CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

5 October 2017

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

Venue Training Room, Ground Floor, Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Membership

Chair Cllr Jasbir Jaspal (Lab)
Vice-chair Cllr Wendy Thompson (Con)

Labour	**Conservative**
Cllr Greg Brackenridge	Cllr Patricia Patten
Cllr Hazel Malcolm	
Cllr Elias Mattu	
Cllr Peter O'Neill	
Cllr Phil Page	
Cllr Paul Sweet	
Cllr Martin Waite	

Quorum for this meeting is two Councillors.

Information for the Public

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS

1 **Apologies**

2 **Declarations of Interest**

3 **Minutes of previous meeting** (Pages 3 - 10)
[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 **Briefing report on the use and control of New Psychoactive Substances (NPSs) - report to follow**
[Neeraj Malhotra, Consultant in Public Health, to present report]

6 **Re-commissioning of Drug and Alcohol Services in Wolverhampton - consultation and engagement findings.** (Pages 11 - 44)
[Neeraj Malhotra, Consultant Public Health, to present briefing on consultation on new proposed drug and alcohol services structure.]

7 **Update on Black Country Sustainability and Transformation Plan - report to follow**
[Andy Williams, Accountable Officer, Black Country Sustainability and Transformation Plan to present update on progress

8 **Wolverhampton Integrated End of Life Care Strategy - update on progress** (Pages 45 - 50)
[Karen Evans, Solutions and Development Manager (Community Care, & End of Life Care) Wolverhampton CCG to present update against implementing the end of life strategy]

9 **Walsall Clinical Commissioning Group - Consultation on changes to hospital stroke services** (Pages 51 - 116)
[Earl Piggott-Smith, Scrutiny Officer, to present consultation report prepared by Walsall CCG on proposed changes to hospital stroke services for panel comments]

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny Panel

Minutes - 20 July 2017 Agenda Item No: 3

Attendance

Members of the Health Scrutiny Panel

Cllr Greg Brackenridge
Cllr Jasbir Jaspal (Chair)
Cllr Hazel Malcolm
Cllr Peter O'Neill
Cllr Patricia Patten
Cllr Wendy Thompson (Vice-Chair)
Jeremy Vanes
Elizabeth Learoyd
Sheila Gill
Steven Marshall

In Attendance

Andrea Smith	Wolverhampton CCG

Employees

Earl Piggott-Smith	Scrutiny Officer
Katie Spence	Consultant in Public Health
David Watts	Service Director - Adults
Helen Tambini	Democratic Services Officer

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies**
Apologies for absence were received from Councillor Leach and David Loughton, RWHT.

2 **Declarations of Interest**
Councillor Malcolm declared an interest in item 7 Black Country Sustainability and Transportation Plan – the wider perspective as an NHS employee.

3 **Minutes of previous meeting**
Resolved:
That, subject to the inclusion of Councillor Brackenridge's name in the apologies for absence, the minutes of the meeting held on 25 May 2017 be confirmed as a correct record and signed by the Chair.

4 **Matters Arising**
Earl Piggott-Smith, Scrutiny Officer confirmed that under Matters Arising from the previous meeting, the dental information regarding tooth extractions had been forwarded to Councillor Judith Rowley.

The report on Open Spaces was still being prepared and would be included on the Panel's work programme for a future meeting, when Planning Services have completed their work

In respect of minute 5, The Royal Wolverhampton NHS Trust Quality Account 2016/17 (Draft), Jeremy Vanes, Royal Wolverhampton Hospital NHS Trust confirmed that the information requested in resolutions 4 and 5 was available and would be circulated to the Panel. In respect of resolution 6, he confirmed that the Hospital-Level Mortality Indicator (SHMI) should be available in the autumn for the Panel to consider.

Councillor Brackenridge referred to minute 7, West Midlands Ambulance Service (WMAS) Quality Account 2016-17 and that a draft response would be produced and shared when available. He suggested that this was too vague and requested that in future, recommendations be more specific regarding timelines.

Earl Piggott-Smith confirmed that in respect of the above comments from Councillor Brackenridge, an initial response had been circulated to the Panel and in future the minutes would include a more definitive response.

5 **Care pathways for the frail elderly**

David Watts, Director of Adult Social Care, City of Wolverhampton Council, and Andrea Smith, Head of Integrated Commissioning, Wolverhampton CCG, presented the report on care pathways for the frail elderly and highlighted the key points.

David Watts referred to the importance of ensuring that care pathways were good in the city. There were several different drivers for health and social care, a key document being the NHS Five Year Forward View which stated that areas should have a plan for integrating health and social care by 2020. He referred to the Better Care Fund (BCF) Programme which was the primary way to implement change through the more efficient use of resources. The programme was currently being refreshed and had yet to be signed off. That delay had primarily been caused by the delay in published guidance from the Department of Health, which had become available on 4 July 2017. Once finalised, the Leader of City of Wolverhampton Council would be asked to sign it off.

He referred to several projects underway which aimed to avoid emergency admission to hospital and Delayed Transfers of Care (DTOCs) and he asked Andrea Smith, Head of Integrated Commissioning, to highlight several them.

Andrea Smith referred to the following projects:

People Living with Frailty Programme. This was in the BCF Programme, with several work streams to support primary and secondary care. GPs were taking part in a pilot scheme looking at patients using a Frailty Index to identify those most in need. By using Care Management Plans, it was hoped to allow the elderly to remain at home for longer.

Review and Redesign of Community Services Programme. This was in the BCF Programme, with all services being provided to ensure the right services in the community setting and the right support.

Admission Avoidance Programme. This was both proactive and reactive; community nurses worked proactively with GPs to look at high risk patients and those frequently using services. The Rapid Intervention Team worked reactively with nurse based teams in the community supported by Social Care teams.

David Watts referred to the following projects:

Discharge to Assess Programme. As from the beginning of 2017 it had become part of the BCF Programme as it was considered that it covered the whole system. A pilot scheme using Discharge Hubs and improved initial assessments had been introduced on four wards at the Royal Wolverhampton Trust.

- Six-month extension of Home Assisted Reablement Programme (HARP).
- Additional Stepdown/Very Sheltered Housing or Extra Care.
- Hospital Discharge Demand Management Implementation.
- Hospital Discharge Voluntary Sector Service.

The above projects were part of additional Adult Social Care. £6.4million would be available this year if three conditions were met. Firstly, stabilising the local care sector, secondly relieving press on the NHS locally by getting more people home safely and quickly, and thirdly helping to deliver the challenges for health. Spending was controlled by the BCF Programme Board and the A & E Delivery Board.

In response to questions from Panel members, officers stated the following:

- Improvements had been made to the assessment process already. The issue related to where an assessment was taking place, given that assessments would often require several visits it was better to do an initial assessment in the hospital and then further assessments when the person had returned home.
- It would depend on the type of adaptation required as to whether this would or could be done before a person left hospital. Under the Small Adaptations Grant stair lifts and other minor adaptations could be completed quickly and it was hoped to pilot the scheme in other areas. If a person was unable to return home as adaptations were still required alternative accommodation would be found.
- Efforts were being made to work with other authorities; however, it was not proving straightforward.
- The NHS was made aware that delays occurred when Wolverhampton was dealing with people transferred from other hospitals. Based on the performance indicators used, the service was in an extremely challenging position. However, improvements had been made during the past year, for example in the number of delayed days during the month, which had fallen from 600 to 400. Other indicators in the dashboard required assistance from other bodies, including GPs and the ambulance service working together better.
- It was important to ensure transparency and have efficient methods of data collection to avoid replication.
- It was important to remember that outside events could influence figures, for example when ambulances were diverted to Wolverhampton from other areas.

- It was unclear why there had been a spike in the figures for the number of delayed days last November 2017; however, NHS delays were more pronounced than social care delays as perhaps more people were unwell.
- One project related to hospital discharge and would bring together data and information from health and social care to ensure that a care package was in place. Also, to ensure the correct support to GP practices, services were now aligned to the CCG footprint based around GP clusters.
- To help the sick and vulnerable to be prepared if they required hospital care a Red Bag Scheme had been successfully piloted in residential and nursing care homes and had seen a huge reduction in discharge times as important patient information is available when a person is admitted which will help reduce delays in diagnosis and treatment. It was hoped that the scheme could be introduced in Wolverhampton and extended to include vulnerable people in their own homes and it was hoped to have that in place by October 2017.
- The Adults Budget Working Group looked at the Transformation Programmes. The Secretary of State has recently announced that a penalty of up to 10% of the budget (£640,000) would be imposed if targets were not reached. That would require Wolverhampton achieving a 36% improvement against performance measures by September which would be very difficult to achieve. Seven of the West Midlands authorities would require an improvement of more than 60% which showed the scale of the task.
- Wolverhampton had a good health and social care system and it was difficult to be required to have those discussions on trying to meet this trajectory even though the system was working well and the NHS and DCLG would receive feedback that it had proved disruptive.
- The link to the BCF guidance was available to be circulated to the Panel. The information including the dashboard which provides information about six key performance measures - for example, the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services. The information is used to track if current performance is on target for reducing the number of delayed hospital attributable to social care. There was concern the table does not capture all the complexity of the factors beyond the control of the local authority which can affect its performance against the published indicators.
- Wolverhampton had been ranked 117 out of 150 but based on current evidence the situation is improving

Members of the Panel welcomed the comments and responses from officers and stated that the main priority should be to ensure patient welfare rather than trying to achieve unrealistic Department of Health targets

David Watts suggested that as the Department of Health would be reviewing the current progress of the dashboard in October 2017, if there were any areas of concern they could be considered at the Panel's meeting on 25 January 2017.

Resolved:

1. That a link to the Government guidance on the BCF be circulated to the Panel.
2. That an update report on the performance of Wolverhampton against six performance measures detailed in the Local Performance Measure performance dashboard is be submitted to the meeting on 25 January 2018.

6 **Healthwatch Wolverhampton Annual Report 2016/17**

Elizabeth Learoyd, Chief Officer, Healthwatch Wolverhampton presented the Healthwatch Wolverhampton Annual Report 2016-17 and highlighted the key points.

She stated that following her appointment as Chief Officer in November 2016, the profile of the organisation had been raised to ensure that it was more visible and putting the public and patients first.

She referred to the following highlights during the year:

- NHS Complaints Advocacy Service working with Wolverhampton Health Advocacy Complaints Service (WHACS) to provide better one to one support.
- Building engagement through community awareness campaigns.
- Development of Experience Exchange digital service to allow the public to search for and provide feedback on hundreds of health and social care service providers.
- Hospital enter and view visits where trained volunteers talked to patients and worked with providers to suggest recommendations.
- Healthwatch Advisory Board setting five priority work areas for 2017/18 based on listening tour information from over 400 people.
- Work with the University of Wolverhampton to improve access for the deaf. A collaborative report and video would be published in October 2017.
- Project with the Urgent Care Centre.

In response to questions from Panel members, Elizabeth Learoyd stated the following:

- When recommendations were made to the Urgent Care Centre, responses were received, the Vocare Improvement Board was invited and some of those recommendations were implemented.
- In respect of priorities and timescales for activities, delayed transfers and GP access were top of the list. The draft document would be shared with the Board after it had been considered by the Healthwatch Board next week.
- In respect of the evaluation of the Urgent Care Centre and the characteristics of the participants, during the month's evaluation most people who used the service were aged between 18-39 as many of them confirmed that rather than attend their GP surgery they had come straight to the centre.

Resolved:
That the report be noted.

7 **Black Country Sustainability and Transformation Plan - the wider perspective**

Steven Marshall, Director of Strategy and Transformation, Wolverhampton CCG presented an update on the developing Black Country Sustainability and Transformation Plan (STP) and highlighted key points.

He confirmed that the report had previously been presented to the Health and Wellbeing Board on 28 June 2017 and it was a review of the Government's Five Year Forward View which had been published on 31 March 2017. It had reiterated the need for change and how different parts of the NHS needed to work together and with partners, including local authorities. There was a need for all hospitals to achieve a better balance in terms of accountable care and to change the way health worked. Progress was being made with the STP, Andy Williams had been confirmed as the STP lead for the Black Country.

A draft 'Memorandum of Understanding' to show how health and social care would develop had been agreed in principle. The four Clinical Commissioning Groups (CCGs) had created a Joint Commissioning Committee to lead the delivery of specialist services.

David Watts, Director of Adult and Social Care confirmed that the draft 'Memorandum of Understanding' would be considered by the Council's Cabinet in September. The other authorities' Cabinets would also be considering the document over the summer.

Steven Marshall confirmed that the intent and design of the STP remained unchanged, with the four localities coming together. The Transition Board had been re-designated as a Systems Development Board and it was hoped that an update would be available in early 2018.

The panel discussed plans for a new partnership between Black Country Partnership NHS Foundation Trust, Birmingham Community Healthcare NHS Trust, and Dudley and Walsall Mental Health Partnership NHS Trust. The new organisation will be created in October 2017.

The Chair suggested that Andy Williams be invited to the next meeting of the Panel.

Resolved:

That Andy Williams, the STP Lead for the Black Country, be invited to the Panel meeting when the STP was next considered.

8 **Health and Wellbeing Board Meeting 28 June 2017 - summary of discussion**

Earl Piggott-Smith, Scrutiny Officer reported to the Panel that the summary of the discussion from the last meeting of the Health and Wellbeing Board would be circulated to the Board once the Leader had agreed it.

Resolved:

That the summary of the discussion from the last meeting of the Health and Wellbeing Board be circulated to the Panel once the Leader had agreed it.

9 **Health Scrutiny Panel - Work Programme 2017/18**

The Chair referred to the successful planning event on 25 May and to the updated work programme, which would continually be reviewed.

Earl Piggott-Smith reminded members of the Panel that any councillors could ask for an item to be considered by scrutiny. Councillor Waite had requested that the issue of Suicide Prevention be considered.

It was suggested that an additional meeting might be required when Andy Williams was invited to consider the Sustainability and Transformation Plan (STP).

Jeremy Vanes, Royal Wolverhampton Hospital NHS Trust suggested that it would be more timely to consider the issue of End of Life Care at the meeting in January 2018 rather than in September 2017.

Earl Piggott-Smith confirmed that a revised version of the Work Programme would be circulated for comment.

The Chair requested that the date of the next meeting be changed from 21 September to 28 September 2017.

Resolved:

1. That a revised version of the Work Programme, incorporating the comments and suggestions referred to above be circulated to the Panel for comment.
2. That the next meeting of the Panel be moved to 28 September 2017.

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Agenda Item No: 6

CITY OF WOLVERHAMPTON COUNCIL

Health Scrutiny

05 October 2017

Report title	Re-commissioning of Drug and Alcohol Services in Wolverhampton – consultation and engagement findings.
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing
Wards affected	All
Accountable director	Susan Milner, Interim Service Director - Public Health and Wellbeing
Originating service	People – Public Health and Wellbeing
Accountable employee(s)	Neeraj Malhotra Consultant Public Health Tel 01902 558667 Neeraj.Malhotra@wolverhampton.gov.uk Michelle Smith Commissioning Officer Public Health Tel 01902 550154 Michelle.marie-smith@wolverhampton.gov.uk
Report to be/has been considered by	PLT 11/09/17

The Panel is recommended to:

1. Note background information and commissioning plans for drug and alcohol services.
2. Note feedback on the findings from the engagement and consultation process and key future challenges.

1.0 Purpose

1.1 This report sets out the findings from the engagement and consultation process which has been used to inform the re-commissioning of drug and alcohol services.

2.0 Background

2.1 Substance Misuse services support people with drug and/or alcohol problems who may also have additional complex needs around mental health, offending or other health issues. These services play a key role in promoting recovery and reducing the harm caused by alcohol and drug misuse which are significant causes of morbidity and mortality in Wolverhampton.

2.2 Delivery of such services contribute to a number of national and local priorities and support the achievement of outcomes within the Public Health Outcomes Framework, National Drug and Alcohol Strategies and City of Wolverhampton Council corporate plan priorities.

2.3 The City of Wolverhampton Council is responsible for commissioning drug and alcohol treatment and recovery services for adults and young people, which forms part of a wider programme of activity to reduce drug and alcohol related harm.

2.4 Current services were retendered in 2012 with the contract starting in April 2013. Several contracts form the basis of the City's drug and alcohol services offer and will expire on 31 March 2018.

2.5 A commissioning and procurement process has been required to replace the current contracts in order to continue to deliver this support. This is at a significantly reduced budget in line with the national and local reduction of the public health grant available to commission these services.

2.6 Preparations for going out to tender have been underway during 2017 including extensive engagement to inform a revised service model and subsequent consultation.

2.7 The engagement and consultation exercise has been endorsed at Health Scrutiny Panel 2 March 2017.

2.8 An interim briefing note outlining engagement feedback and brief consultation findings was provided to panel members on 26 July 2017 under the acknowledgement the timing of this report is after the tender has been has been advertised.

2.9 The future treatment and recovery model for April 2018 onwards has been developed based on the needs of the local population, evidence of what works and findings from engagement and consultation undertaken with service users, wider stakeholders and the general public.

2.10 Key requirements of the new recovery orientated system will be to deliver a safe and effective service to all Wolverhampton residents and will incorporate core treatment and recovery functions. This will include the prescribing function, supervised consumption, needle exchange services, community and residential detox and rehabilitation, service user involvement and support and preventative work.

2.11 The system will work with people who are vulnerable with complex needs around substance misuse (for instance mental health, young people, pregnant women, offenders etc.) therefore quality, partnership working and safety are key considerations.

2.12 The tender provides the opportunity to maintain a treatment system in Wolverhampton; ensuring value for money and the delivery of recovery outcomes and harm reduction.

3.0 Engagement and Consultation Process

3.1 During the engagement phase 356 stakeholders participated in the process. Feedback suggested the current service model provides an extremely comprehensive package of care and is highly valued. Areas for improvement include increased accessibility, assertive outreach and stronger pathways of care across mental health and criminal justice.

3.2 46 stakeholders responded to the online consultation survey with an overwhelmingly positive response to the model proposed. See Appendix one for full details of the engagement and consultation findings.

3.3 Respondents viewed prevention, early identification and harm reduction as a high priority, particularly consideration towards interventions to young people newly introduced to drugs and alcohol.

3.4 The feedback also supported that treatment outcomes from the new system were to be maintained around successful completions for individuals with addictions. A partnership approach to reducing alcohol related mortality and admissions to hospital, engaging people entering and exiting prison into treatment and reducing drug related deaths were also considered to be key areas for development.

3.5 90% of respondents endorsed a Family Support model as a crucial intervention and an integral part of recovery.

3.6 General comments by respondents were very similar to those received throughout the engagement process and included:

- A need to improve recovery support in prisons with seamless transfer from prison to services on discharge.
- Prioritise outreach for vulnerable groups. Homelessness seen as a significant priority group with unmet needs.
- Support around employment needs and getting people off benefits.
- Family support focusing on keeping children within families (where safe to do so)
- Aftercare covering long term peer support, promoting reintegration, supporting access to wrap around services and recovery communities.

- Increasing early engagement and prevention interventions – reducing presentation at points of crisis.
- Delivery of care should be focused across the city and in a variety of community settings.

3.7 The proposed service model and scope of interventions was presented at a market warming event on 12 July 2017 and received positive feedback.

4.0 Future Challenges

4.1 The consultation findings have indicated that the development of services with a wider reach into communities and universal services as well as increased support for complex needs and responses to new drugs such as New Psychoactive substances (NPS) is desirable.

4.2 The service model that has resulted from this has taken account of these aspirations however a 20% reduction in the budget available for the new contract will restrict the scope of growth and development in these areas.

4.3 The provider will be expected to achieve efficiencies but also innovation in delivery to ensure the service remains as accessible and responsive as possible. As a result, a phased approach towards changes in the delivery of substance misuse services, as well as where resources are mainly being utilised (treatment), has been built into the contract over five years to encourage a shift towards more preventative approaches.

4.4 New and or increased demands on the service will need to be managed collaboratively with other services and stakeholders to ensure resource and capacity is available across the health, social care and criminal justice systems to balance rather than subsume these pressures into the contract

5.0 Commissioning Intentions

5.1 The tendering process will commence on 4 September 2017. Tenders will be invited until 18 October 2017

5.2 Tender submissions will be evaluated during October with a report to Cabinet Resources Panel on 14 November 2017 seeking delegated authority to award the contract for drug and alcohol services.

5.3 The service will begin on 1 April 2018 following the contract mobilisation phase during December 2017 – March 2018.

6.0 Financial implications

6.1 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The total allocation for 2017-2018 is £21.3 million. The

allocation for 2018-2019 has not been confirmed as yet, but it is anticipated that there will be a funding reduction when compared to the 2017-2018 allocation.

6.2 The cost of the proposed re-commissioned contract will be contained within an envelope of £4.0 million and will be funded from within the total Public Health grant allocation for 2018-2019. [NM/05092017/O]

7.0 Legal implications

7.1 The Council has a statutory responsibility for improving the health and well-being of its population. There is a legal requirement to conduct a formal consultation. [RB/04092017/F]

8.0 Equalities implications - Equality Impact Assessment

8.1 A full Equalities Impact Assessment has been undertaken. Findings have been fed into the specification and evaluation criteria. Mobilisation will include assurance that equalities issues have been fully explored and responded to.

9.0 Environmental implications

9.1 No environmental implications have been identified relating to the consultation and engagement process.

10.0 Human resources implications

10.1 No human resource implications have been identified relating to the consultation and engagement process.

11.0 Corporate landlord implications

11.1 No corporate landlord implications have been identified relating to the consultation and engagement process.

12.0 Schedule of background papers

12.1 Health Scrutiny Panel 2 March 2017 - Proposed engagement and consultation plan for drug and alcohol commissioning and service redesign.

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APPENDIX 1

Wolverhampton - Drug and Alcohol Services

Findings from Stakeholder Engagement and Consultation
August 2017

Contents

1. Introduction

City of Wolverhampton Council is responsible for commissioning drug and alcohol treatment and recovery services for adults and young people, which forms part of a wider programme of activity to reduce drug and alcohol related harm.

Delivering effective substance misuse treatment has a wide range of positive outcomes for individuals, families and communities including reducing reoffending and antisocial behaviour, and reducing health harms and improving health.

Wolverhampton Public Health team, as part of the commissioning process engaged with key stakeholders regarding the future Drug and Alcohol service model.

A public consultation was held for 12 weeks, commencing in April 2017 comprising of an 8-week engagement process from April – May, followed by a 4-week consultation from June – July. This document details the findings from this engagement and consultation.

The consultation process sought to obtain the views of key stakeholders on current services and to identify the best future service model to include in outcomes for individuals and families. During this process, we consulted with over 400 adults, young people, professionals and parents to inform the development of our proposed service model.

2. Engagement Process

Our engagement activities were designed to give people the opportunity to voice views, experiences and requirements. This approach has enabled us to develop the proposals for future services in conjunction with stakeholders.

We have aimed to address concerns regarding services through open and meaningful engagement with all those affected. This section sets out how we have gone about this. It also sets out the key issues that have been raised by stakeholders and influenced our thinking on this matter.

By the end of this consultation process we hope that everyone – service users, service providers, professional stakeholders and members of the local community - will feel that their voices have been heard. Also, just as importantly, that those voices have helped us achieve our goal of providing a service that is accessible, appropriate and responsive to local needs.

3. How we engaged with stakeholders

We employed a variety of methods to obtain feedback from our key stakeholders. A number of engagement events were held, where providers, health and social care professionals, service users and members of the public attended. Three separate open service user workshops were held, alongside online surveys for stakeholders

and service users. Furthermore, to capture the views of those who are misusing substances but not currently accessing treatment services, insights were sought from vulnerable 'hard to reach' groups where a number of semi-structured interviews were undertaken.

We conducted online surveys for service users and stakeholders. With the assistance of the Councils Communications team - their Facebook and Twitter accounts were used to publicise the consultation process.

Two multi-agency events were held for professional stakeholders.
Information from a variety of sources was shared including data from the needs assessment, learning from evidence reviews and current best practice, service performance data and key challenges.

Early into the commissioning process we established a Drug and Alcohol steering group with responsibility for overseeing the development of the commissioning process including developing and supporting the consultation process. Probation services, Community Safety, Homelessness Services and the Clinical Commissioning Group are represented on the group along with representatives from several council departments.

A summary of the stakeholders we have engaged with is detailed in the table below. Approximately 400 stakeholders have expressed their views.

How we engaged with stakeholders	Who we engaged
Provider engagement event	52 professionals. Managers and staff in current services and key partners including young people's services, criminal justice, Hospital Liaison, GPs Shared Care, pharmacies, voluntary sector services.
Stakeholder engagement event	38 professionals from partner and support organisations including health, social care, criminal justice, education and voluntary sector services.
Online engagement survey	57 Stakeholders responded this survey was made available online as well as via social media platforms through council services, housing services, Youth Council, Service User Involvement Team and circulated widely to all stakeholders.
Service user engagement survey – drop ins	77 respondents. This involved engaging with services users including those from Needle Exchange, Youth Offenders those involved within the Criminal Justice sector, Alcohol and GP Shared

	Care services, Ex users, Young People, Parents Women and Carers.
Three focus groups at Thornhurst location One focus group with men from migrant communities	21 service users
Three service user workshops	54 service users
Vulnerable groups interviews	A number of semi-structured interviews were undertaken with 57 individuals across 8 organisations and included those who support, street homeless people, sex workers, LGBT groups, Women/Carers, Migrant Communities, Young People in supported accommodation and men's groups from mixed ethnic backgrounds.
Consultation survey	46 stakeholder responses

4. Current Services

Current drug and alcohol services in Wolverhampton include:

- Recovery Near You
  - Substance misuse services for adults, young people and families
  - Drug and Alcohol Hospital Liaison Team
  - Criminal Justice interventions
- Shared Care delivered by selected GPs and Recovery Near You
- Addictions Maternity Services
- Needle Exchange Service in community pharmacies (and needle waste disposal services)
- Supervised Consumption in community pharmacies
- Service User Involvement Team (SUIT)

These are currently offered in a range of settings including:

- Two locations in the city centre
- At GP Practices
- Outreach / community settings
- Probation offices
- Pharmacies
- Hospital

These services aim to build recovery and reduce harm through specialist help which includes information, advice and guidance, psychosocial support, and pharmacological (prescribing based) interventions.

5. Overview of key themes identified from all consultation activity

A wealth of information has been received throughout the various consultation activities we have conducted in terms of what respondents wanted from the system. We aimed to hear views from as many people as possible. This included service users, carers, family members, support organisations, professional stakeholders and members of the public in fact, anyone who had a view on drug and alcohol support services.

Responses can be grouped into several themes**:**

Criminal Justice Interventions

- Respondents were in agreement that there was a need to keep people using drugs out of the criminal justice system. There needs to be action in place to stop/address/reduce offending and re-offending. Alternatives to criminal sanctions should be explored.
- Treatment and support should be available for those newly released from Prison.
- Provide holistic support through probation and mental health services.
- Communication and joined up approach required from multiple agencies involved in criminal justice interventions.

Mental Health Support and Awareness

- Strengthened links and clearer pathways with mental health services to address stigma and root causes.
- Target mental health support to vulnerable groups through partnerships with specialist organisations.
- Improve strategies to tackle long and short term mental health in populations including individual and group counselling, workshops, training, mentoring support, telephone support and network ‘meet ups’.
- In house psychiatrist support seen as valuable.

Outreach, Prevention and Intervention

- Tailored and targeted outreach and assertive outreach were identified as something that should be undertaken, especially for “vulnerable groups”. The homeless were identified on a number of occasions as a group particularly in

need. There was also a sense that some people are unlikely to come to services as they do not recognise that they may have a problem.
- Although early identification was recognised to be important there was also a need to have preventative approaches, to stop substance misuse happening in the first place. Through for example education in schools or raising awareness for the public.
- Additionally, it was raised numerous times that there was a need to address the underlying causes of why individuals may be misusing drugs or alcohol.
- Emphasis on awareness, implications and response to New Psychoactive Substances, chemsex and education to LGBT (Lesbian, Gay, Bi-sexual & Transgender) groups.
- Training programmes delivered to professionals (including to wider organisations e.g. hostel staff, LGBT staff) to ensure they understand what advice and support is available, and how they can support those who need services to access them.
- School liaison – improve information sharing as schools often have concerns regarding children and parents at risk.
- Target health promotion with appropriate resources to pupils in vulnerable groups e.g. new arrival communities.
- Online educational support for specific groups.
- Brief intervention sessions available in the community.
- Target interventions to specifically intercept cycle of misuse/abuse in families.
- Enhance workforce capacity through use of a co-ordinated volunteer programme. Invest in well trained, professional dedicated staff e.g. therapeutic support, use of interpreters.

Family Support

- Support, advice and training for family, friends and carers of those who use drug and alcohol services about substance misuse and about how to live with and support service users.
- Explore opportunities for peer (other families) and mentor support.
- Increased opportunities for social outings and children's activities to build resilience and support networks.
- Increased awareness and emphasis on family involvement and family group sessions.

Access and Flexibility

- There was an identification that locality based services would prove beneficial to people. Shared care highlighted as a community based service.
- Requirements for out of hours' provision – evenings and specifically weekends for those who work with telephone support offering brief interventions as a minimum.

- Reduced waiting times to start treatment and prompt access to scripts to maximise service user engagement.
- Increased emphasis on detoxification provision and local availability.
- The use of an appointment reminder system.
- Challenge barriers to service access to improve service uptake from vulnerable groups.
- Visible service promotion in high risk areas, use of community advocates.
- Online advice and support, accessible 24 hours a day with self-referral option.

Recovery

- Understand and meet the wider needs of service users, such as housing, employment and training etc. and consider the needs and requirements of the whole person. Additionally, other services (statutory/voluntary and community/faith organisations) had a role in helping to identify issues/people, and refer/signpost onward; but also, to respond to and help meet needs across a range of issues.
- Facilitate access to positive social support networks – employment, SUIT, community groups, Changing Lives, Hope, housing related support, hobbies, mental health support, sport or recreational activity to support recovery.
- Aftercare support to individuals and families to build resilience and avoid relapse.
- Greater recovery links in GP surgeries.
- Advocacy and support for service users to enable them to access and engage with services including a peer mentoring and buddying system.

Building on achievements

- Current system offer valued particularly staff's ability to be responsive, non-judgemental and understanding.
- The hospital service and criminal justice service were highly valued.
- The role and value of SUIT was also identified because of its work in service user involvement, helping individuals' wider issues, housing, benefits, into volunteering etc. i.e. more holistic help. Seen to be making a practical difference. Valued by service users and stakeholders alike.
- Wolverhampton has a well-established local Shared Care GP prescribing network supported by experienced key workers.
- The current service model provides an extremely comprehensive package of care for families where children have parents or carers who misuse substances and for parents or carers of substance-misusing children. However, as demand for service increases this method of service delivery is likely to be unsustainable.

- All those who leave drug treatment have access to drug-related support and mutual aid groups. This includes easy access back to drug treatment in the case of relapse.
- The treatment system effectively supports recovery, including innovative programmes through a variety of groups including life skills and drop-in support.

Areas for development

- Concerns raised in relation to access to treatment and detox services and availability of key workers.
- Communication between services and interrelated functions such as shared care GP's and the number of dispensing chemists, timely prescriptions and the operation of supervised consumption (the use of consultation rooms and staff).
- Access and availability of needle exchange services (particularly in Bilston) and the disposal of needle equipment and waste.

6. Workforce - What professionals working in drug and alcohol services told us

At the workforce consultation held in March 2017, professionals informed us that in order to ensure we are working with the whole system opportunities can be explored to undertake alcohol screening and brief interventions including a possible alcohol Audit C screening campaign in Pharmacies together with signposting and better training for workers. A key challenge being 'better support' for the population who are consuming alcohol yet 'functioning'. They said there was another opportunity in Primary Care with new GP registrations together with promoting the normalisation of the Audit C screening tool within this setting.

A key gap in current whole system service provision was mental health and the need for greater integration, support and potential co-location of mental health service provision within substance misuse services. The workforce highlighted that currently there is no policy on managing Mental Health and alcohol-the dual diagnosis pathway. The setting up of this would provide greater joint working/management of these two areas. Other gaps identified included meeting the needs of homeless, Black and Minority Ethnic communities better.

In terms of supporting those who are affected by a person's substance use i.e. children and families (otherwise known as "hidden harm") workers suggested several ways to improve outcomes for these groups. They highlighted, there was a need for increased awareness for the whole treatment system (including pharmacies) about Social Service's access routes such as contact information and criteria for referral. The workforce would like to see improvements in multi-agency working, through the strengthening of pathways to family support services e.g. Think Family. In addition, they commented that thresholds for MASH/Safeguarding are unhelpful and more flexibility is required to reduce escalation of need. Having representation within the

MASH, information sharing early and in-house training on 'hidden harm' were suggestions that were highlighted on how drug and alcohol services can improve outcomes for children and families. They also commented that young people's services in Wolverhampton were viewed to be working well but require greater integration with adult services.

7. Stakeholders – What stakeholders told us online and during the stakeholder engagement event

A public consultation was developed for stakeholders which was made available online and circulated widely. 57 responses were received. In addition, a Stakeholder event was held on the 26th April 2017 were 38 attendees were present. We asked stakeholders to tell us how drug and alcohol services might be improved in the new service model. There were several key areas identified by respondents. These are summarised below.

What stakeholders liked about current services:

- The hospital Service and criminal justice service were highly valued and the way they are structured is identified as working well in the hospital and for the police. (As identified by a consultant gastroenterologist and a police officer.)
- 360 were valued because of staff's ability to be understanding, to engage and work and build therapeutic relationships with young people.
- Recovery Near You were praised for non- judgemental staff and an accessible and responsive service.
- The role and value of SUIT was also identified because of its work in service user involvement, helping individuals with wider holistic issues for example housing, benefits, volunteering roles etc. It is seen to be making a practical difference. Valued by service users and stakeholders alike.

Some service user comments about treatment services and their experience of services received:

"Really helpful, good treatment support has helped me to stay abstinent, but continually need after care."

"Staff are very open, understanding and welcoming, listen to problems well and help in any way they can. The support and encouragement you get. Opportunities to engage in new skills and ways of coping. Good advice on healthy lifestyles."

"They are brilliant, they have helped me a lot here. Key worker has helped me to be a good role model for my kids. It was myself who got into this and it's me that's got to get myself out of it."

We asked stakeholders to tell us how drug and alcohol services might be improved in the new service model. There were a number of key areas identified by respondents that could lead to improvements, these are detailed in the table below.

Key themes	Suggestions from stakeholder on how the drug and alcohol service could be improved in the future
The role of Primary Care	GPs could ask improved routine questions about substances in a non-stigmatising way. Questions about substances could form part of other general health assessments /questions.
Collaborative working with Drug and Alcohol Services and Primary Care	There is a need for better joint working between GPs and substance misuse services. Substance misuse services could be based in GP surgeries. Information leaflets could be made available in GP surgeries to raise awareness.
Better pathways from organisations in the community with Drug and alcohol services	Community groups and organisations have a role in sign posting people into services. There needs to be clear pathways between services (the police and A&E) and substance misuse services. Interventions/services could be targeted in locations where there are known problems as identified by housing and the police for example.
Target at risk groups	Interventions could be targeted to at risk groups, such as those who have mental health problems, experience domestic abuse, or are homeless (as they often have associated substance abuse problems) – as a way of identifying and engaging individuals earlier.
Preventative approaches to be adopted	Taking a preventative approach, by taking action in schools, job clubs and through community engagement would negate the need for early intervention.
Greater multi-agency support/collaboration for families	MASH and Strengthening Families were identified as having a role. Discussions about the family should be included in plans. There was a call for more help, support and guidance for parents/carers of substance misusers. Provision of support to parents of adults who misuse substances / better outcomes for children and families
Mental health support	Need for improvements in service delivery. There is a need to address the underlying causes of poor mental wellbeing; as often people are misusing substances as a way of trying to address their problems. Need for closer working (working together) between mental health and other services. Need for more awareness across the

	board for other/all services in their role in offering mental health and well-being support.
Explore opportunities to address substance misuse in the Criminal Justice Sector	Need to address the underlying causes of why people are misusing substances. Need to improve the effectiveness of Alcohol Treatment Requirement/Drug Rehabilitation Requirement Orders. It was identified that the opportunity to help/ support people at caution stage should be taken.
Greater support for vulnerable groups through assertive outreach	Need some form of community based work. "pop up" services in locations/places where there are known issues and concerns with vulnerable groups (such as the homeless). Interventions/services can target groups/sites such as schools, youth clubs/gyms. Voluntary/ community/faith and statutory services/agencies (such as housing) have a role in identifying people who have a problem. There is a need for multi-disciplinary working to support this. More community setting provision, greater assertive outreach.
Training and awareness to organisations to enhance capacity	More training for the general/wider workforce on substance misuse issues. Provision/help also needs to be available through universal services/wider services because of the stigma of substance misuse. Better publicity about services.

8. What service users told us in the service user engagement survey – drop ins

Characteristics of respondents

Drug and alcohol service users had wide age ranges, but predominately 35-54, more male than female, mainly of a white ethnic background, with some from Asian and white and black Caribbean heritage. Just under half said they had a mental or physical health issue.

There were a number of key areas identified by respondents that could be improved in the new service model. These are summarised in the table below.

Key themes	Suggestions from service users on how the drug and alcohol service could be improved in the future
Quicker/easier access to scripts	Currently it can take 4-5 weeks which is too slow to capture the motivation. It was cited as possible in the criminal system and prisons to get the script the same day. More pharmacies dispensing scripts. Option for weekly script not daily.

Mental health support	Mental health is widely recognised as an underlying issuing which needs addressing as well as a holistic approach, which might include counselling. Greater support for mental health issues/emotional support.
More detox/rehab closer to home	Locally accessible service
Current services that are working well	Thornhurst is a good service, staff being friendly, approachable and helpful is appreciated. Drop in and group sessions valued alongside peer support opportunities and breakfast club. Role of SUIT was seen as vital by service users as they provide occupation, direction and wider social support and appreciated as essential recovery support.
Family support	Families need to be included and supported more, both in prevention and treatment
Young people's and family drug and alcohol service to be expanded	Youth offending team, positively and strongly related to 360 service: would like more group sessions, including family. Involving family is cited as important to be addressed in new service.
Service awareness and readiness to change	Those not in services are aware of services and how to contact them: need to be ready to access. There was some vocalisation of wanting to go clean by "do it on your own".
Effective out reach into target populations	This might be achieved by people who previously misused and have been through the journey: empathy but blunt. Improve the offer to homeless services
Focus required to tackle New Psychoactive Substances (NPS) use and alcohol	Greater focus is required for Mamba and alcohol misuse
Greater support in the community	Such as meeting others, keeping busy, employment would enhance living positively in the community.
Improve service access and opening times	Open more hours, particularly evenings and week-ends Appointment reminder system
Location of services	More pharmacies to access scripts. Increased role of GP to aid access. Ensuring the roles of prescriber and keyworker are clear and differentiated

In order to elaborate on the themes collated, below are comments from service users to provide some context specifically around script waiting times;

"If you're offending and committing crimes you can receive treatment very soon, but I have been waiting 5 weeks for my script. When I was in prison, this was instantly in 24 hours as I was a PPO (Prolific, Priority Offender). People do not go to Horizon (RNY) because of the waiting times"

"The induction (re prescribing) when first accessing is a window of opportunity that is being refused (too long 4-5 weeks) for a script. By time they get script the addict loses motivation."

Other service user commented on the importance of education and valued opportunities for service user inclusion regarding service reviews;

"Every couple of months renew what's happening, new drugs coming in, education about these. More reviews in house make sure things are going ok 'on the ground' from service user's point of view, rather than what is planned from the top (managers/keyworkers)."

Other responses were very pragmatic and suggested security in funding of drug and alcohol services alongside extended provision, could lead to service improvement;

"I am not a service user any longer, but to improve an already good service it could be possible, with a reliable source of funding, to extend hours if possible, i.e. weekend."

A number of service users elaborated on the relationship between substance misuse and mental health. They also commented on the challenges of receiving mental health support and opportunities that may exist within the service to receive this help;

"Would like mental health support, have been referred to Healthy Minds but have not rang them. It would be good to have someone to talk to here."

"When people go through drugs, they have experienced an emotional issue. Which has lead them to use. No sensible person wants to destroy their lives. When there is no outlet for emotional problem. The body needs something to eradicate emotional pain 'numb it' "

9. What vulnerable groups who are using substances but not accessing treatment services told us

We interviewed vulnerable people to help us to gain a better understanding of their drug and alcohol use, explore barriers to service access and to identify any behaviour change opportunities. Feedback has been thematically collated below from a range of interviews undertaken at Hope Centre, LGBT services, Changing Lives, P3, 360 Family Event, Refugee and Migrant Centre, YMCA, Central & Eastern

European people focus group, Health Related Behaviour Surveys, New Migrant Young People, Older men's group and rough sleepers. There were several key areas identified by respondents that could be improved in the new service model. These are summarised in the table below.

Key themes	Suggestions from vulnerable groups on how the drug and alcohol service could be improved in the future
Mental health support and awareness and its association to drug and alcohol misuse	Improve strategies to tackle long and short term mental health in populations. Strategies identified include; challenging the stigma of speaking up about mental health issues, improve access to counselling - individual mainly and in groups (LGBT group suggestion), young person counselling (Base 25) workshops/training, mentoring support – to be motivational and reflective, telephone support, support network 'meet ups'. Improve awareness of the link between Drug and Alcohol combined with help seeking (find "the root causes"). Targeted mental health support to vulnerable groups through better partnerships with specialist organisations. addressing issues of isolation, lack of familial support, 'coming out' (LGBT) bullying, early intervention - suicide risk. Migrant communities - impact of shame related to alcohol problems e.g. in Lithuania presents a real barrier to seeking help
Criminal justice interventions to prepare for detox in the wider community and in custody	Early intervention and prevention initiatives to reduce offending rates. Alternatives to criminal sanctions for heroin addicts – specialist support centres to reduce crime. Greater support in prisons for preparation to stay clean following release. Support for vulnerable families – break cycle of generational damage of substance misuse and crime. Holistic support to be provided through probation and mental health services. Person centred, more intense supervision for those deemed to be highly vulnerable.
Enhance drug and alcohol outreach including education	Vulnerable groups, who are homeless, sex working, from migrant communities together with those from closed communities to provide 'proactive outreach' to overcome barriers to access. Education and awareness on the risk of specific substance misuse in those groups e.g. NPS, Mamba risk and consequences with homeless groups. Chemsex, legal issues, harm reduction education to LGBT groups. NPS is a growing issue, the future provider needs to better understand the implications and response to this issue.

	A potential outreach route, suggested by rough sleepers would be by people who have been through the same journey and come out the other side, providing information that is blunt about the impact but caring. Wider support, employment, housing and psychiatrist would enable users not in service to live more positively in the community.
Challenge barriers to service access with vulnerable groups	Challenging barriers to service access in promotional material to improve service uptake from vulnerable groups (confidentiality, shame, labelling, 'being fobbed off', embarrassment, fear, judgement). Many see "stigma" as a real barrier to accessing services, along with just not being ready (rough sleepers). Greater recovery clinics in GP surgeries and community outreach. Improve awareness of services specifically vulnerable groups and families e.g. through advertising in 'high risk' areas, use of community advocates. Visible promotion of support channels, including social media use. Publicity materials in different languages as low awareness of service from migrant communities apart from GP. Promoting these services within new communities. Making it clear that the service is free. Making use of Lithuanian and Polish social media in the West Midlands to get messages out. Explore option for online self-referral and support into alcohol services.
Enhance workforce capacity	Enhance workforce capacity: through the use of a co-ordinated volunteer programme; investment in well trained, professional dedicated staff e.g. trained to provide therapeutic family support, use of interpreters. Training to wider organisations on drug and alcohol issues to maximise resources and to provide holistic support e.g. hostel staff
Better out of hour's provision and aftercare	Telephone helpline offering brief interventions to combat triggers available in the evenings and Sundays. Evening appointment for those who are working. Aftercare service to support individuals and families: to 'stay clean' offering somewhere to go to continue to build resilience and to avoid relapse.
Enhance family support including raising awareness of the impact of drug and alcohol misuse on children and families	Work with the whole family to seek improvement and support change including resources to enable therapeutic family support. Raise awareness of the impact of drug and alcohol use on children and families – due to limited knowledge on long term impact (user perspective) and lack of understanding to support user (for families).

	Greater opportunities for outings and children's activities to build resilience and social support networks. Greater promotion of drug and alcohol services for families, as limited awareness of services that are available for families.
Focus on prevention and early intervention	School liaison: improve information sharing as schools often have concerns regarding children and parents who are at risk. More educational awareness of the impact of drugs and alcohol, especially in schools. Health promotion targeted at pupils from New Migrant communities – development of resources to tackle smoking and e-cigarettes although resources for alcohol, illegal substances would also be relevant. Offering smoking cessation services within secondary schools with a high proportion of pupils from new migrant communities. Early intervention through GPs, Family support, Social Services, SUIT, Hope Centre. Online platforms for education for specific groups e.g. LGBT chat rooms, grinder sites. For older men's group misuse is conceived as problematic when it's reached extremes, life taken over, no money and physical decline - opportunity for awareness raising by services to focus on earlier symptoms. Rough Sleepers described addiction as "a love-hate" relationship with some giving extreme scenarios of when it becomes problematic, there is some recognition of it becoming problematic as a gradual process - consumption slowly creeping up or where others 'tell you it's a problem'. These could be insight moments for raising awareness and indicates who Identification and Brief Advice (IBA) might impact.
Protective strategies and interventions to intercept cycle of substance misuse	Interventions specifically intercepting cycle of misuse/abuse in families. Support from services to implement protective strategies: facilitate access to positive social support networks, employment, SUIT, community groups – Changing Lives, Hope, housing related support, hobbies, more mental health support, sport or recreational activity to divert energy and attention into a positive route to support recovery and mental health. Older men's group, these respondents are all aware of services and have used them in the past. They see their lives as "lost" or unsalvageable and only an extreme event would galvanise them to seek help, some suggestions about living positively were more options to meet others and keep busy.

Greater use of behaviour change strategies	Self-help strategies: to be explored and promoted alongside treatment. Increase sense of control over drug and alcohol use. Rough sleepers were aware of services, which some were engaged with whereas others want to do it on their own. Support which can be given to aid self-attempt, would be useful. Detox programmes. Relapse prevention: Recovering addict's opportunities to access to gym facilities e.g. WV Active, sport as part of recovery. Recovering users to be used as mentors for others entering the system. The mentoring route to be formalised with training and recognition. Use of marketing campaigns: Highlight loss of time (LGBT groups) Loss of money, the effect of alcohol on your health, the effect of alcohol on your family or your ability to work acted as motivators to change (migrant communities and others). Making use of Lithuanian celebrity footage where they talk about giving up drinking and the benefits etc. Developing some life stories from within the Polish and other communities of people who have given up drinking. Polish alcoholics anonymous group.
Tackling environmental and social influences of drug and alcohol misuse	Address wide availability of drugs in Wolverhampton Drinking norms and social pressure to drink to be challenged and ease of availability. More activities for those who have little to do, unemployed or young people in some communities, who drink because they are bored. Environmental improvement, involving the Police, less tolerance in areas known to be a problem, such as the Avion Centre.

The semi-structured interviews with vulnerable groups provided a wealth of information, below are some comments from some of the most vulnerable individuals, who took part in our engagement. One individual shared his beliefs of substance using, providing some awareness into the challenges for services due to the perceived benefits to him;

"I did change my drug use with the crack, I will never stop weed, it calms me down (costs me a lot though). It's a natural herb, unlike some of the other stuff that's out there"

In regards to gaining insights from this group on how services could reach out to those who have not used drug or alcohol services before, a number of service users commented on how this might be achieved and who they would be receptive to;

"Go out be blatant with them about side effects of drugs and alcohol misuse as most don't know. Get ex users to give advice because they have more chance of listening to them."

Individuals were asked to consider where drug and alcohol services have not been accessed, what would help them to live more positively in the community, responses ranged from specialist support to meeting basic living and working needs;

"They need drugs and alcohol because they can help you cope. Talk to psychiatrist worker (not drug worker) who are fully trained to talk about/get to bottom of problems. Because without 'self-power' mental strength won't change"

"I would like somewhere to live and a purpose for living – housing, car, e.g. work"

10. What stakeholders including professionals and the public told us on the on-line consultation survey

The engagement activities and the feedback collated together with information received from a variety of methods, namely: data from the needs assessment, learning from evidence reviews, current best practice and guidelines and service performance data was used to set out a framework for a revised service model. The following consultation provided an opportunity to gain people's views and further develop the detail.

Taking into consideration the financial limitations the future Drug and Alcohol service will be subject to, there was a need to prioritise what the service's core offer should be. Therefore, we asked people to consider the aspects of the service which they value the most and feedback accordingly. The information received during the consultation process is highlighted below and will be used to prioritise service resources.

Characteristics of respondents

46 people from a variety of backgrounds responded to the consultation survey. 20% classified themselves as 'members of the general public', 16% were professionals who work in a Health or Social Care organisations who help people with drug or alcohol services, 18% were respondents from an organisation who provides drug or alcohol services. Most of the respondents to the survey approximately a third (33%) responded to the 'other' category and this group consisted of Shared Care GP's, West Midlands Police Criminal Justice Services, member of an organisation that works with people accessing drug & alcohol provision, Strengthening Families Worker, Housing provider workers, Pupil Referral Unit, Partner Agency, Ex addict working with vulnerable adults, A City of Wolverhampton Council employee, Provider Company for Community Pharmacies and a Youth offending team worker. Second

largest category was ‘general public’, closely followed by the third largest category of respondents ‘drug or alcohol services’.

Views regarding future Drug and Alcohol services

We asked stakeholders to consider and agree on the integral features of the future drug and alcohol system. Respondents to the survey ranked their preferences in order, acknowledging the challenges of this task as many components interconnect with others:

- Adults drug and alcohol recovery harm reduction, specialist treatment, criminal justice interventions, peer support, mentoring, mutual aid, improvements in mental and physical health, housing and employment stability. This category came out the highest with over half of respondents (58.06 %) ranking this as ‘1’ the most important element to be included.

- Young Persons Substance Misuse Harm reduction, targeted interventions, specialist treatment, transitional support, support for those in Youth Offending System scored the second highest category in the survey with 38.71% of respondents scoring this as ‘2’ an important feature of the drug and alcohol system.

- Prevention & Early Intervention Training, educational sessions, screening, signposting, making every contact count-MECC, community outreach, assertive engagement and Service User Involvement was the collective third choice.

- Advocacy Service User, Family and Carer Engagement and Involvement, holistic support - housing, finance and education/training/employment, building and supporting the recovery community was the fourth most important component of the drug and alcohol system.

- Family Support Think Family whole family approach, Adult safeguarding, Children and young people safeguarding, parenting support, school liaison, domestic abuse support was classified in the list as the fifth most important.

Summary of qualitative responses for this question:

Key themes	Further information provided by stakeholders
Difficulty in categorising due to interconnected nature of areas	A significant number of people commented on this theme. It was very hard to rank these as they are all viewed integral to an integrated treatment system. They are all integral to each other with a domino effect of one leading to the success of

	another. Consideration also into existing available provision and professional responsibility e.g. safeguarding. Recognition of need at a preventative level to reduce future demand on services as well as dealing with current level of need in the user population.
Early intervention / prevention in community	This theme was considered to be vital by a number of respondents. Especially for alcohol higher priority provided here, tailoring early interventions for alcohol provision and suitability for offenders. Utilisation of other services for early intervention messages through a staged strategy to improve awareness and create a multi-faceted approach.
Individualised/tailored approaches	Each case is individual and care should be tailored to different needs. Enforced abstinence should be replaced by harm reduction and a holistic approach to meeting the needs of those affected by addiction and their loved ones.
Current services that are working well	Hospital service is well used and provides continuity with community services, with one person commenting that it is vital that this continues
Stability in working environment	One person commented on the need for a stable working environment as essential to support drug and alcohol users.

We asked stakeholders to take into account what we know about people who misuse substances in the City and our current services and narrowing this further what we think the key components of a new system might include:

- The component that ranked highest with a score of ‘1’ (most important) was Prevention and Early Identification Education, Training, Screening, Identification and Brief Advice (IBA) with 36.67% of the responses.
- The second highest scoring component was, Harm Reduction Delivering a full range of harm reduction interventions aimed at reducing the physical risks associated with substance misuse with a score of ‘1’ (26.67%)
- Joint third highest ranking components were: Community Outreach/assertive engagement-to actively identify, engage and support people to enter recovery services and Pharmacological Interventions Delivery of a full range of pharmacological interventions including prescribing for withdrawal, stabilisation, reduction and detoxification.
- The fourth most important ranked area was Criminal Justice Interventions Ensuring the full range of community intervention is proactively offered to

criminal justice clients at each stage of the criminal justice pathway (i.e. point of arrest, court, probation, prison release)

- Finally, Access to Residential Services Assessment for residential treatment provision and subsequent care co-ordination both prior and post interventions was the component that scored the highest for least important component in the new Drug and Alcohol system.

Summary of qualitative responses for this question:

Key themes	Further information provided by stakeholders
Difficulty in categorising due to interconnected nature of areas	Again, really difficult as priorities would be different for young people. Almost impossible to rank these in importance as all link together - or should link together. All of these factors are interlinked and any well designed and delivered holistic service should address all of these domains in an equivalent and effective way.
Whole approach needs consideration	This is something that needs to be looked at as a whole approach, as many areas will overlap; therefore, priorities may naturally change. A risk indicator would need to be determined at project development stage.
Early intervention for alcohol issues	Please consider meaningful interventions for people who are just starting to get into trouble through alcohol

Taking into account what we know about service demand and feedback from the engagement process – support to families has been highlighted as a crucial intervention. We asked stakeholders whether there should be an emphasis on supporting the needs of the family.

The majority of respondents (89.66) agreed with this question. This would appear to contradict the lower ranking placing on this section in the earlier categories, demonstrating the complexity/difficulty in ranking. A summary of respondents reasons for agreeing with this statement is described below.

- **Family and their specific role in recovery:** Families are an integral part of recovery and an individual's support network. Particularly with Young People's service, families play a significant role in recovery. If family have support they will be able to support the individual when services are closed.

- **Support offered to family's better connection to services:** Family members (where feasible) should not only be involved in the treatment journeys of their loved ones, but should also have access to various support to meet their needs. It has such a wide impact - especially on children. Users

create a cycle of misuse and abuse. Partners and children should be supported to reduce the harm on the family. Links to family programmes within the city should be well defined - Stronger Families / Family Matters etc.

- **Families not always ready/available to support:** It must also be recognised that families are not always ready to support / available or a positive influence. Some people have no family support at all. For young people this was deemed to be particularly important, however vulnerabilities were also shared about older users who are more likely to be disconnected with their family. Therefore, the importance for them to create new support networks is vital.

- **Families role in relapse prevention:** As each client has individual needs, person-centred therapy and support is core to success. However, it was highlighted that families should be included in the process as much as possible, including therapy and support, to prevent relapse and raise awareness.

- **Damaging consequence on mental health and family life:** Respondents commented that substance misuse affects the whole family and can have an adverse psychological effect on those growing up in such an environment. This can be portrayed as "normal." The family are at risk of dangerous behaviour from the substance user, which can put them at risk.

  Financial challenges of supporting the family v's the user: One respondent agreed with supporting families but not at the cost of reducing existing elements of service and therefore, dealing with the client will have to take precedence from a funding perspective.

What stakeholders told us in terms of individual and family outcomes that the system needs to deliver.

All those who answered this question agreed with outcome 1- that successful completion of drug and alcohol treatment should be a key outcome that the new system would need to deliver. The majority (94.44%) agreed that Reducing Alcohol-related mortality rates and admissions to hospital (outcome 2), identifying people entering prison with substance dependence issues who are previously not known to community treatment and engaging them in treatment (outcome 3) and Reducing the number of drug related deaths (outcome 4) at 94.44% were all very important outcomes for the new system.

Summarised below:

Respondents ranking	Individual and Family Outcome Priorities

1.	Successful completion of drug and alcohol treatment
2.	Reducing Alcohol-related mortality rates and admissions to hospital
3.	Identifying people entering prison with substance dependence issues who are previously not known to community treatment and engaging them in treatment
4.	Reducing the number of drug related deaths
5.	Life expectancy and healthy life expectancy
6.	Premature death rates from disease considered preventable, including cardiovascular diseases, cancers, respiratory disease and liver disease
7.	Statutory homelessness
8.	Domestic abuse and violent crime
9.	Re-offending
10.	Self-reported wellbeing

Stakeholders identified several additional outcomes for consideration:

- **Reduce alcohol rates and alcohol-related death:** Reduce alcohol use rates. Increase alcohol numbers in treatment, alcohol successful completions, alcohol related mortality.
- **Mental Health and Wellbeing score:** Feeling that quality of life has improved, Self-reported wellbeing. Improved health (reduced hospital admissions). Feeling that relationships have improved. Overall satisfaction with service, mental health support
- **Prevention indicators:** Reduction of young people transitioning to adults as users, early intervention for relapse. BBV screening. Educating young people on addiction.
- **Child safety/ Decrease in safeguarding concerns:** Keeping children safe (safeguarding/hidden harm) Less children put into care due to parental misuse, but only if safe to do so.
- **Decreased drug/alcohol related crime:** (and criminal justice involvement) reductions in prison substance misusers, reduction in violent crime and domestic abuse, identifying people entering prison with substance dependence issues. Reduction in reoffending. Identifying people entering prison with substance dependence issues who are previously not known to community treatment and engaging them in treatment.
- **Engagement in work and accessing support services:** Engagement with support services. Getting people back into work and not reliant on benefits.
- **Family support:** Reduced involvement with social / children services
- **Service access and Aftercare:** Services to be accessible weekends and evenings. Supporting people after addiction, continuation of care post treatment, promoting reintegration and citizenship, supported access to wrap

around services to address additional needs, connecting people to their communities. Long term peer support to ensure sustained recovery.

- **Reducing homelessness:** Reducing homelessness and statutory homelessness, getting homeless people into accommodation. Sustained accommodation, Improved housing.

11. Next Steps

The new service model framework has been produced. Wherever possible the views from our stakeholders during this consultation period have been considered and taken into account. The next steps during this process are to:

- Develop service specification and model in line with findings from stakeholder consultation.
- Commence tendering process on 1 September 2017 in order for the new service to begin on 1 April 2018.

Acknowledgements

We would like to extend our thanks to all those professionals, adults, parents and young people who shared their views during the consultation process. Thank you also to all the staff and partner agencies that supported our engagement and consultation process.

GLOSSARY

Harm reduction

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use.

Needle exchange

A service through which users of intravenous drugs can dispose of used needles and obtain clean ones in order to reduce the transmission of blood-borne infections.

Supervised consumption

Supervised consumption is the supervision of self-administration of prescribed methadone or buprenorphine (also known as 'diversional opioids') in daily instalment doses by a trusted professional, due to the risks associated with these drugs.

Recovery

Recovery is the act or process of becoming healthy after an illness or injury, or the act or process of returning to a normal state after a period of difficulty

Early intervention

Early intervention is about taking action as soon as possible to tackle problems before they become more difficult to reverse.

Prevention

The action of stopping something from happening or arising.

New Psychoactive substances (NPS)

New psychoactive substances – often incorrectly called legal highs – contain one or more chemical substances which were designed to replicate the effects of illegal substances like cannabis, cocaine and ecstasy. The main effects of almost all psychoactive drugs, can be described using four main categories: stimulants, ‘downers’ or sedatives, psychedelics or hallucinogens and synthetic cannabinoids.

LGBT

LGBT is an abbreviation for Lesbian, Gay, Bisexual, and Transgender. An umbrella term that is used to refer to the community as a whole.

Shared Care/Shared care GP

Shared Care is where specialist GPs pick up the prescribing and monitoring of medicines/treatments of regular long term prescriptions for stable patients on behalf of the treatment service.

Mutual Aid

Mutual aid is a voluntary reciprocal exchange of resources and services for mutual benefit

Self-help/Self-help groups

Self-help consists of doing things yourself to try and solve your own problems without depending on other people.

Self-help consists of people providing support and help for each other in an informal way, rather than relying on the government, authorities, or other official organisations.

Think Family Services

A whole family intervention. This means thinking about the child, the parent and the family, with adult and children's health and social care services working together to consider the needs of the individual in the context of their relationships and their environment.

Prime provider

A prime provider is the owner of the contract. They have the full responsibility for the completion of a contract, and have the direct contractual relationship with the commissioner. A prime provider may employ (and manage) one or more subcontractors to carry out specific parts of the contract.

Pharmacological interventions

These are substance misuse specific pharmacological interventions which include prescribing for detoxification, stabilisation and symptomatic relief of substance misuse as well as prescribing of medications to prevent relapse.

Psychosocial interventions

One-to-one and group sessions-based on counselling techniques to promote health behaviour change.

Criminal Justice interventions

A number of programmes and processes designed to engage offenders in relevant and effective treatment at every stage of the criminal justice system, including prisons.

Outreach

Outreach is an activity of providing services to any populations who might not otherwise have access to those services, meeting those in need of outreach services at the locations where those in need are.

Chemsex

Sexual activity engaged in while under the influence of stimulant drugs such as methamphetamine or mephedrone, typically involving several participants.

Brief Intervention

Either a short session of structured brief advice or a longer, more motivationally-based session (that is, an extended brief intervention). Both aim to help someone reduce their drug use and can be carried out by non-drug specialists.

Making every contact count (MECC)

MECC is an approach to behaviour change that utilises the millions of day to day interactions that organisations and people have with other people to encourage changes in behaviour that have a positive effect on the health and wellbeing of individuals, communities and populations.

Agenda Item No: 8

NHS Wolverhampton Clinical Commissioning Group

Health Scrutiny Panel

5 October 2017

Report title	Wolverhampton Integrated End of Life Care Strategy - update
Report of:	Karen Evans, Wolverhampton CCG
Portfolio	Public Health and Wellbeing

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

1. Comment and direct on any actions required in the further implementation of the Wolverhampton Integrated End of Life Care Strategy

1.0 Introduction

1.1 For the Health Scrutiny Panel to receive an update on the progress to date of the implementation of the Wolverhampton Integrated End of Life Care Strategy.

1.2 The strategy was published in October 2016.

2.0 Background

2.1 Wolverhampton's integrated End of Life Care Strategy was published in October 2016 with six key elements:

- Early identification of the dying person to ensure patients are receiving appropriate care
- Advance care planning to facilitate the persons needs and wishes
- Coordinated care to ensure people don't fall through gaps
- Optimum symptom control based on clinical need
- Choice to support preferred place of care and death
- Workforce fit for purpose

2.2 The implementation of each of these elements will ensure that every person approaching end of life will receive person centred, holistic care.

2.3 The Government published its response to the review of choice at end of life '**Our Commitment to you for end of life care**' in July 2016 in which they state:

"*Our commitment to you is that, as you approach the end of life, you should be given the opportunity and support to*:

- *have **honest discussions** about your needs and preferences for your **physical**, **mental and spiritual wellbeing**, so that you can **live well until you die**;*
- *make **informed choices** about your care, supported by **clear and accessible** published **information** on quality and choice in end of life care; this includes listening to the voices of children and young people about their own needs in end of life care, and not just the voices of their carers, parents and families;*
- *develop and document a **personalised care plan**, based on what matters to you and **your needs and preferences**, including any advance decisions and your views about where you want to be cared for and where you want to die, and to review and revise this plan throughout the duration of your illness;*
- *share your personalised care plan with your care professionals, enabling them to take account of your wishes and choices in the care and support they provide, and be able to provide feedback to improve care;*
- ***involve**, to the extent that you wish, your family, carers and those important to you in discussions about, and the delivery of, your care, and to give them the opportunity to provide feedback about your care;*
- ***know who to contact** if you need help and advice at any time, helping to ensure that your personalised care is delivered in a seamless way*.

In making this Commitment, we are sending out the message that high quality personalised care has to be universal. We are determined to end variation in care due to geography, age, diagnosis, background or means. This is a national commitment to high quality care for all".

2.4 Wolverhampton End of Life Care Strategy aligns with and will deliver the Government's commitment.

3.0 Progress

3.1 Since the publication of the strategy great progress has been made with its implementation.

3.2 The Wolverhampton Clinical Commissioning Group (CCG) lead for end of life care has developed a business case for transformation of current end of life care services. This business case is currently going through CCG governance processes for approval.

The business case details the requirement for a transformation of current services to a whole pathway, coordinated approach across the City.

3.3 To ensure earlier identification of the dying person, the CCG has funded an enhanced Primary Care service that will see each GP:

1. Identify people approaching end of life earlier in their disease trajectory
2. Ensure they are placed on the EoL register
3. Establish regular multi-disciplinary team meetings with appropriate professionals to ensure the person has the correct care package based on their care plans

3.4 The CCG has worked in partnership with all stakeholders to develop and pilot a more person centred Advance Care Plan. The plan has been piloted in a number of care homes across the City with initial findings of residents having valued the opportunity to complete it. Following completion of the pilot, we have met with stakeholders (Compton Hospice and Royal Wolverhampton Trust) to agree the roll out of the new document across the pathway.

3.5 As part of the Black Country Digital Roadmap work, the CCG has been successful in obtaining funding to implement an electronic shared care record for end of life care. A steering group has been established with representation from a range of stakeholders including the ambulance service and the out of hour's service. It is hoped that this system will be operational at the end of 2017 or early 2018.

3.6 The CCG has been successful in their bid to be part of the Point of Care Foundation programme for 2017 'Living well to the very end'. We have decided to focus on care homes to improve end of life care in that sector. We have partnered with City of Wolverhampton Council for one element of this project namely the implementation of the 'red bag' initiative proven by one of the End of Life care Vanguards.

The project will also provide education and training on building confidence in staff to care for these residents at the end of their lives and improving skills in how to start and continue difficult conversations. A further element will be resident and staff 'shadowing' to gain further insight into the experience of both groups. This information will be used to formulate a plan to improve experience of both groups for end of life care.

3.7 Our local Hospice has been successful in obtaining funding to build a new Care Coordination Centre beginning in April 2018. Very early discussions are taking place to determine what role this may have in the new pathways.

3.8 The CCG has negotiated a service development improvement programme to improve coding of patients at end of life in the community. The CCG are working with the District Nurses to implement the national coding system 'palliative care currency'. Early indications are showing that this is a significant shift in the way they normally code their activity and further training and education is required to embed this new way of working. This work will help to model activity and demand.

4.0 Next Steps

4.1 Seek approval for the End of Life care business case from CCG Governing body and design new model – December 2017 – January 2018

4.2 Roll out new person centred Advance Care Plan – December 2017 – March 2018

4.3 Continue to work with EoL electronic shared care record steering group to implement a local system – December 2017 – April 2018

4.4 Continue to work with care home sector to implement red bags and improve training and education – November 2017 – August 2018

5.0 Impact on Health and Wellbeing Strategy Board Priorities

Which of the following top five priorities identified by the Health and Wellbeing Board will this report contribute towards achieving?

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

6.0 Decision/Supporting Information (including options)

Not applicable

7.0 Implications

Please detail any known implications in relation to this report:

- Financial implications N/A
- Legal implications N/A
- Equalities implications N/A
- Environmental implications N/A
- Human resources implications – There will be a requirement for the current workforce to work differently in a number of areas to realise a whole system approach.
- Corporate landlord implications N/A
- Risks N/A

8.0 Schedule of background papers

8.1 The background papers (End of Life care Strategy) relating to this report can be inspected by clicking the following link or contacting the report writer:

Wolverhampton CCG
Wolverhampton Science Park,
Glaisher Drive,
Wolverhampton,
WV10 9RU
Karen.evans35@nhs.net
T: 01902 446034

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Agenda Item No: 9

Health Scrutiny Panel

5 October 2017

NHS Walsall Clinical Commissioning Group

Report title **Consultation on changes to hospital stroke services**

Report of: **Dave Whatton**
Senior Commissioning Manager
Walsall Clinical Commissioning Group
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Bloxwich Lane
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Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

1. Agree for the Chair and Vice Chair to consider panel member comments when drafting a response to the consultation document on proposed changes to hospital stroke services.

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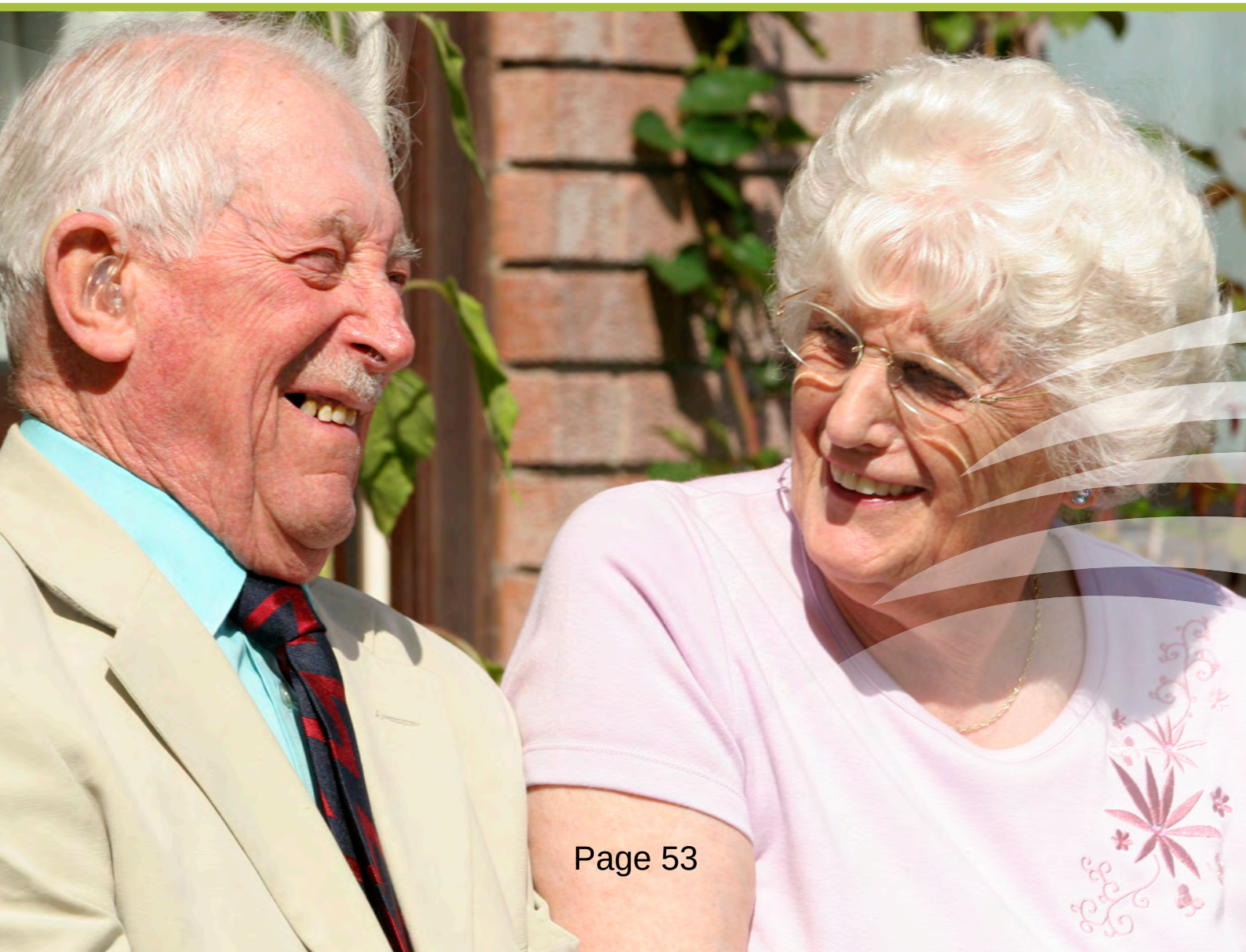
NHS
Walsall
Clinical Commissioning Group

Consultation on changes to hospital stroke services

Engaging with you

14 August to 22 September 2017



Contents

About this document

This document tells you about the way stroke services are managed in Walsall at the moment, and sets out a proposal for making changes and the reasons for those changes.

It also asks you what you think of those changes and what should be considered when making them.

Please look through these pages and answer the short questionnaire at the end. Your answers and your opinions count.

They will be used by Walsall CCG to help make the decisions about future stroke services in the area.

We can provide other versions of this document such as easy read, braille or other languages. Please email **getinvolved@walsallccg.nhs.uk** or call **01922 618388.**

Foreword

Stroke is a serious, life-threatening medical condition that occurs when the blood supply to part of the brain is cut off, due to a bleed or a blood vessel being blocked.

Whilst largely preventable, stroke is one of the main causes of deaths in the UK and is also the leading cause of adult disability. In Walsall almost 400 people had a stroke and were taken to Walsall Manor in 2015/16. Strokes are medical emergencies and urgent treatment in the first 72 hours is essential because the sooner a person receives an effective diagnosis and treatment for a stroke, the less damage is likely to occur.

Current stroke services in Walsall have developed over time as a result of localised planning. An audit of the stroke services in 2015/16 by the Sentinel Stroke National Audit Programme (SSNAP) identified that whilst stroke services provided by Walsall Healthcare Trust overall rated as 'good' (and 'improving' over the previous two years), they achieved low scores in two areas. When compared with national quality standards, they would struggle to meet the new standards for 24 hour, 7 day a week consultant cover and access to diagnostics.

While improvements in care have been made, further work is required to meet the national and regional specifications, so more patients survive their stroke, and stroke survivors can achieve their best level of recovery.

NHS Walsall CCG has been listening to the views of patients, the public and our leading clinicians, to evolve our initial scenarios to strengthen and pool the local good practice for those people who have suffered a stroke or a mini-stroke. This approach is in line with other national approaches already in operation across the country, these revised arrangements are demonstrating a reduction in mortality and improved survival rates for patients who stroke.

The CCG, in collaboration with the Royal Wolverhampton Hospital Trust and Walsall Healthcare Trust, is considering placing the acute part of the stroke pathway with The Royal Wolverhampton Trust and the early supported discharge and community rehabilitation with Walsall Healthcare Trust.

At the moment no decisions have been made about changing services, but the CCG has a preferred option to centralise hyper-acute and acute stroke services, which we feel would give Walsall patients the greatest chance of a good quality of life after their stroke. This isn't about saving money, but it is about providing better patient care and better quality of life for local people after they have had a stroke or mini-stroke.

We are inviting you to take part in our survey and upcoming events about this preferred option. We believe there is compelling evidence for change, and we would like your thoughts and feedback on the proposed changes.

Please take a while to read this report and answer the questions at the back. Your responses could help make a difference to the care of future stroke patients and the quality of life of stroke survivors.

Thank you.

Sally Roberts, Chief Nurse, Director of Quality
Walsall Clinical Commissioning Group

Who we are

We are NHS Walsall Clinical Commissioning Group (CCG). We are leading the consultation across Walsall. The CCG is overseen by NHS England and plans and pays for many major NHS healthcare services across the area.

The key partners involved in this review of local stroke services are:

- Walsall Healthcare Trust
- The Royal Wolverhampton Hospital Trust
- Healthwatch Walsall
- West Midlands Clinical Senate
- Walsall Overview and Scrutiny Committee

Glossary

Acute Stroke Unit (ASU) - Specialist stroke services provided from a main hospital. Patients are treated here after the initial few days of having a stroke and after having been in a Hyper-Acute Stroke Unit. 'Mini strokes' or TIAs are also treated here.

Rehabilitation services - services which could be provided from a hospital bed or at home to support stroke survivors regain their health following a stroke and may include a package of care such as physiotherapy and speech therapy.

Thrombolysis - a procedure to dissolve dangerous clots in blood vessels, improving blood flow and preventing damage to tissues and organs.

Transient ischaemic attack (TIA) - known as a 'mini-stroke' and lasts for a short time and any blockage to the brain is temporary with the blood supply returning to normal and symptoms disappearing.

Stroke and stroke care

A stroke is a rapid loss of brain function that occurs when the blood supply to part of the brain is cut off, leading to brain cells either being damaged or destroyed.
There are two types of stroke:

1. An **ischaemic** stroke resulting from a blockage in one of the blood vessels leading to the brain
2. A **haemorrhagic** stroke resulting from a bleed in the brain.

A transient ischaemic attack or 'mini-stroke' is a sign that a person is at risk of going on to have a full stroke.

Access to the right stroke care at the right time not only helps to reduce death rates, it also improves the resulting condition for the two thirds of patients who survive a stroke, leading to a reduced risk of disability.

What are hyper acute stroke services or units (HASUs)?

Hyper acute stroke services or units (HASUs) are units where you are cared for up to the first 72 hours (or sooner if medically stable) after having a stroke when you need more specialist 'critical' care.

They are **not:**

- **'Acute stroke' units/wards** - which is where you are cared for after the first 72 hours of having a stroke until you are ready to go home from hospital.

- **Rehabilitation services**, such as speech and language and physiotherapies, which help you get better once you've gone home from the hospital

Current local stroke services

Current stroke services in Walsall have developed over time as a result of localised planning, and are as follows:

Manor Hospital - Walsall Healthcare Trust

Based at the Manor Hospital.

The service has treated **375** stroke patients in 2015/16.

Acute Stroke Unit / In-patient rehabilitation with **28** beds

Treatment for TIAs 24/7.

New Cross Hospital - The Royal Wolverhampton Hospital Trust

The Hyper-Acute Stroke and Acute Unit and the Stroke 'step-down' Unit are at New Cross Hospital.

21 Acute Stroke Unit beds

Treatment for TIAs 24/7

Inpatient rehabilitation of **20** beds

Outreach rehabilitation in patients' homes (Wolverhampton patients only).

The current service in Walsall was rated as 'good' in 2015/16 and 'improving' over the previous two years.

Patients may be moved through the stroke services system for diagnosis and treatment in a variety of ways, depending on where they were first taken ill.

Patients sometimes have to be transferred between hospitals in the early stages of their stroke for specialist treatment.

Patients can sometimes stay longer in a hospital than they are required to do so, when care delivered in the community, either through a defined community stroke bed or at home with support is a more preferred option.

What are we proposing to change and where?

We have worked with clinicians, patients and the public to develop a proposal to improve local stroke services. The aim is to ensure that there is a consistent level of service for all residents in Walsall. We now want your views on that proposal.

The proposal we would like your views on:

If you live in Walsall and have a stroke, you would receive hyper acute stroke care at The Royal Wolverhampton Hospitals Trust with stroke rehabilitation provided in Walsall and closer to home.

All stroke patients across Walsall would go to the Hyper-Acute and Acute Stroke Unit at New Cross Hospital in Wolverhampton. They would be diagnosed and treated there until they are ready for discharge and rehabilitation closer to home, either in a community bed or in their own home with clinical support.

The Acute Stroke Units currently at Manor Hospital in Walsall would no longer operate as all patients would be treated in one specialist centre.

However, community-based rehabilitation beds would be available in Walsall, and would be clinically overseen by Walsall Healthcare Trust at Manor Hospital. Rehabilitation would take place over an average period of six weeks but this could be shorter or longer, depending on the patient and would be determined by the treating consultant.

New treatment regimes for stroke patients, for example thrombectomy, would be supported by the Royal Wolverhampton Hospital, but will mean patients follow a defined clinical pathway and this may include treatment at a very specialist hospital.

Overall, this new model would provide a 'Centre of Excellence' for patients in the whole of the Walsall area, meaning that all stroke patients would receive the same level of specialist care in hospital, and the same level of rehabilitation, as near to their homes as possible. All the hospitals, community beds and care in people's homes would have their part to play in providing this 'Centre of Excellence'.

What would future local stroke services look like?

Manor Hospital - Walsall Healthcare Trust

The proposal would be close to the current stroke services based at the Manor Hospital.

In-patient rehabilitation with up to **18** beds (N.B. some of these beds may be in a community setting)

Community stroke rehabilitation at home or community bed.

New Cross Hospital - The Royal Wolverhampton Hospital Trust

All stroke patients would be directed to the Hyper-Acute Stroke and Acute Unit, then repatriated to Walsall for Community stroke services.

39 Acute Stroke Unit beds

Treatment for TIAs 24/7.

Why do we want to improve these services?

The Walsall Manor hyper acute stroke units (HASUs) admit less than 400 patients a year (375 in 2015/16). This is below the national best practice minimum of 600, meaning stroke doctors and nurses in some of our units risk becoming deskilled, which in turn would mean you may not get the best possible or safest care in the future.

We need more stroke doctors and nurses to run the existing services but there are not enough locally and nationally. This means there are problems with medical cover in our local hospitals and we have already seen temporary closures of some of our services because there are not enough doctors or nurses available.

Over the last few years, the NHS has been making improvements in stroke care as increasing evidence has been building about what and how the most effective diagnosis and treatment can be achieved.

National best practice

Evidence shows that patients are 25% more likely to survive or recover from a stroke if treated in a specialist centre. Patients need fast access to high-quality scanning facilities in order to diagnose the type of stroke, and assess those who are suitable for thrombolysis and those who would benefit from other treatments.

According to the National Stroke Strategy, key changes in stroke care have contributed to a reduction in the chances of a patient dying within 10 years of having a stroke, from a 71% chance in 2006 to a 67% chance in 2010.

For example, based on the National Stroke Strategy, the London Stroke Model was developed to look at care throughout the stroke service, including the establishment of Hyper-Acute Stroke Units (HASUs), with the treatment of patients taking place in fewer specialist HASUs, Acute Stroke Units (ASUs), and being provided with improved Early Supported Discharge. This reduction is largely due to improved co-ordination in stroke care, more patients receiving clot removing thrombolysis when needed, and more patients receiving scans within 24 hours of admission to hospital, so that the optimum treatment and care can start as soon as possible. This approach will be supported through the Royal Wolverhampton and Walsall combined model.

Regional Stroke Specification

Some useful work has been done regionally on designing just such a model of stroke care. It is called the Midlands and East Stroke Specification. Our proposal is based on this model which can be summarised as follows:

Hyper-Acute Care

(the first 3 days following a stroke)

All patients with a suspected stroke should be admitted to a hospital with a Hyper-Acute service to be seen immediately by a Stroke Team.

They will be assessed by appropriately trained staff in a consultant-led Team, to determine likely diagnosis and suitability for thrombolysis and on-going care needs.

The unit should have onsite access to brain and artery scanning, and access to a Consultant Stroke Specialist 24/7.

Acute stroke care

(the remaining days whilst stroke is the main health issue)

Access to a stroke-trained multi-disciplinary team should be available seven days a week

Access to (but not necessarily onsite) brain and artery scanning.

Treatment within a week for removing clots from the arteries to the head.

Transient ischaemic attack treatment (TIA)

Rapid diagnosis and access to specialist care for high-risk patients, so lowering the risk of a full stroke. Treatment within a week for removing clots from the arteries in the neck

Access to services seven days a week, with the facilities to diagnose and treat people with confirmed TIAs, and to manage people with conditions which appear similar to a TIA.

Service led by a Specialist Stroke Consultant and provided by a suitable specialist with access to the Consultant Lead or Specialist Stroke Nurse.

Rehabilitation services

(which provide specialist stroke care 5 days a week)

Services can be delivered from a variety of settings, including an inpatient rehabilitation bed in an acute hospital, an inpatient rehabilitation bed in a specialist unit, or in a patient's home with healthcare support provided at home.

Clinical and stakeholder feedback

Taking into account national best practice and the Midlands and East Stroke Specification, our initial work looked at five options, including options which looked at a combination of acute care in both hospitals, Manor House, Walsall and New Cross, Wolverhampton.

However, clinicians have told us that the best clinical outcomes for patients will only be achieved if there is centralised specialist care, with more extensive community support in the rehabilitation phase, in line with new guidelines for stroke services specification.

We have also taken into account the impact changing services in our region would have on neighbouring areas. Through our initial engagement with patients we also have a wealth of feedback on concerns such as access to experts, quality care and travel times.

Key areas the clinicians and stakeholders considered:

Thrombolysis (blood clot removal) - The Royal Wolverhampton NHS Trust has the essential expertise in relation to thrombolysis, which needs to be administered within a certain amount of time following a stroke. Locally the thrombolysis rates are significantly higher for Wolverhampton patients. Centralisation of service would ensure all patients received the same level of service.

Acute hospital beds - As a specialist unit would provide the best possible outcome for patients, there will be less need for beds in the other acute hospitals. Patients will not need to remain in beds in acute hospitals when they actually need rehabilitation in the community.

Clinical skills - The current model does not always provide enough practice for clinicians and therapists in hyper-acute stroke care, meaning that sometimes patients may need to be transferred between hospitals, using up valuable time. There are not enough stroke clinicians to support a 24 hour, 7 day a week service and there is not enough patient activity to support an increase in stroke consultants at Walsall.

Equity of service across the area - Clinicians were keen that there was clinical safety, quality and viability and equity of provision across Walsall area, so it doesn't matter where people live, they have access to the same range of stroke services, based in hospital and the community. It will also help improve clinical practice, as the specialists will be working alongside each other, sharing expertise.

Rehabilitation - Clinicians and the public have all told us of the importance of providing rehabilitation services as close as possible to people's homes. This would involve both bedded rehabilitation and multi-disciplinary teams going into people's homes to provide care following a stroke. This includes medical care, physiotherapy and occupational therapy and social care, as required.

Public and patient feedback to date

The Big Conversation - We have carried out extensive initial engagement with patients, carers, the public and stroke services commissioners as well as doctors and nurses, to understand what their needs and concerns are. These responses, collected as part of the Big Conversation launched in January 2017, have been included in our preparations for this further round of engagement and feedback.

Generally the initial feedback supports the fact that services cannot stay as they are, with most respondents acknowledging that something needed to change. There was a general acceptance of the need for intensive hyper-acute care as early as possible after a stroke.

Travel time - Concerns were raised at the potential for increased travelling for relatives and carers whilst the patient was at a central location, rather than transferred back to their local hospital.

Ambulance travel time - Consideration should be given to the fact that people are concerned that during an acute episode, if they are some distance from Wolverhampton, the increased travel time in an ambulance would negate the specialist care at the Hyper-Acute Stroke Unit. However, evidence shows that the benefits of this specialist care outweighs the additional travel time in an ambulance.

Impact on other services - Respondents raised the question that if the stroke facilities were closed down at one hospital, would this mean closure of other facilities. Walsall CCG and Walsall Healthcare Trust have been conscious of ensuring that proposed changes to the stroke service do not impact on other services.

Communication - Consideration should also be given to the need for better communication between hospital units and consultants. Any new stroke service would operate as a networked team to ensure communication and seamless care is delivered.

Please tell us what you think

Give us your views on the proposed changes by answering the questions below. Thank you for your time.

The proposal we are asking you to comment on is:

To centralise hyper and acute stroke services at The Royal Wolverhampton NHS Trust with stroke rehabilitation provided by Walsall NHS Healthcare Trust in the community or at home.

All patients across Walsall would be taken to The Royal Wolverhampton NHS Trust if a stroke were suspected.

They would be diagnosed and treated there until they are ready for rehabilitation closer to home, either in a community bed in Walsall or in their own home with clinical support.

The Acute Stroke Unit at Walsall Healthcare Trust would no longer operate as all patients would be treated in one specialist centre. However, community-based stroke services would be enhanced and maintained in Walsall.

Q1. Consider this statement as if you were the stroke patient, and respond: "If I have a stroke, I do not mind where my initial diagnosis and treatment takes place, as long as I receive the expert quality of care I need."

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Why do you say this?

Q2. Consider this statement as if you were the stroke patient, and respond: "If I have a stroke I do not mind where my rehabilitation takes place, as long as I receive the expert quality of care I need to recover as best I can."

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Why do you say this?

Q3. Do you think the stroke services proposal would meet patients' needs in terms of ease of access to diagnosis and treatment?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Why do you say this?

Q4. Do you think the stroke services proposal would meet patients' and carers' needs in terms of rehabilitation in the community after a stroke?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Why do you say this?

Q5. Do you think the stroke services proposal would make access to stroke services fairer for all people across Walsall?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Why do you say this?

Q6. Do you think the stroke services proposal would mean stroke services would be safe for all patients across the whole of Walsall?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Why do you say this?

Q7. When thinking about the new proposed model for stroke services Is there anything else you would like us to take into consideration?

Q8. Are you happy with the way you have been consulted with about this proposal?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree nor disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Why do you say this?

Q9. If you would also like to comment on the way the consultation has been run, please add your comment here:

Please tell us a few things about you.

Q10. Are you responding on behalf of an organisation?

☐ Yes
☐ No

If yes, please state the name of the organisation

If no, and you are responding as an individual, please complete the rest of the questionnaire to help our equalities monitoring.

Equalities monitoring

We recognise and actively promote the benefits of diversity and we are committed to treating everyone with dignity and respect regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. To ensure that our services are designed for the population we serve, we would like you to complete the short monitoring section below. The information provided will only be used for the purpose it has been collected for and will not be passed on to any third parties.

Q11. What is the first part of your postcode? e.g. WS13

Q12. What is your gender?

☐ Male ☐ Female ☐ Transgender ☐ Prefer not to say

Q13. If female, are you currently pregnant or have you given birth within the last 12 months?

☐ Yes ☐ No ☐ Prefer not to say

Q14. What is your age?

☐ Under 16 ☐ 16-24 ☐ 25-34 ☐ 35-59 ☐ 60-74 ☐ 75+ ☐ Prefer not to say

Q15. What is your ethnic group?

White
☐ English/Welsh/Scottish/Northern Irish/British ☐ Irish ☐ Gypsy or Irish Traveller
☐ Any other White background, please describe

Mixed/Multiple ethnic groups
☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian
☐ Any other Mixed/Multiple ethnic background, please describe

Asian/Asian British
☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese
☐ Any other Asian background, please describe

Black/ African/Caribbean/Black British
☐ African ☐ Caribbean
☐ Any other Black/African/Caribbean background, please describe

Other ethnic group
☐ Arab
☐ Any other ethnic group, please describe

Q16. Are your day-to-day activities limited because of a health condition or illness which has lasted, or is expected to last, at least 12 months? (Please select all that apply)

☐ Vision (such as due to blindness or partial sight)
☐ Hearing (such as due to deafness or partial hearing)
☐ Mobility (such as difficulty walking short distances, climbing stairs)
☐ Dexterity (such as lifting and carrying objects, using a keyboard)
☐ Ability to concentrate, learn or understand (Learning Disability/Difficulty)
☐ Memory
☐ Mental ill health
☐ Stamina or breathing difficulty or fatigue
☐ Social or behavioural issues (for example, due to neuro diverse conditions such as Autism,
☐ Attention Deficit Disorder or Aspergers' Syndrome)
☐ No
☐ Prefer not to say
☐ Any other condition or illness, please describe

Q17. What is your sexual orientation?

☐ Bisexual ☐ Heterosexual / straight ☐ Gay ☐ Lesbian ☐ Prefer not to say
☐ Other (please state)

Q18. Are you:

Single

☐ Single

Living in a couple

☐ Married/civil partnership
☐ Co-habiting

Not living in a couple

☐ Married (but not living with husband / wife / civil partner
☐ Separated (but still married or in a civil partnership)
☐ Divorced / dissolved civil partnership
☐ Widowed / surviving partner / civil partner
☐ Prefer not to say
☐ Other relationship (please state)

Q19. What is your religion and belief?

☐ No religion
☐ Buddhist
☐ Baha'i
☐ Christian (including Church of England, Catholic, Protestant and all other Christian
☐ denominations)
☐ Hindu
☐ Jain
☐ Jewish
☐ Muslim
☐ Sikh
☐ Other (please specify

☐ Prefer not to say

How to submit your answers and comments

If you would prefer to answer and comment online, anonymously, please visit:
http://walsallccg.nhs.uk/

When you have answered the questions and made your comments in this printed version, please contact **getinvolved@walsall.nhs.uk** or call **01922 618388.**

What happens next?

All your feedback, will be independently analysed and the results and comments will be combined into a report. The findings will be thoroughly examined and discussed by doctors, healthcare professionals and managers. They will produce a final recommendation which will take into account the all feedback and will go before the local Health Overview and Scrutiny Committee. This will then be subject to the approval by the Board of the CCG which are responsible for planning and purchasing these services.

Making sure we consider equalities

A 'due regard' assessment in line with the Equality Act 2010, has been completed, which indicates that the options are unlikely to have a negative impact on people from the groups protected by this legislation. This means that the assessment covered issues such as age, race, gender, maternity, disability, marital or civil partnership status, sexual orientation, religion or belief. This assessment is available upon request.

Do you need further help?

We can provide versions of this document in other languages and formats such as Braille and large print on request. Please contact the Engagement and Communications Team, telephone 01922 618388.

Somali

Waxaan ku siin karnaa bug-yarahaan oo ku qoran luqado iyo habab kale sida farta indhoolaha Braille iyo daabacad far waa-wayn markii aad soo codsato. Fadlan la soo xiriir qaybta Ka-qaybgalka iyo Dhex-gelidda, lambarka telefoonka waa **01922 618388.**

Polish

Jeżeli chcieliby Państwo otrzymać kopię niniejszej ulotki w tłumaczeniu na język obcy lub w innym formacie, np. w alfabecie Braille'a lub w powiększonym druku, prosimy skontaktować się telefonicznie z zespołem ds. zaangażowania pod numerem telefonu **01922 618388**.

Cantonese

如有要求，我們可以將本宣傳手册用其他語言或格式顯示，如盲文或大號字體。 請致電我們的"參與部門" **01922 618388**

Gujarati

અમે આ ચોપાનિયાનું ભાષાંતરો બીજી ભાષાઓમાં અને શૈલીઓમાં જેમ કે બ્રેઇમાં અને વિનંતી કરવાથી મોટા અક્ષરોમાં છાપેલા પૂરાં પાડી શકીએ છીએ. ઇંગેજ-ટ અને ઇ-વૉલ્વમ-ટ વિભાગનો ટૅલિફૉન **01922 618388** દ્વારા સંપર્ક કરો.

Hindi

हम आपको यह परचा दूसरी भाषाएँ में और ब्रेल एवं बडे अक्षरो जैसी रूपरेखा में निवेदन करने पर प्राप्य कर सकते है। कृपया कर के इनगेज्मन्ट और इन्वाल्वमन्ट विभाग में टॅलिफॉन द्वारा **01922 618388** संपर्क कीजिए।

Urdu

ہم درخواست کرنے پرلیفلیٹ کے اس ترجمے کو دیگر زبانوں اورصورتوں مثال کے طورپربریل اور بڑے حروف میں بھی فراہم کرسکتے ہیں۔ براہ کرم اس ٹیلی فون نمبر **01922 618388** پراینگیجمنٹ اینڈ اینوالومنٹ ڈیپارٹمنٹ کے ساتھہ رابطہ قائم کریں۔

Arabic

يمكننا تقديم نسخ من هذه النشرة بلغات أخرى وصيغ مثل برايل والطباعة الكبيرة في الطلب. يرجى الاتصال انخراط وإشراك وزارة، والهاتف **01922 618388**

Punjabi

ਅਸੀਂ ਇਸ ਕਿਤਾਬਚੇ ਦੇ ਸੰਸਕ ਰਨ ਬੇਨਤੀ ਕਰਨ ਤੇ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਅਤੇ ਫਾਰਮੇਟਾਂ ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਪ੍ਰਦਾਨ ਕਰ ਸਕਦੇ ਹਾਂ। ਕਿਰਪਾ ਕਰਕੇ ਐਂਗੇਜ਼ਮੈਂਟ ਅਤੇ ਇਨਵੋਲਵਮੈਂਟ ਵਿਭਾਗ (Engagement anc Involvement Department) ਨੂੰ ਸੰਪਰਕ ਕਰੋ, ਟੈਲੀਫੋਨ **01922 618388**

NHS Walsall Clinical Commissioning Group
Jubilee House
Bloxwich Lane
Walsall
WS2 7JL

Telephone us: **01922 618388**
E-mail us: **getinvolved@walsall.nhs.uk**

Improving Health
and Wellbeing for Walsall

NHS
Walsall
Clinical Commissioning Group

Changes to hospital stroke services

Questionnaire
14 August - 22nd September 2017

Contents

Introduction

The NHS Walsall Clinical Commissioning Group (CCG) is responsible for buying health services for people in Walsall.

We are looking at how we can improve the services for people who have had a stroke in Walsall.

This report explains:

- More about stroke
- How we want to change the way we work to provide the best for people who have had a stroke

We also want to know what you think about our plans.

Please read this report and answer the questions which start on page 13.

Stroke

A **stroke** is where part of someone's brain does not get enough blood.

Their face may drop on one side.

They may not be able to lift their arms.

They may not be able to speak - or their speech may be blurry.

You must dial 999 straight away. It is important to act fast.

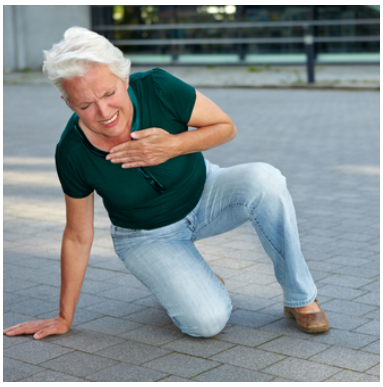
A mini stroke

Some people have a mini stroke.

They will usually fully recover.

People who have had one mini stroke are more likely to have a full stroke.

Stroke services in Walsall



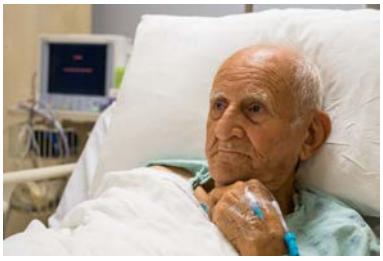
Currently about 400 people in Walsall suffer from a stroke each year.

Strokes are an emergency. It is very important that people get excellent hospital treatment in the first 72 hours.

After that most people are able to recover at home with the support of a community health service.

In Walsall currently people will go to either Manor Hospital or The Royal Wolverhampton Hospital Trust.

Some patients have to move from one hospital to the other if they need specialist treatment.



Some patients stay in hospital longer than they need to because the support may not be available in the community.

Treatment for stroke

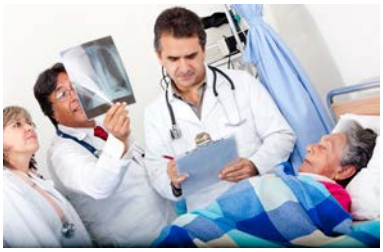
There have been improvements to the treatment of stroke recently.

Many people make a good recovery if they get the right treatment quickly.

Stroke services

If you think you have had a stroke you need to get help straight away.

We can help people best if:



- They get emergency help in a specialist stroke unit in the first 3 days

- They get help to recover afterwards near to where they live

Emergency help

We want to give people emergency help in the first 3 days.

This will include:

- Scans
- Special drugs

- Maybe surgery to get rid of a blood clot

This is best in specialist centre with staff who understand the issues.

These specialist centres don't need to be near to where people live - but they do need to have the best staff who have been trained to work with stroke patients.

Recovery

After the first three days patients need time to recover.

It can take time to start talking again and using arms and legs.

It is important that this is near to home so that family and friends can visit.

Some issues for stroke services

We have been talking to patients, staff and other people about how we should change the services.

The main issues were:

Travel time

People were worried about the extra travelling for relatives going to visit people in hospital

Ambulance travel time

People suffering from stroke may have longer in an ambulance.

But having the specialist stroke staff in one place is best, even if it takes a little longer to get there.

The effect on other services

Some people were worried that if stroke services moved away from certain hospitals, other services might suffer.

We will make sure that changes to stroke services will not affect other services.

Communication

In the past the different hospital staff have not always been good at passing on information.

This will improve with the specialist team in one hospital.

Our plans

We would change it so that everyone who suffers a stroke would go to New Cross Hospital in Wolverhampton.

They would become a centre of excellence for stroke treatment.

People would then recover nearer to home, either at Manor Hospital or at home with support from a community health team.

We will also be working with local Walsall staff to improve the service for people who are recovering from a stroke in the community.

What do you think?

Please tell us what you think by answering these questions.

Question 1: Do you agree or disagree with this? "If I have a stroke, I don't mind where I get my treatment, so long as it is very good treatment."

Agree strongly	Agree	Not sure	Disagree	Strongly disagree	I don't want to say
☐	☐	☐	☐	☐	☐

Why do you think this?

Question 2: Do you agree or disagree with this? "If I have a stroke, I don't mind where I recover so long as it is good care".

Agree strongly ☐ Agree ☐ Not sure ☐ Disagree ☐ Strongly disagree ☐ I don't want to say ☐

Why do you think this?

Question 3: Do you agree or disagree that our plans would help people get the right treatment straight away?

Agree strongly ☐ Agree ☐ Not sure ☐ Disagree ☐ Strongly disagree ☐ I don't want to say ☐

Why do you think this?

Question 4: Do you agree or disagree that our plans would help people get the right care as they recover from a stroke?

Agree strongly ☐ Agree ☐ Not sure ☐ Disagree ☐ Strongly disagree ☐ I don't want to say ☐

Why do you think this?

Question 5: Do you agree or disagree that our plans would be fair to everyone in Walsall?

Agree strongly ☐ Agree ☐ Not sure ☐ Disagree ☐ Strongly disagree ☐ I don't want to say ☐

Why do you think this?

Question 6: Do you agree or disagree that our plans would be safe for all patients in Walsall?

Agree strongly	Agree	Not sure	Disagree	Strongly disagree	I don't want to say
☐	☐	☐	☐	☐	☐

Why do you think this?

Question 7: is there anything else you want to say?

Question 8: Do you agree or disagree with the way you have been consulted about this plan?

Agree strongly	Agree	Not sure	Disagree	Strongly disagree	I don't want to say
☐	☐	☐	☐	☐	☐

Why do you think this?

Question 9: Is there anything you want to say about how the consultation has been run?

About you

Please answer these questions. Your answers will help us to make sure that we are getting the views from all the different communities in Walsall.

Question 10: Are you answering these questions on behalf of an organisation?

☐ Yes ☐ No

If you ticked 'Yes' what is the name of the organisation?

Question 12: Are you...

☐ Male ☐ Female

☐ Transgender ☐ I prefer not to say

Question 13: If you are female, are you pregnant or have you given birth in the last year?

- ☐ Yes
- ☐ No
- ☐ I prefer not to say

Question 14: How old are you?

- ☐ Under 16
- ☐ 16 - 24
- ☐ 25 - 34
- ☐ 35 - 59
- ☐ 60 - 74
- ☐ Over 74
- ☐ I prefer not to say

Question 15: What is your ethnic group?

White

- ☐ British
- ☐ Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other white background - please say

Mixed race

- [ ] White and Black Caribbean
- [ ] White and Black African
- [ ] White and Asian
- [ ] Any other mixed race background - please say

Asian

- [ ] Indian
- [ ] Pakistani
- [ ] Bangladeshi
- [ ] Chinese
- [ ] Any other Asian background - please say

Black

- [ ] African
- [ ] Caribbean
- [ ] Any other Black background - please say

Any other ethnic group

- [ ] Arab
- [ ] Any other ethnic group - please say

Question 16: Do you look after, or support any family members, friends or neighbours because...

- [ ] They are disabled?
- [ ] They are very old?
- [ ] I'd prefer not to say
- [ ] No
- [ ] Other - please say

Question 17: Are your day-to-day activities limited because of any of these health conditions?

- [ ] Poor vision
- [ ] Poor hearing
- [ ] Difficulty in walking or climbing stairs
- [ ] Using your arms and hands
- [ ] Learning disability
- [ ] Difficulty with remembering things
- [ ] Getting very tired all the time
- [ ] Autism, Attention definition disorder or Asperger's
- [ ] No
- [ ] I prefer not to say
- [ ] Another condition or illness - please say

Question 18: Are you...

- [ ] Bisexual - attracted to both men and women
- [ ] Heterosexual or straight- attracted to people of the opposite sex
- [ ] Gay - attracted to people of the same sex
- [ ] Lesbian - women who are attracted to women
- [ ] I prefer not to say
- [ ] Other - please say

Question 19: Are you...

- ☐ Single
- ☐ Married
- ☐ Living together
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ I prefer not to say
- ☐ Another type of relationship - please say

Question 20: What is your religion or belief?

- ☐ No religion
- ☐ Baha'i
- ☐ Hindu
- ☐ Jewish
- ☐ Sikh
- ☐ Other - please say
- ☐ Prefer not to say
- ☐ Buddhist
- ☐ Christian
- ☐ Jain
- ☐ Muslim

Thank you

Thank you for your views.

Please now send your answers back to us by post to:

Freepost NHS QUESTIONNAIRE RESPONSES

That is all you need to write on the envelope. You don't need a stamp.

Please make sure you write in capital letters so the post office machines can read the address.

Please send the questionnaire back to us by Friday 22nd September.

For more information

If you need more information please contact us at:

Post: NHS Walsall Clinical Commissioning Group
Jubilee House
Bloxwich Lane
Walsall
WS2 7JL

Telephone: 01922 618388

E-mail: getinvolved@walsall.nhs.uk

Walsall Stroke Services

Business Case for Public Consultation

CONTENTS

1.0 STRATEGIC CONTEXT

Walsall Context

The aim to reconfigure stroke services for the benefit of Walsall patients has been considered by Walsall CCG in a number of initiatives since the publication of the clinical senate review in 2012, in essence this is not a new concept for Walsall or indeed Black Country as outlined in the following timeline;

- Clinical senate review – 2012
- Stroke services reconfiguration programme – Jan 2014
- 2014 – Walsall HealthCare Trust (WHCT) and The Royal Wolverhampton Hospital Trust (RWHT) discussed proposals to merge stroke services – no agreement reached
- 2015 – WHCT completed an options appraisal of stroke services
- 2016 - Developed Black Country Alliance (BCA) proposal for stroke services to remain at trust with additional activity from South Staffordshire – not viable
- Nov 16 CCG considered stroke provision at Walsall – Five options considered by GB – Agree to engagement exercise to explore options
- Jan 17 – Big conversation undertaken across Walsall
- Feb 17 – Ongoing informal discussions with RWHT and WHCT supported trust discussions for stroke proposal to be explored.
- April 17 – Evaluation of Big conversation – Identified support for ASU/HASU as an alternative provider
- June 17 – CCG/WHCT agree stroke services not sustainable at WHCT

National Policy

The National Stroke Strategy (2007) identified that service improvements for stroke would save lives, reduce disability and make services safer for patients. The strategy identifies major stages in a stroke patients pathway and stresses a need to reorganise the way in which stroke services are delivered from prevention through to support for those who have experienced a stroke. The publication proposed a hub and spoke approach, with the hyper-acute hubs being able to deliver 24 hour CT scans and rapid thrombolysis treatment to improve patient outcomes. This approach has been successfully implemented in London, where all patients displaying stroke symptoms are taken to hyper-acute units and which has demonstrated significant improvements to patient care; in fact, a recent study found that the

service in London has directly saved an additional 94 lives per year since its inception when compared to other variations of the hub and spoke model, such as in Manchester, where only patients displaying stroke symptoms for less than four hours are conveyed to a hyper-acute unit and which has had no effect on mortality rates in the four years of operation in the Manchester area. Both approaches however have led to earlier discharges of stroke patients from hospital.

Black Country Sustainability and Transformation Plan

The proposed stroke service reconfiguration meets the Black Country Sustainability and Transformation Plan vision as described in this extract from the executive summary of the plan;

'For the future, we must transform services to adapt to rising demands. We must make the most of modern healthcare through innovation and best practice in order to change the way we spend money and use our limited resources.

We must also focus on shifting demand away from our hospitals and to a more community-centred approach. When patients need hospital care, however, it should be of the highest quality, providing specialist interventions in the right place and at the right time with less variation in the care that patients receive.

It is clear to us that our current ways of operating are unsustainable. Under our plan, individual organisations and partnerships will continue to make the improvements and efficiencies that are directly within their own control but the overall scale of opportunity will be transformed by our working together as a single system with a common interest.

At the heart of our plan is a focus on standardising service delivery and outcomes, reducing variation through place-based models of care provided closer to home and through extended collaboration between hospitals and other organisations'

The proposals laid down within this business case are fully aligned with the vision of the STP.

Local Plans

Walsall CCG Governing Body, at its meeting of November 24th 2016, agreed the following overarching principles in relation to any future provision of stroke services:

Stroke services will conform to the specifications contained in the NHS Midlands and East Stroke Services Specification, take into account the National Clinical guideline for Stroke (5th Edition 2016) and meet the following WCCG principles:

a) We will only commission services which demonstrably meet accepted clinical safety and quality standards. This must be demonstrated both within the specific clinical services; and within the wider clinical environment e.g. If stenting is to be supported then the stenting standards will have to be demonstrated but the infrastructure will need to be available in case of an untoward incident.

b) We will only pay National Tariff prices for services

c) We will not buy if the overall pathway of care has more components, more complexity and is more expensive than if we went to an alternative provider.

Additionally the CCG requires that all patients, regardless of the length of time they had displayed stroke symptoms, would be conveyed to the hyper-acute unit in the first instance, in line with the London approach referred to previously in this paper.

Walsall Healthcare Trust have explored a proposal produced by the Black Country Alliance (BCA) to consider a merged stroke services arrangement across the BCA; this has been shared with the CCG but is no longer a viable option, with the BCA unable to generate clinical resource and support for the arrangement.

Royal Wolverhampton Trust has produced a document to support the decision making process of Walsall CCG pertaining to the future possibility of Walsall and Wolverhampton Stroke services combining in the form of a single ASU/HASU located at New Cross Hospital.

WCCG has met with both RWHT and WHCT and requested that discussions with both Trusts take place to consider a more viable option between both trusts for the delivery of stroke services for Walsall residents.

2.0 THE CASE FOR CHANGE

Rationale

Good quality stroke services, as defined by the National Stroke Strategy (2007), require 7 day, 24 hour access to thrombolysis treatment and a 7 day high risk TIA clinic. These services require a reasonable scale to ensure that there is sufficient consultant coverage to provide comprehensive, sustainable services. For this reason, stroke networks across the country have reviewed stroke provision and concentrated it on fewer, larger centres. It is likely that this trend will continue as it has a direct correlation with improved outcomes for patients.

Currently all patients in Walsall CCG area exhibiting symptoms of stroke are conveyed to and dealt with by Walsall Healthcare Trust (WHCT) at the Manor Hospital, and according to the Sentinel Stroke National Audit Programme (SSNAP) report for financial year 2015/16, WHCT treated 375 stroke patients. Whilst overall WHCT was rated as ‘good’ (and ‘improving’ over the last two years), the mainly low scoring domains (D or E average) were related to the stroke unit and thrombolysis provision.

The NHS Right Care Commissioning for Value Focus Pack for Cardiovascular Disease (April 2016) shows that Walsall is in worse in a number of areas of the pathway compared to CCG’s of similar size and demographics. In the main these outcomes pertain to lack of clinical resource and lack of capital resource, in particular with regards community beds.

At present Wolverhampton and Walsall see respectively approximately 600 and 400 confirmed stroke patients each year. To be a viable Hyper acute Stroke service it is recommended that there are a minimum of 600 confirmed stroke patients each year. For Walsall Healthcare Trust the income from activity of 400 confirmed stroke patients is insufficient to fund staffing levels to meet the HASU requirements and there is no potential to

increase stroke numbers in future, despite considerations of patient flow arising from other stroke reconfigured areas eg: Burton.

NHS England previously wrote to all providers of urgent care network specialist services requesting an audit of compliance against the seven day services standards for acute stroke, STEMI heart attack, major trauma, emergency vascular and paediatric intensive care services. The aim of this audit was to identify those individual services where attention and action was needed to ensure that all patients requiring services for stroke receive the best possible care on a 24/7 basis. The results of the audit have identified that WHCT are below the standard expected for time to first consultant review (60% not met) and Ongoing consultant-directed review (40% not met). Whilst the formal response from the trust to how it will manage to achieve these standards by November 2017 is awaited, it is expected to advise that it is not able to meet these standards, again due to reduced numbers and the inability to fund and support the clinical capacity required by that time, and the service is therefore unsustainable.

Sentinel Stroke National audit programme (SSNAP) figures have thrombolysis rates for Wolverhampton and Walsall at 14.5% and 10.5% respectively for 15/16. With Service unification we would expect to see the thrombolysis rate for Walsall patients improve as they would be thrombolysed at the RWHT rate. Furthermore after rationalisation of Hyper acute services in London, the stroke thrombolysis rates significantly improved with some centres achieving 20%. We would expect to see the same pattern and therefore expect the thrombolysation rate for the whole Wolverhampton/Walsall population to increase above current rates towards 20%.

Walsall and RWHT would have access to the same thrombectomy pathway, at present the local pathways are at Stoke and University Hospital Birmingham; this would require a defined and commissioned pathway.

With respect to Stroke consultant workforce in Wolverhampton there are 4 WTE consultants and at Walsall there are 2 WTE consultants. The British Association of Stroke physicians (BASP) recommend that a 24/7 Hyper-acute stroke service should consist of at least 6 WTE consultants. Combining two cohorts of consultants will improve the availability of senior decision making cover and more importantly achieve the compliance requirements for seven day services.

There would also be a larger pool of stroke trained nurses to help drive forward the required standard of care. RWHT already has 7- day physiotherapy and occupational therapy which would be maintained, through this process 7- day Speech and language therapy access would also be achieved. The sharing of patient time and therapy spaces can only realistically be achieved in a single unit, preferably one physically laid out to mimic a patient's journey towards recovery. For this to be realistic a capital investment scheme for RWHT has been submitted. Whilst the movement to RWHT is not predicated on the achievement of the bid, it does offer all of the benefits that delivery through a single unit would support. The current arrangement at WHCT would require significant investment and work to enable a like for like unit on this site.

The key requirements to be delivered within the Stroke Services Service Specification:

- A 7 day/24 hour stroke physician led service – *Not possible in WHCT without increasing stroke numbers and increased consultant and specialist nurse capacity.*
- Direct admission to a HASU within 4 hours - *Not possible in WHCT without increasing stroke numbers and increased consultant and specialist nurse capacity.*
- Brain imaging (MRI/CT) within an hour with skilled clinical interpretation to be available 24/7 - *Not possible in WHCT without increasing stroke numbers and increased capacity.*
- 24/7 access to thrombolysis, - *Not possible in WHCT without increasing stroke numbers and increased consultant and specialist nurse capacity.*
- Enhanced staffing levels of stroke specific trained MDT - *Not possible in WHCT without increasing stroke numbers and increased consultant and specialist nurse capacity.*
- Door to needle time less than 60 minutes
- Combined Hyper acute & ASU
- Access to ESD and appropriate long term care support – *Will require review and additional investment to support capacity required.*
- Goal led inpatient rehabilitation for appropriate patients
- Access to TIA clinics, with consideration of a local TIA clinic in Walsall

Early supported discharge is a key element of the overall stroke pathway, including rehabilitation. The current ESD for Walsall results in stroke patients sustaining an increased length of stay in an acute hospital bed due to the non-availability and investment of specialist community provision.

WHCT is to provide Early Supportive Discharge (ESD) and community pathways for Walsall patients and it is proposed that WHCT to host TIA clinic with clinical provision by RWHT. Given the case for change discussed it may be reasonably concluded that stroke services for Walsall are not sustainable with the current arrangements.

3.0 OPTIONS WITH CCG EVALUATION

At the Walsall CCG Governing Body meeting on November 24th 2016 it was resolved *that 'The Governing Body also gave approval to explore all options, including engaging with RWHT on options with them'.* Subsequent CCG discussions with RWHT and WHCT, and discussions between both Trusts, have led to Option 5 becoming the emerging preferred option between all three organisations, and supported by Wolverhampton CCG. Other options considered and discounted by the CCG include:

1. **Maintain status quo** - continue to operate a HASU service, using existing WHCT infrastructure and staffing, with resolution of the gaps as finances allow.

   CCG comment: This option is no longer sustainable, the current service delivery model would continue to be only partially compliant with the HASU specifications, in particular with regards overall stroke activity being less than nationally recommended, consultant

capacity limited and no arrangements in place for community stroke rehabilitation beds and lacks system resilience with regards 24/7 cover.

2. **Financial investment by WHCT**, in a phased approach, to 'fill' the key gaps in the current HASU service delivery model to satisfy the HASU specification requirements and achieve the required performance.

   CCG Comment: This option would require additional funding and investment by WHCT to recruit additional staff to bring the service up to the acceptable HASU standard (as much as £650K) with the CCG possibly asked to provide funding for approximately 22 additional beds in community care. Given the current financially challenged position of both trusts this is not a current option. The comment in Option 1 regarding the CQC report is also applicable here.

   The option also only becomes viable if there is an increased attendance to 600 stroke patients per year. The report asserts that the additional attendances would come from the proposed withdrawal of stroke services by Queens Hospital Burton, and the opening of the Midland Metropolitan hospital in Birmingham, however, it has recently become apparent that stroke services in Burton are to continue due to Burton and Derby hospitals working more closely together, so the anticipated numbers attending Walsall Manor are unlikely to materialise, thereby making this option unviable.

3. **Fusion of capabilities** with Black Country partners under a 'Black Country Alliance' proposal that will be 'utilised' to 'share' staff to fill WHCT gaps to enable WHCT to satisfy with the HASU specification requirements and performance targets.

   CCG comment: the comments relating to option 2 above are applicable here, with the added complication that this option is out of step with the move towards an STP footprint for the Black Country, as the Black Country Alliance does not include Royal Wolverhampton Hospital Trust, a provider that some Walsall patients, particularly on the West of the borough naturally flow to.

4. **Outsource the HASU service to Royal Wolverhampton Hospital** (RWHT) with patients being repatriated back to the WHCT ASU to provide on-going acute bed based care. The community stroke services will be provided by WHCT.

   CCG comment: The implementation of this option would entail the apportioning of the national tariff for stroke between the hyper acute and acute phases of the pathway. The report indicates that the pathway apportionment generally operates on a 70/30 split, so this may bring into question the ability of WHCT to provide the acute part of the pathway on 30% of the tariff. Negotiations for similar arrangements in other areas of the region concluded that, even with a 60/40 split of tariff, it is financially unviable for the Provider of the acute part for the pathway. The business case for the same set of negotiations also placed the cost of a two site option at around 40% above the national tariffs for the whole pathway.

There becomes a further option for the governing body to consider that might satisfy the requirements of the relevant specifications, guidance and principles referred to in the introduction, which is;

5. **Walsall CCG actively considers commissioning Royal Wolverhampton Trust** (RWHT) to provide both Hyper-acute and acute parts of the Stroke pathway for all Walsall patients, thereafter Early Supportive Discharge and a Community Stroke Service provided by WHCT. (**Preferred Option)**

   CCG comment: This option seems to be the most viable in the current circumstances to provide a stroke service for Walsall patients that complies with our CCG overarching principles described earlier in this paper, satisfies the comments made by the WM clinical senate report (Oct 2015): 'The panel are of the view that co-location of HASU and ASU across all units does and will improve integration of acute stroke care and patient flow in the acute phase and, on that basis, will work towards that the proposed service standard of transfer from HASU to ASU at 3 days and discharge / repatriation at 7 days', and would be in line with the move towards an STP footprint for the Black Country.

   If RWHT were commissioned to provide a HASU/ASU service, it is envisaged the success of centralising HASU/ASU services by Heart of England FT could be replicated here. RWHT indicate that the annual flow would increase to around 1,100 patients per year, and they are confident they would be able to cope with these numbers.

Impact and benefits

Placing patients on the correct pathway (Hyper-Acute or Acute and ESD) will maximise the likelihood of best possible outcomes and allow for resources to be used effectively. The general expected outcomes are:

- Improved outcomes for stroke patients, by reducing the levels of death and disability following a stroke consultation
- Improved patient experience and enhanced recovery following a stroke,
- A single service that is sustainable and provides good value for money through effective use of resources,
- Equitable access to Stroke services and quality care across the region,
- Provide a fully integrated, end-to-end stroke service for NHS Midlands and East.
- Implement the recommendations of the National Stroke Strategy.
- In line with the requirements laid down from STP

These gains will partly arise from improved quality of outcomes for Walsall patients but also from economies of scale and the 'hub and spoke' model of specialist care that is proven to give better outcomes for patients.

Capital will be required to create a single stroke facility with flexible bed stock for HASU and ASU elements to be combined, TIA clinics, some degree of rehabilitation and pre-discharge and potentially direct access for Stroke patients brought in by ambulance.

Implications for wider urgent and emergency care system

Confirmation required with WMAS that suspected stroke patients would be conveyed to RWHT on each occasion – ongoing discussion with WMAS.

Potential additional investment to support this arrangement is under negotiation, but worse-case scenario identifies an additional investment of £250k,

Consideration also needs to be given to North Birmingham patient flow and Sandwell patient flow, with approx. 50 and 60 patients per annum currently treated by WHCT. There would be capacity at RWHT to treat these patients, if required, however, support for ESD would need to be established by the receiving trusts and is also a consideration of the proposed revised arrangements.

4.0 STAKEHOLDER AND PUBLIC CONSULTATION

Public and patient consultation

On 24 January 2017, NHS Walsall Clinical Commissioning Group (CCG) launched a seven week pre-public engagement exercise - The Big Conversation.

The purpose of the exercise was to engage with people in Walsall on their views and experiences of health care services and also share ideas for future healthcare delivery to ensure we have sustainable, quality services that are affordable and fit for the future.

One of the main areas of focus for public engagement was Stroke services - To consider how complex care could be delivered differently to reduce the demand for hospital services such as stroke.

Public events

Three public events were held in separate venues across Walsall. In total 173 people attended. The events were advertised via GP surgeries, email newsletters, posters, leaflets, the CCG website, through the local media, social media and through partner communication networks.

The first event was held at Walsall Town hall and focused on setting the scene and updating the public on the CCGs financial situation and other local challenges. Attendees then broke away into smaller discussion groups looking at one of following areas; Walsall Together, Urgent Care, Stroke, Primary Care.

The second event was held at Rushall Community Centre and the main focus was on Walsall Together and primary care only.

The third event was held at Moxley People's Centre and the focus was on stroke and urgent care services.

Community Outreach – Big Conversation Camper Bus

A camper van was commissioned by the CCG to go out into various communities across Walsall. Staff from the CCG and Health watch representatives spoke to members of the public and handed out surveys. Ten venues were visited over a 7 day period, including a weekend.

Voluntary and community organisations were given the opportunity to have a visit from the Big Conversation Bus. Some of the venues that were visited include supermarkets, a place of worship, a leisure centre, libraries and markets.

Alongside the staff, a camera crew invited members of the public to give their feedback on camera. Over sixty three people participated in total.

Walsall CCG Patient and Stakeholder Advisory Group

The main role of the Walsall CCG Patient and Stakeholder Advisory Group is to ensure that the CCG undertake meaningful engagement with patients and public. The group were invited to help shape the engagement plan and kept informed of activity throughout. They were also asked to support the exercise and share the material and messages through their own communities and networks.

Focus groups

Health watch Walsall held 6 focus groups with 112 children in schools across Walsall. The children completed a questionnaire and had discussions about the different areas.

Patient Representative Groups (PRGs)/ Patient Participation Groups

GP practice PRGs were also enlisted to promote the engagement document in their practices. Practice Managers and PRG/ PPG Chairs promoted it within their surgeries and helped members of the public complete the questionnaire where necessary.

Copies of the engagement document were also distributed at the Patient Participation and Liaison Group meeting with is made up of Chairs and Vice-chairs of PPG/ PRGS across Walsall.

Posters/ leaflets / Publications

Promotional material was produced to raise awareness of the public events.

Communication about the engagement exercise and electronic copies of the engagement survey were sent to the CCGs stakeholders list which includes local GPs, MPs voluntary sector, CCG partners and providers.

Media coverage

Regular press releases were issued to the local media and the CCG secured two interviews with Made in Birmingham Television, an article in the Walsall Advertiser and a feature on local community radio station, Ambur Radio. Ambur Radio is the largest multicultural community station in the West Midlands, broadcasting in English, Hindi, Punjabi, Urdu, Bengali and Gujarati to over 200,000 live listeners and over 140,000 online each day.

Articles were also featured on websites and in newsletters from Health watch Walsall, Walsall Healthcare NHS Trust, Walsall Council and Dudley & Walsall Mental Health Partnership NHS Trust.

Social media

Throughout the campaign, the CCG regularly tweeted key messages, communication materials and photos from engagement events using the hashtag #Bigconversation. A total of 63 tweets were sent to over 5,500 followers, which had a potential total reach of 144,000. Messages have also been retweeted by staff, partners, local media and followers.

Website

Dedicated web pages were set up on the CCG's website: http://walsallccg.nhs.uk/be-involved/the-big-conversation

The feedback in relation to stroke to this engagement is as follows;

Stroke Services	
If a relative of yours required care for a stroke, what would be the most important things you would look for?	• Quick response • F.A.S.T • Compassionate people to care for the patient • Appropriate care for family and friends • Look for quality care • Recovery • Prefer to go to New Cross Hospital • Expertise of staff • Physio and Rehabilitation • Speed of being treated • Concerned about aftercare and the finances that go with it • Daily care • Whether there's a lack of support
What are the most important things for the CCG to consider when buying stroke	• Listen to what the public are saying • People want to know what's going on • There's not much in place for patients at home • Doctors being overstretched • Ensure that ambulances can accommodate all cases • Availability to those who need them

support services?	• Good care for patient and families • Easy access • Ensure patients don't feel like a statistic, be more personal • Ensure aftercare won't fully be provided • More local services • Ensure services are easily accessible for those with mobility issues • Hospital departments to meet patients in the community
Stroke Services	If a relative were to suffer from a stroke the most important main priority is fast, effective care with good quality outcomes.
	Good value for money was also an important factor for the CCG to consider alongside the above points. Effective local rehabilitation services with consistency of care was a key theme.
	It was felt the CCG need to consider more patient education on prevention of stroke and raise awareness of the national stroke campaign locally.
	Stroke care does not necessarily have to be in the Walsall area however travel time, road networks and good transport links all need to be considered.

Engagement with OSC

Walsall Health Overview and Scrutiny Committee

The public engagement plan for the Big Conversation was shared with members of Walsall Health Overview and Scrutiny Committee for comments and feedback on the 10th January 2017.

All councillors were also invited to the public events and given the opportunity to complete the questionnaire via the local authority communication channels.

Plan for public consultation

We will be working closely with colleagues at Healthwatch Walsall to engage with local people.

We are proposing our consultation exercise will take place over six weeks starting from 14th August to 22nd September. To ensure we can be as inclusive as possible, we plan to carry out a range of consultation activity which will include a mix of public events, focus groups, social media, production of easy to read and jargon-free material and questionnaires to gather views. A comprehensive plan for public consultation will be prepared with the involvement of the CCGs Patient Advisory Group, which is made up of a range of patient representatives, representatives from a local faith group and the third sector. The types of consultation activity we will carry out are listed below.

As part of our plan we will also make sure that following the consultation exercise, a communications campaign takes place to inform the public and patients of the outcome.

Consultation Activity:-

1. A suite of consultation material will also be prepared with the input of our Patient Advisory Group:
    - A plain English, jargon-free consultation booklet will be available online and as a hardcopy. Versions in different languages will be available on request.
    - An easy-read version will also be produced and distributed to public buildings such as GP surgeries, leisure centres, libraries and community centres.
    - Leaflets will be distributed via the CCGs networks including the third sector
    - A hardcopy and online questionnaire will be produced to capture feedback. This will be tested with our patient representatives before publication.

2. Face-to-face events with a chance to ask questions and hands-on support to complete the questionnaire:
    - A series of drop-in sessions at locations across Walsall where people can find out more about the proposals and give feedback
    - With the support of our Patient Participation Groups (PPGs), we will be canvassing patients to give their views at GP surgeries.
    - Focus groups will take place in schools, third sector groups targeted at people with long- term conditions, carers, mums, homeless people etc.
    - An offer to all local groups of a speaker from the CCG to come out to one of their meetings, explain the proposals, and seek feedback.

3. Web-based consultation activity to reach a wider audience will take place:
    - A social media campaign signposting to the consultation material
    - A dedicated web portal will be set up to access all consultation material and the questionnaire
    - A short video outlining potential changes and how people can get involved will be produced

4. Promoting the involvement opportunities will be a key part of our plan to encourage people to participate:
    - Communication in the local media outlets
    - Flyers and postcards, publishing newsletters, posters and banners

The comments made by participants in the ‘Big Conversation’ public engagement earlier in 2017 have been taken into account and help form the basis of the proposed public consultation on the future of stroke care services.

As mentioned previously the Overview Scrutiny Committee (OSC) was involved in the engagement exercise in 2017. Subject to Governing Body approval of this business case the CCG plans to meet with the Overview and Scrutiny Committee in July 2017 to present the plan for further consultation which is proposed to take place during August and September 2017.

5.0 DELIVERABILITY

Hyper-acute Stroke Unit and Acute Stroke Unit

At RWHT common improvement themes include:

a. Strengthening the delivery of CIP
b. Ensuring the delivery of safe high quality services
c. Ensuring the delivery of national targets for Urgent and Emergency Care, cancer and referral to treatment time

These improvement priorities do not present risks to the delivery of the project. Centralisation of Stroke services and the resultant increase in staff members and availability of the Stroke Team on one site will improve the likelihood of the Trust meeting the national target for Urgent and Emergency Care.

The scheme is intended to support providers to deliver safe, effective clinical care of patients with a potential and actual diagnosis of Stroke.

A capital investment bid has been made by RWHT to enable the centralisation of ASU/HASU arrangements within the trust, the option is not predicated on the capital investment though.

Early Supported Discharge and Community Pathway

There is a requirement to review community capacity for Walsall, there is currently no community based facility to support ESD and no community bed stock, current arrangements are delivered through excess bed days being incurred at the trust due to the lack of any community provision. Initial planning assumption has identified the requirement for approx. 12 (To be Determined) community beds and a defined supported discharge pathway.

The development of the integrated intermediate care model provides a sound base for the principles of early supportive discharge to be made. It is expected this pathway will provide the basis on which the ESD pathway can be implemented.

The likelihood of community stroke bedstock being delivered through a dedicated stroke community building is limited, although some potential areas will be explored. The likely arrangement will be a supportive MDT arrangement delivered through an independent sector care home in Walsall. Costings for such arrangement are to be worked through, but will be expected to be offset by the reduction in LOS and potential closure of the dedicated stroke ward.

It is worth noting, Walsall does have a proven track record of high quality care being delivered through the care home sector and works well with the sector to ensure standards are consistently high and deliver the requirement of such services.

Procurement and contracting

CCG to contract directly with RWHT for the provision of the Hyper acute and acute parts of the stroke pathway, and to contract directly with WHCT for the stroke Early Supported Discharge and Community Rehabilitation services.

Finance & Activity (Capacity and Demand)

Initial investigations into the activity consequences of the transfer of the service from WHCT to RWHT have identified a number of areas of the pathway which require clarification.

Further work will be undertaken to identify activity levels relating to all aspects of the WHCT stroke service (HASU, ASU and ESD). This will inform negotiations between RWHT and WHCT regarding the unbundling of the national Payment by Results stroke spell tariff into pathway element payments.

This work will also identify related non-stroke activity (mimics) to ensure that appropriate capacity and patient pathways are identified.

Indicative implementation timeline

- Stroke business case to CCG Commissioning Committee June 17,
- Governing Body consideration of public consultation business case 4th July 2017
- Stroke paper recommending non sustainability of stroke services to WHCT board 6th July 17
- Presentation of business case proposal to Clinical Senate July 19th
- Presentation of business case proposal to Overview and Scrutiny Panel July 20th
- Consultation of proposal to commence August 17
- Agreement on proposal by CCG – 26th September 17
- Revised service mobilised and in place April 18

Risk and Mitigation

Commissioning risks and mitigations are set out as follows:

Risk	Mitigation
ESD Pathway not established	Principles of new integrated Walsall I.C model supports ESD
Community provision not in place	Independent sector capacity available Potential to secure dedicated site in Walsall quickly
Capital bid not approved for RWT	To consider alternative estate arrangements
Sustainability of clinical staff at WHCT during transitional period	WHCT have worked hard to ensure divisional clinically led decision and involvement
Consultation exercise fails to support proposal	Providers will review the sustainability of stroke services over the short to medium term
Travel time to RWT exceeds therapeutic requirement	Public Health supporting analysis

There are potentially additional risks identified for WHCT and RWHT, these will be managed locally by each trust in the first instance. Once agreed a project board utilising PRINCE2 methodology will be established, a full risk and mitigation log will then be held by the project team during any transition.

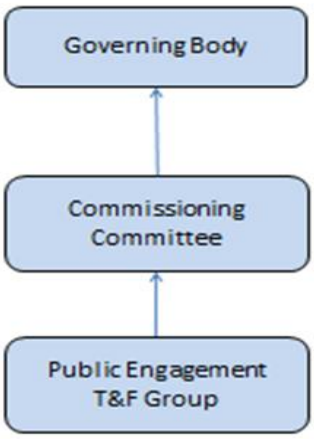
The potential risk to workforce, both in ensuring appropriate recruitment and any potential impact on existing workforce, in particular potentially destabilising medical capacity at WHCT and the potential knock on effect for junior doctor placements is considered to be both a local trust issue and one requiring a network view and solution. It is likely through the forthcoming period, that there will be significant impacts on the workforce of the Black Country and as the STP arrangement progresses and vertical integration develops this will require a wider system and overall network view to ensure ongoing stability and sustainable services through transformation.

6.0 GOVERNANCE

Decision-making

In Walsall CCG the development of commissioning strategy and plans is the responsibility of the Commissioning Committee, with the final decision on the proposals being made by the Governing Body. Both CC and GB have stipulated a requirement to ensure appropriate and relevant consultation prior to any decision being agreed, this includes dialogue with all relevant stakeholders and OSC.

Consultation Governance Framework



- **Public Consultation T&F Group** - in addition to relevant CCG staff, group includes representation from the patient voice panel, patient advisory group, , Healthwatch and Patient Representation Groups. Input from Equality & Diversity. T&F Group will identify and manage risk and escalate when outside scope of influence. Scrutiny of proposal from Consultation Institute, NHSE and Walsall Overview & Scrutiny Committee
- **Commissioning Committee** – main function are to approve the public consultation business case; receive assurance from T&F group that consultation plan is implemented on time, and that risks are recorded and managed; to receive escalated risks for mitigation.
- **Governing Body** - Ensure compliance with the statutory duty to involve the public in commissioning decisions, Equality Act. Director of Commissioning is Lead Sponsor and Chief Nurse is the Clinical Consultation Lead

Once the reconfigured stroke service has been agreed the CCG will receive assurance on performance issues via the contract mechanism and will ensure the service is safe and effective through programmed Clinical Quality Review meetings. There will be an agreed set of Key Performance Indicators to measure the service against which will support the effective monitoring of services, these will form the basis of a revised and robust service specification.

In addition the stroke service at RWHT has a robust governance structure that meets the requirements set out in the Trust's Clinical Governance Strategy. The Trust delivers its clinical and operational services through a Divisional and Directorate structure. Within the directorate-level structure there are three core meetings which look at performance, measurement and improvement of the stroke service. Existing arrangements between

WHCT and CCG will be reviewed to ensure fit for purpose and reflective of any revised arrangements.

Equality Duty

The impact on those people with protected characteristics has been taken in to account in developing the options for public consultation, and has been informed by the Equality Impact Assessment for the Birmingham, Solihull and Black Country Stroke Review published in June 2014.

Whilst the focus of the public consultation will be mainly of the service users and their immediate family or carers as any changes to stroke care must consider the ease of access relatives/friends/carers have to stroke patients. The impact of this proposal on users of this service is relatively small, given that they will invariably be conveyed to hospital under blue light conditions. There is likely to be an impact, in terms of increased travelling time, for relatives visiting the hospital, however the impact will be dependent upon where they reside in Walsall and the duration of the patient stay in hospital. It is important that the protected characteristics groups are covered in the public consultation. This will be included in the consultation plan and the updated equality analysis assessment.

The provision of Stroke Services will meet national standards for access to all groups that are required of all NHS funded services.

Four Tests of Service Reconfiguration

Four tests of service reconfiguration are set out in the Government mandate to NHS England. These are: strong public and patient consultation; consistency with current and prospective need for patient choice; clear, clinical evidence base; support for proposals from commissioners. The government's four tests of service reconfiguration are:

Strong public and patient consultation.

See Section 4: There has been ongoing public and informal consultation on the future of stroke services. The public engagement exercise in January to March 2017 had public and patient involvement in the form of Healthwatch, Patient Representation Groups and the Patient Advisory Group. Planning for the formal consultation to take place from July 2017 has the same level of public and patient involvement. Political and stakeholder consultation is a key feature of this arrangement.

Consistency with current and prospective need for patient choice.

See Section 1: National policy for stroke service care is to deliver the key requirements contained within the Stroke Services Service Specification (NHS Midlands & East) to patients suspected of suffering a stroke. Currently WHCT are currently only partially compliant with the specifications for hyper acute stroke services. The case for change has identified that WHCT is no longer a sustainable organisation to deliver stroke services for local people and to a certain extent choice of provision is therefore limited. That said a public consultation exercise is planned to consider the impact for patients should the option be supported. The initial engagement exercise has identified that patients priorities centre

around high quality services, 24 7 day a week and the destination of these services is less significant as long as they remain local i.e.: Black Country.

Clear, clinical evidence base.

National guidance as cited in section 1 sets out the clinical case for the implementation of a hyper acute and acute stroke service in line with the NHS Midlands & East Stroke specification. Centralisation of hyper-acute stroke care has the potential to improve health outcomes, including mortality, by increasing thrombolysis rates, and possibly through the concentration of expertise and treatment of higher volumes of patients. The specification to be delivered through RWHT will be fully reflective of the NHSE Midlands and East Stroke Services Specification and therefore wholly evidenced based.

Support for proposals from commissioners.

The CCG is leading this formal consultation on changes to stroke care services and is fully supportive of the option being considered. In addition the proposal is in line with the requirements laid down within the STP arrangement for Black Country and therefore in support of a wider commissioning system view.