CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

16 July 2015

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

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

Membership

Chair Cllr Milkinderpal Jaspal (Lab)
Vice-chair Cllr Mark Evans (Con)

Labour	Conservative	Co-opted Members
Cllr Harbans Bagri	Cllr Wendy Thompson	Jean Hancox
Cllr Craig Collingswood		David Hellyar
Cllr Val Evans		Ralph Oakley
Cllr Jasbir Jaspal		
Cllr Peter O'Neill		
Cllr Stephen Simkins		

Quorum for this meeting is two Councillors.

Information for the Public

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

Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1 **Apologies**

2 **Declarations of Interest**

3 **Minutes of previous meeting** (Pages 3 - 6)
[To approve the minutes of the previous meeting as a correct record.]

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

DISCUSSION ITEMS

5 **The end of life strategy update report of The Royal Wolverhampton NHS Trust (RWT)** (Pages 7 - 12)
[To consider the end of life strategy update report and offer comments,]

6 **Musculoskeletal (MSK) Services Consultation Evaluation** (Pages 13 - 30)
[To approve the Musculoskeletal (MSK) Consultation Evaluation Report, and provide any comments.]

Health Scrutiny Panel

Minutes - 15 June 2015

Attendance

Members of the Health Scrutiny Panel

Cllr Milkinderpal Jaspal (Chair)
Cllr Mark Evans (Vice-Chair)
Cllr Craig Collingswood
Cllr Val Evans
Jean Hancox
David Hellyar
Cllr Jasbir Jaspal
Cllr Peter O'Neill
Ralph Oakley
Cllr Stephen Simkins
Cllr Wendy Thompson

Employees

Deborah Breedon	Scrutiny Officer
Jonathan Pearce	Graduate Management Trainee

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
Apologies for absence were received from Cllr Bagri.

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

3 **Minutes of previous meeting**
Resolved:
That the minutes of the meeting held on 12 March 2015 be approved as a correct record and signed by the Chair.

4 **Matters Arising**
There were no matters arising.

5 **Nominations for the election of Vice-Chair**
Nominations for the election of Vice-Chair were received; Cllr Mark Evans was elected the position. Cllr M. Jaspal offered for the Vice Chair (and any other panel members) to attend future planning meetings.

6 **The Royal Wolverhampton NHS Trust's Quality Account 2014/15**

Cheryl Etches, Chief Nurse – Royal Wolverhampton Hospital Trust, gave a verbal presentation of the NHS Trust's Quality Account report by outlining the Trust's three priorities for the year, which are: urgent care, care of the elderly and end of life strategy. The Trust hopes to build on last year's work to improve these areas.

Due to maladministration the panel had not received a copy of the report. It was agreed to circulate the report after the meeting for Councillors to offer their comments - should they wish - with a view to forwarding a response to the Trust by 26 June. Councillors expressed their discontent about not being able to see the report and voiced their frustration about not being able to engage with the report fully. There was a consensus that it would not be appropriate to endorse any recommendations until the document was available. The panel were grateful for the report authors' presentation given the circumstances.

The Chief Nurse and Lynne Fieldhouse, Deputy Chief Nurse Royal Wolverhampton Hospital Trust, provided further details about the Trust's priorities:

- The Trust is redesigning urgent care pathways as part of its development.
- A & E continues to be a challenging area as large numbers of patients are using the service. The Trust has put in control measures to monitor this and is performing well, but not as high as it believes it can.
- Ambulance turnaround times are to a high standard.
- Dementia is a major focus, and the Trust is pleased to have received CCG funding to run a dementia ward for a year. The Trust is also running 'dementia friends' training, which will be completed by all relevant staff members within 12 months.
- Personalised care is a priority due to an aging population. The Trust has identified the issues of pressure sores and ulcers as something that it needs to address. This is a reflection of the types of patients within the community.
- End of life care has improved significantly over the last six months. The Trust has adopted best practice from Salford NHS Trust to ensure staff recognise the needs of bereaved relatives. Mandatory training has been implemented to ensure 8000 staff members will be trained to respond to families appropriately.
- The Trust has increased the number of clinical trials and sees research as a means to enhance practice.
- Newly qualified nurses are receiving an extended period of supervision to help them embed in the organisation. This has helped staff retention of young and oversees nurses.
- Data suggests a valid reduction in hospital mortality rates.
- Patient satisfaction rates are high (between 90 and 93%), but staff satisfaction rates are slightly lower (78%).
- The Trust will continue to focus on the integration of services at Cannock Hospital with the view to creating an elective centre in order to protect emergency beds at New Cross. This will be of importance during the winter period when the need for beds increases.

Cllr O'Neill questioned whether parity of esteem of mental health was an issue for the Trust. It was acknowledged that this issue was of importance despite not being in the verbal update.

Cllr Simkins voiced his concern that the Trust had not changed its priorities since last year and also expressed concern about the integration of services at Cannock Hospital. Jean Hancox, HealthWatch, also questioned why the Trust had not included HealthWatch on its mailing list for the Quality Account, which Cllr Collingswood also expressed concern about. With other panel members' support, Jean Hancox queried the accuracy of the responses to hospital surveys noting that many people would not complete surveys. The Chief Nurse noted that whilst the hospital can provide feedback forms, it cannot coerce patients into completing them.

The panel also raised the issue of nurse training and sought clarity on whether numbers were increasing or decreasing. The Chief Nurse explained that post Francis Inquiry Report the need for more nurses has become a national issue. She explained that the Trust needed to be innovative about investing in nurses and that this issue was reported on internally on a monthly basis. Cllr Thompson added that she also had concerns about nursing and training.

Resolved

1) To note the verbal report and forward the Quality Account report to all panel members to allow for Councillor to make comments to forward a response by 26th June 2015.

7 **Sexual Health Consultation Report**

Katie Spence, Consultant in Public Health, and Ravi Seehra, Commissioning Officer, presented the sexual health consultation report. They provided an overview of the consultation noting that they were pleased to have engaged with a range of groups, such as young people, GPs, the voluntary sector and medical professionals. An extensive consultation ran from a variety of different locations with health partners to establish how best to improve services in the area.

The Commissioning Officer explained that the Public Health aim to commission an integrated service that uses modern technology. There is a need to develop a robust offer to vulnerable groups and this must be supported by the use of social marketing, which can help remove the stigma of service. The next phase of work is for the GUM and CASH aspect of the proposal to go out to tender in July. Further work will be done in the meantime to engage GPs to improve the GP offer. All financial, legal and equalities information acquired during the consultation will be shared with the future commissioners.

Cllr O'Neill queried whether work would be done to train receptionists at locations where a 'spoke' service may be based. The Consultant in Public Health explained that the consultation had shown that generally respondents preferred not to access services at GP surgeries. There is therefore a need for discrete services within the area. She added that the GP offer will be a primary care based model with training for all staff that provides sexual health services. Some GP services will specialise whilst others will offer a more basic package. There are varying degrees of capacity for GP surgeries to provide these services, but Public Health has identified several appropriate locations which could be specialist centres.

Cllr O' Neill also questioned how the consultation has related to teenage pregnancies and abortion. Teenage pregnancy services are not commissioned by Public Health,

but they can infer from available data it is an issue. By addressing the needs of vulnerable people in the city, many of these vulnerable individuals will be supported.

Cllr Simkins made several points. Firstly he questioned the relationship between Public Health and schools. The Consultant in Public Health explained that the Healthy Schools Team is looking to develop work on risk taking behaviour for young people. This new service will link into school nurse services. Secondly, Cllr Simkins also supported the team's plans for an app to provide information to younger people. Finally, he raised the issue of the link between mental and sexual health, focussing on peer pressure and sexting. The Consultant in Public Health agreed with these observations and explained work would be done to help vulnerable individuals.

David Hellyar, HealthWatch, expressed concern about the number of teenage pregnancies in the city and questioned why some of these were not being picked up judicial system. Cllr Evans noted that this was a sensitive issue and would risk criminalising many teenagers.

David Hellyar, HealthWatch, also queried the location of the sexual health Hub, which will be proposed by the tenderers. Contractors will also be responsible for ensuring that any sub-contractors meet the stipulations of their contract. Cllr Simkins stressed that more needed to be done to ensure new contracts should support the sexual health agenda.

Resolved:

1) To uphold the Sexual Health Consultation.

2) To consider the feasibility of public health commissioned services and how reference to sexual health matters can be incorporated into future commissioned public health services where applicable.

3) To encourage closer working partnership relationships between health, schools and the police are addressed in the sexual health specification.

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

16 July 2015

Report title	The end of life strategy update report of The Royal Wolverhampton NHS Trust (RWT)
Cabinet member with lead responsibility	Councillor Sandra Samuels, Health and Wellbeing
Wards affected	All
Accountable director	Gwen Nuttall, Chief Operating Officer (RWT)
Originating service	Royal Wolverhampton NHS Trust (RWT)
Accountable employee(s)	Clair Hobbs — Senior Matron – Adult Community Services Tel — 01902 442590 Email — Clair.hobbs@nhs.net
Report to be/has been considered by	

Recommendation(s) for action or decision:

The Panel is recommended to comment on the content of the report and provide feedback to the reporting organisation (RWT).

1.0 Purpose

1.1 This report is a scheduled update of the progress made by The Royal Wolverhampton NHS Trust in regards to the end of life strategy.

2.0 Background

2.1 End of life care is one of The Trust's three overarching priorities. Since 2013 there have been significant local and national documents about end of life care. The marking of the 2013 halfway point of the Department of Health's 10-year end of life care strategy; the demise of the Liverpool Pathway (2013); the Francis Report (2013) about the failures in care at the Mid-Staffordshire Foundation Trust that led to hundreds of deaths that were potentially avoidable; the publication of the Leadership Alliance for Care of Dying People (LACDP), 'One chance to get it right: Improving people's experience of care in the last few days and hours of life *(*2014); The National Institute for Health and Care Excellence document, Quality standard for end of life care for adults (2011); What We Know Now 2013, National End of Life Care Intelligence Network (2013); Emergency admissions to hospital: managing the demand, National Audit Office (2013); Wolverhampton Clinical Commissioning Group End of Life Care Strategy (2014); and the 2013 CQC RWT inspection made it imperative that the Trust take every opportunity to ensure that end of life care and bereavement care remains a core priority. It is important to note that the term 'end of life care' in this document refers to patients in the last 12 months of life.

2.2 The Trust's vision is to *'continually strive to improve patients' experiences and outcomes'*. With this in mind, the Trust launched a project known as Creating Best Practice with a sole aim to improve the experience of patients in the last days of their lives. This project ensures that learning and change happens across the organisation and not just in certain areas, it has a robust governance framework and is championed by the Chief Nurse.

2.3 With end of life and bereavement high on the Trust agenda, a Creating Best Practice work stream was set up to review and overhaul end of life and bereavement care across all services including community.

2.4 This work stream aimed to implement services that will meet the recommendations of The Leadership Alliance for Care of Dying People following their response to the independent review of the Liverpool Care Pathway that took place in 2014. This detailed clear recommendations for care in the last days and hours of life which included the now nationally recognised five priorities of the dying person; these priorities come into play when it is thought that a person may die within the next few days or hours:

- This possibility is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
- Sensitive communication takes place between staff and the dying person, and those identified as important to them.
- The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

- The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
- An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

In cases of sudden, unexpected death these priorities can expect to be accelerated.

2.5 Other work streams within the Trust are further developing services to improve patient experience and support patient choice in the last twelve months of their lives. These include:

- Development of a Rapid Discharge process and supporting information to facilitate patients in the last days of life being discharged home to die if that is their wish.
- Development of a local electronic palliative care co-ordination system (EPaCCS) that will enable the safe sharing of palliative patient's key information that aims to prevent unnecessary admissions and/or inappropriate treatment decisions and support the patient's wishes regarding their care. This information will meet the needs of the National Information Standard for End of Life Care.
- Piloting of the Gold Standards Framework in Acute Hospitals, which aims to improve recognition of patients in the last 12 months of their lives and facilitate communication between hospital and community teams.
- A single Do Not Attempt Cardiopulmonary Resuscitation form that follows the patient and is accepted across the local health economy, preventing multiple distressing conversations with patients and families within different care environments.
- Piloting of a patient held document that details their wishes around future care, including where they want to be cared for and what is most important to them.
- Successful implementation of a Consultant Nurse led Homes In-reach Team (HIT) that supports end of life care patients in nursing homes, avoiding unnecessary hospital admissions.
- Joint working between Adult and Paediatric Community Nursing services to extend end of life care at home to transitional patients aged 16-18 years old.

3.0 Progress, options, discussion, etc.

3.1 The Creating Best Practice group have developed a new health economy wide document for staff to use when patients are in the last few days or hours of life, which is based on the five priorities. This document was launched in April 2015 and is now in use within all inpatient areas and at Compton Hospice.

3.2 The document encompasses all recommendations from the Leadership Alliance review including meeting the dying person's own needs and wishes in relation to how their care should be managed and any treatment preferences they may want to express. The plan also includes attention to symptom control (e.g. relief of pain and other discomforts) and the person's physical, emotional, psychological, social, spiritual, cultural and religious needs. The person is supported to eat and drink as long as they wish to do so, and their comfort and dignity prioritised.

3.3 This plan of care stays with the patient so that consistent information about the person's needs and wishes is shared with those involved in the person’s care and be available at the time this information is needed, for example a patient who is discharged from New Cross to the care of the District Nursing Service for end of life care.

3.4 Part of the document also has a perforated page called the ‘one page profile’ where the patient and their loved ones can document personalised information about the patient such as ‘what is important to me’, ‘how to support my family’ which stays with the patient and is displayed in wards next to the patient’s bed so it is clear for all staff to see.

3.5 The group has developed a new intranet site for staff to gain information and details regarding end of life and bereavement care.

3.6 A Trust wide launch day was held in April 2015 to introduce the Trust philosophy and new ways of working to as many staff as possible. A total of eight teaching days are also arranged at the Molineux for 50 staff on each day to fully embed the Trust’s new approach. The training days are then set to continue on a monthly basis at New Cross. They are designed to be interactive with staff from all disciplines not just healthcare workers, so that the whole Trust culture and approach will transform.

3.7 The teaching days aim to:

- Raise awareness across the Trust
- Increase knowledge of Trust priorities
- Learn from each other
- Empower staff to provide a truly patient centred approach

Discussions also take place around religious and spiritual care so that staff gain greater insight into the differences between these two areas so that neither is forgotten.

3.8 As part of the development, members of the group visited Salford hospital to observe how they had successfully changed their culture and practice and embedded the five priorities. The Trust has taken some of the excellent work already achieved in Salford and utilised or adopted some of their approaches including the recognised swan symbol, which is a discreet visual aid for all staff to note when a patient is nearing the end of their life or a recently bereaved person. The swan motif is used on all new documentation and as a discreet sign next to the patients bed to assist staff visiting the ward. It also gives staff permission to think outside of the box and ensure they fully utilise a person centred approach. The motif has also been used as a print on canvas bags that will now be utilised by the bereavement office for handing over the deceased person’s belongings to their loved ones rather than a generic plastic carrier bag from the Trust.

3.9 Each area including community areas are to be presented with a swan resource box to utilise, which includes all documentation that may be required, silk pouches for bereaved ones to take home the deceased persons jewellery or locks of hair. The Trust is supporting photographs being taken if bereaved loved ones should wish to do so and hand prints.

3.10 Each area across the organisation including areas such as Estates, Pharmacy and theatres are also involved in the promotion of the new approach and have identified

along with clinical areas 'swan champions' from their patches that will promote and communicate end of life and bereavement within their departments.

3.11 There has been a full refurbishment of the Mortuary department at New Cross Hospital and this re-opened in April 2015. The viewing area for the bereaved has also been refurbished as part of this project.

3.12 To ensure the motivation with this is not lost, quarterly meetings are to be held with the swan champions for the Trust and information from these meetings will be fed back across all departments.

3.13 There will continue to be an end of life and bereavement working group for the Trust which will involve the members of the Creating Best Practice group. This will continue to develop and steer this priority within the organisation.

3.14 Currently individual services carry out their own bereavement survey. To avoid unnecessary burden to bereaved relatives, a bereavement survey is in development that can be utilised across the Trust for inpatient and community areas. It will be co-ordinated by the Patient Advisory and Liaison service and will enable the Trust to monitor and gain valuable insight into the care it is providing to the dying person and their loved ones.

3.15 The Trust has undergone a CQC inspection in June 2015 and is voluntarily taking part in the National End of Life Care audit for inpatient areas later this year. It is hoped that this will give positive feedback to the changes that have been made and embedded.

3.16 In addition to the implementation of these services, the Creating Best Practice group will widen to support and monitor the implementation of end of life care service developments. Progress so far is:

- Rapid Discharge Home – the pilot project is well underway and its efficacy will be evaluated by the end of 2015.
- EPaCCS – Phase one of the development to identify IT requirements is completed, with phase two underway determining practical application via the trusts existing electronic clinical information system.
- Implementation of the Gold Standard Framework in Acute Hospitals pilot is underway on two hospital wards. A pre and post implementation audit will assess efficacy by March 2016.
- The health economy wide Do Not Attempt Resuscitation form is now well embedded and is working well. A bespoke e-learning package and face to face training has been developed to support its use.
- An advance care planning document called 'My Care' is being piloted initially at Compton Hospice and roll out across the health economy is planned, subject to successful outcome of the pilot.
- The HIT team is now well established and has proved extremely effective at helping patients achieve care and death in their normal place of residence, and reducing acute admissions. Following there great success, plans to expand the team are underway.

- In terms of the number of referrals, the demand for Transitional end of life care services is low, but when required, the positive impact on their care is very significant for patients and their families.

4.0 Financial implications

4.1 There are no financial implications arising from this report.

5.0 Legal implications

5.1 There are no legal implications arising from this report.

6.0 Equalities implications

6.1 There are no equalities implications arising from this report.

7.0 Environmental implications

7.1 There are no environmental implications arising from this report.

Agenda Item No: **6**

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

16 July 2015

Report title	Musculoskeletal (MSK) Services Consultation Evaluation	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Well Being	
Wards affected	All	
Accountable director	Steven Marshall, Director of Strategy and Transformation	
Originating service	Wolverhampton Clinical Commissioning Group	
Accountable employee(s)	Clare Barratt	Solutions & Development Manager (Planned Care)
	Tel	01902 444616
	Email	Clare.Barratt@nhs.net
Report to be/has been considered by	None	

Recommendation(s) for action or decision:

The Panel is recommended to receive and note the Musculoskeletal (MSK) Consultation Evaluation Report, and provide any comments.

1.0 Purpose

1.1 To provide health scrutiny with the consultation evaluation report following the MSK Consultation.

2.0 Background

2.1 The Orthopaedic Community Assessment Service (OCAS) was originally established and managed by the Primary Care Trust (PCT) (pre CCG) to provide efficient and effective management of adult non-emergency musculoskeletal (MSK) patients registered with general practices within Wolverhampton. OCAS became part of the Orthopaedic Directorate at the Royal Wolverhampton NHS Trust in 2011 under Transforming Community Services.

2.2 The service was developed to improve the management of patients with MSK problems by ensuring appropriate and timely management of referrals through high quality triage assessment and management, and a source of accessible and expert advice on conservative management. Its other functions included ensuring patients were seen by the right person in the right place at the right time, minimising multiple steps or delays, and supporting the treatment of patients within the 18 week RTT targets.

2.3 Within the current system, the services that deliver MSK (OCAS, Physiotherapy, and Orthopaedics) are disjointed, inefficient and slow. There are many steps in the patient's journey which could be deemed unnecessary; this drives down efficiency in terms of time, capacity and cost.

2.4 The procurement and implementation of an integrated MSK service will provide a more streamlined and efficient service for patients. The development of a new service model could encompass and be extended to include all aspects of MSK care, including secondary care treatment, which could be undertaken in a community setting. A new integrated MSK model could help facilitate an MDT (Multi-Disciplinary Team) approach to care planning with the skills and expertise of each clinician being accessed as needed in a streamlined efficient way.

3.0 Public Consultation

3.1 As part of any procurement process or service development the CCG has a duty to engage with patients and the public on any proposed service changes, and ensure that any feedback is considered in the development of the service specification.

3.2 The Health Scrutiny Panel received and supported the MSK consultation plan at its meeting in March 2015. Stakeholder consultation ran for twelve weeks commencing on Monday 16 March 2015 and ended on Monday 8 June 2015, the consultation evaluation report is provided at Appendix 1.

4.0 Consultation Evaluation

4.1 The consultation evaluation report provided at Appendix 1 demonstrates a wide range of communication and engagement techniques that took place to consult with stakeholders

including staff, clinicians, partners, providers, patients, community groups and the public. These techniques included events and meetings, promotion via existing groups and communication channels and use of the internet both in terms of corporate websites and social media.

4.2 An assessment of the responders has been undertaken in comparison with demographics for Wolverhampton published by the Office for National Statistics. In addition, profiles were collected relating to the protected characteristics stated within the Equality Act 2010. The findings show that a good representation of people who could be affected by the change, were consulted with.

4.3 Of the 138 people that completed the survey, 80% answered the question ‘Do you support our proposal?’ and 94% of people agreed with the proposed model of care for an integrated MSK service. Responders were asked to rate the importance of certain features and provide any additional comments; this information is detailed within the report, however highlights are as follows:

- Waiting time for an appointment is very important.
- Location and access has been a key theme; access in the community is of high importance; parking and public transport is fairly similar in importance.
- A single point of access for MSK services and good communication between departments is very important; a named individual to coordinate care, information about the condition and being able to discuss treatment with professionals is key for users, as well as being involved in decisions about the care they may receive.
- Mechanisms for the CCG to monitor patient outcomes were very important; having a user group to share experiences and having a process to provide comments was split between very and somewhat important.

4.4 Following this consultation period and the analysis of responses, the CCG will develop a service specification and evaluation process that will be used to procure an Integrated MSK service. The feedback from this consultation will be used to inform the service specification and the evaluation criteria thus ensuring that the views of patients and the public are used in service development.

5.0 Financial implications

5.1 The key drivers for the development of an Integrated MSK service are to provide a local, accessible and cost effective service for patients.

6.0 Legal implications

6.1 Wolverhampton CCG is responsible for engaging with patients and the public regarding proposed changes to existing services.

7.0 Equalities implications

7.1 The Integrated MSK Service Specification will adhere to equalities legislation; an Equality Impact Assessment will be undertaken on the new proposed service.

8.0 Environmental implications

8.1 Not applicable.

9.0 Human resources implications

9.1 Not applicable.

10.0 Corporate landlord implications

10.1 Not applicable.

11.0 Schedule of background papers

11.1 12 March 2015 - Musculoskeletal (MSK) Services Consultation

NHS
Wolverhampton
Clinical Commissioning Group

Consultation Evaluation Report

From the consultation on the redesign of muscle, bone and joint services - 16 March to 5 June 2015

1. Executive summary

This report highlights the evaluation of a 12 week consultation into the redesign of muscle, bone and joint services, also known as musculoskeletal (MSK) services.

The consultation took place from 16 March to 5 June 2015. This report describes the range of communication and engagement techniques that took place to inform and consult with clinicians and staff within our organisation, partner organisations, patient/community groups and the public (section 6). This included various events, meetings and promotion of a consultation document that explained the reasons for change and a proposed model. This document also included a survey to capture the views of users and carers, which was also available online. The feedback at each of these meetings and events, along with the data captured in the survey is included in this report – see section 8

The report ends with a reassuring look at the respondents demographic compared to those in the 2011 Census by the Office of National Statistics (ONS) for the population of Wolverhampton. This highlights the profiles of respondents to the online and paper survey including all nine protected characteristics, as stated in the Equality Act 2010 – see section 8.3.

Finally, to note, this consultation period did run through the Election 2015 where, during six weeks, we were not able to proactively engage due to purdah. This was agreed in advance with Overview and Scrutiny Committee and agreed on 12 February 2015. Due to the detailed communication planning and targeted engagement undertaken for this consultation, the findings show a good representative people who could be affected were consulted with.

2 What are MSK services and how are they delivered?

2.1 Musculoskeletal services primarily diagnose, treat and care for conditions or injuries that affect muscles, tendons, ligaments, bones, joints and associated tissues for example arthritis, back pain, and osteoporosis. Such services can include treatment by a physiotherapist, podiatrist, rheumatologist or orthopaedic surgeon, for example.

2.2 Currently, the majority of services that would comprise MSK care are delivered across a number of departments at The Royal Wolverhampton NHS Trust and West Park Hospital.

2.3 Patients access services predominantly through their GP who, where necessary, would refer a patient into the Orthopaedic Clinical Assessment Service, Orthopaedic Service, or Physiotherapy services, for example.

2.4 MSK services are primarily delivered in outpatient settings; outpatient settings are provided for those patients whose treatment does not require them to be admitted or stay in hospital therefore a hospital setting is not essential for the delivery of musculoskeletal care.

3 Case for change

3.1 The population of Wolverhampton is ageing and more people are living with long term conditions. The World Health Organisation (WHO) and Bone and Joint Health strategies Project (2005 cited by DOH) identified that up to 30% of all GP consultations are about musculoskeletal complaints and musculoskeletal problems are cited by 60% of people on long term sickness.

3.2 The current model of delivery is unsustainable for the future and we are unlikely to be able to afford future demand for services if they continue to be delivered in the current way.

3.3 We have looked at patterns across the patient journey in MSK services and found that some patients need care and treatment from multiple services, for example orthopaedics and physiotherapy. Often a patient is referred back to their GP to make a further referral rather than the services working together and communicating to ensure the needs to the patient are met. This is inefficient in terms of waiting time, capacity and cost for both the NHS and the patient.

4 What patients and carers told us

4.1 We arranged six focus groups in February 2015 for patients and carers to share their views on the service and tell us what is working well, what needs improvement and suggestions on how to improve these issues. Each of the groups were well attended.

4.2 The feedback told us what was needed, including; access to specialists in one place with the technology and support services, better information and education for patients,

improved communication across health professionals, access to alternative therapies and group therapy, clear and informative treatment plans and better accessibility.

4.3 In light of this feedback and the case for change, a proposal was formed.

5 The proposal

5.1 Our proposal is to commission a single provider to deliver a high quality, comprehensive service to deliver MSK care. We are not proposing to reduce services nor limit the treatment options that are provided; our aim is to integrate services in order to have a single, streamlined service with clear accountability.

5.2 We don't envisage changes to how patients will access the service; patients will continue to go to their GP in the first instance. The provider will be expected to deliver services from a number of locations across the City ensuring accessibility for all patients.

5.3 By having a single provider of MSK services, the overall experience by the patient will be improved with increased continuity of care, a smoother more efficient journey and faster access to treatment.

6 Consultation approach

A formal consultation took place between 16 March and 5 June 2015. Below are the various communication and engagement methods:

6.1 Formal engagement events

Four consultation events took place across each of the localities of Wolverhampton. Three of the two-hour sessions were held during an evening to encourage attendance from local residents. The fourth event took place during the day to enable staff and clinicians from organisations, partner organisations as well as the public to attend. The aim of each of these sessions was to educate people about the need to change the MSK services and offer the opportunity for people to share their views on the proposed model.

At each event the clinical lead, Dr K Ahmed, led the discussions with support from the planned care commissioning manager and colleagues, as well as a member of the communications and engagement team.

Date	Time	Venue	Attendance
19 March	6.30pm – 8.30pm	Bilston Town Hall	3
24 March	6.30pm – 8.30pm	The Linden Suite, Linden House	8
26 March	6.30pm – 8.30pm	Lowhill Community Centre	5
15 May	2.00pm – 4.00pm	The Tettenhall Suite, Linden House	19

6.2 Drop-in events

We attended five outpatient departments twice to capture real-time views from current patients and carers. At each outpatient department a planned care commissioning manager or communications and engagement colleague was present to discuss the consultation and proposed model. A consultation document was handed to each person who welcomed information about the plans – some completed the survey on the day while others were invited to send the completed survey via post. The findings of all the completed surveys can be found in section 8 of this report.

The below table indicates approximate numbers of people that welcomed to hear about the consultation during those sessions:

Date	Time	Department	Approx. users/carers
18 May	PM	Rheumatology	10
20 May	AM	Rheumatology	25
20 May	AM	Pain Management	10
29 May	AM	Orthotics	10
29 May	PM	Pain Management	10
1 June	AM	Orthotics	10
2 June	PM	Physiotherapy	60
3 June	AM	Orthopaedics	10
4 June	AM	Physiotherapy	60
5 June	PM	Orthopaedics	10
		Total:	**215**

6.3 Scheduled CCG meetings

We support a number of meetings which are attended by leads to cascade relevant information to their local teams. The consultation was discussed at the following meetings:

Date	Meeting	Present
25 March	Primary Care Strategy Event	Various GP practice staff and CCG leads
21 April	Joint Engagement Advisory Group (JEAG)	Black Country Partnership NHS Foundation Trust (BCPFT) rep, Practice Manager rep, Healthwatch rep, Public Health rep, patient rep and CCG leads
14 May	North East GP Locality Meeting	5 GPs, 1 practice representative & 1CCG representative
20 May	South East GP Locality Meeting	4 GPs, 3 practice representatives, 1 Respiratory Consultant and 1 CCG representative
28 May	Patient Participation Group (PPG) Chairs Meeting	18 PPG Chairs and representatives, Healthwatch and 1 CCG representative
4 June	South West GP Locality Meeting	8 GPs, 1 practice representative and 1 CCG representative

6.4 Outreach with existing groups/organisations

Date	Group/Organisation	Method	Present/Reach
15 & 24 March	Healthwatch – progress of consultation, offer of another consultation event for Healthwatch members	Face to face and email	Unknown
18 March	Omega (carers support group)	Email	Forwarded notice to group member s
2 April	The Spread (Housing Association bulletin)	PDF via email	Unknown
April	Peoples Parliament – offer to meet and discuss in further detail. Shared document and survey via email.	Email	Share with members via Chair
April	Changing Our Lives. Shared consultation document and survey via Chair.	Email	Share with members via Chair
22 April	Voice 4 Parents group members via Jane Smith and Sarah Baker	Email	Shared with members via Advice and Support Service e-bulletin
May	City Carer (Carers magazine)	Print copies and online	4,000 printed 600 email distribution

11 May	The Wolverhampton Rheumatology Support Group (WRSG) coffee morning	Face to face workshop	50 users

6.5 Direct messages (electronic and paper based)

Date	Who	Method	Description
17 March	Citizens Forum	Email	Online link to consultation document and survey
17 March	PPG Chairs	Email	Online link to consultation document and survey
17 March	JEAG representatives	Email	Online link to consultation document and survey
17 March	Patient Partners with email addresses	Email	Online link to consultation document and survey
17 March	GPs in all localities	Email	Online link to consultation document and survey
17 March	Practice Managers	Email	Online link to consultation document and survey
20 March	GPs	GP e-bulletin	Online link to consultation document and survey
w/c 23 March	Patient Partners (all others)	Paper	Consultation document & survey
w/c 23 March	Team leaders: physiotherapists, podiatrists, rheumatologists, orthopaedics & GPs	Email	Direct email from planning commissioner manager about start of consultation and links to online document and survey to cascade to staff members
w/c 30 March	Libraries, health centres & pharmacies	Paper	Consultation poster, document & survey
25 March	GP practices (via Primary Care Strategy Event	Paper	Consultation poster, document & survey
31 March	Focus group members	Email/Paper	Thanks for their support. Attached/enclosed consultation document and survey
31 March	Interested people from recent pop-up shop engagement	Email/Paper	Thanks for their interest. Attached/enclosed consultation document and survey
1 April	CCG staff	Staff e-bulletin	Online link to consultation document and survey
16 April	Joint Commissioning Learning Disabilities Lead	Email and Face to face meeting	Shared consultation document and survey
14 May	CCG staff	Staff e-bulletin	Online link to consultation document and survey

6.6 General communications

Date	Type	Method	Reach (where applicable)
16 March	Consultation document that explains current MSK service, case for change, the proposed model and survey	PDF version on: CCG website, and intranet	 761 hits 56 hits
16 March	Consultation survey	Survey monkey	138 completed
16 March	Consultation poster – promoting start of consultation and links to complete survey	Design approved	n/a
Throughout (12 posts in total)	Social media: • Media releases • Encourage to attend events • Encourage to complete online survey	 Twitter Twitter Twitter	 32.9K reach 11 clicks
  17 March 11 May	Local media • media releases sent: ○ start of consultation and online links to document and survey ○ last chance to get involved	Via media team	Various distribution lists
27 March	Market Engagement Event (BRAVO)	Face to face event Online system	n/a

7 Key stakeholders

The following stakeholders were identified to help shape the proposals and encourage people to complete the online survey:

- Wolverhampton patients and carers, including:
  - MSK users and carers (direct and those already involved in pre-engagement)
  - Omega carer support group
  - Children services
  - Learning disability services
  - Voice 4 Parents group
- Patient Partners (CCG Membership scheme – via email and post)
- Citizens Forum group, which includes but is not exhausted to:
  - Age UK
  - Carer Support
  - Zebra Access
  - Hear Our Voice
  - Health Visitors
  - Alzheimer's Society
  - Representatives from patient groups:
    - Diabetes
    - Rheumatology (particularly The Wolverhampton Rheumatology Support Group (WRSG)
    - Chinese
    - Parkinson's
    - Dementia
    - Cancer
    - Sickle Cell
  - Over 50s Forum
  - Samaritans
  - Positive Acton 4 Mental Health
  - Mental Health Empowerment team
  - Haven Refuge
  - St Georges House
  - Catch 22
  - Coronary Aftercare Support Group
  - Ethnic Minority Council
  - Network Consortium
  - West Midlands Ambulance Service (WMAS)
  - Afro Caribbean Community Initiative (ACCI)
  - Healthy Lifestyles
  - Refugee Centre
  - Citizens Advice Bureau
  - Changing Our Lives
- Other CCG engagement groups (all via mailing lists)
  - Joint Engagement Assurance Group (JEAG)
  - GP Practice Partnership
  - Clinician and Allied Professionals' Forum
  - Community Leaders' Forum
  - GP Locality Groups
  - Patient Participation Groups (PPGs)
- GP, practice managers and practice staff (via locality meetings & mailing lists)
- CCG staff (via e-bulletin)
- Staff at Royal Wolverhampton NHS Trust (particularly those at New Cross Hospital currently delivering the MSK service)
- Healthwatch Wolverhampton
- Media (via the CSU Media Team)

8. Feedback

This section highlights the key themes from the consultation events and workshops, as well as the online and paper surveys:

8.1 Consultation events and workshop findings

There were four consultation events and one workshop where patients, carers and people interested in MSK care heard about the proposal for an integrated service. They had the opportunity to raise questions and make suggestions going forward. Here are the key themes from all five events:

Feedback theme	Example comments	Response
Bidding/ procurement process	What providers are out there?	There are good examples. The bid process would involve deciding who is fit for purpose and financially sound. The CCG would then decide the best bidder.
	Who and how will the winning bidder be decided?	A panel of clinical leads, contracting leads and non-clinical leads are normally involved. Users have been involved in the past. The panel would use a scoring system to decide the best provider.
	When will the service go out to tender?	Summer 2015
	How will you monitor performance?	This will be built into the service specification with the new provider once a decision has been made, for example setting key performance indicators.
	Will patients and clinicians be involved?	We have already engaged with focus groups to help shape the specification so far and this consultation will inform it further
	How will the service change?	The service will have an integrated team of health professionals, providing care/treatment in the community.
Logistics of the proposed new model	Will waiting times from referral and between appointments improve?	The new model of integrated services should help improve this and targets will be used to drive improvement.
	How will the integrated team work and deliver?	The service will work together to help offer the patient the right care in the first instance.
	How are patients referred into service?	Patients should see their GP in the first instance. GPs will refer into the new service.
Location of the proposed new model	Where will the new service be located? Will each service area be together or separate?	The location of the service is part of the procurement process and who the winning bidder is. However, we can make suggestions

	Could the proposed service be delivered at New Cross Hospital?	The proposed model hopes to reduce the number of contacts for a patient in hospital and receive care and treatment in the community.
Other comments and examples	"Need to ensure that patient records/images are shared between providers."	
	"Need to improve information for patients to support self-care."	
	Rheumatology patients were grateful of the helpline and said it is useful to gain advice about the condition and treatment between appointments.	
	A few people asked about hydrotherapy services for people with arthritis.	
	A few people rated very highly the support from the physiotherapy team at West Park.	
	A few people talked about increasing preventative options.	
	"I've seen this model elsewhere in the country and it does work."	

8.2 Online and paper survey findings

138 people completed the survey. 118 (91%) of these were responding to the survey as an individual and 12 (9%) as a representative of an organisation or group (eight skipped the question). These groups included local PPGs, BCPFT, Guru Nanak Gurudwara, WMAS and Community Physiotherapy at Royal Wolverhampton NHS Trust.

111 people answered the question 'do you support our proposal?' (27 skipped), of which:

Do you support our proposal?	Response
I agree strongly with the proposal	43 (39%)
I agree with the proposal	61 (55%)
I disagree with the proposal	5 (4%)
I disagree strongly with the proposal	2 (2%)
Total	**111/138 (80%)**

The survey then gave people the opportunity to rate how important certain features of a musculoskeletal service are to them. 136 people (98%) answered (two skipped).

The next few pages indicate all of the responses:

1. Booking an appointment	Very important	Somewhat important	Slightly important	Not important	No opinion
a. Not having to wait very long until my appointment date	104	27	4	0	0
b. An appointment which fits around my commitments, eg early evening/weekends	48	38	14	22	0

This highlights the majority of people feel the waiting time for an appointment is very important, compared to the flexibility of an appointment

2. Location and access	Very important	Somewhat important	Slightly important	Not important	No opinion
a. Access to the majority of treatments in the community	88	26	10	4	1
b. Being able to park at or close to the clinic	72	36	14	4	1
c. A clinic that is accessible by public transport	60	39	14	12	2

Location and access has been a key theme through the consultation events. These results also highlight that access in the community is of high importance. Being able to park near the clinic and access to public transport is fairly similar in importance.

3. Design of the service	Very important	Somewhat important	Slightly important	Not important	No opinion
a. A single point of access for all MSK services where services communicate with each other	99	19	8	3	0
b. Good communication between my GP and MSK services so that everyone understands my condition and treatment	117	10	2	1	0
c. Being seen on time in the clinic	58	57	13	2	0
d. Having a named individual to coordinate all of my MSK care	70	48	8	2	0
e. Consistency in the clinical staff providing my treatment	86	34	10	0	0
f. Being given information so that I am clear about my condition and treatment	107	16	3	0	0
g. Ability to input the decision about the care that I receive	96	24	6	0	0
h. Being able to discuss my diagnosis and treatment further with my consultant and other staff after my appointment	101	20	7	1	0

It is evident from these results that a single point of access for MSK services and good communication between departments is very important to the model of this service. It also highlights that having a named individual to coordinate care, information about the condition and being able to discuss treatment with professionals is key for users, as well as being involved in decisions about the care they may receive.

4. Monitoring and feedback	Very important	Somewhat important	Slightly important	Not important	No opinion
a. Mechanisms for the CCG to assess the quality of care provided and to monitor patient outcomes	74	48	6	0	2
b. Having outpatient services which provider a user group for patients to share their experiences	40	54	22	13	0
c. Having a process through which I can provide comments on the care that I received	50	54	20	2	0

The majority of people that completed this survey felt that mechanisms for the CCG to monitor patient outcomes were very important. They also felt that having a user group to share experiences and having a process to provide comments was split between very and somewhat important.

5. Any other comments

People completing the survey had the opportunity to add comments to explain any of their responses in more detail or add any additional comments. 45 people (33%) responded to this question (93 skipped), of which nine added general positive comments about the proposed model.

Majority of the remaining comments have been categorised into four key themes. These include suggestions for the proposed model and further details about features of the service that were in questions one to four. The themes, and some example comments of each, are listed in the table below:

Feedback theme	Example comments
Good communication between GP and MSK services	"Good communication between providers of this service is vital."
	"Communication between departments is essential."
	Improve information sharing – e.g. a single sheet which is kept by patient / carer with copies held by the doctor / nurses / support services provider (physio etc). It would include treatment, medicine physio etc as well as timescales and review dates
Access, waiting and referral times	"Not convinced that waiting times will be shorter as not fewer patients…Worry about 'hub' restricting earlier access to consultants by diverting patients to cheaper options first."
	"I think length between appointments needs to be reviewed."
	"Children with chronic pain syndromes are poorly served. Access to intensive skilled physiotherapy is limited for them & we (Paediatric Rheumatology team at New Cross Hospital) have no access to essential psychology intervention."

Location of services	"A designated place for diagnostic tests (whether it's the community or the hospital) where patients can be seen quickly. A flexible service with options for evening and weekend appointments and appointments at home."
	"Space to park is essential for arthritis patients and their families."
Quality of service to be delivered	"Providers need to be held accountable to give this vital service."
	"Will holistic therapies be included in options for treatment?"
	"Peer support and knowledge sharing for users could be modelled on what happens in the heart / lung centre (at New Cross Hospital) where ex patients are working voluntarily - they and the coronary aftercare support group give valuable advice and mentoring to existing patients."

8.3 About our online and paper engagement respondents

- The Wolverhampton population (according to the 2011 Census by the Office of National Statistics (ONS)) is made up of 249,470 people, of which 49.5% are male and 50.5% are female. We received completed surveys from 30% male, 70% female.

- We also asked: Is your gender identity the same as the gender you were assigned at birth? Our survey had 100% of respondents as yes.

- 91% of respondents identified themselves as being Heterosexual or straight, with 7% Gay or Lesbian and 2% Bisexual.

- The age range of respondents went from up to 17 to over 75+ years. Majority of respondents were 65 to 74 at 29.7%, 75+ was 21.1%, 55 to 64 was 16.4%, 45 to 54 was 13.3% and 35 to 44 was 6.3%. Up to 17 to 34 was a total of 8.6%. The remaining percentage of respondents preferred not to say.

- We asked respondents to clarify their marital status. 55% of which were married, 10% were divorced, 1.7% were separated, 15.8% were single and 17.5% were widowed.

- The 2011 Census also identifies ethnicity of the population. Please see the table below which shows we were able to engage via the survey with a relatively similar population makeup:

Ethnicity	MSK survey	2011 Census ONS
White: ➢ English, Welsh, Scottish, Northern Irish, British ➢ Irish ➢ Gypsy / Traveller ➢ Polish	78.4%	68%

Mixed / Multiple: ➢ White and Black Caribbean ➢ White and Black African ➢ White and Asian	4.8%	5.1%
Asian / Asian British: ➢ Indian ➢ Pakistan ➢ Bangladeshi ➢ Chinese	9.6%	18%
Black / African / Caribbean / Black British: ➢ African ➢ Caribbean	5.6%	6.9%
Other: ➢ Arab ➢ Other – Swedish, Cypriot	1.6%	1.9%

- We also ask respondents if they are pregnant – of which 1% said yes, 67% said no and 32% stated it was not applicable.

- When asked if their day-to-day activities were limited by a health problem or disability which has lasted or is expected to last over 12 months? 28.6% respondents felt their health problem or disability limited them a lot, 37.8% respondents felt their health problem or disability limited them a little.

- 73% of respondents were Christian, 1% were Hindu and 7% were Sikh. 17% of respondents stated no religion while 2% stated Pagan.

- When reviewing the locality of respondents we received approximately 29% from the North East, 22% from South East and 46% from South West.

9. Overall findings

By reviewing the findings in the consultation process it is clear that a large percentage of the users and carers of the service agree with the proposed model.

It is interesting to note some of the suggestions – highlighted in the feedback section from the events, workshop and survey (section 8) - fall under four key themes. These include location of the service, access and referrals, good communications and ensuring a quality service. These themes reflect our previous findings in the pre-engagement, which helped shaped the survey, are important in shaping the service specification for the procurement process.

Another suggestion is to maintain communication and information with the users i.e. the results of this consultation and any proposed changes. This will be undertaken in due course.

The targeted work undertaken throughout this consultation is of a high standard. It also is a good representation of the residents of Wolverhampton.