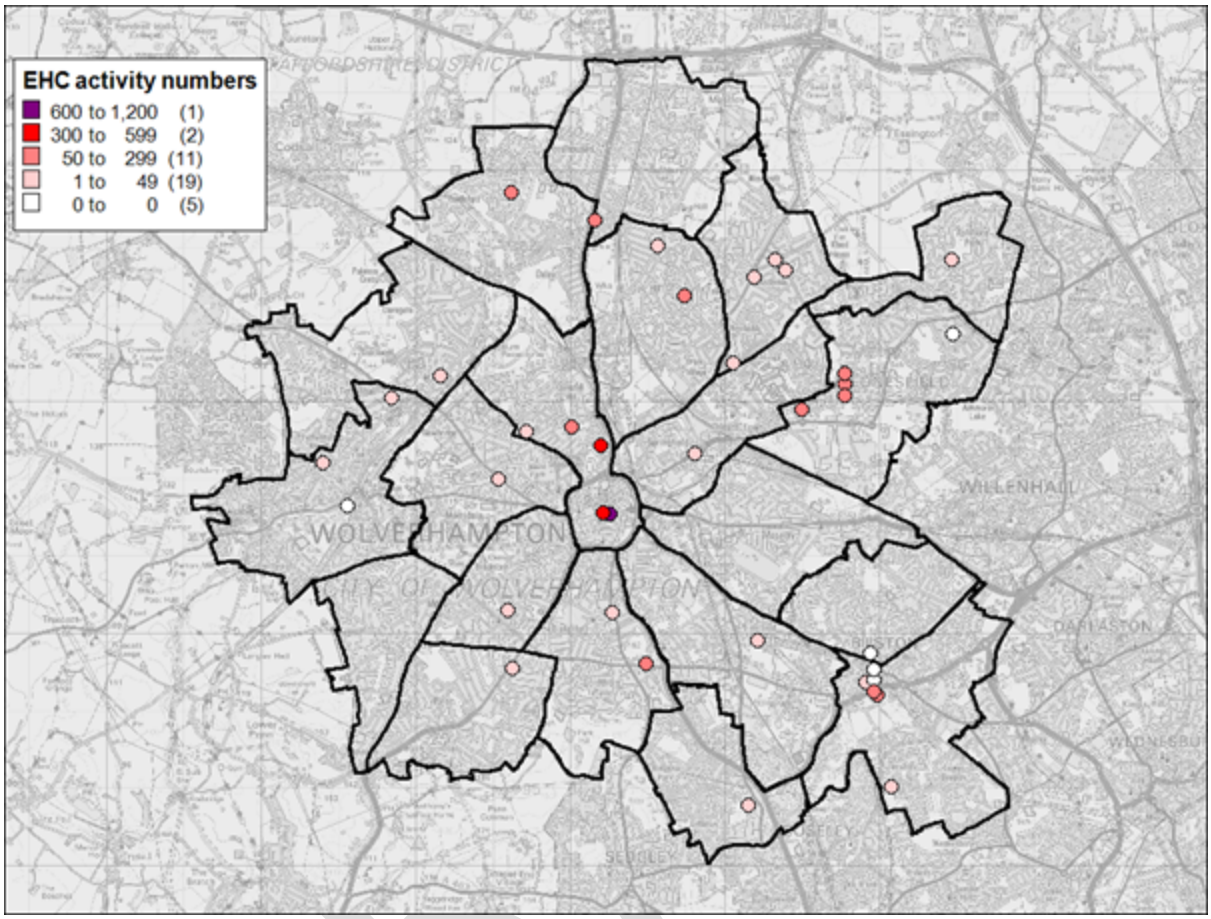
*Choices counselling Base 25* – offers counselling to young people and vulnerable adults under 25.

Local services: Community Pharmacy Emergency Hormonal Contraception Service (EHC)

*Responsible commissioner: Wolverhampton City Council Public Health*

Offering convenient and rapid access to free EHC through pharmacies can help contribute to a reduction in unplanned/unwanted pregnancies as well as increasing choice when accessing EHC. Public Health commissions EHC services from 36 community pharmacies across Wolverhampton, a further 22 pharmacies are willing to provide this service. Pharmacy contractors can provide brief sexual health advice and signposting to other services. Under 25's and those using EHC more than once in a 12 month period should be offered a bag including condoms, contraceptive advice and information on local sexual health service. Data from Q1-Q4 2013/14 shows there were 3,677 consultations for EHC and 3,589 prescriptions issued by 32 community pharmacies. Five pharmacies registered to provide the service had no activity during this time period (shown in yellow on the map). The largest volume prescribers are located in the city centre and Bilston and Wednesfield High Streets. Nearly 57% of the activity occurs in just three pharmacies located in the city centre (2,047 items prescribed in 2013/14). The majority of pharmacy prescriptions are for young women 16-24 years with 63.4% (1205) in the most deprived quintile, which accounts for 51.9% of the Wolverhampton population.

Figure 21: Map of community pharmacy EHC provision across Wolverhampton with prescribing activity 2013/14




Assessment of pharmaceutical need

Community pharmacies are well placed to deliver EHC in the community and provide valuable support to wider sexual health and contraception services. There is good coverage across the city with 36 providers in total. The majority of the activity takes place in the city centre and Bilston and Wednesfield High Streets and captures young people living in the most deprived areas of the city. Many pharmacies indicated willingness to provide contraceptive services other than EHC, this could be considered in future commissioning.

### 7.5.3 Drug and alcohol related harms and services

Local health need: Alcohol misuse

Although the gap appears to be closing, Wolverhampton is consistently significantly higher than the national average for alcohol related mortality, with the most recent rate of 28 per 100,000 population (compared to 18 for England). Rates are much higher for those who reside in the most deprived areas, in particular the South of the city such as, Graiseley, Blakenhall and Ettingshall wards.

The Local Alcohol Profiles for England (2014) indicate that Wolverhampton has a significantly lower rate of hospital admissions for alcohol specific conditions, for individuals under the age of 18 years,

33.3 per 100,000, compared to the England average of 44.9 per 100,000. The rate of adult hospital admissions for alcohol specific conditions for both males, 518.8 per 100,000, and females, 221.7 per 100,000 is similar to the England average of 506.9 per 100, 000 and 232.3 per 100,000, respectively.

The estimated proportion of higher risk drinkers in Wolverhampton is 6.3% which is similar to the England average of 6.75%. This estimate is derived from an updated statistical model of local authority populations in mid-2009. The proportion of binge drinkers in Wolverhampton is 14.7% which is significantly lower than the England average of 20.1%. It should be noted however, this indicator is also an estimated statistic derived from updated data base lined in 2007-2008. It is likely that these estimates do not present an accurate summary of the proportion of higher risk and binge drinkers in Wolverhampton.

Local health need: Drugs misuse

The National Treatment Agency (NTA) provides a calculated prevalence of opiate and/ or crack cocaine users, previously defined as 'problem drug users', by local authority. In Wolverhampton 13.6% of the resident population were estimated to use opiates and /or crack cocaine. This is significantly higher than the England average of 8.6%. However, the proportion of opiate users in Wolverhampton who successfully complete drug treatment is 8.2%, which is the same as the average for England.

Local services: Alcohol and drugs misuse

The Wolverhampton Alcohol Strategy and Action Plan 2011-2015 has a focus on four goals. These are:

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

New and enhanced alcohol services (community and acute sector) for adults and young people were commissioned and became operational during April 2013, including an Alcohol Liaison Service at New Cross Hospital and community detoxification services.

Wider treatment services for drugs and alcohol in Wolverhampton are provided by Recovery Near You (adult service) and Wolverhampton 360 (young people aged 18 and under). The service is provided by Nacro, the crime reduction charity working in partnership with Aquarius, a charity that provides support to individuals dealing with addiction and Birmingham and Solihull Mental Health NHS Foundation Trust providing mental healthcare. As of the 1st of April 2013 the partnership has been providing an integrated service with a single point of contact for adults and young people struggling with drug and alcohol addiction.

Alcohol services are not currently commissioned in Wolverhampton from community pharmacies. 50 pharmacies indicated they would be willing to provide alcohol screening services.

*Case Study Alcohol Awareness Portsmouth – NHS Portsmouth ran a one month campaign in 2010 "Rethink your Drink" through community pharmacies. The aims were to raise awareness of safe levels of drinking and suggest small actions moderate to medium risk drinkers could take to reduce consumption. Pharmacy staff asked service users to complete alcohol scratch cards, approximately 3600 were completed; 40% were at increased risk and 8% at high risk of developing alcohol related problems. An alcohol intervention and brief advice service was commissioned following on from this[12].*

Local services: Community Pharmacy Supervised Consumption

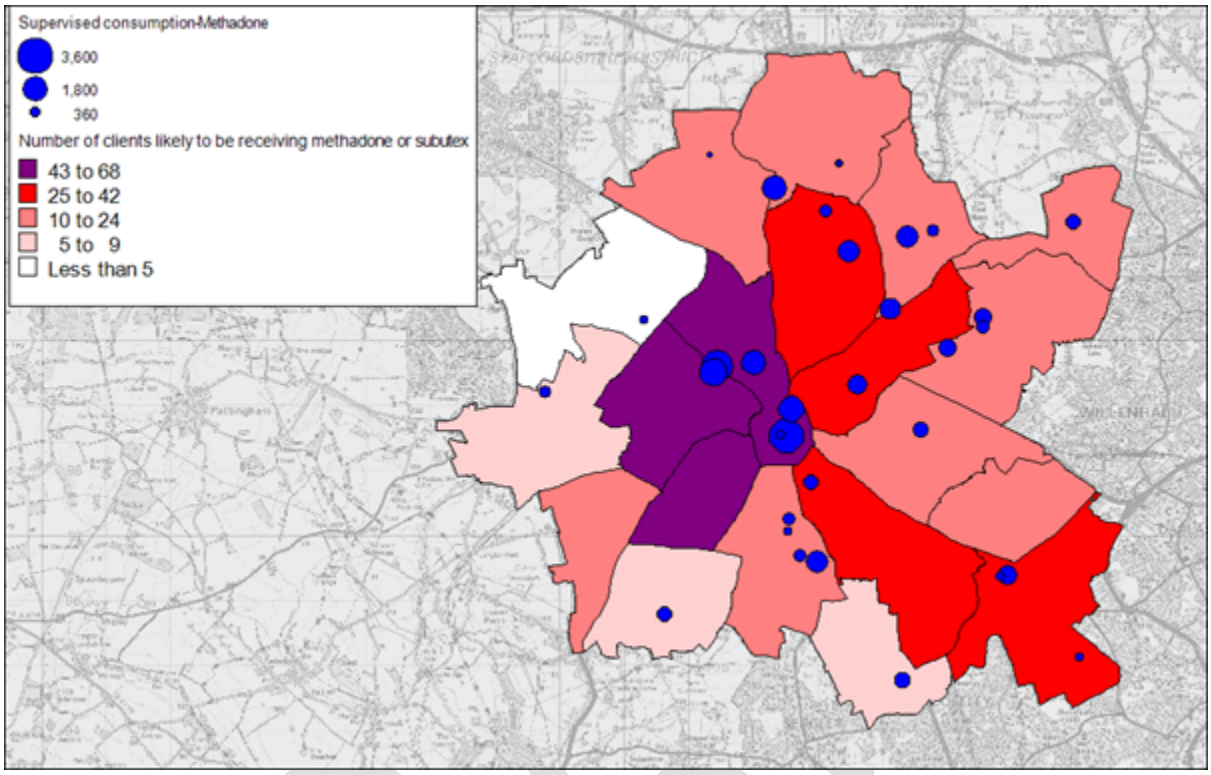
*Responsible commissioner: Wolverhampton City Council Public Health*

The service supports the wider Recovery Near You treatment service in the delivery of drug treatment plans supporting drug users in their local community to move from opioid substitution therapy, to detoxification and abstinence. Supervised consumption provides the best guarantee that medicines are taken as directed, and reduce craving, prevent withdrawal, eliminate the hazards of injecting and improve overall function of service users. Other benefits include better use of prescribed medicines, diversion of prescribed medicines from the illicit drugs market and reduction in accidental exposure to controlled medicines. The service provides regular contact with healthcare professionals and opportunities for signposting to other treatment services.

A total of 32 pharmacies offer the service and 17 are willing to. The top ten pharmacies with the highest volume of activity serve 60% of the supervised consumption client base, this is the case for both Methadone and Subutex supervised consumption. All 32 pharmacies who offer the service claimed activity at least once during 2013-14. The service sees high footfall for pharmacies in the inner city areas, in particular those in or near St Peters ward. Other wards with high activity are Bushbury South & Low Hill, Heath Town and Blakenhall. Unsurprisingly, pharmacies with the largest volume of activity are located near areas that contain a larger numbers of clients that are in treatment and likely to be receiving prescriptions for Methadone and Subutex.

[12] Local Government Association. Community pharmacy: Local government's new public health role. October 2013. Available from http://www.local.gov.uk/publications/-/journal_content/56/10180/5597846/PUBLICATION Accessed August 2014.

Figure 22: Pharmacy provision and activity for supervised consumption (Methadone) 2013/14 with those likely to require the service




Local services: Community pharmacy Needle Exchange Services

*Responsible commissioner: Wolverhampton City Council Public Health*

Although described separately the Supervised Consumption service is commissioned alongside a Needle Exchange service. Community pharmacies in Wolverhampton must agree to deliver both services. Needle exchange services supply injecting drug users with sterile needles, syringes and other paraphernalia to prepare and take illicit drugs (performance and image enhancing drugs (PIEDs), heroin, opiates and crack cocaine). Two varieties of needle exchange packs are distributed to community pharmacies from a central supplier. The service aims to provide harm reduction information and signposting to appropriate services to support drug users achieving a drug free life. Needle exchange helps to reduce rates of blood borne infections and drug related deaths by reducing high risk injecting behaviours such as needle sharing, enforces harm reduction messages and acts as a gateway to hepatitis B immunisation and screening for HIV and hepatitis. Services aim to maximise access and retention of injectors, particularly those who are socially excluded, and ensure return and safe disposal of injecting equipment to protect the health of local communities.

A total of 32 pharmacies offer the service across Wolverhampton with varying degrees of service user footfall. Approximately 60% of packs issued are delivered by 10 of the pharmacies. The top two issuing pharmacies are located in St Peters ward. Other areas of high activity are Bushbury South & Low Hill and prominent locations such as the city centre and Bilston High Street. The rate for packs returned through the scheme is lower than the national average and fluctuates around 25%. High return rates are not necessarily linked to high issuing pharmacies. High levels of packs being issued in conjunction with low return rates can lead to problematic litter issues in several hotspot areas of

the city. It is vital that contractors engage with service users and re-iterate the importance of returning used needle litter through the dispensing pharmacist.

Figure 23: Needle exchange provision with % pack return rate of those issued 2013/14 and injecting population

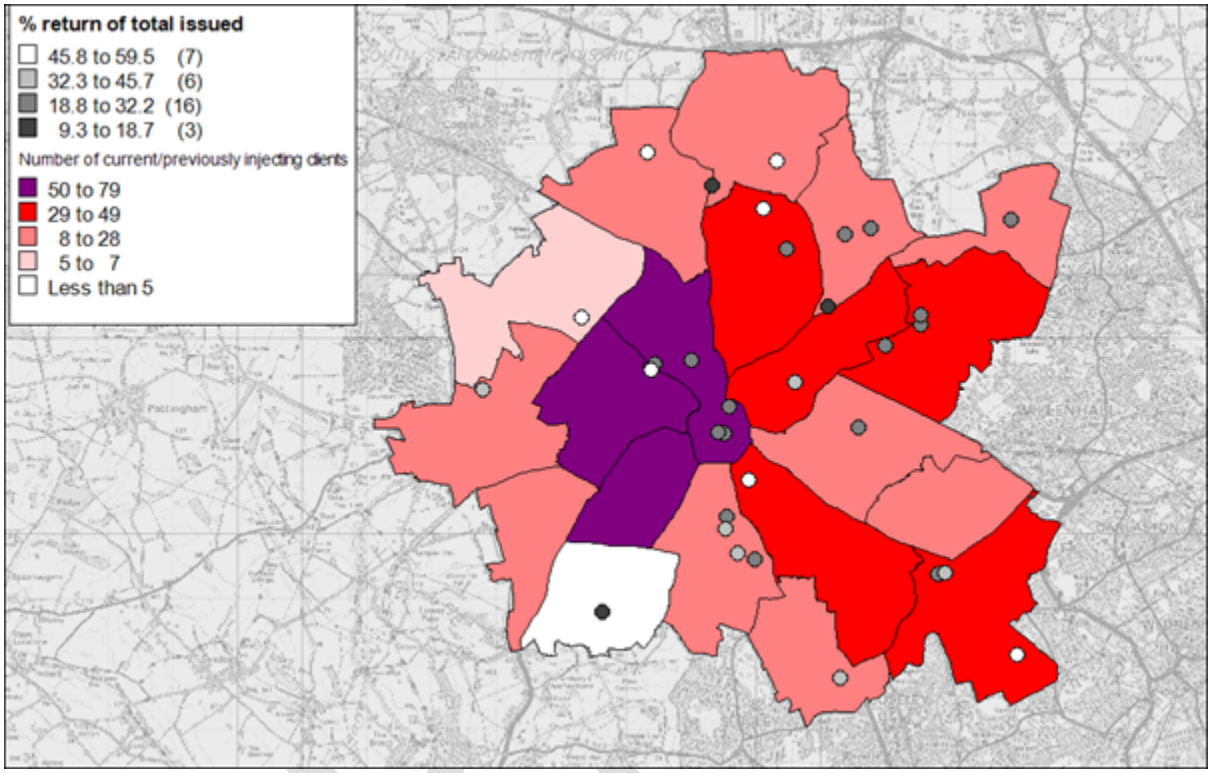
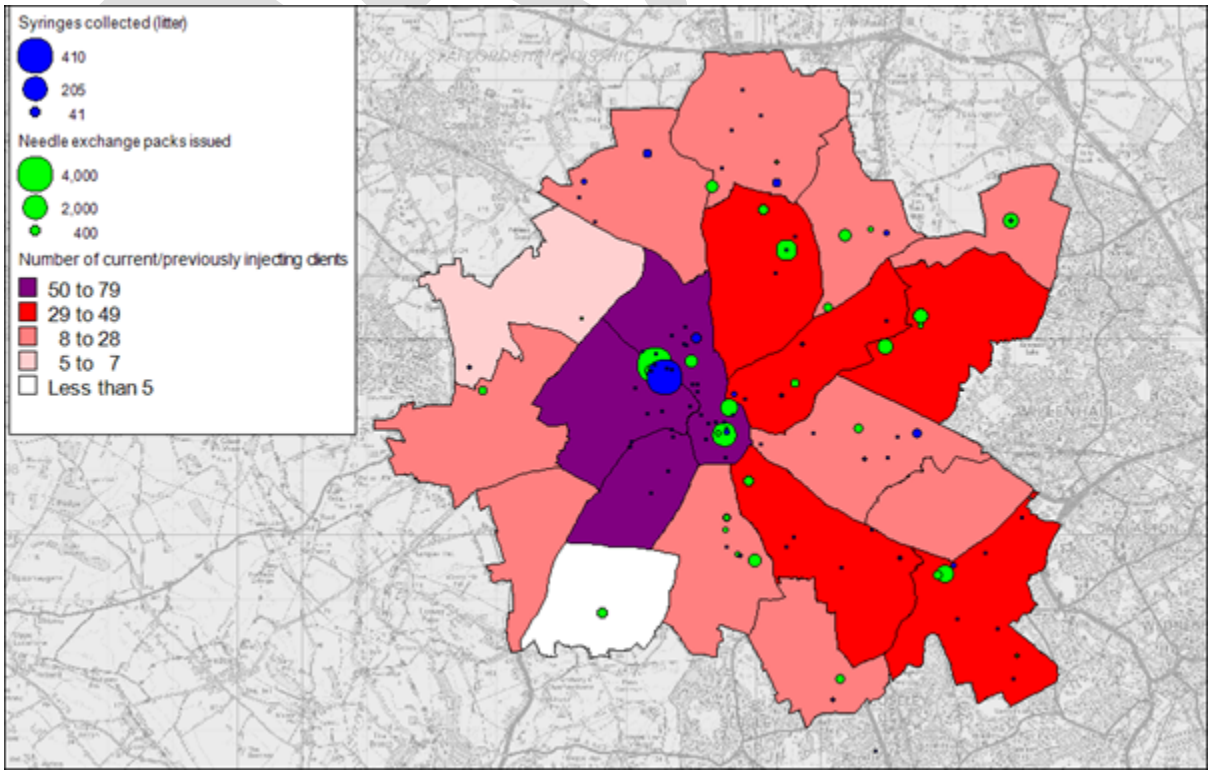



Figure 24: Packs issued with reported levels of syringe litter collected 2013/14 and injecting population



Assessment of pharmaceutical need

Alcohol and drugs are key local priorities outlined in the Wolverhampton HWBS. Community pharmacies do not currently provide specific alcohol services. Review of the local Alcohol Strategy and Action Plan (2011-15) offers an opportunity to consider the role that community pharmacists can play in the provision of local alcohol services (for example brief interventions or screening) and alcohol awareness raising campaigns.

Community pharmacy supervised consumption and needle exchange services provide valuable support to the Recovery Near You service. There is good coverage across the city with highest volume activity taking place in areas with larger numbers of clients in treatment. Pack return and needle litter remain concerns in the city. It is vital that contractors continue to work closely with the Recovery Near You service to engage with service users and emphasise the importance of returning packs and litter to the dispensing pharmacist.

### 7.5.4 Minor ailments

Local health need

Estimations from the Pharmaceutical Services Negotiating Committee (PSNC) suggest that in Wolverhampton there are around 256,000 GP consultations for minor ailments per year in Wolverhampton, this equates to 18% of all GP consultations and 90% of these consultations were for minor ailments alone. In addition to this, in 2011/12 8% (10,500) of A&E attendances were for minor ailments[13]. Nationally an estimated 51.4 million consultations per year take place for minor ailments alone at an estimated cost of £1.5 billion.

Local services

The general population experience the symptoms of minor ailments on a regular basis and usually self-care and self-medicate. As outlined above, some individuals contact their GP or A&E services as a first port of call.

Local services: Community Pharmacy Minor Ailment service

*Responsible commissioner: NHS England Birmingham and Black Country Local Area Team*

The Minor Ailments service has recently been changed with a new specification starting in October 2014. The new scheme aims to promote self-care and, where appropriate the use of over the counter products among patients suffering from minor ailments. The service is available to patients who are exempt from prescription charges and registered with a participating GP. The service covers; acute cough, headache, sore throat, acute fever, earache, diarrhoea, cold and flu, head lice, hay fever, dry skin/simple eczema, bites and stings, cold sores, vaginal thrush, sunburn, nappy rash, mouth ulcers, dyspepsia, constipation and primary eye-care assessment. Patients can register with only one pharmacy and are currently restricted to three visits in a six month period.

[13] http://psnc.org.uk/services-commissioning/psnc-briefings-services-and-commissioning/psnc-briefing-09213-building-a-business-case-for-minor-ailments-september-2013/

The majority of pharmacies indicated they provide or would be willing to provide this service with only four contractors indicating they would not. No activity data is presented as the new specification introduces significant changes.

Sign ups to be confirmed

Assessment of pharmaceutical need

Activity against the new specification will need to be monitored and evaluated. Impacts on local GP and A&E attendances will need to be assessed.

### 7.5.5 Other local services and community pharmacies

Palliative Care drug supply

*Responsible commissioner: Wolverhampton CCG*

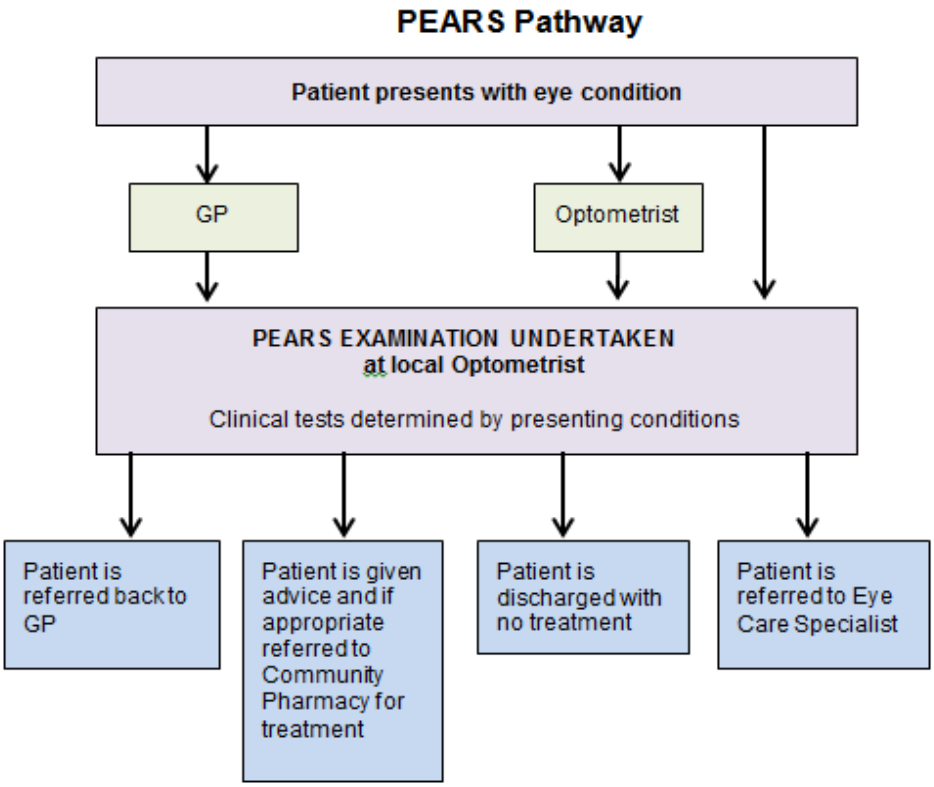
Compton Hospice provide a range of services for end of life care; including day care, home nursing, hospice at home and in patient care. Compton Hospice are supplied with drugs by Tettenhall Wood Pharmacy who also provide support to other pharmacies needing to meet palliative care needs.

Primary Eyecare Assessment and Referral Service (PEARS)

*Responsible commissioner: Wolverhampton CCG*

PEARS started in September 2014. The service acts as a gateway for patients presenting with a range of eye conditions suitable for treatment in primary care. Optometrists can refer to a community pharmacy to supply treatment for a number of self-limiting eye conditions. These patients are provided with a PEARS Diagnosis and Medication form. GP and secondary care eye care specialists manage the remainder of referrals.

Optometrists can select medication recommendations from a set formulary for delivery through PEARS. Patients are free to choose any pharmacy amongst those providing the service. Community pharmacies will supply appropriate drugs in response to receipt of a PEARS form and provide counselling on appropriate usage and steps to take if the condition fails to improve or worsens. Charges for supply are determined by standard charge exemption criteria. 45 pharmacies have signed up to the service




Assessment of pharmaceutical need

This is a new service and will need to be evaluated.

### 7.6 Other health needs and opportunities for community pharmacies to contribute

#### 7.6.1 Screening and immunisation

Local health need

There appears to be good uptake of the initial childhood immunisation programme (diphtheria, pertussis, tetanus, Haemophilus influenza type b (Hib), polio, pneumococcal vaccine (PCV), measles, mumps and rubella (MMR) and meningococcal C in Wolverhampton for children up to the age of two years. Uptake in Wolverhampton is similar to the England average for all these vaccines. An exception at two years is the PCV booster where uptake is 88.1%, which is significantly worse than the England average of 92.5%.

The childhood immunisation boosters at 5 years of age have an estimated uptake that is worse than the England average - MMR, 76.5% compared to 87.7%; Hib/Men C, 89.9% compared to 91.5%. The uptake of the human papilloma virus vaccine (HPV) is similar to the average for England.

There is poor uptake of the vaccines available to adults. The pneumococcal polysaccharide vaccine for adults (PPV) is recommended for people in clinical risk groups and all individuals over 65 years. The uptake of PPV in Wolverhampton is 64.6% which is significantly worse than the England average of 69.1%. The influenza vaccine is also recommended for people in particular clinical risk groups and all individuals over 65 years. Uptake for individuals over 65 years is 70.5%, worse than the England

average of 73.4%. Although uptake for at risk groups is 51.6%, similar to the England average of 51.3%, there is room for improvement as just under 50% of at risk individuals are not immunised.

Local services

NHSE on behalf of PHE commission a range of screening and immunisation services supporting nationally directed programmes. Current programmes are delivered through a range of settings including schools, primary and secondary care.

Local services: Community pharmacies

*Responsible commissioner: Public Health England Birmingham and Black Country Area Team*

Public Health England (PHE) within the LAT have commissioned a pilot service to deliver influenza (flu) vaccines within pharmacies across Birmingham Solihull and the Black Country starting in October 2014. The community pharmacy service will offer flu vaccines to over 65's and those under 65 who are in a clinical risk group (the pilot does not include pregnant women), and will run in addition to existing flu vaccine services offered through GPs. The service aims to increase vaccination uptake amongst the under 65 at risk groups. This is a pilot service and will be evaluated following the end of the flu season.

At this time participating pharmacies have not been confirmed, our survey indicated that 54 community pharmacies would be willing to provide flu immunisation. 83% of respondents to the public survey agreed that flu immunisation should be offered by community pharmacies.

At present this is the only vaccination service commissioned for delivery through community pharmacies. Questionnaires completed by Wolverhampton community pharmacy indicated that:

- 47 would be willing to provide childhood immunisations
- 52 would be willing to provide travel vaccinations
- 45 would be willing to provide hepatitis immunisations to at risk groups

Assessment of pharmaceutical need

Community pharmacies offer a crucial platform to access residents across the city. Introduction of new flu immunisation services in Wolverhampton offers an opportunity to improve uptake across the city. The impact of the new service will need to be evaluated. If successful there is sufficient interest amongst community pharmacy contractors to consider wider immunisation services.

### 7.6.2 Cardiovascular health and NHS Health Checks

Local health need

There has been a 36.5% reduction in the rate of premature mortality from cardiovascular disease in Wolverhampton from 2001-03 to 2010-12. However, the Wolverhampton rate of 105.7 per 100, 000 remains significantly higher than the England average of 81.1 per 100,000. This is primarily due to a similar reduction in the England average over the same period.

Local services

Public Health commission NHS Health Checks for adults aged 40-74. The check includes a broad assessment of lifestyle and health, including; diet, physical activity, Body Mass Index (BMI), smoking, alcohol consumption, blood pressure, blood glucose and cholesterol. Cardiovascular risk is assessed using QRISK2 and individuals are given relevant further information and signposted to services. The NHS Health Check service is currently delivered by both the Healthy Lifestyles Service and General Practices (GPs) signed up to the NHS Health Check and Lifestyle Risk Management service specification.

The NHS Health Checks summary data for the past five years indicates that 39.4% of the eligible population (adults aged 40-74 years) were offered an NHS Health Check. This is significantly better than the average for England (18.4%) and Wolverhampton has the best outcomes for this indicator in the West Midlands. However, uptake amongst those offered the NHS Health Check in Wolverhampton is 23.8%, significantly worse than the England average of 49% and Wolverhampton has the worst outcomes for this indicator in the West Midlands. The latest data for the NHS Health Checks in Wolverhampton (2013/14) indicates an uptake amongst all eligible adults of 9.4%, which is significantly better than the England average of 9.0%.

Local services: Community pharmacies

The NHS Health Check is not currently commissioned for delivery through community pharmacies. 52 community pharmacies expressed interest in offering vascular risk assessments/NHS Health Checks if they were commissioned to do so. In addition 54 were willing to offer cholesterol screening and 51 diabetes screening).

Assessment of pharmaceutical need

Cardiovascular disease is a key contributor to excess years of life lost in Wolverhampton. The offer of NHS Health Checks is better than national figures. However, only 23.8% of those offered a NHS Health Check in Wolverhampton take up the offer. NHS Health Checks are not currently offered in community pharmacies in the city, although existing local providers have indicated willingness to provide this service. Community pharmacies could provide an acceptable alternative venue for NHS Health Checks. The evidence base and patient acceptability of NHS Health Checks should be considered to guide future commissioning.

### 7.6.3 Sexual Health Services

Local health need

Chlamydia and gonorrhoea infection rates in Wolverhampton have been above the West Midlands and England average despite annual decline. Chlamydia diagnoses for 15-24 year olds has improved (2,027 per 100,000) and is now similar to the England average (2,016 per 100,000). However the diagnosis rate for males (1,370 per 100,000) is significantly worse than the England average, whilst the diagnosis rate for females (2,685 per 100,000) is significantly better than the England average. There are large differences in chlamydia screening uptake across the city with poor uptake being closely linked to high infection rates. 55% of chlamydia cases are women and infection rates are

higher in younger age groups with a peak age 20-24, with higher rates in Black and Mixed ethnic groups, and the lowest deprivation quintile.

Herpes and genital wart infection rates are increasing but remain lower than the national average. Prevalence of a positive HIV diagnosis in Wolverhampton is 2.5 per 1,000 population aged 15-59, which is slightly higher than the national average at 2.1 per 1,000. National Institute of Health and Clinical Excellence (NICE) recommend that high prevalence areas, defined as more than 2 per 1,000 population, should consider expanded HIV testing (the routine offer of HIV testing within general medical admissions and new GP registrations). This is not currently in place in Wolverhampton. Uptake of HIV testing in Wolverhampton is lower than the national average. The proportion of, people in Wolverhampton presenting with HIV at a late stage of infection is 58.2%, which is higher than the England average of 48.3%.

Local services

There are a wide range of services that contribute to improving sexual health in Wolverhampton, including those described in the unplanned pregnancy and contraceptive services section.

*Genitourinary medicine (GUM)* – The Royal Wolverhampton NHS Trust provide GUM services based at the Fowler centre, providing specialist STI treatment supporting primary care and CaSH, on-site microbiology with pharmacy and pathology support, STI management and partner notification and specialist HIV treatment. The service averages around 7,000 contacts a year and is predominantly accessed by young people with a peak amongst 20-24 year olds. 65% of contacts are in the most deprived quintile. While 99% of eligible patients were offered HIV and Hepatitis B (HBV) testing only 74% accepted HIV testing and 27% HBV testing.

*Chlamydia screening* – BROOK coordinates the supply of chlamydia screening kits through a range of providers, including CaSH, school nursing, and GP practices (34/53 practices).Tests are analysed at New Cross Hospital and results relayed to BROOK who then provide support for those with positive results. National Chlamydia Screening Programme data for 2012-13 showed there were 4.140 chlamydia tests performed for Wolverhampton residents aged 15-24 years. 60% of these were delivered through the GUM service. Positivity rates through GUM were 12% and 6% for non-GUM tests. Wolverhampton has lower rates of screening coverage and diagnosis compared to regional and national figures.

Figure 25: Chlamydia coverage and diagnosis rates

| Coverage and Diagnosis Rate | | | |
|---|---|---|---|
| | Pop. Coverage Rate/100,000 15-24 year olds | Positivity Rate( % ) all tests performed | Diagnosis Rate/100,000 15-24 Year olds |
| **Wolverhampton** | 11,920 | 10 | 1,215 |
| **West Midlands** | 22,956 | 8 | 1,855 |
| **England** | 24,896 | 7 | 1,967 |

*HIV prevention* – The Terrence Higgins Trust provides a range of HIV prevention activities including, sexual health campaigns and awareness events, condom distribution, and outreach work with key at risk groups (men who have sex with men (MSM), African migrant communities, the Eastern European population and sex workers), alongside early detection testing and ensuring care is coordinated across agencies. In 2013/14 the service met all targets except those for delivery of point of care testing.

Local services: Community pharmacies

Community pharmacies provide brief sexual health advice alongside the Public Health commissioned EHC service. No other sexual health services are currently commissioned for delivery through community pharmacies. Questionnaires completed by Wolverhampton community pharmacy indicated that:

- 46 would be willing to provide chlamydia testing
- 50 would be willing to provide chlamydia treatment
- 44 would be willing to provide gonorrhoea testing
- 43 would be willing to provide HIV testing
- 46 would be willing to provide hepatitis testing
- 45 would be willing to provide HPV immunisation
- 55 would be willing to provide antiviral distribution services

*Case Study Pharmacy based chlamydia screening and treatment, Hampshire – In addition to EHC community pharmacies in Hampshire are delivering a range of sexual health services including, free condoms (13-24yrs), chlamydia screening kits (16-24yrs), and antibiotic treatment for chlamydia under patient group directions (PGDs). In 2012/13 98 pharmacies signed up generating 139 screens with a positivity rate of 7.2%. While the number of screens delivered was low commissioners were encouraged by the positivity rate and developed a 'Just Ask' campaign to encourage young people to ask for the service in their local pharmacy[14].*

Assessment of pharmaceutical need

Sexual health services other than EHC are not currently commissioned through community pharmacies. Wolverhampton data show lower rates of chlamydia screening coverage and diagnosis and lower uptake of HIV testing than national figures. Existing community pharmacies are willing to provide a wider range of sexual health services and may provide a valuable additional setting for certain services. The evidence for community pharmacies as a venue for chlamydia testing and treatment should be reviewed to influence future commissioning intentions.

[14] Local Government Association. Community pharmacy: Local government's new public health role. October 2013. Available from http://www.local.gov.uk/publications/-/journal_content/56/10180/5597846/PUBLICATION Accessed August 2014.

### 7.6.4 Obesity and healthy lifestyles

Local health need

The 2013/14 Director of Public Health Annual report for Wolverhampton focuses on obesity[15]. Data from the National Child Measurement Programme (NCMP) for Wolverhampton tells us that 12.9% children in Reception (age 4-5 years) and 24.6% of year 6 pupils (10-11 years) are obese, compared to England averages of 9.5% and 19.2% respectively. Local obesity rates have continued to rise since the NCMP began and are persistently higher than the England average. The rate of obesity doubles between Reception and year 6 with the largest increase seen in Asian children. The highest rates of obesity in children are found in Bushbury South & Low Hill, Blakenhall and Bilston East, however only Tettenhall Wightwick has rates lower than the England average. Links between obesity rates and deprivation are less apparent than for other health indicators.

Data for adults comes from the 2012 Active People Survey and is used to monitor obesity in the Public Health Outcomes Framework. Although Wolverhampton has similar rates of overweight when compared to the West Midlands and England, local rates of healthy weight are lower and rates of obesity higher (28.5% compared to 24.5% in the West Midlands and 23% for England). Estimates from GP data in the Quality and Outcomes Framework (QOF) are lower than the Active People Survey suggesting that a large number of obese patients are not being picked up by GPs.

Overweight and obesity are risk factors for a range of health problems such as diabetes, heart disease and some cancers. Increasing rates of overweight and obesity contribute to the top 6 conditions leading to excess years of life lost in Wolverhampton.

Local services

Wolverhampton Public Health commission a range of services to influence obesity rates and healthy lifestyles, including:

- School Nurse Service: Healthy Child Programme 5-19 – delivering the National Child Measurement Programme and providing brief advice and signposting
- Food Dudes – an intervention aimed at improving fruit and vegetable intake in school children
- Healthy Lifestyles Service provided by Royal Wolverhampton NHS Trust. The service uses Health Trainers to deliver a range of interventions including NHS Health Checks, Specialist Weight Management, Diet and Physical Activity Support.
- Fit for a fiver – swim and community gym voucher scheme for residents who are overweight or have diabetes
- Weightwatchers adult weight management support

[15] Annual Report of the Director of Public Health 2013/14. *Weight? We can't wait: A call to action to tackle obesity in Wolverhampton.* Available from http://www.wolverhampton.gov.uk/CHttpHandler.ashx?id=4833&p=0 Accessed September 2014.

Local services: Community pharmacies

There are currently no obesity specific interventions commissioned for delivery through community pharmacies. 55 community pharmacies indicated they would be willing to provide obesity management interventions to either adults or children.

Assessment of pharmaceutical need

Obesity is a key local priority for action. A range of interventions and services are already in place across the city, although none are directly commissioned for delivery through community pharmacies. Community pharmacies could provide an alternative platform for screening and signposting to services or brief interventions for obesity. The evidence base for obesity interventions in community pharmacy should be considered to guide future commissioning.

### 7.6.5 Long term conditions (LTCs) and medicines optimisation

Local health need

Major contributors to excess years of life lost are described earlier in this report. A sub group of the HWB focuses on long term conditions, 21% of Wolverhampton residents have a long term condition which is slightly higher than the West Midlands (19%) and national average (18%). Mental health and dementia are key priorities of the HWBS, and diabetes a priority for both the CCG and sub-groups of the HWB as a risk factor for major causes of mortality contributing to excess years of life lost in Wolverhampton.

The prevalence of diabetes is increasing in Wolverhampton, year on year. The percentage of the population diagnosed with diabetes is around 7.4%, compared to the national average of 5.9%. We know from estimated data that this is likely to be an underrepresentation of the true number of people with diabetes. Performance on the management of diabetes patients in primary care is below average on a number of measures. Expected prevalence of diabetes is predicted to rise substantially in the coming years mainly as a result of the increase in obesity rates.

There are 3000 people living with dementia in Wolverhampton and this figure is forecast to rise by 44% over the next 20 years, representing an increase of 75 people per year. Wolverhampton residents have significantly higher than average contacts with Community Psychiatric Nurses than the national average (rate 274 per 1,000 population - compared to 169 per 1,000 population). The directly standardised rate for hospital admissions for mental health was slightly higher than average in Wolverhampton (184) compared to the national average (172).

Local services

A wide range of services contribute to modification of the risk factors leading to the key long term conditions described above. Care for patients with long term conditions is delivered through primary and secondary care services.

Local services: Community pharmacy

No dedicated disease specific management services are commissioned from community pharmacies currently. However community pharmacies provide a range of essential and advanced services that

support disease management, including signposting to services, support for self-care and support for better use of medicines and management of long term conditions through the NMS and MUR services. Pharmacies could play a greater role in the management of long term conditions and supporting self-care. Wolverhampton community pharmacies indicated they would be willing to provide the following services:

- 57- services for  Alzheimers/dementia and asthma
- 56 - services for CHD, depression, epilepsy and heart failure
- 55 - services for Parkinson's disease

Assessment of pharmaceutical need

Community pharmacies already play an important role in the management of long term conditions through existing essential and advanced services. The NMS and MUR services in particular offer opportunities to improve adherence to prescribed medicines and in turn management of long term conditions. Existing providers are willing to offer wider disease specific management services and testing. Ways of better integrating community pharmacies into LTC care pathways should be considered.

## 8. Future need

Expected population changes

Sub-National Population Projections show that Wolverhampton's population is changing. The older population (age 65 years and over) is predicted to increase over the next 10 years both locally and nationally.  It should be noted that Wolverhampton's predicted population growth rate is below the national, regional and Black Country averages. Projections estimate Wolverhampton's population in 2037 as 273,300 with growth being most rapid in the older populations. The projections are trend-based using evidence on fertility, mortality and migration during the period 2007-2012, but do not consider any policy changes or events which might have an impact during the 2012-2037 time period. The estimates show:

- The number of children (aged 0 to 15 years) in Wolverhampton is projected to increase from 50,000 in 2012 to 54,300 in 2037. This is a net gain of about 4,300 children (8.6% growth).
- The number of people aged 16 to 64 years in Wolverhampton is projected to fall slightly from 159,600 in 2012 to 159,200 in 2037. This is a net loss of about 400 (0.3% decline). However, during this period the state pension age will rise, increasing the size of the working-age population.
- The number of people aged 65 years or older in Wolverhampton is projected to grow from 41,400 in 2012 to 59,900 in 2037: a gain of 18,500 (44.7% growth). The number aged 85 years or older is shown to grow by 6,200 (106.9% growth), from 5,800 in 2012 to 12,000 in 2037.

Housing developments

There are currently around 300 homes under construction across Wolverhampton. Sites where construction is currently underway have the potential to deliver 1,600 homes in the short to medium

term (1-8 years). Developments centre on the Stafford Road and Wednesfield, Ettingshall, Bradley, Tettenhall and Whitmore Reans. Planning permission or pre application discussions are in place for a further 725 homes. The figure on the following page shows potential housing sites in orange.

Urgent and Emergency Care Strategy[16]

The Urgent and Emergency Strategy outlines changes to the urgent and emergency care system leading to development of a new Urgent Care Centre based at New Cross Hospital in 2016. The out of hours service and Showell Park Walk in centre will be relocated to the new Urgent Care Centre, offering primary care coverage 24 hours a day and seven days a week. Plans also include development of a new improved Emergency Department. Public consultation on plans received 204 survey responses, of these seven (3.4%) provided comments regarding pharmacy provision, including demand for a commercial pharmacy or a 24 hour pharmacy located within the centre. Current pharmacy provision on site is delivered through a branch of Boots providing out patient prescription dispensing only.

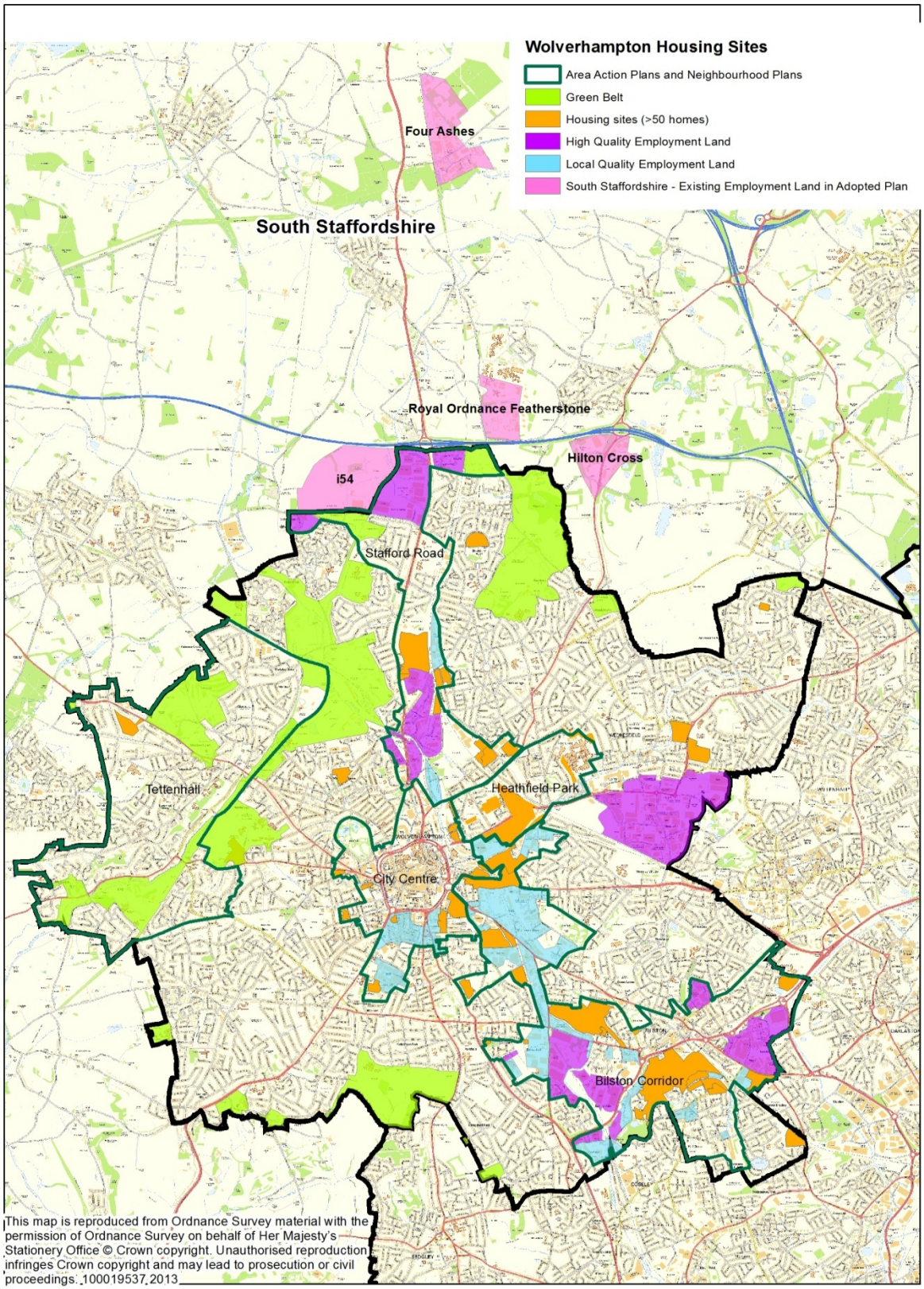
Updating and revising the PNA

At this time the impact of housing developments and the implementation of the Urgent Care Stratecy on community pharmacy provision is unclear.

The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 require a revised assessment of the PNA within three of years of publication. Future developments may require the production of either a revised PNA or a Supplementary Statement in the interim. The HWB will work closely with NHS England LAT, Wolverhampton CCG and the LPC to review local developments impacting on community pharmacy need and provision on a six monthly basis and consider the required response.

[16] Wolverhampton CCG and The Royal Wolverhampton NHS Trust, July 2014: A joint strategy for the provision of urgent and emergency care for patients using services in Wolverhampton to 2016/17. Available from http://www.wolverhamptonccg.nhs.uk/your-health-services/improving-urgent-care Accessed October 2014.

Figure 26: Current and future housing development sites aross Wolverhampton



## 9. Conclusion

Community pharmacies offer a range of services beyond the dispensing of medicines and are a key contributor to meeting the health needs of our population. Provision has developed since the last PNA produced in 2011. At this time there is adequate community pharmacy provision across the city which is sufficient to meet the needs of our population.

New developments in community pharmacy services include a revised Minor Ailments Service, the introduction of a free flu immunisation service, and the Primary Eyecare Assessment and Referral service (PEARs). These services will need evaluation and review.

There are opportunities to increase uptake and quality of current services offered through commissioning and contracting mechanisms. Commissioners, contractors and the LPC will need to continue to work together to develop and improve these services.

There are potential opportunities for community pharmacies to further contribute to key local health priorities. These could include the delivery of chlamydia testing and treatment, NHS Health Checks and brief interventions and signposting to services for both obesity and alcohol. Further work is needed to assess the evidence for community pharmacy contribution and incorporate this into future service reviews.

## 10. Appendices

### Acknowledgements

Membership of the PNA Steering Group

| Name | Title | Organisation |
|---|---|---|
| Jane Fowles | Public Health Specialty Registrar | Wolverhampton Council |
| Katie Spence | Consultant in Public Health - NHS Facing | Wolverhampton Council |
| Karla Bailey | Advanced Public Health Analyst | Wolverhampton Council |
| Glenda Augustine | Consultant in Public Health - Intelligence and Evidence | Wolverhampton Council |
| John Whitmore | Chairperson | Wolverhampton Local Pharmaceutical Committee |
| James Laurence | Secretary | Wolverhampton Local Pharmaceutical Committee |
| Hemant Patel | Deputy Head of Medicines Optimisation | Wolverhampton Clinical Commissioning Group |
| Brian Wallis | Pharmacy Commissioner and Contracts Manager | NHS England Birmingham, Solihull and the Black Country LAT |
| Patricia Roberts | Lay member for Public and Patient Involvement | Wolverhampton Clinical Commissioning Group |

Additional thanks to Sandra Squires, Selena Lavictoire, Sue McKie, Michelle Marie-Smith, Ravi Seehra, Tessa Johnson, Michele Ross, Carol Lamyman, David Birch, Julian Parkes, Julian Morgans, Tom Wedgebury, Dave Newton, Dr Kainth, Gurjinder Bhella and Tracy Cresswell.

## PNA Pharmacy Questionnaire

**Premises Details**

| | |
|---|---|
| Contractor Code (ODS Code) | |
| Name of contractor (i.e. name of individual, partnership or company owning the pharmacy business) | |
| Trading Name | |
| Address of Contractor | |
| Is this pharmacy a Distance Selling Pharmacy? (i.e. it cannot provide Essential Services to persons present at the pharmacy) | ☐ Yes |
| Pharmacy email address | |
| Pharmacy telephone | |
| Pharmacy fax | |
| Pharmacy website address | |
| Can we store the above information and use this to contact you? | ☐ Yes |

**Core hours of opening**

| Day | Open from | To | Lunchtime (From – To) |
|---|---|---|---|
| Monday | | | |
| Tuesday | | | |
| Wednesday | | | |
| Thursday | | | |
| Friday | | | |
| Saturday | | | |
| Sunday | | | |

**Total hours of opening**

| Day | Open from | To | Lunchtime (From – To) |
|---|---|---|---|
| Monday | | | |
| Tuesday | | | |

| | | | |
|---|---|---|---|
| Wednesday | | | |
| Thursday | | | |
| Friday | | | |
| Saturday | | | |
| Sunday | | | |

**Consultation facilities**

There is a consultation area (meeting the criteria for the Medicines Use Review service) (tick as appropriate)

| | | |
|---|---|---|
| On premises | None, or | ☐ |
| | Available (including wheelchair access), or | ☐ |
| | Available (without wheelchair access), or | ☐ |
| | Planned within the next 12 months, or | ☐ |
| | Other (specify) | |
| Where there is a consultation area, is it a closed room? | | ☐ Yes |

| | | |
|---|---|---|
| Off-site | The pharmacy has access to an off-site consultation area (i.e. one which the former PCT or Area Team has given consent for use) | ☐ Yes |
| | The pharmacy is willing to undertake consultations in patient's home / other suitable site | ☐ Yes |

| | | |
|---|---|---|
| During consultations are there hand-washing facilities | In the consultation area, or | ☐ |
| | Close to the consultation area, or | ☐ |
| | None | ☐ |

| | |
|---|---|
| Patients attending for consultations have access to toilet facilities | ☐ Yes |

| | |
|---|---|
| Languages spoken (in addition to English) | |

**IT Facilities**

Electronic Prescription Service (select any that apply)

| | |
|---|---|
| Release 1 enabled | ☐ |
| Release 2 enabled | ☐ |

| | |
|---|---|
| Intending to become Release 1 enabled within next 12 months | ☐ |
| Intending to become Release 2 enabled within next 12 months | ☐ |
| No plans for EPS at present | ☐ |

**Services**

**Essential services**

Does the pharmacy dispense appliances?

| | |
|---|---|
| Yes – All types, or | ☐ |
| Yes, excluding stoma appliances, or | ☐ |
| Yes, excluding incontinence appliances, or | ☐ |
| Yes, excluding stoma and incontinence appliances, or | ☐ |
| Yes, just dressings, or | ☐ |
| Other [identify] | |
| None | ☐ |

**Advanced services**

Does the pharmacy provide the following services?

| | Yes | Intending to begin within next 12 months | No - not intending to provide |
|---|---|---|---|
| Medicines Use Review service | ☐ | ☐ | ☐ |
| New Medicine Service | ☐ | ☐ | ☐ |
| Appliance Use Review service | ☐ | ☐ | ☐ |
| Stoma Appliance Customisation service | ☐ | ☐ | ☐ |

**Enhanced[17] and Other Locally Commissioned Services**

Which of the following services does the pharmacy provide, or would be willing to provide?

| | Currently providing under contract with Area Team | Currently providing under contract with CCG | Currently providing under contract with Local Authority | Willing to provide if commissioned | Not able or willing to provide |
|---|---|---|---|---|---|
| Anticoagulant Monitoring Service | ☐ | ☐ | ☐ | ☐ | ☐ |

[17] 'Enhanced Services' are those commissioned by the NHS England Area Team. CCGs and Local Authorities can commission Other Locally Commissioned Services that are equivalent to the Enhanced Services, but for the purpose of developing the PNA are called 'Other Locally Commissioned Services' not 'Enhanced Services'

| | Currently providing under contract with Area Team | Currently providing under contract with CCG | Currently providing under contract with Local Authority | Willing to provide if commissioned | Not able or willing to provide |
|---|---|---|---|---|---|
| Anti-viral Distribution Service[18] | ☐[2] | ☐ | ☐ | ☐ | ☐ |
| Care Home Service | ☐ | ☐ | ☐ | ☐ | ☐ |
| Chlamydia Testing Service[2] | ☐[2] | ☐ | ☐ | ☐ | ☐ |
| Chlamydia Treatment Service[2] | ☐[2] | ☐ | ☐ | ☐ | ☐ |
| Contraceptive service (not EHC) [2] | ☐[2] | | | | |
| Disease Specific Medicines Management Service: | | | | | |
| Allergies | ☐ | ☐ | ☐ | ☐ | ☐ |
| Alzheimer's/dementia | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ |
| CHD | ☐ | ☐ | ☐ | ☐ | ☐ |
| COPD | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes type I | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes type II | ☐ | ☐ | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Failure | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hypertension | ☐ | ☐ | ☐ | ☐ | ☐ |
| Parkinson's disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other (please state) | | | | | |
| Emergency Hormonal Contraception Service[2] | ☐[2] | ☐ | ☐ | ☐ | ☐ |
| Gluten Free Food Supply Service (i.e. not via FP10) | ☐ | ☐ | ☐ | ☐ | ☐ |

[18] These services are not listed in the Advanced and Enhanced Services Directions, and so are not 'Enhanced Services' if commissioned by the NHS England Area Team. The Area Team may commission them on behalf of the CCG or Local Authority, but when identified in the PNA they will be described as 'Other Locally Commissioned Services' or 'Other NHS Services'

| | Currently providing under contract with Area Team | Currently providing under contract with CCG | Currently providing under contract with Local Authority | Willing to provide if commissioned | Not able or willing to provide |
|---|---|---|---|---|---|
| Home Delivery Service (not appliances)(2) | ☐(2) | ☐ | ☐ | ☐ | ☐ |
| Independent Prescribing Service | ☐ | ☐ | ☐ | ☐ | ☐ |
| If currently providing an Independent Prescribing Service, what therapeutic areas are covered? | | | | | |
| Language Access Service | ☐ | ☐ | ☐ | ☐ | ☐ |
| Medication Review Service | ☐ | ☐ | ☐ | ☐ | ☐ |
| Medicines Assessment and Compliance Support Service | ☐ | ☐ | ☐ | ☐ | ☐ |
| Minor Ailment Scheme | ☐ | ☐ | ☐ | ☐ | ☐ |
| MUR Plus/Medicines Optimisation Service(2) | ☐(2) | ☐ | ☐ | ☐ | ☐ |
| If currently providing an MUR Plus/ Medicines Optimisation Service, what therapeutic areas are covered? | | | | | |
| Needle and Syringe Exchange Service | ☐ | ☐ | ☐ | ☐ | ☐ |
| Obesity management (adults and children)(2) | ☐(2) | ☐ | ☐ | ☐ | ☐ |
| On Demand Availability of Specialist Drugs Service | ☐ | ☐ | ☐ | ☐ | ☐ |
| Out of Hours Services | ☐ | ☐ | ☐ | ☐ | ☐ |
| Patient Group Direction Service (name the medicines covered by the Patient Group Direction) | | | | ☐ | ☐ |
| Phlebotomy Service(2) | ☐(2) | ☐ | ☐ | ☐ | ☐ |

| | Currently providing under contract with Area Team | Currently providing under contract with CCG | Currently providing under contract with Local Authority | Willing to provide if commissioned | Not able or willing to provide |
|---|---|---|---|---|---|
| Prescriber Support Service | ☐ | ☐ | ☐ | ☐ | ☐ |
| Schools Service | ☐ | ☐ | ☐ | ☐ | ☐ |
| Screening Service | | | | | |
| Alcohol | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cholesterol | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ |
| Gonorrhoea | ☐ | ☐ | ☐ | ☐ | ☐ |
| H. pylori | ☐ | ☐ | ☐ | ☐ | ☐ |
| HbA1C | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hepatitis | ☐ | ☐ | ☐ | ☐ | ☐ |
| HIV | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other (please state) | | | | | |
| Seasonal Influenza Vaccination Service[(2)] | ☐[(2)] | ☐ | ☐ | ☐ | ☐ |
| Other vaccinations[(2)] | | | | | |
| Childhood vaccinations | ☐[(2)] | ☐ | ☐ | ☐ | ☐ |
| Hepatitis (at risk workers or patients) | ☐[(2)] | ☐ | ☐ | ☐ | ☐ |
| HPV | ☐[(2)] | ☐ | ☐ | ☐ | ☐ |
| Travel vaccines | ☐[(2)] | ☐ | ☐ | ☐ | ☐ |
| Other – (please state) | | | | | |
| Sharps Disposal Service[(2)] | ☐[(2)] | ☐ | ☐ | ☐ | ☐ |
| Stop Smoking Service | ☐ | ☐ | ☐ | ☐ | ☐ |
| Supervised Administration Service | ☐ | ☐ | ☐ | ☐ | ☐ |

| | Currently providing under contract with Area Team | Currently providing under contract with CCG | Currently providing under contract with Local Authority | Willing to provide if commissioned | Not able or willing to provide |
|---|---|---|---|---|---|
| Supplementary Prescribing Service (what therapeutic areas are covered?) | | | | ☐ | ☐ |
| Vascular Risk Assessment Service (NHS Health Check)[2] | ☐[2] | ☐ | ☐ | ☐ | ☐ |

**Non-commissioned services**

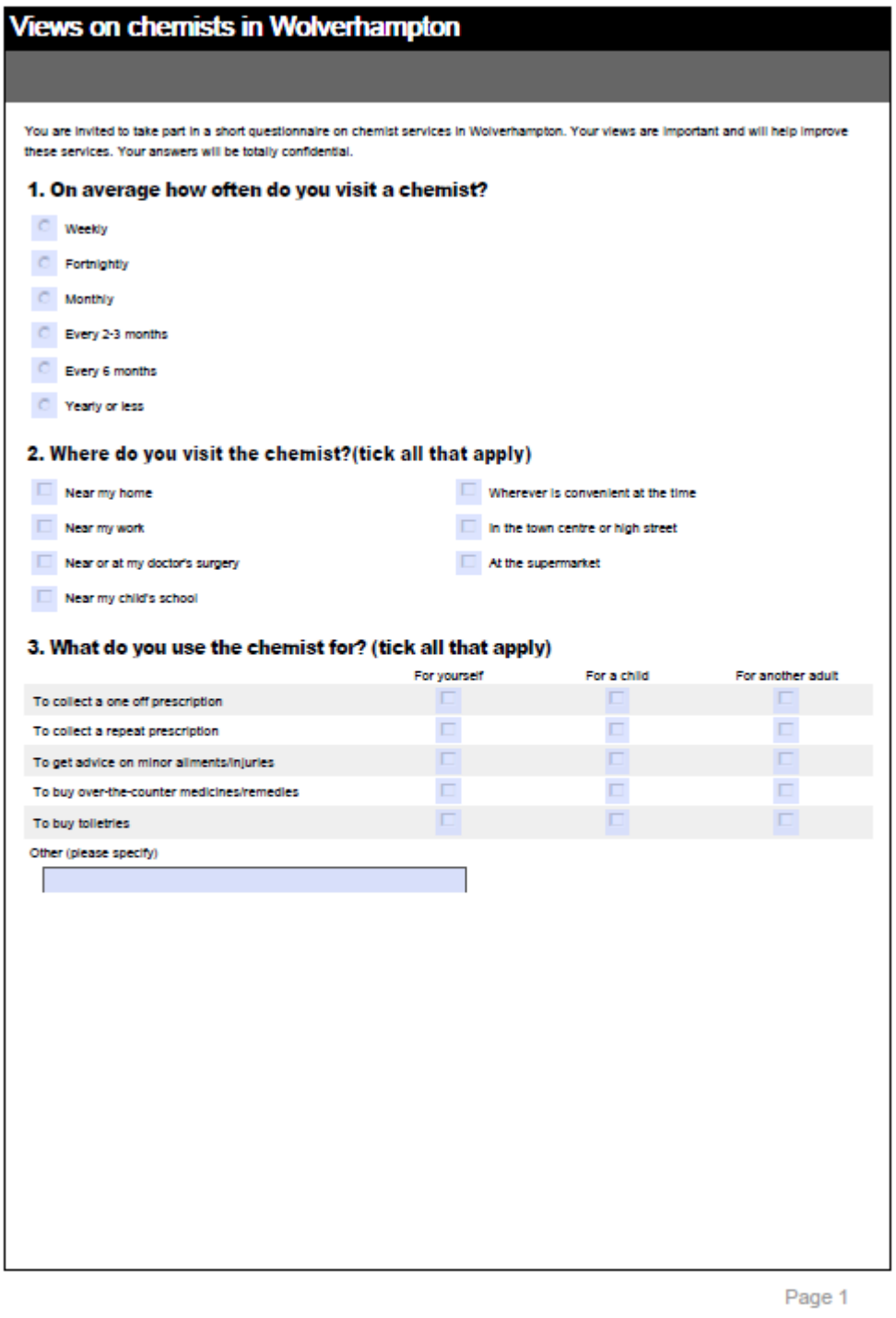
Does the pharmacy provide any of the following?

| | |
|---|---|
| Collection of prescriptions from GP practices | ☐ |
| Delivery of dispensed medicines – Free of charge on request | ☐ |
| Delivery of dispensed medicines – Selected patient groups (list criteria) | |
| Delivery of dispensed medicines – Selected areas (list areas) | |
| Delivery of dispensed medicines - chargeable | ☐ |

**Details of the person completing this form:**

| Contact name of person completing questionnaire, if questions arise | Contact telephone number |
|---|---|
| | |

## PNA Public Questionnaire



# Views on chemists in Wolverhampton

You are invited to take part in a short questionnaire on chemist services in Wolverhampton. Your views are important and will help improve these services. Your answers will be totally confidential.

**1. On average how often do you visit a chemist?**

- ○ Weekly
- ○ Fortnightly
- ○ Monthly
- ○ Every 2-3 months
- ○ Every 6 months
- ○ Yearly or less

**2. Where do you visit the chemist?(tick all that apply)**

- ☐ Near my home
- ☐ Near my work
- ☐ Near or at my doctor's surgery
- ☐ Near my child's school
- ☐ Wherever is convenient at the time
- ☐ In the town centre or high street
- ☐ At the supermarket

**3. What do you use the chemist for? (tick all that apply)**

| | For yourself | For a child | For another adult |
|---|---|---|---|
| To collect a one off prescription | ☐ | ☐ | ☐ |
| To collect a repeat prescription | ☐ | ☐ | ☐ |
| To get advice on minor ailments/injuries | ☐ | ☐ | ☐ |
| To buy over-the-counter medicines/remedies | ☐ | ☐ | ☐ |
| To buy toiletries | ☐ | ☐ | ☐ |

Other (please specify)

Page 1

## Views on chemists in Wolverhampton

**4. Do you usually visit the same chemist?**

- Yes
- No

Thinking about your usual chemist...

**5. Is the chemist open at the times you want to use it?**

- Yes
- No

**6. If answering no to the above, what time would be better?**

**7. How do you usually travel to the chemist?**

- Walk
- Call a taxi
- Travel by car or motorcycle
- Cycle
- Use public transport
- Other (please specify)

**8. Approximately how long does your usual journey take?**

- Under 10 minutes
- Between 20 and 30 minutes
- Between 10 and 20 minutes
- Over 30 minutes

**9. Thinking about the location of the chemist, which is the most important to you? (tick one only)**

- It's near my home
- It's in my local supermarket
- It's near my work
- I can park easily
- It's near or at my doctor's surgery
- I can get there using public transport
- It's near my child's school
- I can walk there
- In the town centre or high street
- I can find a chemist open on a Saturday/Sunday

**10. When do you usually visit the chemist?(tick all that apply)**

- Midnight-8am
- 8pm-midnight
- Between 8am and 12pm
- Monday-Friday
- Between 12pm and 5pm
- Saturday
- Between 5pm and 8pm
- Sunday

Page 2

## Views on chemists in Wolverhampton

**11. Please rate how strongly you agree with the following statements-please tick one for each statement**

| | Strongly agree | Agree | Disagree | Strongly disagree |
|---|---|---|---|---|
| I find it easy to find a chemist close by | ○ | ○ | ○ | ○ |
| I can find a chemist open during 5pm-8pm | ○ | ○ | ○ | ○ |
| I can find a chemist open during 8pm-8am | ○ | ○ | ○ | ○ |
| I can find a chemist open on a Saturday | ○ | ○ | ○ | ○ |
| I can find a chemist open on a Sunday | ○ | ○ | ○ | ○ |
| I find my usual chemist helpful and friendly | ○ | ○ | ○ | ○ |
| The chemist offers helpful advice on NHS services | ○ | ○ | ○ | ○ |
| I ask my chemist for health advice | ○ | ○ | ○ | ○ |
| It is important that the chemist staff know me | ○ | ○ | ○ | ○ |
| I prefer to see the same chemist staff | ○ | ○ | ○ | ○ |

**12. Have you used any of the services at a chemist within the past 12 months?(tick all that apply)**

| | Yes | No |
|---|---|---|
| Stop smoking advice (vouchericonsultation) | ○ | ○ |
| Emergency contraception (morning after pill) | ○ | ○ |
| Minor ailments advice (e.g. sore throat, hayfever) | ○ | ○ |
| Repeat dispensing service (for regular medicines) | ○ | ○ |
| Drugs service (e.g. needle exchange, Methadone supply) | ○ | ○ |
| Returning your unwanted medicines | ○ | ○ |
| Home delivery service | ○ | ○ |

**13. Do you think these services are well advertised?**

○ Yes ○ No

**14. Do you think these services should be provided in your local chemist?(Please choose one option for each service)**

| | Strongly agree | Agree | Disagree | Strongly disagree |
|---|---|---|---|---|
| Stop smoking advice (vouchericonsultation) | ○ | ○ | ○ | ○ |
| Emergency contraception (morning after pill) | ○ | ○ | ○ | ○ |
| Minor ailments advice (e.g. sore throat, hayfever) | ○ | ○ | ○ | ○ |
| Free flu jabs | ○ | ○ | ○ | ○ |
| Substance misuse (e.g. needle exchange, Methadone supply) | ○ | ○ | ○ | ○ |
| Repeat dispensing service (for regular medicines) | ○ | ○ | ○ | ○ |
| Returning your unwanted medicines | ○ | ○ | ○ | ○ |
| Home delivery service | ○ | ○ | ○ | ○ |

Page 3

# Views on chemists in Wolverhampton

## About you

We will not be able to identify you from any of the information provided in this questionnaire

**15. Are you**

- Male
- Female

**16. Your age**

- Under 18
- 18-24
- 25-39
- 40-49
- 50-59
- 60-69
- 70+

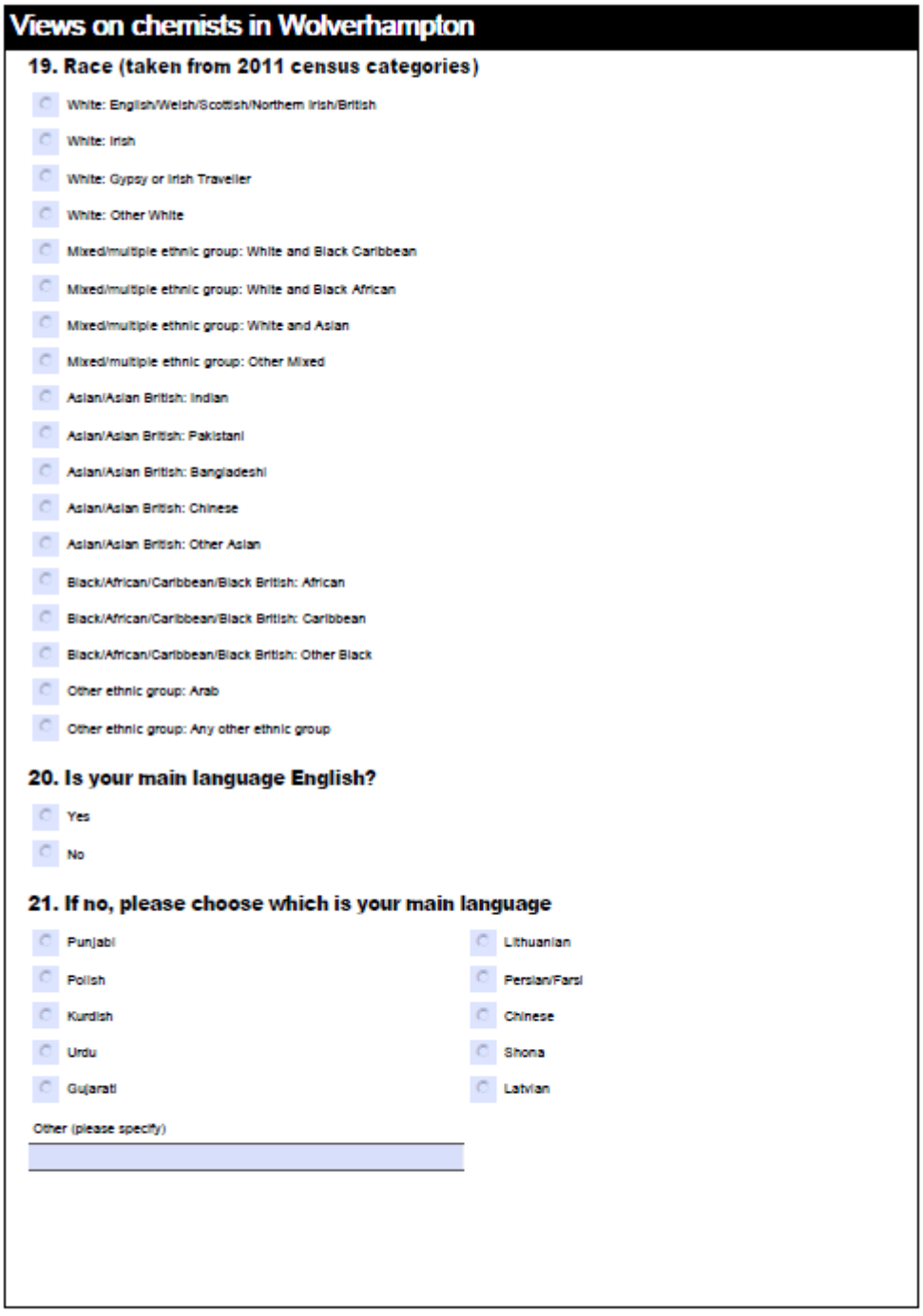
**17. Employment status**

- Full-time
- Part-time
- Unemployed
- Student
- Retired

**18. Do you have a long-term health problem and/or a disability?**

- Yes
- No

Page 4



## Views on chemists in Wolverhampton

### 19. Race (taken from 2011 census categories)

- White: English/Welsh/Scottish/Northern Irish/British
- White: Irish
- White: Gypsy or Irish Traveller
- White: Other White
- Mixed/multiple ethnic group: White and Black Caribbean
- Mixed/multiple ethnic group: White and Black African
- Mixed/multiple ethnic group: White and Asian
- Mixed/multiple ethnic group: Other Mixed
- Asian/Asian British: Indian
- Asian/Asian British: Pakistani
- Asian/Asian British: Bangladeshi
- Asian/Asian British: Chinese
- Asian/Asian British: Other Asian
- Black/African/Caribbean/Black British: African
- Black/African/Caribbean/Black British: Caribbean
- Black/African/Caribbean/Black British: Other Black
- Other ethnic group: Arab
- Other ethnic group: Any other ethnic group

### 20. Is your main language English?

- Yes
- No

### 21. If no, please choose which is your main language

- Punjabi
- Polish
- Kurdish
- Urdu
- Gujarati
- Lithuanian
- Persian/Farsi
- Chinese
- Shona
- Latvian

Other (please specify)

Page 5

Appendix A

## Community pharmacies and opening times

| Name | Full address | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|---|---|---|---|---|---|---|---|
| The Co-operative Pharmacy | Pendeford Health Centre, Whitburn Close, Wolverhampton, WV9 5NJ. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-13:00 | 9:00-18:00 | Closed | Closed |
| HN Pharmacy | 124 Cannock Road, Wednesfield, Wolverhampton, WV10 8PW. | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-17:30 | 9:00-18:30 | Closed | Closed |
| All Saints Pharmacy | 91-93 Vicarage road, Wolverhampton, WV2 1DR. | 9:00-19:00 | 9:00-19:00 | 9:00-18:00 | 9:00-19:00 | 9:00-19:00 | Closed | Closed |
| Brooklands Pharmacy | 48 Brooklands parade, wolverhampton, WV1 2NE. | 9:00-18:30 | 9:00-18:30 | 9:00-18:00 | 9:00-17:30 | 9:00-18:00 | Closed | Closed |
| Central Pharmacy | Unit 6, Park Parade, Overfield Drive, Sedgmoor Park, WV14 9XW. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | Closed | Closed |
| A Brickley Ltd | 88 Griffiths Drive, Wolverhampton, WV11 2JW. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | Closed | Closed |
| Alpha Pharmacy | 468 Stafford Road, Wolverhampton, WV10 6AN. | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | Closed | Closed |
| Essington Chemist | 129 Long Knowle Lane, Wednesfield, Wolverhampton, WV11 1JG. | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | Closed | Closed |
| Upper Green Pharmacy | 5 Upper Green, Tettenhall, Wolverhampton, WV6 8QQ. | 9:00-17:30 | 9:00-17:30 | 9:00-17:30 | 9:00-17:30 | 9:00-17:30 | Closed | Closed |
| Ettingshall Pharmacy | 3 New Street, Wolverhampton, WV2 2LR. | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | Closed | Closed |
| Brutons Pharmacy | 1 Mervyn Place, Bradley, WV14 8DD. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | Closed | Closed |
| The Co-operative Pharmacy-Internet | Unit 2, Stonefield Walk, Bilston, Wolverhampton, WV14 0EZ. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | Closed | Closed |
| Pharmacydirect2u-Internet | Unit 14A, Hollies Industrial Estate, Graiseley Row, Wolverhampton, WV2 4HE. | 8:30-17:00 | 8:30-17:00 | 8:30-17:00 | 8:30-17:00 | 8:30-17:00 | Closed | Closed |
| The Co-operative Pharmacy | 331 Bushbury Lane, Bushbury, Wolverhampton, WV10 9UJ. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | Closed | Closed |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Portobello Pharmacy | 1A Vaughan Road, Willenhall, WV13 3TJ. | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | Closed | Closed |
| Supercare Pharmacy | 135 Dudley Road, Wolverhampton, WV2 3HD. | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | Closed | Closed |
| Andersons Chemist | 311 Dudley Road, Wolverhampton, WV2 3JY. | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | Closed | Closed |
| Bridgnorth Road Pharmacy Ltd | 41 Bridgnorth Road, Compton, Wolverhampton, WV6 8AF. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | Closed | Closed |
| Fallings Park Pharmacy | 212 Bushbury Road, Wolverhampton, WV10 0NT. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | Closed | Closed |
| Lloyds Pharmacy | 18-20 The Broadway, Bushbury, Wolverhampton, WV10 8EB. | 8:30-18:00 | 8:30-18:00 | 8:30-18:00 | 8:30-18:00 | 8:30-18:00 | 9:00-17:30 | Closed |
| The Co-operative Pharmacy | 248 Jeffcock Road, Pennfields, Wolverhampton, WV3 7AH. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | Closed | Closed |
| Staveley Pharmacy | 212 Staveley Road, Wolverhampton, WV1 4RS. | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-12:00 | Closed |
| Church Pharmacy | 45 Church Street, Bilston, WV14 0AX. | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | 9:00-17:00 | Closed |
| Newbridge Pharmacy | 325 Tettenhall Road , Newbridge, Wolverhampton, WV6 0JZ. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | Closed | Closed |
| J Docter Pharmacy | 73 Stubby Lane, Wednesfield, Wolverhampton, WV11 3NE. | 9:00-17:30 | 9:00-17:30 | 9:00-17:30 | 9:00-17:30 | 9:00-17:30 | 9:00-13:00 | Closed |
| Boots | Bilston Health Centre, Prouds Lane, Bilston, WV14 6PW. | 8:30-19:00 | 8:30-19:00 | 8:30-19:00 | 8:30-13:00 | 8:30-19:00 | Closed | Closed |
| J Docter Pharmacy | 295 Wood End Road, Wednesfield, Wolverhampton, WV11 1YQ. | 9:00-17:30 | 9:00-17:30 | 9:00-17:30 | 9:00-17:30 | 9:00-18:00 | 9:00-13:00 | Closed |
| Bradley Chemist | 83 Hall Green Street, Bradley, Bilston, WV14 8TH. | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | 8:45-13:00 | 8:30-18:30 | 9:00-12:00 | Closed |
| The Co-operative Pharmacy | 8 Showell Circus, Low Hill, Wolverhampton, WV10 9BA. | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | Closed | Closed |
| Murrays Chemist | 128 Childs Avenue, Coseley, West Midlands, WV14 9XB. | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-17:30 | Closed |
| Mayfield | 272 Willenhall Road, East Park, | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | Closed | Closed |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Pharmacy | Wolverhampton, WV1 2GZ. | | | | | | | |
| Poonian Pharmacy | 663 Stafford Road, Wolverhampton, WV10 6QG. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-13:00 | Closed |
| The Co-operative Pharmacy | High street, Bilston, Wolverhampton, WV14 0EY. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-14:00 | Closed |
| The Co-operative Pharmacy | 490 Stafford Road, Oxley, Wolverhampton, WV10 6AN. | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-14:00 | Closed |
| Tettenhall Wood Pharmacy | 12 School Road, Tettenhall Wood, Wolverhampton, WV6 8EJ. | 8:45-18:30 | 8:45-18:30 | 8:45-18:00 | 8:45-18:30 | 8:45-18:00 | 9:00-13:00 | Closed |
| Lloyds Pharmacy | Lower Green Health Centre, Lower Street, Tettenhall, WV6 9LL. | 8:15-19:30 | 8:15-18:00 | 8:00-18:00 | 8:15-18:00 | 8:15-18:00 | Closed | Closed |
| Boots | 8 Trysull Road, Wolverhampton, WV3 7HT. | 9:00-17:30 | 9:00-17:30 | 9:00-17:30 | 9:00-17:30 | 9:00-17:30 | 9:00-17:30 | Closed |
| Superdrug Pharmacy | 1 Market Way, Bilston, Wolverhampton, WV14 0DR. | 8:30-17:30 | 8:30-17:30 | 8:30-17:30 | 8:30-17:30 | 8:30-17:30 | 9:00-17:30 | Closed |
| Boots | 100a Church Street, Bilston, Wolverhampton, WV14 0BJ. | 8:30-17:00 | 8:30-17:00 | 8:30-17:00 | 8:30-17:00 | 8:30-17:00 | 8:30-17:00 | Closed |
| Boots | 92 Windmill lane, Castlecroft, Wolverhampton, WV3 8HG. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-17:00 | Closed |
| Boots | 98 High Street, Wednesfield, Wolverhampton, WV11 1SZ. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-17:30 | Closed |
| Superdrug Pharmacy | 65-67 Mander Square, Wolverhampton, WV1 3NN. | 8:30-17:30 | 8:30-17:30 | 8:30-17:30 | 8:30-17:30 | 8:30-17:30 | 9:00-17:30 | Closed |
| Penn Care Pharmacy | 48 Warstones Road, Penn, Wolverhampton, WV4 4LP. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-9:00 | Closed |
| The Co-operative Pharmacy | 6 Bargate Drive, Wolverhampton, WV6 0QW. | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-17:00 | Closed |
| Boots | 233 Trysull Road, Merry Hill, Wolverhampton, WV3 7LF. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | Closed |
| Lloyds Pharmacy | 18 High Street, Wednesfield, Wolverhampton, WV11 1SZ. | 8:30-18:00 | 8:30-18:00 | 8:30-18:00 | 8:30-18:00 | 8:30-18:00 | 9:00-15:30 | Closed |
| Lloyds Pharmacy | Manor Road , Penn, Wolverhampton, | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | 9:00-13:00 | Closed |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | WV4 5QF. | | | | | | | |
| Lloyds Pharmacy | 34-35 Thornley Street, Wolverhampton, WV1 1JP. | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | 8:30-18:30 | 9:00-13:30 | Closed |
| Hingley Pharmacy | 179 Lea Road, Wolverhampton, WV3 0LG. | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-18:00 | 9:00-18:30 | 9:00-17:00 | Closed |
| Millstream Pharmacy | 151 Tettenhall road, Wolverhampton, WV3 9NW. | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-16:30 | Closed |
| Jhoots Pharmacy | 50 Newhampton Road West, Wolverhampton, WV6 0RY. | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 | 9:00-18:00 |
| Rexell Pharmacy | 204 Penn Road, Penn, Wolverhampton, WV4 4AA. | 8:30-19:00 | 8:30-19:00 | 8:30-19:00 | 8:30-19:00 | 8:30-19:00 | 9:00-13:00 | Closed |
| Lloyds Pharmacy | 59 High Street, Wolverhampton, WV11 1SZ. | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-17:30 | Closed |
| The Co-operative Pharmacy | 425 Dudley Road, Wolverhampton, WV2 3AH. | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-17:30 | Closed |
| Lloyds Pharmacy | 181 Wednesfield Road, Heath Town, Wolverhampton, WV10 0EN. | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-17:30 | Closed |
| Boots | 2 Blackhalve Lane, Wolverhampton, WV11 1BQ. | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-19:00 | 9:00-17:30 | Closed |
| The Co-operative Pharmacy | 1 Raynor Road, Wolverhampton, WV10 9QY. | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-18:30 | 9:00-17:30 |
| Boots | 40-41 Dudley Street, , Wolverhampton, WV1 3ER. | 8:00-18:00 | 7:45-18:00 | 8:00-18:00 | 8:00-18:00 | 8:00-18:00 | 8:00-18:00 | 10:30-16:30 |
| Morrisons Pharmacy | Blaydon Road, Pendeford, Wolverhampton, WV9 5PG. | 8:30-19:00 | 8:30-19:00 | 8:30-20:00 | 8:30-20:00 | 8:30-20:00 | 9:00-20:00 | 10:00-16:00 |
| Morrisons Pharmacy | Black country route, Bilston, Wolverhampton, WV14 0DZ. | 8:30-20:00 | 8:30-20:00 | 8:30-20:00 | 8:30-20:00 | 8:30-20:00 | 8:00-18:00 | 10:00-16:00 |
| Boots | Bentley Bridge Retail Park, Wednesfield, Wolverhampton, WV11 1BP. | 8:00-20:00 | 8:00-20:00 | 8:00-20:00 | 8:00-20:00 | 8:00-20:00 | 8:00-20:00 | 10:30-16:30 |
| Boots | Boots Pharmacy, Waitrose, Marston Road, WV2 4NJ. | 8:00-20:00 | 8:00-20:00 | 8:00-20:00 | 8:00-20:00 | 8:00-20:00 | 8:00-20:00 | 10:00-16:00 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Asda Pharmacy | Molineux Complex, Jack Hayward Way, Wolverhampton, WV1 4DE. | 9:00-22:00 | 9:00-22:00 | 9:00-20:00 | 9:00-22:00 | 9:00-22:00 | 8:30-22:00 | 10:00-16:00 |
| The Pharmacy Clinic | The Avion Centre, 10 Bargate Drive, Wolverhampton, WV6 0QW. | 7:00-22:30 | 7:00-22:30 | 7:00-22:30 | 7:00-22:30 | 7:00-22:30 | 7:00-22:30 | 10:00-17:00 |
| Bilston Pharmacy | 74 Church Street, Bilston, WV14 0AX. | 7:00-23:00 | 7:00-23:00 | 7:00-23:00 | 7:00-23:00 | 7:00-23:00 | 8:00-20:00 | 10:00-18:00 |
| Sainsburys Pharmacy | Rookery Street, Wednesfield, WV11 1UP. | 7:00-23:00 | 7:00-23:00 | 7:00-23:00 | 7:00-23:00 | 7:00-23:00 | 7:00-22:00 | 10:00-18:00 |
| Phoenix Pharmacy | Parkfield Road, Wolverhampton, WV4 6ED. | 8:00-22:30 | 8:00-22:30 | 8:00-22:30 | 8:00-22:30 | 8:00-22:30 | 8:00-22:30 | 9:00-22:00 |

## Pharmacy questionnaire return summary

| Opening hours |
|---|
| 67% (43) open from 9:00am Mon-Fri<br>33% (21) close at 18:00pm and 19% (12) close at 17:00pm, only nine (14%) stay open after 19:00pm Mon-Fri<br>66% (42) open on Saturday, it is fairly evenly split between those that close around lunchtime or stay open until at least 17:00pm<br>19% (12) open on Sunday, mainly between 10:00am and 16:00pm |
| **Consultation facilities** |
| 60 (94%) pharmacies have access to consultation facilities and this is a closed room in most cases (56 in total). Of those, 46 have wheelchair access.<br>Toilet facilities are available at 29 pharmacies and hand washing is available in 53 of them (for 43 pharmacies this is in the consultation area)<br>39 (60%) pharmacies are willing to undertake consultations in the patients home or another suitable location<br>75% (48) of pharmacies, as well as speaking English, also speak Punjabi. Other popular languages spoken are; Urdu (21, 33%), Hindi (19, 30%) and Gujarati (18, 28%). |
| **IT facilities** |
| 62 pharmacies are release 2 enabled |
| **Essential services** |
| 55 pharmacies dispense all types of appliances (stoma, incontinence and dressings) |
| **Advanced services** |
| 60 pharmacies provide medicines user review services and two are intending to begin within the next 12 months<br>59 pharmacies provide new medicine services and three are intending to begin within the next 12 months<br>Appliance review services are provided by only 11 pharmacies, however, 15 are intending to provide in the next 12 months<br>Only eight pharmacies are providing a stoma appliance customisation service and 11 are intending to provide in the next 12 months |
| **Local services – currently commissioned** |
| **Local authority Public Health**<br>Emergency hormonal contraception service; 32 pharmacies provide this and 26 are willing to provide this<br>Needle syringe and exchange service; 30 pharmacies currently provide this*)* and 17 are willing to provide this<br>Sharps disposal service; 40 pharmacies are willing to provide this, eight provide this – sharps disposal is commissioned in relation to the needle syringe and exchange programme only.<br>Stop smoking service; 23 pharmacies are willing to provide this, 35 currently provide this<br>Supervised administration service; 22 pharmacies are willing to provide this, 28 currently provide this<br>**NHS England or CCG**<br>Minor ailment scheme; 11 are willing to provide this and 42 currently provide this<br>The two services below could describe palliative care and optometry prescribing and dispensing support services currently commissioned.<br>On demand availability of specialist drugs service; 47 pharmacies are willing to provide this<br>43 pharmacies are willing to provide patient group direction services, four currently provide this |
| **Non-commissioned services** |
| 62 pharmacies collect prescriptions from GP practices<br>57 pharmacies deliver dispensed medicines free of charge on request |

48 pharmacies deliver dispensed medicines to selected patient groups
43 pharmacies deliver dispensed medicines to selected areas
5 pharmacies deliver dispensed medicines with a charge

**Other services – not currently commissioned**

Pharmacies were asked about a range of services that are not currently commissioned for delivery through community pharmacies in Wolverhampton. The numbers of community pharmacies willing to provide services are listed below:

56 - anticoagulant monitoring service
55 - anti-viral distribution service
41 - MUR plus/medicines optimisation service
50 - prescriber support services
50 - provide chlamydia treatment
50 - medicines assessment and compliance support services
48 - school services
47 - a care home service
46 - chlamydia testing
45 - supplementary prescribing services
45 - independent prescribing service
42 - phlebotomy services
40 - language access services
36 - out of hours service
32 - contraceptive services (not EHC)
58 - services for COPD, diabetes type 1 & 2 and hypertension
57 –services for alzheimers/dementia and asthma
56- services for allergies, CHD, depression, epilepsy and heart failure
56 - obesity management services, for adults and children.
55 - services for Parkinson's disease
55 - gluten free food supplies
54 - cholesterol screening
52 - vascular risk assessment services
51 - diabetes screening
50 - alcohol screening
48 - HbA1C testing
46 - hepatitis testing
44 - gonorrhoea testing
43 - HIV testing
54 - Seasonal influenza vaccination;
47 - Childhood vaccinations;
45 - provide immunisations for hepatitis (at risk workers or patients) and HPV vaccination
52 - travel vaccines

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**Agenda Item No. 14**

# Health and Wellbeing Board

5 November 2014

| | | |
|---|---|---|
| **Report title** | Healthwatch Wolverhampton Annual report | |
| **Cabinet member with lead responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing | |
| **Wards affected** | All | |
| **Accountable director** | Sarah Norman, Community | |
| **Originating service** | Health and Wellbeing | |
| **Accountable employee(s)** | Kathy Roper<br>Tel<br>Email | Disability Commissioning Team Manager<br>01902 550975<br>Kathy.roperwolverhampton.gov.uk |

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**Recommendation(s) for action or decision:**

The Health and Wellbeing Board is recommended to:

1. Acknowledge the work undertaken by Healthwatch Wolverhampton, the community engagement activity undertaken and the priorities identified for 2014/15.

## 1.0 Purpose

1.1 The purpose of the report is to present the Healthwatch Wolverhampton Annual Report 2013-14 (Appendix A) which outlines the range of community engagement undertaken, how Healthwatch Wolverhampton has influenced local decision making and the priorities for 2014/15.

## 2.0 Background

2.1 The Health and Social Care Act 2012 made provision for the establishment of National and Local Healthwatch. Healthwatch England and Healthwatch Wolverhampton were established in April 2013. The Local Authority is responsible for commissioning Healthwatch Wolverhampton, and for contract monitoring its activities. Healthwatch is an independent organisation that carries out statutory functions, under contract to the Local Authority. Healthwatch Wolverhampton is registered as a Community Interest Company.

2.2 Healthwatch Wolverhampton has responsibilities for promoting patient and public involvement and to seek views on services which can be fed back to local commissioners. They also have the right to enter and view provider services, to comment on changes to local services and to signpost people to information about health and social care services.

2.5 It is the government's ambition that Local Healthwatch gathers people's views and experiences of health and social care services so that the communities views can meaningfully influence the commissioning decisions made in each area.

2.6 The Independent Chair of Healthwatch Wolverhampton is a member of the Health and Wellbeing Board helping to ensure that the consumer voice is integral to the wider, strategic decision-making across local NHS services, adult social care and health improvement.

## 3.0 Progress.

3.1 Healthwatch Wolverhampton's Annual report highlights some clear achievements which has given the organisation a strong basis to build on for the coming year. The priority for the first year was to build effective relationships and establish structures to enable Healthwatch to influence change and gather intelligence to evidence the experience of local people in relation to health and social care services.

3.2 Healthwatch Wolverhampton has been welcomed into key structures across health and social care including Wolverhampton Adult Safeguarding Board, the regional Quality Surveillance Group, Wolverhampton Clinical Commissioning Group and meetings with the Royal Wolverhampton NHS Trust. Much of this engagement has resulted in the opportunity to influence decisions and support improvement in a number of areas, including the peer review for the Adult Safeguarding Board, re-consideration for service provision around foot health, contributing to the successful Headstart programme.

3.3 Healthwatch Wolverhampton has responded to consultation on the Urgent and Emergency Care Strategy and was able to input the views of local people at the Health and Well Being Board, which contributed to a re-submission of a revised strategy.

3.4 The Healthwatch innovative website with its built in Patient Feedback centre provides a platform for the public to share their experiences of services as it takes place. This also gives the opportunity to rate the quality of the service received based on their personal experience. All comments and feedback is moderated and any issues are reviewed and followed up as appropriate. Other Healthwatch organisations have developed similar formats for their websites and we are considering ways to continue to improve the site and how we manage the data collated. The site was successfully launched by our very own Ambassador local and international football legend Steve Bull MBE. This was another first for Healthwatch and provides us with a vehicle for continued promotion.

3.5 The signposting service delivered by Healthwatch continues to grow with nearly 250 people contacting the service during our first year. As part of this service we built a Carers Corner into the website which aims to provide information and support to carers and professionals. This was in partnership with a local GP and has had national acknowledgement.

3.6 Community engagement and involvement is a significant part of our activities where we actively engage with the public and the community to gather their feedback about services, both positive and negative. During 2013/14 we spoke to over 2000 people about their experiences.

3.7 Healthwatch has commenced its Enter and View programme, with 30 volunteers completing the training and used our statutory powers to conduct 2 Enter and View visits during the year.

3.8 Our key priorities for 2014/15 are impacted by our ability to build our capacity to respond to local and regional priorities.

- Build Healthwatch Capacity. We aim to increase the number of Healthwatch Champions and volunteers supporting Healthwatch and further develop our business model to improve operational performance and income generation opportunities to enhance our statutory funding.
- Revise our workplan to reflect current topical areas including the Better Care Fund and the development of the proposals for Cannock Chase Hospital, and therefore improve our influencing role.
- Revise and implement actions from our Communications and Engagement plan. Build and strengthen relationships, which will enable us to effectively deliver our workplan, including partnership with Wolverhampton University.
- Further enhance our core offer, including maximising the Signposting service offer, the website capability and information flows.

## 4.0 Financial implications

The 2014/15 allocation for Healthwatch is £195,000, this is funded by mainline budget of £117,000 and Health Reform Grant of £78,000.
[As/23102014/T]

## 5.0 Legal implications

5.1 There are legal implications associated with this report. The requirement for the establishment and monitoring of a Local Healthwatch is a statutory responsibility as set out in the Health and Social Care Act 2012 This report outlines the council's requirements to commission and monitor Healthwatch Wolverhampton. [RB/20102014/P]

## 6.0 Equalities implications

6.1 There are no equal opportunities implications associated with this report; however there is an exception that Healthwatch Wolverhampton is commissioned to be representative of the local communities.

## 7.0 Environmental implications

7.1 There are no environmental implications associated with this report.

## 8.0 Human resources implications

8.1 There are no human resource implications associated with this report.

## 9.0 Corporate landlord implications

9.1 There are no corporate landlord issues associated with this report.

healthwatch
Wolverhampton


# Healthwatch Wolverhampton

# Annual Report 2013/14

# CONTENTS


| | |
|---|---|
| *Foreword and Overview* | *Page: 3 - 4* |
| *Executive Summary* | *Page: 5* |
| *Board biographies* | *Page: 6 - 9* |
| *Background* | *Page: 10 - 11* |
| *Who we are* | *Page: 12* |
| *Aims and Purpose* | *Page: 13* |
| *Partnership Working* | *Page: 14 - 16* |
| *Enter & View* | *Page: 16* |
| *Volunteer Office Recruitment* | *Page: 17* |
| *Healthwatch Website and Carer's Corner* | *Page: 18* |
| *Demonstrating impact through action* | *Page: 19 - 21* |
| *Steve Bull MBE - Exclusive Healthwatch* | *Page: 22* |
| *What are we doing to make Healthwatch accessible?* | *Page: 23* |
| *Engaging Local People and Receiving Feedback* | *Page: 24 - 26* |
| *Facts and Figures* | *Page: 27* |
| *Key priorities for 2014/15 and beyond* | *Page: 28 - 30* |
| *Expenditure* | *Page: 31* |
| *Acknowledgements, Publication & Contact Us* | |

# Foreword and Overview

*Independent Chair*
**Maxine Bygrave**

**As I look back over this first year as Chair of the Board for Healthwatch Wolverhampton I am pleased to report on achievements and successes during 2013-14.**

It has been a year of transition and change as Healthwatch Wolverhampton picked up the mantle from Wolverhampton's successful Local Involvement Network and took its first steps. We have been fortunate to have the expertise and knowledge to support our development, which has culminated in a number of fantastic achievements and changes, which will see us go from strength to strength.

Our Annual Report demonstrates the importance of our role in ensuring local people have the opportunity to influence and improve local services, and highlights the breadth of work undertaken by the dedicated team of staff and volunteers under the guidance and support of the Board.

Our vision is to be the first choice for people in Wolverhampton when they want help to improve their experiences of local health and social care services.

Healthwatch has been launched into an environment which was still reeling following the largest shake up of the NHS architecture since its inception in 1948, including the introduction of the GP-led Clinical Commissioning Groups. Developing relationships and engaging with stakeholders has played an important part in our first year. We have had active support from Healthwatch England, which has seen us develop local networks to increase our level of influence and reach.

We have been welcomed on to the Health and Wellbeing Board, by Health Scrutiny and Wolverhampton Safeguarding Adult Board, and become the first Healthwatch to participate in their Peer review playing a starring role in their newly launched DVD. Our relationship with Wolverhampton Clinical Commissioning Group is maturing which provides greater opportunities to raise issues directly with them and challenging the GPs to provide solutions and improvements. Over the past 12 months we have worked with partners to ensure the user voice influences decision making in public health, the development of the Better Care Fund and the local consultation on Urgent and Emergency Care services.

We met with the Chief Executive and the Chair of the Royal Wolverhampton Hospital NHS Trust David Loughton and Jeremy Vanes to discuss their plans for their latest

acquisition, Cannock Hospital, following the Trust Special Administrators recommendations on Mid Staffordshire Hospitals NHS Foundation Trust. We will be engaging with our support network and local people regarding the plans as they develop.

I have the pleasure to work with a fantastic team of staff, volunteers and supportive Board. Sadly, we have said goodbye to a number of key individuals. over the year including the LINk Chair John Mellor, OBE (who passed away last summer), long standing and committed Board Director Brian Griffiths, Board members Pat Burton and Maxine Wragg. Also, hardworking LINk coordinator Jane Viner moved to work for Healthwatch Brighton.

We welcomed new Board directors Sandra Jones, Angela Aitken and Chief Officer Carol Bott, who have all brought additional professionalism, expertise and enthusiasm to the Board. Our achievements have been heralded by our Ambassador, local football legend Steve Bull, MBE.

An Annual Report is always a time to reflect and look back but also a time to look forward and consider the challenges and opportunities ahead. We are heading into a period of continued transformation amidst a backdrop of financial challenges as organisations work to deliver services with restricted resources, as budget cuts impact the health and social care economy. As a champion for the voice of local people our primary function is to ensure the quality of those services does not reduce but is maintained and improved.

I would like to thank all the staff - Carol, Shooky, Pav and Kal for the sterling job they do, daily - without their dedication our achievements would not have been possible. I would also like to thank the Board for maintaining their vigilance and commitment to our core values and focus on improving the experience of those using health and social care services. Finally, I extend a very special appreciation to all our volunteers for their tremendous hard work

**Independent Chair**
**Maxine Bygrave**

# Executive Summary

**We have pleasure in presenting this Annual Report outlining the progress and successes achieved by Healthwatch Wolverhampton between 1st April 2013 and 31st March 2014. The overall role of Healthwatch is to engage and involve members of the public and patients in the commissioning of Health and Social Care services. From the outset, the Healthwatch Staff team and Board were united in their aim to be a 'trail blazer' for innovative developments for patients, service users and key stakeholder partners.**

Through undertaking extensive community engagement, we were able to identify a number of key themes which the Board approved as the basis of our ambitious Work Plan. We have attained significant progress in a number of other areas; particularly the work that Community Engagement Officer Pavitter Mainn has achieved with the Young Assessors group. The over-subscribed Public Event held in October 2013 highlighted many concerns particularly around Mental Health provision and GP access. We deliberated widely and included some items in our strategy for the year.

Again, early on, research was undertaken to develop a bespoke website to help Healthwatch Wolverhampton reach out to and gain the views of as many people as possible. With the assistance of the dynamic Social Media Partnership Company based in Birmingham, we (along with Healthwatch Birmingham) saw the need for an innovative website and Feedback Centre.

The launch of this Trip Advisor style site has proved to be a triumph, enabling us to predict 'trends' surrounding Health and Social Care issues in this locality and allowing us to share these efficiently with service executive leads. Alongside this innovation, our signposting service ably run by Administration Assistant Kal Patel has seen a steady increase in calls to Healthwatch Wolverhampton.

Two other significant developments that reached fruition during our first year were the setting up of the unique Carer's Corner micro site – a 'one stop shop' for carers and professionals in Wolverhampton. Our Administrator Shooky Devi dedicated many hours to the planning of this much acclaimed information tool. She worked closely with Dr Nejla Hussain, a local GP in this regard. Secondly, we secured soccer legend, Steve Bull, MBE as our high profile, exclusive Healthwatch Wolverhampton Ambassador. Due to his popularity, particularly amongst the male population, Steve has brought a powerful endorsement to our Healthwatch.

Indebted to our Board for their strategic input, I would like to thank them but especially our Chair, Maxine Bygrave for her professional approach to Healthwatch Wolverhampton throughout the last twelve months.

We look forward with much enthusiasm to our second year, building on the successes of the first!

C A Bott.

**Carol A Bott**
**Chief Officer**

# Healthwatch Wolverhampton

# Board Brief biographies (at 31st March 2014)

**Maxine Bygrave – Independent Chair** hails from Manchester originally but moved to Wolverhampton when she attended University here. Throughout her career she developed and implemented strategies to deliver services effectively and manage change efficiently. She was instrumental in establishing the PALS service for Wolverhampton which has successfully supported local people, staff and communities in relation to health service delivery and improvement in a number of areas.

During the last ten years and before leaving the employ of the Primary Care Trust, Maxine managed the PALS service, the Expert Patient Programme (EPP) team and then the Patient and Public engagement team. She also contributed widely to communications and policy team within the Chief Executive Directorate. She provided leadership and support in relation to developing strategies to review and monitor patient experience in order to facilitate change, implementing action plans and activities to support the Assistant Chief Executive. A skilled facilitator with training experience in a number of approaches including Voice training from the Voice and Echo facilitation programme, Maxine is a pivotal lead on many strategic Wolverhampton committees and fora.

For nine years she has been a Governor at two schools in Wolverhampton. She has one daughter, Shelby who is about to enter University.

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**Angela Aitken** (Director) currently works as a Senior Commissioning Manager in Public Health outside of the Wolverhampton locality. She has extensive public health and management experience combined with significant front-line knowledge of health and social care.

An experienced trainer, Angela has a track record in project, service and change management, being skilled in innovative practice, community engagement and motivating and leading multi-agency teams to improve population health, driving quality, safety and efficiency of health and care services.

Possessing an MSc in Public Health, a postgraduate diploma in Health and Social Care, currently she is undertaking an MSc in Commissioning for Health and Social Care. Angela is a qualified teacher of Adult education and has over 17 years experience of working in Health and Social care. She represents the Board on the Public Health Delivery Board for Wolverhampton.

In her spare time, Angela enjoys spending time with her family, cycling and baking.

**Collette Henry** was born and educated in Wolverhampton and has lived here all her life. A former social worker, working mainly with adults with learning difficulties she has in-depth knowledge of many specialist areas of health and social care including Dementia/Alzheimer's disease, end of life care, drug and substance misuse, youth offending, the homeless and nursing home care.

She believes wholeheartedly in equality and fairness and was health and safety/union representative for Unison Wolverhampton for several years, helping to effect change for the better for staff and service users in the city. She is a busy Mum and grandmother but still finds time to undertake her role, attending meetings and many events for Healthwatch Wolverhampton.

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**Gloria Gordon's** career was heavily entrenched in the NHS being a senior nurse for 38 years. Possessing an in-depth knowledge of Wolverhampton, Gloria's skills surround research and development of health-related to policies. She is a member of the NHS retirement fellowship where she participates in activities surrounding young people and is a first aider.

She is a Public Governor of Royal Wolverhampton NHS Trust and has involvement with the West Midlands Caribbean Parents and Friends Association. At Healthwatch Wolverhampton, Gloria participates in furthering Chiropody and Mental Health services.

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**Jacqueline Hunter** is a native of Wolverhampton and had a career in retail. She enjoys providing input into a number of health and social care work topics on the Healthwatch Board and has an affinity with the Sickle Cell and Thalassaemia Support Project. A former member of the Patient Involvement Participation group at New Cross hospital, Jacqueline is trained to undertake Enter & View.

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**Jean Hancox** enjoys working with and formulating policies and practices to improve peoples' lives and work. A background in social work, welfare and housing, she has been an expert consultant throughout her working life. She is Chairperson of The Breast Cancer Action and Support Group, Wolverhampton, Vice Chairperson of the Patient Action Cancer Team (PACT), Chairperson of her GP Patient Participation Group and is a Peer Reviewer for NHS England.

Jean is an active member of the Healthwatch Wolverhampton Board undertaking Enter & View visits, sits on the Publicity and Engagement sub-group and champions for health and care issues at all times particularly in terms of urgent care and at Clinical Commission Group meetings.

In her very limited spare time, Jean enjoys reading, travel and cooking.

**Sandra Jones** (Director) was appointed to the voluntary role of Director on the Board of Healthwatch Wolverhampton in October 2013. Prior to taking up this position, she worked for Wolverhampton City Council for 25 years, retiring in August 2012 having enjoyed a successful career in various senior strategic roles in housing, regeneration and social services.

After spending 12 months relaxing, spending time with grandchildren and visiting National Trust houses and gardens, she felt ready to put to good use, the skills, knowledge and expertise built up over her working life. Possessing a Masters Degree in Housing and a BA (Hons) Degree in Humanities, Sandra saw getting involved with Healthwatch Wolverhampton offered a way of drawing on her experience of working with care commissioners, providers and service user groups to ensure that residents opinions and experiences regarding the services they have or continue to receive, are used to improve services and influence the commissioning process.

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**Sutinder Herian** has been working as the Project Co-ordinator for the Sickle Cell and Thalassemia Support Project for the past 17 years. Prior to moving to Wolverhampton some 23 years ago worked for various civil service organisations to include Land Registry and Employment Service in Coventry. Current voluntary roles include chairing a BME Health and social care charity, Director on a local social enterprise supporting people back to work, training and business start-ups and a Governor at a local secondary school.

Possessing a Level 5 Diploma in management and Masters of Business Administration (MBA), Sutinder was instrumental in acquiring and maintaining the Investors in People standard for her employment.

She is mother to two adolescent girls both studying at University in their respective fields, and married to her husband of 23 years. In her spare time, Sutinder enjoys socialising, eating out, and spending time with the family

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**David Hellyar** spent the whole of his working life as a career NHS Manager, during which time he covered every aspect of the NHS including running an individual hospital to an entire Health District as well as commissioning new developments. Since retiring from the NHS, David has retained an interest in it as a (patient) member of the Wolverhampton Patient Advisory Cancer Team, as a member of LINk and now Healthwatch Wolverhampton. He is also a Shadow Governor of the Royal Wolverhampton NHS Trust.

In the course of his working life, David worked in many different parts of England, where he was able to build a much better knowledge and understanding of services including picking up a wider view of both good and bad practices. Currently he leads on Mental Health issues for Healthwatch Wolverhampton.

**Desmond Halestrap** enjoyed a successful career in education being a lecturer in Wolverhampton for many years. As a member of the Healthwatch Wolverhampton Board, he represents the Board at West Midlands Ambulance meetings and also had an interest in services for the older person including the work of Age UK.

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**Gordon Howells** had a career as a Local Government Officer and Chartered surveyor. For 20 years he has been involved with the Wolverhampton Coronary After-Care Support group and is currently the much acclaimed Assistant Treasurer.

At Healthwatch Wolverhampton, he leads on the Transport to Health Appointments element of the Work Plan, former Patient Participation Group at New Cross as well as deputising at Trust Board meetings whenever necessary.

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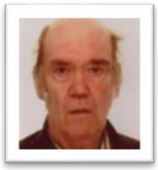

**Ralph Oakley** is a much sought-after local author and health and social care services user. He enjoyed a successful and interesting musical

career being just nine years old when he made his first appearance on a public stage at Coseley Scouts Club singing Frankie Laine's *Sixteen Tons*. During the last 50 years he has written a number of beautiful songs and his novel *'Children of the Gorge'* was a vivid, fictional account of children living in the Ironbridge area during the Industrial Revolution.

During the 1960s to 80s Ralph was instrumental in setting up and running companies in Third World countries. Currently, he is Chair of 'One Voice' in Wolverhampton, and also a session advocate for the organisation. He is also sits on the Board of the Black and Minority Ethnic Group in Wolverhampton.

Ralph participates in a number of Healthwatch work areas namely: Nursing & Care Homes, Publicity and Engagement Sub-group and Enter & View.

# Background

## Local Healthwatch and Healthwatch England

Healthwatch Wolverhampton is the local consumer voice for health and social care. We are a new independent organisation that has been set up to enable consumers of health and social care services in Wolverhampton to influence and improve the way these services are provided and run.

Our Healthwatch transitioned from Wolverhampton Local Involvement Network (LINk), and is building on the best practice elements done by that organisation. Healthwatch Wolverhampton has various powers and duties to make sure that services meet local needs and that local people's views have a real impact. The statutory role and function of Healthwatch is laid down in the NHS and Social Care Act of 2012, but local areas have discretion about how their local Healthwatch delivers its services. This act also gave councils the legal responsibility to set up a local Healthwatch by April 2013.

Healthwatch Wolverhampton is funded by the Department of Health via Wolverhampton City Council. However, it is an organisation in its own right and independent of the council. Although a funding allocation is made to councils for the provision of local Healthwatches, it is not ring fenced; it is left to the Local Authority as to how they use this funding to provide the service. There are one hundred and fifty two local Healthwatch in total.

Healthwatch Wolverhampton has a statutory seat on the Wolverhampton Health and Wellbeing Board which brings together key organisations responsible for providing health and social care e.g. Wolverhampton City Council and the NHS. We represent the consumers' voice on the Board and take our role extremely seriously.

Healthwatch operates both locally and nationally. As well as local Healthwatch, Healthwatch England works at the national level. They take the experiences of local Healthwatch and use them to influence national policy. By law, the organisations that plan, run and regulate health and social care services have to listen to what Healthwatch England has to say. When Healthwatch England is alerted to failing services, they report issues to key national organisations, including the Care Quality Commission, of which they are a sub-committee, and central government. These organisations must submit a public response to Healthwatch England's concerns.

# Development of Healthwatch Wolverhampton

## Healthwatch Wolverhampton was incorporated as a Community Interest Company (CIC) for the start of April 2013.

As an organisation our main focus is to make sure Wolverhampton people's views and experiences of local services are disseminated to the decision makers and service delivery organisations. We have an ongoing Work Plan that reflects the topics that are of concern to the public we serve. Directors and Board members recognise that we need to take into account a range of evidence and not anecdotal incidents.

The other factor to consider is capacity – we are a relatively small staff team and Board; therefore we must concentrate our efforts to achieve maximum effect.

The Board consists of individuals from a range of backgrounds, including the NHS, statutory organisations, private companies, retail and voluntary organisations. Our Board members are also users and carers of those Wolverhampton Health and Social Care services.

# Governance

Healthwatch Wolverhampton is governed by its Board Directors (3) and eight members who are ultimately responsible for the strategic decision making. The day to day operational management is the responsibility of the Chief Officer (CO), who also assists with the strategic direction.

The three other staff team members play an active role in supporting the CO, Directors and Board. Thematic sub-groups assist in developing various procedures, structures and plans, based around Business and Finance, Communications and Research / Intelligence. Plans are afoot to recruit, in the next year, additional Directors to the Board.

As the organisation has matured, it has moved to a more traditional structure with the Board taking a strategic overview delegated through the CO to staff. The Chair has an executive function and works on Healthwatch Wolverhampton strategic business for at least one day per week, meeting regularly with the CO and key stakeholder.

All forms of training are a very important part of the ongoing development and motivation of members. Board members are active in representing Healthwatch and collecting information from their communities and other sources about health and social care issues. This activity includes sitting as Healthwatch Wolverhampton representatives on groups ranging from the Public Health Delivery Board to the Clinical Commissioning Group.

## Board Directors/Members

Maxine Bygrave - Independent Chair

Angela Aitken - Director

Sandra Jones - Director

Collette Henry - Board member

Gloria Gordon - Board member

Jacqueline Hunter - Board member

Jean Hancox - Board member

Sutinder Herian - Board member

David Hellyar - Board member

Des Halestrap - Board member

Gordon Howells - Board member

Ralph Oakley - Board member

## Staff

**Carol A Bott – Chief Officer**

**Shooky Devi - Administrator**

**Pavitter Mainn – Community Engagement Officer**

**Kal Patel – Administration Assistant**

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**(Jane Viner – Co-ordinator from April to July 2013)**

## Volunteers

**Simran Dhani**

**Alex Campbell**

**Najma Saleem**

**Joyce Umukoro**

**Tarah-Hartley Johnson**

**Sonia Mcnab**

**Aaron Clarke**

## Acknowledgement to previous Board members who retired in 2013/14:

**Pat Burton – Board member**

**Brian Griffiths – Board Director**

**John Mellor – Previous LINk Chair & Healthwatch Board member**

# Aims and Purpose

*What We Do*: ***Healthwatch Wolverhampton works with the public and key partners in the following ways:***

## Advice & Guidance

- Identifying and clarifying the rights of consumers of health and care services.
- Promoting and providing information on these rights, and advice on enforcing them.

## Engagement and Consultation

- Promoting and supporting the involvement of local people in the monitoring, Commissioning, provision and scrutiny of local services.

## Influence and Involvement

- Healthwatch Wolverhampton obtains the views of people about their needs and experiences of local care services.

## Scrutiny and Reporting

- Making reports and recommendations as well as influencing national priorities

# Partnership Working

## Statutory seat on Health and Wellbeing Board

The Health and Well Being Board exists to serve Wolverhampton by bringing together representatives from NHS Clinical Commissioning Group, education, housing, police and voluntary sector as well as local councillors. Wellbeing plays a significant part in people's overall health quality and this board aims to tackle the wide range of topics that not only form the traditional health issues that affect the citizens of Wolverhampton but also areas surrounding general wellbeing.

We have been granted a statutory right to representation on the Health and Wellbeing Board so as to allow our organisation to act as the conduit between the Board and the public. In this way, we are able to ensure any concerns raised by the public are at the centre of the Board's decision-making.

## Representation on Quality Surveillance Group

Healthwatch Wolverhampton is a member of the Quality Surveillance Group for the Wolverhampton locality. This is part of NHS England, bringing Health and Social Care Commissioners, providers and regulators together to ensure that services are delivered in a safe and effective way.

### Escalating concerns to Healthwatch England and Care Quality Commission

The Care Quality Commission (CQC) regulates the providers of Health and Social Care services. Healthwatch Wolverhampton has established an appropriate liaison and working relationship with the CQC. Meetings are held between the two organisations on an ad-hoc basis when we are able to provide constructive feedback that may assist the CQC's inspectoral role.

If issues raised locally to the CQC cannot be resolved, we can escalate these to Healthwatch England who will pursue these on a national basis.

## Statutory Bodies

Healthwatch Wolverhampton has established good working relationships with many organisations and key stakeholders. These include the Local Authority, Clinical Commissioning Group (CCG), the Royal Wolverhampton NHS Trust, the local voluntary sector and service providers. Although we are based within the Wolverhampton Voluntary Sector Council offices and as such have benefitted from services offered within e.g. Volunteer Centre, we have been remained wholly independent in our approach and delivery of our extensive Work Plan.

Participation in a number of fora is vital. Within this year, the Chair and CO in particular, as well as some Board Directors/members attended many key groups e.g. Health Scrutiny, Joint Engagement Assurance group, Patient Participation Forum, Adult Delivery Board, Public

Health Delivery Board, Creating Best Practice Steering Group, Wolverhampton Safeguarding Group etc. The Chair appeared in an awareness-raising DVD made by the latter group. She also takes the lead pm ensuring user experience informs and improves practice in relation to safeguarding.

During this year, the Chair attended and provided input to the Public Health Transformation panel. This participation ensured the experiences of the public, patients and users were highlighted and included in the decisions taken in relation to projects which applied for funding to deliver transformational change for local people.

In monitoring the Clinical Commissioning Group (CCG), the Chair ensures they undertake full and comprehensive evaluation which includes user-experience in their current pilot delivery programmes in Primary Care.

## Activity

The first year has been a busy, exciting and profitable one for our Healthwatch. Activities have been varied and appropriate to our Work Plan.

We have amassed 900 supporters, all of whom have access to our regular Newsletter, held an over-subscribed, successful public event, been inundated with requests to participate in community events, worked with *Social Media Partnership* to develop and set up our innovative website and Carer's Corner, engaged widely with the diverse community of Wolverhampton including young people and recruited our exclusive Ambassador, football legend, Steve Bull, MBE.

## The establishment of an effective Signposting Service

From the very outset, Healthwatch Wolverhampton has strived to ensure local people are provided with information and advice to help them access and make choices about Health and Social Care services. This has been done, primarily, by our part- time Administration Assistant, Kal Patel who offers a sympathetic ear and sound guidance. The number of individuals assisted during the first year in this way, amounts to 369.

## How Healthwatch Wolverhampton helps to influence change?

### *Example 1 - Podiatry Service*

A Patient aged 81 years old rang to explain that he had been waiting for over 8 months for a podiatry appointment. He was walking with the aid of a stick and struggled to put on his shoes due to the length of his nails that were causing him pain. Healthwatch Wolverhampton contacted his GP surgery and Foot Health Clinic on his behalf but was unable to get an appointment for him immediately. Healthwatch then contacted the local CCG who agreed to find an early resolution for the patient. The CCG will also be looking into this concern as part of a wider investigation into podiatry services waiting times.

### *Example 2 - Waiting times in the acute sector*

Miss T had been waiting some time for a knee operation. She had contacted the hospital on a number of occasions but had been unable to secure a date. She was approaching the 3 months' waiting list deadline and asked Healthwatch advice as to what to do next. Healthwatch advised her to contact the hospital again to ascertain what arrangements they have in place if the waiting time deadline is not met.

Miss T followed this advice and shortly afterwards the hospital contacted her to advise that there had been an operation cancelled, she would be offered the slot and therefore the 3 month deadline for her operation would be met.

### *Example 3*

As a result of our feedback and input at Health and Well Being Board, the development of the Urgent and Emergency Care strategy was reconsidered and the options reviewed. This also had a positive impact on the subsequent consultation.

# Enter & View

Healthwatch Wolverhampton is able to enter and view all publicly funded health and social care services premises – either as an unannounced spot check or at a previously arranged visit. All volunteers who sign up to undertaking this program of work are thoroughly vetted and trained. Three training sessions were held during this year with more planned. Twelve individuals are signed up to undertake this work with more committed for next year.

We are unswerving in our aim to report on findings to the providers and commissioners of services; and where appropriate, the regulators.

In December 2013 we undertook a previously arranged pilot visit to a Care Home and in March undertook an unannounced visit to New Cross Hospital A&E department.

Once a visit is undertaken and a report is compiled, findings are shared with the Healthwatch Board. The report is then shared with the service provider and recommendations made. Checks are made within a reasonable period of time to ensure that outcomes are satisfactory.

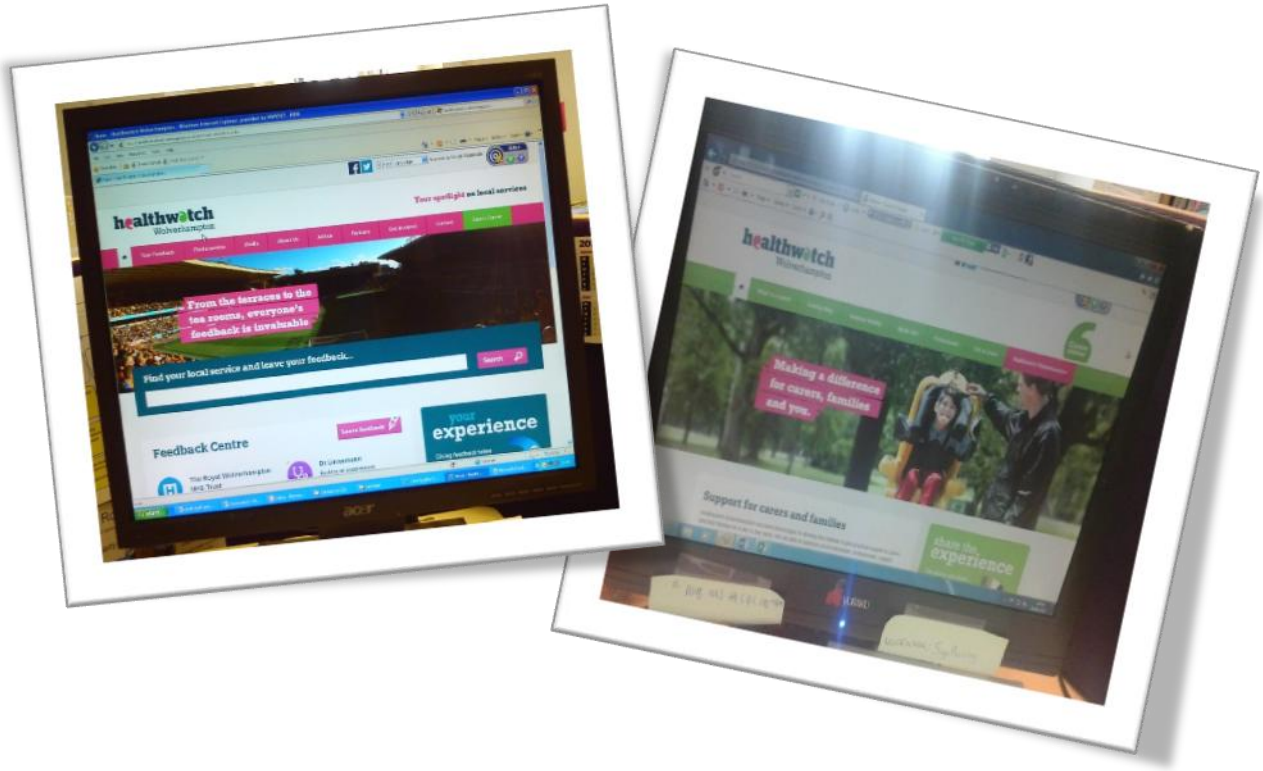
# Volunteer Office recruitment

With a small Staff complement (2 full time and 2 part time workers), Healthwatch Wolverhampton in order to follow a challenging but essential Work Plan needed to seek additional help to undertake administrative tasks within the office. Office Administrator, Shooky Devi was proactive in seeking enthusiastic volunteers for this purpose. During the last year, eight individuals have provided over 1300 volunteer hours, assisting with a variety of tasks from telephone calls, to distributing leaflets and assisting at public events and training sessions.

# Healthwatch website: Carer's Corner

From the very outset, Healthwatch Wolverhampton had a very clear objective – to be as innovative as possible in getting our messages across to the public we serve. One way we have achieved this is by setting up a ground-breaking website and Feedback Centre. Individuals are able to make a comment in 'real time' about the Health or Social Care services they receive. Feedback can be left anonymously but all comments are checked and moderated if necessary. We want positive, motivational information as well as the indifferent or negative data. For those who don't possess a mobile phone or PC, members of the public can leave their feedback on postcards available at a number of outlets.

Within our website we have Carer's Corner – a 'one stop shop' for individuals who are themselves carers or for professionals who have an interest in caring. This is unique to any Healthwatch and is proving popular with the public.



# Demonstrating impact through action

## Communications and engagement

We use a variety of traditional methods of outreach along with new media to market ourselves, enabling a range of diverse consumers to engage with us and contact us according to the method that suits them best.

## HW Posters and Brochures

During the last year we distributed posters to 112 Wolverhampton organisations and 2000 newsletters and leaflets.  Countless others were disseminated electronically.


## Social Media

The Healthwatch Facebook account was developed to access a younger target audience and is used to keep our Facebook  'Friends' up-to-date with Healthwatch activity, including posts about, local and national policy, consultations and events. As to the end of March 14 Healthwatch Wolverhampton had 500 Twitter followers and 700 Facebook friends.

# Community Groups and Events

***Consultation gathering – Healthwatch Wolverhampton***

From 1st September 2013 to 31st March 2014, the Healthwatch Community Engagement Officer attended numerous events, interacting with **2032** people.

The variety of different organisations and event attended comprised: - BCP Health Fair, Tenants' Association, women's support groups, Local Neighbourhood partnerships, Beacon for the Blind, Diabetes groups, PACT meetings, Autism groups, disabilities' groups, International Women's Week events, Carers' Association, Young People's consultations (Headstart), Ageing Better Consultation and Headstart Big Lottery workshop.


# Healthwatch Newsletter

The newsletter has a distribution of 10,000 and includes, updates on the progress if the Healthwatch, reports on Healthwatch activities, local and national policy and news and opportunities to get involved

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healthwatch
Wolverhampton

**UPDATE from HEALTHWATCH WOLVERHAMPTON**

**Healthwatch Wolverhampton is going from strength to strength! A member led, independent organisation, it captures vital information from the public about what is good and what can be improved about health and social care services delivered in Wolverhampton. We are careful to ensure that the service user's view is used appropriately and in a way that will help develop better services overall.**

Members of Healthwatch set out the matters of greatest concern to the local Wolverhampton community and our work plan looks at these issues in greater detail. Currently we are compiling data on GP appointment accessibility, problems that people have in finding an NHS dentist, etc. If you find it hard to use or access services or share your views we want to make it better and easier for you. In particular, if you belong to a group or know of one whose views are 'seldom heard', then do get in touch.

Looking for people who may wish to become actively involved, if you think you can discuss health and social care issues in an objective way and make some important decisions, we would like you to contact us for consideration as a Board member or even a non-executive director. Being a member of the Board is worthwhile yet challenging. If you possess good communication and observation skills, perhaps you would like to join our 'Enter & View team? This is a programme of work where Healthwatch Wolverhampton can use its statutory ability to go into health and/or social care environments and ask service users or residents of care homes what THEY think about their treatment or living environment and care.

**For further information, please call Healthwatch Wolverhampton 01902 426271 and ask for Carol Lamyman or contact us at info@ healthwatchwolverhampton.co.uk**

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Follow us on Twitter@HWolverhampton and facebook healthwatchwolverhampton

# Media

The Chair and CO have both engaged widely with the media at a national and local, level during the first year. Community Engagement Officer, Pavitter Mainn undertakes conversations with the public via Community Radio too. Regular updates in the Express and Star newspaper has helped raise awareness and recruit new Healthwatch Champions for a number of key roles.

# *Steve Bull, MBE – exclusive Healthwatch Wolverhampton Ambassador*

## Background

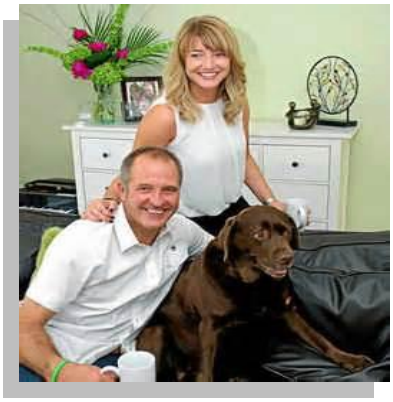
Wolverhampton is a West Midlands city famous for many reasons. It was given city status in 2001 and according to the last census has a population of around 250,000. In the 1950s and 60s Wolverhampton saw years of prosperity but in recent years has seen a decline following a slump in the manufacturing industry. The city has a number of challenges, especially around public health issues, with high instances of obesity, smoking and infant mortality.

The city is highly regarded in soccer terms because of Wolverhampton Wanderers FC. One of its famous sons is Steve Bull MBE whose expertise (holding the club record of 306 goals) on the pitch escalated him to play for the England team. Today Steve is an Honorary Vice-President of the 'Wolves' club.

When Healthwatch Wolverhampton was seeking a high profile person to help: a) raise awareness as to our vital work and, b) ensure the male population had someone they would pay attention to regarding health issues, Steve Bull was our first choice to become exclusive Ambassador.

As well as his prowess on the football pitch, Steve is a person who dedicates much time and energy to promoting the Steve Bull Foundation – a charity that provides support to reputable good causes such as helping seriously ill and terminally ill children and their families. Since the launch of his charity, Steve has raised nearly £2m.

From the outset, Healthwatch Wolverhampton has benefitted from his involvement. He participates at our public events e.g. Website launch, proudly wears the Healthwatch Wolverhampton badge at all his own events, raises our profile through his weekly blog and has our name and logo printed on all his calling cards. Additionally, he kindly donates promotional materials to our events.



We would like to take this opportunity to formally thank Steve and his wife, Kirsty for all their efforts on behalf of Healthwatch Wolverhampton. Long may the partnership continue!

# What are we doing to make Healthwatch Wolverhampton more accessible to all?

When individuals and groups become members of Healthwatch Wolverhampton, data is gathered regarding members' access requirements including:

- Communication - large print, magnifier, braille, audio;
- Hearing - BSL/SEE Interpreter, infrared systems, induction loop, deaf blind Interpreter, speech to text reporter, lip speaker;
- Language - translation of documents, interpretation service, CD format and writing with pictures;
- Mobility and any specific dietary requirements.

As detailed above provisions are made to ensure Healthwatch Wolverhampton members have access to communication formats that meet their individual needs. As part of the membership process, individuals are asked for their preferred communication method i.e.:

- Text - Large Print, Coloured Paper, Magnifier, Braille, Audio;
- Hearing - BSL/SEE Interpreter, Infrared Systems, Induction Loop, Deaf Blind Interpreter, Speech to text report, 'Browse Aloud' – text to speech software, Lip Speaker;
- Language - translation of documents, Interpretation Service;
- CD Format; Writing with Pictures.

This information is used to ensure that when information is sent out to members it is sent in an appropriate format i.e. in response to requests; we currently send information to some individuals in large print, on yellow paper, audio, Punjabi and Gujarati languages. The data is also used when planning events to ensure that venues and catering meet members' specific requirements.

# Engaging Local People & Receiving Feedback

Healthwatch Members and supporters have been involved in having their say about the following consultations:

**Healthwatch Launch Event October 2013**

Our Healthwatch Public Launch took place on 17th October 2013. It was a successful day with 135 attendees and 14 new recruits. The programme of the day allowed presentations on the role and purpose of local and national Healthwatch. It also included a presentation form Healthwatch England & table top discussions surrounding issues of concern to the attendees, namely: GP Appointments, Public Health, Maternity Services, Mental Health services, Nursing & Care Home provision and Adult Safeguarding.


*Collette Henry gathering feedback*

*David Hellyar facilitating a Mental Health workshop*

# Wolverhampton Parent Partnership October 2013

A packed event involving Wolverhampton Parent Partnership, Voice 4 Parents and Healthwatch Wolverhampton Information Day was held in October 2013. A facilitated session with 50 parents in attendance; two new recruits were enrolled to Healthwatch.

The day's programme included a presentation from the Healthwatch Young Assessor, Lisa Howells. A plethora of topics were discussed including the 'No Health without Mental Health' strategy and table top interaction surrounding child health services, Social Care, hospital and GP appointments.


# Emergency Care Consultation February 2014

Following deliberations with the Board members and the receipt of comments from the wider Healthwatch Wolverhampton membership, we held a specific event to discuss this important development. Following this well-attended meeting, it was agreed that RWHT would be advised that Healthwatch Wolverhampton was supportive of a new A&E department on the New Cross hospital site. Everyone felt that the current provision is not able to meet demand and cannot always respond effectively to individual needs.

Local people shared with us their experiences of the service which can be inconsistent; staff members are not always aware of how to support patients with Dementia, mental health and other long-term conditions. Parents of children with disabilities have told us that they sometimes have long waiting times with their children becoming increasingly agitated and therefore difficult to treat.

Following this major consultation, Healthwatch Wolverhampton is now being involved in the design of the new A&E service specification. It will be important to include local community and voluntary organisations that provide specialist care and support and would therefore be able to identify ways to improve the patient journey and experience of urgent and emergency care.

# Ageing Better Consultation March 2014

Wolverhampton Local Authority was one of thirty two across England shortlisted for a share in a £70m Big Lottery Fund's Fulfilling Lives: Ageing Better programme tackling social isolation for vulnerable older people. Healthwatch Wolverhampton added vital input to this consultation by contacting residents of Wolverhampton to ascertain their priorities in determining the factors that impact upon their ability to live healthier lives later in life.

# HeadStart Consultation March 2014

Lisa Howell supported Healthwatch staff to facilitate two days' consultation at a Mander Centre shop when we interacted with 331 young people & their parents. The majority of the young people took away an information pack bag. We made the most of interacting with young people who wouldn't have normally had contact with Healthwatch.

HW staff also supported YOW at the bowling alley consultation where 50 young people and 10 support workers took part.

A HeadStart workshop was held in London by Big lottery and HW young assessor, Lisa Howell was invited to take part and have input in the HeadStart programme

Lisa Howell was also invited to attend the Wolverhampton Safeguarding Children's Board Development Day to speak about her experience of support received during the loss of her granddad. A letter of thanks was received.

# Facts & Figures

**1300**
Office Volunteering Hours

**500**
Tweets

**700**
Facebook Friends

**369**
Issues dealt with at events

**3047**
Individuals requested information at Community Engagement events

**54**
Interactions with Community Groups

**11**
Interactions with Community Groups

# Key Priorities for 2014/15 and beyond

It has been an extremely successful and innovative year for Healthwatch Wolverhampton, building strong foundations and putting in place systems and processes to encourage intelligent and appropriate capture of information to influence current and future NHS and Social Care activity. However, we are determined that in Year 2 there will be further clarity around our challenging Work Plan. The Board plans to recruit new directors to offer additional strategic focus to its dedicated membership.

The Board will hold a planning day in late summer to reaffirm its in-year strategy and ascertain its 3 three year intentions. Key Performance indicators will play an integral part in this objective.

Our broad intentions in Year 2 are threefold:

- To improve operational performance across all Work Plan areas;
- To consolidate our locality and stakeholder relationship in order that we may extend our influencing role. We have already had a positive impact upon the Health Scrutiny Board and the ways in which we are able to offer a strong, patient /service user voice;
- To build upon our successful start in raising additional income to boost our statutory funding.

## Independence and Transparency

The Healthwatch Wolverhampton Board and Staff team has been active from the very outset. The Chair has assisted in the recruitment of new directors and has commenced the transfer of staff from Wolverhampton Voluntary Sector Council to Healthwatch Community Interest Company (CIC). At the time of writing, there is no immediate plan to relocate the office out of WVSC but consideration may be given to this in 2014/15. The current arrangement allows our Healthwatch to derive maximum benefit from the extensive experience and connections WVSC has.

The Healthwatch Board will need to agree the future format of Board meetings – their frequency and structure whilst connecting on a regular basis with stakeholders and being involved in events and meetings organised by staff on behalf of the Board.

## Communications

Part of Year 2 planning involves the comprehensive review of communications which will include assessing the effectiveness of campaigns, development sessions and our communication tools including our innovative website and Feedback Centre. Currently, evidence would indicate that social media is proving an effective means of communicating with the younger to middle-aged element of society. A benchmarking exercise will be conducted to give an indication of the increased brand awareness and understanding of the role and functions of Healthwatch Wolverhampton.

## Information and Advice

Healthwatch Wolverhampton has, through its signposting function made significant impact during its first year of operation offering *in-depth* assistance to 233 individuals and signposting hundreds of others to an appropriate service. Our innovative website has allowed members of the public to leave a 'Trip Advisor' style review which has enabled us to provide accurate trend analysis (of NHS and Social Care issues) to Commissioners and service providers.

We have held fruitful discussions with the Executive Team at Royal Wolverhampton NHS Trust that has resulted in Healthwatch Wolverhampton holding Drop-In advice sessions commencing in the summer of 2014. These sessions will be held at a variety of locations throughout New Cross, West Park and beyond. The capture of 'real time' patient views will be made easier via the use of PC tablets.

## Community Engagement

Healthwatch Wolverhampton is currently reviewing the effectiveness of all its engagement activity which has been busy throughout 2013/14. Community Engagement Officer Pavitter has built relationships with hitherto unattainable, harder to reach groups e.g. the Roma Community. Whilst continuing with successful methods we will be seeking innovative approaches of engagement and involvement with ongoing focus on young people, Mental Health service users, and those not currently on our radar.

The popularity of our Ambassador Steve Bull MBE has helped us reach out to the male population of Wolverhampton who are often reticent to seek help regarding male health issues.

There is also a target of 100 in the recruitment of Healthwatch Champions to undertake a variety of 'hands on' roles e.g. Enter & View, Mystery Shopper etc.

## Influence

Our Healthwatch has continued to build on its intelligent use of information and patient experience (over 3,500 individual items) given to us by the citizens of Wolverhampton. Successful, planned Enter & View training (3 sessions) have resulted in Healthwatch Champions being able to deliver on this vital area of work with Enter & View visits commencing in December 2013.

There are plans to involve our Healthwatch Office Volunteers and the Young Assessors which will allow increased involvement in the Authorised Representative activity supporting key Work Plan areas.

Healthwatch Wolverhampton will continue to share information and best practice with the West Midlands/Black Country Healthwatch and also liaise with Healthwatch England in contributing to national pieces of work and highlighting patient experience.

## Value for Money

Healthwatch Wolverhampton's priorities in this area include the organisational review of staff and productivity and the development of hands-on operational assistance by Board members and Healthwatch Champions. We will also continue in our endeavors to raise additional income streams as we did during our inception year i.e. Carer's Corner.

We are pleased with the way in which we have been frugal with limited finances in our first year. There is an unprecedented level of change facing the NHS now and in the future. Healthwatch Wolverhampton is confident that our future funding will be utilised fully as the public's interest in the NHS and Social Care landscape becomes more prominent, especially the continued advances made by our organisation in reaching the public and receiving ongoing feedback surrounding concerns and issues. Our extensive engagement will need to be properly resourced, our Staff complements increased and our training of volunteers funded.

| EXPENDITURE | 230,934 |
|---|---|
| **Staffing & Set Up Costs**<br>Including on costs, travel, and recruitment. | 114,360 |
| Office & Other Running Costs<br>Including website construction & development, telephone, copying, promotional materials, postage, stationery, all premises costs, management and additional other staff (including CAB) support time. | 36,736 |
| Member Support Costs<br>Interpretation and translation, venue hire & young people's work. | 10,145 |
| HW Board Budget<br>Including travel, room hire, refreshments, Stationery, carer expenses, training. | 3,383 |
| VAT Repayment to HMRC | 5,000 |
| Overhead Recharge | 29,159 |
| TOTAL SPEND | 198,783 |

**Total Income Received**

These accounts are the draft accounts of the Healthwatch Wolverhampton budget within WVSC's draft final accounts 31.3.14, prior to audit. There may be slight variation at the point of WVSC's approved final accounts. Published accounts may be viewed after 31st July 2014.

**Acknowledgements**

Ian Darch, Chief Executive Officer, WVSC

David Loughton, CBE, Chief Executive, Royal Wolverhampton NHS Trust

Cheryl Etches, OBE, Chief Nurse, Royal Wolverhampton Trust

Jeremy Vanes, Chief Operating Officer, Wolverhampton CAB

Councillor Claire Darke, Wolverhampton City Council

Councillor Sandra Samuels, Wolverhampton City Council

Ros Jervis, Director of Public Health, Wolverhampton

Pat Roberts, Patient Experience Lay Representative, CCG Wolverhampton

Everyone who has assisted in making Healthwatch Wolverhampton a success.

**Published June 2014**



Any enquiries regarding this publication should be sent to us at
info@healthwatchwolverhampton.co.uk

You can download this publication from www.healthwatchwolverhampton.co.uk

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**Agenda Item No. 15**

# Health and Wellbeing Board

5 November 2014

| | |
|---|---|
| **Report title** | Better Care Fund Programme Update |
| **Decision designation** | AMBER |
| **Cabinet member with lead responsibility** | Councillor Sandra Samuels<br>Health and Wellbeing |
| **Key decision** | Yes |
| **In forward plan** | Yes |
| **Wards affected** | All |
| **Accountable director** | Sarah Norman, Community<br>Helen Hibbs, Chief Officer, CCG |
| **Originating service** | Health, Wellbeing & Disability |
| **Accountable employee(s)** | Sarah Carter — Programme Director<br>Tel 01902 445941<br>Email Sarah.carter21@nhs.net<br><br>Viv Griffin — Assistant Director<br>Tel 01902 555370<br>Email Vivienne.griffin@wolverhampton.gov.uk |
| **Report to be/has been considered by** | Cabinet, 10 September<br>Executive Team, 10 September |

**Recommendation(s) for action or decision:**

The Health and Wellbeing Board is recommended to::

1. Approve he next steps of the plan programme

2. Approve the delegated approval of the final BCF detailed scheme descriptions and submission to the Chair of the Health and Wellbeing Board.

The Health and wellbeing Board is asked to consider the following questions:

1. Should the BCF operational performance oversight be delegated to the Transformation Commissioning Board, and exception reported into the Health and Wellbeing Board?

2. Does the Board require an extraordinary meeting post outcome advisory to discuss the implications of the approval given, or does the Board wish to delegate this to the Transformation Commissioning Board?

3. What information, support, briefing in advance of efficiency reporting doe the Health and Wellbeing Board need to support the detailed understanding of the financial profile, metrics and plans associated with the BCF Programme?

The Health and Wellbeing Board is asked to note:

1. That a further report will be provided to Health and Wellbeing Board on 7 January 2015 outlining proposed pooled budget arrangements, and finalised Section 75 proposed draft agreement.

## 1.0 Purpose

1.1 To provide Health and Wellbeing Board with an update on progress made in relation to the development of the Better Care Fund Programme Plan in Wolverhampton, and to note the next steps with regard to the sign off of the Better Care Fund Plan.

## 2.0 Background

2.1 Over the last 18 months Wolverhampton Clinical Commissioning Group and Wolverhampton City Council, in collaboration and partnership with our two main NHS providers, and other stakeholders, have been working together to define and develop the plans for Wolverhampton which deliver transformational change at both a provision and commissioning level, utilising the Better Care Fund programme.

The output from this collaboration is a programme of work which has clearly defined impact synergies and is underpinned by the jointly held vision as outlined in section 1a.

The table below demonstrates the synergies of the schemes and the impact upon patient and service user outcomes.

Our vision for the impact on patient and service user outcomes over the lifecycle of the programme is;

- ✓ People will spend less time in hospital
- ✓ People will live longer
- ✓ The home will be considered the hub for the delivery of all services
- ✓ Less people will move into residential and nursing home care
- ✓ People will be more in control of the care and support they receive through the implementation of personal budgets
- ✓ An individual's experience of receiving health and care services will be different. One person will co-design the care plan, with the patient or service user, there will only be one care plan, and care will be coordinated by a single professional on behalf of the health and care neighbourhood teams
- ✓ Patients and service users will have self-care and self-management plans which focussing on maximising the potential for good quality independence

## 2.2 What Does This Mean For The People of Wolverhampton?

| Wolverhampton Health and Wellbeing Board BCF Programmes | Total non-elective admissions into hospital (general and acute), all age, per 100,000 population | Permanent admissions of older people to residential and nursing care homes per 100,000 population | Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation | Delayed transfers of care from hospital per 100,000 population | Patient/service user experience | Local metric: Dementia diagnosis rates |
|---|---|---|---|---|---|---|
| | **Impact on outcomes PA** | **Impact on outcomes PA** | **Impact on outcomes PA** | **Impact on outcomes PA** | **Impact on outcomes PA** | **Impact on outcomes PA** |
| **Primary and Community Care Redesign Programme (Integrated health and social care neighbourhood teams/enhance nursing and care home support)** | Yes<br><br>649 less people admitted on an emergency basis | Yes<br><br>9 less permanent admissions of older people to residential and nursing care homes | 13 less people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation | Yes<br><br>54 less delayed transfers of care from hospital | Yes | Yes<br><br>35 more people within Wolverhampton having a diagnosis of dementia |
| **Intermediate Care Programme (integrated health and social care reablement service with a focus on accelerated discharge, home based reablement, and admission avoidance)** | Yes<br><br>366 less people admitted on an emergency basis | Yes<br><br>9 less permanent admissions of older people to residential and nursing care homes | Yes<br><br>7 people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation | Yes<br><br>118 less delayed transfers of care from hospital | Yes | 10 more people within Wolverhampton having a diagnosis of dementia |
| **Mental Health Programme (integrated health and social care community services, enhanced admission avoidance and psychiatric** | Yes<br><br>108 less people admitted on an emergency basis | 0 | 1 less person (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation | Yes<br><br>30% reduction in people placed outside of the area in a hospital | Yes | 2 more people within Wolverhampton having a diagnosis of dementia |

| | | | | | | |
|---|---|---|---|---|---|---|
| **liaison)** | | | | | | |
| **Dementia Care Programme (a fully integrated care pathway from pre diagnosis to end of life care with a focus on home as hub)** | 24 less people admitted on an emergency basis | Yes<br>0 | Yes<br>0 | | Yes<br>0 | Yes<br>0 |
| **Integrated Care Information System** | Enabling Scheme | Enabling Scheme | Enabling Scheme | Enabling Scheme | Enabling Scheme | Enabling Scheme |

2.3 As a result of this planning we anticipate over the next five years of service transformation and integration development that the way in which we deliver services, and the way in which they are structured will be significantly changed in order to deliver the outcomes we expect for the people of Wolverhampton.

**Developing an integrated approach to asset based community development, and building community capacity to improve health and reduce social isolation around the person**

In 2019/20 we will have facilitated a structure of three neighbourhoods in Wolverhampton. The neighbourhood approach will support a move away from more traditional methods of delivery, to utilising the whole system to promote and maintain emotional, physical and social wellbeing. We will develop a profile of community facing support which harnesses existing voluntary and community services, augmenting them to support the whole person in a non-statutory, community, and person centred way. This will be achieved by realising the benefits of a reduction in hospital facing services, and transforming the traditional approach we currently have to service delivery.

**A material shift from care and support being delivered on an episodic basis to support and interventions being wrapped around the individual to maximise the potential for independence**

The Better Care Fund schemes will support the delivery of effective care coordination which is consistent irrespective of complexity. At the heart of our service delivery changes are integrated neighbourhood teams that have the scope and range of skills to support an individual irrespective of changing needs. This will allow a more consistent wraparound approach, particularly in the support of people who have multiple complex comorbidities.

**Fully integrated mental health, dementia, community health and social care neighbourhood teams and urgent care pathways that support person centred care and provide community facing alternatives to admission.**

In redesigning the way in which our primary and community care services are structured we will see, in 2019/20, a major shift in the landscape of care across Wolverhampton. Our services will be structured around three core neighbourhoods in Wolverhampton, and wrapped around a cluster of GP practices, to enable more effective primary care engagement and integration with the way in which services are delivered. Access to services will be improved through 7 day a week delivery, and services operating across a broader range of the 24 hour clock. Health and social care will be delivered under a single management structure, and effective care coordination and co-design of care plans with service users and patients will be at the heart of our delivery model. A crisis function will be mainstreamed into all care pathways, with contingency planning shared and owned by both professionals and patients/service users.

**Effective coordination of care irrespective of levels of complexity held by the most appropriate person**

Everyone in Wolverhampton with one or more complex condition will have their care coordinated by the most appropriate professional. The effectiveness of care coordination will be delivered through the adoption of a partnership approach to care planning with service users/patients, and an emphasis on reducing dependency and increasing self-help and resilience development, supporting care as close to the home, or in the home wherever possible. In dementia services this means that by 2019/20, anyone with a diagnosis of dementia will have an advanced plan and have the opportunity to consider advance decisions.

**Improved approaches to accelerated discharge planning and post discharge from hospital support which is delivered and coordinated on an integrated basis in the community**

Our integrated neighbourhood teams will include an accelerated discharge function which will mean that anyone being discharged from hospital will have access to five days of intensive follow up support across health and social care services delivered into their own home, where need has been identified.

**Consistent and responsive community access and effective support in a crisis**

All those patients and services users with a care coordinator who have a developed and shared crisis contingency plan. A pathway will be in place, through our urgent care centre, for access to intensive home treatment in order to avoid unnecessary hospital admissions, build confidence in community facing accessibility and services, and enhance resilience and a self-guided approach. Intensive home treatment will be available to all, based upon assessed need, and the function will be delivered for up to 5 days.

**Clear, agreed health and social care defined outcomes**

Services will be commissioned and performance assessed on an outcomes basis in 2019/20. Pathways will be designed and specifications developed which reflect the anticipated outcomes of health and social care commissioners and the people of

Wolverhampton. We will encourage integrated service delivery on a more enhanced basis through our commissioning approaches, to drive effective delivery of outcomes.

**Innovative approaches to the co-design and commissioning of services**

In 2019/20, we will have an embedded approach of whole system engagement in design where providers will confidently bring forward ideas for change and innovation. We will have an established, multi-agency, design innovation network, where commissioners and providers will collaborate to deliver innovation ideas which meet the identified needs of the population of Wolverhampton.

Incrementally, we will have increased the pooled commissioning budget for integrated services, building on successes and applying them to other areas

We will be utilising a range of payment and benefit systems for different types of care, depending on the aspirations for different services and populations, and will have reviewed the strategic value in mixing payment models.

## 3.0 Development of the Wolverhampton Better Care Fund Programme Plan.

### 3.1 Plan Submission

On 19 September 2014, our final submission was made for the Health and Wellbeing Boards Better Care Fund Programme. Plans are now being reviewed at a regional and then national level and whilst we will not know the outcome of the review process until after the moderation exercise and subsequent announcement at the end of October, we have already received some feedback regarding our plan, and its deliverability.

3.2 At the end of October, having undergone a comprehensive review and triangulation exercise, the plans will be awarded one of the following status;

**Approved**

The aim is for all plans to have reached this standard by April. If our plan is ‘Approved’ following the NCAR process at the end of October, the regional and national team will request to work with us in order to provide support as we prepare for delivery.

**Approved with Support**

This means that overall the review team and the moderation panel have confidence in our plan. However, there may be some items of evidence or information that will need to be submitted to provide full assurance. The team will want to review these before our plan can be fully approved. Areas in this category will be assigned a relationship manager from the task force to agree a plan to provide the further information identified through the NCAR process – this will be a straightforward and light-touch process and the aim is for all HWBs in this category to be fully approved before December.

**Approved subject to Conditions**

If our plan is approved subject to conditions, it means there are some substantial issues or risks in your plan without enough demonstration of how these will be mitigated. Areas in this category will not be able to progress to implementation for the aspects of their plan affected by the conditions placed on them. They will be assigned a relationship manager who will work with the local team to agree an action plan to address areas of weakness identified through NCAR, access available support and agree the level of resubmission required to secure removal of conditions. The aim is to have these areas fully approved before January.

**Not Approved**

Areas in this category will not be given approval for their plan, and will not be able to progress to implementation until their plan is approved. They will be assigned a relationship manager and will be required to work closely with them to agree an action plan that will ensure they submit a fully revised plan in January so they are approved in time to begin implementation. Areas in this category will receive more intensive support to help them improve their plan. These areas will be required to resubmit a full plan for a further NCAR assessment process at the end of January.

3.3 **Next Steps**

Letters communicating the outcome of plan assurance will contain very clear next steps, and the HWB membership will be advised accordingly upon receipt of this letter. Current activity continues in relation to strengthening our plan and planning for delivery across all work streams, engaging partners and stakeholders in the process. Point of consideration: As the next Health and Wellbeing Board is not until 7 January 2015, does the Board require an extraordinary meeting post outcome advisory to discuss the implications of the approval given, or does the Board wish to delegate this to the Transformation Commissioning Board?

Workstream Programmes will continue the development of their plans, case for change and service design proposals for submission by December 2014.

Approval of proposals via Health and Wellbeing Board will be sought in January 2015 for implementation development in the last quarter of the year.

Reporting to the Health and Wellbeing Board will materially develop to include progress against plan - highlight and exception reporting, and will support the Board in demonstrating outcomes and impact, considering strategic direction and synergies, and the whole system view against priorities.

## 4.0 Financial implications

4.1 The purpose of the BCF is to achieve a greater level of integration across health and social care to improve outcomes and in so doing to shift investment from acute to community and primary care and deliver greater efficiency and value for money. Although the fund itself is new, the money is drawn primarily from existing NHS and council funding streams and currently-funded services are in the scope of the fund.

4.2 The plan submitted on the 19 September included a revenue pooled budget for 2015/16 of £73.0 million. Of this £23.5 million is made up of budgets that are currently managed by the Council. It should be noted that the funds includes £6.3 million representing the NHS transfer to social care (Section 256 funding). In addition to the revenue budget the bid includes capital grants amounting to £2.1 million (Dedicated Facilities Grant and Social Care Capital Grant).

4.3 The method for management of the agreed pooled budget and the management of financial risk and benefit remains under development, and will be set out in the Section 75 agreement. This will be brought to the Health and Wellbeing Board for consideration in January 2015.

4.4 The proposed 2015/16 allocation includes funding of £2.0 million for the forecast financial impact of demographic growth of social care, and £1.0 million for Care Act implementation costs. The ongoing demographic growth pressures for 2016/17 and beyond is forecast to increase by £2.0 million per year; it is essential that the pooled budget is of sufficient scale to enable these efficiencies to be realised. Efficiency and QIPP requirements have been locked into the redesign programmes for 2015/16. The Health and Wellbeing Board will be required to have a detailed understanding of the progress, risks and mitigations being undertaken on behalf of the pooled budgets. [AS/24102014/J]

## 5.0 Legal implications

5.1 The Planning Guidance for the Better Care Fund confirms that the Fund will be allocated to local areas where it will be put into pooled budgets under Section 75 NHS Act 2006 (“Section 75 Agreements”).

5.2 The BCF funding from 2015/16 will be put into pooled budgets as part of Section 75 joint governance arrangements between CCGs and Council, with plans for spending the funds needing to be jointly agreed. Although this represents a shift in how decisions are made about investment this funding will be drawn primarily from CCG budgets. Taking this into account there will still be a significant reduction in resources across health and social care in Wolverhampton as a consequence of reductions in local authority budgets. The Health and Wellbeing Board will need to consider the approach it takes regarding operational oversight of the performance of the BCF programme, against its strategic and system leadership requirements. Whilst an

integrated governance structure has been agreed the questions set out in this report will need to be considered RB/20102014/N

## 6.0 Equalities implications

6.1 There are no equalities implications specifically relating to the sign off of this submission. However, the detailed plan to implement the programme will require a detailed Equalities Impact Assessment.

## 7.0 Environmental implications

7.1 There are no environmental implications.

## 8.0 Human resources implications

8.1 Some transformational change outcomes may require TUPE arrangements to apply between providers if procurement is utilised to enhance provide a more mixed health and social care economy. This will not have a direct impact other than in relation to procurement advice and support.

## 9.0 Corporate landlord implications

9.1 There are no corporate landlord implications.

## 10.0 Schedule of background papers

10.1 Better Care Fund – Detailed Scheme Descriptions

Deatiled Scheme Descripts All.docx

WOLVERHAMPTON CHILDREN'S TRUST
**CHILDREN'S TRUST BOARD**
Minutes of meeting held on 30th September 2014
Civic Centre

| Item | Notes | **Action** |
|---|---|---|
| | **Present**<br><br>Councillor Val Gibson (Chair)<br>Chief Supt Simon Hyde (West Midlands Police)<br>Doctor Cathy Higgins (Royal Wolverhampton NHS Trust)<br>Sarah Norman (WCC – Community)<br>Emma Bennett (WCC – Community)<br>Ian Darch (Voluntary Sector Council)<br>Lynne Law (School Improvement Partnership)<br>Noreen Dowd (Wolverhampton CCG)<br>Ros Jervis (WCC – Public Health)<br>Janet Anderson (for Jeremy Vanes - Royal Wolverhampton NHS Trust)<br>Mary C Keelan (Wolverhampton Secondary Head Teachers –WSIP)<br><br>**In attendance**<br><br>Russell Stanley (WCC – Education & Enterprise)<br>Eileen O'Callaghan (WCC – Community)<br>Fiona Ellis (WCC – Community)<br>Louise Bath (WCC – Safeguarding and Quality) | |
| **1.** | **Welcome, Apologies & Introductions**<br><br>Apologies were received from:<br><br>Councillor Mark Evans<br>Tim Johnson<br>Alan Coe<br>Jeremy Vanes (Royal Wolverhampton NHS Trust) | |
| **2.** | **Declarations of Interest**<br><br>None | |
| **3.** | **Notes of the Meeting of 11th March 2014**<br><br>Agreed as a true record.<br><br>**Matters Arising**<br><br>None | |

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| **4.** | **Appointment of a Vice Chair:**<br><br>• Cllr Gibson explained reason for VC; and it was requested by SN that this not be a WCC member but a Trust Partner.<br>• Noreen Dowd - CCG – volunteered to act in the capacity of VC in the interim until permanent post holder appointed.<br><br>**Noreen Dowd ratified by Board as Vice Chair of CTB.** | |
| **5.** | **Annual Public Health Report – obesity:**<br><br>• RJ apologised to those members of the Board who had already received this report at other meetings.<br>• The Annual Public Health Report is a statutory requirement; however this years report responds to the challenge to in 2013 made by Sir Liam Donaldson at the Healthy, Wealthy and Wise Debate which was to focus on report on a key challenge for Public Health in Wolverhampton. This year's report focuses on obesity and aims to promote a fuller discussion about 'how' to tackle the challenges hence the 'call to action'.<br>• The report identifies the scale of the problem, outlines areas of work that need to be supported by agencies; but does not go into the details of how this will be achieved<br>• VS – indicated that Community Champions need to be identified<br>• SEB – WCC Planning Agenda, Sports and Leisure Facilities<br>• CTB – The numbers of children defined as obese has increased since the report was written. There is a role for all partners to support reducing numbers of children who are obese. Certain life points at which it is possible to effect change for individuals (pregnancy, illness etc) – all agencies need to use these opportunities to support change.<br>• Pledge Cards – Will be hosting a summit on 10.11.2014, invites to be circulated shortly.<br>• LW – Issue relates to parents and need to educate them; using school nurse was very difficult. One child on CP Plan which supported multi-agency action for the child. Really important and then don't participate as actively as they could.<br>• ID – Where is it most effective to intervene – there is a direct correlation with adult obesity; but best place to start is across Early Years.<br>• RJ - Looking to develop Community Champions across agency's – especially in schools<br>• CH – See's children in clinic identified a need to create a directory for purposes of signposting.<br>• LW – Around City there are sports colleges that are well resourced and could act as community hubs. | |

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| | **Action** – Pledge Cards to be returned to Public Health who will use responses to draw up a City wide Action Plan. All to promote this within their respective organisation - **ALL**<br><br>**Recommendations in report were accepted and point 4 noted.** | |
| **6** | **Children, Young People and Families Plan – final plan:**<br><br>• FE – explained the arrangements for monitoring progress against the Plan.<br>• ND – Queried whether some of this could be more child focused and where are the links with safeguarding agenda issues; especially MH and Drug and Alcohol<br>• FE – technical documents sit behind the Plan – and this will incorporate the issues affecting children in their home environment.<br>• FE to share technical document if it is acceptable.<br>• EB – 10 year plan quite wide in its focus and there is a link to what will be monitored by CSC; and would look at each area of Plan and the impact on children.<br>• EB – FrF, WSCB Plan, Alcohol Strategy, Hidden Harm are linked to the overarching Plan.<br>• FE – other strategies will also underpin this, to ensure needs do not escalate<br>• Police – measure around DV – issue of under reporting Police agenda is to increase the number of 1st time reporting.<br>• FE no targets have been set yet – so there may be an expectation that indicator does increase in some instances; and then work towards a decrease. In depth analysis will be key.<br>• RJ – use re-commissioning of services as an opportunity to address outcomes contained within Plan.<br>• FE – timescales gives a real opportunity to be able to see real progress against outcomes.<br>• FE – Wolverhampton in Profile – all plans/strategies that contribute to the Plan can be added to this electronic hosting site. **ACTION here**<br><br>**Recommendation agreed.** | |
| **7.** | **Protocols with other Partnership Boards:**<br><br>• LB updated meeting and advices that the protocols would be circulated with the minutes. | |
| **8.** | **Learning from frontline practice – "Preventing children becoming LAC through partnership working":** | |

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| | The meeting split into two groups to examine the case study provided.<br><br>EB Group Feedback:<br><br>• EB indicated that the group needed more information – specifically in regards to what was the nursery, midwife and health visitor doing about this and how information was being shared.<br>• Where was the EHA, nobody appeared to have done anything about this.<br>• Are thresholds too low?<br>• Things are left until situation reaches crisis point. Inter-agency working and EHA was not apparent.<br>• Useful to get key frontline reps together to look at a number of cases. Issues around training and info sharing.<br>• LB queried whether there was a way to flag children's status on each of the electronic databases used to record information.<br><br>SN Group Feedback:<br><br>• ideal situation picked up by EHA around July 2013 to generate a solution focused approach at point A was in a previous relationship.<br>• ntelligence regarding current relationship should have been incorporated into new family and EHA be developed.<br>• At point of crisis should have found alternatives to PPO and Bail conditions – dialogue with Police and Courts.<br><br>**ACTION**<br><br>1. Flagging system on EHA and CSC databases to be explored<br><br>2. FrF programme – deep dive to be undertaken on a couple of cases involving partners to explore what would action would agencies take and to identify what barriers (if any exist).<br><br>3. Case Study for next meeting – Obesity Case from Health Visiting | |
| **9.** | **Health Related Behaviour Survey 2014:**<br><br>• RS – circulated a more detailed version of report.<br>• Drew attention of Board to presentation document – allows for a number of themes and ways of analysing data; and explained the methodology and headline results for KS1 & 2.<br>• RJ – Guns and Gangs highlighted and this needs to be looked at more closely.<br>• ND – what do we do with the information – what is the drop down list for worries in the questionnaire. Provides an opportunity for re-design of services.<br>• LL– From School perspective very good; used for PSHE curriculum team and other experts to address within the schools environment. School interrogate worries and consider | |

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| | how this should be addressed.<br>• RJ – so what **– how valuable do partners find survey**<br>o ID – need to look at trends arising from data survey by survey and the reasons for changes. More trend analysis would be helpful<br>o CH – noted that the survey findings are useful<br>o EB – used by MAST and Children's Commissioning and links to Children and Young Peoples Plan – feedback from C&YP<br><br>**Recommendations within report were supported.**<br><br>**ACTION:**<br><br>1. WSCB Q&P and full Board circulate to WSCB partnership in relation to Results Event.<br>**2.** Feedback of findings to agencies. | |
| **10.** | **Families R First update:**<br><br>• **EB –** provided updating report and highlighted key areas identified in the PowerPoint presentation provided. Launch may slip slightly to January so this links with the WSCB Threshold document launch. All actions are currently on track – LAC numbers have stabilised, but no decrease noted as yet. Reviewed all 16/17 year olds and identified a cohort that do not need to be LAC; also reviewed children placed with parents and there are a number of revocations of orders that need to be required. Retention and Recruitment of foster carers – to reduce costs linked to agency carers. Submitting a number of bids for funding in relation to early intervention and links with adult services (triggers); innovation fund – to develop FSS re-adolescents.<br><br>• **ND** 3.0 – Action Plan – Edge of Care Meetings do these link to MSMG External Placements– no link as these are case specific.<br>• **ID –** EHA any issues regarding with signup<br>• **EB –** every agency to act as a champion, and group chaired by Steve Dodd will QA take up of EHA. Taken on feedback from learning from CAF. Electronic system being put into place.<br>• **VG –** Use of Boarding Schools – DM leading on this and will prepare a report to look at how these can be used more creatively.<br>• **VG –** Interviews for analyst – appointed.<br>• **ID –** changing the culture – managing away days – is this targeted to all partners?<br>• **EB –** EHA training – linked to WSCB training and thresholds, risk | |

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| | analysis, measuring the gap.<br>• **ND –** links to Child Poverty Strategy.<br><br>**Recommendations Agreed:**<br><br>Emma was thanked for driving forward this big piece of work as it is important for outcomes for children and financial implications of LAC. Thanks to be passed onto staff. | |
| **11.** | **Adult Services representation on Children's Trust Board:**<br><br>• EB – has no update as yet – needs chasing in respect of MH – this should be VG? | |
| **12.** | **Key messages from Health & Wellbeing Board:**<br><br>• CllrG – WSCB Annual report 12/13 Health & Wellbeing – would be useful to have this circulated to Board for information; and then invite Chair to present 13/14.<br><br>Minutes of H&WB to be noted. | |
| **13.** | **Key messages from Children's Trust Delivery Board:**<br><br>• Minutes noted | |
| **14.** | **Any other business:**<br><br>• NA | |
| **15.** | **Date of Next Meeting**<br><br>Next meeting is **17th December 2014 - 2.00 pm- 4.00 pm** | |

**ACTION LOG**

| ACTION | RESPONSIBILITY | COMPLETION DATE |
|---|---|---|
| Pledge Cards to be returned to Public Health who will use responses to draw up a City wide Action Plan. All to promote this within their respective organisation. | **ALL** | November 2014 |
| Joint Protocols with WSCB and other partnership Boards to be circulated with Minutes. | **LB** | October 2014 |

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| CBT members to provide amendments, additions, comments. | | 10.11.2014 |
| Flagging system on EHA and CSC databases to be explored in respect of key concerns about children.<br><br>FrF programme – deep dive to be undertaken on a couple of cases involving partners to explore what would action would agencies take and to identify what barriers (if any exist).<br><br>Case Study for next meeting – Obesity Case from Health Visiting | **EB**<br><br>**EB**<br><br>**Health** | Next meeting<br><br>December 2014<br><br>Next Meeting |
| **Health Behaviour Survey:**<br><br>1. WSCB Q&P and full Board circulate to WSCB partnership in relation to Results Event.<br>2. Feedback of findings to agencies. | **EB**<br><br>**All** | November 2014<br><br>November 2014 |
| **FrF**<br><br>Multi-agency Steering Group – feedback required from schools. | **LL** | Next Meeting |
| **Adult Services representation on CBT**<br><br>1. VG to be approached to attend CBT. | **EB** | Next Meeting |
| WSCB Annual Report 12/13 to be circulated to CBT members.<br><br>AC (WSCB Chair) to be invited to report on WSCB Annual Report 13/14. | **LB/CO**<br><br>**LB/CO** | With Minutes<br><br>Next Meeting |

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**Agenda Item No. 16(iii)**

# Health and Wellbeing Board

5 November 2014

| | |
|---|---|
| **Report Title** | Public Health Delivery Board: Chairs Update |
| **Cabinet Member with Lead Responsibility** | Councillor Sandra Samuels<br>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<br>Tel — 01902 551372<br>Email — ros.jervis@wolverhampton.gov.uk |

**Recommendation(s) for action or decision:**

1. Attend the obesity summit on 10 November 2014.

2. Make a pledge as part of the call to action to tackle obesity in Wolverhampton.

3. That the Health and Wellbeing Board (HWBB) notes progress against the newly agreed key work streams of the Public Health Delivery Board (PHDB) which will form the Boards work programme for 2014/15.

## 1.0 Purpose

1.1 To inform the HWBB of the new work streams of the PHDB, as agreed through the Business Planning Cycle and matters arising from its meeting of 9 October 2014.

## 2.0 Background

2.1 A key focus of the October meeting was to present an update of the public health business plan for 2014/15. A progress report on each priority was presented to provide assurance of service delivery and support for the Community Directorate and Corporate Business Plans. This update is detailed in section 3 which reviews each of the seven priority areas.

## 3.0 The Public Health Delivery Board Work Programme

3.1 The activities related to achievement of each priority are tabulated in Appendix One alongside the performance measures, targets and progress to date.

3.2 Priority One - Effective public health commissioning

3.2.1 The commissioning strategy is now out to consultation with the Clinical Commissioning Group (CCG), primary care and Public Health England (PHE) and through the Councils Corporate reporting structures. Cabinet resources panel will also receive a report on the Public Health contracts portfolio in October which will identify current status with contracting options and a savings profile. Other commissioning plans include:

- Health Visiting transfer from NHS England to Public Health, negotiations are underway in relation to the budgets.
- Smoking cessation and NHS health check services reviews are continuing.
- A draft sexual health service model will be published next month for consultation between November and January 2015. A final specification will then be drafted before the procurement programme commences in April 2015.
- The school nursing review is underway and a separate report was provided for PHDB.
- The Drug and Alcohol quality review has been completed and an improvement plan is now in place. The needle exchange tender evaluation will take place in November.
- The main contracts are being risk assessed by size, and commissioning priority to assure appropriate governance is in place and or being developed.

3.3 Priority Two - Developing public health processes to support transformation

3.3.1 The processes to support transformation are progressing as follows:

- The development of the Public Health governance framework continues to progress and the Public Health risk register has been completed. The workforce development plan is still subject to slippage due to capacity issues across the team and new timescales have been agreed. An induction pack has been

produced for new 'trainees' and a learning and development forum has commenced which will assist with identifying training needs.

- An annual plan of public communication based on Public Health priorities has been partially completed but a change in the timescale has been required due to initial lack of human resource to support development of the communications plan.
- The quality assurance of commissioned programmes will be activated as contracts are reviewed and service specifications are renewed.
- There is Local Authority awareness of the Research Governance function within Public Health and further work is planned to develop formal programmes of learning.

3.4 Priority Three - Integrating the Healthier Places Team into Public Health

3.4.1 With the successful appointment to the Head of Healthier Place service post, work is now being progressed to implement the Healthier Place project plan. As part of influencing the wider determinants of health work area, a Council group has been established with representatives from Planning, Housing, Transportation, Neighbourhood Services and Environmental Services to review existing work programmes and their impact upon health outcomes. The refresh of the Sport Development and Investment Strategy has been replaced by a revision of the document which takes into account the Public Health priority of tackling obesity within the City.

3.5 Priority Four - Reducing obesity across the life course

3.5.1 The publication of the Public Health Annual Report 2013/14 was the first key milestone achieved – the focus now is on other strands of this priority. These are:

- Organising and delivering a whole economy obesity summit to agree a Wolverhampton wide approach to tackling obesity - summit will be held on 10 November 2014 with the objectives of gaining commitment and active participation to an action plan to tackle obesity in Wolverhampton.
- Produce a multi-agency action plan for tackling obesity in Wolverhampton following the summit and the collection of pledges – both individual and organisational, a multi stakeholder action plan will be produced.
- Community involvement in the obesity call to action - On 22 September 2014, the members' obesity challenge was launched in the media where Councillors Sweet, Simkins and Warren publicly began their personalised weight loss programme.
- Links to Healthier Places Priority three - there are particular links with the Healthier Places priority three and the milestones to complete an asset map of the city and the refresh of the sports development and investment strategy.

3.6 Priority Five – Healthcare Advice

3.6.1 The Memorandum of Understanding (MOU) for Public Health's core offer with the CCG continues to be delivered.

3.6.2 Additional work includes:

- Support for a review of infection prevention services, Public Health advice on the Special Educational Needs and Disabilities (SEND) Local Offer health workstream.
- Support for the harmonisation of commissioning policies across Birmingham and the Black Country and the Individual Funding Request (IFR) screening process, support on the development of clinical guidelines for care homes, support on the commissioning of falls prevention, and facilitation of scrutiny of Clostridium Difficile across the CCG and Royal Wolverhampton Trust (RWT).
- The initial objective to look at a risk stratification tool is currently on hold following further discussion with the CCG. The CCG is interested in support with the development of a primary care strategy with a key element of addressing inequalities. Options for this are being considered.
- The development of the Pharmacy Needs Assessment is well underway, and the Local Pharmaceutical Committee, GPs, Health watch and the CCG Patient Engagement Lead are advising through a Reference Group.

3.7 Priority Six – Smoking

3.7.1 In July 2014, a paper was presented to the Health and Wellbeing Board regarding the Local Government Declaration on Tobacco Control with a recommendation that the Council sign up to reducing the harms from tobacco. This has now been approved by full Council so local work will concentrate on the development of a Tobacco Control Strategy for Wolverhampton, starting with the completion of the Tobacco Control assessment Tool CleaR.

3.7.2 Other areas which are being addressed include:

- The Contracts that the Council holds with both the Healthy Lifestyles Service and Local GP practices are weighted towards targeting disadvantaged communities.
- Public Health is leading the work to reduce our high infant mortality rates with a plan to target not just smoking in pregnancy but also the smoke free homes agenda. This will include scoping the potential for delivery of this work within our current providers and also exploring other national campaigns.
- Smoking in Pregnancy, illicit sales and smoking in young people are issues being dealt with at a Black Country (BC) and regional Tobacco Control Network level.
- Healthy Lifestyles Service will be holding a number of promotional events in and around Wolverhampton in connection with the‘Stoptober’ campaign.
- Following a peer mentoring campaign carried out in a number of Wolverhampton primary and secondary schools, resources that were developed have been disseminated wider to other schools in the City.

3.8 Priority Seven – Health Protection and Emergency Preparedness Resilience and Response (EPRR)

3.8.1 The Health Protection and EPRR priority progresses as follows:

- The Health Protection Lead Practitioner post has been appointed to and, the Health Protection work plan is now a key objective for development.
- The Wolverhampton concept of operations (ConOps) for the management and response to Public Health incidents was agreed at the Health Protection Forum in May 2014, with a few minor amendments.
- In order to further develop assurance, a framework for EPRR through contractual assurance though the PH commissioned services is under development. This will ensure that all services commissioned by Public Health are required to demonstrate how they are able to respond to incidents, outbreaks and emergencies, and have robust and tested plans and policies in place to do so.
- Wolverhampton CCG are now purchasing EPRR services from Public Health. In addition Wolverhampton, Walsall and Sandwell CCGs and Public Health teams continue to discuss a joint EPRR function, with a preferred option currently out for consultation.

## 4.0 Financial implications

4.1 This report has no direct financial implications. Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The total funding settlement for Public Health for 2014/15 is £19.3 million. The work streams set out in this report will be funded from this allocation.

[NM/20102014/L]

## 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/20102014/O]

## 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. By taking a needs based approach to all commissioned services including the use of equality impact assessment tools we aim to ensure that the needs and rights of equalities groups are considered.

## 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 resource implications arising from this report.

## 9.0 Corporate landlord implications

9.1 There are no direct corporate landlord implications arising from this report.

## 10.0 Schedule of background papers

10.1 Health & Wellbeing Board 3 July 2013 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 4 September 2013 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 6 November 2013 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 8 January 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 4 February 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 8 April 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 8 April 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 7 May 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 9 July 2014 Public Health Delivery Board – Progress Report

Health & Wellbeing Board 3 September 2014 Public Health Delivery Board – Progress Report

## Appendix 1: Public Health Business Plan: Priority One - Effective public health commissioning

| Activity | Performance Measures | Target | Progress to Date (September 2014) |
|---|---|---|---|
| **1. Develop Public Health strategic commissioning plan in line with the Public health Outcomes Framework and Local Priorities.** | **100% of milestones against development and production of plan achieved** | **Commissioning plan completed by December 2014** | • **Final draft commissioning strategy document completed and consultation commenced.**<br>• **Communication plan in place.** |
| **2. Identify joint commissioning priorities with the Local Authority and CCG. To include Children's Public Health, 0-5 years, health visiting function transfer from NHS England.** | | **Contract reviews and tender preparation completed by March 2015** | • **Health visiting transfer; Finance and budget transfer agreements have not been agreed between all DsPH and NHS England and negotiations are commencing across the region.** |
| **3. Define clear healthy lifestyles outcomes for Wolverhampton incorporating our obesity call to action and reducing harm from smoking and smoking related activities.** | | | • **Obesity reported separately.**<br>• **Smoking cessation services and NHS health check reviews continue.** |
| **4. Prioritise contracts requiring retender and review during 2014-15 and develop and implement the frameworks in order to undertake these programmes.** | | | • **Consultation on the sexual health service model is to commence between November – January**<br>• **School nursing reported separately for commissioning approval.**<br>• **Needle exchange tender issued.** |
| **5. Contract management process established against all specifications/minimum data sets/targets and outcomes in place.** | | | • **Contract management variations**<br>• **Minimum data sets created and shared with providers** |

| Priority Two – Developing public health processes to support Transformation | | | |
|---|---|---|---|
| **Activity** | **Performance Measures** | **Target** | **Progress to Date (September 2014)** |
| **1. To provide a robust Governance framework to support Public Health functions** | **A Governance Framework is agreed by September 2014** | **100% of all components of the Governance processes in place with agreed audit criteria by March 2015** | • **Public Health risk register complete**<br>• **Work commenced to identify the governance requirements for Public Health commissioned services** |
| **2. Establish Public Health Communications plan that addresses internal and external communication needs** | **The Public Health communications plan is agreed and established by December 2014** | **100% of the communication needs identified in the plan are delivered by March 2015** | • **There is some slippage in development of the communications plan but there is progress with external communications mapping** |
| **3. A comprehensive Public Health Workforce Development plan is in place to ensure effective delivery of public health function** | **All eligible Public Health staff will have a work plan by December 2014** | **100% of all eligible staff will have an induction, appraisal and personal development plan by March 2015** | • **Slippage means new timescales have been agreed**<br>• **Partial completion of the induction packs** |
| **4. Establish a quality audit programme to maintain and improve the quality of commissioned services** | **A Quality assurance process has been identified for all commissioned services by December 2014** | **100% of all commissioned services to have an audit programme by March 2015** | • **Activation anticipated as services are commissioned**<br>• **Work to commence on identifying specific quality components required for the new service level agreements** |

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| **5. To provide a comprehensive research governance service across the council that ensures all research is robust and of high quality** | **A research governance framework is established by September 2014** | **95% of all research governance requests are responded to within the agreed timescale** | • **There is evidence that the Local Authority is aware of Public Health research governance function**<br>• **Further work is required to develop formal programmes and an ethical review panel** |

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| **Priority Three – Integrating the healthier communities team into Public Health** |

| Activity | Performance Measures | Target | Progress to Date (September 2014) |
|---|---|---|---|
| **1. Implement restructure for Healthier Places Team following transfer and disaggregation of budgets for Sports Development / Healthier Schools / and Parks (Development) and Countryside** | **Creation of project plan, structure and work programmes for individual teams** | **Project plan to be developed by May 2014**<br><br>**New Structure to go live by end of September 2014** | **Head of Service Post appointed to. Budgets realigned for Sport Development and Parks. Further work required for Healthy Schools team. Work in progress for wider determinants of health programme involving council departments (Leisure, Housing, Planning, Transportation, Neighbourhood Services, Environmental Services and Education). Visioning session planned for October 2014.** |
| **2. Complete Asset mapping profile for the City to include physical and non-physical assets and develop an electronic database.** | **Production of database** | **Database to be established by October 2014** | **Sport Development and Parks profiles have been drafted. Schools work to be progressed.** |
| **3. Refresh the Sport Development and Investment Strategy** | **Refresh the document** | **Document to be politically endorsed by November 2014** | **Radical change in approach has been made as document is to be revised (as opposed to being refreshed) to take into account obesity priority for the City. Expected completion is January 2014.** |

| Priority Four – Reducing obesity across the life course | | | |
|---|---|---|---|
| **Activity** | **Performance Measures** | **Target** | **Progress to Date (September 2014)** |
| **1. To produce an Annual Report of the Director of Public Health for 2013-14 on the health of the population in Wolverhampton** | **A report produced which focusses on a 'call to action' to kick-start Wolverhampton wide action on the important health issue of obesity.** | **Completed by May 2014** | • **Report now completed and published and presented to Health and Wellbeing Board in July 2014.**<br>• **The report has been presented to internal and external committees and boards and these presentations will continue to promote the 'Call to Action'** |
| **2. To follow up the Annual Report with a whole health economy summit to agree a Wolverhampton wide approach** | **Summit organised and held** | **Completed by end of October 2014** | • **The date for the summit has been agreed – 10th November 2014 and will be held at Wolverhampton Racecourse.**<br>• **The programme for the day is being finalised and will be interactive.**<br>• **Delegates will be asked to make a pledge to support the Call to Action to tackle obesity in Wolverhampton** |
| | **Action plan agreed by the Health and Wellbeing Board** | **Action plan agreed by December 2014** | • **The action plan will be developed following the summit and utilise the pledges made.**<br>• **A further element will be to develop a work strand to involve and engage the community.** |
| **3. Community involvement in the obesity call to action** | **Establishment of members obesity challenge** | **Launched in the media on 22nd September 2014** | • **Cllrs Sweet, Simkin and Warren are participating in the challenge and using social** |

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| | **Launch of Million Miles for Wolverhampton challenge and associated Million Pounds Lost challenge** | **To be launched at the Obesity Summit** | **media to chart their progress**<br>• **Is part of the Obesity Summit programme** |
| **4. Links to Healthier Places Priority** | **Complete an asset map of the city** | **To be completed by October 2014** | • **Database is ongoing and being completed by Healthier Places team** |

| Priority Five – Healthcare advice: delivering mandated function | | | |
|---|---|---|---|
| **Activity** | **Performance Measures** | **Target** | **Progress to Date (September 2014)** |
| **1. Agreement and delivery of the Core Offer Work Plan with a focus on infant mortality and child health and wellbeing.** | **Work plan agreed and completed** | **100% of the Core offer is delivered by March 2015** | • **Work plan is being delivered. 6 monthly review with CCG is due.**<br>• **Infant mortality working group meetings held in May, July and September**<br>• **Action planning meeting scheduled for November 2014** |
| **2. Development of a prevention strategy for Wolverhampton to support the reduction in long term conditions. database.** | **Prevention strategy output informs Primary Care and Public Health commissioning** | **100% of the Prevention Strategy is completed by December 2014** | • **Prevention strategy in progress** |
| **3. Work with Wolverhampton Clinical Commissioning Group and Central Midlands Commissioning Support Unit apply a risk stratification tool to the local population** | **A valid risk stratification tool is agreed and the process for implementation finalised by August 2014** | **50% of the population has been included in the risk stratification process by December 2014** | • **This objective is currently under review due to change in CCG plans** |
| **4. Establish a Public Health pharmacy work stream to include the production of the pharmaceutical needs assessment.** | **Work plan agreed by October 2014** | **100% of the pharmacy work plan is completed by March 2015** | • **A PNA Reference Group has been established and met in mid-July. The questionnaire to pharmacies questionnaire and community questionnaire are complete. A Stakeholder Event was held in Sept.**<br>• **The job description for the PH Pharmaceutical Lead has now been approved.** |

| Priority Six – Tackling Health Inequalities: reducing smoking | | | |
|---|---|---|---|
| **Activity** | **Performance Measures** | **Target** | **Progress to Date (September 2014)** |
| **1. Develop a plan for prevention in schools to increase tobacco control activities in schools** | **Education prevention plan evaluated and disseminated by July 2014** | **100% of schools informed of education prevention** | • **Resources developed by young people as part of the ECLIPSE Peer mentoring programme have been disseminated to schools and are now included in the wider drug education programme. Smoking in young people is being considered as part of the school nursing and sex education reviews with regard to future commissioning arrangements.** |
| **2. Develop a local Tobacco Control Strategy that includes E Cigs** | **Tobacco Control Strategy completed with partners** | **Tobacco Control Strategy completed and partners signed up by December 2014** | • **Following a recommendation at the Health and Wellbeing Board the Council signed up to the Local Government Declaration on Tobacco Control on the 14th Sept 2014. The next stage is to undertake a local assessment and gap analysis to inform the development of a strategy. Training for this is to take place early October 2014.** |
| **3. Develop a strategy to reduce infant mortality** | **Multi-agency strategy to reduce infant mortality developed by September 2014** | **100% of interventions commissioned to reduce infant mortality are evidence based and have robust evaluation plans** | • **There have now been 3 multi-agency meetings with all partners in agreement to develop a plan to reduce infant mortality. Action plan development is in progress but** |

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| | | | **there is already some progress to note: The healthy lifestyles service is now providing an increased presence in the maternity unit and antenatal clinics.** |

| Priority Seven – Health Protection and Emergency Planning and Preparedness: delivering mandated function | | | |
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| **Activity** | **Performance Measures** | **Target** | **Progress to Date (September 2014)** |
| **1. Develop the Health Protection Forum Work Plan 2014-15.** | **Work plan agreed within six months** | **100% of the work plan delivered by March 2015** | • **Data dashboard to aid prioritisation agreed by Health Protection Forum**<br>• **HP Lead appointed** |
| **2. Develop robust Health Protection monitoring and surveillance systems** | **Monitoring and surveillance systems operational by June 2014** | **100% of cases reported and recorded within the system** | • **Developed a suite of methods, including the HPF data dashboard, the screening and immunisation assurance framework, a quarterly report from PHE on cases reports and incidents, and care homes infection surveillance group**<br>• **Work has commenced on developing a contractual assurance framework for PH commissioned services.** |
| **3. Establish Joint Clinical Commissioning Group/Public Health Emergency Planning Resilience and Response function (EPRR)** | **Agreed function operational by September 2013** | **100% recruitment to the EPRR function** | • **PH EPRR lead providing a service to CCG from 1st June 2014 unitl 31st March 2015**<br>• **Preferred option for BC joint EPRR service out for consultation** |
| **4. Develop and integrate Public Health incident response into WCC Incident Plan and conurbation plans** | **Plans agreed by Health Protection Forum by October 2014** | **100% of the Incident Plan established and fully operational by December 2014** | • **Wolverhampton ConOps for PH incident response agreed at Health Protection Forum.**<br>• **Need to develop process for testing plan**<br>• **Communications Strategy development has commenced.** |

David Johnston
Project Lead – Primary Care Regeneration
5th November 2014

Agenda Item No. 17

**NHS Capital Programme Projects - GP Premises in Wolverhampton**
**Wolverhampton Health and Wellbeing Board**
**Wednesday 5th November 2014**

Representatives from NHS England, Wolverhampton CCG and NHS Property Services met with Council Officers on the 12th September to discuss the council and NHS development plans with a view to understanding how those plans can best be co-ordinated. Meetings will be held on a regular basis in the future.

**Bradley**
There are two practices in Bradley operating from premises that are in need of improvement. One of them is in a council owned premise which is converted from a school. Consideration is being given to whether a new development to house both practices would be a suitable solution or investment in the current premises to bring the practices up to a good standard. We discussed this at the above meeting and an assessment will be made as to whether the school building could be sufficiently improved. The council are assisting in identifying new sites that might be suitable while the NHS is exploring the potential for developing and modernising the current premises.

**Bilston Urban Village**
NHS England has approved in principle the development of a new Health Centre on the Urban Village site. Work is now progressing towards a full business case and a project board has been formed to manage that process. Regular meetings have commenced to work towards the production of a business plan with the site developers that is in line with the timescales envisaged for the Urban Village generally. The sale of the site by Homes and Community Agency to the developers, Stofords, can be finalised as soon as the business case for the development is finalised and approved by NHS England. But all parties are now content that the project is progressing in the timescales required and the plan for the building are largely complete..

**The Scotlands**
Two practices are now operating from the Cannock Road surgery and have merged, as the practices that were formerly on Blackhalve Lane have now moved into these premises. Plans are now being drawn up for the extension of those premises to cope with the increased list size and additional GPs in the premises. Capital resources have been secured for the development and NHS Property Services are working with the practice to agree the extension needed. Car Parking is an issue and we discussed this at our meeting with the council and options to improve that situation are being explored.

**Heath Town**
A number of discussions have been held with the practice and with officers of the council. The council had made NHS England aware of the availability of a building they own on Hobgate Road that could be converted to a surgery and replace the one that is due for demolition in the centre of Heath Town. However an alternative site is now looking preferable on the site of the former Duke of York pub that will possibly also have Extra Care facilities. The GP in Heath Town has been a single handed practice but the intention is to make it a two GP practice to allow for the recruitment of a new partner for the practice that will provide succession when the current GP retires. This also takes account of the increased housing units that will be in Heath Town after the area development.

**Showell Park**
The prospective development of this area has been discussed with the council and will be considered with regard to decisions about the future development of the practice and walk in centre in that locality.

David Johnson
Project Lead – Primary Care Regeneration

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