



Health and Wellbeing Together

10 April 2019

Time 12.00 pm **Public Meeting?** YES **Type of meeting** Oversight
Venue Committee Room 3 - Civic Centre, St Peter's Square, Wolverhampton WV1 1SH

Membership

Councillor Roger Lawrence (Chair)
Chief Superintendent Andy Beard
Emma Bennett
Katherine Birch
Helen Child
Tracy Cresswell
John Denley
Dr Helen Hibbs
David Loughton CBE
Councillor Hazel Malcolm

Juliet Malone
Steven Marshall

Joanne Melling
Councillor Sandra Samuels OBE
Linda Sanders

Councillor Paul Sweet

Meredith Teasdale
Councillor Wendy Thompson
Professor Steve Field CBE
David Watts
Lesley Writtle

Leader of the Council
West Midlands Police
Director of Children's Services
Faculty of Education, Health and Wellbeing
Third Sector Partnership
Healthwatch Wolverhampton
Director of Public Health
Chief Officer, Wolverhampton CCG
Royal Wolverhampton Hospital NHS Trust
Cabinet Member for Public Health and Wellbeing
Operations Commander
Director of Strategy & Information, Wolverhampton CCG
NHS England
Cabinet Member for Adult Services
Independent Chair of Adults and Children's Safeguarding Board
Cabinet Member for Children and Young People
Director of Education
Conservative Party Leader
Royal Wolverhampton Hospital NHS Trust
Director of Adult Services
Chief Executive, Black Country Partnership Trust

Information for the Public

If you have any queries about this meeting, please contact the Democratic Services team:

Contact Shelley Humphries
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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS - PART 1

- 1 **Apologies for absence**
- 2 **Notification of substitute members**
- 3 **Declarations of interest**
- 4 **Minutes of the previous meeting** (Pages 5 - 12)
[To approve the minutes of the previous meeting as a correct record.]
- 5 **Matters arising**
[To consider any matters arising from the minutes of the previous meeting.]
- 6 **Health and Wellbeing Together Forward Plan 2018 - 2019** (Pages 13 - 20)
[To receive the Health and Wellbeing Together Forward Plan 2018 – 2019.]

ITEMS FOR DECISION OR DISCUSSION - PART 2

AGEING WELL

- 7 **Joint Dementia Strategy for Wolverhampton 2019 - 2024** (Pages 21 - 116)
[To approve the updated Joint Dementia Strategy for Wolverhampton 2019 – 2024.]

LIVING WELL

- 8 **No Recourse to Public Funds - Request for Numbers** (Pages 117 - 118)
[To receive information on numbers of people with No Recourse to Public Funds.]
- 9 **Homelessness Prevention Strategy 2018-2022** (Pages 119 - 146)
[To approve an action plan and steering group to deliver the Homelessness Prevention Strategy 2018 – 2022.]

SYSTEM LEADERSHIP

- 10 **Developing the Health and Wellbeing Dimension in All Policies** (Pages 147 - 150)
[To receive an update on progress towards adopting Health in all Policies.]

- 11 **Wolverhampton Clinical Commissioning Group (CCG) and Black Country and West Birmingham Sustainability and Transformation Partnerships (STP) Operating Plans** (Pages 151 - 218)
[To receive Wolverhampton CCG and Black Country and West Birmingham Sustainability and Transformation Partnerships Operating Plans.]

ITEMS NOT OPEN TO THE PRESS AND PUBLIC - PART 3

GROWING WELL

- 12 **Progress on the Early Years Strategy** (3)
[To receive a presentation on the progress of the Early Years Strategy.] Information relating to the financial or business affairs of any particular person (including the authority holding that information).



Health and Wellbeing Together Minutes - 23 January 2019

Attendance

Members of the Health and Wellbeing Together

Councillor Roger Lawrence (Chair)	Leader of the Council
Emma Bennett	Director of Children's Services
Brendan Clifford	Service Director - City Health
Tracy Cresswell	Healthwatch Wolverhampton
John Denley	Director of Public Health
David Loughton CBE	Royal Wolverhampton Hospital NHS Trust
Councillor Hazel Malcolm	Cabinet Member for Public Health and Wellbeing
Steven Marshall	Director of Strategy & Information, Wolverhampton Clinical Commissioning Group
Linda Sanders	Independent Chair of Adults and Children's Safeguarding Board
Meredith Teasdale	Director of Education
Councillor Wendy Thompson	Conservative Party Leader
David Watts	Director of Adult Services

In Attendance

James Annakin	Principal Public Health Specialist
Lucy Armstrong	Wolverhampton BID
Jennifer Brake	Service Director Strategy and Change
Jo Cadman	Black Country Partnership Foundation Trust
Madeleine Freewood	Development Manager – City Health
Sheila Gill	Healthwatch Wolverhampton
Shelley Humphries	Democratic Services Officer
Tanya Johnson	P3
Lina Martino	Consultant in Public Health
Cheryl Rock	Anti-Social Behaviour Team Leader
Anthony Walker	Homelessness Strategy and External Relationships Manager

Part 1 – items open to the press and public

Item No. *Title*

- 1 **Apologies for absence**
Apologies for absence were received from Dr Alex Hopkins, Chief Superintendent
Andy Beard, Sarah Smith, Tim Johnson, Councillor Paul Sweet, Councillor Jasbir

Jaspal, Councillor Sandra Samuels OBE, Dr Helen Hibbs, Lesley Writtle and Jeremy Vanes.

2 **Notification of substitute members**

Jo Cadman attended on behalf of Lesley Writtle.

3 **Declarations of interest**

There were no declarations of interest made.

4 **Minutes of the previous meeting**

Resolved:

That the minutes of the meeting held on 17 October 2018 be approved as a correct record and signed by the Chair.

5 **Matters arising**

There were no matters arising from the minutes of the meeting held on 17 October 2018.

6 **Health and Wellbeing Together Forward Plan 2018 - 2019**

Resolved:

That the Health and Wellbeing Together Forward Plan 2018 – 2019 be noted.

7 **Working Together to End Rough Sleeping**

Madeleine Freewood, Development Manager – City Health, presented the Working Together to End Rough Sleeping report. The report outlined that a multi-agency Task Team, chaired by the Leader, had been established to tackle the issue of individuals sleeping rough in the City and had operated from July 2017. Health and Wellbeing Together had been asked to commit to collaborating with the work undertaken by the Task Team and to have oversight of the Homelessness Prevention Strategy 2018 – 2022.

Anthony Walker, Homelessness Strategy and External Relationships Manager delivered a presentation which provided an update on the aims and achievements of the Task Team and included plans for the next steps and sustainability of the programme.

Focus was drawn to the 'Day of Action' event of 8 June 2018 which had involved volunteers and Task Team members providing immediate support to rough sleepers and offering advice to access other available support. This event included an exercise to record the number of individuals sleeping rough in the City.

Tanya Johnson, Service Co-ordinator P3 and Cheryl Rock, Antisocial Behaviour (ASB) Team Leader delivered a summary of the involvement and extensive work of the P3 Charity which included providing emergency accommodation and working with rough sleepers to support them in gaining access to services. Partners were invited to attend further Day of Action exercises and contribute to the work being undertaken.

Lucy Armstrong, Wolverhampton BID provided an introduction to the Alternative Giving Campaign, a charity which assisted in funding services such as P3, emergency accommodation and other support for rough sleepers. It was noted that local businesses had been encouraged to participate and donation boxes had been

placed in 19 locations, including the Civic Centre and large stores such as Boots and Sainsbury's.

It was highlighted that £14,858 had been raised to date and that ways to encourage more businesses to participate were being explored. It was reported that some of the businesses approached, including Jaguar Land Rover, Tarmac and the transport network had shown an interest already.

City Ambassadors had become involved in raising awareness of the Alternative Giving Campaign and its activity in the City Centre. It was noted that there had been instances of individuals bedded down in shop doorways becoming aggressive towards staff opening up in the early morning. It was noted that awareness of who to report to in this situation may help alleviate the problem. It was noted that there were already several trustees for the charity in place who were to meet in early February.

It was reported that a monthly count took place to allow for a better understanding of figures, however accuracy was an issue as the number of people identified as rough sleepers fluctuated throughout the day. This was also affected by the fact that there were several transient individuals as well as entrenched rough sleepers.

The ongoing work was commended as excellent and it was noted that, due to the complexity of the needs of these vulnerable individuals, there was no simple solution to the issue and further commitment from the Authority and partner organisations was needed to tackle it.

Attention was drawn to a number of rough sleepers bedded down in a subway near Bentley Bridge. The advice to partners from P3 was to call the helpline to advise when they were there and an outreach team would be sent to the location to assist.

It was confirmed that case information about individual clients was used by services to enable a person-centred approach to support rough sleepers. This was facilitated by the Public Health-led monthly group.

In relation to safeguarding, the work was commended as a practical and proactive partnership undertaking. It was highlighted that John Denley, Director of Public Health had agreed to contribute to national work on safeguarding and prevention of homelessness. Anthony Walker, Homelessness Strategy and External Relationships Manager was invited to join a Safeguarding Work Committee to share ideas.

A concern was raised regarding individuals discharging themselves from hospital over the weekend where services and medication had potentially limited availability. It was noted that P3 had a hospital discharge team to provide support. It was added that there was a Council link within New Cross Hospital to assist with these issues.

The work was again praised by Councillors and it was agreed that the final Homelessness Prevention Strategy 2018 – 2022 report would be provided at a future Health and Wellbeing Together meeting.

Resolved:

1. That the progress and achievements of the Leader's Tackling Rough Sleeping multi-agency Task Team be noted.
2. That the recommendations for the Leader's Tackling Rough Sleeping multi-agency Task Team's 'next steps' be agreed.

3. That a commitment to collectively tackling rough sleeping through a partnership model be agreed.
4. That the final Homelessness Prevention Strategy 2018 – 2022 report would be provided at a future Health and Wellbeing Together meeting.

8 **Healthwatch Deaf and Hard of Hearing Report**

Tracy Cresswell, Wolverhampton Healthwatch presented the Healthwatch Deaf and Hard of Hearing report. The report outlined that a consultation had been conducted to ensure that the deaf and hard of hearing community could share their experiences of health and social care services and provide feedback on improving access.

It was outlined that the attached appendix, Access to Health and Social Care Services for Deaf and Hard of Hearing People in Wolverhampton, had been compiled in conjunction with the University of Wolverhampton and went into detail about the experiences of British Sign Language users (BSL) both deaf and hard of hearing, from which a set of responses was published. Comprehensive case studies had been included to inform decisions for improvements.

The report had been shared with the deaf and hard of hearing community through the Deaf-led charity Zebra Access in September 2018 and had been met with a positive response. It was noted that the community had welcomed the fact that their feelings and suggestions had been taken into consideration.

Health and Wellbeing Together were asked to support the following:

- To encourage the Clinical Commissioning Group (CCG), City of Wolverhampton Council (CWC) and Royal Wolverhampton Trust (RWT) to deliver deaf awareness training to their staff.
- To continue to include deaf and hard of hearing users in commissioning BSL interpreters.
- To only use one provider of BSL interpreters as the current use of three different providers had caused confusion.

David Watts, Director of Adult Services stated that the opportunity to be involved was welcomed, although it was suggested that earlier involvement of the Council may have been beneficial. This was not to diminish the content of the report, which was particularly good, however a joint strategic approach was usually favourable.

It was also noted that, following the consultation, communication cards had been introduced to offer to individuals accessing health and care services. The cards identified the service user as deaf or hard of hearing and included a list of preferred forms of communication to be used by healthcare professionals. The cards had been funded by the Authority and were reported as working well.

Resolved:

1. That the responses to the consultation be supported by Health and Wellbeing Together.
2. That the Clinical Commissioning Group, City of Wolverhampton Council and Royal Wolverhampton Trust be encouraged to have deaf awareness training delivered to their staff.
3. That deaf and hard of hearing users would continue to be included in the commissioning of interpreters.

4. That only one provider of interpreters be commissioned across CCG, CWC and RWT.

9 **Consultation Feedback and Joint Health and Wellbeing Strategy 2018-2023**
James Annakin, Principal Public Health Specialist delivered the presentation on the Consultation Feedback for the Joint Health and Wellbeing Strategy. The presentation covered the seven priorities as outlined in the Joint Health and Wellbeing Strategy 2018 – 2023, the outcomes under each priority identified in the consultation and the proposed 'Future Focus' commitments asked of Health and Wellbeing Together.

The results of the consultation had shown that the majority of participants had supported the approach presented in the strategy.

The survey conducted as part of the consultation had also asked participants what would help them lead happier, healthier lives. 1,230 people had taken part and their responses identified the key themes as:

1. Feeling Safe
2. Green Spaces, Clean Air and Good Housing
3. Rewarding Work, Good Mental Health and Less Stress
4. Eat Well, Exercise More and Social Life
5. Easy Access to Health Services

The outcomes from the public consultation were weighed against the outcomes from the Health and Wellbeing Together self-assessment undertaken at the meeting of 17 October 2018 and provided insight into what other issues could be addressed. The Future Focus of Health and Wellbeing Together statements for each priority had been based on the issues raised in the public consultation responses.

Resolved:

1. That the Joint Health and Wellbeing Strategy 2018 – 2023 be approved.
2. That the findings of the public consultation be noted.

10 **Joint Public Mental Health and Wellbeing Strategy for Wolverhampton**
Lina Martino, Consultant in Public Health presented the Joint Public Mental Health and Wellbeing Strategy for Wolverhampton. The report outlined the aims and scope of the Strategy which had been developed in close collaboration by City of Wolverhampton Council and Wolverhampton Clinical Commissioning Group (CCG) led by Sarah Fellows. The report stressed the importance of mental health as being equal to physical mental health and that each had a fundamental effect on the other.

It was noted that the Joint Public Mental Health and Wellbeing Strategy for Wolverhampton had been approved by Cabinet on 12 December 2018 and had been brought to Health and Wellbeing Together for approval and for the Full Board to consider its role in the implementation of the Strategy.

It was added that the Strategy had been submitted to the Wolverhampton CCG governing body and fully endorsed.

The collaboration was commended by Councillor Hazel Malcolm as excellent and it was anticipated that the implementation of the Strategy would greatly improve quality of life.

Resolved:

That the Joint Public Mental Health and Wellbeing Strategy for Wolverhampton be approved.

11 **Autism Strategy Progress Report**

Robert Hart, Head of Inclusion Support presented the Autism Strategy Progress Report. The Board was advised that the Autism Strategy was halfway through its life and had needed refreshing. The report outlined progress in all areas achieved during the delivery of the strategy to date. It proposed a new focus on three key themes; promoting awareness and understanding; developing service pathways; and promoting independence. It also included proposals for new governance arrangements for the oversight of the Autism Strategy.

It was noted that the strategy had been developed jointly with Wolverhampton Clinical Commissioning Group (CCG) and City of Wolverhampton Council, involving input from people with autism, their families, carers and other stakeholders.

Three organisations had been highlighted to work with the National Autistic Society towards achieving Autism Friendly Organisation status:

- City of Wolverhampton Council
- Royal Wolverhampton Hospital Trust
- University of Wolverhampton

This would include offering co-ordinated awareness training for employees and developing a network of 'Autism Champions' to promote awareness and understanding throughout the City. It was noted that renewed focus was on the City of Wolverhampton achieving Autism Friendly City status.

The review and improvement of post-diagnostic support was also highlighted as a priority and work was being undertaken to ensure that people with autism could be supported to live an independent life. This would include ensuring a smooth and effective transition to adulthood and support in seeking employment.

It was explained that an Autism Partnership Board had been established which was to meet on a quarterly basis to provide oversight of the strategy. David Watts, Director of Adult Services had been identified as Chair. Three strategy implementation groups had been also been developed to focus on each of the three key themes, which were to feed back into the Autism Partnership Board.

Another key aim of the strategy was identified as providing effective support. It was to be explored how many people with autism were receiving support and how many more could be helped. A support group had been established for parents of autistic children and, as part of the Talent Match scheme, a young person had successfully secured funding to establish their own support programme in April 2019.

It was also noted that the strategy was due to be subject to a Scrutiny review in March 2019.

Resolved:

1. That the proposals for the refresh of the Autism Strategy be approved.

2. That the proposed governance arrangements for the Autism Strategy be approved.

12 **City of Wolverhampton Council Plan 2019 - 2024 Consultation**

Jennifer Brake, Service Director Strategy and Change delivered a presentation on the City of Wolverhampton Council Plan 2019 – 2024 Consultation. It was stated that the plan set out the priorities and framework for the next five years and was intended to supersede the existing Corporate Plan 2016 - 2019. It was highlighted that the focus was on delivering improved outcomes for the City whilst continuing to deliver the expected savings.

It was reported that engagement had taken place over the last six months including face to face sessions and online surveys, during which over 3,000 people had supplied their views. There had been organisational development with Council employees and the it was reported that Tim Johnson, Managing Director had participated in ward walks.

The six key priorities of the Plan were outlined as:

1. Children and Young People Get the Best Possible Start in Life
2. More good Jobs and Investment in Our City
3. Well Skilled People Working in an Inclusive Economy
4. Better Homes for All
5. Strong, Resilient and Healthy Communities
6. A Vibrant, Green City that We Can Be Proud Of

It was highlighted that it was important to recognise the City's diverse culture and cohesion whilst improving the City's reputation. It was noted that maintaining a realistic approach considering the financial position, managing expectations and honesty about what the Council aimed to do were also of key importance.

It was highlighted that collaboration was key and it was requested that the delivery of the outcomes be aligned with the work of the Board and that members support the aims of the Strategy. It was agreed that a copy of the draft City of Wolverhampton Council Plan was to be circulated to all members following the 25 January 2019 meeting and any feedback could be provided outside of the meeting.

The Council Plan 2019 – 2024 was to be reviewed at C3 Scrutiny Board on 6 February 2019, followed by approval by Cabinet in March 2019 and Council in April 2019.

Resolved:

1. That the City of Wolverhampton Council Plan 2019 – 2024 Consultation be noted.
2. That Health and Wellbeing Together members provide feedback on the draft City of Wolverhampton Council Plan.

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Health and Wellbeing Together

10 April 2019

Report title	Health and Wellbeing Together Forward Plan 2018 - 2019	
Cabinet member with lead responsibility	Councillor Hazel Malcolm Cabinet Member for Public Health and Wellbeing	
Wards affected	All wards	
Accountable director	John Denley, Director of Public Health	
Originating service	Governance	
Accountable employee	Shelley Humphries	Democratic Services Officer
	Tel	01902 554070
	Email	shelley.humphries@wolverhampton.gov.uk

Recommendation for action:

The Health and Wellbeing Together Executive Group is recommended to:

1. Note the Health and Wellbeing Together Forward Plan 2018 - 2019.

1.0 Purpose

- 1.1 To present the Forward Plan to Health and Wellbeing Together for comment and discussion in order to jointly plan and prioritise future agenda items for the Executive Group and Full Board.
- 1.2 The Forward Plan will be a dynamic document and continually presented in order to support a key aim of the Health and Wellbeing Together Full Board and Executive Group – to promote integration and partnership working between the National Health Service (NHS), social care, public health and other commissioning organisations.

2.0 Background

- 2.1 As agreed at the meeting of the Full Board in October 2016, the attached Forward Plan document seeks to enable a fluid, rolling programme of item for partners to manage.

3.0 Financial implications

- 3.1 There are no direct financial implications arising from this report.

4.0 Legal implications

- 4.1 There are no direct legal implications arising from this report.

5.0 Equalities implications

- 5.1 None arising directly from this report.

6.0 Environmental implications

- 6.1 None arising directly from this report.

7.0 Human resources implications

- 7.1 None arising directly from this report.

8.0 Corporate Landlord implications

- 8.1 None arising directly from this report.

9.0 Health and Wellbeing implications

- 9.1 The health and wellbeing implications of each matter will be detailed in the individual report submitted to the Group.

10.0 Schedule of background papers

- 10.1 Minutes of previous meetings of the Health and Wellbeing Together Full Board and Executive Groups regarding the forward planning agenda items.

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Health and Wellbeing Together: Forward Plan

Updated 13 March 2019

Health and Wellbeing Together is comprised of a Full Board and an Executive.

Full Board meetings are structured to shift focus from service silos to system outcomes by adopting a thematic approach to addressing the priorities identified in the Joint Health and Wellbeing Strategy. The primary focus of the Executive group is to sign off statutory documents and provide a strategic forum for the Council and health partners to drive health and social care integration.

KEY

Items in red are new or amended from the previous version.

Items in **bold** are regular or standing items.

Thematic areas: Growing Well, Living Well, Ageing Well, System Leadership

Joint Health and Wellbeing Strategy (JHWBS) priority areas:

1. Early Years
2. Children and young people's mental wellbeing and resilience
3. Workforce
4. City Centre
5. Embedding prevention across the system
6. Integrated Care; Frailty and End of Life
7. Dementia Friendly City

[E] Executive

[FB] Full Board meeting

Date	Theme	JHWBS Priority	Title	Partner Org/Author	Format	Notes/Comments
FB 10 April 2019	Ageing Well	Dementia Friendly City	Dementia Strategy	David Watts, CWC	Paper	
	System Leadership		Governance and Impact – Developing the Health and Wellbeing Dimension in All Policies	John Denley, CWC	Paper	Agreed at Executive Group Meeting 07 September 2018 to bring to a future Full Board meeting following further internal CWC consultation
	Growing Well	Early Years	Progress on Early Years Strategy	Meredith Teasdale, CWC		Requested at Full Board meeting 17 October 2018.
	System Leadership		Data identifying responsible authorities for NRPF within the City	Neeraj Malhotra, CWC	Paper	Requested at Full Board meeting 17 October 2018.
	Living Well	City Centre	Homelessness Prevention Strategy 2018-2022 and Associated Action Plan	Kate Martin, CWC	Paper	Discussion Item. Agreed at Full Board meeting 23 January 2019.

	System Leadership		Wolverhampton Clinical Commissioning Group (CCG) and Black Country and West Birmingham Sustainability and Transformation Partnerships (STP) Operating Plans	Dr Helen Hibbs, CCG	Paper	Agenda item request agreed by the Chair.
E 22 May 2019						
FB 03 July 2019	System Leadership		Annual Joint Health and Wellbeing Together Strategy Day (Focus) 12:00 – 16:00 Venue TBC	Madeleine Freewood, CWC	Facilitated discussion	Outlined in Terms of Reference.
E 04 September 2019						

FB 16 October 2019						
To be scheduled...	Growing Well		Black Country Strategic Child Death Overview Panel Development Update	John Denley, CWC	Update	Agreed at Executive Group on 20 February 2019.
		Integrated Care	Integrating Care in the City of Wolverhampton – Progress Update Report	Dr Helen Hibbs, WCCG	Update Report	



Health and Wellbeing Together

10 April 2019

Report title	Joint Dementia Strategy for Wolverhampton 2019 - 2024	
Cabinet member with lead responsibility	Councillor Sandra Samuels OBE Cabinet Member for Adults	
Wards affected	All wards	
Accountable Director	David Watts, Director of Adult Services John Denley, Director of Public Health Steven Marshall, Director of Strategy and Transformation and Deputy Chief Operating Officer, NHS Wolverhampton Clinical Commissioning Group (CCG)	
Originating service	People Commissioning	
Accountable employees	Andrew Wolverson Susan Eagle Tel Email	Head of Service - People Commissioner 01902 555344 susan.eagle@wolverhampton.gov.uk
	Sarah Fellows	Mental Health Commissioning Manager NHS Wolverhampton CCG
Report has been considered by	Adult Leadership Team NHS Wolverhampton CCG Governing Body	19 February 2019 28 February 2019
Report to be considered by	Strategic Executive Board Health and Wellbeing Together Cabinet	26 March 2019 10 April 2019 05 June 2019

Recommendation for decision:

The Health and Wellbeing Together Board is recommended to:

1. Approve the Joint Dementia Strategy 2019 – 2024 for Wolverhampton.
2. Approve the topic specific Joint Strategic Needs Assessment for Dementia in Wolverhampton.

Recommendations for noting:

The Health and Wellbeing Together Board is recommended to note:

1. The updated Joint Dementia Strategy 2019-2024 is an overarching document that incorporates City of Wolverhampton Council and NHS Wolverhampton CCG's commissioning intentions. It includes not just commissioned services to support people with a dementia diagnosis, but wider public services and workstreams to prevent dementia risk factors and promote community asset-based services to enable people affected by dementia to live well in their community.
2. The updated Joint Dementia Strategy 2019-2024 was informed and developed by an extensive consultation that was carried out as part of the development for the Strategy and the Joint Strategic Needs Assessment (JSNA) completed in February 2019 by Public Health. Initial feedback was sought on the draft Strategy and JSNA from Public Health, Council and NHS professionals, members of the Wolverhampton Dementia Action Alliance and the voluntary sector.
3. The action plan developed to accompany the Strategy document will be monitored by the Better Care Fund Dementia workstream group.

1.0 Purpose

- 1.1 This report describes the aims and scope of the updated Joint Dementia Strategy 2019 - 2024 for Wolverhampton, produced by a multi-agency workgroup including representation from the voluntary and community sector as well as carers of people who are living with dementia.

2.0 Background

- 2.1 The City of Wolverhampton's previous strategy was developed in 2015 by a multi-agency partnership. Since 2015 there has been significant progress in developing and delivering support to people affected by Dementia, including families and carers. This includes Wolverhampton Dementia Action Alliance being recognised as Dementia Friendly Community of the Year 2018 by the Alzheimer's Society.
- 2.2 In terms of population needs analysis, dementia is one of the world's major causes of disability and dependency in older people. It has an impact on the quality of life of not only those that have dementia, but of their families and carers too. The impact on carers and family can be physical, psychological, social and economic. There is often a lack of awareness and understanding of dementia, which can result in stigmatisation of the disease and barriers to care and diagnosis. Worldwide, the number of people with Dementia is estimated to triple by 2050. In 2015, the cost of dementia to the global community was \$818 Billion and is estimated to cost \$2 Trillion by 2030 (Source: JSNA <http://www.who.int/mediacentre/factsheets/fs362/en/>)
- 2.3 The Prime Ministers Challenge 2020 document stated the Governments key aspirations and commitment for improving Dementia support services in England by 2020:
- "The best country in the world for dementia care and support and for people with dementia, their carers and families to live; and
- "The best place in the world to undertake research into dementia and other neurodegenerative diseases". The updated Strategy is aligned to the priorities outlined in the Prime Ministers Challenge.

3.0 National and local context

- 3.1 According to The Prime Ministers Challenge 2020 document:
- There are 676,000 people with Dementia living in England and this figure is set to grow.
 - Dementia costs society an estimated £26 billion a year, more than the costs of cancer, heart disease or stroke.
 - A recent study estimated that by 2030, dementia will cost companies more than £3 billion, with the numbers of people who will have left employment to care for people with dementia set to rise from 50,000 in 2014 to 83,100 in 2030.

3.2 The JSNA for Dementia in Wolverhampton:¹

- estimated that there are over 3,000 people living with dementia
- projected that this figure will rise to 4,703 people by 2035
- demonstrated the relatively high prevalence of dementia in the City of Wolverhampton, with approximately five percent of citizens aged 65 and over living with the condition.

3.3 Recommendations in the JSNA include connecting people to support services earlier, ensuring that Black and Minority Ethnic Groups can access support, and promotion of both prevention messages and existing support available.

4.0 Joint Dementia Strategy 2019-2024

4.1 The Joint Dementia Strategy is underpinned by the topic specific Joint Strategic Needs Assessment (JSNA). The aim of this JSNA was to analyse the current and future 'needs' of people living with dementia, and their carers, in the City of Wolverhampton. Both the Strategy and JSNA were informed by extensive consultation. This included:

- a. A public and professionals Survey completed in 2018, which included specific questions related to dementia support and barriers.
- b. Focus groups with the community such as people affected by dementia, professionals and carers. The JSNA also analysed, local and national data sources.
- c. JSNA and Strategy Development Groups.

4.2 Reflecting both the local and national vision for transforming dementia care and support, the 2015 strategy seeks to develop proactive services and ensure good quality care and support that best meets the needs of people living with dementia, their families and carers. It follows a person-centred approach, aligned with NICE Quality statements and Prime Ministers Challenge on Dementia. This updated strategy keeps these central themes whilst recognising the opportunity to redesign services in a challenging climate with growing demand on resources.

4.3 The updated Strategy was developed in partnership with Public Health, City of Wolverhampton Council, Health Professionals and voluntary sector representatives. A Dementia Strategy Group met bi-monthly to review and discuss the pathways, need and demand to support people affected by dementia. The NHS Living Well Pathway for Dementia was used to provide thematic group discussions and ensure all elements of the pathway was discussed. This framework underpins the updated Joint Dementia Strategy 2019-2024 as detailed below and is grouped into themes, as follows: Preventing Well, Diagnosing Well, Living Well, Supporting Well and Dying Well.

¹ Source: <http://www.poppi.org.uk/>

Our Aims for people affected by Dementia in Wolverhampton

Preventing Well	The City of Wolverhampton will be 'memory aware' and promote risk reduction through healthy lifestyles.
Diagnosing Well	People living with dementia in the City of Wolverhampton will receive a timely diagnosis with an offer of early support.
Living Well	The City of Wolverhampton will be a Dementia Friendly City that supports people to continue to live well and connect to their community.
Supporting Well	People living with dementia in the City of Wolverhampton will receive support that adapts to changing needs with access to good quality secondary care.
Dying Well	People with dementia in the City of Wolverhampton can die with dignity and respect.

- 4.4 In developing the updated Strategy it is recognised that there are pockets of good practice. However, this support was not always clear to individuals and professionals, and that work could be joined up better across the wider system. This Strategy will help to avoid unnecessary duplication and allows the identification of any gaps or unmet need such as in respect of the experience of those who are hard of hearing or deaf or from specific ethnic communities.
- 4.5 The updated Joint Dementia Strategy 2019-2024 provides a high-level summary of current achievements and planned workstreams across the City of Wolverhampton Council and CCG. It promotes messages of prevention, including specific pieces of work to engage with Black and Minority ethnic groups through all levels of support including being able to use good practice such as advance end of life care planning. It provides key actions, covering all levels of support from universal to specialist services.

4.6 The aim is to not only meet the specific needs of people diagnosed with dementia but also recognise the levels of support required as a person ages, or their dementia advances, whilst promoting positive messages of wellbeing and related risk factors.

5.0 Key Themes in the Joint Dementia Strategy 2019-2024

5.1 In addition to the recommendations of the JSNA, the key redesign highlighted in the Strategy is the development of a new integrated offer that supports the delivery of targeted specialist care and support in people's homes, this also includes residential care homes.

5.2 The Strategy also highlights gaps in the community pathway to support people with dementia to access day/community respite.

5.3 There is a commitment in the Strategy to engage with Black and Minority ethnic communities.

5.4 The partners are requested to continue to work together to deliver the actions and utilise partnership working groups including the Better Care Fund workstreams.

5.5 This updated Strategy has provided a framework for developing an action plan based on systematic identification of where support may be lacking, and opportunities for working across teams, sectors and organisations to deliver quality outcomes during challenging demands and budget pressures.

6.0 Financial implications

6.1 There are no financial implications arising directly from this report. Any costs related to delivery of the strategy will be met from existing budgets.

[AJ/15022019/N]

7.0 Legal implications

7.1 The CCG has statutory obligations to commission safe, effective services that deliver value for money in partnership with key stakeholders and in response to levels of need and service user and carer views. This is in keeping with the seven key principles of the NHS Constitution (2015) and also with operational and planning guidance as laid out in the mandate to NHS England by the Department of Health.

The Health and Wellbeing Board is a statutory board established under the Health and Social Care Act 2012. It has a statutory duty to promote the integration of commissioning.

[TS/14022019/Q]

8.0 Equalities implications

8.1 A reduction in health inequalities is an overarching aim of the Strategy. Equalities impact assessments will be carried out as appropriate within the work programmes that make up the overarching Strategy.

8.2 The Strategy is inclusive and considers support for all needs and will continue to develop an understanding of potential barriers to access support and services. For example, considering the particular concerns from the Black and Minority Ethnic Groups, the deaf community and adults experiencing sight loss.

8.3 The Council and CCG are committed to ensuring the correct assessments are completed through any associated projects.

9.0 Environmental implications

9.1 There are no environmental implications directly associated with this report. If specific implications arise in redesign projects, these will be highlighted through separate workstreams and reports.

10.0 Human resources implications

10.1 There are no human resources implications directly associated with this report. If specific implications arise in redesign projects, these will be highlighted through separate workstreams and reports.

11.0 Corporate Landlord implications

11.1 There are no Corporate Landlord implications directly associated with this report. If specific implications arise in redesign projects, these will be highlighted through separate workstreams and reports.

12.0 Health and Wellbeing Implications

12.1 A Joint Dementia Strategy in place will have a beneficial impact on the local population but through facilitating discussions between partner organisations and key stakeholders an opportunity exists to ensure pathways, processes and in turn outcomes improve across organisations and sectors.

13.0 Schedule of background papers

14.0 Appendices

14.1 Appendix 1 - Joint Dementia Strategy 2019-2024 (draft)

Appendix 2 - Joint Strategic Needs Assessment – Dementia 2019 (draft)

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Joint Dementia Strategy 2019 – 2024

*Improving the lives of people affected by dementia in the City of
Wolverhampton*

2015/17 Strategy Update

Executive Summary

To be added after approval.

Introduction

Dementia is one of the biggest challenges facing the nation today.

Some **650,000 people** in England are believed to be living with dementia, including **3,100 people in the City of Wolverhampton**, with somebody diagnosed with the condition every **four seconds worldwide**.

Dementia is an umbrella term used to describe many different types of dementia, particularly Alzheimer's Disease, Vascular Dementia and Dementia with Lewy bodies.

It can affect anyone and causes a decline in a person's cognitive (intellectual) abilities, affecting their memory, language, understanding, reasoning, problem solving and concentration, but each person's dementia is unique and so affects their lives in very different ways.

Cases of dementia increase with age, and as life expectancy increases, more and more people will be affected. Currently, one in 50 people between the ages of 65 and 70 have a form of dementia, compared to one in five over the age of 80. Around 42,000 people under 65 are living with dementia and this number is increasing.

Diagnosis is often made at a later stage of the illness and this can affect the person's ability to make choices and decisions.

Of course, dementia does not just have a devastating effect on the individual, but also their families and friends. An estimated 21 million people know a close friend or family member with dementia – that's nearly half of the population, and it's important that they get the help and support they need to carry out their caring role.

Life should not stop because of dementia. People with dementia and their family and carers may need support to enable them to carry out activities and engage in relationships in a positive way, so that they can continue to lead a full and active life.

Source: Alzheimer's Society, Dementia UK, Fingertips PHE



The City of Wolverhampton's Joint Dementia Strategy

The City of Wolverhampton Dementia Action Alliance were proud to be awarded Dementia Friendly Community of the Year 2018. Already a great deal of good work has taken place locally to improve the lives of people with dementia and their families.

The City of Wolverhampton's previous strategy was developed in 2015 by a multi-agency partnership with representation from the City of Wolverhampton Council, Wolverhampton Clinical Commissioning Group, Royal Wolverhampton NHS Trust and Black Country Partnership Foundation Trust. Businesses, organisations, community groups and individuals also came together through Wolverhampton Dementia Action Alliance to develop this strategy for people affected by dementia in the City of Wolverhampton.

Image

Reflecting both the local and national vision for transforming dementia care and support, the strategy seeks to develop proactive services and ensure good quality care and support that best meets the needs of people living with dementia, their families and carers. It follows a person-centred approach, putting the service user at the heart of the decision-making process. The Strategy is aligned with NICE Quality statements and was developed in line with Living well with dementia 2012 and Prime Ministers Challenge on Dementia.

It highlights several key areas and actions, and an implementation plan to ensure a range of improvements are delivered.

Since 2015 there has been significant progress in developing and delivering support to people affected by Dementia, including families and carers.

Due to the consultation and partnership approach to developing this updated Strategy, the core aspirations remain unchanged. The way in which we design, develop and deliver support is changing due to many factors, including the increasing population and the increasing number of people being diagnosed with dementia in a climate of greatly reduced finance and resources.

This update is therefore an opportunity to:

- Align our strategic approach with national policy and relevant local delivery models
- Review the aspirations of the Strategy
- Work with partners, service users and carers to set new actions to continue delivering outcomes for people affected by dementia in the City of Wolverhampton.
- Drive new ways of working that will improve outcomes and the support available
- Promote prevention messages and healthy lifestyles especially to key age groups and Black and Minority Ethnic communities in line with the findings from Dementia UK, who highlighted in their recent study key groups of people whose understanding of dementia is lower, including those from black, Asian and minority ethnic backgrounds, and adults under 24 and over 65.
- Reflect a stronger offer of support through strengthening partnerships with health, social care and community organisations

Joint Dementia Strategy Headlines

The Joint Dementia Strategy 2015-17 included several aims and objectives which have a big impact on the lives of people with dementia. The headlines include:

- **Making the City of Wolverhampton a Dementia Friendly City**, in which people with dementia and their carers feel confident to participate in everyday life and can live well and independently for as long as possible.
- **Developing dementia awareness programmes for all members of the community**, including health and social care staff, public and emergency service workers, retailers, businesses, schools, colleges and universities, councillors and community groups, leisure and cultural facilities, care homes and housing associations.
- **Reducing waiting times for assessment and diagnosis**, and improving diagnosis, prescribing and post diagnosis support.
- Providing **written and verbal information** about dementia to people who are newly diagnosed and their carers, about the different types of treatment available to them and the kind of support on offer in Wolverhampton.
- Offering a **comprehensive health and well-being assessment** to carers and agreeing care plans which will help and support them in their role as a carer.
- **Improving access to key services**, including those provided by voluntary and community groups.
- Enabling more people with dementia and their carers **to attend dementia cafes** in the City of Wolverhampton, where they can meet other people with the condition, share their experiences and find out more about the help and support available to them.
- Ensuring people with dementia and their carers **play a part in developing personalised care plans** so they can maintain their independence for as long as possible.
- Improving services for people living with dementia such as **housing, extra care support and adaptations within the home** to help maintain their independence for as long as possible.
- Offering people with dementia and their carers **health and well-being assessments** to develop care plans which enable them to maintain a healthy lifestyle and their independence.
- Providing carers with a range of **respite and short-break services** that meet their needs, and the needs of the person they care for.
- Increasing the number of **people aged 40-74 who receive NHS health checks**, which includes dementia screening.
- Enabling more **people with dementia and their carers to be involved in advanced decision making**.
- Supporting people to plan and prepare for end of life care and **make informed decisions about their treatment**.
- **Improving clinical guidance** for managing symptoms for people with dementia.
- **Improving access to palliative care** services for people living with dementia.

There are also several pledges aimed at improving the way health, social care and other organisations work together to continue developing dementia services in the City of Wolverhampton. These include integrating health and social care teams, improving dementia awareness among practitioners and sharing best practice.

Our Progress

The City of Wolverhampton is now an **award-winning Dementia Friendly Community** reflecting the excellent work taking place through organisations who are members of Wolverhampton Dementia Action Alliance. Significant progress has been made in raising awareness of dementia within communities. This progress is reflected in our diagnosis rates, which are among the highest in the Country at 73.3 percent compared to 67.5 percent nationwide. Wolverhampton also has **13,000 Dementia Friends** in the City.

Through individual initiatives and collaborative efforts, more support is now available to people living with dementia in the City of Wolverhampton. Together, we are:

- Offering support and a free 'carers assessment' to **carers of people affected by dementia**.
- Commissioning a **new Dementia Navigator Community Service** that provides early, and ongoing one-to-one support.
- Undertaking a targeted approach to ensure people can access their **full benefit entitlement**.
- Enabling more people with dementia and their carers to attend **dementia cafes**, with more cafes being developed within our communities.
- Social Care deliver **Memory Matters and Talking Points** across the community to raise awareness and support people who are concerned about their or a loved one's memory.
- Equipping libraries with **Reading Well Books** on prescription.
- Extending **social prescribing**.
- Promoting independence with **Telecare**
- Becoming as dementia friendly as possible, with **organisations across the city reviewing their services**.
- Rolling out **Dementia Friendly GP Practices**, to raise awareness of dementia, support diagnosis and improve post diagnostic support.
- Strengthening the support offered in **care homes**, through partnership working on quality and providing training around Advanced Care Planning and End of Life care.
- Enabling people with dementia to **avoid hospital admissions** by reviewing the support available in the community through an early identification project delivered by the CCG.
- The University of Wolverhampton continue to **undertake research** and share their findings
- Improving support for people with dementia in hospital with the **enhanced Mental Health Liaison Service**.
- Enhancing the experience that people affected by dementia have in hospital by **developing a new Reminiscence Room**.
- Providing excellent care, with the Royal Wolverhampton NHS Trusts' specialist acute medical ward and outreach service recognised as a **centre of excellence**.
- **Supporting patients** better by offering a **bespoke training programme** on dementia for hospital staff.
- Delivering a **cognition clinic** to support in diagnosing people where there may be other causes of cognitive impairment.
- Improving outcomes for dementia patients by using **Graphnet**, which enables GPs and Consultants to share information.
- Developing the **SWAN Programme**, which will support End of Life Care.
- Developing a **GSF framework** to better equip care homes in supporting people with dementia during end of life.
- Sharing knowledge and improving support through our **Better Care Fund Group**.
- Extending the **Red Bag Project Wolverhampton** across all care homes and nursing homes, to help ensure patients receive safe, efficient and effective care.
- Refining our approach to dementia, by developing the **first topic specific Dementia JSNA for the City of Wolverhampton**.

Key Priorities 2019 - 2024

From our engagement exercises and partnership discussions, we know a lot of good work has taken place in the City of Wolverhampton. We are committed to continue the good work and will also continue to listen to our communities to support us in developing and improving services.

We know that our priorities need to focus on developing a whole system pathway that includes:



Playing our role in prevention, by promoting healthier communities and supporting the NHS Health Checks programme - raising awareness of Cardiovascular dementia and younger onset.



Raising awareness of available support for dementia and sharing this information with agencies and people affected by the condition. This includes working with partners across health and care to improve the quality, completeness and linkage of data. This also includes work with Black Asian and Minority Ethnic communities, the deaf community and adults with sight loss, to promote engagement and improve outcomes within all communities.



Working with GP's to ensure co-ordinated support throughout a persons dementia diagnosis.



Strengthening our offer around community support, including proactive support for people awaiting diagnosis and improved post diagnosis support.



Enabling people with dementia to live in their communities for as long as possible by ensuring a wide range of support. this includes connecting people to existing support such as existing community groups, frailty pathway, and integrated health and social care



Extending the cultural and leisure opportunities available to ensure that people living with dementia can connect to their community and have opportunities to do the things they enjoy.



Redesigning community services to facilitate a range of support that can meet people's needs, from young onset dementia to early stages and advanced dementia.



Strengthening our offer to carers and people affected by dementia by reviewing respite and day support.



Developing the support which helps people stay in their own homes, including care and nursing homes, thereby reducing avoidable hospital admissions and equipping people well as their dementia advances.



Connecting people to services and support early to avoid emergency crisis situations – this includes Advance Care Planning to enable a good death.

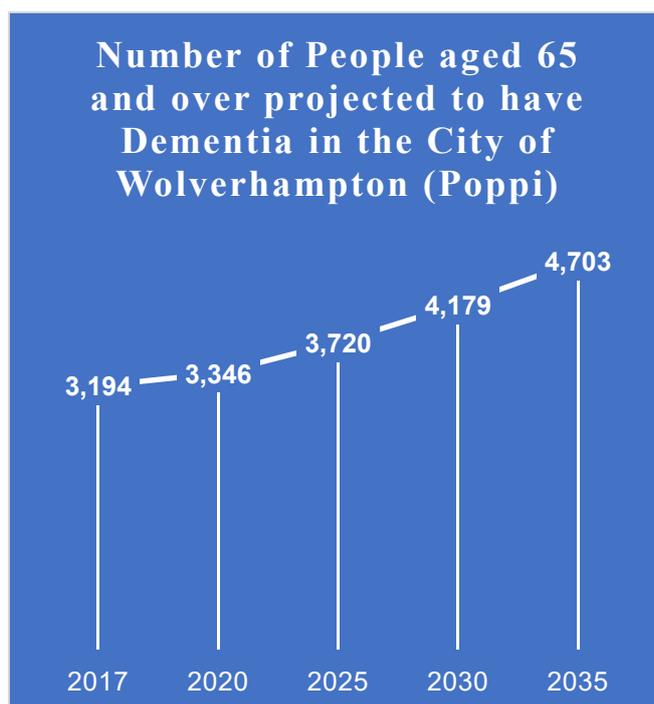
Joint Strategic Needs Assessment for Dementia

Nationally and locally the number of people living with dementia is rising.

In response, the City of Wolverhampton Council, the Royal Wolverhampton Hospital Trust and Wolverhampton Clinical Commissioning Group collaborated to produce the city's first Joint Strategic Needs Assessment (JSNA) for dementia.

The aim of this JSNA was to analyse the current and future 'needs' of people living with dementia, and their carers, in the City of Wolverhampton.

It demonstrated the **relatively high prevalence of dementia in the City of Wolverhampton**, with approximately 5 percent of citizens aged 65 and over living with the condition. This figure is significantly higher than the national and regional rates and is expected to grow in line with national projections. The graph depicts Poppi's projections for Dementia in the City of Wolverhampton.¹



Our research and engagement with stakeholders identified the following from a cohort of people diagnosed with dementia, carers and professionals:

- One in five respondents with dementia told us that they were 'not living well' with the condition.
- Less than one third of respondents with dementia said they have used a Dementia Café in the last three years, with many not being aware of the support and others struggling to access the service.
- The directly standardised rate of emergency admissions for dementia among people aged 65 and over has significantly increased and is significantly higher in Wolverhampton than nationwide.
- Many professionals working with dementia told us that they were not confident that the specific needs of people with the condition were being met or will be met in the future.

Key Recommendations:

- Raise awareness of the support available for people with dementia – especially BAME communities and connect support to other groups such as those people with sight loss, 'hard of hearing' and the deaf community.
- Connect people to the support available in the community by promoting Dementia diversifying Cafes.
- Ensure health and social care professionals are aware of the available support and equipped to signpost and refer people affected by dementia to the correct service in a timely way, using personalised care plans based on This is Me.
- To develop a whole system pathway to demonstrate how services connect to support anyone diagnosed with dementia.

To see the full JSNA please visit: <http://win.wolverhampton.gov.uk/dementia>

¹ <http://www.poppi.org.uk/>



Our Strategic Direction: A Dementia Friendly City

The various actions contained within the Joint Dementia Strategy supported the City of Wolverhampton's ambitions of becoming a Dementia Friendly Community. Having achieved this status in 2018, we will continue efforts to make the City of Wolverhampton as dementia friendly as possible.

A dementia friendly community is one that is aware of and understands the needs of people with dementia, encourages them to seek support from their local community and, most importantly, gives them the help they need to live their lives.

It empowers people with dementia to aspire and feel confident to take part in everyday activities, enabling them to remain living independently and take greater control over their lives.

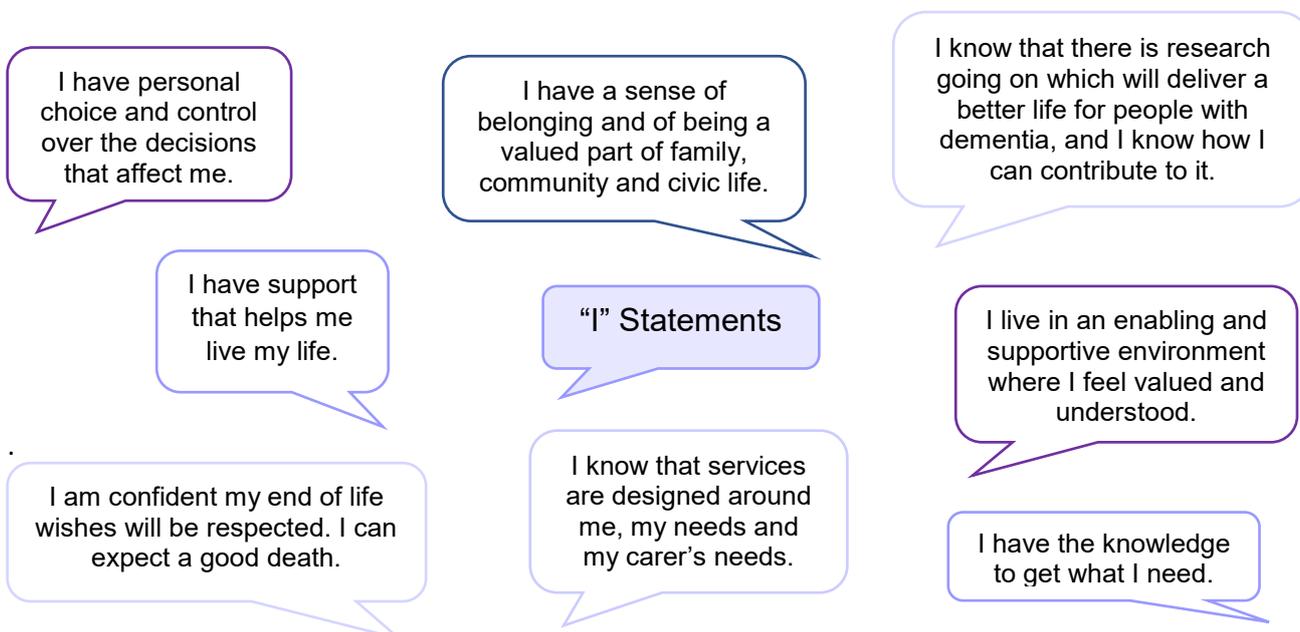
To become a dementia friendly community, the City of Wolverhampton needs the help and support of organisations which people with dementia access on a regular basis, and so a local Dementia Action Alliance has been established.

It has brought together more than 30 local organisations, including health and social care providers, retailers, banks, the emergency services, religious groups, education providers and more, who are working together to ensure people live well with dementia. Each organisation has produced its own action plan to ensure that it responds to the needs of people with dementia and their carers.

You can find out more at:
win.wolverhampton.gov.uk/Dementia

Guiding Principles

Our approach will be guided by the 'I' statements outlined in the 2020 Challenge on dementia and the NICE Quality Statements for dementia (QS30).



NICE QS30 Quality Statements for Dementia	
1	People worried about possible dementia in themselves or someone they know can discuss their concerns, and the options of seeking a diagnosis, with someone with knowledge and expertise.
2	People with dementia, with the involvement of their carers, have choice and control in decisions affecting their care and support.
3	People with dementia participate, with the involvement of their carers, in a review of their needs and preferences when their circumstances change.
4	People with dementia are enabled, with the involvement of their carers, to take part in leisure activities during their day based on individual interest and choice.
5	People with dementia are enabled, with the involvement of their carers, to maintain and develop relationships.
6	People with dementia are enabled, with the involvement of their carers, to access services that help maintain their physical and mental health and wellbeing.
7	People with dementia live in housing that meets their specific needs.
8	People with dementia have opportunities, with the involvement of their carers, to participate in and influence the design, planning, evaluation and delivery of services.
9	People with dementia are enabled, with the involvement of their carers, to access independent advocacy services.
10	People with dementia are enabled, with the involvement of their carers, to maintain and develop their involvement in and contribution to their community.

Our Framework

	Our Aims	Measures
Preventing Well	The City of Wolverhampton will be 'memory aware' and promote risk reduction through healthy lifestyles.	<ul style="list-style-type: none"> • Number of Dementia Friends and organisations signed up to the Dementia Action Alliance • Promoting public health and wellbeing to reduce the vascular risk factors for dementia in our City • https://www.nhs.uk/conditions/dementia/dementia-prevention/ • Increase the number of NHS health checks and utilisation of dementia screening tools
Diagnosing Well	People living with dementia in the City of Wolverhampton will receive a timely diagnosis with an offer of early support.	<ul style="list-style-type: none"> • Increase the rate of timely diagnosis including younger onset dementia • Reduced waiting times for a memory assessment • Offer early support at assessment, diagnosis and beyond • Offer information on support agencies, including benefits, carers support and Dementia Café's or groups.
Living Well	The City of Wolverhampton will be a Dementia Friendly City that supports people to continue to live well and connect to their community	<ul style="list-style-type: none"> • We will be accredited as a 'Dementia Friendly City' • Reduction in inappropriate prescribing of anti-psychotic medication • More people with dementia using self-directed support • More people with dementia and their carers connecting to support through their Navigator, who will use an asset-based approach to enable people to continue to live well • People have access to community support and information to prepare them for the future through personalised support plans
Supporting Well	<p>People living with dementia will receive support that adapts to changing needs with access to good quality secondary care.</p> <p>The Trust will continue to deliver excellence in dementia care within the Trust, when hospital admission is unavoidable.</p>	<ul style="list-style-type: none"> • Integrated support for dementia is offered through health and social care teams and voluntary or community organisations – connect to existing pathways such as frailty and integrated care • People affected by dementia will have a named Navigator to connect them to the available support • Develop community teams to treat more people in their own home leading to; • Reduction in admissions to acute care • More people with dementia will have an Advanced Care Plan that includes end of life planning – including lasting power of attorney information and support.
Dying Well	People with dementia in the City of Wolverhampton can die with dignity and respect	<ul style="list-style-type: none"> • Develop a clear understanding of the end of life pathway and the support available for people affected by dementia, including families and carer • Reduction in unnecessary hospital admissions within the last year of life • Bereaved carer's views on the quality of end of life care received to improve outcomes

Actions: Preventing Well

NHS Well Pathway Aim	Outcome	Action	Leads
<p>The risk of people developing dementia is minimised.</p>	<p>Promoting healthy lifestyles information with key messages about awareness, early intervention, prevention and risk factors for developing dementia</p>	<p>Targeted prevention messages in GP practices, both literature and screens.</p> <p>Regular messages in carers newsletters.</p> <p>Targeted awareness by all agencies during Dementia Action Week and business as usual.</p> <p>Ensure prevention messages and healthy lifestyles for people affected by dementia are included as part of public health events, literature and campaigns.</p> <p>Ensuring existing campaigns feature dementia.</p> <p>Link dementia to healthy ageing city initiatives and healthy lifestyles.</p> <p>Collect baseline of NHS health checks and measure the increase of the number of people taking them.</p> <p>Ensure Dementia Friends Sessions continue to be delivered in all areas of the community.</p>	
	<p>Raising awareness to seek assessment early if there are memory concerns</p>	<p>Leaflets available in health services covering hospital, primary care and community settings (e.g. pharmacies)</p> <p>Promote Memory Matters and Talking Points as ways to discuss early concerns.</p> <p>Continued service user, carer and provider engagement.</p>	
	<p>Enable key staff such as community nurses, Dom care and care home staff are aware of prevention and risk reduction and where to signpost</p>	<p>Increase the number of Dementia Friendly GP Practices.</p> <p>Increase the number of NHS Health checks and the utilisation of dementia screening tools.</p> <p>Promote dementia friendly training and sessions as part of inductions.</p>	
	<p>Increase early diagnosis and access to targeted groups – including all protected characteristics</p>	<p>All agencies to promote awareness and support information to BME communities, people with disabilities, deaf communities and those with co-morbidities. This includes people under 65.</p>	

Actions: Diagnosing Well

NICE Statement/ Dementia Declaration	Outcome	Action	Leads
<p>Timely, accurate diagnosis, a care plan and a review within the first year for all.</p>	<p>Continue to increase the rate of timely diagnosis</p>	<p>Work with NHS England to deliver targets in place.</p> <p>Memory Matters Service continues to raise awareness and strengthen referral to GP.</p>	
	<p>Reduced waiting times for a memory assessment</p>	<p>Strengthen and formalise the assessment process where people receive a diagnosis at RWT by ensuring the screening and cognition pathway is utilised.</p> <p>Ensure GP's discuss diagnosis with patients when diagnosis is received and signpost to Dementia Navigator Community Service for post diagnostic support.</p> <p>Continue to strengthen diagnosis in acute settings and offer dementia support at RWT through staff induction and utilising dementia outreach team.</p> <p>Ensure BCPFT maintain assessment waiting times below the 12-week threshold.</p> <p>Explore a high-quality memory assessment through the achievement of MSNAP accreditation.</p> <p>Explore the diagnostic role in community pathways such as pharmacies and community nurses and strengthen communication when a diagnosis is made, to ensure post diagnostic support is available earlier on.</p> <p>Improve diagnosis rates in care homes through early identification. Staff to receive appropriate training.</p>	
	<p>People are offered early post diagnostic support at assessment, diagnosis and beyond</p>	<p>Care Navigators at GP surgeries refer to Dementia Navigators Community Support Service and Carer Support Team.</p> <p>GP's are given messages on early support, dementia friendly initiatives and continue to deliver on QOF targets.</p> <p>Explore Dementia Navigators joining BCPFT at the end of assessment process to strengthen post diagnostic support.</p> <p>Community nurse teams know how to refer to Dementia Navigators.</p> <p>Share information on support agencies, including benefits, carers support and Dementia Café's on websites, leaflets, GP.</p>	

Actions: Living Well

NICE Statement/ Dementia Declaration	Outcome	Action	Leads
<p>People with dementia can live normally in safe and accepting communities.</p>	<p>More people with dementia and their carers connecting to support through their Navigator, who will use an asset-based approach to enable people to continue to live well. Ensure high quality, appropriate post-diagnostic support is available to all, including younger people, those with comorbidities and those from BME groups</p>	<p>Ensure all agencies are referring directly to the Dementia Navigator Support Service delivered by the Alzheimer's Society.</p> <p>Make links with BME groups, community and faith groups.</p> <p>Advertise all post diagnostic support available to the public and professionals.</p> <p>Explore Dementia Navigators meeting patients at Assessment.</p>	
	<p>More people with dementia engaged with agreeing advanced care plans and using self-directed support</p>	<p>Dementia Navigators will ensure a plan is in place that promotes independence and supports in planning for changes in the future.</p> <p>An asset-based approach will be taken to support people in what they can continue to do, like to do and enjoy doing to enable people to live fulfilling lives. This includes, healthy lifestyles, community activities, dementia cafes and benefit checks.</p> <p>Information on where to go when things change will be readily available to avoid patients and carers entering crisis.</p> <p>All agencies will encourage people affected by dementia to plan for the future with early conversations and refer where appropriate, to compassionate communities and dying well.</p>	
	<p>Continue the work of the Dementia Action Alliance and remain accredited as a Dementia Friendly Community</p>	<p>Deliver community events.</p> <p>Increase members.</p> <p>Increase in number of dementia friends.</p> <p>Expand activity to schools and transport.</p> <p>Explore cultural, leisure and social opportunities are available and promoted.</p>	

	<p>Carers and family support</p>	<p>Continue the assessment and support delivered by the Carer Support Team.</p> <p>Explore the development of the CRISP programme for carers.</p> <p>Ensure carers needs are assessed and support is in place to maintain their own wellbeing.</p> <p>Enable carers to access support and promote community support available to them.</p>	
	<p>Promote independence</p>	<p>Information on what is available is accessible in all community and statutory agencies.</p> <p>Navigators will make referrals to enable people to continue their independence by referring to assistive technology, welfare support and where to seek advice and guidance.</p> <p>Explore the possibility of commissioning Admiral nurses.</p>	

Actions: Supporting Well

NICE Statement/ Dementia Declaration	Outcome	Action	Leads
Access to safe, high quality health and social care for people with dementia and carers.	People affected by dementia will have a named Navigator to connect them to the available support	All agencies to refer. All services are equipped to signpost people to support, particularly for people who are receiving a late diagnosis.	
	More people with dementia will have an Advanced Care Plan that includes end of life planning.	Early conversations by all care co-ordinators to ensure the completion of an Advanced Care Plan- services are equipped to refer to teams that can complete Plans. Care plans should be personalised and specific on patient's wishes and deter hospitalisation which would cause further deterioration. All patients will have a Care Plan, and this will be based on 'This is me' - this should include information on mental capacity and lasting power of attorneys.	
	Integrated support for dementia is offered through health and social care teams and voluntary or community organisations	Supporting Well strategy group continues to meet and ensures shared information to improve services by problem solving and sharing information. This may include, shared protocols and training between services. Co-ordination of services to be improved and full offer of support to be mapped and implemented. Agencies make connections to existing services, such as the Frailty pathway and Telecare. Explore Frailty Co-ordinators in GP clinics who will connect to health and social care services. Report the impact of EPAC once rolled out – improve the expectations of GP's as care coordinators once EPAC is in place and LES in place.	
	Developing community teams to treat more people in their own home leading to below;	Supporting Well strategy group continues to meet and ensures shared information to improve services by problem solving and ensuring actions are undertaken. Explore GP groups who have an interest in dementia and service improvement.	
Reduction in admissions to acute care	Review respite and day support for people affected by dementia and develop a new model in line with modernised day		

		<p>services and incorporating new health community team input.</p> <p>Map independent community services such as Age concern sitting service, carer support, community support and extra care schemes.</p>	
	<p>Improving the quality of care in the community to reduce unplanned admissions, delayed discharges and placement breakdowns</p>	<p>Rapid Intervention Team already treating people in care homes and at home. This offer to be formalised to support hospital avoidance.</p> <p>Develop a bespoke community team that offers clinical support to care homes and to people in their home. Particularly to improve outcomes for patients with dementia where hospital admission often provides further challenges and confusion. Explore mental health teams home treatment team and crisis resolution model.</p> <p>Explore a targeted training and support package to those homes with high admissions to hospital.</p> <p>Explore Dementia Outreach Team and expanded offer in hospital to home.</p> <p>Develop D2A and Reablement pathway to ensure staff and professionals are able to support people with their primary goals with a dementia diagnosis.</p> <p>Work with the Integrated Care Alliance to ensure outcomes are monitored and recorded.</p> <p>Work with care home, domiciliary and care home staff to equip them in supporting people with dementia.</p> <p>Quality assurance teams to share best practice within care homes to raise improvements in dementia friendly environments and activities.</p> <p>Explore national models of community support and targeted support for people with advanced dementia.</p> <p>Explore Admiral nursing programme to deliver training to health professionals.</p> <p>Ensure all agencies have and refer to This is Me /About Me document – continued use in Red Bag.</p>	
	<p>Excellence in Dementia Care Programme</p>	<p>The Trust will continue to develop and deliver the Excellence in Dementia Care programme through the development and delivery of RWT's Strategy and campaigns.</p>	

Actions: Dying Well

NICE Statement/ Dementia Declaration	Outcome	Action	Leads
<p>People with dementia die with dignity and in the place of their choosing</p>	<p>Develop a clear understanding of the end of life pathway and the support available for people affected by dementia, including families and carers</p>	<p>Share the pathway within the End of Life strategy - ensure criterion are as flexible as possible to provide a person-centred approach.</p> <p>Ensure information is given to people about mental capacity and lasting power of attorneys.</p> <p>Ensure agreed documentation is in place for teams who can complete Advanced Care Plans, advanced directives and refusal for treatment and that they are aware of responsibilities.</p> <p>Continue the work between quality teams and care homes to equip staff with difficult conversations and ensure correct documentation is in place.</p> <p>Build on the work between Compton Care and CCG to ensure staff are confident to deliver this pathway and promote available training on end of life care conversations.</p>	
	<p>Reduction in unnecessary hospital admissions within the last year of life</p>	<p>Explore the expansion of low-level palliative care and support.</p> <p>Promote rapid discharge to home pathway as this is currently underutilised.</p>	
	<p>Bereaved carer's views on the quality of end of life care received</p>	<p>Promote Bereavement Hubs that provide advice and opportunities to connect with people who are in the same position as you.</p> <p>Continue to deliver Dying Matters awareness weeks and promoting conversations.</p> <p>Ensure support plans and plans in place are used to respect patient's wishes.</p> <p>Ensure everyone has access to information to enable a good death.</p>	
	<p>Test the pathway</p>	<p>Undertake a walkthrough of all dementia interfaces and services. This will enable further understanding to develop areas and share good practice.</p>	

Dementia Action Alliance

The City of Wolverhampton's Dementia Action Alliance is part of a national movement which aims to encourage and support local communities and organisations to bring about a society-wide response, including practical actions which enable people to live well with Dementia. The Alliance is co-ordinated through City of Wolverhampton Commissioning Team and chaired independently. Some examples of our members actions include, ensuring all staff become Dementia Friends, holding social spaces for people living with dementia and their carers, holding awareness days in their organisation and during Dementia Action Week, making their space more dementia friendly.

Members of Wolverhampton Dementia Action Alliance include but not limited to:

Age UK	Dementia UK	Newhampton Arts Centre
Alzheimer's Society	Diocese of Lichfield	Ring and Ride
Asda	FBC Manby Bowdler Solicitors	The Royal Wolverhampton NHS Trust
Accord	Fiddle Finger Quilts	Trading Standards
Beacon Centre	Grand Theatre	University of Wolverhampton
Black Country Partnership	Healthwatch	West Midlands Fire Service
NHS Foundation Trust	HSBC Bank	West Midlands Police
BME United	Home Instead	West Midlands Ambulance Service
Citizen's Advice Bureau	Interfaith Wolverhampton	Wolverhampton Clinical Commissioning Group
City of Wolverhampton Council	Lloyds Bank	Wolverhampton Homes
Compton Care	Memory Matters	
Dementia Friendly GP Surgeries	Mid-Counties Co-op/Alz Cafe	

We hope our membership continues to grow – to become a member please contact the People Commissioning Team on people.commissioning@wolverhampton.gov.uk

Dementia Friends

As well as providing dementia awareness training to people from all walks of life, the Joint Dementia Strategy also seeks to encourage more people to become Dementia Friends.

Nationally, more than one million people have signed up to become Dementia Friends through the Alzheimer's Society, and in doing so have developed a greater understanding of dementia, and what can be done to help people who are living with the conditions. Becoming a Dementia Friend does not mean befriending someone with Dementia.

In Wolverhampton we have over 13,000 registered Dementia Friends! We hope this number continues to grow. Anyone can become a Dementia Friend and there are many ways in which you can become a Dementia Friend, to find out more please visit www.dementiafriends.org.uk for more details.

Appendix: key standards

Our Joint Dementia Strategy and Joint Strategic Needs Assessment will underpin the work we do to improve outcomes for people living with dementia and their carers in the City of Wolverhampton.

We are also aligning our approach with the national ‘2020 Challenge on Dementia Implementation Plan’ (2016).² This plan sets out a ‘Well Pathway’ for people’s journey with dementia and will continue to hold pertinence in the future. The City of Wolverhampton has aligned its measures and actions for support for dementia with this framework, as set out within this document.

Other key standards include:

- Prevention (NICE Guideline)
- Risk reduction (OECD Dementia Pathway)
- Health information (NICE Pathway)
- Supporting research (OECD Dementia Pathway)
- Preventing people dying prematurely (NHS Outcomes Framework)
- Diagnosis (NICE Guideline and OECD Dementia Pathway)
- Memory assessment (NICE Guideline and NICE Quality Standard 2010)
- Concerns discussed (NICE Quality Standard 2013)
- Investigation (NICE Pathway)
- Provide information (NICE Pathway)
- Integrated and advanced care planning (NICE Guideline, NICE Quality Standard 2010, NICE Quality Standard 2013 and OECD Dementia Pathway)
- Healthcare public health and preventing premature mortality (Public Health Outcomes Framework)
- Integrated services (NICE Guideline, NICE Quality Standard 2013 and OECD Dementia Pathway)
- Supporting carers (NICE Quality Standard 2010, NICE Pathway and OECD Dementia Pathway)
- Carers respite (NICE Quality Standard 2010)
- Coordinated care (NICE Guideline and OECD Dementia Pathway)
- Promote independence (NICE Guideline and NICE Pathway)
- Relationships (NICE Quality Standard 2013)
- Leisure (NICE Quality Standard 2013)
- Safe communities (NICE Quality Standard 2013 and OECD Dementia Pathway)
- Enhancing quality of life for people with long-term conditions (NHS Outcomes Framework)
- Choice (NICE Quality Standard 2010, NICE Quality Standard 2013 and NICE Pathway)
- Behavioural and psychological symptoms of dementia (NICE Quality Standard 2010)
- Liaison (NICE Quality Standard 2010)
- Advocates (NICE Quality Standard 2013)
- Housing (NICE Quality Standard 2013)
- Hospital treatments (NICE Pathway)
- Technology (OECD Dementia Pathway)
- Health and social services (OECD Dementia Pathway)
- Hard to reach groups (NICE Quality Standard 2013 and OECD Dementia Pathway)
- Ensuring people have a positive experience of care (NHS Outcomes Framework)
- Treating and caring for people in a safe environment and protecting them from avoidable harm (NHS Outcomes Framework)
- Palliative care and pain (NICE Guideline and NICE Quality Standard 2010)
- End of life (NICE Pathway)
- Preferred place of death (OECD Dementia Pathway)
- Prime Ministers Challenge 2020

² <https://www.gov.uk/government/publications/challenge-on-dementia-2020-implementation-plan>

Glossary

Glossary of key health and social care terminology that has been used in this document:

BCPFT	Black Country Partnership Foundation Trust
BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
CRISP	Carer Information Support Programme
D2A	Discharge to Assess
EPACC	Electronic Palliative Care Co-ordination
GP	General Practitioner
GSF	Gold Standard Framework
JSNA	Joint Strategic Needs Assessment
LES	Local Enhanced Service
MSNAP	Memory Services National Accreditation Programme
NHS	National Health Service
NICE	The National Institute for Health and Care Excellence
OECD	Organisation for Economic Co-operation and Development
POPPI	Projecting Older People Population Information System
QOF	Quality and Outcome Framework
RWT	Royal Wolverhampton Trust
SWAN	End of Life Programme
THIS IS ME	A support tool to enable person-centred care

Member logos to be refreshed.



Wolverhampton Homes

JSNA DEMENTIA

Topic Specific Report

Final Draft

Developed: 2017-18

Published: April 2019

Public Health

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To be added:

Service Mapping

Executive Summary

Dementia Key Indicators

- Since 2014-15, the prevalence of Dementia in all ages in Wolverhampton (0.82%) has been significantly higher than the prevalence in England and the West Midlands. Similarly, the prevalence of Dementia in Wolverhampton in the over 65 population (5.04%) is significantly higher than England (4.33%), West Midlands (4.21%) and the Black Country (4.43%).
- In England, the highest prevalence figures of Dementia are seen in the most deprived deciles, between 4.60% and 4.75% in the three most deprived deciles, compared to 4.16% in the least deprived decile.
- The number of Wolverhampton residents aged over 65 predicted to have Dementia, is projected to increase by around 47.2% between 2017 (3,194) and 2035 (4,702). The largest increase is predicted to be in the 90 and over age group, with figures predicted to increase two-fold. However, increase in Wolverhampton is predicted to be smaller compared to the national projections.
- In Wolverhampton, the directly standardised rate (DSR) of emergency admissions that were for patients with Dementia in the over 65 population increased significantly in a 4-year period from 2,955 per 100,000 (2012-13) to 5,045 per 100,000 (2015-16). Current figures (4,458 per 100,000) in Wolverhampton are significantly higher than national and regional figures.
- The proportion of emergency admissions with Dementia which were short stays (defined as a stay of less than 1 day) in Wolverhampton increased significantly from 16.71% in 2012-13 to 30.70% in 2016-17. Current figures are significantly higher than national and regional figures.
- The most recent data (2016) suggests that the rate of mortality in people with Dementia in Wolverhampton is significantly higher than national and regional figures, though this has not always been in the case in previous years.

GP Records

- On GP records in Wolverhampton, there are 2,323 patients with a diagnosis of Dementia, of whom 1,441 are female and 882 are males. Over a quarter of these patients are aged between 85-89 years.

Social Care

- In Wolverhampton, social services have a record of 1,740 people in Wolverhampton with Dementia. There are 874 social care service users that have a diagnosis of Dementia, 601 service users are female and 273 service users are male. Each service user has an assigned care package.
- Of the 874 social care service users with Dementia in Wolverhampton, 306 live in the community either with family or in their own homes and 568 live in residential or nursing homes.
- The most provided care packages are Domiciliary Care (201) and Residential Care (232). There are also a significant number of packages for Nursing (112) and Day Support (71).

NHS Clusters

- In Wolverhampton, there are around 1,250 patients registered to a NHS Mental Health cluster that is indicative of a diagnosis of Dementia. Just under half of all patients are in the 80-89 year age group.
- Just over half of all patients registered to a cluster that suggest a diagnosis of Dementia fall into cluster 19. Patients in Cluster 19 are characterised by having moderate needs.

People with Dementia Engagement

- There were 52 surveys returned from respondents that had been diagnosed with Dementia, of which 1 survey was completed online and 51 surveys were completed on paper. Of the 52 respondents, 35 reported their gender as female, 13 as male and 4 left the question blank.
- The majority (60%) of people with Dementia that responded to the survey said they were living well with Dementia. However, over a fifth (21%) stated they were not living well with Dementia.
- Around 69% of respondents said they had enough family and friends around them that they could count on for support. But less than half of respondents (44%) said they felt involved enough with decisions about their care and support.
- Under a third of respondents (31%) said they had used a Dementia café over the past three years. The most common reasons why the 67% of respondents had not used a Dementia Café included:
 - Have never heard of it
 - People with Dementia struggle to get out of the house - so cannot attend
 - Carers or family members unable to take them due to the opening times.
- There were a mixture of positive and negative comments about Dementia Café's when respondents were asked what was or was not, useful about them. The positive comments centred around the social aspect of the service; the negative comments centred around logistic issues and age of attendees.
- Around 42% of respondents said they were able to make decisions about how they spend their time on a general day to day basis, however, 37% said they were not able to make those decisions and 17% said they did not know.

Carers of people with Dementia Engagement

- The 83 respondents consisted of 51 females, 24 males and 8 who either left their gender blank or said that they preferred not to say. The 83 respondents cared for 44 Females, 28 Males and 11 people whose gender was not stated, all of whom were living with Dementia.
- 37% of carers were the spouse of the person with Dementia being cared for and 34% were the child. More than half of carers (57%) had been caring for the person with Dementia for more than 3 years.
- More than a third of carers (37%) said they found getting information of services to support them 'Quite' difficult and a further third (33%) found it 'Neither easy nor difficult, just OK'. The most selected reasons for finding it difficult to get hold of information were:
 - Not knowing where to get the information needed
 - Not knowing who to ask for the information needed
 - Not being told about something until it's too late
 - It takes too long to actually receive the information you need
- The most commonly used services identified by respondents were Dementia Café's, Carer Support, Memory Clinics, Social Services and Nursing Teams.

- Although most respondents did not find services difficult to access, a common theme among reasons for finding it difficult to access services was that carers were unable to get the information required to access services from professionals, requiring them to either find the information themselves or get in contact with other support services to obtain the information.
- Respondents that found Dementia Café's the most useful support, said they found the social aspects for people with Dementia useful, helped lift spirits, gave them somewhere to go and provided useful information.
- When asked about needs that were not met, carers said there was a lack of support for carers when exploring their options for services and care homes, with one respondent suggesting there should be a carers information support programme that is available in other areas.
- More than two-thirds of carers (69%) said there were no cultural or social issues that got in the way of the care they provided. However, 31% stated that there were cultural or social issues.

Professionals working with Dementia engagement

- **There were 24 responses from professionals that work with people with Dementia. Of these responses, 19 were completed online and 5 were completed on paper.** Respondents were from a variety of services. **Ten of the 24 respondents** were managers within their services.
- **Nine respondents did not think the additional needs of people with Dementia using their services were being met.** The themes within the comments for this question included: **Services not able to be proactive when personalising services, individuals isolated due to lack of social facilities and the need for a carers information programme.**
- Fourteen respondents said they thought their service did meet the needs of adults currently using their service and four respondents said they did not think the needs were being met. **The comments provided by those that didn't think the needs were being met included: more courses and information programmes for carers required, more personalisation of services is required, a Dementia Café aimed at younger people with Dementia required and more staff/multi-agency working is required.**
- **Twelve respondents said that they were not aware of any changes or new trends in the needs for their current clients** and seven respondents said they were aware of changes or new trends. Five respondents said their service had the right skill mix and capacity to meet the future need. However, 9 mentioned they did not and provided comments on what they needed.
- **Some respondents said there were certain groups of people with Dementia that do not use their service but could benefit from extra support. These groups of people include those with early on-set Dementia, limited mobility and vision impairment, as well as carers and people from ethnic minorities.**
- Eight respondents said there were some cultural issues that needed addressing when working with their clients, which included:
 - **Meeting cultural and religious needs by creating more links with religious organisations**
 - **Encourage people with BME backgrounds to use services**
 - **Need to reach out to hard to reach communities, such as homeless and LGBT communities**
 - **Need a more ethnically diverse specialist workforce**

- **Improve awareness of services among communities where sight loss might be more prevalent**

DRAFT

Recommendations

- Raise awareness of services available to people with Dementia and their carers, in a formal, well-structured manner, especially among those with an ethnic minority background and those who may be harder to reach, such as LGBT and homeless.
- To provide and/or raise awareness of services which support those with Dementia and sight loss, whilst simultaneously raising awareness of the association between Dementia and sight loss.
- Increase awareness and provision of Dementia Café's. Increase provision of Dementia Café's for younger people with Dementia, aged under 65.
- Introduce provision of a Dementia friendly transport service, in order to improve accessibility of Dementia services.
- Service providers should aim to provide care/services that are personalised for the individual with Dementia and ensure their needs are considered when providing their service.
- Service providers need to ensure they are prepared to support an increasing number of clients and ensure that staff are better informed, by increasing the amount of support and training provided, especially for lower graded staff.
- Service providers should aim to provide forward thinking community based activities, support services and training to enable staff to help people continue to connect with the world, rather than 'just holding' people with Dementia.
 - What community assets do we have that could contribute to this?

Population group whose needs are to be assessed

This needs assessment will examine the needs of people with dementia and their family carers living in the City of Wolverhampton. This includes the area covered by the Royal Wolverhampton Hospital Trust and Wolverhampton Clinical Commissioning Group (CCG).

Aims and objectives

The overall aim of this Dementia needs assessment is to assess whether the services for people with dementia, their families and/or carers are meeting the current need and any future needs that may arise. The objectives of the needs assessment are to:

1. Determine the scope of dementia in Wolverhampton, through descriptive and comparative epidemiological analysis.
2. Map dementia services currently provided in Wolverhampton and identify potential gaps in provision.
3. Review evidence of best practice.
4. Conduct stakeholder engagement, including professionals that work with people with Dementia, those caring for people with Dementia and those diagnosed with Dementia, to identify the needs and discuss potential solutions.
5. Frame recommendations for processes that would address the unmet need identified, which would improve the quality of life of people living with dementia and those that care for them.

The 'need' of a population for a service can be defined as the capacity to benefit from that service. However, this may differ from a demand for a service or the supply of a service. This needs assessment aims to outline the needs of the population and consider any inconsistencies between need and supply.

What is Dementia and what is the impact of Dementia?

Dementia is a syndrome most commonly seen in older people and is characterised by impaired cognitive function. World Health Organization (WHO) define Dementia as *'Dementia is a syndrome – usually of a chronic or progressive nature – in which there is deterioration in cognitive function (i.e. the ability to process thought) beyond what might be expected from normal ageing. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement. Consciousness is not affected. The impairment in cognitive function is commonly accompanied, and occasionally preceded, by deterioration in emotional control, social behaviour, or motivation.'* [<http://www.who.int/en/news-room/fact-sheets/detail/dementia>]

Dementia is one of the world's major causes of disability and dependency in older people. It has an impact on the quality of life of not only those that have Dementia, but of their families and carers too. The Impact on carers and family can be physical, psychological, social and economical. There is often a lack of awareness and understanding of Dementia, which can result in stigmatisation of the disease and barriers to care and diagnosis.

Worldwide, the number of people with Dementia is estimated to triple by 2050. In 2015, the cost of Dementia to the global community was \$818 Billion and is estimated to cost \$2 Trillion by 2030. [<http://www.who.int/mediacentre/factsheets/fs362/en/>]

Types of Dementia

Alzheimer's Disease

Alzheimer's disease is the most common cause of dementia. There are thought to be more than 520,000 people in the UK with Alzheimer's disease. The disease causes proteins to build up in the brain to produce structures called plaques and tangles, causing the loss of connections between nerve cells, eventually leading to the death of nerve cells and loss of brain tissue. Alzheimer's disease is a progressive disease, which means that over time, more parts of the brain are damaged.

The vast majority of people who develop Alzheimer's disease will develop it after the age of 65, however some people do develop Dementia before reaching the age of 65. This is known as early-onset Alzheimer's disease, which is often reported under the umbrella term 'early onset dementia'. There are over 40,000 people with early onset dementia in the UK.

Age is the greatest risk factor for Alzheimer's disease. Above the age of 65, a person's risk of developing dementia doubles every 5 years. There are about twice as many females as males who have Alzheimer's disease, for which the reasons are not yet confirmed. This observation is not fully explained by the fact that women live longer than men, on average. Genetics can play a part in increasing the risk of developing Alzheimer's disease. A number of genes are known to affect a person's chances of developing Alzheimer's. In rare cases, early onset dementia can be passed down through generations of a family. Medical conditions such as diabetes, stroke, high blood pressure, high cholesterol and obesity in mid-life are all known to increase the risk of Alzheimer's disease. This risk can be reduced by keeping these conditions under control and adopting a healthy, active lifestyle.

Vascular Dementia

Vascular dementia is the second most common type of dementia and estimated to affect around 150,000 people in the UK. Vascular dementia is caused by disruption in blood supply to the brain. This disruption is due to diseased blood vessels, leading to the blood vessels leaking or becoming

blocked and causing brain cells to die. The death of these brain cells bring about the symptoms which are characteristic of dementia.

Vascular dementia can develop following a stroke. A stroke occurs when blood supply to the brain is suddenly cut off, due to a blood vessel in the brain either narrowing or being blocked by a clot. The severity of strokes depend on where the blocked vessel is and how long the disruption of blood supply is (could be permanent). This sudden disruption in blood supply reduces the oxygen supplied to the brain and leads to the death of a large volume of brain tissue. However, not everyone who has a stroke will develop vascular dementia, around 20% of people who have a stroke will develop dementia within the following six months. Consequently, once a person has suffered a stroke, they are at a higher risk of suffering another stroke, therefore increasing their risk of developing dementia.

Other types of vascular dementia include:

Single-infarct and multi-infarct dementia, which are caused by one or more smaller strokes. An infarct is a small area of brain tissue that has died due disruption of blood supply to the brain. A single infarct in an important part of the brain can cause dementia, but more often it is a number of infarcts spread around the brain that cause dementia (multi-infarct).

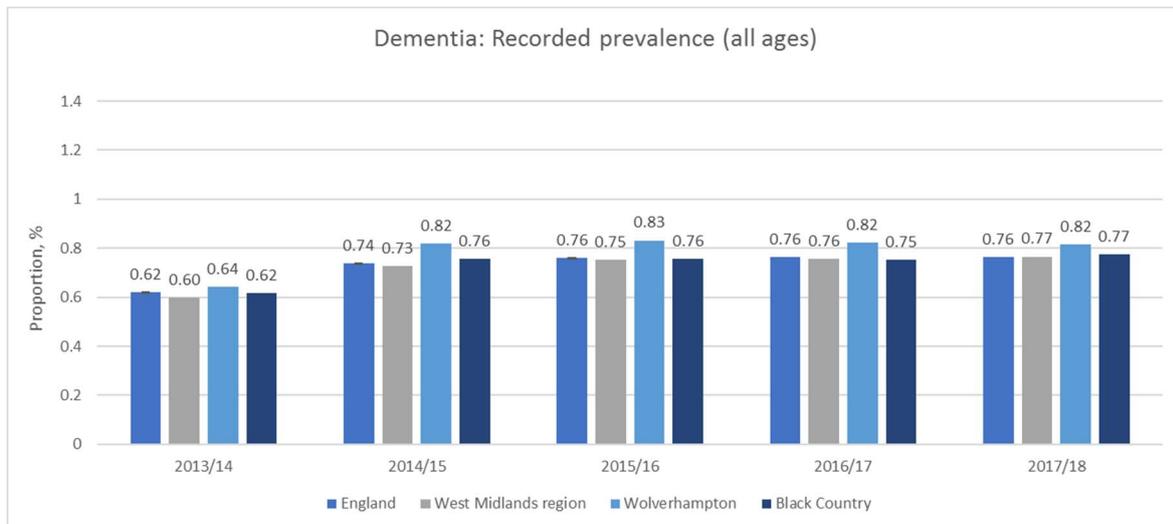
Subcortical dementia is caused by diseases of the very small blood vessels that lie deep in the brain, which cause them the vessel walls to thicken and vessels to become stiff and twisted. This causes damage to the nerve fibres that carry signals around the brain (white matter). It can also cause small infarcts around the base of the brain. Diseases of small vessels develop much deeper in the brain, compared to the damage caused by many strokes, therefore the symptoms are often different to stroke-related dementia.

Mixed Dementia

Around 10% of people with dementia are diagnosed with mixed dementia, which means that both Alzheimer's disease and vascular dementia have caused the dementia. Symptoms of mixed dementia can vary between the symptoms of Alzheimer's disease and vascular dementia.

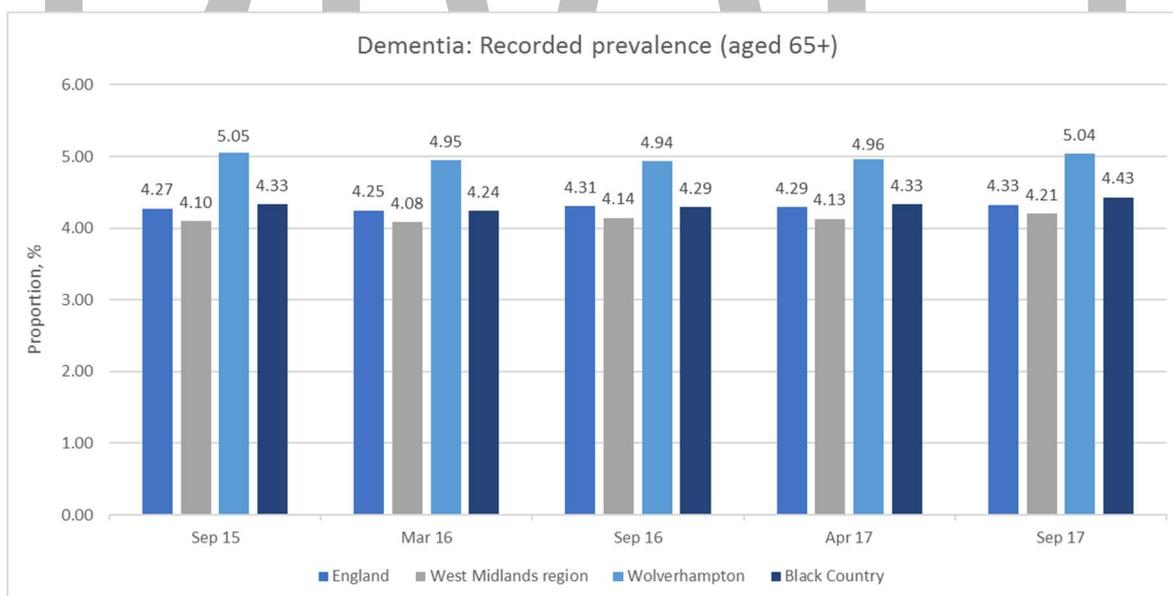
Dementia Indicators

Prevalence of Dementia



Source: Fingertips, PHE

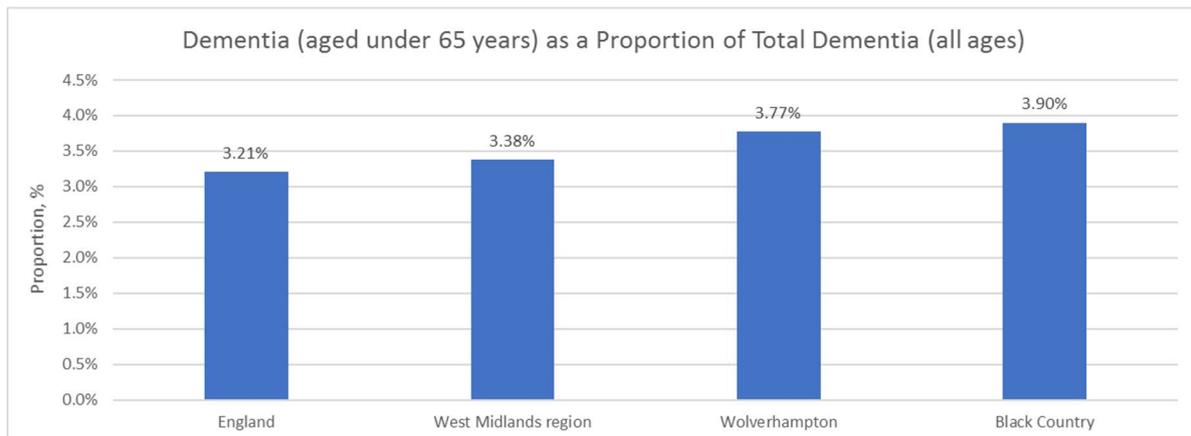
In Wolverhampton, the prevalence of Dementia in all ages has consistently been slightly higher than the prevalence in England, the West Midlands and the Black Country, however, this difference has only been statistically significant since 2014-15. In 2017-18, the proportion of the Wolverhampton population that had a diagnosis of Dementia was 0.82% (2,286 individuals), compared to 0.76% across England and 0.77% across the West Midlands. In Wolverhampton, the prevalence of Dementia increased significantly over a 5-year period from 0.54% (2011-12) to 0.83% (2015-16), an increase of 835 individuals and has remained steady since.



Source: Fingertips, PHE

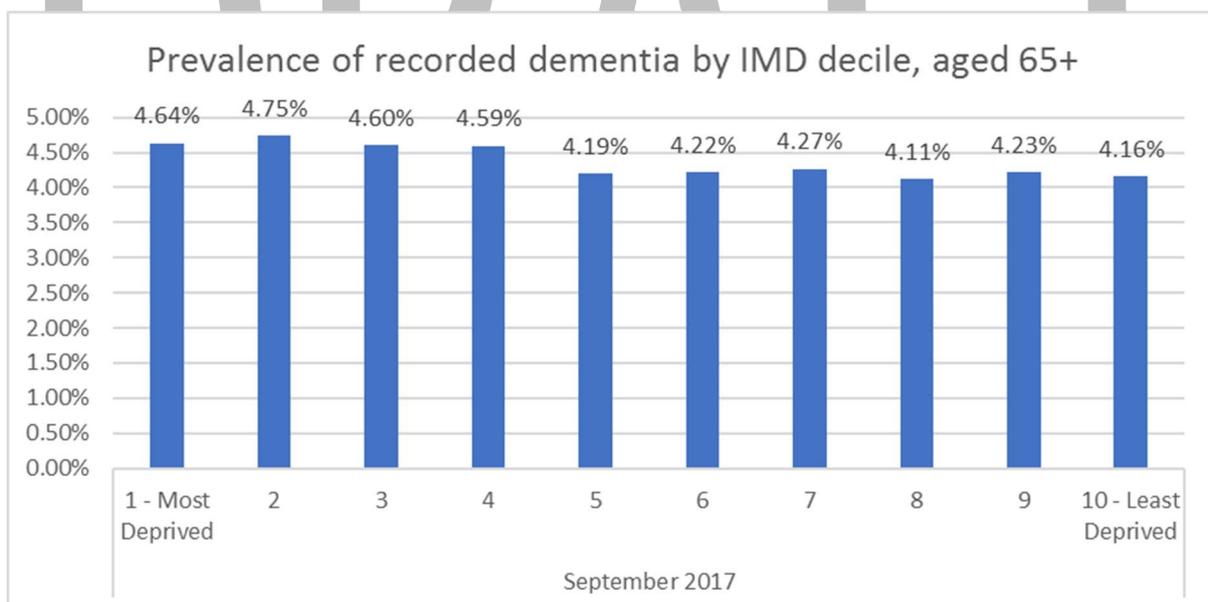
The prevalence of Dementia in Wolverhampton in the over 65 population has consistently been significantly higher than England, the West Midlands and the Black Country in the two-year period for which data was collected. In Wolverhampton, the proportion of over 65's with a diagnosis of Dementia has remained steady, ranging between 4.94% and 5.05%. The prevalence across England

and the West Midlands also remained steady across the two-year period, although the prevalence in England remained significantly higher than the West Midlands.



Source: Fingertips, PHE

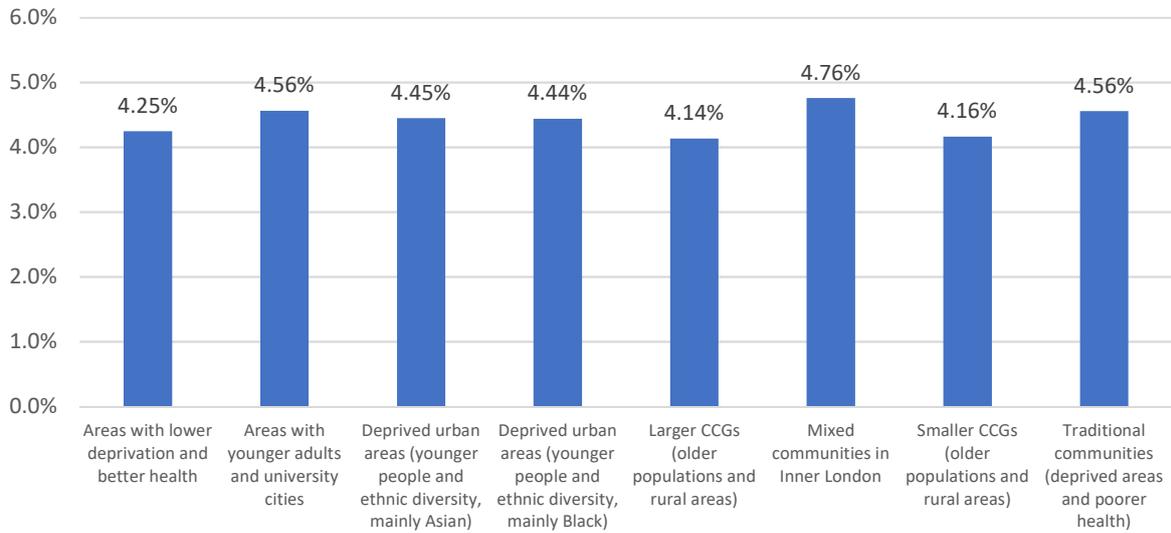
As a proportion of Dementia in all ages, the population of under 65's with a diagnosis of Dementia in Wolverhampton is 3.77%, which is statistically similar to the proportion in England (3.21%), the West Midlands (3.38%) and the Black Country (3.90%). This accounts for 86 individuals in Wolverhampton, aged under 65 that have been diagnosed with Dementia.



Source: Fingertips, PHE

The prevalence of recorded Dementia varies by Index of Multiple Deprivation in the 65+ population of England. This indicator is not available at Local Authority level, however in England the highest prevalence figures of Dementia are seen in the most deprived deciles, between 4.54% and 4.83% in the four most deprived deciles, compared to 4.19% in the least deprived decile. This trend remained similar at all three data points available: September 2015, March 2016 and September 2016.

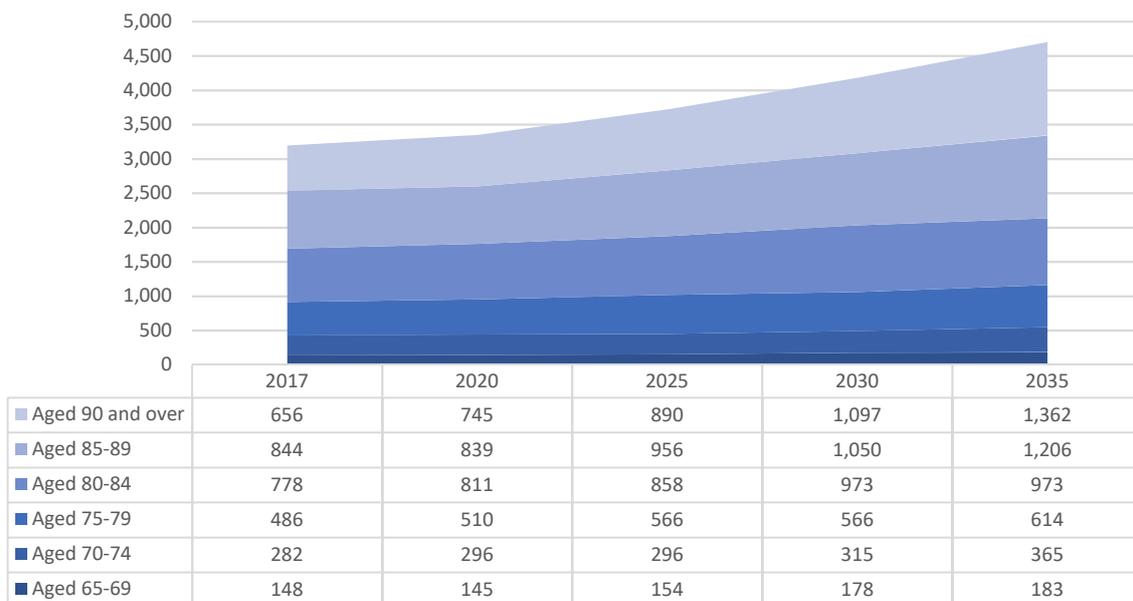
Prevalence of recorded dementia among those aged 65+ by CCG Clusters, September 2017



Source: Fingertips, PHE

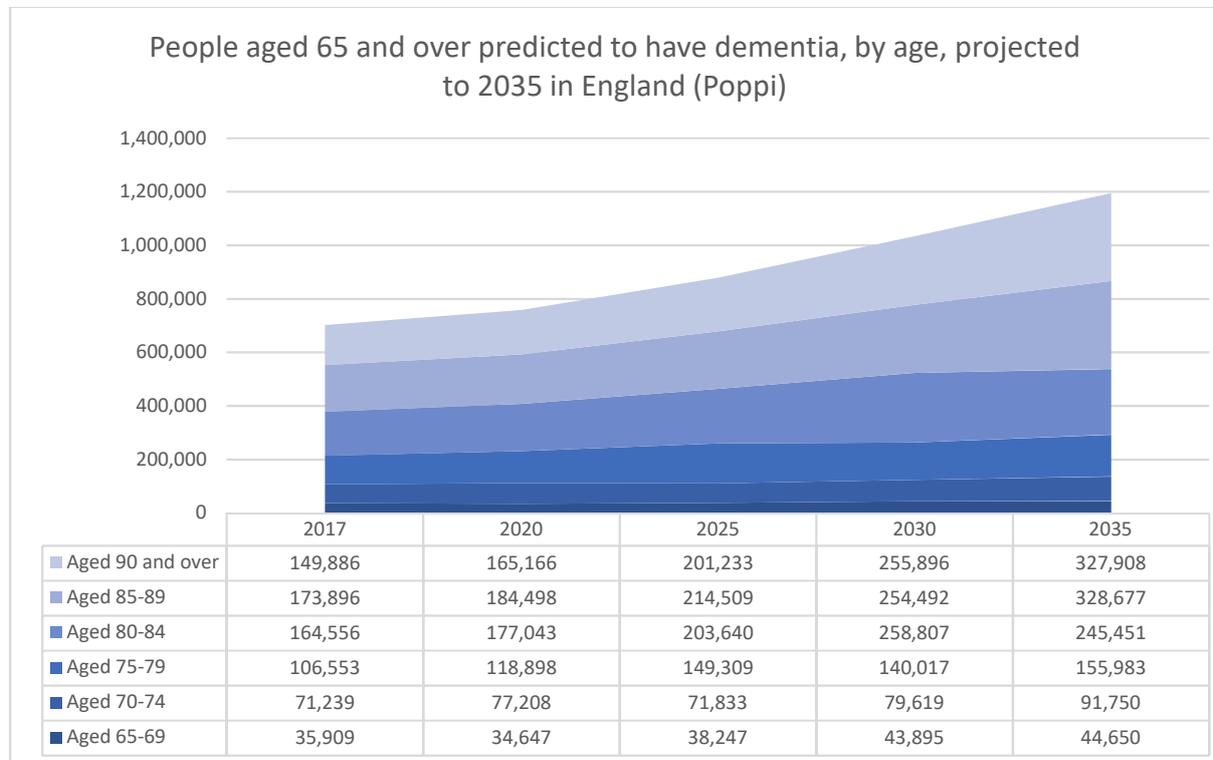
CCG Clusters are used to group CCGs with similar geographic and/or population characteristics across England. In England, the highest prevalence of Dementia is seen in 'Mixed communities in inner London' (4.76%), followed by 'Areas with younger adults and university cities' (4.56%). The lowest prevalence figures were seen in 'Smaller CCGs (older populations and rural areas)' (4.16%) and 'Larger CCGs (older populations and rural areas)' (4.14%). The characteristics of the population of Wolverhampton CCG would put it in the 'Deprived urban areas (younger people and ethnic diversity, mainly Asian)'.

People aged 65 and over predicted to have dementia, by age, projected to 2035 in Wolverhampton (Poppi)



Source: Poppi

The number of Wolverhampton residents aged over 65 predicted to have Dementia is projected to increase by around 47.2% between 2017 (3,194) and 2035 (4,702). The largest increase is predicted to be in the 90 and over age group, with figures predicted to increase two-fold, from 656 in 2017 to 1,362 in 2035. The second largest increase is predicted to be seen in the 85-89 year age group, with an increase of 42.9% over the 18-year period.

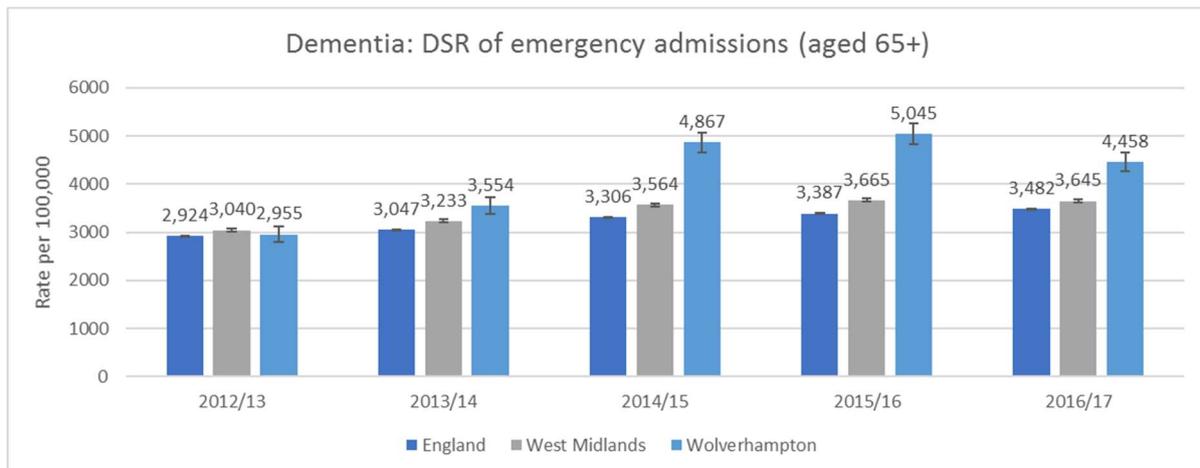


Source: Poppi

The number of people in England aged 65+ is projected to increase by 70.1% between 2017 and 2035, from 702,039 to 1,194,419. The largest increase is predicted to be in the 90 and over age group, with figures predicted to more than double over the 18-year period, from 149,886 to 327,908. The second highest increase is predicted to be in the 85-89 year age group, with an increase of 89.0%. The youngest age group presented, 65-69 years is projected to increase by 24.3% over the 18-year period.

The overall increase in Wolverhampton is predicted to be smaller compared to the national projections. The projections by Poppi suggest that the number of people aged over 65 predicted to have Dementia in England is to increase by 70.1% between 2017 and 2035.

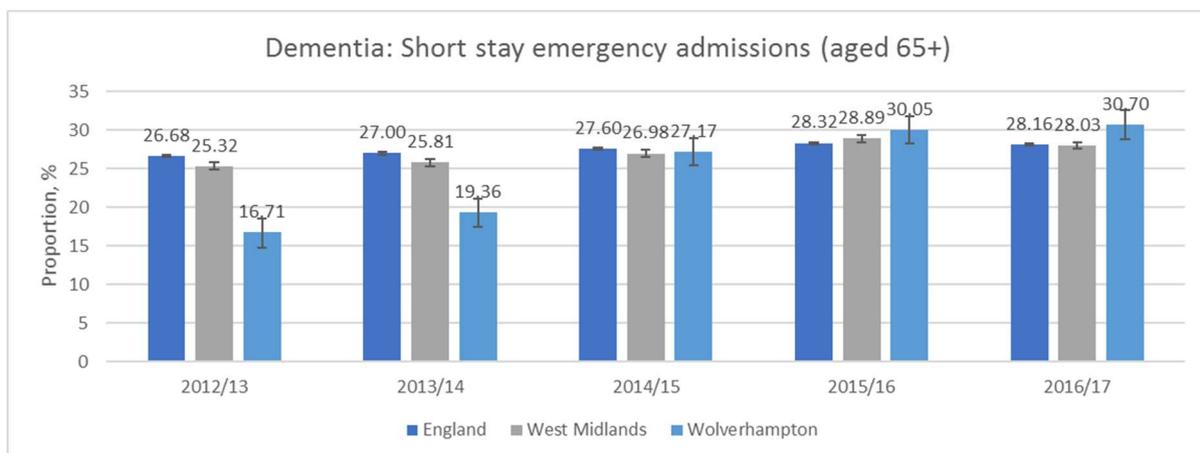
Hospital Admissions due to Dementia in Wolverhampton



Source: Fingertips, PHE

In Wolverhampton, the directly standardised rate (DSR) of emergency admissions with Dementia in over 65s increased significantly in a 5-year period from 2,955 per 100,000 (2012-13) to 4,458 per 100,000 (2016-17). In terms of numbers, the increase was from 1,307 in 2012-13 to 2,082 in 2016-17. The DSR for Wolverhampton consistently increased significantly between 2012-12 and 2014-15. In comparison to the England and West Midlands DSR's, in 2012-13, the Wolverhampton figure was not significantly different, however, the rate of increase over the following 3 years was much higher in Wolverhampton than England and the West Midlands. In the West Midlands, figure increased significantly from 3,040 per 100,000 in 2012-13 to 3,645 per 100,000 in 2016-17.

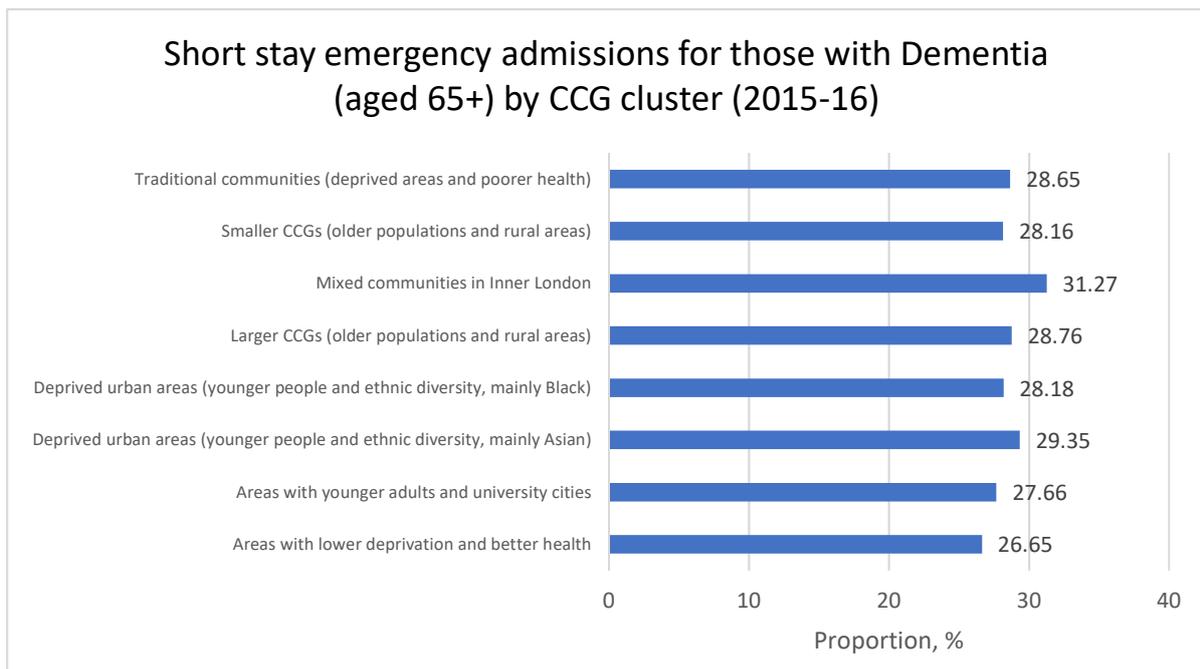
In England, the DSR for adults with dementia aged 65+ increased significantly year on year between 2012-13 and 2016-17. Overall, over the 5-year period, the rate of emergency admissions for Dementia in over 65's has increased by 16.0%, accounting for 558 admissions per 100,000 population.



Source: Fingertips, PHE

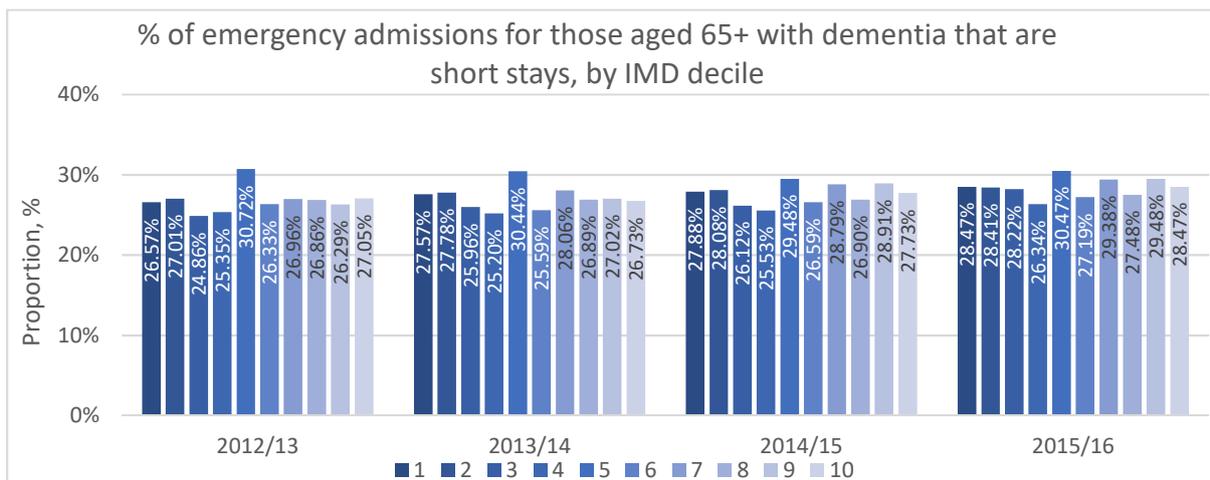
Short stay emergency admissions are defined as hospital admissions which last 1 night or less. Short stay emergency admissions are considered to potentially be detrimental to the health of individuals with Dementia. This is due to changes in the surrounding environment increasing the levels of anxiety and stress for an individual. Furthermore, people with dementia can be more susceptible to these changes, which can cause additional distress.

The proportion of emergency admissions for Dementia which were short stays (defined as a stay of less than 1 day) in Wolverhampton increased significantly from 16.71% (2012-13) to 30.70% in 2016-17. In terms of numbers this increase was from 243 in 2012-13 to 719 in 2016-17. The figures in England and the West Midlands also saw significant increases over the five-year time period, but at much smaller scales. In 2012-13 and 2013-14, the Wolverhampton figures were significantly lower than England and the West Midlands, however, following significant increases, Wolverhampton's figure in 2016-17 was significantly higher than England and the West Midlands figures. In England, there were two consecutive statistically significant increases in the four-year period, increasing from 27.00% in 2013-14 to 28.16% by 2016-17. Overall in England, there was an increase of 5.3% over the five-year period.



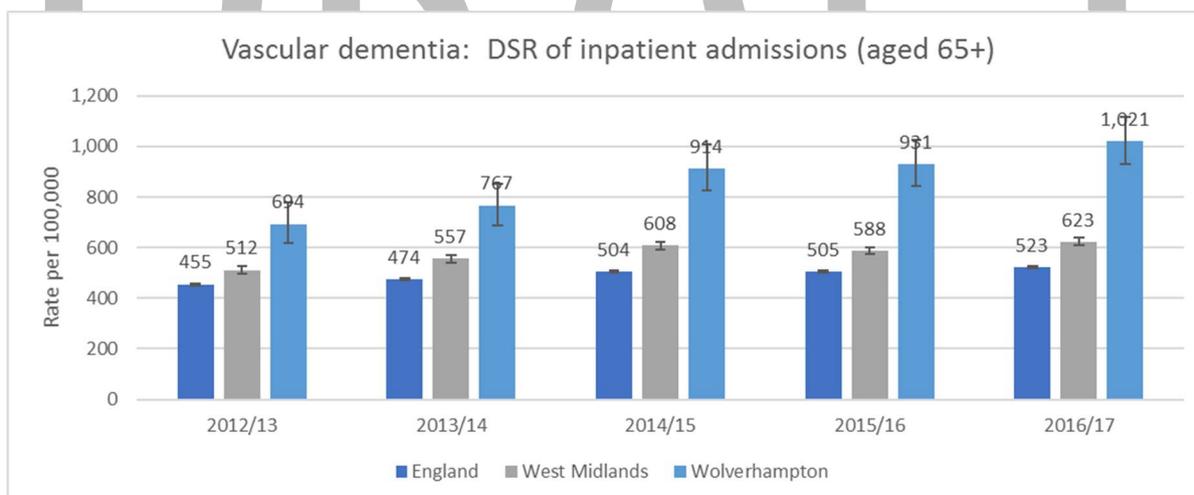
Source: Fingertips, PHE

CCG Clusters are used by the NHS to group together populations with similar characteristics. The population of Wolverhampton would be most similar to the 'Deprived urban areas (younger people and ethnic diversity, mainly Asian)'. In England, there is some variation between the CCG Clusters in regards to short stay emergency admissions for those with Dementia and aged 65+. The highest percentage of emergency admissions in those aged 65+ with Dementia is seen in 'Mixed communities in inner London' at 31.27%, followed by 'Deprived urban areas (younger populations and ethnic diversity, mainly Asian)' at 29.35%. The lowest figure is seen in 'Areas with lower deprivation and better health' at 26.65%. The data would suggest that there is some association between higher deprivation and higher proportions of short stay emergency admissions for over 65's with Dementia. The figures for this indicator, in all of the CCG Clusters have experienced some level of increase over the three-year period between 2013-14 and 2015-16.



Source: Fingertips, PHE

The proportion of emergency admissions for those aged 65+ with Dementia that were short stays by IMD were not available at a Wolverhampton level. However in England, by IMD deciles there is no noticeable trend, with figures varying between 26.34% and 30.47% in 2015-16. Figures in the three previous time periods also varied to similar extents. One constant in the four data periods was that the percentage of emergency admissions for those aged 65+ with Dementia that were short stays, in the 5th most deprived decile was the highest. The figure varied slightly between 29.48% and 30.72% over the four-year period.

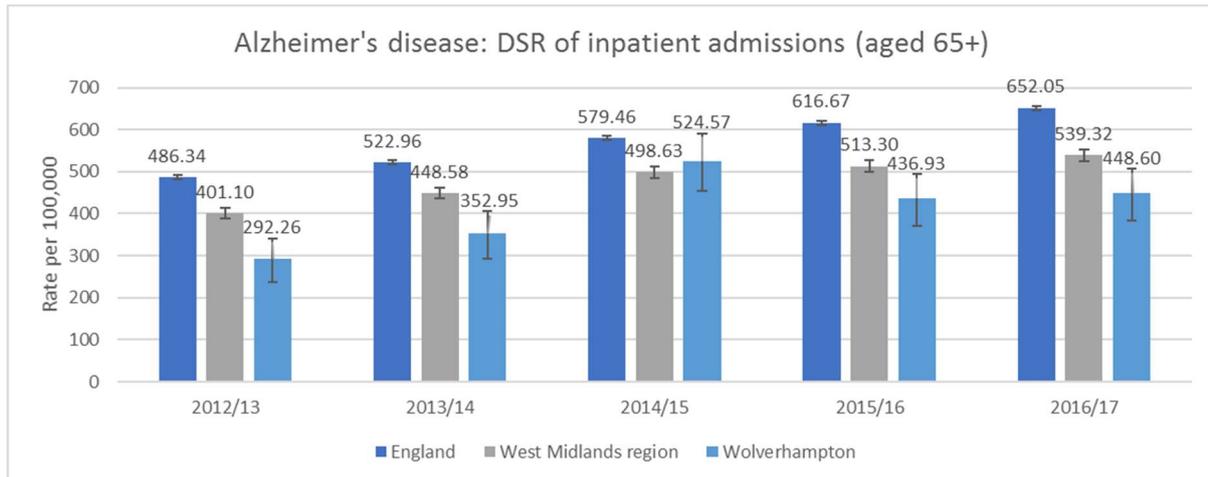


Source: Fingertips, PHE

Vascular Dementia is the second most common form of Dementia, affecting around 150,000 adults in the UK. The symptoms are often similar to Alzheimer’s disease, though the issues affecting memory are often milder. The cause of Vascular Dementia is a reduced blood supply to the brain due to diseased blood vessels, resulting in the death of brain cells. The most common type of Vascular Dementia is thought to be Subcortical Dementia, which involves reduced blood flow through the very small blood vessels deep in the brain. Vascular Dementia can also be caused by Strokes and Transient Ischaemic Attacks’ (TIAs). [Alzheimers.org.uk]

The DSR of Vascular dementia in Wolverhampton has consistently been significantly higher than in England and the West Midlands, over the five-year period between 2012-13 and 2016-17. The rates

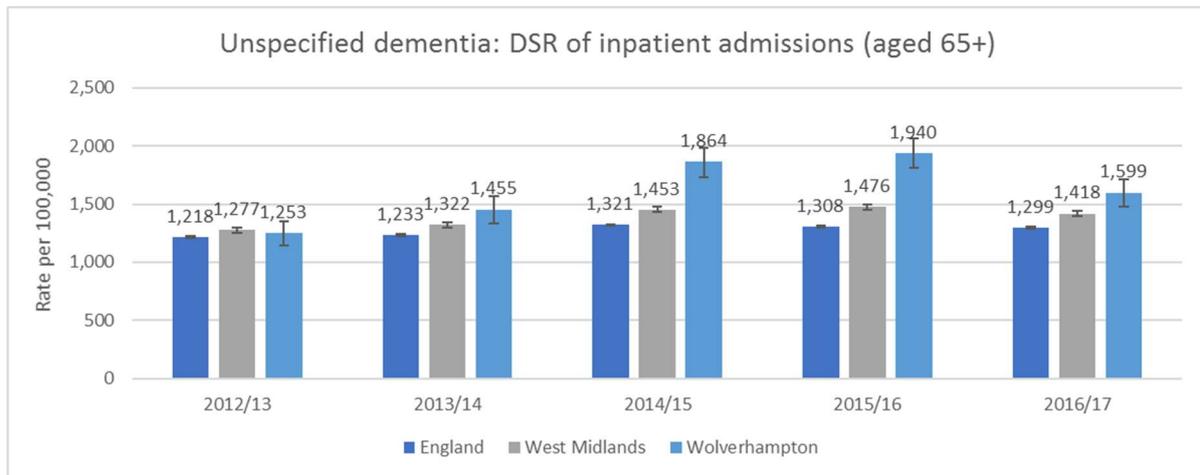
in all three geographies have significantly increased. The figures in Wolverhampton have increased from 693.7 per 100,000 (2012-13) to 931.3 per 100,000 (2015-16). In terms of numbers, the increase was from 308 in 2012-13 to 476 in 2016-17. In England, the directly standardised rate of inpatient admissions for Vascular Dementia in those aged 65+, increased significantly year on year between 2012-13 and 2014-15. Following this period of significant increase, figures continued to increase into 2016-17. In Wolverhampton, the rate of inpatient admissions in over 65's increased by almost a third (32.0%), equivalent to around 168 more admissions per year.



Source: Fingertips, PHE

Alzheimer's disease is the most common form of Dementia, with more than 520,000 people in the UK estimated to have Alzheimer's disease. Alzheimer's disease is a progressive disorder and the symptoms include: loss of short-term memory, language difficulties, visuospatial problems, orientation and difficulties in concentrating, planning and organising. [Alzheimers.org.uk]

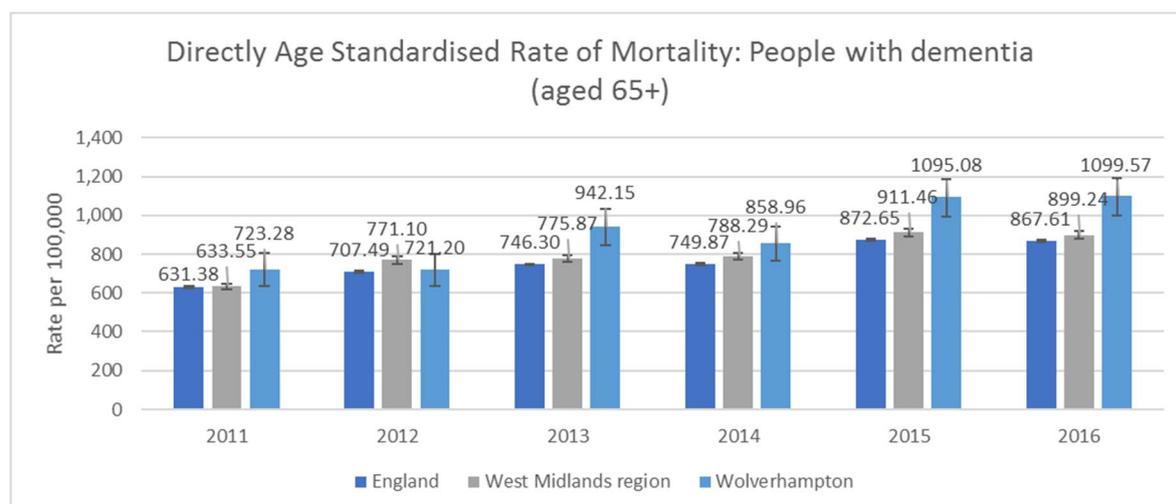
In 2016-17, the DSR of inpatient admissions for Alzheimer's disease in Wolverhampton (448.6 per 100,000) was significantly lower than the England figure (652.1 per 100,000) and the West Midlands figure (539.3 per 100,000). The Wolverhampton figures saw a significant increase between 2012-13 and 2014-15, followed by a slight non-significant decrease in 2015-16 and remained relatively constant going into 2016-17. Whereas, the England and West Midlands figures consistently increased significantly over the five-year period. The rate of inpatient admissions in England increased by 34.1%, accounting for around 166 more inpatient admissions per 100,000 adults aged 65+. In terms of numbers, in Wolverhampton, there were 208 inpatient admissions for Alzheimer's disease in people aged 65+, in 2016-17.



Source: Fingertips, PHE

Inpatient admissions for Unspecified Dementia are when the record of admission includes a mention of Unspecified Dementia in the diagnosis fields. The DSR of unspecified dementia in Wolverhampton increased significantly over a five-year period between 1,253 per 100,000 in 2012-13 to 1,599 per 100,000 in 2016-17, despite a fall in 2016-17. In terms of numbers, the increase in Wolverhampton was from 552 in 2012-13 to 748 in 2016-17. In comparison, the DSR's for England and the West Midlands also saw significant increases, but at much smaller scales. The Wolverhampton figures were significantly higher than England and the West Midlands between 2013-14 and 2016-17. In England, the directly standardised rate of inpatient admissions for Unspecified Dementia, in over 65's increased significantly between 2012-13 and 2014-15, followed by a significant decrease in 2016-17. In Wolverhampton, between 2012-13 and 2016-17, there was a 21.7% increase, equivalent to 196 more inpatient admissions per year in over 65's.

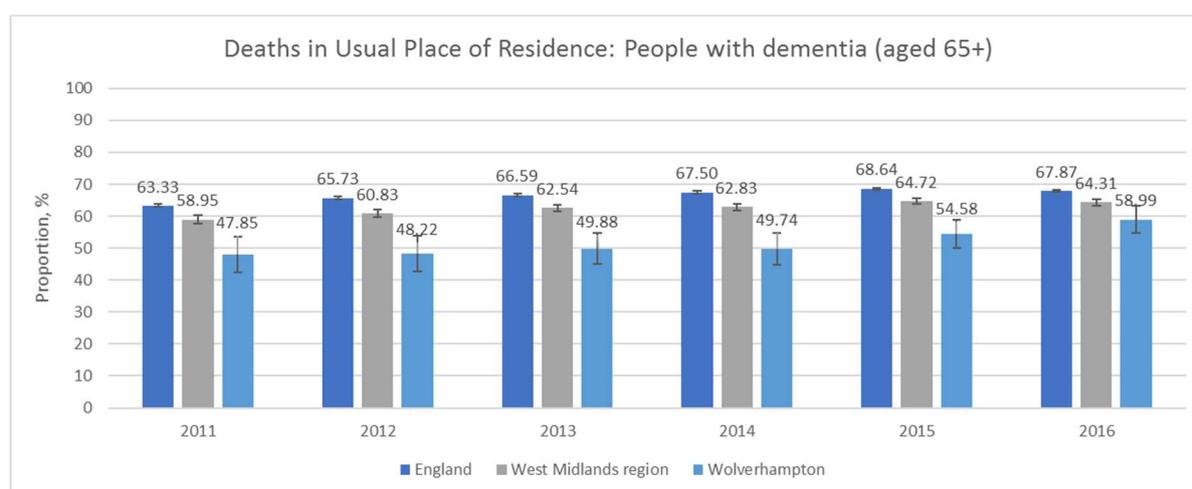
Mortality in people with Dementia



Source: Fingertips, PHE

In 2016, the DSR of mortality in people with Dementia aged over 65 was significantly higher in Wolverhampton at 1,099.6 per 100,000, than England (867.6 per 100,000) and the West Midlands (899.2 per 100,000). Over the five-year period between 2012 and 2016, the figures for Wolverhampton saw a general statistically significant increase from 721.2 per 100,000 to 1,099.6 per 100,000 (2016). Wolverhampton was significantly higher than England in four of five years (all but 2012), but only significantly higher than the West Midlands in three of the five years (2013, 2015 and 2016). In terms of numbers, there were 505 deaths of people with Dementia in 2015.

In England, the directly standardised rate of mortality with a mention of Dementia in those aged 65+, was 872.65 per 100,000 in 2015, which is significantly higher than each of the previous five years data points. The rate of mortality in those aged 65+ with Dementia increased significantly between 2011 and 2015, with figures increasing significantly year on year, except between 2013 and 2014. The cause of such an increase could be explained by looking at the increases in Dementia prevalence and diagnoses.

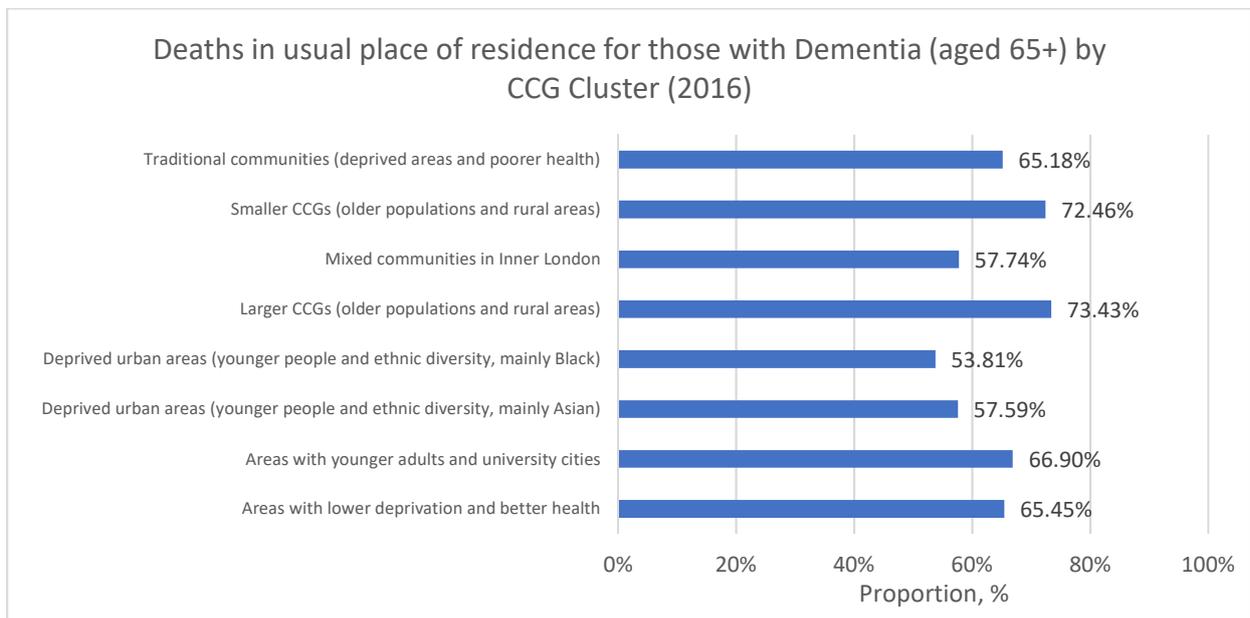


Source: Fingertips, PHE

End of life care for those with Dementia was a key objective in the National Dementia Strategy (2009) and a key measure of the quality of end of life care is 'death in usual place of residence'. The

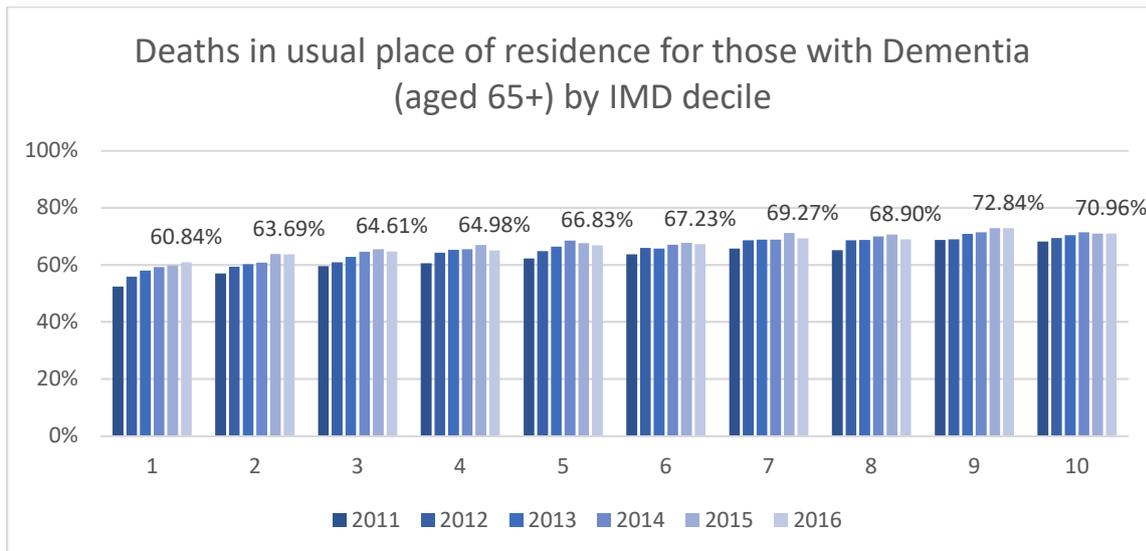
term ‘usual place of residence’ can refer to the individual’s own home, a care home or other residential setting.

In Wolverhampton, the proportion of people who die with Dementia whose death occurs at the usual place of residence increased slightly over a five-year period from 48.22% (2012) to 58.99% (2016). In terms of numbers, this increase was from 149 in 2012 to 292 in 2016. However, throughout the five-year period, the Wolverhampton figure was significantly lower than the England and West Midlands figures. In England, the proportion of deaths in over 65’s with Dementia that died in their usual place of residence consistently increased significantly, year on year, until 2016 when there was a slight decrease. Over the six-year period presented in the chart (2011 – 2016), there was a 4.54 percentage point increase, from 63.33% to 67.31%.



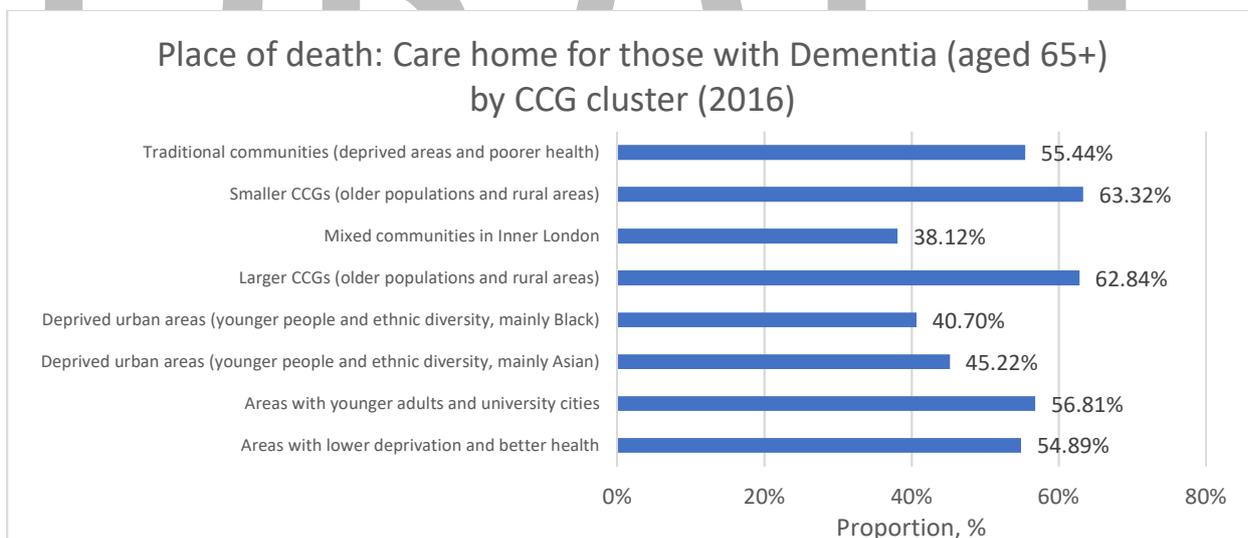
Source: Fingertips, PHE

In England, the proportions of deaths in over 65’s with Dementia that occur in the individuals usual place of residence were highest among the Smaller CCG (72.46%) and Larger CCG (73.43%) CCG clusters. Both CCG clusters are described as having older populations and being predominantly rural areas. The lowest figures were seen in the ‘Deprived urban areas (younger people and ethnicity diversity, mainly Black)’ with 53.81% and ‘Deprived urban areas (younger people and ethnicity diversity, mainly Asian)’ with 57.59%. The figure for ‘Mixed communities in inner London’ is also considerably low, at 57.74%.



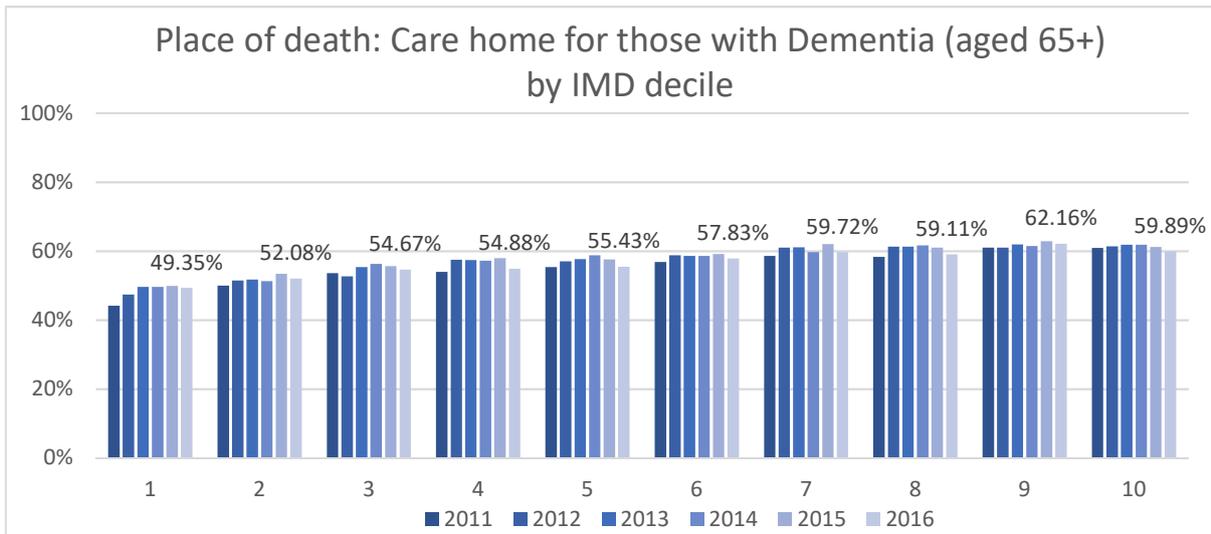
Source: Fingertips, PHE

The proportion of Deaths in usual place of residence for those with Dementia is not available by IMD deciles in Wolverhampton. However in England, over the six-year period between 2011 and 2016, the proportion of deaths of those aged 65+ with Dementia which occurred in the usual place of residence increased within each IMD decile. The largest increase was seen in the most deprived decile, an increase of 8.47 percentage points; the smallest increase was seen in the least deprived decile, an increase of 2.83 percentage points. In general, in each of the six years, the proportions of deaths in usual place of residence in those aged 65+ with Dementia increased and the level of deprivation decreased, with the highest figures in the most affluent deciles.



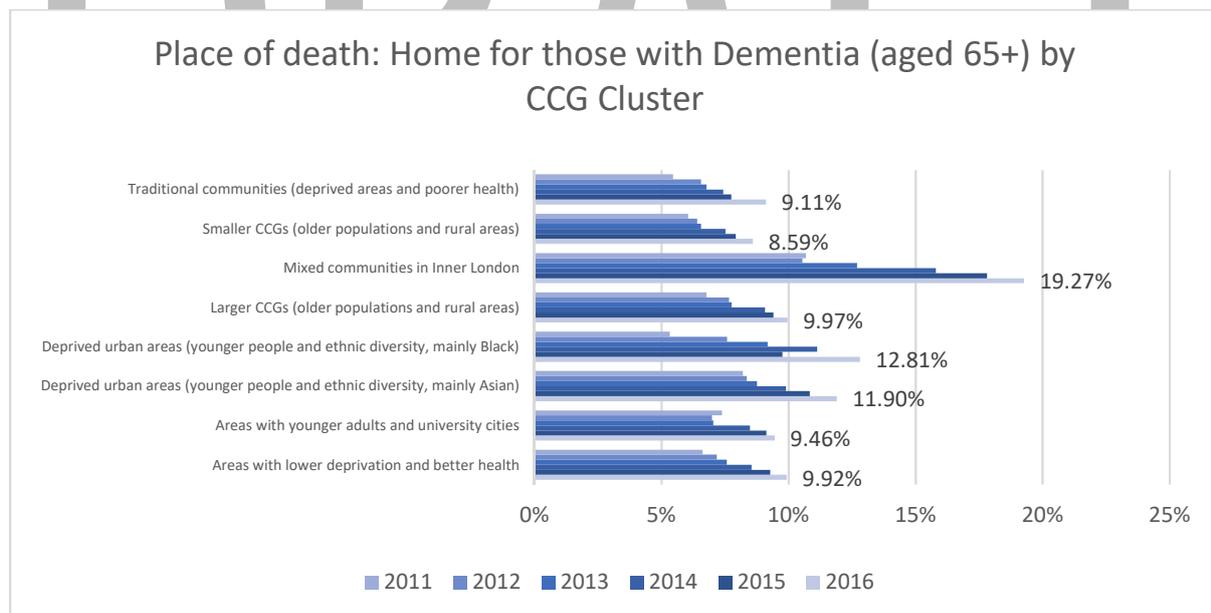
Source: Fingertips, PHE

In England, the proportion of deaths occurring in Care Homes, for individuals with Dementia and aged over 65 was highest among Smaller CCG's and Larger CCG's, which are both described as having an older population and rural areas. The lowest figures were seen in 'Mixed communities in inner London', 38.12%, Deprived urban areas (younger people and ethnic diversity, mainly Black), 40.70% and Deprived urban areas (younger people and ethnic diversity, mainly Asian), 45.22%. There were notable trends seen in the figures for the previous 6 data points (2011-2016).



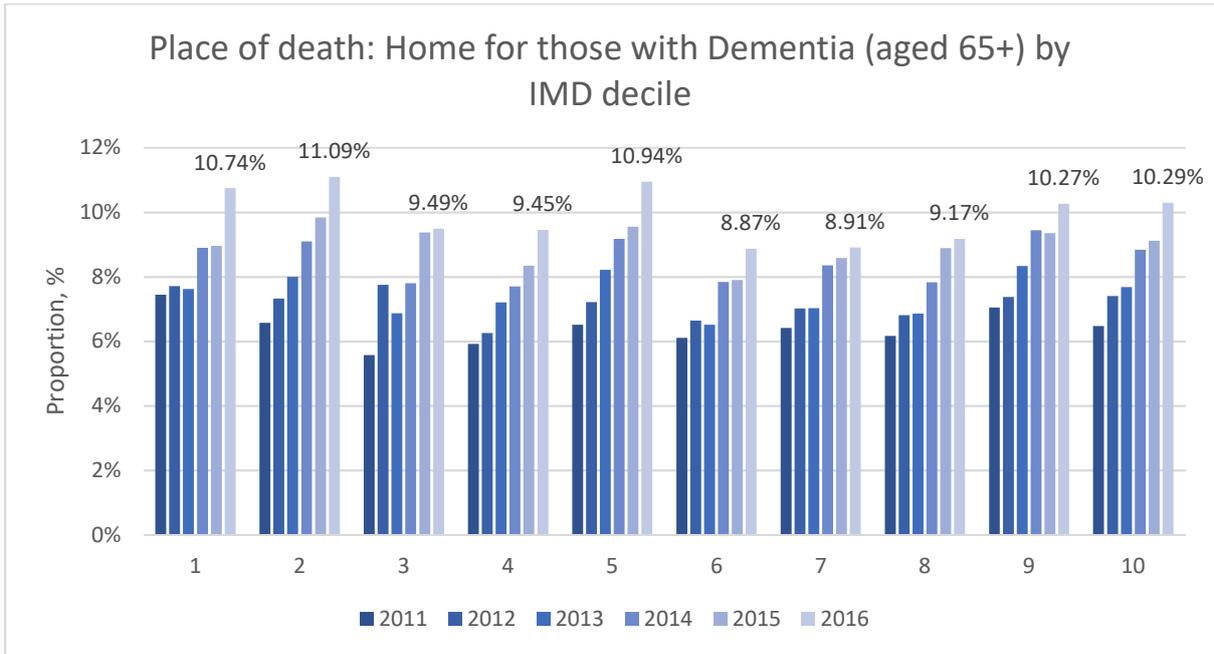
Source: Fingertips, PHE

The proportion of Deaths for those with Dementia that occurred in a care home is not available by IMD deciles in Wolverhampton. However in England, the proportion of deaths in those aged 65+ with Dementia that occurred in a care home increased as deprivation decreased, in 2016. There was a 10.54 percentage point difference between the most deprived and the least deprived areas of England. There have also been changes over time within each IMD decile, with figures within the majority of deciles increasing until 2014 and falling slightly by 2016.



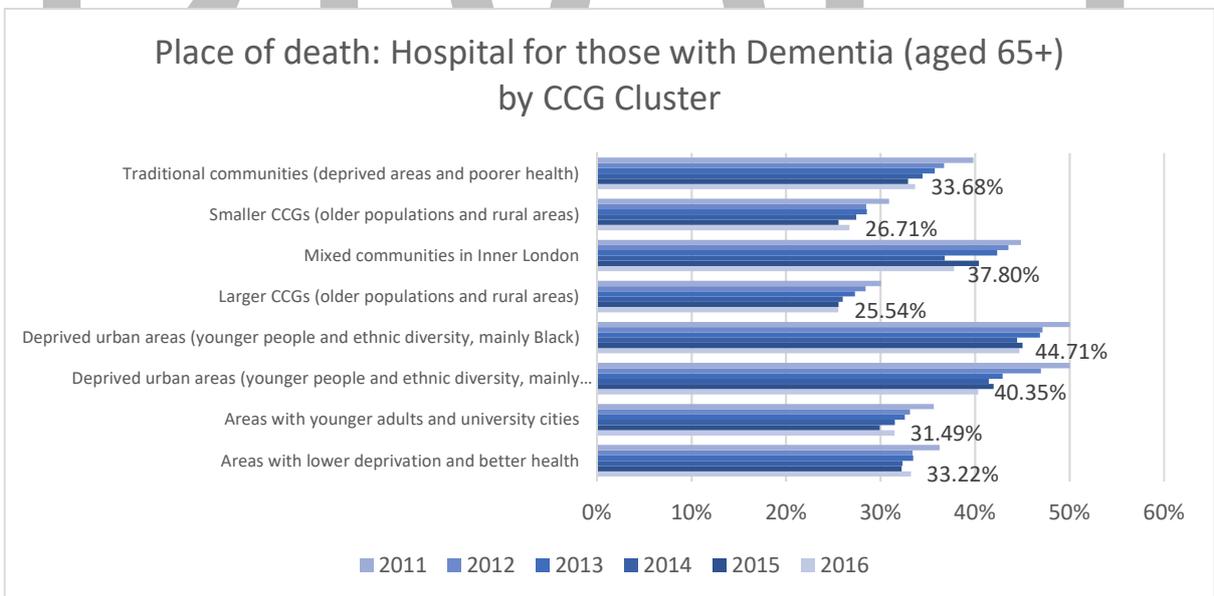
Source: Fingertips, PHE

In England, the proportion of deaths of over 65s with Dementia that occurred at home was, in 2016, highest in the 'Mixed communities in inner London' CCG cluster (19.27%). The rate in all other CCG clusters ranged between 9.11% in 'Traditional communities (deprived areas and poorer health)' and 12.81% in 'Deprived urban areas (younger people and ethnic diversity, mainly Black)'. Over the 5-year period between 2011 and 2016, the proportion of deaths, in those aged over 65 with Dementia, occurring at home increased in all of the CCG clusters. The largest percentage increases were seen in the 'Deprived urban areas (younger people and ethnic diversity, mainly Black)', with an increase of 140.3%. The smallest increase was seen in 'Areas with younger adults and university cities' with a 28.2% increase.



Source: Fingertips, PHE

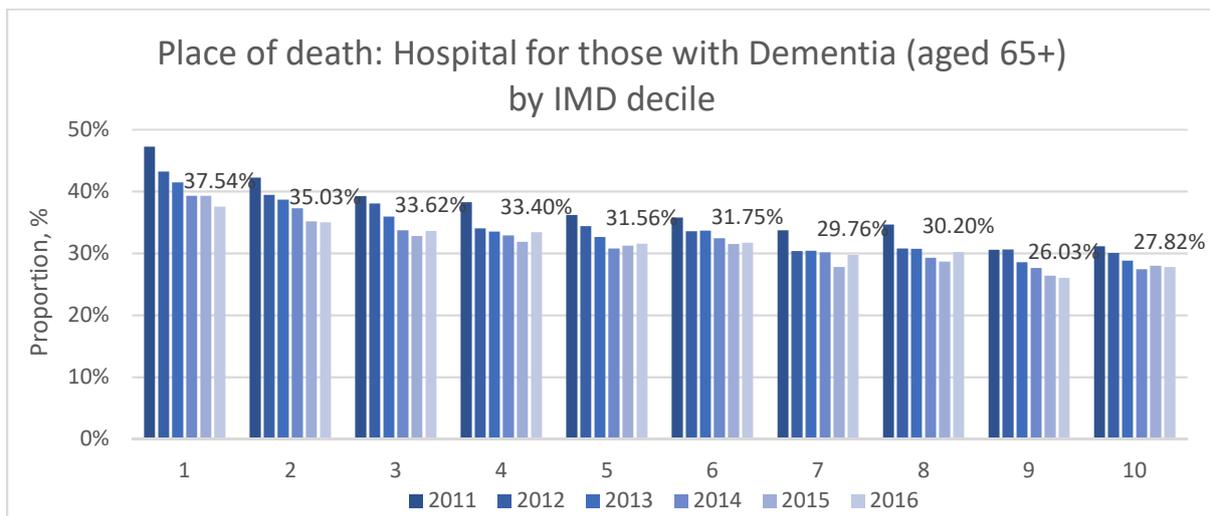
The proportion of Deaths for those with Dementia that took place within their own home, is not available by IMD deciles in Wolverhampton. However in England, there is slight variation and no notable trends between the proportions of deaths, of those aged 65+ with Dementia, occurring at home, in the different IMD deciles. The 2016 figures range from 8.87% in the 6th most deprived decile to 11.09% in the 2nd most deprived decile. However, over the five-year period, the figures have increased in every IMD decile between 2011 and 2015. The increases did not follow any notable trend, despite varying considerably between 38.8% and 70.4%.



Source: Fingertips, PHE

In England, the proportions of deaths, of those aged 65+ with Dementia, that occurred in a Hospital setting were highest in the 'Deprived urban areas (younger people and ethnic diversity, mainly Black)' (44.71%) and 'Deprived urban areas (younger people and ethnic diversity, mainly Asian)' (40.35%) CCG Clusters. The 2016 figure for the 'Mixed communities in inner London' CCG Cluster

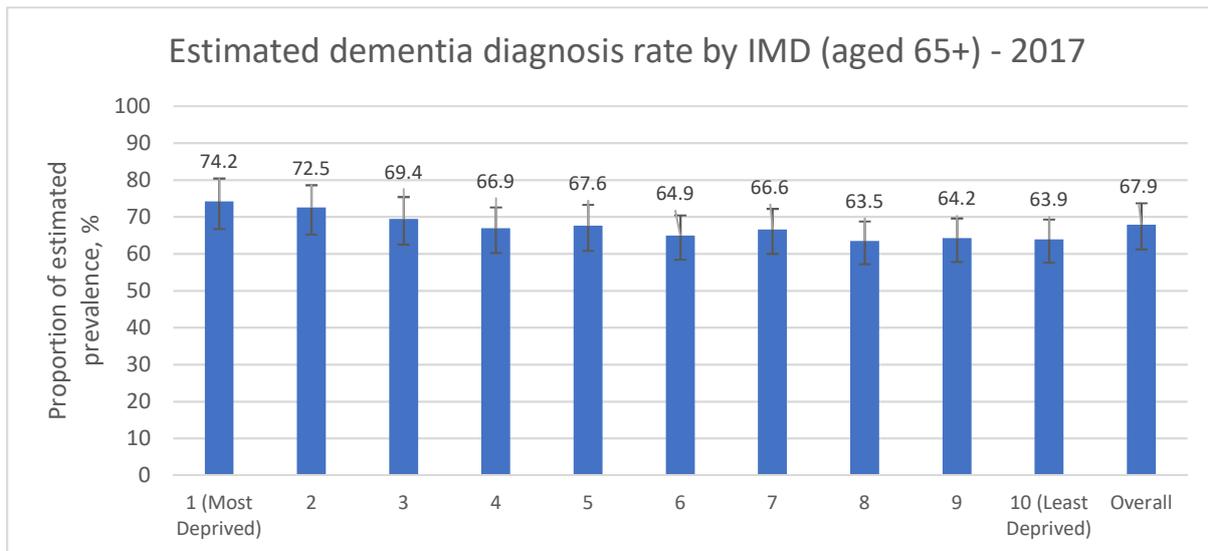
was also higher than average, at 37.80%. The lowest figures were seen in the 'Larger CCGs (older populations and rural areas)' CCG cluster, at 25.55%, and the 'Smaller CCGs (older populations and rural areas)' CCG cluster, at 26.71%. The figures also decreased in the six-year period between 2011 and 2016, with the largest percentage decreases seen in 'Traditional communities (deprived areas and poorer areas)' (17.36%) and 'Smaller CCGs (older populations and rural areas)' (17.25%). Therefore, suggesting that though numbers would be higher in the areas with older populations, there are increasingly higher proportions of over 65's with Dementia dying in hospitals in areas with younger populations.



Source: Fingertips, PHE

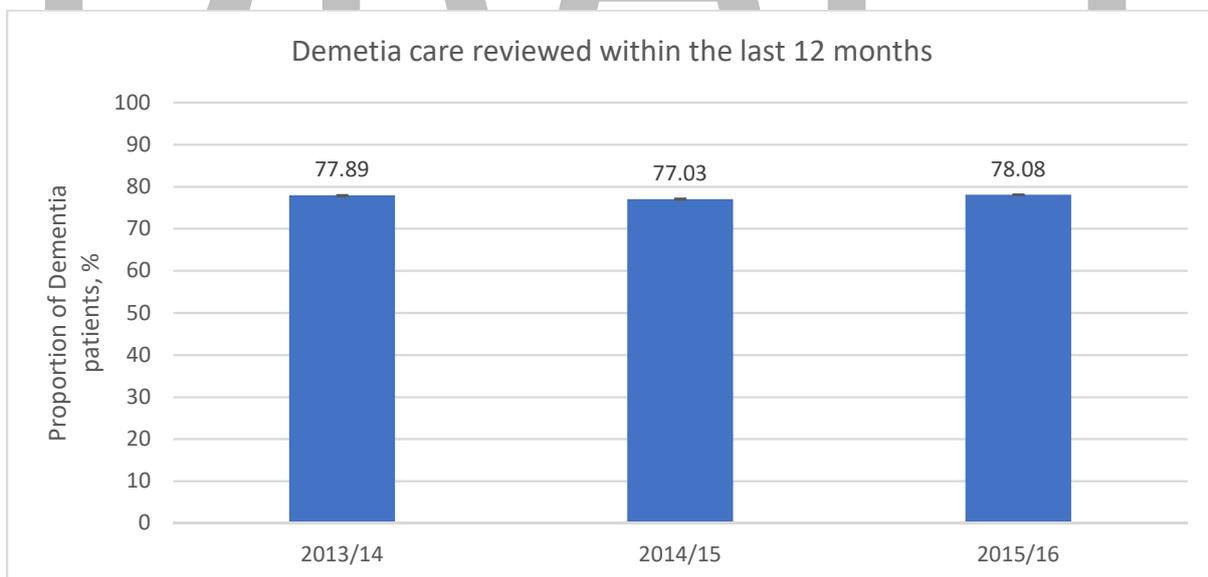
The proportion of hospital deaths for those with Dementia is not available by IMD deciles in Wolverhampton. However in England, the proportions of deaths of those aged 65+ with Dementia, that occurred in a Hospital setting were higher in the more deprived deciles, compared to the least deprived deciles. The proportions of deaths occurring in hospitals, for those with Dementia and aged 65+, in the three most deprived deciles were 37.54%, 35.03% and 33.62%, respectively; compared to the 30.20%, 26.03% and 27.82% in the three least deprived deciles. This suggests that the proportion of death is strongly associated with deprivation. Over the six-year period between 2011 and 2016, there were also decreases in figures within each decile. The smallest percentage decreases were seen in the least deprived deciles compared to the most deprived deciles, 11.96% in the least deprived decile compared to 25.87% in the most deprived decile.

Other Dementia indicators



Source: Fingertips, PHE

In England, around two-thirds (67.9%) of people aged 65+ estimated to have dementia, have received a diagnosis. This figure is known as the estimated diagnosis rate and is only available at a national level. The estimated diagnosis rate decreases slightly in line with decreases in deprivation, however, these decreases are not statistically significant. The figures suggest that there is poorer dementia diagnosis in the more affluent areas of the country, compared to the more deprived areas. Just under three-quarters (74.2%) of the people estimated to have dementia have been diagnosed in the most deprived decile, compared to less than two-thirds (63.9%) in the least deprived decile.



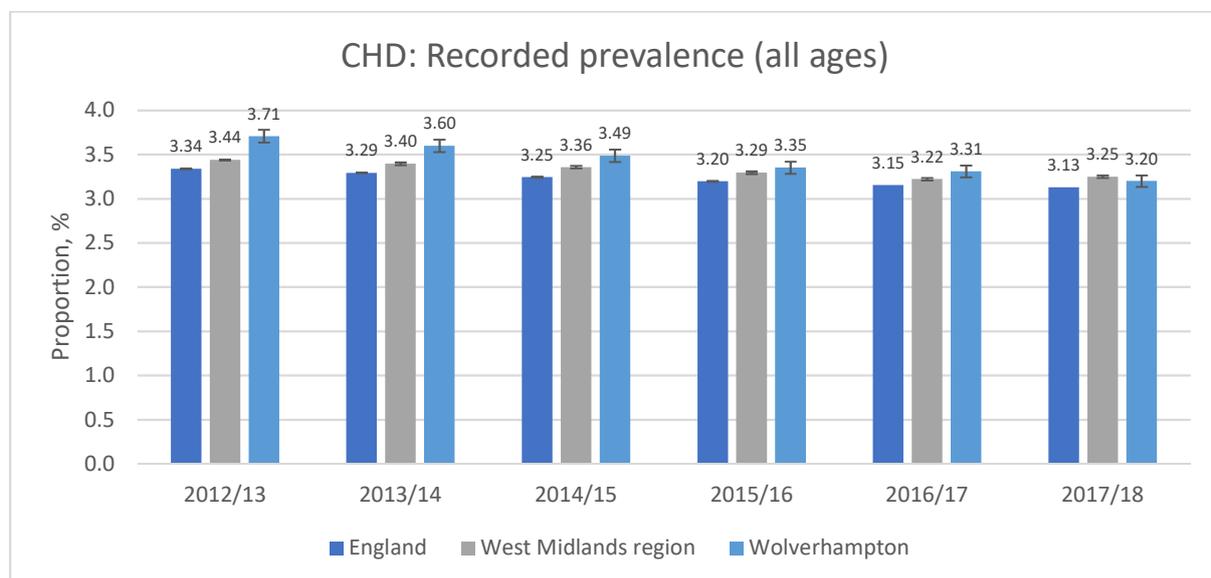
Source: Fingertips, PHE

The proportion of Dementia patients, in England, that had their care reviewed within 12 months of reporting ranged between 77.03% and 78.08%. This indicator is only available at a national level. Due to the variations between the three figures, a trend cannot be accurately reported. Although, the 2014/15 figure was significantly lower than both the 2013-14 and 2015-16 figures.

Risk Factors for Dementia

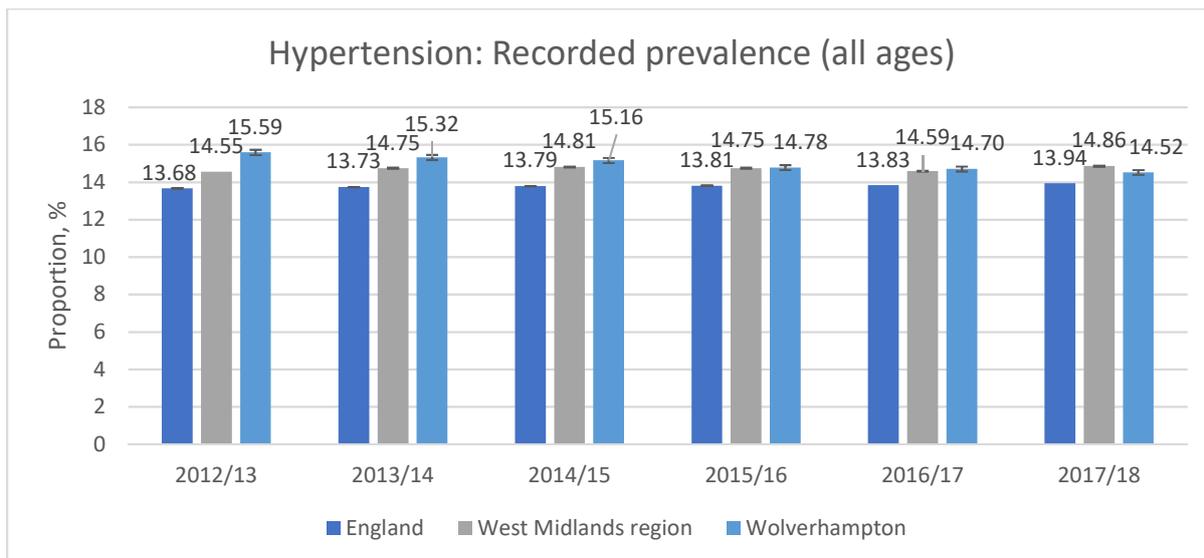
Research into Dementia have discovered a number of factors that affect the risk of developing Dementia. Some of these risk factors are genetic and age related, which are not controllable, but some are lifestyle factors which can be altered. Genetic and age-related risk factors include gender (females are more likely than males to develop Dementia, even when allowing for females living longer on average), ethnicity (there is some evidence that suggests South Asian people are more likely to develop Vascular Dementia than White Europeans) and inherited genes (there are around 20 genes which have been found to increase the risk of developing Dementia). Other risk factors are the presence of health conditions and lifestyle related, including: cardiovascular factors (such as type 2 diabetes, high blood pressure, high cholesterol levels and obesity), pre-existing mental health conditions (such as depression and Parkinson's disease), lack of physical activity, smoking and excessive alcohol consumption.

Detailed below is the prevalence of some of these risk factors in Wolverhampton.



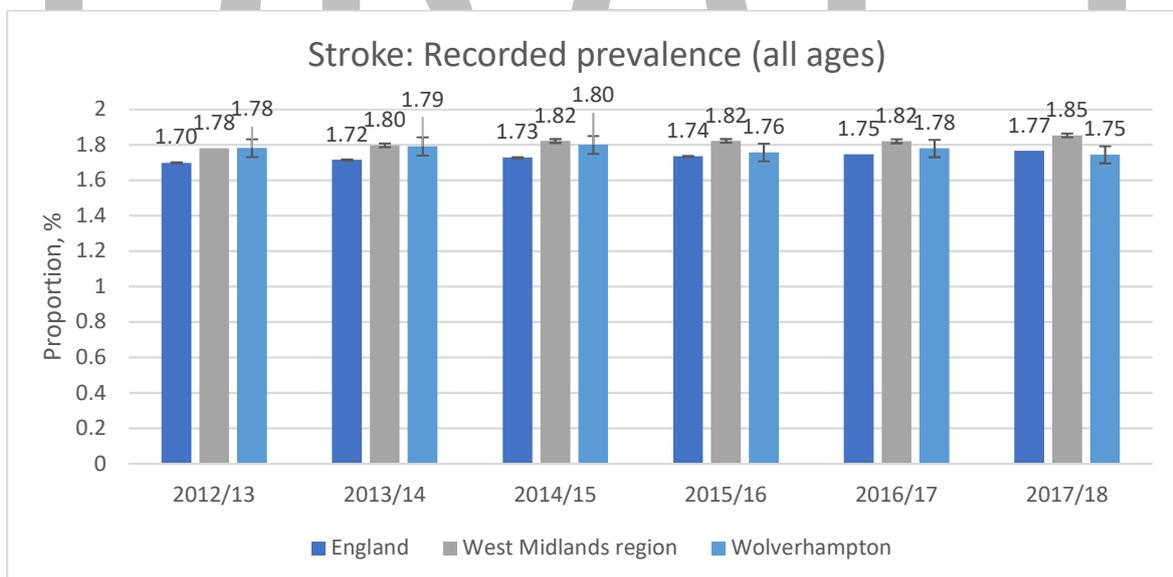
Source: Fingertips, PHE

The prevalence of Coronary Heart Disease, CHD, in Wolverhampton had consistently been significantly higher than England and the West Midlands, between 2012-13 and 2014-15, however figures in Wolverhampton have been consistently decreasing and since 2015-16 have statistically similar to the West Midlands. Over the six-year period, the figures in Wolverhampton decreased significantly, from 3.71% in 2012-13 to 3.20% in 2017-18. The figures for England and West Midlands also decreased significantly over the same time period. In terms of numbers, there were 8,969 people in Wolverhampton on the QOF register for CHD in 2017-18.



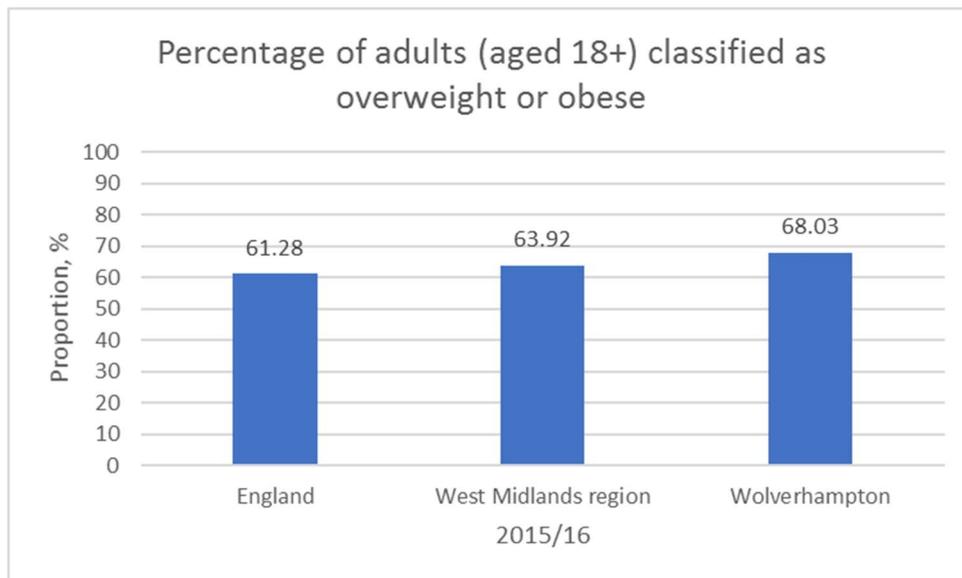
Source: Fingertips, PHE

Similarly, to the prevalence of CHD in Wolverhampton, the prevalence of Hypertension was consistently significantly higher than England and the West Midlands, prior to 2015-16, since which the prevalence has been similar to the West Midlands. The prevalence in Wolverhampton has reduced significantly over the six-year period from 15.59% in 2012-13 to 14.52% in 2017-18. However, during the same period, the prevalence of Hypertension in England and West Midlands significantly increased. In terms of numbers, there were 40,700 people in Wolverhampton on the QOF register for Hypertension in 2017-18.



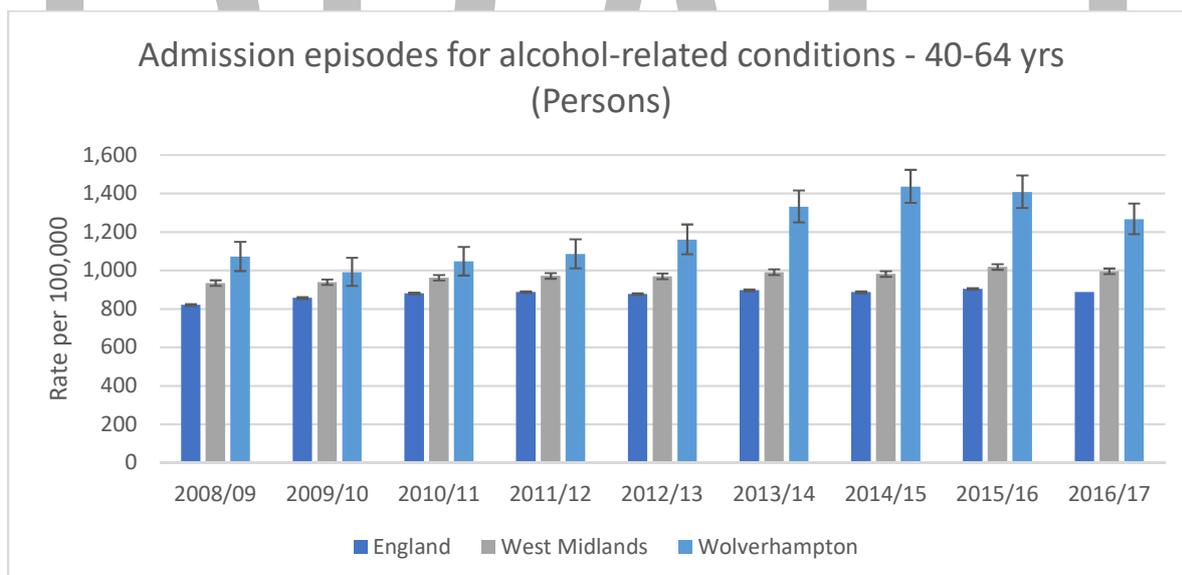
Source: Fingertips, PHE

In Wolverhampton the prevalence of people on the Stroke register was significantly higher than England in the 3 years between 2012-13 and 2014-15, but Wolverhampton was statistically similar to England between 2015-16 and 2017-18. The prevalence in Wolverhampton varied over the six-year period, between 1.75% in 2017-18 and 1.80% in 2014-15. However, in England and the West Midlands, the prevalence significantly increased over the same four-year period. In terms of numbers, there were 4,891 people in Wolverhampton on the QOF Stroke register in 2017-18.



Source: Fingertips, PHE

In 2015-16, just over two-thirds of adults (68.03%) in Wolverhampton are overweight or obese, which is significantly higher than the England figure (61.28%), but not significantly different to the West Midlands (63.92%).



Source: Fingertips, PHE

The rate of admission episodes for alcohol-related condition in 40-64 year olds in Wolverhampton has increased significantly over the past nine years, from 1,071.2 per 100,000 (2008/09) to 1,265.8 per 100,000 (2016-17). This equates to an increase of 18.2%. The Wolverhampton figures were consistently significantly higher than England over the nine-year period, but only significantly higher than the West Midlands from 2011-12 to 2016-17.



Source: Fingertips, PHE



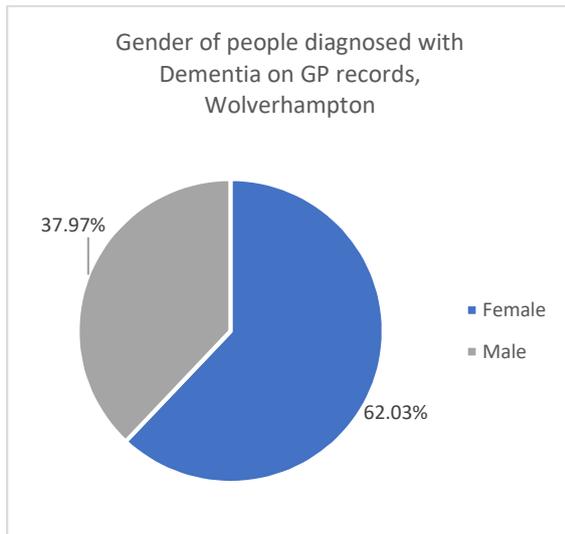
Source: Fingertips, PHE

When separated into males and females, the rates for males are considerably higher than females. In 2016-17, the rate of admission episodes for males was 1,516.6 per 100,000 and the rate for females was 1,018.4 per 100,000, a difference of 498.2 per 100,000. There have been notable increases in the rates for both genders, with figures for males increasing by 10.4% and females increasing by 32.0%, over the nine-year period.

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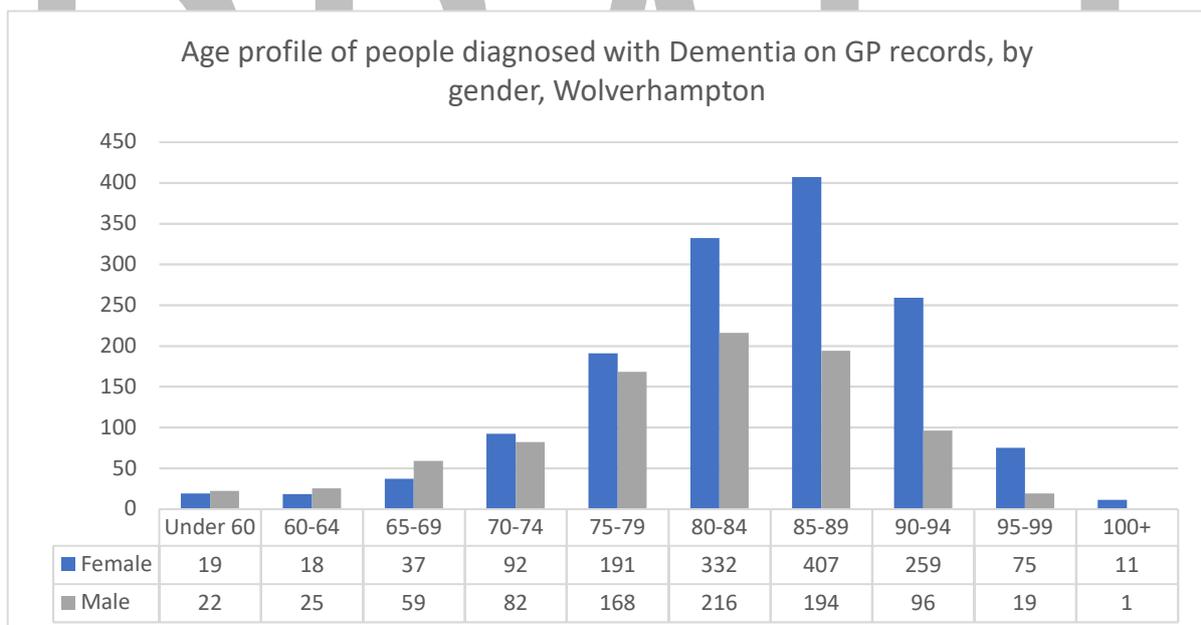
GP Records – Graphnet

In Wolverhampton, there were 2,323 people with a diagnosis of Dementia registered with a Wolverhampton GP.



Of the 2,323 people with a diagnosis of Dementia in Wolverhampton, around 62.03% were Female and 37.97% were Male. This accounts for 1,441 Females and 882 Males.

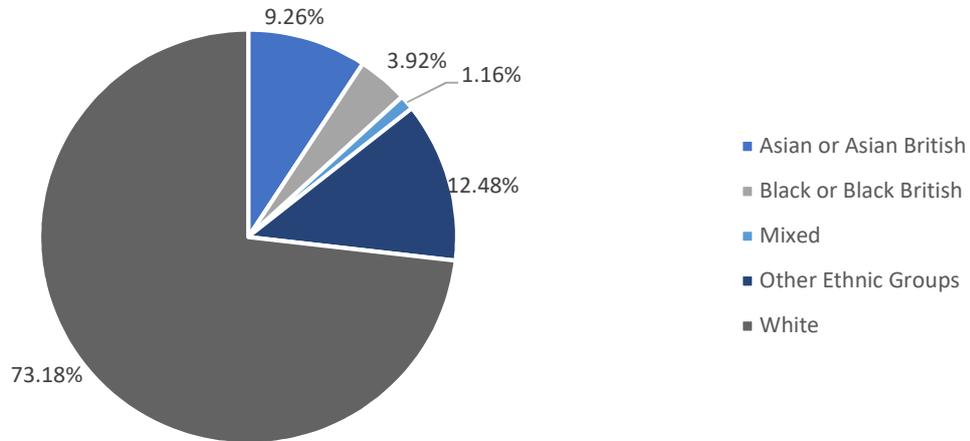
Source: Graphnet



Source: Graphnet

The age profile of the population of Wolverhampton diagnosed with Dementia on GP records is slightly skewed towards older people. The most populous age group was 85-89 years, with 601 patients, making up just over a quarter of all patients (25.87%) with a diagnosis of Dementia. In the 85-89 year age group, there were more than two-times the number of Females (407), than there were Males (194). The 80-84 year age group was the second most populous age group, with 548 patients, making up 23.59% of all patients diagnosed with Dementia. The 80-84 year age group, was made up of 332 Females and 216 Males. The mean age of an individual with a diagnosis of Dementia was 82.51 years. The average age for Females was slightly higher (83.81 years) than Males (80.38 years).

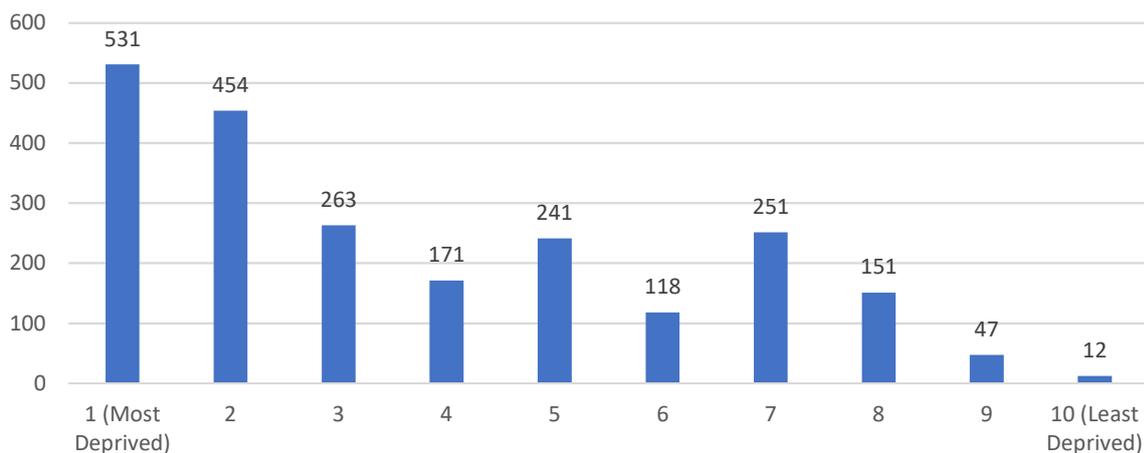
Ethnicity of people diagnosed with Dementia on GP records, Wolverhampton



Source: Graphnet

Almost three-quarters of people with a diagnosis of Dementia had a White ethnic background, 73.18%, which is significantly higher than the proportion of people with a White ethnic background in the general population of Wolverhampton. The second largest proportion was of those with an ethnic background listed as 'Other', which made up 12.48% of people with a diagnosis of Dementia. This is likely to a recording error, where the ethnicity of the patient was not correctly recorded. Just under a tenth of people diagnosed with Dementia had an Asian or Asian British ethnic background, which was significant lower than the proportion of people with an Asian or Asian British ethnic background in the general population of Wolverhampton. Similarly, the proportion of people with Dementia with a Black or Black British ethnic background (3.92%) is also significantly lower than the proportion in the general population.

Number of people diagnosed with Dementia on GP records, by IMD Decile, Wolverhampton



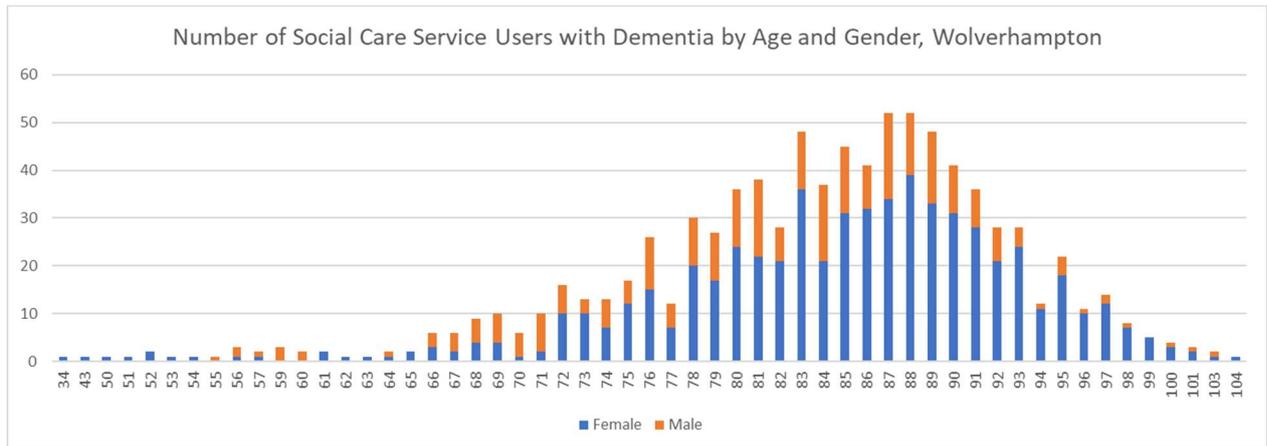
Source: Graphnet

The number of people with a diagnosis of Dementia decreases as Deprivation decreases, in Wolverhampton. More than half of those diagnosed with Dementia (53.72%) in Wolverhampton reside in areas which are in the top 30% most deprived areas nationally. Whereas, only 9.04% of those with Dementia live in the top 30% most affluent areas nationally. This is due to there being a

CareFirst – Service Users with Dementia Analysis

In Wolverhampton, there are 1,740 people known to social care service users that have a diagnosis of Dementia. Of these people, 874 are currently receiving services funded by the City of Wolverhampton Council. Of those currently receiving services, 601 service users are female and 273 service users are male.

Service User Demographics



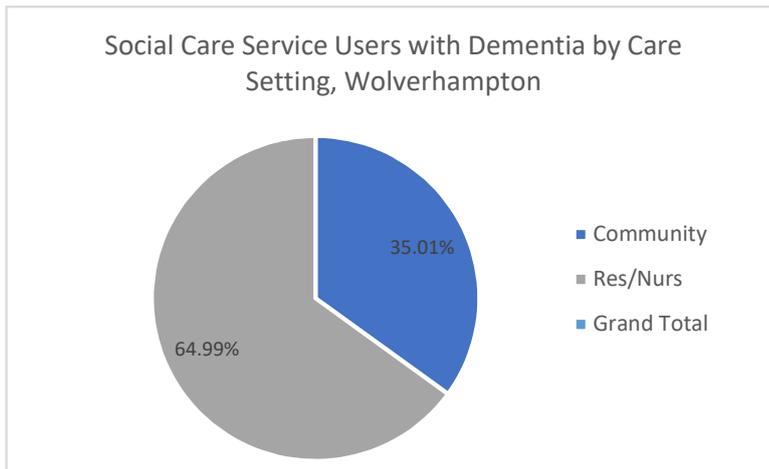
Source: CareFirst, CWC

The number of social care service users with Dementia are aged between 49 and 103 years of age. However, the numbers are less than 10 service users per year of age in the ages below 72 and above 95 years. The interquartile range is between 80 and 89 years of age, which is the range in which the middle 50% of service users reside and the median age is 85 years. The distribution of ages is slightly positively skewed, which means that the majority of service users are aged towards the older end of the 49 – 103 years age range.

	Female	Male
100+	58.82%	41.18%
90-99	48.78%	51.22%
80-89	59.41%	40.59%
70-79	68.94%	31.06%
60-69	81.46%	18.54%
Under 60	70.00%	30.00%

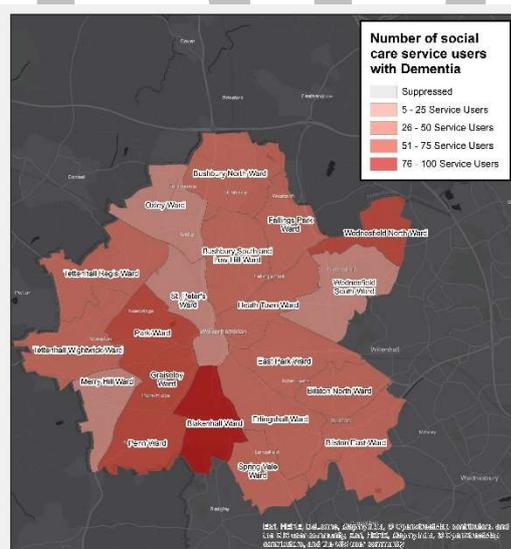
Source: CareFirst, CWC

In the most populated age groups, 70-79, 80-89 and 90-99, the proportion of service users that were female was higher compared to the proportion of males. The largest difference was seen in the 90-99 year age group, which was comprised of 81.5% female and 18.5% male service users. However, in the age groups with smaller numbers, the proportions varied, with a slightly higher proportion of males compared to females in the 60-69 year age group. In general, the proportion of female compared to male service users increased as the age groups got older.



Source: CareFirst, CWC

Of the 874 social care service users receiving services with Dementia in Wolverhampton, 306 live in the community either with family or in their own homes and 568 live in residential or nursing homes. Of those living in the community, around 64.7% are female, 35.3% are male. Of those service users living in residential or nursing homes, 71.0% are female and 29.0% were male. On average, service users who live in the community were on average 6 years younger, at 78 years, compared to those that live in residential or nursing homes, at 84 years.



Source: CareFirst, CWC

The number of service users with social care needs with Dementia are highest in Blakenhall ward, with more than 75 service users, followed by Wednesfield, Park, Penn and Graiseley wards, with between 51-75 service users. The wards with the highest number of service users are some of the more affluent parts of the city, except from Blakenhall which is in the 3rd most deprived IMD quintile. However, this is not a strong correlation, because the most deprived wards of Wolverhampton do not necessarily have the lowest numbers of service users. The geographical trend of social care service users does not have a strong correlation with the proportion of over 65's in each ward. Wednesfield North does indicate a correlation with over 50 service users and 24.56% of residents in the ward are aged 65+. However, Blakenhall ward contains over 75 service users, but the proportion of residents aged 65+ in the ward is considerably lower at 15.34%. The ward with the highest proportion of over 65's is Tettenhall Wightwick, 27.66%, but only has between 30-39 service users.

The number of service users with social care needs with Dementia are highest in Blakenhall ward, with more than 75 service users, followed by Wednesfield, Park, Penn and Graiseley wards, with between 51-75 service users.

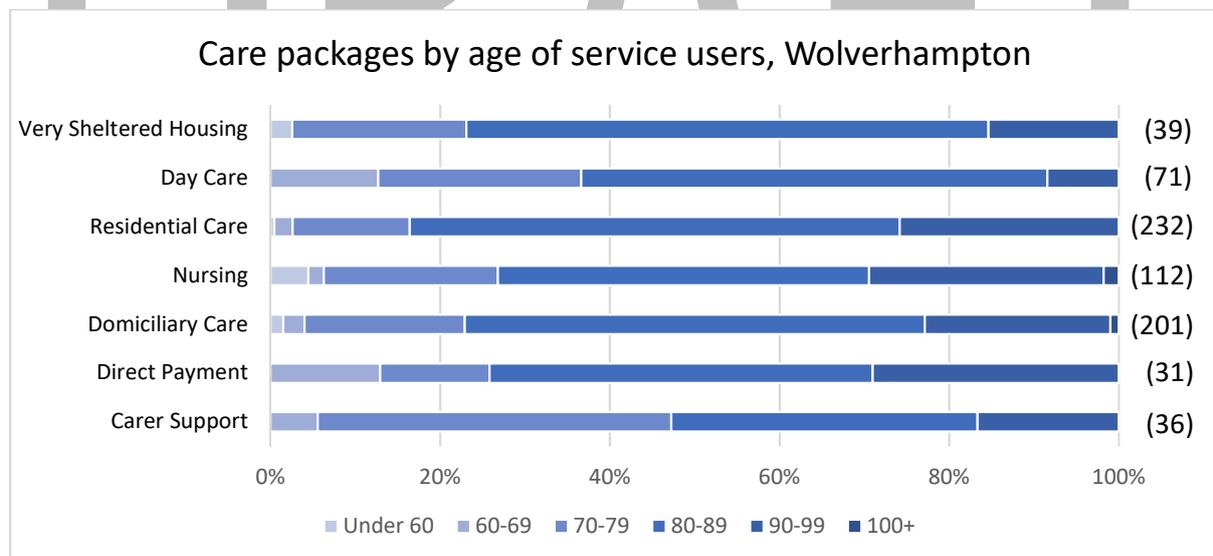
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The geographical trend of social care service users does not have a strong correlation with the proportion

Care Package Distribution

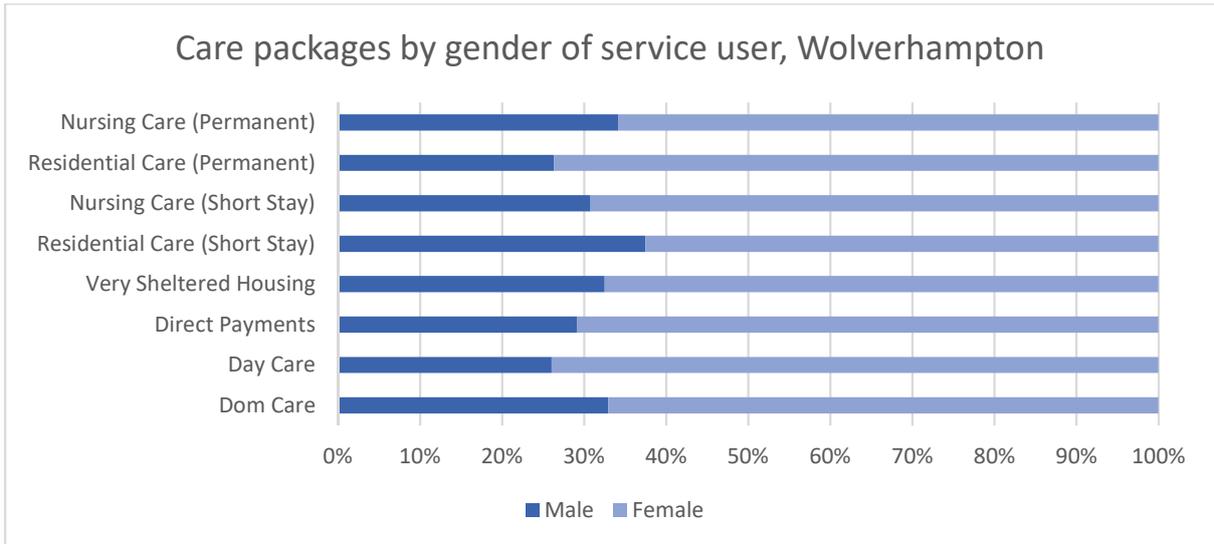
Service Setting	Number of Service Users
Dom Care	167
Day Care	73
Direct Payments	24
Individual Service Fund	<5
Supported Living	<5
Very Sheltered Housing	40
Shared Lives	<5
Residential Care (Short Stay)	24
Nursing Care (Short Stay)	52
Residential Care (Permanent)	369
Nursing Care (Permanent)	199
Carer's Services	50

In Wolverhampton, Social Care provide 952 services for the 874 service users. The table above shows the number of each type of care package. Around 38.76% of services provided were Residential Care (Permanent) services, this was the highest proportion of services. Just over a fifth (20.90%) of services were for Nursing Care (Permanent). Around 17.54% of services were for Domiciliary Care and 7.67% of services were for Day Care.



Source: CareFirst, CWC

For all types of care packages, except carer support, the highest proportion of service users are in the 80-89 year age group. More than half of service users that receive residential care and domiciliary care are aged between 80-89. The second largest proportions of service users that receive residential care, nursing and domiciliary care are aged 90-99.



For all types of care packages, the majority of service users are female. Day Care and Residential Care (Permanent) have the highest proportion of females for any of the care packages in the chart, with 74% of service users being female. Residential (Short Stay) has the lowest proportion of females of any of the care packages, with only around 63% of service users being female.

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NHS Dementia Clusters Analysis

Care Cluster Definitions

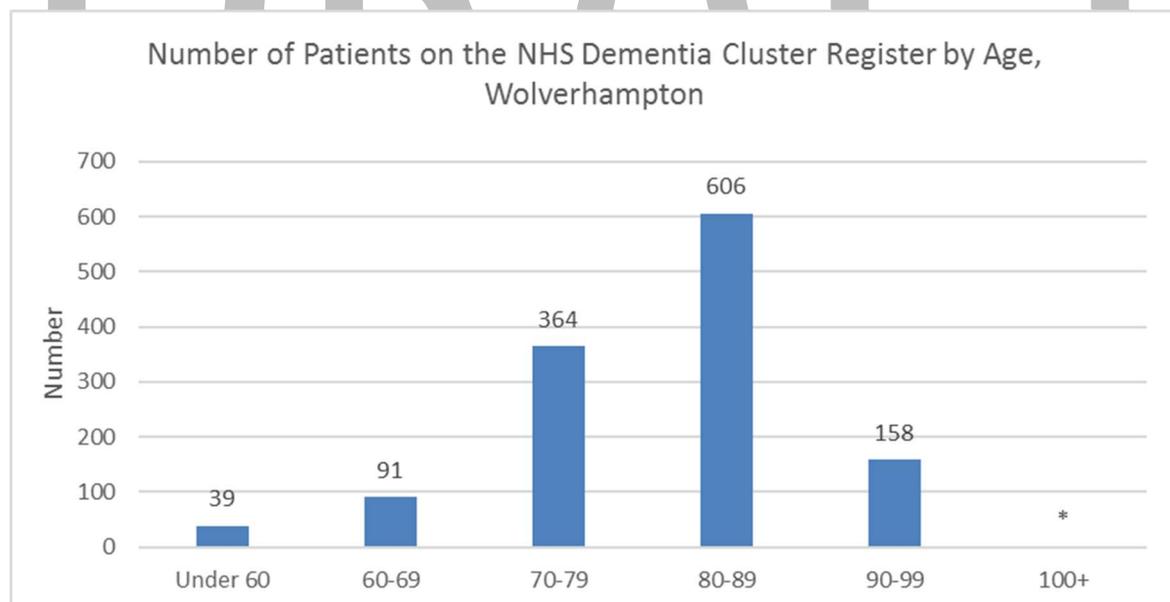
Care Cluster 18: People who may be in the early stages of dementia (or who may have an organic brain disorder affecting their cognitive function) who have some memory problems, or other low level cognitive impairment but who are still managing to cope reasonably well. Underlying reversible physical causes have been ruled out.

Care Cluster 19: People who have problems with their memory, and or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self-neglect or harm to others and may be experiencing some anxiety or depression.

Care Cluster 20: People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms or significant problems such as aggression or agitation. They may not be aware of their problems. They are likely to be at high risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down.

Care Cluster 21: People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down.

Patients registered to all clusters



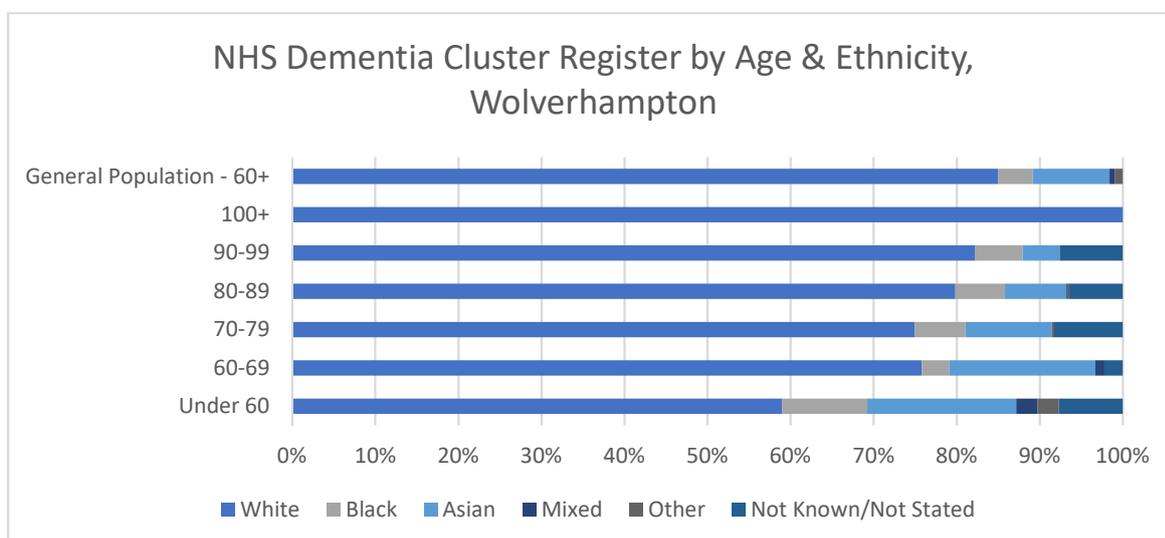
Source: NHS BCPFT

In Wolverhampton, there are around 1,250 patients registered to a cluster that is indicative of a diagnosis of Dementia. Just under half of all patients (606 patients) are in the 80-89 year age group. The second most populated age group is the 70-79 year age group, in which there are 364 patients.

	Population	Number in Cluster	Rate per 100,000
Under 60	199,144	39	19.58
60-69	24,397	91	373.00
70-79	18,303	364	1,988.75
80-89	10,384	606	5,835.90
90+	2,178	159	7,300.28

Source: NHS BCPFT

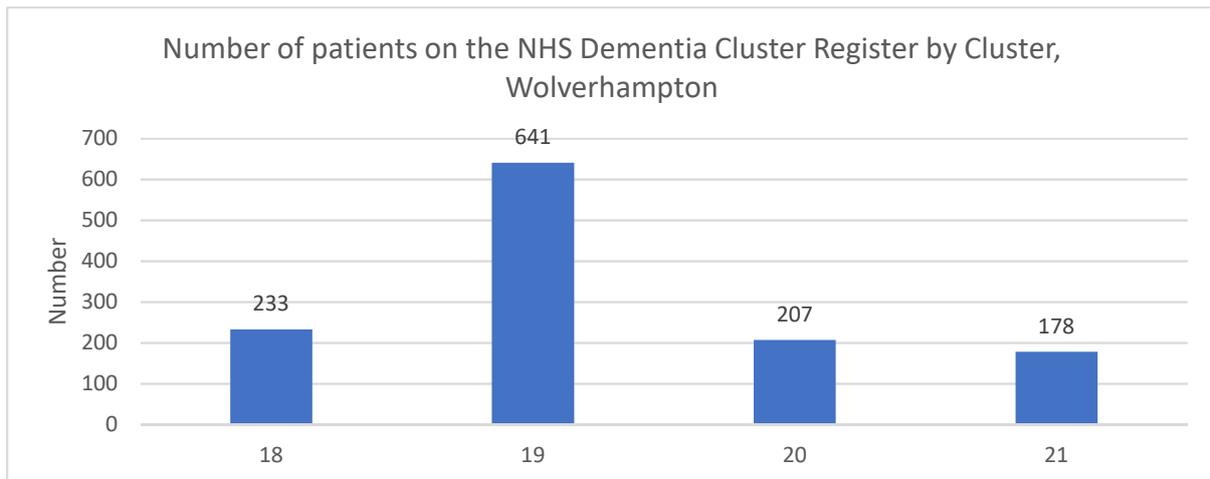
However, when the number of patients registered to a cluster are compared to the general population, the highest rate of residents registered to a cluster is in the 90+ age group, at 7,300 per 100,000. The rate for the 80-89 year age group, of which around 48% of all registered patients fall into, has the second highest rate of 5,836 per 100,000. The rates for the 70-79, 60-69 and under 60 age groups are considerable lower.



Source: NHS BCPFT

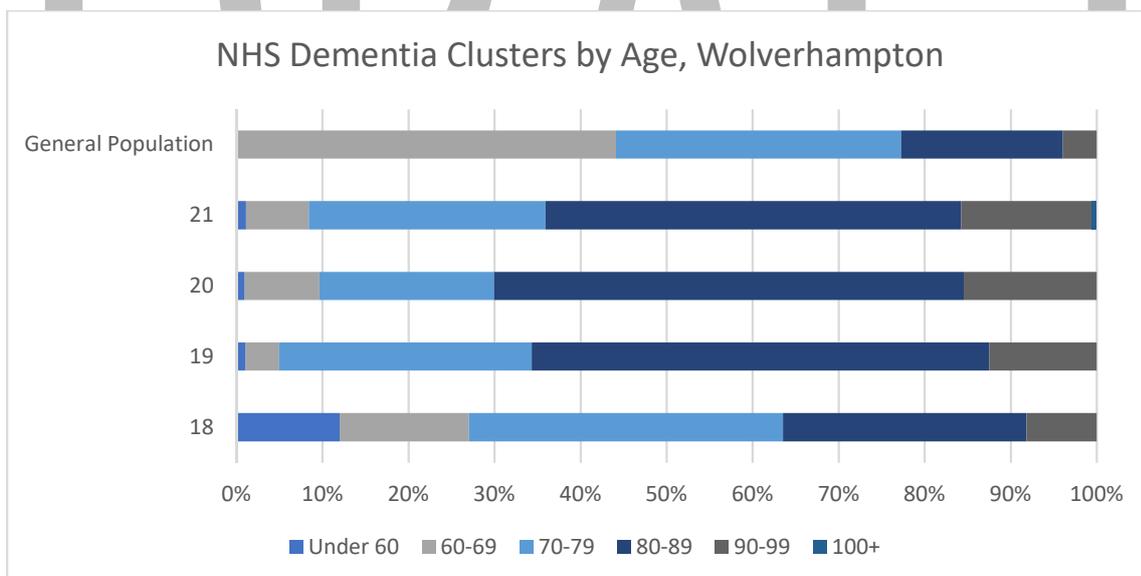
The majority of patients registered to clusters that are related to Dementia are of a White ethnicity. In the most populated age groups (70-79, 80-89 and 90-99), between 75.0% and 82.3% of those registered in clusters are of a White ethnicity. Compared to the general population of Wolverhampton aged 60+, the White ethnic group in the three most populated age groups is slightly under-represented. The Asian ethnic group is also slightly under-represented in the 80-89 and 90-99 year age group, but slightly over-represented in the 70-79 year age group. The Black ethnic group is slightly over represented compared to the general population of Wolverhampton aged over 60 (4.1%), with figures between 5.7% and 6.0% in the three most populated age groups.

Patients within clusters



Source: NHS BCPFT

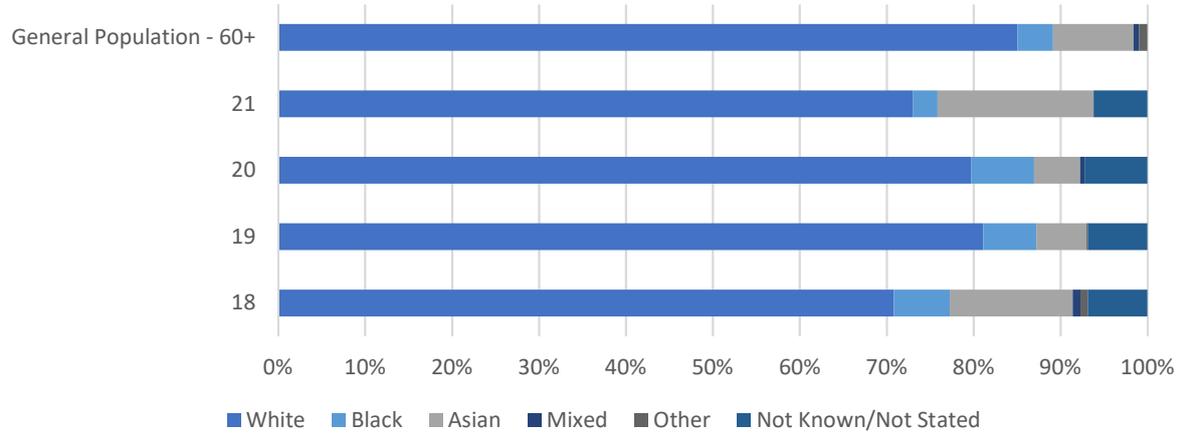
Just over half of all patients registered to a care cluster that suggest a diagnosis of Dementia fall into cluster 19. Patients in Cluster 19 are characterised by having moderate needs. The number in the cluster with the least needs, Cluster 18, have just under a fifth of all patients registered for Dementia related needs. The two clusters which contain patients with significant needs, Clusters 20 and 21, contain 16% and 14% of patients, respectively.



Source: NHS BCPFT

The age profiles for each of the dementia clusters vary slightly. Cluster 18, which is characterised as having the least severe cognitive symptoms, on average has the youngest patients, with a median of 76 years of age. Almost 40% of patients in Cluster 18 are aged between 70-79, the highest among the four clusters for that age group. Cluster 18 also has the highest proportion of under 60's and the lowest proportion of over 90's. In Clusters 19, 20 and 21 around half of patients are aged between 80-89. On average the patients in Clusters 19, 20 and 21 are older than the patients in Cluster 18, the median age is 83 years for Cluster 19 and 20, and 82 years for Cluster 21. The proportion of patients in the 90-99 age group increases as the severity of symptoms increases, with the highest proportions seen in Cluster 20 and 21, 15.5% and 15.2%, respectively.

NHS Dementia Clusters by Ethnicity, Wolverhampton



Source: NHS BCPFT

The majority of patients registered to a dementia cluster were of a White ethnicity, although the proportion of patients with a White ethnicity was lower compared to the proportion of the White population in the Wolverhampton population aged 60+. The lowest proportions of patients of a White ethnicity are seen in clusters 18 and 21. The proportion of patients of an Asian ethnicity is highest in clusters 18 and 21, at 14.2% and 18.0%, respectively. Whereas, the proportions in clusters 19 and 20 were much lower at 5.8% and 5.3%, respectively. Compared to the general population of Wolverhampton, the Asian ethnicity is over represented in clusters 18 and 21; and underrepresented in clusters 19 and 20. There is also a slight data quality issue in this chart, with between 6.2% and 7.2% of patients in each cluster, with an ethnicity recorded as 'Not Known/Not Stated'.

Stakeholder Views

Surveys were conducted to obtain the views of service providers, professionals working with people with Dementia, carers and people diagnosed with Dementia on services provided for people with Dementia. Three separate surveys were conducted to obtain stakeholder views. One survey for professionals working with people with Dementia, one for carers of people with Dementia and one for people diagnosed with Dementia. The results of these surveys are only the views and opinions of the people who responded to the survey and should be interpreted with caution as they may not reflect the views of all the survey audience in Wolverhampton. A summary of the stakeholder engagement processes is presented below and a detailed stakeholder engagement report is available on request.

Methodology

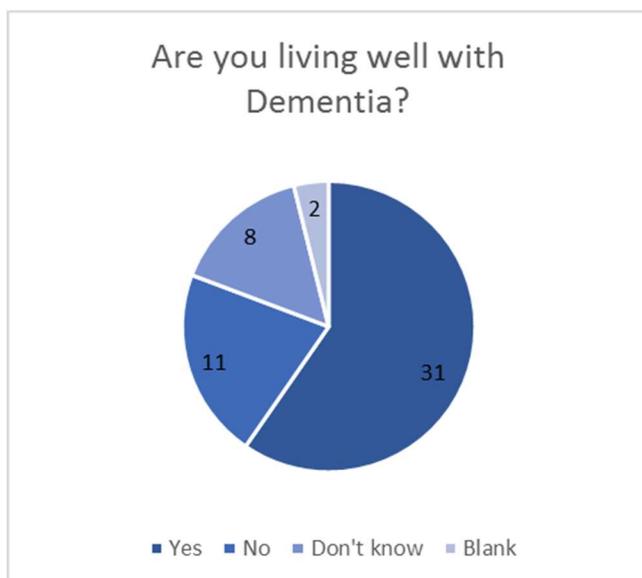
The three survey questionnaires were co-produced with colleagues from social care commissioning and with consultation of the JSNA Steering Group members, which includes membership from the Wolverhampton CCG, Royal Wolverhampton Trust and Black Country Partnership Foundation Trust. An implementation plan was agreed to ensure timely administration.

The questionnaire was sent to the stakeholders via a survey monkey link along with an email detailing the importance of the Dementia JSNA and how stakeholders could help to shape future services. There were also hard copies of each of the surveys for those respondents who were either unable to fill it online or did not wish to. The JSNA Steering Group supported dissemination to key stakeholders and there was additional direct distribution to further known networks. The links to the surveys were also disseminated via the City Council's communications team with press releases, articles on the Council's intranet and local newspapers. Colleagues from social care commissioning that were involved with Dementia Café's also took along hard copies of the surveys for people diagnosed with Dementia and asked service users to fill them in and assisted respondents with this.

Survey for people diagnosed with Dementia

There were 52 surveys returned from respondents that had been diagnosed with Dementia, of which 1 survey was completed online and 51 surveys were completed on paper. Of the 52 respondents, 35 reported their gender as Female, 13 as Male and 4 left the question blank.

Are you living well with Dementia?



The majority (59.62%) of respondents reported 'Yes' when asked 'Are you living well with Dementia?'. Around a 21.15% of respondents reported 'No' to the question, a further 15.38% said they 'Don't know' and 2 respondents left the question blank.

Alongside the response, respondents were asked for any comments they may have to along with their answer. Comments from those who responded 'Yes' included: 'With lots of help from carers and daughter', 'Yes, because my wife looks after me' and 'Best I can'. Comments alongside those that responded 'No' included: 'Every day it's different. You don't know what you are

going to face. (People with Dementia do not feel comfortable around new people).' Other comments from those who reported to being unsure were around the themes of not being able to say how they were feeling.

What is your type of residency?

Type of Residency	Number	Percentage
Living alone at home	10	19.23%
Living at home with partner	23	44.23%
Living in residential care	2	3.85%
Living in supported accommodation	4	7.69%
Living with extended family	9	17.31%
Blank	4	7.69%

Respondents were asked about the living arrangements using a closed question: 'What is your type of residency?'. Almost half of the 52 respondents (44.23%) said they live at with their partner, a further 10 respondents said they live at home alone and 9 respondents said they lived with extended family.

Do you have enough family and friends around you that you can count on for support?

Responses	Number	Percentage
No	8	15.38%
Yes	36	69.23%
Don't know	6	11.54%
Blank	2	3.85%

Respondents were also asked whether they have enough family and friends around them that they could count on for support. Around two-thirds of respondents reported that they had enough family

and friends around for support, whereas a further 14 respondents reported that they either did not have enough (15.38%) or did not know (11.54%).

Of the 10 respondents that reported to living at home alone, 6 said they had enough family and friends around for support, 3 said they didn't and 1 said they did not know. There were 32 respondents who reported to living with either their partner or extended family, 4 of these respondents said they did not have enough family or friends around them and 3 said they did not know. None of the respondents living in either supported accommodation or residential care said they did not have enough friends or family around to count on for support.

Are you receiving any support to live well with Dementia?

Responses	Number	Percentage
No	13	25.00%
Yes	26	50.00%
Blank	5	9.62%
Don't know	8	15.38%

Respondents were asked if they received any support to live well with Dementia. This question had a text box alongside it for respondents to identify who they received support from and to explore what people with Dementia may identify as support.

Half of the respondents said they received some support to live well with Dementia, accounting for 26 respondents. In the comments, respondents elaborated on this. The common themes were:

- Support from carers from social services/council
- Nurse visits
- Carer support to carry out tasks such as getting changed and shopping
- Support from family

Do you feel involved enough in decisions about your care and support?

Responses	Number	Percentage
No	9	17.31%
Yes	23	44.23%
Blank	3	5.77%
Don't know	17	32.69%

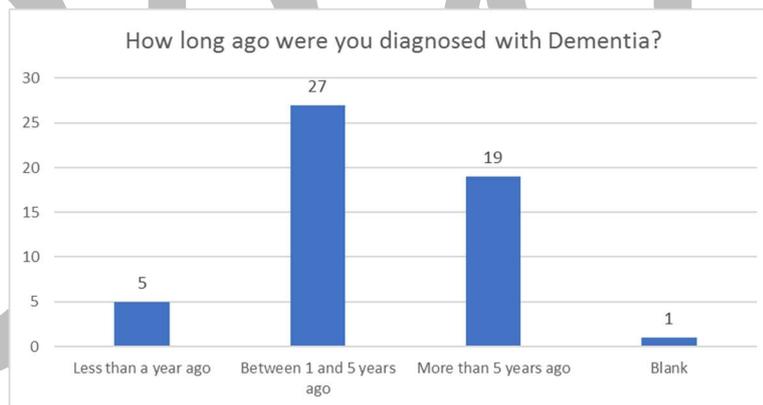
Respondents were also asked whether they felt involved enough in decisions about their care and support, via a closed question. Almost a third of respondents (32.69%) reported that they did not know if they were involved enough with decisions about their care and support. However, the majority of respondents said they did feel involved enough with decisions (44.23%) and just under a fifth (17.31%) said they did not feel involved enough.

If you have a carer (family or friend), do they receive help to care for you?

Responses	Number	Percentage
No	20	38.46%
Yes	25	48.08%
Blank	4	7.69%
Don't know	3	5.77%

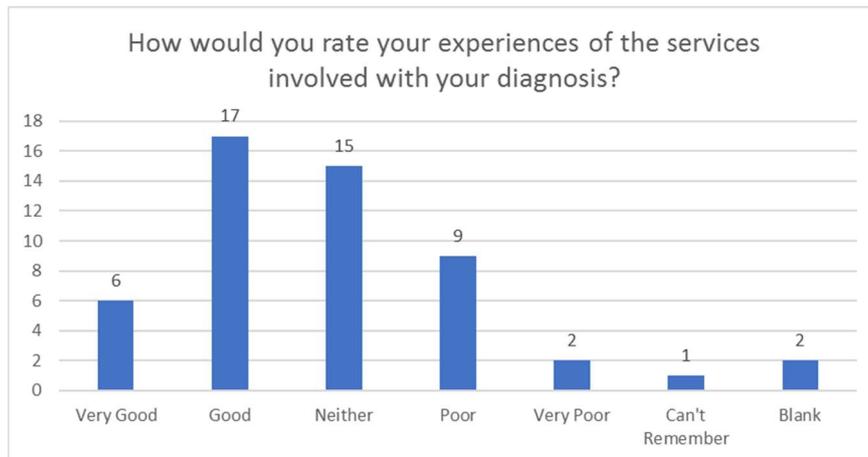
Respondents were asked if they had a carer (family or friend), whether that carer received help to care for them, with an open text box asking who the help was provided by. Just under half of all respondents (48.08%) reported that their carers received support to care for them. The common themes from the text within the free text box were financial support, additional carer support and family support. Around 38.46% of respondents said their carers did not receive any help and 5.77% said they did not know. None of the respondents who said their carers did not or they did not know whether their carers received any help, left any comments alongside their answer. Four respondents left the question blank, but did say that their family helped their carer in the text box.

How long ago were you diagnosed with Dementia?



Respondents were asked how long they had been living with a diagnosis of Dementia, via a closed question with three-time periods. Just over half of respondents (51.92%) had been diagnosed with Dementia for between 1 and 5 years, at the time of the survey. There were 19 respondents (36.54%) who reported to had been diagnosed more than 5 years ago and only 5 respondents were diagnosed less than a year ago.

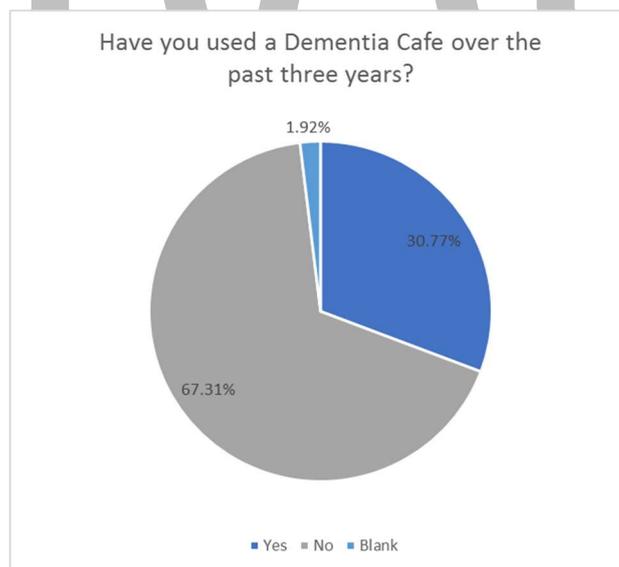
How would you rate your experiences of the services involved with your diagnosis?



Respondents were asked to rate their experiences of the services involved with their diagnosis. Just under half of respondents (44.23%) said their experience with the services involved with their diagnosis was either 'Good' or 'Very Good'. Over a fifth of respondents (21.15%) said their experience was 'Poor' or 'Very Poor'.

Of the respondents that were diagnosed more than five years ago (19 respondents), nine said they rated their experience of services as 'Good' or 'Very Good', whereas only 4 respondents rated it as 'Poor' or 'Very Poor'. A similar split was seen in respondents who were diagnosed between 1 and 5 years ago, with 13 rating their experience as 'Good' or 'Very Good'; 6 rating it as 'Poor' or 'Very Poor'. However, in respondents that were diagnosed less than a year ago, 60% rated their experience as 'Neither' (3 respondents).

Have you used a Dementia Café over the past three years?



Respondents were asked whether they have made use of the Dementia Café's based in Wolverhampton at any point over the past three years. Of the 52 respondents, only 16 (30.77%) said they had used the Dementia Cafe service. Over two-thirds of respondents (67.31%) said they had not used a Dementia café.

If not, what stops you using a Dementia Café?

A further question was asked to those respondents who said they had not used the Dementia Café service in order to explore the reasons why they did not use them, using a list of three potentially common reasons and an 'Other' option for respondents who had reasons that were not in the list. Respondents may have chosen more than one option for this question.

Reason	Responses
Isn't one near me	4
Have never heard of it	15
It is not useful	3
Other	14
Blank	16

The most common reason for not using Dementia Cafés was that respondents had not heard of the service. A small number of respondents reported that they did not have a Dementia Café near them (4 respondents) or that they did not think the service was useful (3 respondents). The common themes that were presented alongside the 'Other' category were:

- People with Dementia struggling to get out of the house
- Carers or family members unable to take them due to the opening times.

Do you have any comments about the Dementia cafes? What is useful/not useful?

There was also an opportunity for respondents to provide comments on Dementia Café's and which aspects of the service respondents thought were useful or not useful. Common themes arising from the responses to this question were:

- Positive:
 - Somewhere to meet and talk to people about their condition
 - Somewhere to share problems and get help
 - Volunteers and users are very good and very friendly
 - Social aspects and activities
- Negative:
 - All run in the morning, need some café's open in the afternoon in the local area
 - Lack of fellow younger attendees can unsettle younger attendees that do attend
 - No transport available

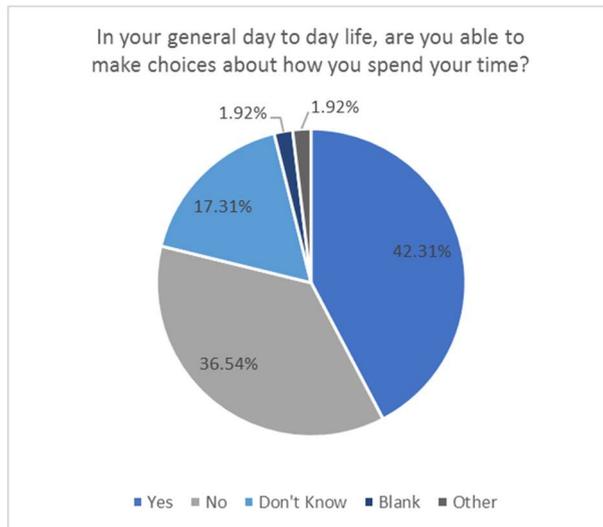
If you feel well supported with your Dementia in your local area, please tell us why?

Respondents were also asked if they felt supported to live well with Dementia in their local area, there were 14 responses to this question. This question was asked to explore which aspects of the respondent's environment support them to live well with Dementia. The responses to this question were quite diverse, the responses included:

- Carers are provided to support me
- Dementia cafes are good but more support is needed for more one to one [illegible] for dementia sufferers
- I attend Blakenhall Day Centre two days a week for dementia and feel well supported while I am there
- I feel well supported in my area because there is people to help you

- I have a number of Dementia cafes to choose from. However, there are non-catering for people from the Afro-Caribbean Community
- No - nothing in local area to me - just need to be with others i.e. social meetings - not organised facilities
- The dementia cafes are very supportive

In your general day to day life, are you able to make choices about how you spend your time?

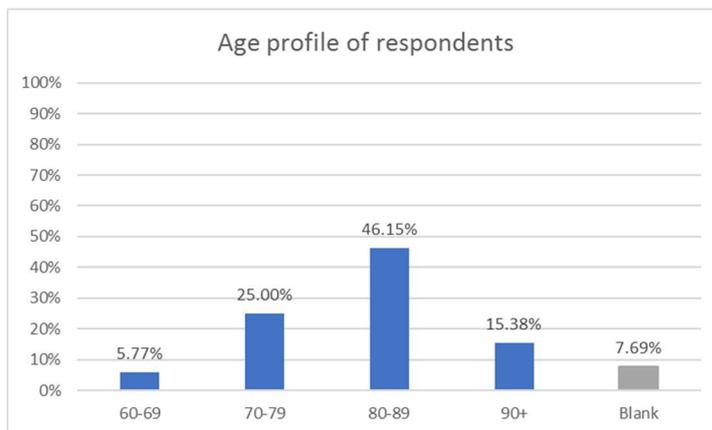


Respondents were asked whether they felt that they able to make decisions about how they spend their time, in their general day to day lives. There were 22 respondents who said they were able to make decisions, which was the highest proportion of responses (42.31%). Just over a third of respondents (36.54%) said that they were not able to make those decisions and 17.31% said they did not know. Two respondents did not select a response, but one of those wrote a comment to answer the question: 'Not always'.

Demographics of Respondents

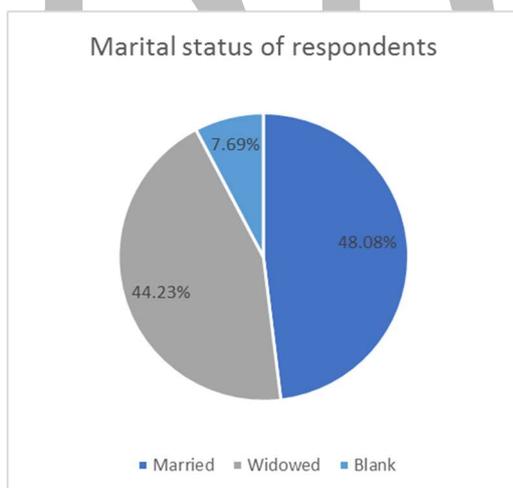
To complete this survey, we asked a set of demographic questions to understand the responses and to ascertain whether the current Dementia services provided in Wolverhampton are fair and accessible to a diverse range of people with dementia. Respondents were asked about a range of characteristics, such as gender, age, ethnicity and sexuality. This information will also allow us to determine how representative our sample of respondents is against the population of Wolverhampton with Dementia.

Age:



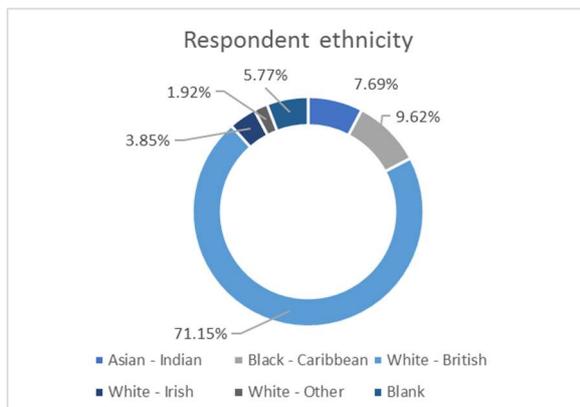
Just under half of all respondents said they were aged between 80-89 (46.15%). A quarter of respondents reported to being aged between 70-79, with lower proportions reporting to be aged below 70 and over 90.

Marital status:



Similar proportions of respondents reported to being Married or Widowed, at 48.08% and 44.23%, respectively. Four respondents did not leave a response and a number of options were left unticked (Civil Partnership, Co-habiting, Divorced, Single, Prefer not to say and Other).

Ethnicity:



The majority of respondents reported that their ethnicity was White – British (71.15%), whilst a further 3.85% said their ethnicity was White Irish and 1.92% said that it was White – Other. The second highest proportion of respondents reported that their ethnicity was Black – Caribbean (9.62%), followed by the proportion that said they were of an Asian – Indian ethnicity (7.69%).

Religion:

In addition to ethnicity, respondents were also asked which religion they followed, if any at all. The vast majority of respondents said they were Christian (including Catholic and Methodist), making up 78.85% of all respondents. Around 5.77% said they were Hindu, 1.92% said they were Sikh and 7.69% said they did not follow a religion. A further 5.77% left the question blank.

Sexuality:

Respondents were also asked about their sexuality, in order to see if there was any variation in the access and experience of living with Dementia between people with different sexualities. However, the vast majority reported their sexuality as Heterosexual/Straight (78.85%) and the remaining 21.15% either chose 'Prefer not to say' (4 respondents) or left the question blank (7 respondents).

Further Comments:

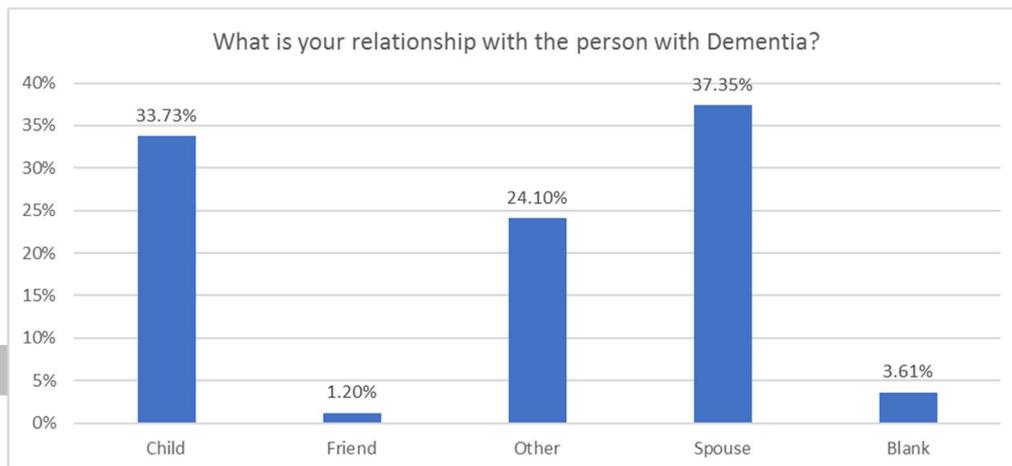
Further comments were also placed at the end of some of the hard copies of the survey. Three of the comments were regarding completing the form, informing us that the person with Dementia was unable to complete the form, so a daughter filled it out with the person with Dementia. The other comment explained that the person with Dementia struggles to intercept letters and that due to English not being their first language, carers can struggle to communicate and understand her needs.

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Survey for people caring for a person with Dementia

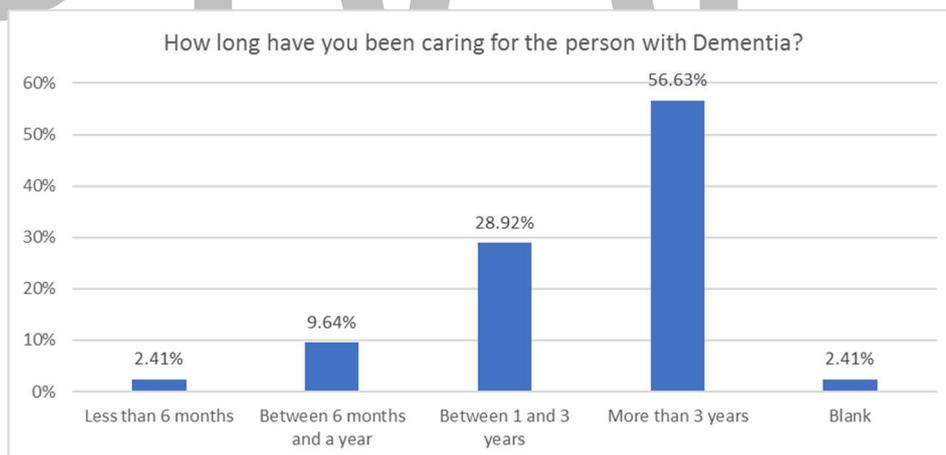
The survey aimed at carers generated 83 responses, 26 of the responses were done online and 57 were completed on paper. The 83 respondents consisted of 51 females, 24 males and 8 who either left their gender blank or said that they preferred not to say. The people with Dementia, that the 83 carers cared for, consisted of 44 females, 28 males and 11 people whose gender was not disclosed.

What is your relationship with the person with Dementia?



Respondents were asked what their relationship is with the person with Dementia that is cared for, the vast majority of carers were close relatives to the people they cared for. The most common relationship was 'Spouse', which made up 37.35% (31) of respondents, followed by carers that cared for a parent, with 34.94% (29) saying that they were the child of the person they cared for. Just under a quarter of respondents, 22.89% (19) of respondents said they were in the 'Other' category, which included other relatives and care workers.

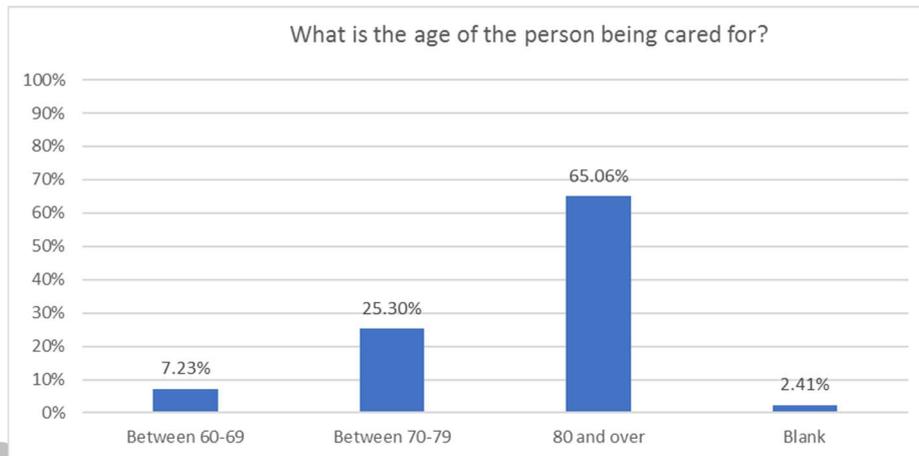
How long have you been caring for the person with Dementia?



Carers were asked how long they had been caring for the person with Dementia, more than half of the 83 carers said they had been caring for more three years (47 respondents). Over a quarter said they had been caring for between 1 and 3 years (24 respondents) and 9.64% said they had been caring for between 6 months and a year. Only 2 respondents said they had been caring for less than 6 months and a further two left this question blank.

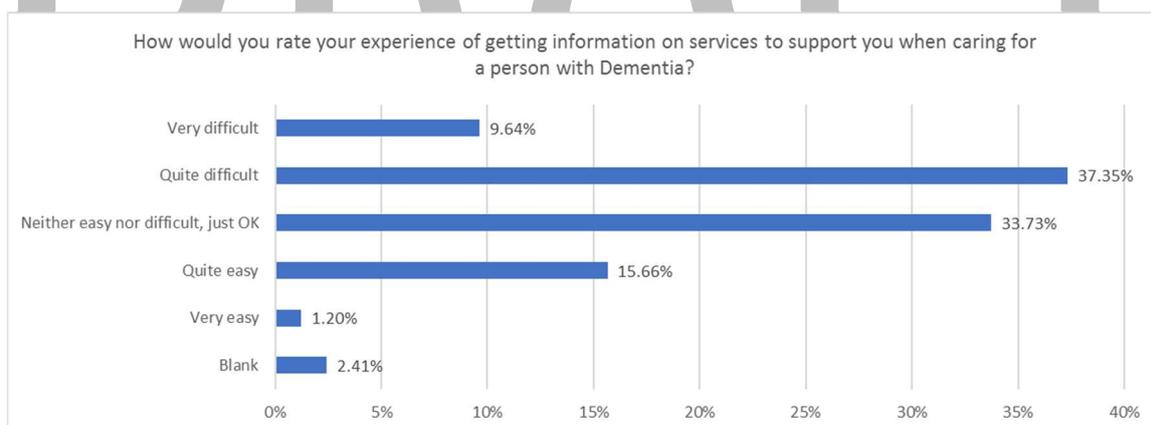
Around 60.71% of carers that care for a parent said they had been caring for them for more than 3 years and 32.14% said they had been caring for between 1 and 3 years. More than two-thirds (67.74%) of carers caring for a spouse said they had been caring for them for more than 3 years.

How old is the person with Dementia?



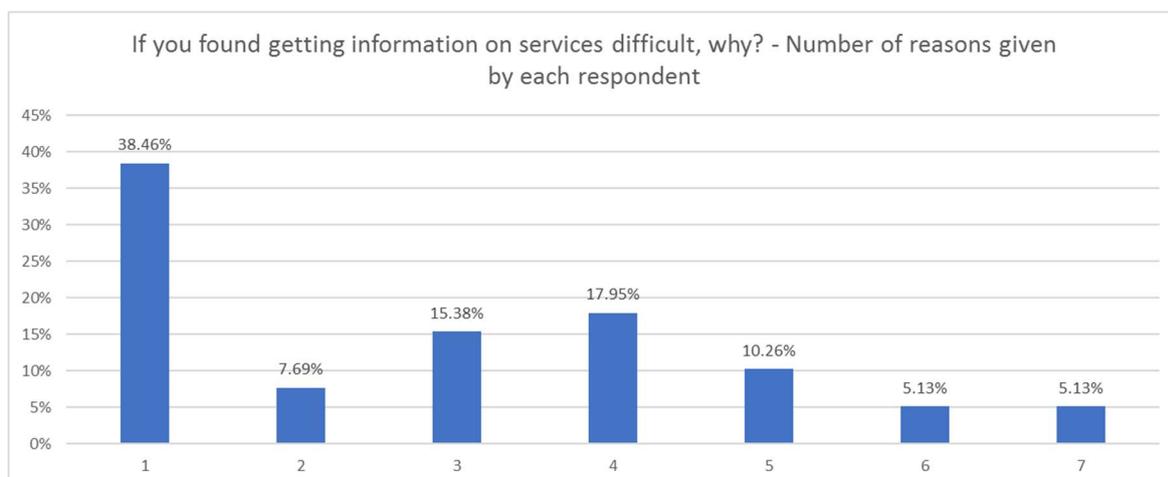
The majority (65.06%) of the people cared for by the respondents were aged 80 and over, accounting for 54 respondents. Around a quarter of those cared for were aged between 70-79, accounting for 21 respondents (25.30%). There were six respondents that said they were looking after someone aged between 60-69 (7.23%). None of the respondents reported to be caring for someone below the age of 60 with Dementia, however 2 respondents did not answer the question.

How would you rate your experience of getting information on services to support you when caring for a person with Dementia?



Carers responding to the survey were asked how they would rate their experience of getting hold of information on services to support them when caring for someone with Dementia. The responses were slightly skewed towards people finding it difficult to get hold of information, with 'Quite difficult' getting the most responses, 37.35% of responses. The second most common response was for 'Neither easy nor difficult, just OK', which was selected by 28 carers (33.73%). A further 8 respondents said they found it 'Very difficult', making up 9.64% of respondents. Only one respondent found it 'Very easy' to get hold of information and 13 found it 'Quite easy'.

If you found getting information on services difficult, why?



A follow up question was asked, looking into the reasons why respondents may have found getting information on services difficult, 21 respondents left this question blank. There were nine potential reasons provided, including an 'Other (please specify)' category and respondents could select as many as were appropriate. Around 38.46% of carers that found getting information difficult said they only had 1 reason. The proportion of respondents that said they had 2 reasons was much lower, at 7.69% and higher for respondents saying they had 3 or 4 reasons.

Reasons	Number
Not knowing where to get the information needed	24
Not knowing who to ask for the information needed	19
Not being told about something until it's too late	14
It takes too long to actually receive the information you need	14
Not knowing what services to look out for	9
Health and/or Social Care professionals have not been able to provide the information you need or where to get it from	8
The services for which you received information were not suitable	7
The information was in a format you couldn't use (e.g. online only)	5
Other (please specify):	17

The most commonly selected reason for finding it difficult to obtain information on Dementia services was 'Not knowing where to get the information needed', which was selected by 24 respondents, making up 38.71% of respondents that answered this question. The second most commonly selected reason was 'Not knowing who to ask for the information needed', which was selected by 19 respondents, (30.65%). The least selected reason was 'The information was in a format you couldn't use (e.g. online only)', selected by 5 respondents, making up 8.07% of respondents. The 'Other (please specify)' option was selected 17 times.

Common themes from the comments provided by those that selected the 'Other (please specify)' option included respondents saying that difficulties were a mixture of the option and provided specific examples of difficulties they encountered; lack of information provided around costs of care; fragmented information and support services; examples of difficulties involving multiple services, getting in touch with a certain support service was a 'waste of time' and that there is a lack of concern for individuals with Dementia and carers.

Which Dementia support services have you used?

Type of Service	Number
Dementia Café	26
Carer Support	21
Other	14
Memory Clinic	10
Social Services	10
None	9
Nursing Teams	9
Day Centre	6
Care Home	5
Telecare	3
GP	2

Respondents were asked to identify which services they had used to support them to live well with Dementia. This question had a free text box, so that we could also explore which services respondents thought supported them to live well with Dementia. The most commonly identified service by respondents were Dementia Cafés, of which six individual Dementia Cafés were identified. The second most common form of support identified by carers was Carer Support, which was identified by 21 respondents. The least commonly identified services were GP's, with only two carers identifying them. However, it could be assumed that the majority of people that the respondents cared for visit their GP on a regular basis, but would not list them as a support service for Dementia.

Did you find accessing any of these services difficult?

A follow up question was asked looking to explore whether carers found accessing services difficult and if so, why they found it difficult. Of the 21 carers that said they had used Dementia Cafés, the majority said they had no difficulties accessing the service. However, two difficulties were detailed in the responses in relation to difficulties accessing Dementia Cafés. One respondent commented that the dates and times of Dementia Cafés made it difficult for them to access the service and another respondent's comment was unclear. Another respondent left a positive comment regarding the Dementia Cafés, in which they suggested that the Cafés provided information which opened doors to other services. A common theme among the answers for this question was that carers were unable to get the information required to access services from professionals, requiring them to either find the information themselves or get in contact with other support services to obtain the information. Other recurring themes were the initial diagnosis at the GP taking too long delaying the access to services, carers unable to contact either the service or the healthcare/social care professional who is working them and carers unable to access online only information.

What type of Dementia support have you found most useful? And why?

Respondents were asked which type of support they found most useful and why. This question was asked to explore what support carers find beneficial and the aspects of the support that has the most effect. The types of support identified in the responses to this question were similar. Respondents that found Dementia Cafés the most useful type of support said they found the social aspects for people with Dementia useful. Carers also said Dementia Cafés helped lift spirits, gave them somewhere to go and provided useful information. Respondents that found Carers Support

and Agency carers most useful said that they supported carers with challenging tasks, provided a break for carers and signposted to other support services. Carers said they found day care services useful because they provide respite and provide other support such as personal hygiene. Memory clinics were found to be useful to carers, however there was a lack of detail provided about which aspects of Memory clinics were most useful.

Do you think there are any needs that are not being met by Dementia services?

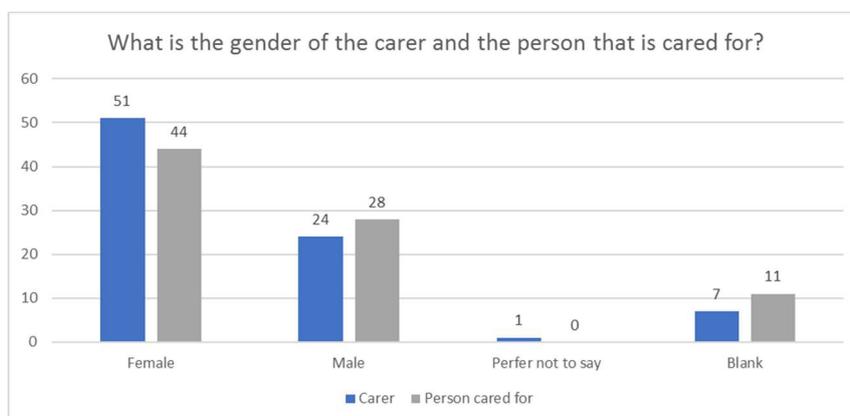
Respondents were also asked in an open question, whether they thought there were any needs that were unmet by current service provision. There was a diverse range of responses, however, some key themes did emerge. Carers said there was a lack of support for carers when exploring their options for services and care homes, with one respondent suggesting there should be a carers information support programme that is run in other areas. A number of respondents said that there was a lack of readily available information on what support was available to them, some saying that the onus was on the carer to find the information themselves. A number of respondents said they didn't think the level of support provided was adequate and in particular that there was a lack of quick response support either when newly diagnosed or in case of emergencies.

Are there any cultural or social barriers affecting the care you provide?

Respondents were also asked to comment on whether there were any cultural barriers that affect the care that they provide. The majority of respondents, 68.67%, either ticked the 'No' box or left the question blank, which means that just under a third of respondents, 31.33%, found that cultural issues affected the care they provided. There were nine responses from carers with a BME background, of whom six carers said there were cultural or social barriers. This suggests that those from a BME background are twice as likely to face cultural or social barriers that affect the care they give, although it should be noted numbers were small. There were a diverse range of comments and there were very few common themes. However, some themes which did stand out were that there was a lack of support in different languages for both carers and people with Dementia, a lack of Dementia friendly transport to/from services and a lack of understanding of the condition among the community.

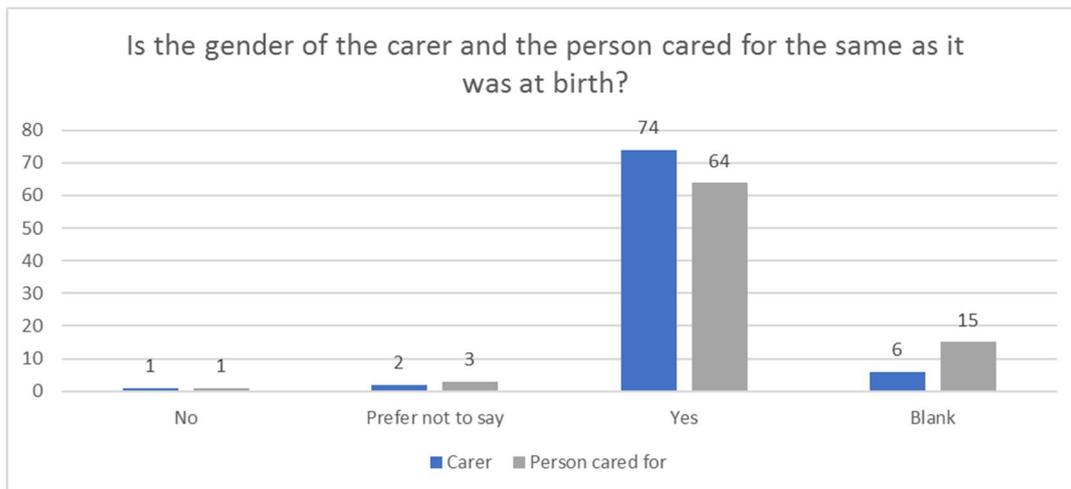
Demographic of carers and people cared for

Gender:



The majority of respondents (61.45%) said they were Female and around 28.92% said they were Male. When asked about the people they cared for, the majority said they cared for a female (53.01%) and around a third said they cared for a male (33.74%).

Is your gender identity the same as the gender you were assigned at birth?



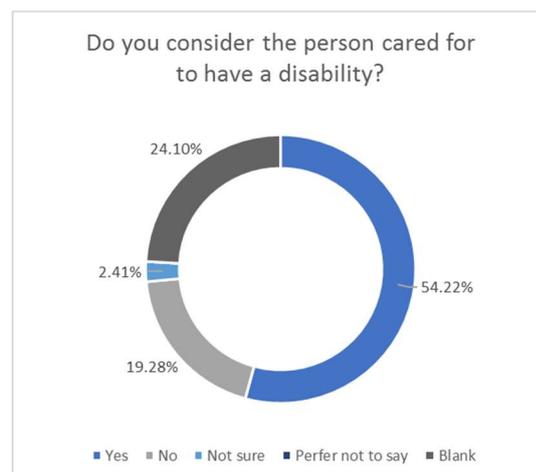
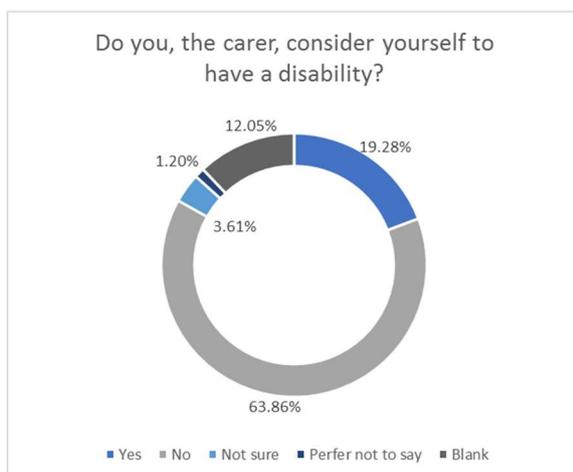
The majority of respondents said their gender and the gender of the person they cared for was the same as it was at birth, at 89.15% and 77.11%, respectively. There were 8 carers who either left the response about their gender blank or preferred not to say and 18 carers who either left the response about the person they cared for blank or preferred not to say.

Marital Status:

Marital Status	Carer	Person cared for
Co-habiting	8	0
Divorced	4	5
Married	53	33
Single	10	1
Widowed	3	28
Prefer not to say	1	0
Blank	4	16

Almost two-thirds of carers stated that their marital status was 'Married' (63.86%) and a further 12.05% said they were 'Single'. Regarding the people cared for, the carers said that 39.76% of them were 'Married', 33.73% were 'Widowed' and 19.28% of responses were left blank.

Do you have a disability which affects your day to day activities, which has lasted, or you expect to last, at least a year?



Respondents were asked whether they considered, both themselves and the person they care for, to have a disability. There were 53 carers, making up almost two-thirds of carers (63.86%), that stated that they did not consider themselves to have a disability. There were 16 carers (19.28%) that considered themselves to have a disability and the remaining 14 respondents (16.87%) either were unsure, preferred not to say or left the question blank.

There were 45 carers that stated they considered the person they cared for to have a disability, making up 54.22% of responses. A further 16 respondents (19.28%) said they did not consider the person they cared for to have a disability and the remaining 22 respondents (26.51%) said they were either unsure or left the question blank.

Ethnicity:

Ethnicity	Carer	Person cared for
Asian – Indian	5	6
Asian – Pakistani	0	1
Black	3	4
White – British	67	61
White - Irish	1	1
White - Other	0	1
Other - Any Other	1	0
Blank	6	9

Respondents were asked to describe their ethnicity as well as the ethnicity of the people they cared for. The majority of carers said that their ethnicity and the ethnicity of the person they cared for was 'White – British', making up 80.72% of carers and 73.49% of people cared for. Respondents stated that around 6.02% of carers and 7.23% of the people cared for had an 'Asian – Indian' ethnic background. A further 3.61% of carers stated that their ethnic background was 'Black' and 4.82% of carers stated that the person they cared for had a 'Black' ethnic background.

Religion:

Religion	Carer	Person cared for
Christian	56	55
Sikh	3	4
Hindu	3	3
Muslim	1	1
Prefer not to say	4	1
No religion	9	4
Blank	7	15

Respondents were asked which religion they and the person they cared for followed. Around two-thirds of respondents said that they (67.47%) and the person they cared for (66.27%), followed Christianity. Around 10.84% of respondents said they did not follow any religion and 4.82% of respondents said that the person they cared for did not follow a religion. Around 8.43% did not leave an answer for their religion and 18.07% did not leave an answer for the person they cared for.

Survey for Professionals working with people with Dementia

There were 24 responses from professionals that work with people with Dementia, of these responses 19 were completed online and 5 were completed on paper.

What sector do you work in?

Sector	Number	Percentage
Health	3	12.00%
Social Care	6	24.00%
Private Sector	3	12.00%
Voluntary Sector	8	32.00%
Primary Care	1	4.00%
Other	3	12.00%
Blank	1	4.00%

The most responses came from professionals working in the Voluntary sector, making up just under a third of responses (32.00%). The second highest number of responses came from Social Care, making up just under a quarter of responses (24.00%) and there were 3 responses each from professionals who worked in the Health, Private and Other sectors.

At which level is your role?

Role	Number	Percentage
Carer	2	8.00%
Frontline	2	8.00%
Manager	10	40.00%
Nursing	3	12.00%
Volunteer	4	16.00%
Other	2	8.00%
Blank	2	8.00%

There were 10 responses from professionals who said they had a managerial role within their organisation, this made up 40.00% of the 25 responses. There were 4 responses from professionals who said they were volunteers within their organisation, two of whom stated that they were volunteers at Dementia Café's. There were two carers that responded to this survey, one of whom also said they were also a volunteer at a Dementia Café.

Brief description of service:

Respondents were also asked to provide a brief description of the service provided by the service they worked for. The three responses from professionals that worked in the Health economy stated that they provided:

- Dementia outreach service
- Provision of Dementia services across an acute hospital trust
- Work to improve the health and wellbeing of residents of the city

The responses from professionals that worked in Social Care stated that they provided:

- Community care for those living with Dementia, ranging from companionship to personal care
- Advising carers and people with Dementia how to live with Dementia, delivering carers information support program and living well with Dementia programme for Dudley
- Domiciliary care for elderly within their own homes
- Day services
- Social care assessment for adults

The responses from professionals working in the private sector stated they worked for organisations which run care homes, providing care for elderly and frail people, including those with Dementia.

The responses from professionals working in the voluntary sector stated that they work for organisations that provided:

- Services for people of all ages living with sight loss across the Black Country and Staffordshire, which include a diverse range of on site and community based services with the aim of nurturing independence, reducing isolation, building confidence and physical and mental well-being. The service also provides residential care, including hospital to residential packages.
- Dementia Café's via Alzheimer's Society UK
- Providing day care to visually impaired who have pan disabilities
- Provision of Dementia Café's, Dementia support workers and providing access to the National Dementia Hotline and online forum.

There was one respondent that said they worked in a Primary Care organisation, the respondent stated that the organisation they worked for provided a day service for older adults with mental health conditions.

Three respondents classed the organisation they worked for as 'Other', these respondents said that their organisations provided:

- A ring and ride service transport service for people with limited mobility, to help individuals maintain independence and quality of life
- Listening to the effects on carers living with a partner with Dementia, watching their deterioration, acknowledging the impact on them and coming to terms with their loss
- Wolverhampton older adult mental health service

Age range you work with:

Sector	18-65	65-75	75-85	85+	Total Responses
Health	2	3	3	3	3
Social Care	3	6	5	5	6
Private Sector	2	2	3	2	3
Voluntary Sector	2	5	5	5	8
Primary Care	1	1	1	1	1
Other	3	3	2	2	3
All Sectors	13	20	19	18	24

Respondents were asked what age range their organisation worked with and the following age ranged were provided: 18-65 (working aged adults), 65-75, 75-85 and 85+. Out of the 24 respondents, 13 said their organisation worked with working aged adults (18-65), 20 worked with 65-75 year olds, 19 worked with 75-85 year olds and 18 worked with 85+ year olds. All three of the respondents in the Health economy said that their respective organisations worked with people aged 65-75, 75-85 and 85+, whereas only two respondents said they also worked with working aged adults. There were six respondents who said they worked in a Social Care organisation, of which only three said they worked with working aged adults, all six said they worked with 65-75 year olds, 5 respondents said they worked with 75-85 year olds and five said they worked with those aged 85+. Out of the eight respondents that worked in the Voluntary Sector, only two said that their organisation worked with working aged adults, whereas five respondents said their organisations worked with people in the 65-75, 75-85 and 85+ age groups.

How many adults diagnosed with Dementia do you work with, in a year (12 months)?

Sector	0-4	5-10	11-16	17-19	20+	All Ages
Health	-	-	-	-	2	3
Other	1	-	-	-	2	3
Primary Care	-	-	-	-	1	1
Private Sector	-	1	-	-	2	3
Social Care	1	-	1	-	4	6
Voluntary Sector	-	1	-	1	5	8
All Sectors	2	2	1	1	16	24

There were two respondents that said their organisation worked with less than 4 individuals that are living with Dementia, of which one respondent worked in Social Care and the other respondent classed their organisation as Other. There were also two respondents who stated that their organisation worked between 5-10 people with Dementia, of which one respondent worked in the Private Sector and one in the Voluntary Sector. Only one respondent said their organisation worked with 11-16 people with Dementia, which was a Social Care organisation, similarly only one respondent said their organisation worked with between 17-19 people with Dementia, which was a Voluntary Sector organisation. Two-thirds of respondents said their organisation worked with more than 20 people with Dementia. Of the 16 respondents that said their organisation worked with more than 20 people with Dementia, five worked in the Voluntary Sector, four worked in Social Care and 2 respondents each worked in the Health economy, Private Sector and in an Other sector. The only respondents from a Primary Care setting reported to work with more than 20 people with Dementia.

What are the referral routes into your service?

Referral Route	Number of times identified
Local Authority	10
Anyone Can Refer	8
Self-Referral	8
NHS Hospital	6
GP	5
NHS BCPFT	4
Other	3
CPN	2
Electronic Referral System	2
NHS	2
Alzheimer's Society	1
Carers	1
CCG	1
Church	1
NHS Eye Hospital	1
N/A	1

There were 56 referral routes identified by the 24 respondents. Due to the question requiring a free text response, the responses needed to be categorised into over-arching categories. The most common referral route was identified as Local Authority, which includes Social Care and other parts of the local authority. Local Authority was a referral route identified by 10 respondents. Self-referrals and 'Anyone can refer' were identified by 8 respondents each. NHS Hospitals were identified by 6 respondents, including one respondent who identified a specific ward that refers into their service. Referrals by GP's was also a commonly identified route into services, identified by 5 respondents. NHS BCPFT, who operate memory clinics, were also identified by 4 respondents as a common referral route.

How do you manage demand for your service (if applicable)?

Method	Number
Refer to other organisations for extra support	8
Criteria	7
Waiting Lists	6
Not seeing as often as preferred	4
Not applicable	4
Utilise varied grade of professional staff	2
Other	2
Shorter appointments	1

Respondents were asked how they managed the demand for their service, if applicable. This question had some potential answers provided, including an 'Other' option. There were 34 methods selected by the 24 respondents, although 8 respondents did not make a selection.

The most selected method of controlling demand was 'Refer to other organisations for extra support', which was selected by 8 respondents. The respondents who selected this option worked in a variety of areas, such as Social Care, in the Health economy and the Voluntary Sector. The second most selected option was 'Criteria', which means that clients must meet the criteria that a service has set to receive their support. Seven respondents selected Criteria as a method of managing the demand for their service, who worked in a variety of areas, including the health economy, social care and the voluntary sector. 'Waiting lists' was also a common method, selected by 6 respondents. Four respondents selected the 'Not applicable' option, which suggests that they have the capacity to deal with the demand for their service and do not need to implement any of these measures. The two respondents that selected 'Other' provided some further comments on the question, one respondent said their service works on a 'First come, first served basis' and the other respondent, working in social care, said they operate a continuous recruitment policy, but it is not clear whether this is in relation to staff or clients.

For the adults diagnosed with Dementia you see in your service, do you think their additional needs are being met?

Respondents to this survey were asked if the additional needs of adults they see with Dementia using their service were being met. Six respondents said they thought the additional needs were being met, nine respondents said they did not think additional needs were being met and eight of them left comments. Ten respondents did not select an answer, although one respondent did leave a comment.

The themes which arose from the comments written by respondents that did not think additional needs were being met were:

- Services are not able to proactive when personalising their services for individuals with Dementia
- Care assessments do not achieve helpful outcomes
- Many individuals with Dementia are isolated due to a lack of social facilities
- Lack of provision for under 65's with early on-set Dementia
- Smaller services do not have the time to spend therapeutically with patients
- Need for a carers information program and living well with Dementia program that is run in Dudley.

In your view, do you provide a service which meets the needs of adults diagnosed with Dementia currently using your service?

Respondents were also asked whether the service they provide meets the needs of adults with Dementia that are currently using their service. Fourteen respondents said they thought their service did meet the needs, whilst four stated they did not think the needs were being met and 5 respondents left the question unanswered.

The common themes which arose in the comments from respondents that thought their service met needs of adults using their service were:

- Provision of a personalised service that consider the individuals needs
- Providing the opportunity for social engagement for people with Dementia
- Well trained staff help meet the needs of people with Dementia and good access to GP's and interdisciplinary teams.

One respondent said that they thought their service met the needs of their service users, but the comments suggested that this may change in the future. The respondent's concerns were:

- Decisions are based on finances rather than clinical needs of people with Dementia
- Managers do not consider the vital opinion of clinicians
- Loss of resources and poor relationships with partners leading to loss of multi-agency working
- Currently the only place where an accurate diagnosis of Dementia can be made

The themes which arose from the comments left by respondents that did not think needs of adults using their service were being met were:

- More courses and information programmes are required for carers and people with Dementia to inform them about the condition and services available to them
- More personalisation and consideration of an individual's needs are needed by services
- A Dementia Café is required that is aimed at younger people with Dementia
- More staff and multi-agency working are required

Are there any key issues or needs for the adults diagnosed with Dementia you currently work with, which you don't provide, but wish to or someone else could deliver?

Respondents were asked whether they are aware of any key issues or needs for adults with Dementia that they work with, that they cannot support and would either like to support or someone else could support. Of the 24 respondents, five did not leave a response, eleven responded that they were aware of issues and needs and 8 respondents said they were not aware.

The common themes that arose from the comments provided by respondents who said they were are of issues and needs that they are not able to support were:

- Being able to raise more awareness of local services available to support people with Dementia
- Provision of forward thinking activities that socially stimulate people with Dementia rather than just 'holding them'
- Provision of more support for carers/family, including a sitting service to give carers a break and the Carers Information and living well with Dementia programs that are run elsewhere in the Black Country.
- Provision of services aimed at people with Dementia aged under 65

Are you aware of any changes or new trends in the needs for your current clients over the next 3-5 years?

Has your service got the right skill mix and capacity to meet this future need?

Respondents were asked whether they were aware of any changes or new trends over the next 3-5 years, in the needs of their current clients. Those that answered yes to this question were asked a follow up question, exploring whether services had the right skill mix and capacity to meet these future needs. Respondents who answered no to the follow up question were asked to elaborate on what they required to be prepared to meet the future need.

Twelve respondents said that they were not aware of any changes or new trends in the needs for their current clients. Whilst, seven respondents stated they were aware of changes or new trends and six did not respond. Although there were seven respondents who were asked to answer the follow up question, there were 14 responses.

There were 5 respondents that said 'Yes' their service had the right skill mix and capacity to meet the future need and 9 said they did not have the right skill mix and capacity. Those that said they did not have the right skill mix or capacity were asked to elaborate on what they would need to be prepared to meet future need. The comments provided were:

- Services need to be prepared to work with more clients, due to an aging population and be able to provide an accessible service with the needs of the customer at the centre
- Forward thinking community based outcomes, activities, support services and training to enable staff to help people continue to connect with the world
- Increase of capacity to provide support from point of diagnosis
- More support and training for staff, especially lower graded staff
- More local services
- Better informed staff
- More senior medical staff

Beyond the adults diagnosed with Dementia currently using your service, are there any further groups of adults diagnosed with Dementia that you feel would benefit from extra support from your service?

Respondents were asked whether there were any people with Dementia, beyond those that currently use the service, that would benefit from extra support from their service. Eleven of the respondents said 'No' and eight respondents said 'Yes' and five respondents did not answer the question. Respondents that said they did think there were people with Dementia that would benefit from extra support from their service were asked to elaborate on their answer. The themes which arose from the comments were:

- People with early on-set Dementia
- People with limited mobility
- People with vision impairments, due to the lack of awareness among services about the link between Dementia and sight loss.
- Carers
- Ethnic minorities

Are there adults who don't meet your service criteria but you think need some sort of support by your service?

Respondents were also asked whether there were any adults that did not meet their services criteria but they thought would need some support from their service. Four respondents said there were people that did not meet their service criteria that would need support, 12 said there were not any and 8 respondents did not answer the question. The four respondents that said there were adults who would need support were asked to elaborate on their answer, their comments included:

- Aging learning disability adults whose nursing needs are increasing and they are also a minority group that do not receive the appropriate care in hospital and most nursing homes
- Those in the early stages of Dementia, service provision could enable them to plan for the future and maintain independence
- Those who cannot afford to pay for the service

Are there any services or support you think your clients need, which are not being met by other services, including secondary diagnosis?

Respondents were asked whether there were any services or support that service users needed, but were not being provided by other services. Six respondents said there were services and support needed by their clients but were not being provided, 11 respondents said there were not aware of any and 7 respondents did not answer the question. The six respondents that said there were services and support not provided were asked to elaborate on their answer. Their comments included:

- More community based options are required, because people keep being referred into the same services
- More one to one support, rather than group support
- Clients with Dementia who have been hospitalised are not consistently assessed prior to discharge to ensure correct and appropriate care/support is in place, considering their reason for hospitalisation
- Other health care professionals may reassess clients, but no other help is provided even if it is deemed necessary
- Services for people with alcohol-related brain damage
- Because of the evidence between Dementia and sight loss, there needs to be a link between specialist organisations to ensure appropriate interventions are provided

Are there any social or cultural issues which need addressing to work with your current or any potential future adults diagnosed with Dementia?

Respondents were asked whether they thought there were any cultural issues that needed addressing to work with current clients or any future clients with Dementia. Eight respondents said there were some cultural issues that needed addressing, 12 respondents said there were no cultural issues and 4 respondents did not answer the question. The eight respondents that said there were some cultural issues were asked to elaborate on their answers, the comments include:

- Meeting cultural and religious needs by creating more links with religious organisations
- Encourage people with BME backgrounds to use services
- Need to reach out to hard to reach communities, such as homeless and LGBT communities
- Need a more ethnically diverse specialist workforce
- Improve awareness of services among communities where sight loss might be more prevalent.

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Briefing Note

Title: No Recourse to Public Funds – Request for Numbers **Date: 10 April 2019**

Prepared by: Neeraj Malhotra

Job Title: Consultant in Public Health and Chair, No Recourse to Public Funds Forum

Intended Audience: Internal Partner organisation Public Confidential

Purpose

1. To provide a snapshot of information on numbers of people with No Recourse to Public Funds (NRPF) in the City of Wolverhampton.
2. To provide an update on the multi-agency protocol and accompanying training.

Overview

Information on numbers of families, adult individuals and children with NRPF status was requested from both social care and the Refugee and Migrant Centre. There are stark differences between these figures, highlighting the complexity in trying to arrive at a realistic estimate of NRPF populations in the city.

Background and context

Information on numbers of people with NRPF status was asked for by Health and Wellbeing Together on 17 October 2018, following the presentation of the draft multi-agency protocol.

Latest data

Data has been provided by the 'NRPF Team' recently established within Children's Services:

- The number of NRPF families currently being supported in Wolverhampton: 29
- The total number of children in NRPF status families: 55

In contrast, data from the Refugee and Migrant Centre shows that, for 2018, 1651 individuals were recorded by their service as NRPF. Of these, 1045 were recorded as having no dependents. 600 adults had 1237 dependents between them.

These two data sources are not comparing 'like with like'; one is a current snapshot and the other covers a 12-month period. The data does indicate what is to be expected, namely

that there are significantly greater numbers of people with NRPF status in the city than the population who are supported by the Council.

In the future, the NRPF forum will bring together these data sources with other 'soft intelligence' from the voluntary sector to help the partnership keep an eye on numbers, trends and needs, whilst being mindful of the difficulties with obtaining accurate information.

Update on the protocol and accompanying training

The draft protocol which was brought to Health and Wellbeing Together in October has been going through some small but important changes. This is to ensure the messages to partners are unambiguous. Specifically, this is in regard to the circumstances in which partners should notify the Council about people with NRPF status, including what to do when such a family is under the care of a social work team from a different locality. The revisions have been carried out in conjunction with senior staff in Children's Services. This has delayed the launch of the protocol and the scheduling of the training by approximately eight weeks and training should commence in April 2019. The forum will ensure training is offered to elected members.



Health and Wellbeing Together

10 April 2019

Report title	Homelessness Prevention Strategy 2018-2022	
Cabinet member with lead responsibility	Councillor Hazel Malcolm Cabinet Member for Public Health and Wellbeing	
Wards affected	All wards	
Accountable director	Kate Martin, Service Director of City Housing	
Originating service	City Housing	
Accountable employee	Anthony Walker	Homeless Strategy Manager
	Tel	01902 551631
	Email	Anthony.walker@wolverhampton.gov.uk

Recommendations for decision:

The Health and Wellbeing Together Board is recommended to:

1. Approve the development of a new action plan for the delivery of the Homelessness Prevention Strategy 2018-2022.
2. Approve the development of a multi-agency steering group to oversee the Homelessness prevention Strategy 2018-2022.

Recommendations for noting:

The Health and Wellbeing Together Board is asked to note:

1. The findings of the Homelessness Prevention Strategy 2018-2022.

1.0 Purpose

- 1.1 To inform board of the City of Wolverhampton Homelessness Prevention Strategy for 2018-2022.
- 1.2 To agree to the development of a robust action plan and steering group to monitor the action plan.

2.0 Background

- 2.1 The Homelessness Act 2002 places a statutory obligation on local authorities to undertake a review of homelessness in their area and develop and publish a strategy to prevent homelessness.
- 2.2 This is Wolverhampton's fifth homelessness strategy and has been developed at a crucial period for the City. The current state of the economy has put increased pressure on housing and homelessness services, whilst at the same time changes to the welfare system have decreased the security of tenure for many households.
- 2.3 With the introduction of the Homelessness Reduction Act (HRA) in mid-2018 local authorities were requested to refresh their strategies in line with the new duties therefore the current strategy came to end two years early.
- 2.4 Across the period covered by the last strategy (2015-2018) there has been a reduction in public spending which unfortunately has meant pressure on statutory and voluntary organisations and in some extreme cases the closure of important services leading to an increase in most forms of homelessness therefore this strategy.
- 2.5 Through joint working between the Local Authority and partners, Wolverhampton had reduced the numbers of homeless applications to incredibly low numbers via well-developed processes to prevent homelessness. However, over the last 24 months the numbers of applications have increased as well as a reduction in the number of preventions.
- 2.6 In October 2017 work began on developing the new strategy by working with partners and organizations in relation to reviewing:
 - Current numbers of homeless clients
 - Gaps in provision
 - Trends
 - General data
- 2.7 From the collection of this quantitative and qualitative data the findings led to the development of the strategy for the City, concentrating on four key areas of homelessness.

2.8 These four elements are:

- **Homelessness prevention** - deliver a prevention service to meet the aims and intentions of the Homelessness Reduction Act.
- **Tackle rough sleeping** - continue to work on tackling rough sleeping in Wolverhampton with a plan on reducing to as close to zero by 2022 and linking into the national rough sleeper strategy.
- **Vulnerability and Health** - ensure services remain accessible to the most vulnerable households and can support those who need it most, such as those affected by domestic abuse, modern day slavery, etc. We aim to increase the resilience of households and communities, equip them with the necessary skills to prevent crises, such as homelessness, before they occur.
- **Responding to the local housing market** - respond to the challenging local housing market conditions by working collaboratively with, and offering advice and support to, households and landlords to develop suitable private rented sector offers for all client groups.

2.9 The strategy and its headings were approved by Cabinet in September 2018 therefore after a period of time to understand the impact of the HRA we are now in a position to implement the new prevention strategy.

3.0 Implementation

3.1 The proposal is that these four key themes will form the strategic foundation for an implementation plan to reduce homelessness as well assist those who find themselves in housing need.

3.2 The distinct themes are:

- Access to affordable, sustainable, suitable accommodation.
- Access to good quality advice, support and assistance
- Pathway into services
- Partnerships and training.

3.3 To oversee the plan there will be a strategic group made up representations from multiple sectors (Health, Housing, Education, WM Police, Voluntary Sector, Faith Groups, etc).

3.4 The initial meeting will be in early May 2019 and will look to set the priorities for the next 12 months.

4.0 Financial implications

- 4.1 There are no direct financial implications from the strategy. However, a successful strategy for preventing homelessness will help to ensure that the council spends within budget in this area.
[JM/01042019/P]

5.0 Legal implications

- 5.1 Under the Homelessness Act 2002, all housing authorities must have in place a homelessness strategy based on a review of all forms of homelessness in their district. The strategy must be renewed at least every five years. The strategy must set out the authority's plans for the prevention of homelessness and for securing that sufficient accommodation and support are or will be available for people who become homeless or who are at risk of becoming so.
[DC/01042019/P]

6.0 Equalities implications

- 6.1 A full equality impact assessment is to be undertaken if required.

7.0 Environmental implications

- 7.1 There are no direct environmental implications from the strategy.

8.0 Human resources implications

- 8.1 There are no direct human resources implications from the strategy.

9.0 Corporate Landlord implications

- 9.1 There are no direct Corporate Landlord implications from the strategy.

10.0 Health and wellbeing implications

- 10.1 The impact that homelessness has on the health and wellbeing for the population is well documented therefore steps to assist and prevent must be taken.

10.0 Schedule of background papers

- 10.1 None.

11.0 Appendices

- 11.1 Appendix 1: Homelessness Prevention Strategy 2018-2022.
11.2 Appendix 2: Steering Group.

Wolverhampton Homelessness Prevention Strategy 2018-2022



#Prevention and Intervention

Foreword

Since the publication of our last Homelessness Strategy, we have seen dramatic changes to the environment in which homelessness services are delivered.

Changes resulting from the economic downturn, and in particular welfare reform, are impacting detrimentally on many low- income groups and those susceptible to homelessness. Well documented funding cuts to Councils are coupled with falls in support and funding streams to other statutory agencies, and those in the voluntary and community sector.

As a result, this new strategy is being developed in a context of shrinking resources and increasing demand for services. There is also considerable uncertainty over the future.

These factors weigh heavily on the determination of what can realistically be achieved in the years ahead. Nevertheless, the challenge and our aspiration remains to prevent homelessness wherever possible in line with the new Homelessness Reduction Act.

The response to this challenge will be based on the same core principle as that which underpinned our previous strategies effective partnership working.

**Councillor Roger Lawrence
Leader of the Council
Member for**

**Councillor Peter Bilson
Deputy Leader and Cabinet**

City Assets and Housing

City of Wolverhampton Council

City of Wolverhampton Council

1. Introduction

The Homelessness Act 2002 places a statutory obligation on local authorities to undertake a review of homelessness in their area and develop and publish a strategy to prevent homelessness.

While the Homelessness Review paints a picture on homelessness locally, the Homelessness Strategy sets out how to address the problem. The strategy seeks to tackle all forms of homelessness, including those owed a statutory duty (typically families with dependent children, or vulnerable adults), but also those who are single, sleeping on the streets, or other transient arrangements (e.g. sleeping on a friend's sofa). This is Wolverhampton's fifth homelessness strategy and has been developed at a crucial period for the City. The current state of the economy has put increased pressure on housing and homelessness services, whilst changes to the welfare system have simultaneously decreased the security of tenure for many households.

Across the period covered by the last strategy (2015-2018), there has been a reduction in public spending which has put pressure on statutory and voluntary organisations, and in some extreme cases led to the closure of important services.

Through joint working between the Local Authority and partners, Wolverhampton had reduced the numbers of homelessness applications to incredibly low numbers via well-developed processes designed to prevent homelessness. However, over the last 12 months the numbers of applications have increased, and there has been a reduction in the number of preventions.

The Homelessness Reduction Act of April 2018 has an emphasis on the prevention of homelessness, as well as effective partnership work with statutory, voluntary, and third sector agencies. This is to ensure households' needs are met, and that they are assisted as they engage with agencies to work through their personalised plans. The Act has a focus on helping households to access housing. We need to make sure we have effective pathways to encourage and work collaboratively with households to secure their own accommodation.

The role of this strategy will therefore be to offer housing options to prevent homelessness in a time of austerity, as well as assisting those who are homeless to access quality affordable accommodation in a timely fashion.

Reducing homelessness is a key priority for the City of Wolverhampton Council, and over the last five years numerous steps have been taken to prevent homelessness and assist those in urgent need. These include:

- Development of a multi-agency team (MASH) who work with vulnerable adults and children.
- Increased numbers of units for single persons in supported accommodation.
- Introducing a hospital discharge service to assist vulnerable homeless clients pre- and post-admission.

- Continuation of the joint protocol to work with 16-17-year olds in need of advice and or housing. The protocol links housing providers with children and families' social services looking to offer an alternative to statutory homelessness.
- The continued delivery of housing related floating support to assist vulnerable households with sustaining their tenancies.
- Transfer of operational homeless services across to Wolverhampton Homes to improve on Citywide delivery.
- The implementation of a localised private landlord's accreditation scheme (Rent with Confidence).
- Alternative giving campaign to direct public funding towards services that work.
- Sanctuary scheme providing victims of domestic abuse with security measures, thus preventing homelessness.

2. Development of the strategy

To develop an effective homelessness strategy, we must be aware of current local and national issues related to homelessness and housing need. Through several forums and assessment tools we have assessed the current situation in Wolverhampton.

To develop our previous homelessness strategies, we concentrated on the local effects caused by the lack of accommodation on households. However, it became very clear early on that we had to look at homelessness more widely, especially the effects it has on health, the economy, and criminal justice.

3. Defining Homelessness

a) Statutory Homelessness

The Ministry of Housing, Communities and Local Government (MHCLG) defines households as statutorily homeless if they do not have accommodation they are entitled to occupy, which they cannot physically access, or if they have accommodation but it is not reasonable for them to continue to occupy this accommodation.

Priority need groups include households with dependent children, a pregnant woman, and people who are in some way vulnerable, such as due to their mental and/or physical health and wellbeing. In 2002, an Order under the 1996 Housing Act extended priority need to include those aged 16 or 17, aged 18-20 who were previously in care, vulnerable because of time spent in care, custody, or in HM Forces, or vulnerable because of fleeing their home due to violence or violent threats.

b) Non-Statutory Homelessness

Typically, single people or childless couples who are not assessed as being in 'priority need' and are only entitled to advice and assistance if homeless. Some non-priority homeless cases are offered access to Local Authority housing support services.

c) Rough Sleepers

MHCLG defines rough sleepers as people sleeping, about to bed down, or bedded down (lying down or sleeping) in the open air, or people in buildings or other places not designed for habitation (e.g. barns, car parks, cars). This does not include people in hostels or shelters, or people in campsites, squatters, or travellers.

d) Intentional Homelessness

A person can be considered to have made themselves homeless if they have deliberately given up their home when it would have been reasonable to remain, or deliberately did or didn't do something which they knew would mean losing their home (such as not paying rent). They are also intentionally homeless if they have planned to stay somewhere, they had no legal right to stay with the intention of claiming to be homeless, or if they have had legal or financial advice or assistance to help find somewhere to live and didn't act on it. If a person is intentionally homeless, the council has no duty to find them somewhere to live but is required to give advice and assistance.

4. National Context

Homelessness affects and ruins the lives of adults and children across the country. It is far from solely being a housing issue. People who are homeless often suffer greater levels of ill health, unemployment, and drug and alcohol dependency, and in the case of children, lower levels of educational attainment due to prolonged, unavoidable absence.

Examples of these large-scale inequalities nationally are:

- One in five homeless people suffer from mental health problems.
- The suicide rates of homeless people are 34 times greater than the general population.
- 80% of street homeless people are addicted to drugs or alcohol
- Homeless children in temporary accommodation miss 11 weeks of schooling on average.
- 440 individuals have been highlighted as rough sleepers and will therefore be sleeping on the streets at any given day.
- The life expectancy of someone who is street homeless is 42.
- People who are street homeless are 13 times more likely to be a victim of violent crime.

- 77% of households who are within homeless temporary accommodation (hostels, refuge etc.) are not in any form of paid employment.

The UK Government published strategies for preventing homelessness and ending rough sleeping in 2011 and 2012. Despite this, statistics collected by all English local housing authorities show that homelessness has worsened.

Between 2009-2010 to 2016-2017, there was a:

- 25% increase in the overall number of people assisted by local authorities
- 30% reduction in the number of people for whom homelessness was prevented
- 42% reduction in the number of people for whom homelessness was relieved
- 33% increase in the number of people owed the main housing (homelessness) duty of assistance (s.193(2), part 7, Housing Act 1996)
- 34% increase in the number of households living in local authority temporary accommodation
- 58% increase in the number of people sleeping rough.

Homelessness Data

Decisions about homelessness law for England is the responsibility of the UK Government, and is a devolved matter for the governments of Northern Ireland, Scotland and Wales. The Department of Communities and Local Governments is charged with leading on policy formulation and implementation.

The report shows that Homelessness acceptance rates have gone up nationally and locally in recent years. At nearly 58,000, annual homelessness acceptances were some 3000 higher across England in 2015-2016 than in 2014-2015.

Summary of national Homelessness Statistics	2014-2015	2015-2016	% change 2014-2015- 2015-2016	Summary for Wolverhampton	2014-2015	2015-2016	% change 2014-2015- 2015-2016
Rough sleeping in England – snapshot (1)	3,569	4,134	16	Rough sleeping in England – snapshot (1)	7	17	142
Local authority statutory homelessness cases – annual (3)	112,350	114,780	2	Local authority statutory homelessness cases – annual (3)	1,748	1,708	-5

Summary of national Homelessness Statistics	2014-2015	2015-2016	% change 2014-2015- 2015-2016	Summary for Wolverhampton	2014-2015	2015-2016	% change 2014-2015- 2015-2016
Local authority statutory homelessness acceptances – annual (4)	54,430	57,740	6	Local authority statutory homelessness acceptances – annual (4)	336	376	12
Local authority homelessness prevention and relief cases (5)	220,800	213,300	-3	Local authority homelessness prevention and relief cases (5)	1,988	1,848	-7
Total local authority homelessness case actions (6)	275,230	271,050	-2	Total local authority homelessness case actions (6)	2,324	2,224	-4

*snapshot from national data P1e Oct-Nov

These statistics show that more people are approaching local authorities for assistance, however, the method in which they are being assisted has changed. Fewer people are having their homelessness prevented or relieved. At the same time, more people are benefiting from the statutory safety net - applicable to those who have a priority need for accommodation and are not intentionally homeless. This has driven up the number of people provided with temporary accommodation. Additionally, the levels of people experiencing street homelessness has gone-up to a volume not seen since 1997.

Wolverhampton over 2015 - 2017 has seen an above the national average increase in rough sleeping and homelessness acceptances, though there has been a general decrease in statutory homeless cases.

The vast bulk of statutory homelessness in recent years is attributable to the sharply rising numbers made homeless from the private rented sector, with relevant cases having almost quadrupled over the period – from less than 5,000 to almost 18,000.

Homelessness Prevention and Relief

Local authorities have voluntarily carried-out activities to prevent and relieve homelessness since 2003 onwards. There are a range of discretionary initiatives used to assist people who are homeless or threatened with homelessness. Any casework action taken is done so outside any legal obligation. The UK Government recognises three forms of homelessness prevention:

- Early Prevention – By identifying people at risk of homelessness, accommodation and necessary support can be made available in time to prevent homelessness. Early identification can target people in known risk groups (e.g. those leaving local authority care) before they reach crisis point.
- Pre-Crisis Prevention - This can take the form of advice services and proactive intervention, such as negotiation with landlords on behalf of tenants. Even if this only delays the leaving date, it can allow time to manage a move to alternative accommodation and so preventing homelessness.
- Preventing Reoccurring Homelessness - By providing support to formerly homeless people who have been accommodated, and ensuring tenancy sustainment, repeat homelessness can be prevented in cases where the provision of accommodation by itself is insufficient.

Typically, local authorities can help people to remain in their existing home or obtain alternative accommodation. Previously (in 2009/10), 55% of people were helped to obtain alternative accommodation, and 45% were assisted to remain in their existing home. More recently this trend has reversed, with 53% of people being helped to remain in their existing home compared 47% being helped to obtain alternative accommodation.

UK Government Priorities

The UK Government has received criticism about rising levels of homelessness and their lack of a coherent strategy for tackling the problems. These criticisms came from the UK Statistics Authority (in 2015), the Communities & Local Government Select Committee (in 2016), the National Audit Office, the Local Government & Social Care Ombudsman, and the Commons Public Account Committee (all in 2017).

Subsequently, the UK Government declared an ambition to halve rough sleeping by 2022 and end it by 2027. To help accomplish this a taskforce has assembled, whose membership includes influential figures from public authorities and voluntary organisations, to provide advice on the formulation of a strategy.

The UK Government has allocated a substantial sum of funding to help tackle homelessness. During the present spending period (2016-2017 – 2019-2020), £932.7m has been awarded:

- £315m Homelessness Prevention Grant, 2016-2017 – 2019-2020
- £100m Move-on Accommodation Fund, 2016
- £20m Homelessness Prevention Trailblazers, 2017
- £10m Rough Sleeping Fund, 2017

- £10m Rough Sleeping Social Impact Bond, 2017
- £402m Flexible Homelessness Support Grant, 2017/2018 – 2018-2019
- £72.7m Homelessness Reduction Act 2017 New Burdens Grant, 2017-2018 – 2019-2020
- £3m Homelessness Reduction Act 2017 Data Systems Upgrade Grant, 2017

West Midlands Combined Authority

The strategic authority for the West Midlands Metropolitan County has no devolved responsibility for homelessness policy - this remains a matter for national and local governments. Despite this, the Elected Mayor of West Midlands has established a taskforce to co-ordinate efforts across the city region to tackle homelessness. This was prompted by the fact that rough sleeping has more than tripled across the Combined Authority area, with 55 people bedded down on the street on any given night.

The taskforce has adopted the following seven principles:

- Tackle all forms of homelessness, not just rough sleeping.
- Influence the Mayor's priorities across other policy areas (e.g. housing, mental health, transport).
- Support existing work rather than replacing it.
- Have an honest discussion about difficult topics (e.g. welfare reform).
- Harness skills and expertise from across the region and different sectors.
- Focus on where the Mayor and West Midlands Combined Authority can have maximum impact.
- Make decisions based on hard evidence and data.

The Homelessness Taskforce is led by a steering group, with task-groups working in specific priorities. The membership of the Taskforce includes representatives from:

- Birmingham City Council
- Birmingham & Solihull
- Coventry City Council
- Crisis UK
- Gowling WLG
- KPMG
- Public Health England
- Sandwell Metropolitan Borough Council

- Solihull Metropolitan Borough Council
- St Basil's
- Walsall Metropolitan Borough Council
- WM Housing Group
- West Midlands Combined Authority
- West Midlands Fire Service
- West Midlands Police
- Wolverhampton City Council
- YMCA Black Country Group

Task-groups have been established, each having clear roles with different needs for skills and expertise on the following themes:

- Rough sleeping
- Children and Families
- Young People
- Older

Local Context

During the homelessness review information was obtained from a number of local partners to highlight the levels and causes of homelessness, as well as the client groups that are most affected by homelessness at a citywide level.

Data from 2016-2017 highlights that Wolverhampton has again seen a decrease in the number of households submitting homelessness applications during both 2014-2015 and 2015-2016 by 48 cases and eight cases respectively.

As per manual Duty referral statistics	2016-2017
Initial Interview (Referral)	2851
Housing Advice only	1151
Homeless Applications	1700
Percentage of Apps as per Referrals	59.62%

*statutory Homelessness Data 2016-2017

The following reasons why households become homeless show that by far the largest group are those who are homeless from the private sector at nearly 400 cases, closely followed by 'Parents unable/unwilling to accommodate' at 267, and 'other loss of rented/tied accommodation' at 166 cases.

End of assured shorthold tenancy	393	Other violence	025
Fire flood or another emergency	011	Parents unable/unwilling to accommodate	267
Friends unable/unwilling to accommodate	210	Racial violence	002
Leaving institution or care	032	Relationship breakdown violent other	054
Leaving NASS (BIA) accommodation	041	Rent arrears HA repossession	014
Living in a hostel	038	Rent arrears LA repossession	022
Mortgage arrears repossession	014	Rent arrears private	030
Newly forming family	004	Rough sleeper	054
Nonviolent breakdown unable to return	108	Split household	002
Other harassment	010	Unreasonable circumstances	033
Other loss of rented/tied accommodation	166	Violent relationship breakdown	170

Demographic Data

The annual review highlighted that there were trends in relation to age, ethnic origin and gender based on the demographic data.

Age data highlights that the ages of 16-34 are the prime age ranges for homelessness to occur.

Performance compared to previous year Showing increase or decrease in %	16 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 to 74	75 to 99
2016 to 2017	422	586	375	203	79	21	14
2015 to 2016	332	443	292	159	77	19	4
Differential figure	21.32%	24.40%	22.13%	21.67%	2.53%	9.52%	71.14%

Gender data highlights that there are disproportionately higher numbers of females approaching authorities as homeless.

Performance compared to previous year Showing increase or decrease in %	Male	Female	Not Known	Transsexual M to F
2016 to 2017	688	1012	0	0
2015 to 2016	495	813	17	1
Differential figure	28.05%	19.66%	-83%	-99%

As expected, the highest numbers of cases are amongst White -British households. This was anticipated as the group constitutes nearly 70% of the UK population.

Performance compared to previous year	Showing increase or decrease in %		
	2016 to 2017	2015 to 2016	Differential figure
Asian or Asian British: Bangladeshi	5	8	-37.5%
Asian or Asian British: Indian	80	63	26.98%
Asian or Asian British: Pakistani	28	27	3.70%
Asian or Asian British: Any Other Background	20	16	25%
Black or Black British: African	137	97	41.23%
Black or Black British: Caribbean	126	103	22.33%
Black or Black British: Other	34	21	61.90%
Chinese	6	2	200%
Declined to Supply Information	17	10	70%
Eastern European	29	25	16%
Gypsy / Romany / Traveller	5	4	25%
Information Not Supplied	11	8	37.5%
Middle Eastern	25	28	-10.71%
Mixed: Any Other Mixed Background	10	9	11.11%
Mixed: White and Asian	16	11	45.45%
Mixed: White and Black African	6	3	100%

Mixed: White and Black Caribbean	81	70	15.71%
Other	13	12	8.33%
Unknown	30	30	0%
White: Any Other White Background	47	38	23.68%
White: British	967	736	31.38%
White: Irish	7	5	40%

Other variations in demography can affect the demand on homelessness services in several different ways. Due to several cultural and economic factors that are evident both nationally and in Wolverhampton, the total number of households is increasing, whilst the average size of these households is decreasing.

This trend directly impacts the numbers of households presenting themselves as homeless, and the demand for affordable accommodation - particularly single person accommodation and two bed houses.

Under One Roof

In late 2017, City of Wolverhampton Council transferred all operational homeless services to Wolverhampton Homes.

This transfer meant that the majority of public facing housing services are now under one organisation, making the customer's journey simpler and more effective.

This exciting transfer means that people at risk of homelessness, and those in need of immediate accommodation, could now approach three local locations across the City for assistance.

With the Reduction Act on the horizon, this transfer will allow a more flexible and responsive service to be provided Citywide.

Strategic Context

The Homelessness Prevention Strategy is one of a suite of strategic documents by Wolverhampton City Council that aim to improve the lives of current and future residents in the city.

The overarching theme of homelessness and housing need is shared across a variety of the strategic documents. These include:

New Horizons - Our vision for the City of Wolverhampton in 2030

A vision document that highlights what the City of Wolverhampton might look and feel like in 2030.

Wolverhampton City Strategy 2011-2026

A plan to create opportunities that encourage enterprise, empower people, and re-invigorate our city.

Corporate Plan 2016-2019

Our Corporate Plan sets out how we will deliver better outcomes for residents and businesses in the City of Wolverhampton. It is also the cornerstone of our transformational plans to build an ever more Confident, Capable Council.

Neighbourhoods, Homes & People Wolverhampton Housing Strategy 2013-2018

The Strategy will support Wolverhampton in achieving its long-term ambitions for housing, improving the quality and supply of housing, and supporting current and future residents who will have a fundamental role to play in developing Wolverhampton's identity and economic function as a key place on the regional, UK and international stage.

Wolverhampton Joint Health and Wellbeing Strategy – 2013-2018

A collective focus to improve health and wellbeing for all, so individuals and communities are able to live healthier lives, and to reduce some of the stark gaps in health experienced across the city.

Violence Against Women and Girls - Wolverhampton's Multi-Agency Strategy 2016 – 2019

Violence Against Women and Girls (VAWG) has been cited as being perhaps the most pervasive violation of human rights across the globe and continues to have devastating consequences for millions of victims. This strategy addresses the needs of victims of domestic abuse, violence, female genital mutilation, forced marriage, honour-based violence, and sexual violence.

The plan is that the Homelessness Prevention Strategy is not a strategy in isolation, and is document that is owned by the City, not just the Local Authority.

Homelessness Strategy 2018-2022

Main strategic Objectives

1. To offer high quality and innovative services to homeless households and households threatened with homelessness.
2. To work in partnership with other services to find long-term, affordable housing solutions for people threatened with homelessness.
3. To increase the number of employment opportunities for vulnerable clients, including those who are homeless or at risk of homelessness.

To achieve these objectives, we have broken these down into four strategic priorities to focus on over the four-year duration of this strategy.

1. Homelessness prevention.

To deliver a prevention service to meet the aims and intentions of the Homelessness Reduction Act and beyond.

2. Tackle rough sleeping.

To continue to work on tackling rough sleeping in Wolverhampton, with a plan on reducing numbers to as close to zero as possible by 2022.

3. Vulnerability and Health.

To ensure services remain accessible to the most vulnerable households, and can support those who need it most, such as those affected by domestic abuse, modern day slavery, etc.

We aim to increase the resilience of households and communities, equipping them with the necessary skills to prevent crises, such as homelessness, before they occur.

4. Responding to the local housing market.

To respond to the challenging local housing market conditions by working collaboratively with, and offering advice and support to households and landlords, to develop suitable private rented sector offers for all client groups.

1. Homelessness prevention.

The findings from the Homelessness Review confirmed the main causes of homelessness in Wolverhampton. The primary reason being 'Termination of assured short hold tenancy.

This has contributed to a rise in cases accepted as homeless in Wolverhampton.

Since 2003, the City of Wolverhampton has had a floating accommodation support service that works with over 1,000 households each year.

The objective is to grow and promote the concept of support to prevent homelessness, with a plan to make this more accessible and robust.

We also recognise the importance of utilising technology and partnership working with statutory, voluntary and third sector agencies to help us deliver an efficient preventative service.

The requirements set out in the Homelessness Reduction Act are clear, but we must have bigger ambitions to digitalise the service. The advantages of online PHPs are that households will be able to view and report updates frequently, and partners will also be able to interact with the permission of the household. This will help ensure that households' needs are met, and that they are assisted as they engage and work through their personalised plans.

The aims of preventative working

- Develop a city-wide approach to preventing and tackling homelessness.
- Working in partnership to prevent and tackle homelessness and the new duties in the Homelessness Reduction Act, including the duty of public authorities to refer cases to the local housing authority.
- Improve the quality and effectiveness of prevention work to meet the requirements of the new section 195 prevention duty under the Homelessness Reduction Act.
- Improving the quality and effectiveness of help to single applicants, helping them to find accommodation to meet the new section 189B 'Help to Secure' Duty under the Homelessness Reduction Act.
- Develop several new initiatives to support the new section 189B 'Help to Secure Accommodation Duty' for single people and families.
- To develop a suitable private rented sector, offer for all client groups, including advice support and incentives to both client and landlord.
- Managing the Discretionary Housing Payment fund (DHP), which is used to help tenants cope with housing costs.
- Managing the Rent Arrears Fund, which provides a maximum payment of £500 to stop landlords evicting tenants because of rent arrears.
- Providing advice and assistance to those affected by welfare reforms, such as the Social Sector Size criteria (otherwise known as Bedroom Tax), Benefit Cap, Local Housing Allowance reforms or Universal Credit).
- Helping with budgeting and finding alternative solutions to housing needs (for example, providing a deposit so that households can move into a more affordable property).

- To utilise assistive technology and aids adaptations to assist vulnerable households to remain in their homes.
- Develop/modify pre-court and pre- eviction protocols for vulnerable clients.
- Manage expectations around provision of council accommodation by supporting homeless/risk of homeless households into accessing affordable and well managed PRS property (RWC, WH's PSL, other 'registered' and on-board landlords etc).

Rough Sleepers

Both the Leader of the Council at a local level and West Midlands Mayor Andy Street who have developed task groups to address the increase in rough sleeping and homelessness.

Each year local authorities are duty bound to either count or estimate the numbers of people sleeping rough on a particular day. The official figures from the estimate of the 6th November 2016 Wolverhampton had 18 people sleeping rough (information supplied by outreach services, police, accommodation providers and the voluntary sector. Since 2010 rough sleeping in England has increased by 134%.

Local Authority	2014-2015	2015-2016	2016-2017
Birmingham	20	34*	55
Coventry	18	22	13
Dudley	6	3*	3
Sandwell	2	4	11
Solihull	6	5	6
Walsall	4	8	26
Wolverhampton	8	13	18

Even though this evidence suggests rough sleeping is increasing nationally, this strategy sets out the plans for making further steps towards Wolverhampton bucking the trend.

Wolverhampton has for the last five years had a No Second Night Out hub, where individuals are given a roof over their head for the night before a more permanent housing solution is sought.

The aims to end rough sleeping in Wolverhampton:

- Develop a No First Night Out Model.
- Develop a Housing First Model.
- Develop a multi-agency assessment hub within the target and prevent people sleeping rough.

- Develop small scale accommodation project for customers who approach services and have nowhere safe to stay that evening.
- Recruit former rough sleepers and customers to Wolves@work programme.
- Develop a mentoring service for rough sleepers via the recruitment of former rough sleepers.
- Develop a corporate social responsibility (CSR) project for working to assist rough sleepers
- Develop a project to assist NRPF rough sleepers.
- Undertake Behavioural insight into lack of engagement by rough sleepers
- Develop and publish city wide rough sleeper plan

Vulnerability and Health.

We will ensure our services remain accessible to the most vulnerable households and can support those who need it most, such as those affected by domestic abuse.

We aim to increase the resilience of households and communities, equipping them with the necessary skills to prevent crises, such as homelessness, before they occur.

For many people who become homeless, the provision of suitable accommodation is the only problem that needs to be addressed. However, many other people can become homeless or be threatened by homelessness due to a range of support needs.

For example, this can be related to a mental or physical disability or circumstances such as domestic violence, a history of offending behaviour or drug and alcohol misuse. By working with our partners to provide targeted, specialist support, we endeavour to limit the number of vulnerable people who become homeless.

Homelessness and temporary accommodation have an impact on health and wellbeing of a household. A national survey conducted by Shelter of 2,000 people in temporary accommodation, found that more than half said that they were suffering from depression, and that depression and other mental health problems were two of the most common health conditions reported.

It is a strategic priority to reduce the number of households in temporary accommodation, particularly in nightly rate (bed and breakfast style) by developing suitable offers of private rental sector accommodation.

The council pledged a long-term aspiration to eliminate the usage of bed and breakfast style accommodation. Over the lifespan of this strategy we will aim to make progress towards this. This is in accordance with The Homelessness (Suitability of Accommodation) Order 2003 which sets out the statutory duty to limit bed and breakfast usage for only when no other suitable accommodation is available. It also sets a limit of six weeks for the length of time families, pregnant women and single under 18-year-olds can legally be placed into bed and breakfast accommodation.

Vulnerabilities

The Review of Homelessness in Wolverhampton found that over 75% of the 1700 homeless applicants have additional vulnerabilities other than just a lack of housing.

Housing Options works in partnership with a range of agencies to ensure that it meets the housing and support needs of those customers who suffer from a range of additional issues.

A report by Homeless Link 2015 using information supplied by over 2,500 people highlights the extent to which homeless people experience some of the worst health problems in society. It showed that 80% of homeless households reported some form of mental health issue, while 73% reported physical health problems.

Homeless people are more likely to die young, with an average age of death of 47 years old and even lower for homeless women at 43, compared to 77 for the general population, 74 for men and 80 for women. It is important to note that this is not life expectancy; it is the average age of death of those who die on the streets or while resident in homeless accommodation.

Drug and alcohol abuse are particularly common causes of death amongst the homeless population, accounting for just over a third of deaths. Homeless people have seven to nine times the chance of dying from alcohol-related diseases and 20 times the chance of dying from drugs.

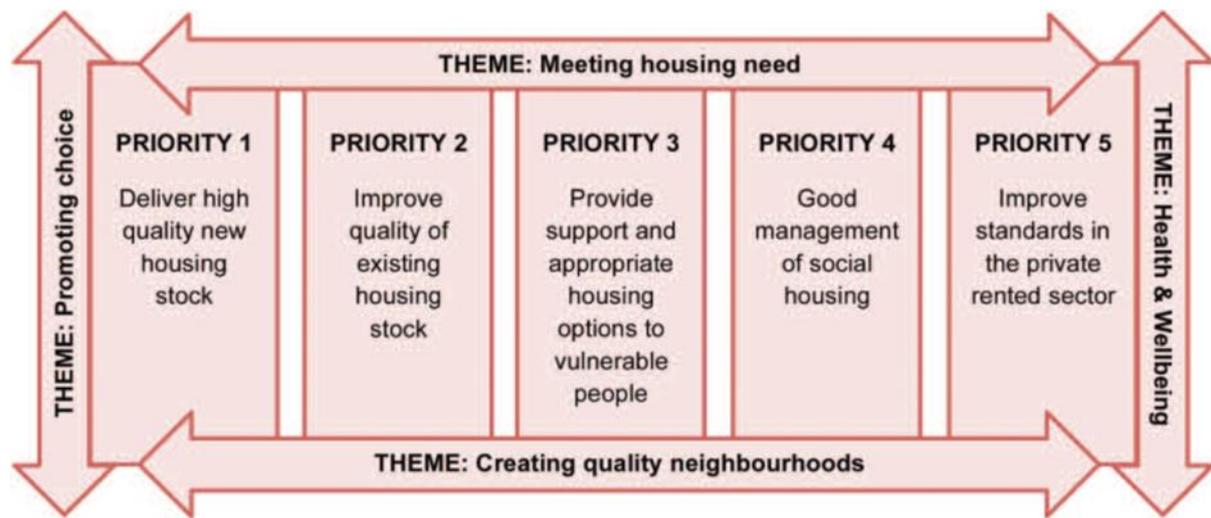
The aims to assist households with poor health and vulnerabilities in Wolverhampton:

- Remodel and recommission violence and abuse services
- Remodel Safe Homes Sanctuary service
- Remodel and recommission drug and alcohol services
- Develop a robust process for early housing referrals from health, social care and external partners
- Continue with the delivery of the hospital discharge service
- Develop suitable housing options for a variety of vulnerable groups including veterans
- Develop employment and training opportunities for people who are homeless or at risk of homelessness.
- Continue to reduce the use of B&Bs for young people and families via offering alternative and suitable accommodation options.

Responding to the local housing market.

Having a stable home enables people to access support services, integrate into their local community and to obtain and sustain work and training. We will continue to manage the expectations of customers and ensure that we maximise access and availability not only to social rented accommodation but to other housing options. This approach will help us to meet housing need, prevent homelessness and reduce the use of temporary accommodation.

City of Wolverhampton Council have identified five priorities for housing activity in Wolverhampton. There are also four crosscutting themes that will run through all strategic housing work in Wolverhampton.



We anticipate growth of around 11% in the number of households between 2006 – 2026, driven by a significant increase in the number of people living alone and a 3% increase in population.

The Black Country Core Strategy target for Wolverhampton is to build 13,400 new homes between 2006 and 2026 to accommodate these households. 2,129 additional homes were built during 2006-2012 and there is a requirement to provide 760 additional homes every year up to 2018. The Wolverhampton Strategic Housing Land Availability Assessment (April 2013) identifies sufficient deliverable housing sites to provide 6,438 homes by 2018, 41% above target.

The Strategic Housing Market Assessment (SHMA) identifies a need for 621 extra general-purpose affordable homes each year, and additional need for affordable specialist accommodation. As it has never been possible to meet this level of need, a local target which equates to an average of 115 affordable homes per year was set based on the Core Strategy and historical build levels, as at the Neighbourhoods, Homes and People 11 times an average of 124 affordable homes were being delivered each year since 2006.

In addition to new builds this would have included affordable housing achieved through a variety of mortgage assistance products including conversions to affordable housing.

In line with the Reduction Act we will need to deliver a comprehensive approach to responding to the present market conditions. These will address procurement of temporary accommodation, with specific regard to the cost and suitability of the options. We are aspiring to increase the number of leased accommodation used for TA. Leased accommodation offers greater stability for households in contrast to nightly rate bed and breakfast style accommodation which also often have shared facilities, and the use of social housing stock which is in high demand.

The Homelessness Reduction Act encourages local authorities to embed an approach to use the private rented sector accommodation to discharge a duty to homeless households and households threatened by homelessness. As a result, we will explore how we assist households to find accommodation that meets their needs in the private sector. By guiding households via the Rent with Confidence scheme with finding their own accommodation, they will have more control over their choices.

Aims of responding to local housing market:

- Reconfigure and recommission single person homeless accommodation and support.
- Develop standards framework for the provision of temporary accommodation.
- Increase the provision of private sector accommodation via Rent with Confidence.
- Work with developers and housing providers into the development of affordable accommodation for people at risk of homelessness.
- Enable discharge of homeless duty into the private sector with Rent with Confidence rated Landlords.
- Investigate the development of temporary accommodation via WV Living.

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Wolverhampton Homelessness Prevention Strategy Group Terms of Reference

Purpose:

To meet quarterly to:

- Report progress against implementation Plan Homelessness Strategy
- Work in collaboration regarding the implementation of the Action Plan and Wolverhampton Homelessness Strategy
- Record progress against the implementation plan
- Also consider local actions and areas of joint working, including operational issues, pressures and good practice
- Play a lead role in driving delivery of the Homelessness Prevention Strategy
- Positively communicate and engage with stakeholders and partners about the Strategy and its implementation plan
- Proactively take a lead on key themes and activities as contained in the action plan.

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Report title	Developing the Health and Wellbeing Dimension in All Policies	
Cabinet member with lead responsibility	Councillor Roger Lawrence Health and Wellbeing Together Chair Councillor Hazel Malcolm Cabinet Member for Public Health and Wellbeing	
Wards affected	All wards	
Accountable director	John Denley, Director of Public Health	
Originating service	City Health	
Accountable employees	Brendan Clifford Tel 01902 555370 Email Brendan.Clifford@wolverhampton.gov.uk	Service Director – City Health
	Madeleine Freewood Tel 01902 550352 Email Madeleine.Freewood@wolverhampton.gov.uk	Development Manager – City Health
Report has been considered by	Public Health Leadership Team	5 March 2019

Recommendation for action:

The Health and Wellbeing Together Board is recommended to:

1. Identify opportunities to adapt their internal governance processes to raise the profile of health and wellbeing in decision making.

Recommendations for noting:

The Health and Wellbeing Together Board is asked to note:

1. The progress made by City of Wolverhampton Council towards adopting a ‘Health in All Policies’ methodology and next steps for further development within the Council.

1.0 Purpose

- 1.1 To update partners on progress made by City of Wolverhampton Council as a Public Health Council where health and wellbeing is embedded into all decision making.
- 1.2 To invite the wider membership of Health and Wellbeing Together to identify opportunities to adapt their own internal governance processes as appropriate to raise the profile of health and wellbeing in decision making as part of the development of a system wide approach to 'health in all policies.'

2.0 Background

- 2.1 Health and Wellbeing Together is the forum where key leaders from the health and care system come together to improve the health and wellbeing of people in the City of Wolverhampton, work towards reducing health inequalities and support the development of improved and joined up health and social care services. It is the name given to the City of Wolverhampton Health and Wellbeing Board, a statutory Board established under the Health and Social Care Act 2012.
- 2.2 Health and Wellbeing Together is responsible for preparing and publishing a Joint Health and Wellbeing Strategy that is evidence based through the work of the Joint Strategic Needs Assessment (JSNA) and other supporting needs assessments.
- 2.3 The current Joint Health and Wellbeing Strategy 2018 - 2023 was approved at the 23 January 2018 board meeting. It is thematically presented, with priorities identified using a place based and life course approach. Health and Wellbeing Together is committed to an annual evaluation of the impact of the strategy via a series of self-assessment criteria, including demonstrating buy in by partners at all levels of their respective organisations.
- 2.4 In October 2018 the City of Wolverhampton Council Executive approved the inclusion of a 'health and wellbeing implications' heading within the corporate report template as a first step towards developing a Wolverhampton approach to 'health in all policies'.¹ This approach is a tool to strengthen the influence of consideration of health and wellbeing implications across all policy areas.
- 2.5 The draft Council Plan, set to be approved by Cabinet on 20 March 2019 and Full Council on 03 April 2019, includes six priorities to enable Wulfrunians to live longer, healthier and more fulfilling lives.

3.0 Progress and next steps

- 3.1 Early feedback of the inclusion of a 'health and wellbeing implications' heading in the City of Wolverhampton reports template indicates a growing corporate awareness of how decision making across all Council directorates can impact on the health and wellbeing of citizens. The planned development of training material/ short guidance notes will further enhance this.

¹ Health in All Policies – a manual for local government
<https://www.local.gov.uk/sites/default/files/documents/health-all-policies-manua-ff0.pdf>

- 3.2 In addition, the development of interactive mapping dashboards to inform live decision making as part of the development of a 'JSNA interactive' toolkit is enabling health and wellbeing data to proactively inform corporate decision-making processes. For example, the recently launched Local Area Risk Assessment Tool designed to ensure gambling operators have robust policies, procedures and control measures in place to address the issues associated with problem gambling.
<http://www.wolverhampton.gov.uk/article/13804/New-tool-will-help-mitigate-risk-of-problem-gambling-in-city>
- 3.2 A more detailed and related approach is the use of Health Impact Assessments (HIA). This is a structured approach to assessing the formal health impact of a specific policy and/or decision. They are more detailed assessments of the health impact of a policy and/or decision. For example, HIAs could be undertaken to inform large scale planning, transportation or environmental schemes such as assessing the health effects of an energy from waste facility or housing redevelopment project. The Council has agreed to use this approach where the circumstances suggest it might be helpful. This would be agreed on a case-by-case basis with the Council and / or other partners as relevant. It could be linked to scrutiny processes as appropriate. As part of the next steps a draft template is being developed to be brought through required governance internal processes for consideration.
- 3.3 Once approved the Council Plan will embed opportunities for coproduction and collaboration with city partners and citizens in relation to each of its priority areas.
- 3.4 Having received an update of the progress and next steps made by City of Wolverhampton Council towards adopting Wolverhampton 'health in all polices' methodology Health and Wellbeing Together partners are invited to identify opportunities to adapt their internal governance processes to raise the profile of health and wellbeing in decision making as part of the development of a system wide approach to 'health in all policies.'

4.0 Financial implications

- 4.1 There are no direct financial implications arising from this report.
[MI/04032019/B]

5.0 Legal implications

- 5.1 The Health and Wellbeing Together Board is a statutory Board established under the Health and Social Care Act 2012. It has a statutory duty, with clinical commissioning groups to produce a joint strategic needs assessment and a joint health and wellbeing strategy for its local population.
- 5.2 Councils have a statutory duty to improve the health of the local population.
[LW/08032019/N]

6.0 Equalities implications

6.1 Equalities are a key consideration of impact for health and well-being. Developing our approach to health impact will strengthen our approach to equalities.

7.0 Environmental implications

7.1 Environmental factors in certain circumstances e.g. air pollution or waste management, may be key elements of assessing the health and well-being impact of a policy.

8.0 Human resources implications

8.1 There are no direct human resources implications arising from this report, but the health and wellbeing of the workforce is always a key consideration in successful delivery of organisational aims.

9.0 Corporate Landlord implications

9.1 There are no direct Corporate Landlord implications arising from this report. In certain circumstances, there could be a positive contribution to health and wellbeing impact arising from decisions made in respect of our corporate landlord responsibilities such as making land available for more housing.

10.0 Health and wellbeing implications

10.1 The content of this report is to enable partnership discussion to enhance a whole system to embedding health and wellbeing in decision making.

10.0 Schedule of background papers

10.1 Maximising Health and Wellbeing Together Board impact and associated governance. Executive Team 15 October 2018.



Report title: Wolverhampton Clinical Commissioning Group (CCG) and Black Country and West Birmingham Sustainability and Transformation Partnerships (STP) Operating Plans

Report of: Dr Helen Hibbs
Accountable Officer, Wolverhampton CCG

Portfolio: Public Health and Wellbeing

Recommendation for noting:

Health and Wellbeing Together is recommended to note:

1. The Wolverhampton CCG and Black Country and West Birmingham STP Operating Plans for assurance.

1.0 Purpose

- 1.1 A copy of both the Wolverhampton CCG Operating Plan 2019/20 and the Black Country and West Birmingham STP Summary Narrative Operating Plan 2019/20 are attached for assurance. The group are asked to note the Wolverhampton CCG plan for assurance and the STP plan for information.

2.0 Background

- 2.1 Originally Wolverhampton CCG was instructed to submit a 12-month Operating Plan for the CCG however, this guidance then changed nationally. The CCG is now only obliged to contribute towards an STP wide 12-month Operating Plan which is attached. The CCG Executive team took the decision to develop a local operating plan for our own local requirements to assist in planning for 2019/20. Both of these reports are attached. The STP 12-month Operating Plan narrative was populated following a template with instructions to ensure it is a concise report. There is an expectation that a further five-year plan will be written for the STP in the early Summer. Necessary arrangements have been made via the STP to complete this plan once the full guidance is published.

The local Wolverhampton Operating Plan covers:

- The NHS Long Term Plan
- Financial Sustainability
- All areas of Commissioning
- Workforce
- Digital
- Medicines

As the STP transitions to an Integrated Care System (ICS) with a single commissioner voice it is important that we have a clear articulated plan setting out our ambitions for the year.

3.0 Implications

There are no known implications in relation to this report.

4.0 Schedule of background papers

- 4.1 The background papers relating to this report can be inspected by contacting the report writer:

**c/o Mike Hastings, Director of Operations
Wolverhampton CCG
01902 441811**

Wolverhampton Clinical Commissioning Group

Operational Plan 2019/20



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1. Introduction

*‘2019/20 will be the foundation year which will see significant changes proposed to the architecture of the NHS, laying the groundwork for implementation of the Long Term Plan’.*¹

For Wolverhampton CCG, this means focusing on maintaining work currently underway in key priority areas, both locally and regionally, as well as supporting planned transitions to an Integrated Care System (ICS) and integrated care provision for the four ‘places’ of the Black Country and West Birmingham Sustainability and Transformation Partnership (BCWB STP) – Wolverhampton, Walsall, Dudley and Sandwell and West Birmingham. This focus will enable us to align the CCG with the ICS as it develops, transitioning to the local, regional and national healthcare system set out in the NHS’s Long-Term Plan (LTP).²

This Operational Plan for 2019/20 is a response to the context outlined above; to make the appropriate decisions as to our operations to be fit-for-the-future, whilst maintaining our eye on existing responsibilities to our population.

Our vision for the future **is to commission the right healthcare services for our population, in the right place, at the right time, within the context of limited resources.** In order to achieve this, we have five priorities for the coming year:

- continue to commission high quality, safe healthcare services within our budget;
- focus on prevention and early treatment;
- ensure our services are cost effective and sustainable;
- Align our clinical priorities, as appropriate, to the Black Country and West Birmingham STP/ICS;
- Build on our Primary Care Networks (PCNs), wrapping community, social care and mental health services around them.

The detail provided in the remainder of this planning document outlines how we will achieve these priorities.

¹ NHSE, NHSI. *NHS Operational Planning and Contracting Guidance 2019/20*. 2019. Available at <https://www.england.nhs.uk/wp-content/uploads/2018/12/NHS-Operational-Planning-and-Contracting-Guidance-201920-FULL-VERSION.pdf>

² NHSE, NHSI. *NHS Long Term Plan*. 2019. Available at <https://www.longtermplan.nhs.uk/>

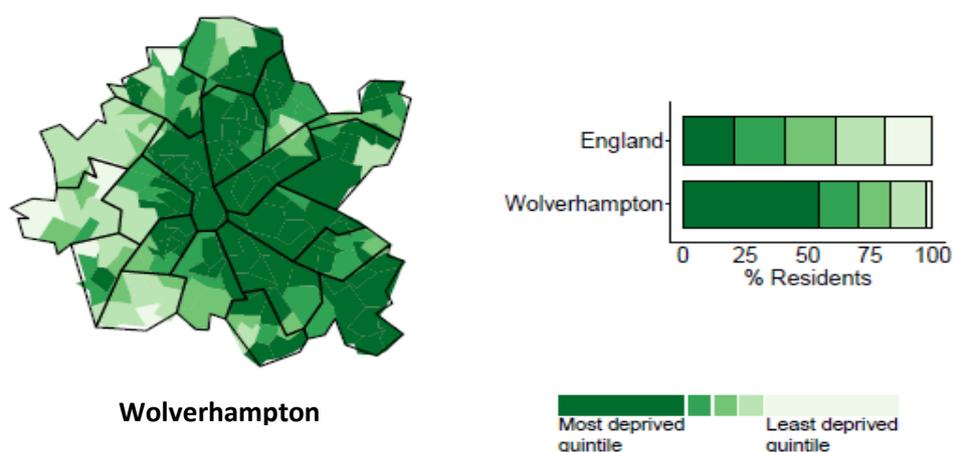
2. Local challenges

Wolverhampton has a population of 258,100 (2016) which is estimated to grow to 264,000 by 2020 and 275,900 by 2030. Wolverhampton is a diverse city and 32 per cent of our population belongs to black minority ethnic (BME) communities compared to 15 per cent for England.³ Table 1 provides some of the key demographic detail for Wolverhampton, compared to the national picture:

	Wolverhampton (persons)	England (persons)
Population (2016)*	258	55,268
Projected population (2020)*	264	56,705
% population aged under 18	23.0%	21.3%
% population aged 65+	16.7%	17.9%
% people from an ethnic minority group	27.6%	13.6%

Table 1: Sociodemographic profile of Wolverhampton and England. Taken from Public Health England. Wolverhampton Local Authority health profile (2018).

Wolverhampton is one of the most densely populated local authority areas in England and is amongst the most deprived areas within the country ranking as the 11th most deprived local authority area in England. In recent years unemployment has fallen in the city but it remains the sixth highest unemployment rate per local authority in England. Figure 1 demonstrates Wolverhampton's deprivation and its distribution across the city:



³ WCCG, *Annual Report 2017/18*. (2018). Available at <https://wolverhamptonccg.nhs.uk/about-us/10-about-us/660-annual-report-2017-18>

Figure 1: Deprivation profile of Wolverhampton and England. Taken from Public Health England. Wolverhampton Local Authority health profile (2018).

The previous trend of increasing life expectancy for men and women in Wolverhampton has begun to level off in recent years and the gap to England is not increasing. Healthy life expectancy data shows that in Wolverhampton, men and women live 7.0 and 4.6 years respectively in poorer health than the England average. In Wolverhampton the average man and woman can expect to live the last 21 years and 21.9 years of their lives respectively in poor health. It is these years lived in poor health that leads to higher demand on our health and social care services in Wolverhampton.

There are six conditions which account for over half of the difference in life expectancy that exists between Wolverhampton and England. These are heart disease, stroke, infant mortality, lung cancer, respiratory illness and alcohol mis-use. The impact of these conditions is seen disproportionately in the most disadvantaged communities. We are committed to reducing unwarranted variation where possible, drawing on RightCare⁴ analysis.

Cancer, in particular, is a low performance area for the city and plans are being realised in 2019/20 to mitigate against this (see section 5.3).

It is recognised that there will always be variation in clinical care and this is at the heart of place-based systems. Some variation is based on clinical need and appropriate decision-making; on early adoption of innovation and of new technology, for example. However, unwarranted variation is not acceptable and can often lead to poorer outcomes. We understand that the healthcare needs of our population will be different across localities. Whereas we are committed to reducing unwarranted variation, some intended variation will be necessary across localities to reflect the fact that each patient is different, and interventions should be assessed according to the needs of the population served.

3. National context

3.1 The Long Term Plan

In January 2019 NHS England (NHSE) published its LTP, setting out a vision for the NHS over the next ten years, supported by the £20.5 billion additional investment in

⁴ The NHS RightCare teams work locally with systems to present a diagnosis of data and evidence across that population.

real terms by 2023/24 and building on the new models of care tested and refreshed as part of the *NHS Five Year Forward View*⁵ and *Next Steps on the NHS Five Year Forward View*⁶ respectively. The key service priorities set out in the LTP are:

- **Boosting ‘out-of-hospital’ care and dissolving boundaries between primary and community care;**
- **Reducing pressure on emergency hospital services;**
- **Giving people more control over their health and providing more personalised care where appropriate;**
- **Mainstreaming digitally-enabled primary and outpatient care across the NHS;**
- **A nationwide shift to ICSs with a focus on population health.**

These priorities will be enabled locally and nationally by:

1. **Doing things differently** – giving people more control over their own health and care, encourage collaboration between GPs, their teams and community services, as ‘primary care networks’, to increase the services they can provide jointly, and increase the focus on NHS organisations working with their local partners, as ‘Integrated Care Systems’, to plan and deliver services which meet the needs of their communities;
2. **Preventing illness and tackling health inequalities** – increasing NHS contributions to tackling causes of ill health;
3. **Backing our workforce** – increasing the NHS workforce, training and recruiting more professionals, including clinicians, providing more routes into the NHS and improving retention by making the NHS a better place to work;
4. **Making better use of data and digital technology** – providing more convenient access to services and health information for patients, with the new NHS App as a digital ‘front door’, better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data; and
5. **Getting the most out of taxpayers’ investment in the NHS** – working with clinicians to reduce duplication and make better use of the NHS’s combined buying power to reduce costs.

⁵ NHSE. *Five Year Forward View*. (NHSE, 2014). Available at <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>

⁶ NHSE. *Next steps on the NHS Five Year Forward View*. 2017. Available at <https://www.england.nhs.uk/publication/next-steps-on-the-nhs-five-year-forward-view/>

This Operational Plan details how Wolverhampton CCG is already planning on delivering against these priorities locally, laying the ground work for their realisation at the system level.

3.2 National Strategies

Various national strategies have informed the plans detailed here for 2019/20: These include (but are not restricted to):

- *Five Year Forward View (2014) and Next Steps on the NHS Five Year Forward View (2017)*
- *Achieving World Class Cancer Outcomes (2015)*
- *Building the right support (2015)*
- *General Practice Forward View (2016)*
- *The Five Year Forward View for Mental Health (2016)*
- *Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care (2016)*

The work we have carried out in delivering against these strategies to date has laid the foundations for us to transition to the health system set out in the LTP. More specifically, they support the emergence of PCNs and other local infrastructure to deliver care in the right place, at the right time, making best use of local resources.

4. Transitioning to the Long Term Plan

As highlighted above, Wolverhampton is part of the BCWB STP consisting of 18 partners including NHS commissioners, providers and local authorities. The STP set out a five-year plan⁷ in 2016 to transform the local health and care system around the following priorities:

- Implementing local place-based models of care that deliver improved access to better coordinated community and primary care that provides greater continuity for patients who can and should receive integrated services in an out of hospital setting;
- Extending collaboration between acute service providers to create a coordinated system of care across the Black Country to reduce variation, improve quality and deliver organisational efficiencies;

⁷ Available at <http://www.dudleyccg.nhs.uk/wp-content/uploads/2016/11/Black-Country-STP-Full-Plan.pdf>

- Building on existing plans to transform mental health and learning disability services;
- Addressing the significant challenges faced in maternal and infant health through the development of a single maternity plan;
- Working together on key enablers such as digital infrastructure, public sector estate utilisation and workforce transformation to deliver modern patient centred services and commissioning functions; and
- Acting in partnership with the West Midlands Combined Authority (WMCA) and other partners to address the wider determinants of health including employment, education and housing.

It is likely that these priorities will be reviewed in 2019/20 as part of the development of the STP five-year plan in response to the LTP. **The challenge for 2019/20 is to continue to integrate patient pathways at the local level, whilst working towards strategic and operational alignment as described in the LTP.**

4.1 Delivering system alignment

Black Country ICS Transition

By 2021, NHSE have stipulated that all STPs will have transitioned into ICSs, bringing together local organisations to redesign care and improve population health. In 2019/20, therefore, significant progress is required in the Black Country in realising this transition. This will be overseen by a Transition Board, made up of Accountable Officers (AOs) and Chairs.

Our vision for the Black Country ICS is **working together to improve the health, wellbeing and prosperity of our local population.**

The four CCGs in the Black Country: Sandwell and West Birmingham, Dudley, Walsall and ourselves, have formed a Joint Commissioning Committee (JCC) to enable us to commission some services at scale for people across the Black Country. This committee is complemented by the work of a Clinical Leadership Group (CLG) which has been integral to the development of the STP's clinical strategy. It is planned for the JCC to be delegated greater responsibility in 2019/20 for spending in mental health, learning disabilities, community services delivered by the Black Country Partnership Foundation Trust (BCPFT) and acute services. Furthermore, in 2020/21, an options appraisal will be carried out to determine the organising framework for a 'single commissioning voice' in the Black Country and

planning for this will commence in 2019/20. Figure 2 shows the transition timeline for the system:

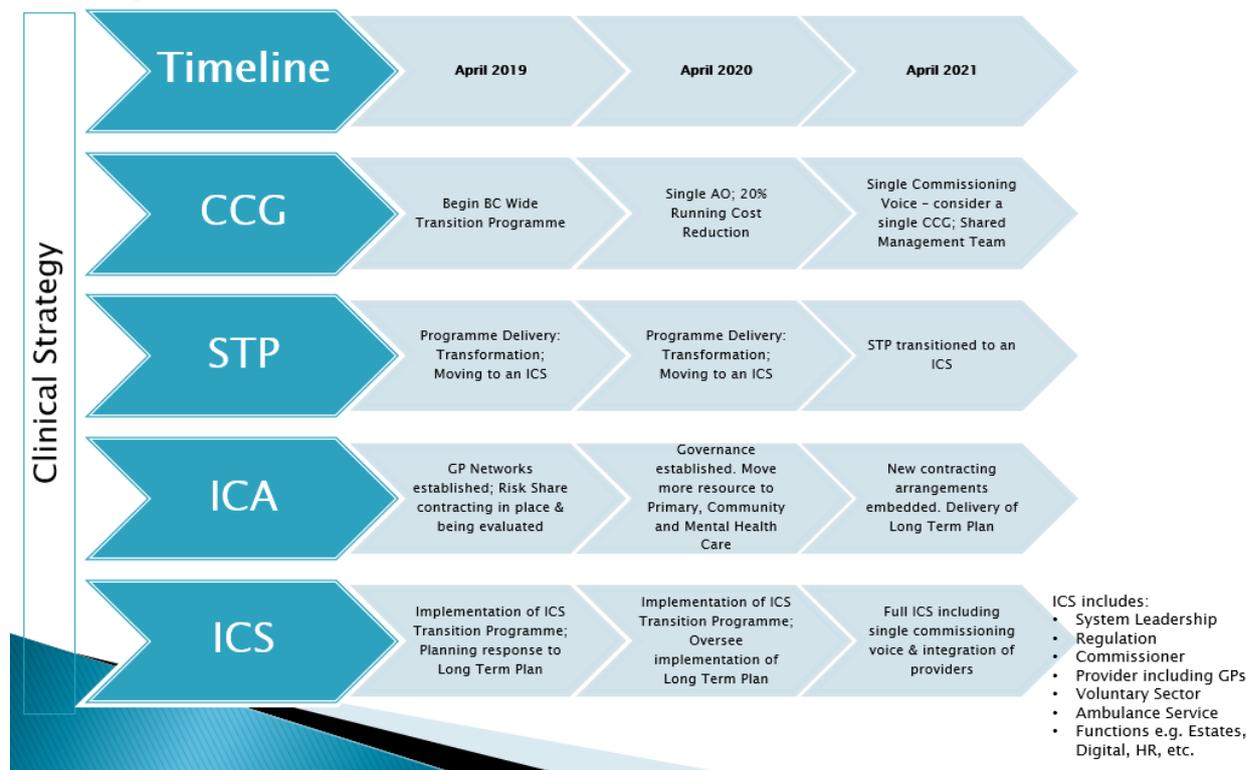


Figure 2: System transition timeline for BCWB

STP Clinical Strategy

As we align our strategic planning to the STP, we must review our local commissioning priorities against the STP clinical strategy. This strategy will shape system transformation in terms of the ‘triple aim’: the triple aim is part of the NHS *Five Year Forward View*. This sets out areas where action must be taken to ensure that people in England receive **Better Health; Better Care; Better Value.**

This strategy will inform the phasing of the transformation work required, providing focus for the areas where immediate attention and action is required. **For the CCG, it enables the shift towards an Integrated Care Alliance (ICA) and closer system working for Wolverhampton and sets out a pathway which informs our operating requirements for 2019/20.**

Consistent with the *Five Year Forward View*, the clinical strategy will support delivery of national priorities:

- 7-day services – right care, right time, right quality;
- Integrated mental health and physical health;

- The promotion of good mental health and prevention of poor mental health;
- Driving up early cancer diagnosis as well as treatment times.

In addition to describing our local commissioning priorities therefore, the sections below will also discuss relevant clinical priorities at the STP level to demonstrate how alignment will take place between the STP clinical strategy and the CCG plans. Underpinning this alignment are a number of system enablers which we will support the delivery of in 2019/20 (figure 3).



Figure 3: Drivers for integrated care in BCWB STP

As an introduction, Table 2 includes the clinical priorities for the STP which have been based on the *Five Year Forward View*, 2018/19 NHSE Planning Guidance and opportunities identified via RightCare.

Proposed Priority Area	Scope includes
Primary Care*	Primary Care Networks – sustainability of General Practice and the integration of care at the 'locality' level (30-50k population) working towards the involvement other providers of primary care (dental, pharmacy and optometry).
Cancer*	RTT, Urology, Upper GI, Haematology, screening, radiotherapy, services requiring 1m+ population
Mental Health*	Access for children and young people, IAPT, crisis care, dementia, suicide prevention, integrating mental/physical health
Learning Disability Services*	Transforming Care programme, including shift towards greater community provision
Maternity & Neonates*	Better Births, infant mortality, maternity capacity (incl. consultant-led vs MLU, antenatal and newborn screening and maternal and neonatal immunisation programmes).
Children and Young People	It is our ambition that the Black Country is a place where children and young people thrive: that all children in the Black Country get a good start in life and are healthy; that all families are supported to be independent, responsible and successful; where the most vulnerable children are protected; and where our children are supported to become function and productive members of our communities We want to move the Marmot curve for our CYP population. Services work towards this ambition including specialist 24/7 care, TCP, CAMHS, Community services, prevention (e.g. oral health, screening and immunisations, Healthy Child Programme safeguarding etc.
Urgent & Emergency Care*	Reducing attendance/admission, UTC specification, emergency general surgery, trauma/ITU provision, emergency/elective split
Cardiovascular Disease	Prevention
Clinical Support Services	Pathology, interventional radiology
Musculoskeletal Conditions	Standardising elective orthopaedics
Respiratory Disease	Smoking cessation, COPD pathway
Frailty	UTIs, falls, dementia

Table 2: BCWB STP Clinical Priorities taken from BCWB Clinical Strategy

*NHSE Five Year Forward View priorities

Local Integrated Care Provision

Local place-based models of care are being developed and implemented for each of the four STP places in support of the clinical strategy. These models are emerging vehicles for bringing together health and care services for defined populations in a more integrated way. They aim to deliver improved access to local services for their whole population, greater continuity of care for those with ongoing conditions and more coordinated care for those with the most complex needs.

This work is consistent with the process of transitioning to an ICS, built on accountable care organisations providing more effective services to defined populations for the long term.

Each ‘place’ has its own plan, but each plan is drawn from the same central principle. This will bring health, social care and voluntary sector organisations together, to achieve improved health and wellbeing. This will deliver models of care that are tailored to their populations, but which also benefit from working alongside each other as part of a system as described in figure 4. In Wolverhampton, this has been defined as an Integrated Care Alliance (ICA).

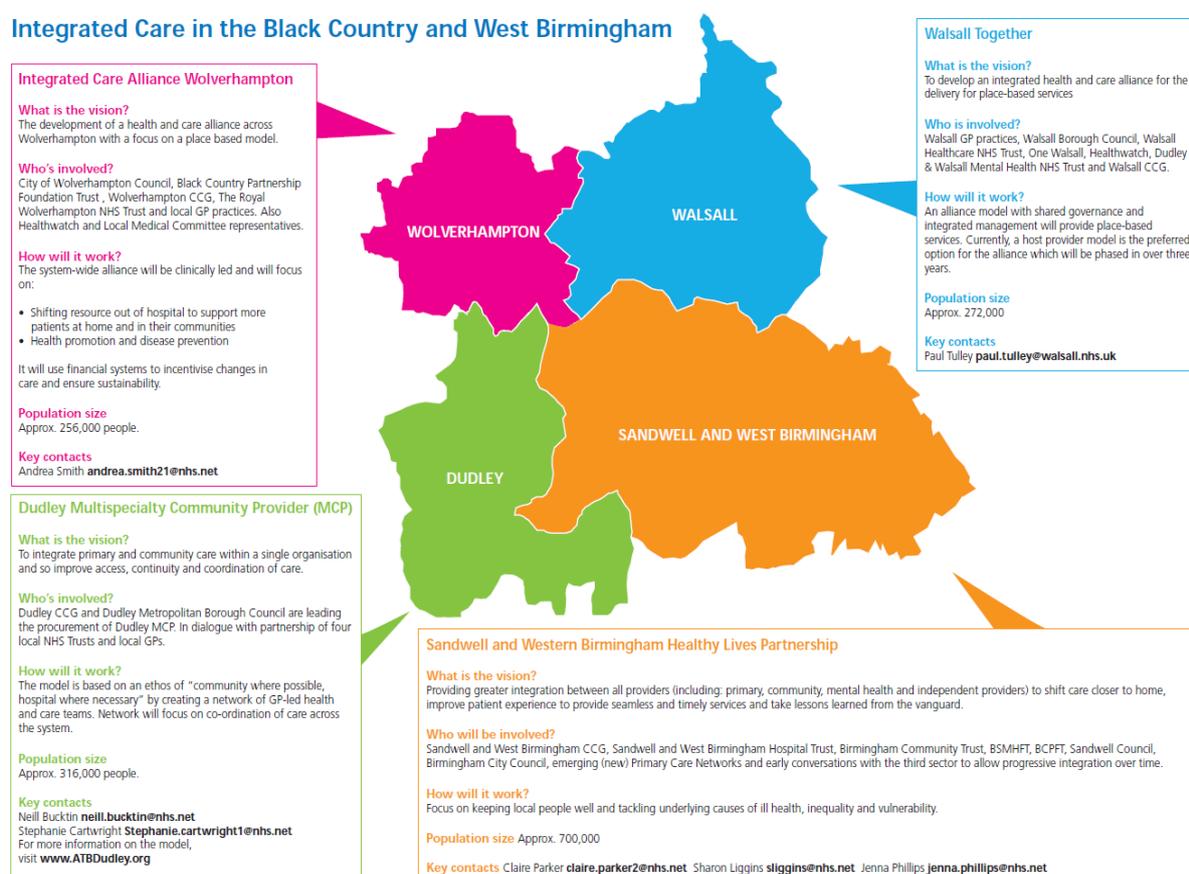


Figure 4: Place-based care in the BCWB STP

Wolverhampton Integrated Care Provision

The Wolverhampton ICA focuses on Wolverhampton working as a system rather than through independent processes. The strategy is clinically led, managerially supported and patient centred. There is a shared governance system across the alliance stakeholders which provides system leadership and who are mutually accountable for delivery.

The ICA will shift resources from hospital to out-of-hospital services so that more people are supported proactively in their home and communities. It will focus on health, developing our approach to health promotion and disease prevention to support the wellbeing of our communities alongside the care that we already provide.

A key feature of the ICA is an integrated data system where all parties can access data to support the patient's pathway. This reduces delay, encourages cooperation and supports integrated working.

The ICA must be financially sustainable, making the best use of the resources that we have collectively. This will mean amending the current funding flows as they do not always incentivise best practice.

The ICA has a number of key aims that are guiding its programme:

- To modernise and support ALL primary care to improve care quality and financial sustainability;
- To redesign our local NHS system by removing barriers that act against integrated care, to support strategic commissioning;
- To redistribute risk in a better a way across the system;
- Improve population health outcomes in partnership with the commissioner's mental health services, social care services, public health and the voluntary sector;
- To improve co-ordination of services and move care out of hospital where appropriate- Integrated user focussed care delivery;
- Facilitate networked solutions for hospital services where there is opportunity to improve care quality and financial sustainability.

Four clinical priorities have been identified for the ICA for 2019/20. For each of these clinicians from across local providers have determined areas of focus:

Children and Young People's Services

- Development of the Wolverhampton 'Big 6' (six most common conditions/symptoms that can cause children and young people to present for emergency and urgent care);
- Implementation of the standards in 'Facing the Future – Together for Child Health';
- Shift in activity from secondary care to community (care closer to home)
- Joint specialist and generalist clinics;

- Targeted care for vulnerable groups (CAMHS, SEND, etc.);
- Co-design of services with parents/carers.

Mental Health

- IAPT;
- Long Term Condition IAPT;
- Dementia;
- Mental health and the cross over with physical health;
- Implementation of the Wolverhampton Mental Health Strategy (see section 5.4).

End-of-life

- Care coordination;
- Advance care planning;
- Targeted engagement with the public;
- Raising awareness of death and dying;
- Community model of palliative and end of life care;
- Developing a workforce fit for purpose;
- Targeted care for vulnerable groups (learning disability, dementia, etc).

Frailty

- Designing targeted services for the different cohorts of patients classified as living with frailty;
- Standardising identification and assessment across the pathways;
- Integrating pathways of care to improve patient experience and care;
- Developing a workforce fit for purpose;

ICA working groups have also been established to consider:

- Information governance
- Contracting and finance
- Outcomes development

Primary Care networks

Within the ICA are four PCNs – a central feature of health systems as set out in the LTP. These are formally recognised networks of GPs, each serving between c. 55,000-95,000 patients in Wolverhampton. PCNs represent the building blocks of

place-based models of care and are the key to preserving the integrity of NHS service provision going forward.

For our service users, patients and carers, PCNs will bring:

- Access to a wider range of professionals than may have been available in individual practices enabled by a shared patient record;
- Improved/shorter waiting times that are focused around the access needs of those using services including extended GP hours;
- Improved access to a wider range of services and support through use of the resources and partners within the PCN;
- Using the wider access to professionals and services, provide a focus on increasing access to care locally (place-based care) and avoiding admission avoidance and hospital attendance where possible.

In 2019/20 service and pathway integration will reach beyond primary care to include other health and care services, building on work carried out during the previous year. This will include district nursing, pharmacy, social workers, community psychiatric nursing, social prescribing, housing and a range of other roles to support patients' care in their own communities, organised in Integrated Community Teams (see section 5.6). Figure 5 describes some of the services that will be wrapped-around PCNs.

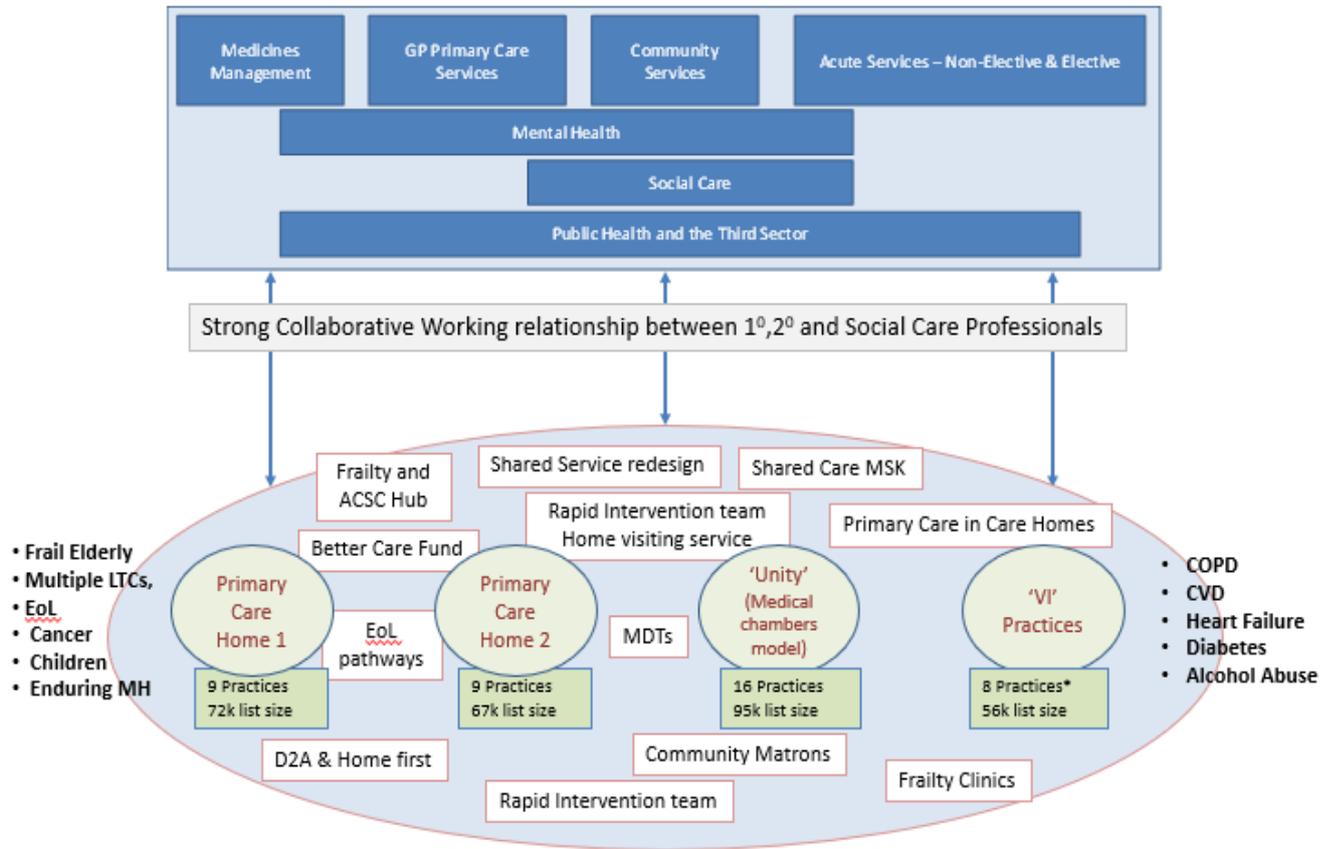


Figure 5: High level model for PCNs in Wolverhampton STP/ICA

The PCN model is being developed across the STP as per the requirements in the LTP.

4.2 Financial sustainability

Several priorities and actions have been defined for the CCG in 2019/20 in order to ensure financial sustainability and contribute to delivering financial balance across the NHS. These refer directly to our stated priorities to:

- continue to commission high quality, safe healthcare services within our budget; and
- ensure our services are cost effective and sustainable.

1. Deliver CCG organisational control total to support local system financial control totals.

- Long term financial model in place to deliver control totals during lifetime of plan;
- Contracts in place from March 2019 with providers based on financial plans;

- QIPP plans in place and agreed in contracts with providers;
- Ensure CCG does not exceed management cost allowance and plan to achieve 20% real terms reduction by 2020/21;
- Deliver efficiency ask of 1.1% per year.

2. Implement local STP plans to moderate demand growth and increase provider efficiencies

- Financial plans aligned with STP plans and assumptions;
- Local delivery plans aligned with STP priorities;
- Work to simplified CQUIN scheme indicators as defined in upcoming guidance.

3. Implementing demand reduction measures to support financial sustainability.

- Reduce variation in spend and outcomes, utilising RightCare opportunities;
- Develop options for elective care redesign;
- Urgent and emergency care reform;
- Implementation of 'Place' strategy;
- New pathways and services that support self-care and prevention;
- Medicines optimisation;
- Improving the management of continuing healthcare processes.

4. Enhanced investment in out-of-hospital care

- Increase investment in mental health services in-line with MHIS, including Children and Young People (CYP) mental health services;
- Commit recurrent funding to developing and maintaining primary care networks;
- Shift funding from acute to community services in support of the ICA.

5. Meeting our 2019/20 Operating Plan Requirements

We are developing a commissioning for outcomes framework that will be implemented during 2019/20. The following sections detail the clinical priorities in key service areas for the STP and then locally for the CCG to demonstrate where they are most closely aligned. Local commissioning priorities will also form part of the activity happening at the ICA level described above. The purpose is to

demonstrate how plans for 2019/20 respond to local need, whilst also transitioning to the healthcare systems laid out in the LTP.

5.1 Urgent and Emergency Care

Summary

Patients in the Black Country will benefit from both localised and system-wide approaches to Urgent and Emergency Care (UEC). The CCG, during 2019/20, is focused on working in partnership across the STP to avoid unnecessary hospital admissions and ensure care is provided in the right place, at the right time, particularly with regards to frailty. The CCG is developing an Urgent and Emergency Care Strategy during 2019/20 which will identify and address both identified local need and opportunities for commissioning services at a STP level, supporting the system priorities outlined below.

Urgent and emergency care at the STP level

At the STP level, the scope of the clinical priorities has been informed by the *Five Year Forward View* and includes:

- Reducing attendance/admission
- Urgent Treatment Centre (UTC) specification
- Emergency general surgery
- Trauma/ITU provision
- Emergency elective split

The vision for UEC at the STP level is **to sustainability meet the urgent and emergency care needs of local people through the development and delivery of a comprehensive and integrated care services**. The triple aim opportunities for UEC have been identified as:

- **Better Health** - Addressing societal and lifestyle issues that drive poor health outcomes;
- **Better Care** - Increase access to primary care to free up the time of specialist UEC clinicians to service serious or life-threatening cases; and
- **Better Value** - Stem the growth of people using UEC, providing a more joined up and consistent service.

Two early priorities have been defined to deliver against these opportunities in 2019/20:

- The development of primary care to offer 7-day access and multidisciplinary care through PCNs;
- Place-based integration with local authorities to further reduce delayed transfers of care.

We will continue to work in partnership with CCGs across the STP and Urgent and Emergency Care Network to identify how the Clinical Assessment Service (CAS) could be enhanced to support admissions avoidance.

Urgent and emergency care services in Wolverhampton

The CCG is working in collaboration with Royal Wolverhampton Trust (RWT) clinicians to ensure the reduction of avoidable admissions through the establishment of an acute frailty service, which is one of the key components of the frail elderly pathway which entails cross-boundary and multi-agency working to support:

- healthy living/ageing well
- proactive care
- assess to admit
- frail elderly Emergency Department team
- acute admission under geriatrician
- discharge to assess
- comprehensive reablement.

Further work will take place during 2019/20 to ensure that clinical pathways are well developed and that the appropriate workforce is in place to ensure that patients are being assessed, treated and supported by skilled multidisciplinary teams.

Other key priorities for 2019/20 include:

- The CCG will develop its Urgent and Emergency Care Strategy during 2019/20 which will identify and address both identified local need and opportunities for commissioning services at a STP level and will help inform the future model of care we wish to commission;
- The CCG will continue to work towards delivering Delayed Transfer of Care (DToc) targets and will continue to reduce bed occupancy by long stay patients;
- The CCG will continue to review the Directory of Services (DOS) to ensure that information and profiling reflects locally commissioned services and supports the 'right place, first time' approach;

- The CCG will ensure that the accreditation of UTCs is in place by December 2019;
- We will continue to build links with key partners such as West Midlands Ambulance Service (WMAS) to identify how activity could be diverted into existing admission avoidance commissioned services in the community such as the Rapid Response Team and identify where there may be gaps in provision;
- We will work with the integrated Urgent Care Alliance and WMAS to pilot 'intelligent conveyance' across the West Midland including the Black Country. The intended outcomes are to improve integration across systems, collaborative working, that would support improved 4 hour performance, better patient flow, better management of capacity and improved hospital handover through immediate identification of pressures;
- Improve GP access in primary care for urgent appointments and continue work between RWT and our GP-led UTC to build on the work already in place with the joint integrated triage. This will deliver a consistent reduction in conveyance rates to bring Wolverhampton health economy in line with the rest of the Black Country and see increased numbers diverted to the UTC, see and treat and discharge at triage. A working group has been established to review ambulance conveyances and consider methods for reduction;
- Improve A&E Access Standards by playing a key leadership role in the local A&E Board to support delivery of a programme of work to address locally identified areas of pressure. Key nationally mandated deliverables for this work include:
 - streaming at A&E to ensure patients are seen by the appropriate clinician
 - transfer of NHS 111 calls to clinicians
 - ambulance response times
 - improving patient flow and discharge
- The CCG will review its High Intensity User (HIU) support offer for demand management in UEC. This has a CQUIN place and a mental health nurse in support.

Each of these activities will contribute towards the triple aims for UEC identified by the STP.

5.2 Referral to Treatment Times and Elective Care

Summary

Patients in the Black Country will benefit from both localised and system-wide approaches to RTT and elective care. The CCG, during 2019/20, is focused on ensuring access to elective care is within national targets, opportunities for delivering care closer to home are utilised and unnecessary referrals are reduced. Working with partners across Wolverhampton will be integral to this and this activity will support the clinical priorities set by the STP outlined below.

Referral to treatment times and elective care at the STP level

The STP have determined the following clinical priorities around elective care:

Interventional Radiology: Patients will have access to a service that will deliver high quality clinical outcomes. Early intervention and quicker access to services will improve outcomes and offer better value.

Pathology: Delivering prompt diagnostic and clinical intelligence in cost effective and efficient organisations. Provide earlier intervention to prevent disease progression and promote lifestyle changes and deliver more standardisation and efficiency across the service.

Musculoskeletal (MSK) Conditions: Patients will have good outcomes, high quality of care and experience efficiency in service delivery. Referral processes will be streamlined and waiting times reduced through reduction in unnecessary referrals and avoiding secondary care follow ups where unwarranted.

Respiratory: Mortality rates will be reduced below the England average and patients will be able to access consultants through outreach in the community. Detection and prevention through lifestyles interventions will improve outcomes and reduce spend on respiratory related conditions.

Maternity and Neonates: Maternity pathway will involve women and those close to them in making the right choices for them to give birth in a safe and caring environment. Reducing rates of stillbirths, neonatal death, maternal death and brain injury during birth and engaged with the Maternity and Neonatal Health Safety Collaborative.

Referral to treatment times and elective care in Wolverhampton

In Wolverhampton, we will deliver services in 2019/20 to ensure delivery against the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment. To do this we will streamline elective care pathways and, where required, robustly performance manage our providers using contractual levers where necessary to achieve performance standards. The CCG will continue active monitoring of very long waits (over 52 weeks) to ensure each case is investigated with the Trust responsible and resolution plans agreed. In addition to managing contracts as 'lead commissioner' the CCG also actively works collaboratively with other lead commissioners where we are associates, to understand any waiting time challenges, the core issues and remedial actions.

Also during 2019/20 the CCG will implement our demand management plan aimed at reducing avoidable hospital referrals and ensuring patients receive the right care, at the right time, in the right setting. Schemes continuing into 2019/20 include:

- Targeted peer review of referrals by GP practices;
- Access to expert advice and guidance in primary care;
- Out-of-hospital care for the most common conditions (MSK, and Ophthalmology);
- A GP Education and Training Programme;
- Implementation of commissioning policy to restrict procedures of limited clinical value.

During 2019/20 work will continue to embed MSK best practice pathways and improve surgical conversion rates, redesign dermatology services, enhance primary care eye care services and continue clinical evidence reviews of procedures of limited clinical value. The CCG will be seeking to establish a Joint Elective Care Programme Board with our local Trust, to transform and redesign elective care services in partnership.

5.3 Cancer Treatment

Summary

Patients in the Black Country will benefit from both localised and system-wide approaches to cancer. The CCG, during 2019/20, is focused on improving early diagnosis, compliance with national waiting targets and patient experience. Working

with partners across Wolverhampton will be integral to this and will support the clinical priorities set by the STP outlined below.

Cancer services at the STP level

The STP has described a vision for cancer services that are in **the top quartile for prevention, early diagnosis and treatment**. This has informed the triple aim opportunities of:

- **Better Health:** Taking concerted action to address some of the environmental, societal and lifestyle issues that drive poor health outcomes;
- **Better Care:** Our key opportunities are targeted interventions to improve the uptake of cancer screening; implement the national faster [28 day] diagnosis pathways; deliver Living With and Beyond Cancer; and
- **Better Value:** Taking actions to increase screening uptake and earlier diagnosis should not only save lives but reduce costs for unplanned cancer care.

Early priorities to deliver this work are to:

- Achieve the 62-day waiting time standard
- Implement early diagnosis
- Improve the patient experience
- Review opportunities for collaboration between Walsall and Wolverhampton cancer units.

Cancer services in Wolverhampton

The number of people diagnosed and living with cancer each year will continue to grow rapidly. The primary reasons for this are our ageing population and our success in increasing survival rates. This will place significant additional demand on our health and social care services.

Together with City of Wolverhampton Council (CWC), we have drafted a five-year Wolverhampton Cancer Strategy to be initiated in 2019. This strategy sets out our local ambition to improve cancer outcomes in Wolverhampton so that by 2024:

- fewer people are being diagnosed with preventable cancer;
- more people survive for longer after a diagnosis;
- more people have a positive experience of care and support; and
- More people enjoy a better long-term quality of life.

We will achieve this by a greater focus on prevention, earlier detection and improved treatment. Critically, we will focus on improving health and wellbeing across all the areas but also significantly reducing inequalities and variations in outcomes between local areas and between different population groups. Local cancer incidence data indicates that there is a correlation between deprivation, age, lifestyle and cancer incidence. Screening data also highlights that in areas of low deprivation and a high BME population there is a low take up of screening services.

Part of our commitment to early detection is to improve our performance in terms of emergency diagnoses. Table 3 shows Wolverhampton’s performance in this area compared to the national picture.

CCG	Emergency diagnoses of invasive malignant tumours The data shows the proportion of tumours diagnosed in A&E, by CCG, expressed as a percentage.						National position based on 2017 Data
	2012	2013	2014	2015	2016	2017	
NHS Wolverhampton CCG	23.41%	22.95%	21.18%	23.25%	23.89%	20.75%	158/194
England	20.94%	20.25%	20.04%	19.84%	19.49%	18.75%	

Table 3: Emergency presentation data

Cancer screening provides an opportunity to diagnose cancer at an earlier stage before signs and symptoms have developed and when treatment may be less complex and outcomes better. There are three cancer national screening programmes (Breast, Bowel and Cervical) and Wolverhampton has a lower take-up than the national average in all three. Increasing take-up of screening programmes will therefore be an important part of our activity in 2019/20 through:

- Working collaboratively with Public Health England, Bowel Cancer Screening Hub, Breast Screening Service and Cancer Research UK (CRUK) to develop robust plans to support GP Practices, Healthy Living Pharmacies and the wider community to increase cancer screening uptake;
- Working collaboratively with other primary care staff including Healthy Living pharmacy staff care navigators and practice cancer champions; and
- Delivering targeted education events.

Three priorities have been defined for cancer services in Wolverhampton which will be achieved through eight key actions (figure 6). These support the delivery of National Cancer Standards and West Midlands Cancer Alliance

priorities and are aligned with the STP and national cancer priorities (appendix B).

Priority 1: Reduce the growth in the number of new cancers

Key Action:

- Promote, encourage and empower people to adopt healthier lifestyles

Priority 2: Improve survival of people diagnosed with cancer in Wolverhampton

Key Actions:

- Increase diagnosis through screening programmes before signs and symptoms appear
- Empower patients to present early with cancer signs and symptom
- Support primary care to manage patients in accordance with best practice
- Ensure prompt access to diagnostic tests and referral pathways

Priority 3: Improve the quality of life of patients after treatment (access to the Recovery Package and other support)

Key Actions:

- Provide individualised care and support to cancer patients
- Reduce risks and improve long term outcomes amongst those diagnosed with cancer
- Monitor progress and performance of the strategic aims

Figure 6: Wolverhampton Cancer Strategy priorities and actions

Year one priorities:

This is a five-year strategy so it will be necessary to focus on improving identified areas in 19/20 to support the delivery of future years. These priorities for year one will be:

- Develop robust QOF+ to support the increase in screening uptake and early diagnosis / develop robust communication and promotion plan;
- Improve cancer waiting time standard 62-day RTT and review root cause analysis;

- Support the implementation of nationally agreed rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers; Cancer Alliance priority to include Upper Gastrointestinal cancers;
- Improve patient experience and quality of life outcomes / continue with patient engagement ;
- Further develop and implement Risk Stratified follow-up pathways for breast cancer;
- Continue 104-day harm review to identify any physical or psychological harm to patients;
- Continue to deliver 28-day target;
- Monitor performance and capacity;
- Continue dialogue across cancer teams.

5.4 Mental Health

Summary

Patients in the Black Country will benefit from both localised and system-wide approaches to mental health services. The CCG, during 2019/20, is focused on delivering against its mental health commissioning strategy which has a stated intention to deliver a Mental Health Integrated Care System and close gaps in service provision across our footprint, working with partners to support the clinical priorities set by the STP outlined below.

Mental health services at the STP level

The STP has described a vision for mental health services that provide patients with **access to universal and specialist mental health and mental wellbeing initiatives that improve the quality of life chances and opportunities**. This has informed the triple aim opportunities of:

- **Better Health:** Improved access to universal and specialist mental health and mental wellbeing initiatives, with increased focus upon prevention and early intervention at key moments in life, reducing levels of complexity and chronicity including physical health and improving the quality of life chances and opportunities;
- **Better Care:** Improved access to integrated health and social care initiatives including focus on primary care mental wellbeing and the wider determinants of mental ill health in individuals, families and communities;

- **Better Value:** Transformed outcomes, experience and reduced demand on mental and physical health secondary and tertiary services. Releasing savings through reductions in inappropriate out of area placements.

Early priorities to deliver this vision have been defined as:

- Identify services that will benefit from being jointly commissioned at the STP level;
- Deliver against the STP Mental Health ‘One Commissioner’ project on a page.

Mental health services in Wolverhampton

The table below shows the number of people affected by mental health problems based on Wolverhampton’s 2011 census total population of 248,470, of whom adults are 186,508.

	Prevalence	Wolverhampton
Number of people at risk of mental health problem	250/1,000	46,627
Of those at risk attending GP	230/1,000	42, 897
Subsequently diagnosed as having mental health problem	130/1,000	24,246
Referred to Specialist Mental Health Service	20-30/1,000	5,595
Admitted to Mental Health Hospital	<10/1,000	1865

Table 4: Prevalence of mental health problems in Wolverhampton

We have worked with services users and carers to develop an outcomes-based system of care with an agreed and cohesive set of values which includes:

- Responsiveness kindness and compassion – being helpful, making every contact count;
- Professionalism, effectiveness and accountability, seamlessness;
- Self-efficacy, learning, growth, self-expansion and recovery;
- Supporting personal aspirations, hopes, dreams, goals and purpose including a focus on practical things – housing benefits employability.

We have recently developed a new Mental Health Commissioning Strategy (MHCS) that outlines our **seven priorities**:

Priority	Detail
1. Closing the treatment gap	Improving access to evidence-based quality services and improving access to and responsiveness of services including referral to treatment and waiting times
2. Closing the data quality gap	Improving Data Quality
3. Closing the mortality gap	Integration of mental and physical health
4. Closing the parity of esteem / funding gap	Maintaining the CCG's commitment to Mental Health Investment Standard
5. Closing the early intervention and prevention gap	Improving the Wider Determinants of Mental Health
6. Closing the information gap.	Delivering an information revolution - working with all key stakeholders to ensure that together we have a joined-up approach to information sharing, advice and guidance, navigation, communication, marketing and engagement
7. Closing the workforce gap.	Delivering a workforce plan in line with Stepping Forward to 2020 to develop capacity and capability across our services

Table 5: WCCG Mental Health Priorities

The **15 goals of our MHCS** outline our implementation plan of service re-design across universal, primary, secondary and tertiary services, including commissioning of a new service model for mental health and dementia community and in-patient services across mental health urgent and planned care. This includes our work with local authority and provider colleagues as part of the Better Care Fund (BCF: see section 5.6) to ensure we deliver early intervention and prevention across the life span, pro-active support at times of crisis and ill health and on-going support to deliver admission avoidance, helping people to stay well and achieve and maintain personalised recovery.

This MHCS describes our plans to develop our Mental Health Integrated Care System and close gaps in service provision across our footprint, working with partners across our STP to deliver evidence-based services of critical mass and at scale and pace delivering value for money and avoiding unnecessary duplication of costs. **Further evidence of alignment between national, STP and local planning around mental health is described in appendix C.**

5.5 Adult Learning Disabilities and Autism

Summary

People with LD and/or autism in the Black Country will benefit from both localised and system-wide approaches to LD and autism services. The CCG, during 2019/20, is focused on providing support and services that increase the opportunities for people to live valued lives in their communities, as well as sharing best practice and learning across health and care as to working with patients with LD and/or autism. Working with partners across Wolverhampton is integral to this and this activity will support the clinical priorities set by the STP outlined below.

Learning disability and autism services at the STP level

The vision for services in the STP is for **those with learning disability and/or autism to be seen as citizens with rights, who should expect to lead active lives in the community**. The triple aim opportunities to support this include:

- **Better Health:** The Transforming Care Partnerships (TCP) programme will result in people with a learning disability and/or autism seen as citizens with rights, who should expect to lead active lives in the community;
- **Better Care:** The TCP programme will improve the quality of life for people with a learning disability and/or autism. The right specialist community services will be in place to allow service users to benefit from maintaining links with their local support network and family;
- **Better Value:** The reduced reliance on bed-based care, reduced A&E attendances, fewer inpatient admissions and fewer delayed discharges of care will release costs; expensive out of area placements can be reduced.

Early priorities to deliver this vision have been defined as:

- Reduce premature mortality by improving emergency department education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism;
- Share learning across emergency departments and maximise the use of out-of-hospital interventions to provide alternatives to emergency attendance.

Learning disability and autism services in Wolverhampton

Our vision remains to support citizens with learning disabilities to be equal citizens, leading valued, healthy lives as contributing members of their local communities.

We will continue to implement our ambitious plans to transform care and support for people with learning disabilities by delivering our Transforming Care Delivery Plan, developed across the Black Country, and in response to the national plan: *Building the Right Support*.

Building on learning from Wolverhampton's Intensive Support Service (ISS), in 2018/19 **we have commissioned Intensive Support across the Black Country, with extended hours of operation, and planned weekend working**. We have also commissioned a specialist health forensic learning disability team across the Black Country, and this new service is working in partnership with Wolverhampton's dedicated learning disability forensic social work team to ensure that care and treatment delivers good outcomes and works to clear timescales.

We have also developed a forensic Supported Living Framework (SLF) **to support the timely discharge of citizens with forensic needs into highly specialist community placements**. These new services will be reviewed in 2019/20 in order to further develop them and ensure that they are meeting needs effectively.

We will continue to develop our Transforming Care Quality Dashboard (TCQD) by rolling out recently developed citizen questionnaires, a quarterly self-assessment tool for both community and inpatient providers, and by **using data and system intelligence to support us to improve the quality, safety and effectiveness of services, and improve both citizen experience and outcomes**. The principles of stopping the over medication of people with a learning disability, autism or both (STOMP) will be fully embedded and reflected in this dashboard, with careful monitoring of medication, a clear emphasis on reducing restrictive practices and developing a workforce which has positive behaviour support as its ethos.

We will review and re-specify the specialist health community learning disability teams in 2019, with a revised agreed specification across the Black Country in order to deliver consistent, evidence-based care and support.

We will use the recently developed risk registers and enhanced multi-disciplinary working **to plan robust care and support with people with learning disabilities who are at risk of coming into hospital, or coming into contact with the**

criminal justice system, with strong Care and Treatment Reviews supporting decision-making and planning.

We will continue to place emphasis on designing individual solutions, and creatively meeting needs, and will enable more people to take control of their care through using personal health budgets in order to achieve this (see section 8). Increasing the number of annual health checks completed, and reviewing their quality and effectiveness are key actions in 2019, in addition to continuing to embed and learn from the Learning Disabilities Mortality Review (LeDeR) programme through membership of the steering group and quality and consistent planning around LeDeR reviews.

We will work with our NHS providers to ensure that they have robust plans in place to deliver awareness raising with their workforce, agree how the impact of this will be evaluated, and how such awareness raising could be shared more widely. We will continue to support work between our acute provider, primary care and specialist health to ensure that people with learning disabilities have the opportunity to have a digital flag in their patient record to alert clinicians to high risk clinical or behavioural issues to help them to support their care through reasonable adjustments.

Further evidence of alignment between national, system and local planning for learning disability and autism services can be found in appendix D.

5.6 Primary Care and Community Health Services

Summary

Patients in the Black Country will benefit from both localised and system-wide approaches to primary care and community services. The CCG, during 2019/20, is focused on developing our PCNs, wrapping community services, mental health services and social care around them to provide the populations they serve with a holistic model of care to ensure they receive the right care quickly and help them stay closer to home. Working with partners across Wolverhampton is integral to this and this activity will support the clinical priorities set by the STP outlined below.

Primary and community care at the STP level

The vision for primary care in the STP is for **patients to have access to resilient, accessible primary care**. The triple aim opportunities for primary care identified in the STP clinical strategy are:

- **Better Health:** Involving GPs in commissioning discussions and decision making enables new approaches to prevention and management of ill health for our population;
- **Better Care:** Networks supporting local populations will allow the provision of personal care. Move from disease management alone, towards prevention, wellbeing and self-care, optimising patient outcomes;
- **Better Value:** Rebalancing the investment between primary and secondary care providers makes sense as optimising the use of out of hospital services averts the current waste.

Early priorities to deliver this vision have been identified as:

- Develop and deliver a collective STP programme of work that fulfils the requirements of the *GP Forward View*;
- Have dedicated resource to implement the programme;
- Work with national bodies to ensure available funding is accessed and deployed across the STP;
- Continued engagement with general practice;
- Continue to implement the STP workforce strategy to support sustainability within primary care;

Primary and community care in Wolverhampton

The LTP confirmed a £4.5 million uplift to primary medical and community health services, placing key responsibilities on PCNs to improve out-of-hospital care.

As a CCG, we want to design and commission primary and community care services that:

- Reduce hospital admissions and provide more care closer to home through community-based services, improving coordination and access;
- Give us more responsibility for GP services;
- Focus on preventing illnesses, working with public health to look at lifestyle factors that increase the risk of ill-health;
- Give patients better access to GPs as well and innovate to reduce pressures on GPs; and
- Deliver seamless health and social care through closer collaboration with the City of Wolverhampton Council.

Primary Care Strategy

We implemented a five-year primary health care strategy in 2016 that stated as its vision to **achieve high quality out of hospital care which is accessible to everyone.**⁸ This will, in turn, promote the health and wellbeing of our local community. We want to ensure that the right treatment is available in the right place at the right time and to improve the quality of life of those living with long term conditions and reduce health inequalities.

This strategy will be refreshed in 2019/20 to reflect the activity described in this section.

Governance arrangements

In Wolverhampton our GP Practices have split into four different groups to help us shape primary and community services for the future. A group of eight practices have joined with our local NHS Trust, RWT, as part of a vertical integration programme. Part of vertical integration is a greater level of back office support which will take care of the business element of general practice. All staff, including the GPs of these practices, have become employees of RWT. All other practices in Wolverhampton are aligned to three further groups. These groups are Unity Limited, Wolverhampton Total Health and Wolverhampton Care Collaborative. Each group is a limited company and are working towards the principles of the Primary Care Home Model (NAPC).⁹

This approach enables access to services to improve whilst practices work together to share their workforce and become more resilient in the services they deliver. This means that patients may access services through practice group hubs and shared teams across practices. The introduction of care hubs will help to increase access as well as co-ordinate care so that, where possible, care can be given closer to home and in a community setting.

The CCG is committed to supporting each model of care to help streamline patient pathways, deliver more care in the community and aid the development of the ICA.

Primary Care Investment

⁸ WCCG, *Annual Report 2017/18*.

⁹ <http://napc.co.uk/primary-care-home/>

In addition to the £3 per head invested during 2017/18 and 2018/19, the CCG has committed £500,000 each year into the support, mentoring and training of practices, as well as engagement and development of our PCNs. Support and development of at-scale working and provision of services and other funding from both local budgets and national funding streams have enabled leadership and development training to be made available to practice teams and staff groups to allow their skills and competence to be further developed and strengthened.

In 2019/20 and 2020/21 the CCG will fund £1.50 per patient in line with the national Directed Enhanced Services (DES) to enable PCNs to flourish.

Primary Care Network Development

The integration of out-of-hospital services is central to our ambitions for 2019/20, reflected by the co-dependency of primary and community care in this operating plan. The main priorities for community services for the coming year are highlighted in figure 7.

Priority 1 – Wrapping community services around PCNs

There is currently one co-located community team in Wolverhampton with social care, community and district nursing, mental health, social prescribing and housing. We will be looking to deliver two more in 19/20 to address wider determinants of health. These teams will become more closely aligned with PCNs.

Priority 2 - Delivering an appropriate Multi-disciplinary Team (MDT) model for Wolverhampton

We are presently running pilot schemes for MDTs at selected sites in Wolverhampton. Based on the learning from these pilots, a model for MDT working will be rolled out across the PCNs. QOF+ funding will be used to support this.

Priority 3 – Shifting services out of hospital into community settings

During 19/20, services that can be appropriately shifted from hospitals into community settings will be identified and business cases for the change developed with a view to first significant shifts in 2020/21.

Priority 4 – Support delivery of ICA priority clinical pathways

Four pathways have been prioritised for 2019/20: frailty, end-of-life, children and young people and mental health.

Figure 7: Community Care priorities for WCCG 2019/20

As part of our activities around integration of services we will be reviewing which CCG activities might be better delivered at the STP level. During 19/20 the following areas of work will be considered as opportunities for working at scale:

- QOF
- Digital technology
- Progress against the 10 High Impact Actions¹⁰
- Supporting people living with long-term conditions to self-care
- Accessibility of primary care including:
 - Extended access
 - GP capacity
 - Communications
 - Inequalities

Further evidence of alignment between national, system and local planning for primary care and community services can be found in appendix E with the note that the local strategy is being refreshed in 2019/20.

Better Care Fund

The BCF provides an opportunity to develop a single pooled budget to allow health and social care services to work together more closely. Wolverhampton's Better Care Plans are an integral and important component of our vision for services in Wolverhampton.

The CCG will continue to work together with partners in an integrated way, aiming to improve pathways and services for patients, moving care closer to home where appropriate.

The BCF's vision statement is to:

'Provide individuals and families in Wolverhampton with the services, methods and knowledge to help them to live longer, healthier and more independent lives no matter where they live in the city. Health & Social Care colleagues will work better together, alongside local community organisations to deliver support closer to where individuals and families live and in line with their needs.'

There are five workstreams within the programme:

- Adult Community Care

¹⁰ <https://www.england.nhs.uk/gp/gpfv/redesign/gpdp/>

- Mental Health
- Dementia
- CAMHS
- Integration

Within these workstreams are a number of projects that will be delivered during 2019/20:

Adult Community Care

- Continued implementation of People Living with Frailty Programme;
- Continued review and redesign of community services programme;
- Managing transfers of care and reducing length of stay;
- Development of community neighbourhood teams including co-location of remaining two localities and expansion of MDT working;
- Admission avoidance programme.

Mental Health

- Implement new community pathways/services based on gap analysis of existing services (including prevention);
- Implement integrated models for mental health.

Dementia

- Review and refresh of joint dementia strategy;
- Implementation of dementia strategy.

CAMHS

- Workforce development to be continued;
- Mapping of all services available to CYP for emotional mental health and wellbeing, giving consideration to all commissioned services by both NHS and Local Authority;
- Introduction of a pilot for self-referrals for parents of all CYP and those aged 14+ to begin in Oct 2019.

Integration

- Continued delivery of integrated health and social care record;
- Continued review and development of Data Sharing Agreements across BCF;
- Joint communications and engagement activity;
- Manage any estates requirements of the programme;
- Oversight of finance and performance of the programme.

5.7 Children and Young People's Services

Summary

Patients in the Black Country will benefit from both localised and system-wide approaches to CYP services. The CCG, during 2019/20, is focused on developing services for CYP specifically relating to maternity and neonatal, mental health, learning disability and/or autism services, as well as avoiding unnecessary hospital admissions and keeping care closer to home. Working with partners across Wolverhampton is integral to this and this activity will support the clinical priorities set by the STP outlined below.

Children and young people's services at the STP level

The STP has set out a vision for CYP services **that they are in good physical and mental health, enabling them to become independent and productive members of our society**. The triple aim opportunities have been identified as:

- **Better Health:** To ensure that CYP in the Black Country are in good physical and mental health;
- **Better Care:** CYP receive care as close to home and their social networks as possible; and
- **Better Value:** Maximise opportunities for high value interventions such as prevention and proactive care and disinvest in low value interventions such as reactive care in an emergency.

Early priorities to deliver this vision have been identified as:

- Invest in services for CYP;
- Identify good practice across the STP and nationally in relation to CYP services with positive outcomes;
- Expand scope of safeguarding across STP.

Children and young people's services in Wolverhampton

The LTP has set a clear ambition to improve the mental and physical health of CYP. Specifically, the LTP has defined health priorities that require CCG response as:

Maternity and neonatal

- Improve continuity of care
- Expand roll-out of maternity digital care records

- Improve access to perinatal mental health
- Improving access to postnatal physiotherapy
- Redesigning and expanding neonatal critical care services

Mental Health

- Expanding mental health services for CYP
- Improving access to mental health services
- Embedding mental health support in schools and colleges
- Developing support around the transition to adulthood

Learning disability and autism

- Tackling the causes of morbidity and preventable deaths
- Better understanding of the needs of people with learning disabilities or autism
- Increasing investment in intensive, crisis and community support
- Improving the quality of inpatient care

CYP with cancer

- Providing children with cancer whole genome sequencing
- Supporting CYP to take part in clinical trials
- Offering boys aged 12 and 13 HPV vaccination

Redesigning other health services for CYP

- Improving childhood immunisation
- Reduce A&E attendance of CYP
- Improving quality of care for children with long-term conditions
- Providing more paediatric critical care and surgical services as close to home as possible

We have already set in train services to support CYP and will continue to develop our interventions during 2019/20. In particular:

Maternity and Neonatal

- Deliver Better Births: tackle infant mortality, identify foetal growth restriction, address reduced foetal movements, collaborative cross boundary working, women-centred clinical pathways as directed by NICE;
- Saving Babies' Lives Care Bundle: objective to halve stillbirth rates, neonatal and maternal deaths and brain injuries by 2030, reduce premature mortality

rates, support breast feeding, reduce obesity and diabetes, reduce smoking in pregnancy;

- Personalised Care Planning: early contact, improved patient choice, continuity of carer, single point of access, single digital patient health record, enhanced community engagement;
- Reduce health inequalities: improve experiences and outcomes for groups such as migrants, asylum seekers and refugees, deprived communities, seldom heard communities.

Mental Health

- Continue to expand mental health services for CYP, resulting in easier access with young people over the age of 14 and their parents/carers being able to self-refer into services by October 2019;
- Continue to embed the new emotional mental health and wellbeing service as well as the digital online counselling offer across the city;
- The workforce development offer will enable staff working with CYP in schools and colleges to have more confidence when supporting them with their mental health needs;
- Continue to ensure that the transition process for CYP from CAMHS to adult mental health services is a smooth process and one where they are aware of what the expectations of the service will be going forward.

Learning Disabilities and Autism

- We will participate fully in the LeDeR process to ensure that we understand the causes of morbidity and preventable deaths for CYP with learning disability and/or autism;
- Our young people will be supported to ensure that they grow to live as equal citizens, leading valued, healthy lives as contributing members of their local communities;
- We will use the recently developed risk registers and enhanced multi-disciplinary working to plan robust care and support with CYP with learning disabilities and /or autism who are at risk of coming into hospital, or coming into contact with the criminal justice system, with strong care, education and treatment reviews supporting decision-making and planning;
- A pilot project is currently being run to establish what an intensive support service for CYP with autism and/or learning disability may look like which on evaluation will help us to develop our long term intensive support services offer in the community for this vulnerable group of young people and look to

prevent admission to a Tier 4 mental health hospital or the criminal justice system.

Avoiding hospital admissions and delivering care closer to home

- We will increase the number of immunisations to CYP who have missed or were not offered the BCG vaccine at birth, particularly in line with the immunisation against infectious diseases guidance;
- We are keen to ensure that CYP are seen in the right place, at the right time and by the right people so work is being undertaken to establish what service could be commissioned to support reducing the number of CYP who attend A&E.
- Develop work around the 'Big Six' which refers to the six most common conditions/symptoms that can cause CYP to present for emergency and urgent care. This guide will promote evidence-based assessment and management of unwell CYP for the most common conditions when accessing local NHS services in an emergency or urgent scenario. There will be a development of joint clinics between primary care staff and secondary care staff to support care closer to home.

5.8 Longer term deliverables

The preceding sections have outlined our commissioning plans for 2019/20 across a number of areas and themes. **In addition to these, reducing health inequalities forms part of a long-term objective for the CCG.** To this end, we have, with CWC, developed a Joint Health and Wellbeing Strategy 2018-2023¹¹ that sets out the following priorities:

- Early Years
- CYP mental wellbeing and resilience
- Workforce
- City Centre
- Embedding prevention across the system
- Integrated Care; Frailty and End of Life
- Dementia friendly city

¹¹ WCCG and CWC. *Wolverhampton Joint Health and Wellbeing Strategy 2018-2023*. 2018.

The strategy highlights the importance of collaborative working in making a positive impact in these areas, and also aligns this work with the Wolverhampton Public Health vision for 2030.¹²

6. Workforce

There are several workforce strategies being implemented by WCCG during the course of 2019/20.

Primary care workforce strategy

Our shared vision across the STP is to develop and sustain a workforce built around the needs of our population, which has the skills, knowledge and values to transform at scale and deliver high quality care within Wolverhampton. **Primary Care will be delivered across primary care networks, across multidisciplinary integrated teams, 7 days per week offering prevention and treatment services to reduce demand, integrated with partners and Local Authorities.** This vision is supported by a primary care workforce strategy that is itself informed by the *General Practice Forward View*.

Central to the STP programme of work is to introduce the new roles that will lead to delivering our PCNs that are central to our own ICA in Wolverhampton, as well as provide for additional investment in current staff. Figure 8 provides an example of the transformed workforce described by the STP primary care workforce strategy:

¹² CWC. *The vision for Public Health 2030. Longer, healthier lives*. Undated. Available at <http://www.wolverhampton.gov.uk/CHttpHandler.ashx?id=15370&p=0>

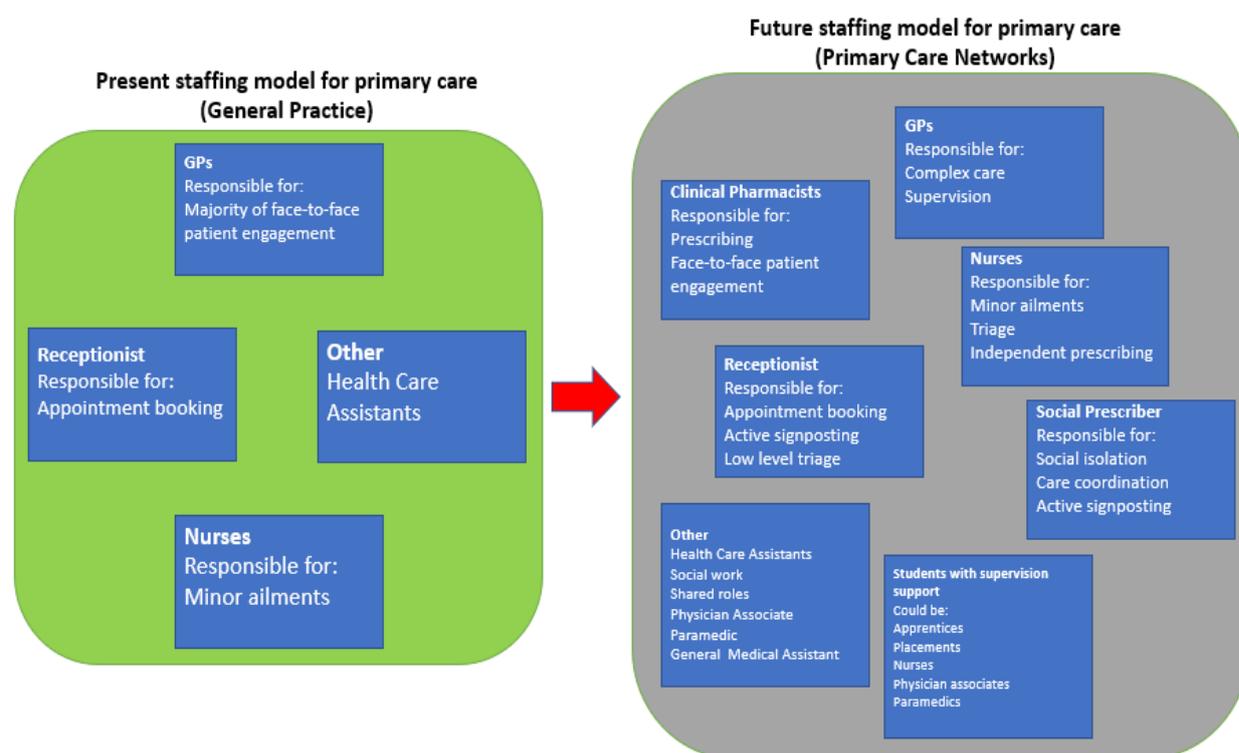


Figure 8: Primary Care workforce transformation

As a CCG our mission is to lead workforce planning locally, and during 2019/20 we will make decisions with our partners as to which funding and service delivery decisions will be best made at the STP level, and which should stay with the CCG. Wolverhampton CCG will continue to support and enable primary care workforce development through new ways of working. Access to innovation funding, commissioning and piloting of new roles and building relationships with other partners to ensure workforce development are key enablers for transformation. **We have developed a retention plan and are learning from intensive support to recruit and retain GPs and nurses.**

Mental health workforce strategy

Delivering the required workforce to respond to the national mental health workforce plan¹³ is a core component of our MHCS. At a national level, this should include an expansion in the capacity and capability of the CYP workforce, building towards 1,700 new staff and 3,400 existing staff trained to deliver evidence-based interventions by 2020/21.

¹³ HEE. *Stepping forward to 2020/21: The mental health workforce plan for England*. 2017. Available at https://www.basw.co.uk/system/files/resources/basw_62959-3_0.pdf

We will also support the development of the next generation of practitioners and leaders through continued participation in the Think Ahead programme for social workers working in mental health and other areas across the NHS.

Child and adolescent mental health services workforce

Consideration of the workforce required in future CAMHS services forms part of the discussion in the Wolverhampton *CAMHS Transformation Plan Refresh 2018-2020*.¹⁴

The main focus is to contribute to the national plan through the creation of new roles which will increase access to services at a much lower level rather than waiting for the child/young person to become so ill that they require significant specialist intervention.

Staff increases for 2019/20 are planned in the Emotional Mental Health and Wellbeing service and Neurodevelopmental service.

STP Workforce Strategy

The STP are developing a system-wide workforce strategy with the objective of recruiting and retaining a workforce that contributes to achieving a sustainable health economy. This will continue to be developed and implemented during 2019/20.

7. Data and Technology

We have pursued a strategy to identify and adopt new technologies that can benefit patients and staff in the Wolverhampton health economy. **We were one of the first CCGs to implement GP Remote Consultation for GP Practice groups**, which supports extended opening hours and the ability of clinicians to hold and record consultations with patients from any of the practices within the federated GP Groups. The development of online consultation follows the trend of the CCG implementing new technologies for patients and builds on the CCG being the first to fully implement free NHS patient Wi-Fi .

For the coming year we have a large portfolio of work. This includes:

- The provision of a texting solution that increases the range of texts that we can send to patients while allowing patients to cancel appointments by text;

¹⁴ Available at

<https://wolverhampton.moderngov.co.uk/documents/s87953/Wolverhampton%20CAMHS%20Transformation%20Plan%20Refresh%202018%20v6.pdf>

- An ambitious project to migrate to Windows 10 from Windows 7; we aim to migrate to the new operating system over the next 18 months, ensuring that the migration is complete before Windows 7 goes end of life on 14 January 2020;
- We have secured additional funds through the Estates and Technology Transformation Fund (ETTF) scheme to continue the development of the insight shared care record. This will support the CCG working closely with Walsall and the use of EPaCC's (End of Life Care Plans) across all care settings;
- Working with the STP we have successfully bid and received funding to upgrade our electronic document management solution (Docman) to the latest cloud-based solution;
- Continue to register patients for online services at each GP practice (current target 30% coverage);
- The CCG continues to support GP practices through the provision of servers, switches, printers, scanners, monitors, laptops and PCs. This is done on a rolling 5-year replacement scheme that ensures that the IT infrastructure within the CCG is current and fit for purpose;
- The CCG is embarking on a new network redesign to improve on the old N3 broadband lines and installing ultra-fast 100mb leased lines to connect the GP practices to the network. This will improve access speeds for clinical systems but will also support the development of online triage and video consultations through provision increased bandwidth. The ultra-fast network backbone will also support practice work across sites in federated groups and support hub working; and
- Updated patient auto-arrival solution: the CCG will be looking to improve the existing solution to update the software from local isolated media players and windows touch screen to hosted central managed cloud estate using Jayex Connect.

Local Digital Roadmap

The digital priorities for the CCG are aligned closely with those of the STP, which has a stated vision of a **digitally connected Black Country Health and Social Care System that enables self-care and promotes wellbeing**. This vision is focused on the following digital themes:

- **Empowerment:** Through the use of technology there will be patient and citizen access and contribution to their health and care records;

- **Infrastructure:** A resilient infrastructure across the Black Country health and social care economy enabling access to required information to support decisions from anywhere, aiding place-based working;
- **Integration:** Creating opportunities for systems to be interlinked across the STP, with the potential for further integration in the future; and
- **Intelligence:** Development of robust business intelligence across the Black Country to support decision making and identification of best practice models leading to improved patient care.

One of the key aims underpinning these themes is interoperability. This allows for variation in delivery mechanisms for digital technologies across the STP whilst ensuring the ability to exchange information; to provide a single consolidated view of the patient in the context in which the patient is being viewed, supporting operational excellence within our new models of care.

The CCG have been a key driver in the development of the STP SharePoint solution that is already used by the STP PMO team, Transferring Care Partnership, Joint Commissioning Committee and Local Maternity System team. Plans are in place to expand this to the Local Digital Roadmap and other groups in the coming year. The development has been made possible by the support of the ETTF funds that have supported the online solution for a further 3 years.

NHS App

In 2018, we were one of the private beta testers for the NHS App and will continue to support its uptake amongst patients.

8. Personal Health Budgets

Personal health budgets (PHBs) are part of a wider drive to personalise health, social care and education set out clearly in the LTP:

‘Within five years over 2.5 million more people will benefit from “social prescribing”, a personal health budget, and new support for managing their own health in partnership with patients’ groups and the voluntary sector’.

We are committed to meeting the increased targets for PHBs, as set out for us by NHSE.

We are currently developing plans and a work programme to help us address some of the challenges experienced to date and reaching these additional numbers. In line

with the NHSE directive to make PHBs the default position for continuing healthcare (CHC) we will have a standard PHB offer for all new and existing CHC cases from February 2019.

Other priority areas we will be focussing on during 2019/20 are Education, Health and Care (EHC) plans, wheelchairs, Section 117 aftercare¹⁵ and joint packages of care that involve a health element.

The programme will bring focus and momentum identifying and engaging with key staff leads with local knowledge and experience who will be responsible for having ongoing ownership and oversight of PHBs in their work area. Additional training and awareness of PHBs for staff that require this will be provided.

We will be working closely with providers and the wider market to help shape additional options for budget holders that will promote greater choice and control.

Personalised Care

The Black Country STP is a Demonstrator Site for personalised care. Wolverhampton CCG is committed to this programme of work which includes:-

- Personalised Care Plans
- Health Coaching
- Social Prescribing
- Peer Support
- Structured Self-Management / Education Sessions
- Patient Choice
- Co-production
- Workforce Development

The work already underway with Care Closer to Home, community neighbourhood teams, MDT and integrated working all supports this national and local drive for personalised care.

9. Medicines Optimisation

The CCG has a medicines optimisation strategy for 2019-2021 that sets out the following aims:

- Ensure opportunity for patients to be involved in 'shared decision making' about their medicines i.e. a collaborative process through which a clinician supports a patient to reach a decision about their treatment;

¹⁵See <https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/section-117-aftercare/#.XFxe-Vz7SUK>

- Evidence based cost effective prescribing;
- Medicines optimisation is considered in all commissioning arrangements;
- Medicines optimisation Quality, Innovation, Productivity, Prevention (QIPP) delivery;
- Work with stakeholders to ensure medicines optimisation is part of routine practice; and
- All medication is used safely.

For 2019/20, these aims have been distilled into the following priorities for the CCG to maximise value from medicines:

- Reviewing repeat prescription management systems;
- QIPP delivery;
- Continuing to maximise uptake of biosimilars;
- Continued implementation of over the counter medicines guidance and the drugs of limited clinical value;
- Expanding our current provision for medicines reviews in care homes;
- Continued focus on appropriate prescribing of antibiotics in line with AMR;
- Support and facilitate nutrition reviews.

These objectives align with the medicines optimisation and pharmacy agendas for the STP and LTP in that they:

- Promote evidence-based cost-effective prescribing;
- Improve safety;
- Encourage shared decision-making; and
- Continually implement polypharmacy reviews.

10. Quality

We will maintain a strong emphasis on a system-wide approach to quality assurance and safety improvement through our quality and safety strategy which will be reviewed on the basis of the LTP in 2019/20. Our work focuses on avoiding and reducing avoidable harm in health and care and where harm has occurred, ensuring timely, transparent reporting and robust processes to ensure local and system-wide learning is critical. Learning from local and national incidents and inquiries is key to ensuring safer services for our population.

Contracts with provider organisations provide a basis to drive improvement and we have revised our contract schedules for 19/20. Scrutiny of the quality of care is undertaken in a consistent way by the CCG and includes a number of quality

assurance arrangements, which are used to collate and triangulate information gathered. These include formal meeting arrangements with provider organisations, announced and unannounced visits, patient and partner feedback, use of 'soft intelligence' and working in a collaborative way with regulators, including CQC, NHSE and NHSI. We also have an opportunity to share our intelligence at Quality Surveillance Group, which is a regional group convened to share best practice and escalate any particular system wide issues of concern.

Emerging priorities for 2019/20 are:

- Reviewing mortality rates within 30 days of discharge;
- Reviewing cases of sepsis and patient deterioration;
- Support to care and residential homes from quality nurse advisors;
- Ensuring adherence to national CHC contract;
- Working with schools to assure support and services for CYP with SEND;
- Strengthen the monitoring of Safeguarding Children and Adults arrangements in all commissioned services;
- Continue to work closely with providers to strengthen reporting arrangements for our Looked After Children to ensure strategic oversight and enable more robust challenge, implementing any changes through the contract.

11. Engagement

We recognise that robust engagement processes and procedures will be essential to ensuring we meet our operational priorities. We remain committed to engaging with local people and communities in a meaningful way that enables us to understand their needs and improve their experience of care.

Over the past 12 months, as part of our Black Country STP, we have worked with partners across the health and care system to develop Black Country-wide systems and processes. This is enabling us to involve local people in Black Country-wide service change, for example around learning disabilities and local maternity services. We will build on the collective work we have undertaken with partners so that we continue to play our part in delivering integrated care by place and across the Black Country. In this way, we will ensure Wolverhampton residents have a role in the developing health and care landscape and that their voices are heard.

The development of place-based care through PCNs will be an engagement priority for the CCG over the coming year. We will also continue to work with a range of patient and community groups including: HealthWatch, Citizen Forum, Wolverhampton Voluntary Sector and our Patient Partners. We will draw on a range of two-way communications channels and engagement techniques to reach and listen to our target groups, including:

- Regular stakeholder mapping – to refine our understanding of the communities we need to engagement with;
- Outreach activity such as events and roadshows;
- Press and PR including regular content for print and broadcast media, where appropriate;
- Social media;
- Newsletters and other communications collateral; and
- Surveys and formal consultations

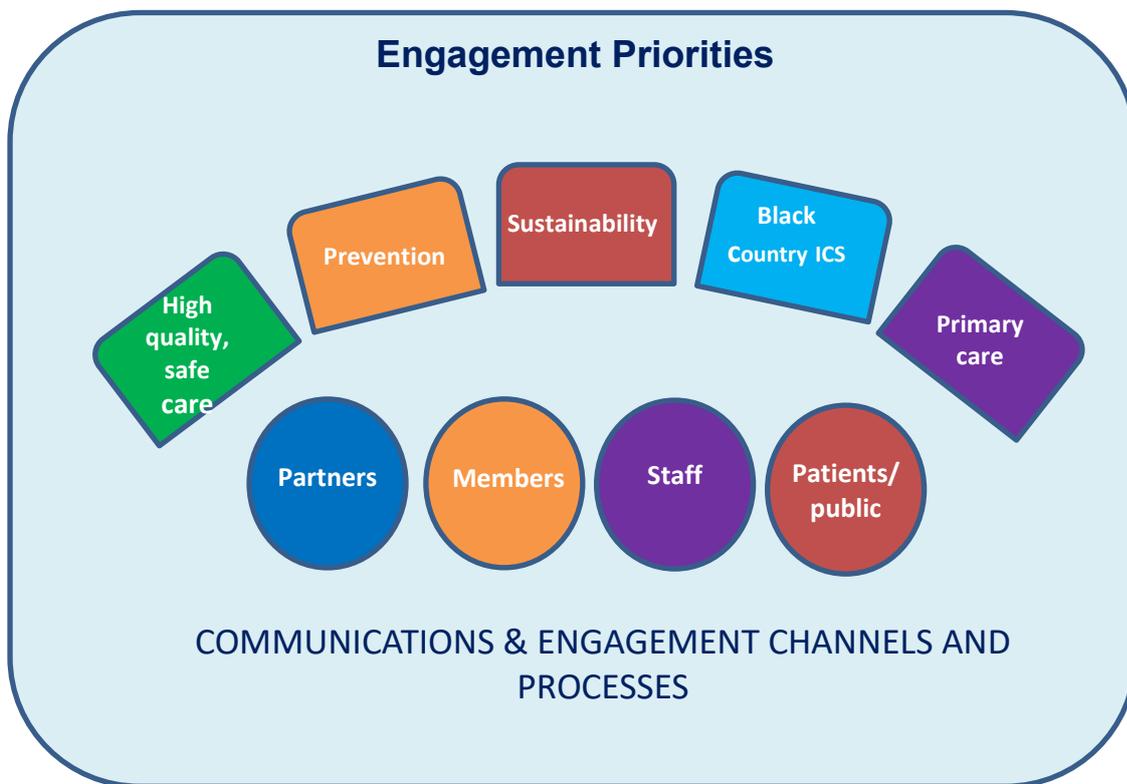


Figure 9: WCCG engagement priorities

12. Risks

The CCG monitors the potential risks to its activities at a strategic level through its corporate risk register. Those presently considered are presented in appendix A.

13. Concluding remarks

At the outset of this document we described the five priorities for WCCG for 2019/20:

- continue to commission high quality, safe healthcare services within our budget;
- focus on prevention and early treatment;
- ensure our services are cost effective and sustainable;
- Align our clinical priorities, as appropriate, to the Black Country STP/ICS;
- Build on our Primary Care Networks (PCNs), wrapping community, social care and mental health services around them.

This document has described the future national, system and local (place) context within which health and care will be delivered to populations. Incumbent within this future context is that organisations do not exceed their financial means by working at scale where appropriate and sharing risks and rewards. In section 4.2 the steps that will be taken to ensure financial sustainability have been highlighted and section 5 has demonstrated that within this financial settlement we can commission high quality, safe services locally that are cost effective and sustainable and align these services with partners through the emerging ICA, and also with the priorities set at the STP level.

Prevention will be a key feature of many of our commissioning decisions, particularly around cancer services, and PCNs will play an important role in acting before emergency intervention is required. To this end, this plan has described how primary and community care will be more closely integrated, with MDT models tested where a number of services will be mobilised to support patients in communities.

As has been alluded, during this year the building blocks must be secured for closer alignment between STP partners in view of transitioning towards an ICS. During 2019/20, we shall further develop our ambitions for more integrated working across Wolverhampton, as well as identifying and implementing opportunities for activity at the STP/ICS level.

Appendix A – Wolverhampton CCG Corporate Risks

Relevant Departmental/ Programme Risks & Committee Risk IDs	Title and Summary
QIPP: Delivery of Targeted GP Peer Review Scheme	<p><u>Failure to meet QIPP Targets</u> QIPP Delivery is vital to ensuring that the CCG meets its financial targets. A challenging QIPP target of 3.5% has been set equivalent to £14m in 2018-19</p>
	<p><u>Cyber Attacks</u> Cyber attacks on the IT network infrastructure could potentially lead to the loss of confidential data into the public domain if relevant security measures are not in place. There is also serious clinical/financial and operational risks should there be a major failure leaving the organisation unable to function normally. In such an instance, Business Continuity Plans would need to be enacted.</p>
Increased Activity at RWT 62 Day Cancer Target	<p><u>NHS Constitutional Targets</u> There is a risk that ongoing pressure in the system will lead to Providers missing statutory NHS Constitutional targets with the associated impact on patient outcomes</p>
	<p><u>EPPR Support</u> There is a risk that effective plans will not be in place for CCG and other agencies will not be in place</p>
Executive capacity	<p><u>New Ways of Working across the STP</u> The STP is complex and works across both providers commissioners and local authorities. This requires building new relationships and overcoming organisational barriers . Management capacity to fulfil new roles will be a risk to the CCG as well as the move to new ways of working with partners in a complex system</p>
	<p><u>BCF Programme Success</u> The Better Care Fund Programme is an ambitious programme of work based on developing much closer integration between NHS and Local Authority Social Care services. There are significant risks associated with the programme not meeting its targets both financially and for patient outcomes</p>
	<p><u>New Ways of Working in Primary Care</u> There are a number of issues with the developing new approach to working. This potentially puts at risk the benefits for patients and the prospect of system change</p>
Maternity Capacity & Demand	<p><u>Maternity Services</u> Following the decision to transfer a number of births from Walsall to Royal Wolverhampton Trust there have been consistently high midwife to birth ratios and there is a risk that the level of demand may affect the safety and sustainability of services</p>

Relationship with Local Authority Capacity of Public Health to contribute to strategic change Relationship with local providers Complexity of financial modelling	<u>Developing Local Accountable Care Models</u> The potential complexity of the developing new models locally will mean having to balance competing priorities for different organisations and against other drivers in the system to clearly articulate the rationale for change and the direction of travel. This means that there is a risk that the objectives of improving patient care and delivering financial stability across the system will not be realised
Workload pressures of STP Workload pressures - Black Country Joint Commissioning Committee Impact of unexpected events on overall workload CSU Capacity	<u>CCG Staff Capacity Challenges</u> The level of change across the system means that existing staff resources are stretched to contribute to change based work streams including Black Country Joint Commissioning, STP and local models of care in addition to existing responsibilities. This creates a risk that gaps will be created as well as the existing risk of recruiting sufficiently skilled staff to fill any vacancies that arise in an uncertain environment.
	<u>Governing Body Leadership</u> The recent changes in the CCG's Governing Body, including changes in the Executive Team and the resignation of the chair have created a risk that it will become more difficult for the Governing Body to provide clear strategic leadership as new individuals familiarise themselves with the CCG and the issues it faces.
Primary Care estate improvements	<u>Failure to secure appropriate Estates Infrastructure Funding</u> Much of the plans to improve services, particularly in Primary Care, is dependent on securing improvements in the facilities across Wolverhampton. There are a number of possible avenues for funding these improvements but there is a risk that the complex nature of the funding streams and the profile of the estate itself may put delivery of improvements at risk
Over Performance Acute Contract Prescribing Budget CHC Budget	<u>Failure to Deliver Long Term Financial Strategy</u> Recurrent Financial pressures across the system may make it difficult to deliver the CCG's financial plans for future years
Transforming Care - Financial Impact	<u>Transforming Care Partnership</u> There are a number of risks to the delivery of the Black Country Transforming Care Partnership's programme of work that cause result in a failure to deliver improvements in the quality of service for patients with Learning Disabilities
	<u>Insight Shared Care Record – Governance Arrangements</u> If robust governance arrangements are not put in place to support the implementation of the Insight Shared Care record then it may not be possible to deliver the intended benefits of the programme to support direct care for patients and improved population health planning in order to support overall strategic aims across the health economy.

Appendix B – Cancer priorities at national, system and place

Achieving World Class Cancer Outcomes	Black Country STP Clinical Strategy	Wolverhampton CCG and CWC Joint Cancer Strategy 2019-2024
Spearhead a radical upgrade in prevention and public health	Achieving the 62-day waiting time standard	Reduce the overall growth in the number of all cancer cases
Drive a national ambition to achieve earlier diagnosis	Implementing early diagnosis by 2020	Improve survival of people diagnosed with cancer
Establish patient experience on par with clinical effectiveness and safety	Improving patient experience, incl. through the national Recovery Package	Improve the quality of life of patients after treatment and at the end of life
Transform our approach to support people living with and beyond cancer	Improving patient experience, incl. through the national Recovery Package	Improve the quality of life of patients after treatment and at the end of life
Make the necessary investments required to deliver a modern, high quality service	Review options for collaboration between Walsall cancer unit and Wolverhampton cancer centre	
Ensure commissioning, provision and accountability processes are fit-for-purpose	Review options for collaboration between Walsall cancer unit and Wolverhampton cancer centre	

Appendix C – Mental health priorities at national, system and place

Mental Health Forward View	Black Country STP Clinical Strategy	Wolverhampton CCG Mental Health commissioning strategy 2018-2021
A 7 day NHS – right care, right time, right quality	Improved access to universal and specialist mental health and mental wellbeing initiatives	Closing the treatment gap
Building a better future		Closing the data quality gap
An integrated mental and physical health approach	Improved access to integrated health and social care	Closing the mortality gap
Creating mentally healthy communities	Transformed outcomes, experience and reduced demand on mental and physical health secondary and tertiary services	Closing the parity of esteem / funding gap
Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens/Prevention at key moments in life	Increased focus upon prevention and early intervention at key moments in life, including focus on the wider determinants of mental ill health	Closing the early intervention and prevention gap
Building a better future		Closing the information gap.
A 7 day NHS – right care, right time, right quality	Releasing savings through reductions in inappropriate out of area placements	Closing the workforce gap.

Appendix D – Learning disabilities and autism priorities at national, system and place

Building the Right Support	Black Country STP Clinical Strategy	Wolverhampton
Specialist multidisciplinary health and social care support in the community	The right specialist community services will be in place	Increased access to intensive support services
Where I live and who I live with and the right hospital services	People with LD and/or autism will be seen as citizens with rights, who should expect to live active lives in the community	Supported discharge into appropriate community placements for citizens with forensic needs
Mainstream health services and hospital services	Reduced reliance on bed-based care, reduced A&E attendances, less inpatient admissions and fewer delayed discharges of care will release costs	Better use of data to improve the quality, safety and effectiveness of services, and improve both citizen experience and outcomes.
Support to my family and paid staff	People with LD and/or autism will be seen as citizens with rights, who should expect to live active lives in the community	Review the requirements for the LD workforce and increase awareness of LD across health and care workforce
Mainstream health services and specialist multidisciplinary health and social care support in the community	The right specialist community services will be in place	Embed preventative work as part of MDT working
A good and meaningful life	Citizens will benefit from maintaining links with their local support network and family.	Increased agency for citizens through more personalised care

Appendix E – Primary and community care priorities at national, system and place

General Practice Forward View	Black Country STP Clinical Strategy	Wolverhampton CCG Primary Health Care Strategy 2016-2020
Expansion of workforce capacity	Networks supporting local populations will allow the provision of personal care.	GPs to provide a cradle to cradle prevention and treatment service
Support to strengthen and redesign general practice	Rebalancing the investment between primary and secondary care providers makes sense as optimising the use of out of hospital services averts the current waste.	There is continuity in an individual's care
Expansion of workforce capacity	Networks supporting local populations will allow the provision of personal care.	Practices will work as part of a Primary Care Network providing patients with essential services 7 days a week
Support to strengthen and redesign general practice	Move from disease management alone, towards prevention, wellbeing and self-care, optimising patient outcomes.	Patient are empowered to manage their own health
More integration with the wider health care system; support to strengthen and redesign general practice	Networks supporting local populations will allow the provision of personal care.	Care will be provided by integrated community teams including social care and the voluntary sector
	Involving GPs in commissioning discussions and decision making enables new approaches to prevention and management of ill health for	Take a population health management approach

	our population.	
Increase the level of investment in primary care; More integration with the wider health care system	Rebalancing the investment between primary and secondary care providers makes sense as optimising the use of out of hospital services averts the current waste.	Using innovative tools and methods to manage more care outside of hospital – including technology and access to specialists
Invest in better technology	Working with STP partners to implement a shared patient record	Patients will have a single record accessible to all appropriate healthcare professionals

Black Country & West Birmingham Sustainability and Transformation Partnership (STP)

Black Country and West Birmingham STP 2019/20 Operational Plan: Summary Narrative Submission

19 February 2019

Purpose

This document is designed to provide a system overview and data aggregation for the Black Country and West Birmingham (BCWB) STP for 2019/20, representing the first year of the system's five-year strategic plan to be published in autumn 2019.

1. System priorities and deliverables

The system priorities for its population for 2019/20 are closely aligned to the Long Term Plan (LTP):

- **Boosting 'out-of-hospital' care and dissolving boundaries between primary and community care**
 - Four places within the STP providing integrated care provision, underpinned by Primary Care Networks (PCNs). In 2019/20 service and pathway integration will reach beyond primary care to include other health and care services. This will include district nursing, pharmacy, social workers, community psychiatric nursing, social prescribing, housing and a range of other roles to support patients' care in their own communities;
 - Bringing together mental health provision under one Trust in the STP footprint.

- **Reducing pressure on emergency hospital services**
 - Increase urgent treatment centre capacity;
 - Establish an acute frailty service at Royal Wolverhampton Trust (RWT);
 - Increase access to primary care to free up the time of specialist emergency care clinicians to service serious or life-threatening cases.

- **Giving people more control over their health and providing more personalised care where appropriate**
 - PCNs supporting local populations will allow the provision of personal care. Move from disease management alone, towards prevention, wellbeing and self-care, optimising patient outcomes;

- On-going delivery of Transforming Care programme for Learning Disabilities across the Black Country.
- **Mainstreaming digitally-enabled primary and outpatient care across the NHS**
 - Development of a Local Digital Roadmap for the STP to deliver a digitally connected Black Country health and social care system that enables self-care and promotes wellbeing.
- **A nationwide shift to ICSs with a focus on population health**
 - Transition Board created to oversee the shift to an ICS. Figure 1 below shows the system transition timeline including CCG integration;
 - Increased responsibility for the STP Joint Commissioning Committee to commission certain services at scale, supported by the system clinical leadership group.

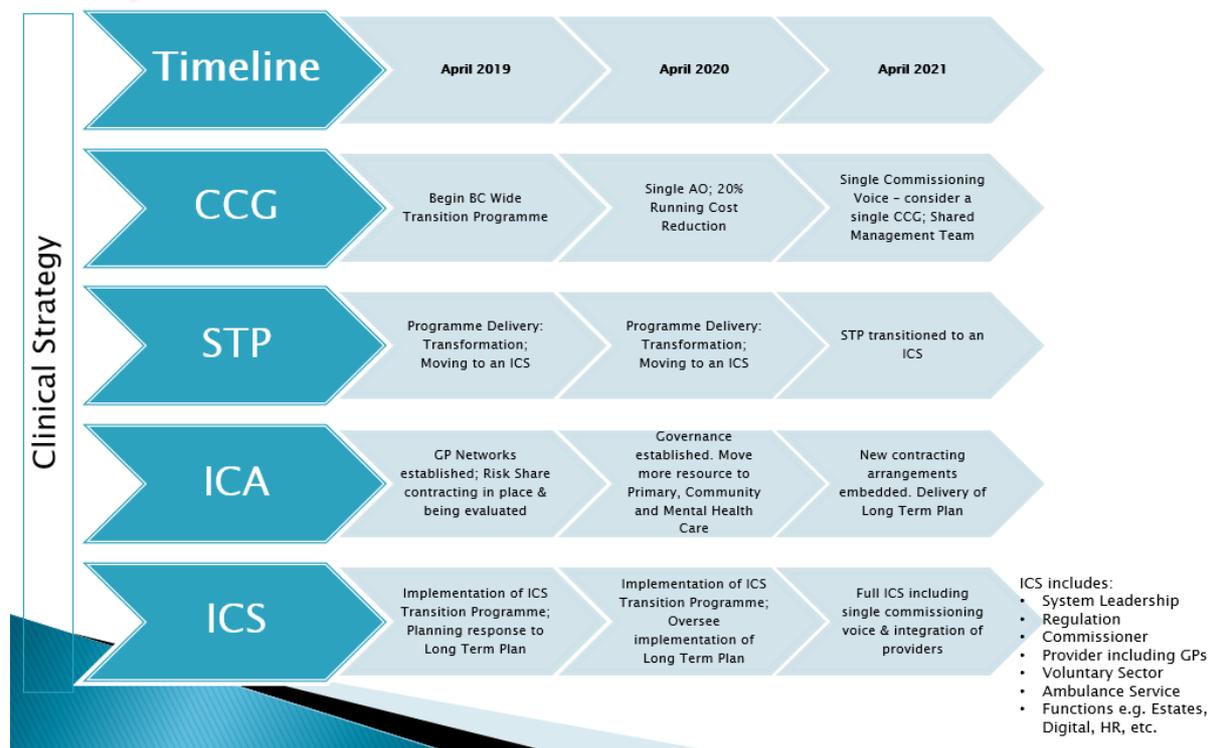


Figure 1: System transition timeline for Black Country and West Birmingham STP

Commissioning across the STP

Also in-line with the LTP is the focus for the STP on providing a strong start to life for children and young people and better care for major health conditions.



BCWB STP Clinical Strategy

The BCWB STP clinical leadership group have developed a clinical strategy for the STP that describes 12 priority areas, each with its own case for change, quality of care statement and triple aim opportunities. These areas are:

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

A STP primary care strategy will be in place from August 2019. Further areas with early defined cross-STP planning are described below.

Mental health commissioning

There are 11 mental health workstreams that will be commissioned as one across the STP from 2019/20. These are:

- ADHD (Adult)
- ASD (Adult)
- CAMHS Core
- CAMHS Crisis
- Core 24
- Criminal Justice
- Crisis Care
- Dementia Diagnosis
- Eating Disorders
- EIP
- Personality Disorder

By the beginning of 2019/20 all 11 workstreams will have finalised service specifications and will have been processed through the 4 CCG's Commissioning Committees and Governing Bodies for approval.

STP Cancer commissioning

The Black Country and West Birmingham Cancer Group¹ have set out a number of priorities in order to improve cancer outcomes for the resident population; deliver the National Cancer agenda and deliver the West Midlands Cancer Alliance priorities which are:

- To achieve all national cancer waiting time standards.
- To work with providers to ensure the implementation of nationally agreed rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers; Cancer Alliance priority to include Upper Gastrointestinal cancers.
- To agree and implement a plan to improve screening uptake
- To agree and implement a plan to improve early diagnosis.
- To support the Cancer Alliance in making progress towards implementation of stratified cancer pathways
- To agree and implement a plan to improve implementation of the Recovery Package

Performance monitoring

The STP has a programme delivery working group that monitors its performance against constitutional standards and progress against milestones on transformational assurance requirements.

Digital Roadmap

A Local Digital Roadmap for the Black Country is in development. Wolverhampton CCG hosts a monthly programme board whereby commissioners and providers across the STP have successfully bid for funding in collaboration, from sources such as LHCRE, HSLI and ETTF. The digital solutions that are being implemented are enablers for change to new clinical ways of working and empowering patients to care

¹This group is comprised of cancer managers and lead nurses of all four Trusts, all four CCGs, as well as from MacMillan, West Midlands Cancer Alliance, NHS England, Health Education England and NHS Right Care. The group is chaired by the STP lead cancer consultant and supported by the STP lead commissioning director for cancer.

for themselves. Interoperability standards underpin bespoke clinical and administrative systems, supporting a single joined up care record suitable for direct care and population health management.

Estates Strategy

The STP has an interim estates strategy in place. This will be further developed in 2019/20 in line with the following principles:

- Co-location with other health and care services
- Improve the effective utilisation of the estate
- Estate meets the demands of the clinical strategy
- The strategy supports the delivery of new models of care
- Rationalisation and disposal of surplus or unfit estate
- Improve the quality and condition of the estate
- Improve collaboration across providers and commissioners
- Achieve the principles identified within the Naylor report
- Reduce running costs and back log maintenance
- Achieve the Carter metrics where possible and appropriate
- Building a flexible estate – adoption of bookable systems
- Estate is fit for purpose and where not is disposed of
- Address population increases and demographics

Population Health Management

The BCWB STP has recently established a PHM workstream with a named SRO. The priorities and deliverables described above will provide the system with the core capabilities for PHM of infrastructure, intelligence and interventions.

2. Activity Assumptions

The mechanism for aligning activity assumptions at the system level is a joint DoF meeting. This will be extended to include directors of commissioning and strategy from system stakeholders. This body will also manage in-year demand fluctuations.

Activity growth levels have been determined through joint agreement at place level and reflect the local estimated demand requirements for patient healthcare, beginning with the national 2018/19 published growth levels which have been adjusted to reflect the actual demand seen during the past 12 months.

3. Capacity Planning

There is a system lead in place for winter planning who works with counterparts in each of the system's four places.

Demand and capacity plans from each of the four places for end of life care are being reviewed by the STP in order to establish a system-wide view. Work is also being undertaken at this level to identify and avoid non-beneficial acute sector treatments in the last 12 months of life. This, and other work, will inform an end-of-life strategy for the STP to be in place for the winter of 2019.

Capacity in out-of-hospital services will also be reviewed in 2019/20 as part of enhanced care in care homes and activity to avoid delayed transfer of care.

4. Workforce

The STP, through the LWAB, will review workforce in 2019/20 with the following priorities:

- Long-term workforce requirements
- Immediate requirements

STP workforce programmes are in place for:

- Mental Health
- Primary Care
- Transforming Care Together

These will be consolidated for the STP workforce plan that will be developed during 2019/20. There is an STP-wide review of challenged services that will also inform this plan.

5. System financial position and risk management

The organisations within the STP have a strong record in financial management, however the final quarter of 2018/19 has seen some substantial pressure emerging, particularly within the Acute Trust sector. The financial environment is challenging and a number of provider organisations have individual control totals which are very demanding.

The commissioning sector is largely break-even, with the exception of Dudley CCG which has been allowed to draw down £2m of its historical surplus.

The overall control total for the Black Country has been notified as £48.5m deficit excluding provider sustainability and marginal rate funding, which will deliver a

£9.7m surplus should all of the funding be achieved. However as mentioned above, this is a very demanding target and given the performance standards required to be achieved, this will be very challenging.

Through the work of the DoFs group, system performance and risks are regularly assessed throughout the year. Performance reports are presented monthly to both the DoFs and STP Board which highlight the financial and non-financial achievement against plans. These reports highlight anticipated risks and assist the STP to implement mitigations against under delivery of plans.

6. Efficiencies

The STP is working towards aligned QIPP and CIP programmes.

The STP will closely monitor the quality impact of identified efficiencies through the review of relevant quality impact assessments.

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