Health Scrutiny Committee

Thursday 20th November, 2014, at 6.00pm
In Committee Room 2 at the Council House, Priory Road, Dudley

Agenda - Public Session

(Meeting open to the public and press)

1. Apologies for absence.

2. To report the appointment of any substitute Members for this meeting of the Committee.

3. To receive any declarations of interest under the Members' Code of Conduct.

4. To confirm and sign the minutes of the meeting held on 22nd September, 2014 as a correct record.

5. Public Forum – To receive questions from members of the public:-

   The Public are reminded that it is inappropriate to raise personal cases, individual details or circumstances at this meeting, and that an alternative mechanism for dealing with such issues is available.

   Please note that a time limit of 30 minutes will apply to the asking of questions by members of the public. Each speaker will be limited to a maximum of 5 minutes within the 30 minutes.

6. Medium Term Financial Strategy

7. Quality Transfers of Care Between Hospital and Community Settings

8. The Better Care Fund

9. Dudley Group National Health Service Care Quality Commission Outcomes (Verbal report)

10. Mental Health Services Care Quality Commission Inspection (Presentation)

11. Clinical Commissioning Group : BBC and Solihull Stroke Review – Programme Development (Verbal report)

12. Dudley Group NHS Foundation Trust : Patient Experience

13. Update on Urgent Care Development (Verbal report)

14. To consider any questions from Members to the Chair where two clear days notice has been given to the Director of Corporate Resources (Council Procedure Rule 11.8).

Director of Corporate Resources
Dated: 12th November, 2014

Distribution:
Members of the Health Scrutiny Committee:
Councillor C Hale (Chair)
Councillor N Barlow, (Vice-Chair)
Councillors C Elcock, M Hanif, D Hemingsley, S Henley, K Jordan, M Roberts, E Taylor, K Shakespeare and K Turner
Ms Pam Bradbury – Co-opted Member

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- Please turn off your mobile phones and mobile communication devices during the meeting or set them to silent.

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- Information about the Council and our meetings can be viewed on the website **www.dudley.gov.uk**

- The Democratic Services contact officer for this meeting is Manjit Johal, Telephone 01384 815267 or E-mail manjit.johal@dudley.gov.uk

Minutes of the Health Scrutiny Committee

Monday 22nd September, 2014 at 5.00 p.m.
in Committee Room 2 at the Council House, Dudley

Present:-

Councillor C Hale (Chair)
Councillor N Barlow (Vice-Chair)
Councillors D Brothwood, C Elcock, M Hanif, D Hemingsley, S Henley, K Jordan, I Kettle, M Roberts and E Taylor

Officers

M Farooq (Assistant Director – Law and Governance (Lead Officer to the Committee), B Clifford (Interim Assistant Director for Adult Social Care), A Sangian (Senior Policy Analyst – Directorate of Adult, Community and Housing Services) and M Johal (Democratic Services Officer – Directorate of Corporate Resources)

Also in Attendance

Ms Paula Clark – Chief Executive (Dudley Group NHS Foundation Trust)
Ms Liz Abbis – Dudley Group NHS Foundation Trust
Mr Robert Greaves – Dudley Group NHS Foundation Trust
Dr David Hegarty – Dudley Clinical Commissioning Group
Mr Richard Haynes – Dudley Clinical Commissioning Group
Ms Laura Broster – Dudley Clinical Commissioning Group
Mr Jason Evans – Dudley Clinical Commissioning Group
Mr Neill Bucktin – Dudley Clinical Commissioning Group

9 **Introductions and Comments by the Chair**

Members, Officers and all those present introduced themselves to the meeting.

The Committee noted that the Director of Corporate Resources had been notified of a change to the Conservative Group's appointments on this Committee and that Councillor Barlow would be the Vice-Chair with immediate effect.

With regard to Agenda Item No 6 – Dudley Group of Hospitals Care Quality Commission (CQC) Outcomes and Financial Strategy Update it was reported that the presentation to this meeting would cover an update on the financial strategy only and that a report on the CQC outcomes would be submitted to a future meeting.

The Chair referred to Agenda Item No 9 – Delayed Transfers of Care and informed the meeting that the item would be deferred to the next meeting pending further information.

10 **Apologies for Absence**

Apologies for absence from the meeting were received on behalf of Councillor K Shakespeare and Ms Pam Bradbury – Chair of Healthwatch.

11 **Appointment of Substitute Member**

It was reported that Councillor I Kettle had been appointed as a substitute member for Councillor K Shakespeare for this meeting only.

12 **Declarations of Interest**

No Member made a declaration of interest in accordance with the Members' Code of Conduct.

13 **Minutes**

Reference was made to Minute No 6 – Update on Urgent Care Development with regard to preliminary drawings and floor plans and it was reported that these had not been circulated to Members as requested. In responding Mr Evans, Dudley Clinical Commissioning Group reported that the information was not as yet available due to a delay in the completion of the tendering process and that information submitted by the final two providers was currently being considered with a view to awarding a contract.

It was queried why there were no representatives of Interserve in attendance as the Committee had previously requested that they attend this meeting to respond to concerns relating to parking charges. The Senior Policy Analyst undertook to pursue the matter.

Resolved

That the minutes of the meeting of the Health Scrutiny Committee held on 16th July, 2014 be approved as a correct.

14 **Public Forum**

No issues were raised under this agenda item.

15 **Dudley Group of Hospitals Financial Strategy Update**

A presentation was made by Ms Clark – Chief Executive, Dudley Group NHS Foundation Trust to update the Committee on the Dudley Group of Hospitals Financial Strategy.

During the course of the presentation Ms Clark explained that the Trust, together with all Trusts in England, were under extreme financial pressure due to budget freezes over a number of years and a requirement to make efficiency savings, year on year. Trends in funding and demand, had in part led to a financial gap in the Dudley Group of £21 million for 2014/15 and £30 million over the next two years and in view of this the organisation and the wider health service had to change to meet the challenges. An array of measures were being considered to "balance the books" and difficult decisions would need to be made with a view to maintaining services and if required the withdrawal of some services.

Arising from the presentation and in responding to Members' queries Ms Clark made the following points:-

- Although massive investment was being directed into Information Technology it was difficult to predict the amount of monetary savings that would be made as the initiative mainly focused on achieving a more efficient and integrated service that would save time on resources such as chasing manual records and duplication.

- An exercise had been undertaken to minimise agency staff, where possible, as it was recognised that this was a significant cost cutting measure and efforts would be made to recruit for the vacant posts in the near future. Latest figures on the number of agency staff that were still employed and those that were no longer with the Trust could not be given but it was stated that they had been reduced to approximately half the original number.

- The Trust were confident that the public were getting value for money and assured Members that this was not an area of concern.

- The projected deficit ranged from £7 million to £15 million and it was predicted that it would be in the region of £10 million. However, if the deficit reached the upper level, Monitor, the regulator would take over and be responsible for the "turnaround".

- It was confirmed that the Trust were currently under investigation by Monitor and regular monthly review meetings were being held with them.

- It was acknowledged that there was a problem with bed management and patient flows and that discharge processes could be improved. The Trust were financially penalised for missed targets although it was pointed out that the fines were reinvested.

Resolved

(1) That the information contained in the presentation on the Dudley Group of Hospitals Financial Strategy, be noted.

(2) That a report on the Care Quality Commission Outcomes be submitted to a future meeting of the Committee.

16 **Update on Urgent Care Development**

A report of the Chief Accountable Officer was submitted on progress made towards the opening of the new Urgent Care Centre (UCC) in Dudley.

Mr Evans, Dudley Clinical Commissioning Group in presenting the report updated Members on progress made since the last meeting. He informed the Committee that they had contacted Centro with a view to consideration being given to improving public transport to the hospital.

There had been a slight delay in choosing the final provider and work was currently underway to consider the submissions of two providers with a view to selecting one of the two final bids and it was hoped to award the contract during October or November. It was explained that the selection process was complex and rigorous and had involved a large number of Panel members that had to judge and score the providers on their submissions which had inevitably led to some delays as Panel members had differing views and had to reach an agreement.

Arising from the presentation of the report and in responding to Members' queries representatives of the Dudley Clinical Commissioning Group made the following points:-

- Initially there had been expressions of interest from twenty providers and varying submissions had been made from both profit and non profit organisations. There was a limit to the amount of profit that could be made by the provider; it was a modest amount set by NHS contractual terms and a document detailing the legal and governance rules applicable could be provided, if required.

- In terms of patient confidentiality and access to records it was explained that it was essential that providers were Care Quality Commission registered as they are then governed by the rules. It was pointed out that non-clinical staff had to access patients records, however, patients had the option to have their records restricted by writing to NHS England. It was also commented that during the consultation process strong views had been expressed that the UCC should be able to access patients' medical history and General Practitioner (GP) records for efficiency purposes.

- An explanation was given on the process involved when patients attended the UCC and it was stated that patients could turn up to the centre at anytime but it was hoped that the 111 service would also be used so that patients could be directed to other appropriate services.

- With regard to the number of staff that would be available at the UCC at any one time it was commented that both providers' submissions contained varying numbers and levels of staff. However, it was confirmed that there would be in excess of fifty staff although that number of staff may not be on site and available at the same time.

- It was confirmed that there would be continual reviews and audits of processes would initially be undertaken on a daily basis to ensure a smooth and efficient service was being provided.

- Patient data was available which aided the determination of a safe ratio of staff and an assurance was given in that the service specification stated that the UCC should always have sufficient numbers of staff available. Monitoring processes were in place and penalties would be issued if it was found that there were staff shortages.

- When patients were initially assessed this would be conducted by a Senior Nurse and the patient would be streamed with a view to being assessed as an urgent or non urgent case. Insofar as the level of experience of the nurse it was stated that the specification specified Band 7 which was of a high level.

- Although there had been some delay in the procurement process owing to meticulous legalities it was anticipated that the scheduled timings would still be adhered to. However, if there were to be any slippage there was provision to extend existing contracts, if required.

- In relation to car parking it was pointed out that a number of actions had been taken to alleviate the problems including “freeing up” the maternity car park that had originally been allocated for staff. Since these further spaces had become available for public use there had been no noticeable issues with car parking, however, it was acknowledged that there were problems with broken barriers which caused traffic to tailback. Alternative plans for staff car parking were being pursued to include the introduction of a Travel Policy.

  Some Members disagreed and commented that there were parking problems as they had received several complaints from members of the public. It was further commented that because of parking fees and parking problems people were parking in the surrounding roads which caused nuisance to residents. It was considered that provision should be made for a multi-storey car park.

- In response to a query on whether there would be provision for car parking spaces to be made available directly at the front entrance, particularly for patients that were elderly or had children, it was stated that although there were no allocated spaces, there would be a drop off and pick up point.

  Members considered that patients, particularly in emergency situations, should not be burdened with the worry of parking their cars and then having to walk to the main entrance. A Member suggested that a marshalling service should initially be provided at the front entrance to assist elderly and unwell patients and it was considered that volunteers that currently worked at the hospital could be utilised.

- Regarding redirecting patients from the UCC and the danger of a potential increase in patients being redirected it was stated that the payment mechanism in place would prohibit this from happening and would be to the providers' disadvantage. Further details of financial incentives were available in the UCC Commissioning Standards document and could be circulated to Members for information, if required.

- There were various key performance indicators in place and random sample checks would be undertaken to ascertain that patients were appropriately redirected. However, following redirection to a third party provider or service outside of the UCC it was not possible to check whether the patient had attended.

- The rules relating to recharging patients from other areas and patients from abroad were explained. It was pointed out that when treating patients from other areas the relevant General Practitioners' Clinical Commissioning Group were recharged. It was stated that anybody could turn up to the Accident and Emergency section and the first point of call was to ensure the patient was safe and treated appropriately. General tariffs that were charged were given and a list of charges for all procedures and operations could be made available, if required.

- When a patient was initially registered a record would automatically be created and any follow up action recorded.

- Following the opening of the UCC there would initially be rigorous monitoring on a daily basis and data could be provided on patients at anytime. In response to a request it was confirmed that data information could be made available to Members with a view to providing updates on performance of the UCC.

- It was confirmed that there would be a sufficient number of GP's available and further information on the staffing structure could be made available once the contract had been awarded. It was also stated that staff employed at the current walk in centre would have the option to transfer if they so wished.

- It was confirmed that the provider was obligated to abide by the specification requirements including delivering a primary care service to children and ensuring that paediatric training and safeguarding awareness was a key component of the clinical and non-clinical UCC staff team.

  A Member referred to the recent review of specialised mental health services for children and young people and asked if a copy of the report could be made available to Members.

The Chair requested that a further report be submitted to a future meeting of the Committee detailing information on the number of patients attending the UCC to include information on how they were assessed, whether treated or redirected. The report should also include information on the numbers of staff that were available over a twenty four hour period.

Resolved

(1) That the information contained in the report and Appendix to the report on progress made towards the opening of the new Urgent Care Centre (UCC) in Dudley, be noted;

(2) That a further report detailing information on the number of patients attending the UCC to include information on how they were assessed, whether treated or redirected and information on the numbers of staff that were available over a twenty four hour period, be submitted to a future meeting of the Committee.

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17 **Clinical Commissioning Group/Council: Better Care Fund Planning and Care Act Reforms – Update**

A report of the Chief Accountable Officer was submitted on the current position in relation to the Better Care Fund.

Resolved

(1) That the information contained in the report submitted on the current position in relation to the Better Care Fund, be noted.

(2) That a further detailed report be submitted to the next meeting of the Committee to be held in November, 2014.

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18 **Delayed Transfers of Care**

The Committee noted that the report had been deferred to the next meeting pending further information.

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19 **Future Meetings**

Following brief discussions on future meetings it was:-

Resolved

(1) That reports to the next meeting include:-
(i) Delayed Transfers of Care
(ii) The Better Care Fund
(iii) Update on the Urgent Care Centre to enable questions to be formulated for a detailed discussion to be held in January, 2015.

(2) That the next meeting of the Committee be held at 5pm if required and that timings of future meetings remain under review.

The meeting ended at 7.50 p.m.

CHAIR

Dudley
Metropolitan Borough Council

Agenda Item No. 6

Meeting of the Health Scrutiny Committee – 20th November 2014

Joint Report of the Chief Executive, Treasurer and Interim Director of Public Health

Medium Term Financial Strategy

Purpose of Report

1. To consult the Scrutiny Committee on the Medium Term Financial Strategy (MTFS) to 2017/18, with emphasis on those proposals relating to the committee's terms of reference.

2. For this committee the directly relevant items are those relating to the proposed Public Health budget for 2015/16 in paragraphs 25 to 27. Members may also wish to consider any of the proposals in terms of their wider impact on health and wellbeing.

Background

3. At its meeting on 29th October 2014, the Cabinet considered a preliminary Medium Term Financial Strategy to 2017/18 for further consultation, including consultation with Scrutiny Committees, in accordance with the Constitution. In framing their responses to these budget proposals, Scrutiny Committees are being asked to consider both the spending and funding implications (including the impact on Council Tax) of any observations they may wish to make.

Forecast 2014/15 Position

4. Forecast General Fund revenue spend compared with budget for each Directorate is shown in Appendix A.

5. Latest monitoring indicates favourable Treasury variances amounting to £0.5m resulting from better than expected cash flows. This is a prudent estimate and may improve by the year end.

Looked After Children

6. In July, we reported to Cabinet that a review of Looked After Children had been undertaken. That review produced a number of recommendations for increased revocations of care orders, improved prevention and diversion, better commissioning and lower cost provision of care. On the basis of that review the Directorate of Children's Services predicted that numbers of Looked After Children could be reduced by around a third by the end of 2017/18. In particular, it was predicted that large reductions could be made in the numbers of children in the highest cost categories of care (external residential care and independent foster agency placements). It was forecast that these reducing numbers would lead to cumulative savings of £7.0m from the direct costs of Looked After Children and further consequential savings in social work, transport costs, etc of £0.8m by 2017/18.

7. Monitoring in the current year shows that overall numbers of Looked After Children have not started to reduce as predicted and, within that overall number, external residential and independent foster agency placements have risen. In addition, there are overspends in the Social Work budget and in the budget for 14+ supported accommodation. The Directorate of Children's Services has identified some measures to partially offset the pressures set out above and, on this basis, the latest financial monitoring by the Directorate forecasts an overspend of £1.0m although there is a risk that this overspend will increase.

8. In view of the current position, the Directorate of Children's Services has reviewed its forecasts for numbers of Looked After Children taking into account the age profile of the children currently in care and numbers of children likely to come into care in future. This review is not complete but indications so far are that any reductions in numbers will not be at the rate predicted in July. Savings in future years that are based directly or indirectly on reducing numbers of Looked After Children have therefore been removed from the proposed MTFS set out in this report, pending further review by the Strategic Director (People Services) and the Chief Officer (Children's Services) as and when they are appointed.

9. In light of the above, Cabinet agreed that all senior managers be reminded of the need for strict budgetary control in accordance with the Financial Management Regime and care and caution in managing the budget, particularly in the context of commitments into later years and the impact that any overspending in any one year will have on the availability of resources to meet future budgetary demands.

General Fund Balances

10. The use of balances for 2014/15, as approved by Cabinet and Council in July, is set out below. Members are asked to note the risk to this position if the Directorate of Children's Services fails to control the forecast overspend set out in paragraph 7 above. In view of this risk, there is no proposal at this stage to amend the current year budget to reflect the favourable forecast Treasury variance in paragraph 5.

	Budget £m
Balance at 31st March 2014	**25.1**
Planned use 2014/15	-0.1
Forecast balance at 31st March 2015	**25.0**

Medium Term Financial Strategy to 2017/18

11. In updating the Council's Medium Term Financial Strategy, Members will need to consider carefully:

    (a) the levels of Government support allocated to the Council;

    (b) spending pressures, opportunities to free up resources (including savings), and Council Plan priorities;

    (c) the implications of spending levels in later years as part of the Council's medium term financial plan;

(d) the views of consultees;

(e) the external factors and risks inherent in the Strategy;

(f) the impact on Council Tax payers.

(g) the Government's stated intention to offer Council Tax Freeze Grant for 2015/16 (see paragraph 14 below);

(h) the potential impacts on people with protected characteristics as defined in the Equality Act 2010. Members will need to have due regard to the public sector equality duty under the Equality Act 2010. (Further details are set out in the Equality Impact section below.)

Government Funding

12. The provisional settlement for 2014/15 included indicative figures for 2015/16. Figures for 2016/17 onwards have not been announced. Our current forecasts for 2016/17 and 2017/18 are in line with latest Treasury indications based on the 2013 Autumn Statement that for those years total Government expenditure will continue to fall in real terms at the same rate as over this Parliament. The implications of this for Local Government funding in general and Dudley's funding in particular are subject to a number of assumptions. However, if:

- expenditure on welfare is constrained such that departmental expenditure is not cut more steeply than over this Parliament;
- elements of departmental expenditure, in particular Education, the NHS, International Development and the devolved regions, are protected in real terms;
- Dudley's funding changes in line with overall Local Government funding,

then RSG would reduce by around 23% (£13m) in 2016/17 compared with 2015/16 indicative figures, and a further 27% (£11m) in 2017/18 compared with 2016/17.

13. We have assumed that New Homes Bonus will continue to increase at the same underlying rate as for 2014/15 up to 2016/17 after which it will remain stable.[1]

14. The Government has indicated that it will offer a grant equivalent to a 1% Council Tax increase to Councils who freeze Council Tax in 2015/16, and that this funding will be included in the "base" position for future funding reviews. No announcement has been made at this point in respect of subsequent years.

15. The Government has indicated that Education Services Grant (the grant that funds support services to schools which become the responsibility of academies after conversion) will reduce by around 20% in 2015/16, equivalent to around £1m.

[1] New Homes Bonus is received for 6 years for each new home or long term empty home brought back into occupation. As the scheme commenced in 2011/12, homes for which grant was received in that year will no longer count from 2017/18. This will continue in each subsequent year as the "oldest" year falls out of the formula. We have assumed that this fall out will be offset by more new homes at similar levels so that overall grant will not vary significantly.

Other Forecasts

16. The new Local Government pension scheme came into operation from April 2014. In order to smooth the impact of the significant increase in employers' contributions that would have otherwise occurred from 1st April 2014, both Future Service employer contributions and Past Service Deficit contributions are being stepped up over the period 2014/15 – 2016/17. The difference between stepped contributions and un-stepped contributions will then be added to the contributions certified by the Fund actuary for the period 2017/18 to 2019/20 (i.e. an additional £2.5m per annum).

17. In addition to the direct impact of changes in employer pension contributions, the current National Insurance rebate for employees and employers for "contracting" out of the Additional State Pension into the Local Government Pension Scheme will end from 1st April 2016 as part of the move to the new Single Tier State Pension from that date. Although the Government has indicated the impact of this on public sector employers will be taken into account in funding allocations, it would not be prudent to assume this means the cost will be funded.

18. The Collection Fund includes income from council tax and business rates. From 2013/14 there has been a transfer of risk from central to local government in respect of both these areas:

    - Nationally set and funded Council Tax Benefit was replaced by locally determined Council Tax Reduction schemes (see below). As part of this change the risk relating to changes in claimant numbers and value of claims is now borne by Councils.

    - 49% of business rates collected are retained by the Council, involving significant new risks resulting from any changes in rateable value as a result of new building, change of use, demolitions, or successful appeals. The latter may be backdated, sometimes as far as 2005, and give rise to substantial refunds to ratepayers.

    The flip side of this risk transfer is that local authorities equally stand to gain from positive movements in either of these income streams. The impact in both areas is difficult to predict, and will continue to be monitored closely, and the position will be reviewed when reporting to Cabinet in February 2015.

19. We have assumed that the Integrated Transport Authority (ITA) Levy will reduce by 5% in 2015/16 in accordance with the ITA's own MTFS, and will be frozen in cash terms thereafter.

Council Tax Reduction Scheme

20. The Council agreed at its meeting on 2nd December 2013 that the Council Tax Reduction (CTR) scheme be amended from 1st April 2014 to be based on the eligibility and calculation rules of the current (2013/14) scheme with a 20% cut in the resulting level of the reduction; and that a transitional arrangement of an 8.5% cut in the calculated reduction apply at least up to 31st March 2015 - with full protection from any scheme changes being given to pensioners, disabled adults, disabled children, war pensioners and lone parents with a child under 5.

21. Cabinet agreed at its meeting on 29th October 2014 to recommend to Council that the transitional arrangement be terminated on 31st March 2015 and that the full 20% cut be implemented from 1st April 2015, and that full protection from any scheme changes should continue to be given to pensioners, disabled adults, disabled children, war pensioners and lone parents with a child under 5. This has been assumed in the forecasts of the Council's tax base for 2015/16 onwards along with other estimated changes as a result of increased property numbers, etc.

Base Budget Forecasts

22. The following key assumptions have been made (and are also referred to in the risk analysis in paragraph 32):

(a) The provision for pay in 2015/16 reflects the employers' current pay proposals, covering the 2 year period up to 31st March 2016. These comprise a minimum 0.45% non-consolidated lump sum to cover the period 1st April 2014 – 31st December 2014, and a 2.2% minimum increase from 1st January 2015 – with larger increases to the lower pay grades. We are expecting pay awards for local government to continue to be settled at very low levels in the next few years, and have provided 1% each year for pay for the remainder of the MTFS.

(b) The provision for prices of 2% each year for the duration of the MTFS assumes that competitive contract management and tendering will continue to minimise the impact of price rises on Council budgets.

(c) Interest rates will continue to have a relatively low impact in the medium term.

23. Details of Base Budget Forecasts including the cost of demographic and other pressures for the next three years are set out below.

	2015/16 £m	**2016/17 £m**	**2017/18 £m**
2014/15 Base(*)	240.0	240.0	240.0
Pay & Prices	3.1	6.4	9.9
Capital Programme and Treasury	0.2	-0.8	-1.8
Pensions and National Insurance	1.7	5.1	6.7
Other Adjustments (**)	2.5	2.9	2.9
Spending Pressures (***)	1.1	2.2	3.3
Base Budget Forecast	**248.6**	**255.8**	**261.0**

(*) Following amendment by Cabinet and Council in July.
(**) Mainly the costs of Single Status, and the Government's planned reduction in Education Services Grant (ESG).
(***) Reflects increased numbers of adults with learning disabilities and clients with dementia, and pressures relating to waste collection and disposal costs.

Savings

24. The following savings have been identified. Detailed proposals are set out in Appendix B.

	2015/16 £'000	2016/17 £'000	2017/18 £'000
Adult, Community and Housing	11,801	12,907	12,907
Children's Services	1,695	2,157	3,540
Urban Environment	5,338	5,598	6,107
Corporate Resources	3,613	4,067	4,167
Chief Executive's	477	561	701
Total	**22,924**	**25,290**	**27,422**

The savings above include a number of proposed savings at Assistant Director and Head of Service level that were developed by directorates in advance of the corporate review of senior management. In order to avoid double counting, these earlier proposals will in due course be removed from the MTFS and replaced by savings arising from the corporate review. The precise impact on the MTFS of the review will be calculated when the proposals have been finalised, and will reflect the proper accounting for the General Fund, Housing Revenue Account, Public Health budget and Dedicated Schools Grant.

Public Health

25. The provisional core allocation for Dudley in respect of Public Health grant for 2015/16 remains unchanged from the 2014/15 allocation at £18.974m. The proposed budget for consultation is shown at Appendix C.

26. The Government intends that from 1st October 2015, local authorities will take over responsibility from NHS England for commissioning public health services for children aged 0-5. The initial transfer of funding will be handled separately to the core allocations. From 2016/17 onwards, the 0-5 baseline funding will be added to existing local government public health grant allocations to form an overall public health grant allocation.

27. The General Fund savings proposals in Appendix B include proposals to support Sports Development and Park Rangers from Public Health grant on the basis of the contribution that these services make to delivery of health and wellbeing outcomes. It is proposed that this support will be funded from a combination of Public Health reserves, decommissioning and redirection of funds within the Public Health budget.

Human Resource Implications

28. It was agreed by Council in July that:

- An "Expressions of Interest" process for voluntary redundancy to open from July through to early September 2014 with clear communication relating to priority given to areas of savings and that the process will be for a register to be held for future consideration including budget saving requirements and service restructures.

- That directors through HR may continue to offer the opportunity of volunteering for redundancy to any employee whose service is undergoing a restructure involving the saving of posts as it may be that some employees did not express an interest through the corporate process that might wish to consider this option if and when their service is reviewed.

- The continued delegation for approval of voluntary redundancies to the Cabinet Member for Human Resources, Legal, Property & Health and the Director of Corporate Resources, and of compulsory redundancies to the Cabinet Member for Human Resources, Legal, Property & Health and the Assistant Director for Human Resources and Organisational Development.

Redundancy costs, including those relating to pension strain, are dependent on the age and length of service of the individuals being made redundant and therefore cannot be precisely calculated at this stage. However, it is anticipated that they can be met from use of resources earmarked for committed capital expenditure (which in turn could be funded from prudential borrowing), review of earmarked reserves, and general balances. Cabinet, at its meeting on 29th October, agreed to recommend to Council that the above delegation be confirmed up to an initial maximum of £5.0m for direct redundancy costs and the capitalised cost of pension strain, in respect of redundancies required to achieve the proposed savings set out in this report.

Medium Term Financial Strategy

29. The MTFS reflecting the revised spending proposals set out above, and forecasts of likely resource availability can be summarised as follows.

	2015/16 £m	**2016/17 £m**	**2017/18 £m**
Base Budget Forecast - see para 23	248.6	255.8	261.0
Savings - see para 24	-22.9	-25.3	-27.4
Total Service Spend	**225.7**	**230.5**	**233.6**
Revenue Support Grant (RSG)	54.5	41.8	30.6
Retained Business Rates	48.3	50.0	51.2
Top-Up Grant	15.3	15.7	16.1
Business Rate Grant	1.4	0.8	0.8
New Homes Bonus	4.1	4.8	4.8
New Homes Bonus Adjustment Grant	0.5	0.5	0.5
Council Tax Freeze Grant	2.3	3.5	4.6
Collection Fund Deficit – Business Rates[2]	-0.7	-0.7	-0.7
Council Tax	95.4	95.9	96.4
Total Resources	**221.1**	**212.3**	**204.3**
Deficit funded from Balances	**4.6**	**18.2**	**29.3**
Balances brought forward	25.0	20.4	2.2
Balances carried forward	**20.4**	**2.2**	**n/a**

[2] Forecast deficit as a result of technical accounting issues relating to back-dated appeals.

30. As demonstrated by the table above, balances are adequate to fund the deficit for 2015/16 and 2016/17, but it will be necessary to identify significant further savings to ensure that the Council can deliver a balanced budget in 2017/18 and beyond.

31. The table above assumes, as a prudent basis for forecasting, that Council Tax is frozen for 2015/16. Whilst there has been no Government announcement in respect of Council Tax Freeze Grant (CTFG) for subsequent years, a freeze for 2016/17 and 2017/18 has also been assumed as a prudent basis for forecasting. Any increase in Council tax above 1.2%[3] would increase available resources.

Estimates, Assumptions & Risk Analysis

32. The proposals in this report are based on a number of estimates, assumptions and professional judgements, which are subject to continuous review. These may lead to further increases in expenditure and, therefore, the need to identify alternative funding sources, and include:

(a) Revenue Support Grant for 2015/16 is as per the indicative figures announced with the 2014/15 settlement, and for 2016/17 and 2017/18 is in line with Government indications of ongoing national deficit reduction. It should be noted that these forecasts in particular remain highly uncertain;

(b) income from Business Rates (net of appeals etc.) will be in line with current forecasts;

(c) the cost of Council Tax Reduction awarded will not substantially exceed forecasts, and the tax base will continue to grow in line with recent years;

(d) New Homes Bonus funding for future years increases at the same underlying rate as for 2014/15;

(e) Equal Pay costs are no more than estimated;

(f) general levels of inflation, pay and interest rates do not vary materially from current forecasts;

(g) income and expenditure relating to treasury management activity, including airport dividend income, are in line with forecasts;

(h) the impact of schools transferring to academy status can be managed within existing Directorate budgets;

(i) there will be no other unplanned expenditure (including any resulting from demographic pressures) or shortfalls in income, which cannot be met from reserves;

(j) Council Tax will be frozen in each year and the Government will continue to offer an ongoing Council Tax Freeze Grant equivalent to a 1% increase;

[3] Council Tax Freeze Grant is calculated with reference to a higher tax base than that used for Council Tax setting - to make it consistent with the calculation prior to localisation of Council Tax Benefit / Support. It is therefore worth more than 1% of actual Council Tax income.

(k) income from the Better Care Fund will be as forecast, taking into account that a substantial element of this is contingent on achieving challenging performance targets;

(l) there will be no overall pressure on resources resulting from implementation of the Care Act. (The Care Act received Royal Assent in May 2014 and has wide ranging implications for adult social care services some of which take effect in April 2015 and the remainder in April 2016. There are significant financial risks associated with the delivery of the Care Act and the likely costs are currently very difficult to identify with reasonable accuracy. The Government has committed to fully funding the additional costs, but we have no details of the impact on the financial settlement at this time.)

(m) that the Directorate of Children's Services will contain spend within its current approved budget (noting that previously identified savings on Looked After Children have now been removed from the future years of the MTFS pending further review).

Consultation

33. Following the high profile and extensive Big Question consultations held over the previous two years a significant number of residents are now subscribed to the council's e-bulletin service. To minimise costs, last year's consultation was carried out predominantly online through the e-bulletin service, website and social media and it received a total of 2,500 responses. Over the last year, the number of people in receipt of the e-bulletin has continued to grow as the communication channel develops and there are currently more than 18,000 subscribers. The proposal for this year's consultation is to again utilise the successful online channels of the e-bulletin, internet and social media. We will also make hard copy, printed versions available in borough libraries and Dudley Council Plus through a consultation which will run through November, December and January.

34. Detailed consultation will also be undertaken with groups identified as being potentially affected by the specific savings proposals, with a particular emphasis on equalities issues. Further information is set out in the Equality Impact section below. Unions will be consulted in the context of the redundancy process considered in a separate report elsewhere on this agenda.

35. The Council is required by law to consult with representatives of Business Ratepayers before the final budget and Council Tax are agreed. A consultation meeting will be held to consider the issues set out in this report. Further detailed information (as required by law) will be distributed in February for comment before the Council Tax setting meeting.

36. In accordance with the Council's Constitution, Scrutiny Committees are being asked to consider the issues set out in this report and any related specific issues relevant to their Council Plan and service responsibilities. For this committee, the directly relevant items are those relating to Public Health in paragraphs 25 to 27. Members may also wish to consider any of the proposals in terms of their wider impact on health and wellbeing.

The Interim Director of Public Health as well as representatives of all directorates will be available at the meeting to address any queries. In framing their responses, the Scrutiny Committees are being asked to consider both the spending and funding implications (including the impact on Council Tax) of any observations they may wish to make.

Finance

37. This report is financial in nature and relevant information is contained within the body of the report.

Law

38. The Council's budget setting process is governed by the Local Government Finance Acts 1988 and 1992, and 2012 and the Local Government Act 2003.

39. The Local Government Act 2003 requires the Chief Financial Officer to report on the robustness of estimates made for the purpose of final budget calculations, and the adequacy of the proposed financial reserves and this will be included in the final budget report.

40. The Localism Act 2011 introduced a new chapter into the Local Government Finance Act 1992 making provision for council tax referendums to be held if an authority increases its council tax by an amount exceeding principles determined by the Secretary of State and agreed by the House of Commons.

Equality Impact

41. Section 149 of the Equality Act 2010 - the general public sector equality duty - requires public authorities, including the Council, to have due regard to the need to:

- eliminate discrimination, harassment and victimisation and other conduct that is prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and those who don't;
- foster good relations between people who share a protected characteristic and those who don't.

42. Having due regard to the need to advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

- remove or minimise disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic
- take steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it

- encourage persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

43. The legislation states that "the steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities." In practice, this means that reasonable adjustments should be made for disabled people so that they can access a service or fulfil employment duties, or perhaps a choice of an additional service for disabled people is offered as an alternative to a mainstream service.

44. Having due regard to the need to foster good relations between persons who share a relevant protected characteristic and persons who do not share it involves having due regard, in particular, to the need to:

- tackle prejudice, and
- promote understanding.

45. Compliance with the duties in this section may involve treating some persons more favourably than others; but that is not to be taken as permitting conduct that would otherwise be prohibited by or under this Act.

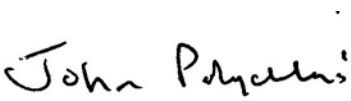
The duty covers the protected characteristics of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

46. An initial assessment of the budget proposals has been made. Where proposals are likely to have a significant equality impact, they will undergo an equality impact assessment informed by consultation with the protected groups who may be adversely affected, during the autumn. The results of this process and any steps which emerge that might help to mitigate any potential impact of the budget proposals on the protected groups will be reported to Members so that they can pay due regard to the Public Sector Equality Duty in making decisions on the budget. In making decisions on budget proposals, Members will need to weigh the Public Sector Equality Duty against the forecast financial position, risks and uncertainties set out in this report.

47. With regard to Children and Young People, the proposed budget for the Directorate of Children’s Services will be spent wholly on maintaining and improving services for children and young people. The expenditure of other Directorates’ budgets will also have a significant impact on this group.

Recommendations

48. That the Committee considers the Cabinet's proposals for the Medium Term Financial Strategy to 2017/18, taking into account the considerations set out in paragraph 36.



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John Polychronakis
Chief Executive

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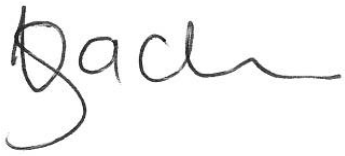
Iain Newman
Treasurer



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List of Background Papers
2013 Autumn Statement
Report to Cabinet 3rd July 2014
Report to Cabinet 29th October 2014

Appendix A

Latest Forecast 2014/15

Directorate	Revised Budget £m	Outturn £m	Variation £m	
Adult, Community and Housing	101.162	101.162		
Children's Services	68.997	69.997	+1.000	See note 1
Urban Environment	56.268	56.268		
Chief Executive's	4.206	4.206		
Corporate Resources	9.363	8.889	-0.474	See note 2
Total Service Costs	**239.996**	**240.522**	**+0.526**	

Note 1: Costs of Looked After Children, social work and 14+ accommodation, partially offset by one-off savings in other parts of the Children's Services budget.

Note 2: Favourable Treasury variances.

Appendix B

Proposed Savings

Adult, Community and Housing	**2015/16**	**2016/17**	**2017/18**
	£'000	**£'000**	**£'000**
Learning Disability - Assertive review of residential care and care packages for people, including Supported Housing. Leading to a re-modelling of how we deliver services to people with a Learning Disability, which will see more people supported in community based settings and through the delivery of Direct Payments	1175	1175	1175
Health integration – These savings will be achieved through the transfer of monies from the Clinical Commissioning Group (CCG) via the Better Care Fund. This transfer is made up of two elements. The first element relates to a reduction in unplanned admissions to hospital and forms the payment by results part of the fund. The target reduction in unplanned admissions to hospital that will generate the planned transfer of resources to the Local authority is 7% in 2015/16; a further reduction in unplanned admissions of 2.4% is planned for 2016/17. In the event the performance targets are delivered in full, Dudley MBC will receive £3.75m performance related benefit. The second element is a transfer of resources from Dudley CCG to Dudley MBC of £3.12m. This sum supports the protection of adult social care and implementation of the Care Act.	6870	6870	6870
Health integration - This option reflects the efficiencies that will be generated within DACHS as a result of the integration of services with the CCG, and the efficiencies identified following the redesign of the Adult Social Care model in respect of access to services and the customer experience.	700	1606	1606
Mental Health Services - Assertive review of residential care and care packages for people, including Supported Housing. Leading to improved value for money from existing care packages and increased use of telecare, extra care housing, and Direct Payments**.**	156	156	156
Reduction of management and staffing costs across adult social care	200	200	200

Adult, Community and Housing	**2015/16**	**2016/17**	**2017/18**
	£'000	**£'000**	**£'000**
Physical Disability - Assertive review of residential care and care packages for people, including Supported Housing. Leading to a remodelling of how we deliver services and more people supported in community based settings.	250	250	250
Older People/ Learning Disability - Review of existing shared lives service, with development of extending existing service provision to provide alternative to residential care.	250	250	250
Queens cross day centre - Remodelling of services at Queens Cross Network - remove in-house transport and replace with robust independent travel planning service and develop a traded service to include use of building by external organisations or individuals.	100	100	100
Unicorn day centre – this is a day centre for people with profound Learning Disabilities. A range of options including externalisation, community asset transfer and community fundholding are being considered. Final proposals following detailed consultation will be finalised shortly.	300	300	300
Employment Plus – this is a service that looks for employment opportunities for people with disabilities. The saving would be achieved through providing the service through a different delivery model and identifying efficiencies through the current use of resources	200	200	200
Savings arising from new running arrangements for New Bradley Hall	250	350	350
Changes to Reablement service - Following an independent review some changes in respect of the delivery of services will deliver the savings identified.	100	200	200
Extra Care Housing - The renegotiation of the contract for the running of the extra care housing provision will see current block contract being replaced with spot purchased care, which will see a reduction in the overall number of hours commissioned together with a reduction in the unit costs.	250	250	250
Introduction of tighter criteria for support to voluntary sector that is more aligned to the local authority preventative model.	300	300	300
Reduced support, and cancellation of schemes supported through Supporting People monies.	700	700	700
Total	**11,801**	**12,907**	**12,907**

Children's Services	**2015/16 £000**	**2016/17 £000**	**2017/18 £000**
Generate additional surplus traded service income.	65	109	317
Restructure the integrated youth support service.	267	397	597
Reduce the voluntary and community sector commissioning budget together with efficiencies in the Directorate's commissioning arrangements .	55	55	135
Asset Management Services will make staffing reductions.	50	50	50
Home to school and college transport budgets for pupils and students will be reduced through efficiencies and some redesign of the service provision.	210	210	210
A consultation on the future delivery of the Children's Centre service in Dudley was undertaken in 2013 resulting in a revised model of delivery for all 20 children's centres into 5 clusters together with a restructure of family support and partner contributions from the Dedicated Schools Grant.	450	450	504
Review the scope for closer integration between Children's Centres and the health visitor service focussing on improving health and wellbeing outcomes for children and families. This will involve a contribution from Public Health Grant to sustain the service in the short term pending the delivery of savings from integration.	350	350	350
Restructure within the Education Services division.	146	181	441
Options will be explored for Dudley Performing Arts (DPA) service to become 100% financially sustainable by 2016/17, through traded service income, grants, partner contributions and trust status.	-	160	160
Redesign the early help and family support service.	40	113	277
Restructure the Directorate leadership and management arrangements.	62	82	499
Total	**1,695**	**2,157**	**3,540**

Urban Environment	**2015/16**	**2016/17**	**2017/18**
	£'000	**£'000**	**£'000**
Service related savings			
Reduction in the Road reconstruction and resurfacing programme	461	461	461
Reduction in routine Street Lighting, signs and bollards maintenance	50	50	50
Reduction in Gully Drain Emptying with a greater focus on problem 'hot spots'	52	52	52
Reduction in the Grounds Maintenance of parks, open spaces, verges and other amenities including grass cutting, shrubs, hard surfaces & pitch marking and the pruning of trees	265	265	265
Office staff related savings			
Ongoing efficiencies, service transformation and corporate restructuring	3,105	3,105	3,444
Income generation			
Increase Bereavement charges	190	350	520
Other efficiency and contractual savings			
Gym equipment contract negotiated savings	40	40	40
New technology within Street Lights will reduce light pollution and save significant energy costs	205	205	205
Switch off selected Street Lighting from midnight	0	100	100
Redesign of Pest Control service	100	100	100
Review of rechargeable Green Care workloads	140	140	140
Further efficiencies including vehicle utilisation, overtime, fuel usage	200	200	200
Business efficiency and transformation	200	200	200
Sports Development and Park Rangers services to be maintained with support from the Public Health Grant on the basis of their contribution to health and wellbeing outcomes.	330	330	330
Total	**5,338**	**5,598**	**6,107**

Corporate Resources	2015/16	2016/17	2017/18
	£'000	£'000	£'000
ICT - service redesign, management savings, rationalisation of equipment and licenses and contract renegotiation following the consolidation of corporate and directorate ICT teams and reflecting the council's accommodation strategy and reducing workforce.	822	822	822
Accountancy - service redesign and management savings, focussing on strategic financial management and reducing non-core and transactional activity.	500	500	500
Management restructure within Internal Audit.	55	55	55
Customer Services - service redesign focussing mainly on self service / automation, reducing non-statutory activity, a payments review and management & staff savings .	589	846	846
Reduce grant to Dudley and West Midlands Zoological society.	0	0	100
Directorate management restructure. Removal of Assistant Director post.	0	100	100
Human Resources & Organisational Development - staff and management savings from system development & self service.	802	826	826
Staff and management savings from Law & Governance Division.	140	193	193
Increased Management & Valuation, conveyancing and lease income.	5	25	25
Office accommodation savings. Town Centre project - disposal of 12 sites.	200	200	200
Staff, energy and further efficiency savings within a consolidated property function. Council wide property restructure resulting in savings around £250,000. Energy Management savings expected to deliver around £250,000 savings.	500	500	500
Total	**3,613**	**4,067**	**4,167**

Chief Executive's	2015/16	2016/17	2017/18
	£'000	£'000	£'000
Reduction in voluntary sector grant	0	40	40
Staff savings across Policy and Customer Access to Services (CATS) teams	153	164	210
Admin support and directorate running costs savings	34	34	80
Communications and Public Affairs staff savings and additional income	96	129	177
Community Safety staff savings	169	169	169
Emergency Planning savings	25	25	25
Total	**477**	**561**	**701**

Appendix C

Proposed use of Public Health Grant 2015/16

	£'000	£'000
Substance misuse (alcohol & drugs) - adults	4,698	
Substance misuse (alcohol & drugs) - young people	487	
Substance Misuse Programme total		**5,185**
Sexual health services - STI testing and treatment (prescribed function)	478	
Sexual health services - contraception (prescribed function)	1,935	
Sexual health services - advice, prevention & promotion	255	
Sexual Health Services Programme total		**2,668**
Obesity (prevention & tiers 1 & 2 treatment) Programme		**1,454**
Children 5-19 - (School health & PH healthy school programmes)	1,532	
Children 5-19 - (National Child Measurement programme)	304	
Children 5-19 Programme total		**1,836**
Tobacco Control (prevention & treatment) Programme		**1,480**
Public Health Advice (core offer) (prescribed function)		**1,081**
Physical Activity Programme (including sports development and park rangers)		**1,281**
Community Health Improvement Programme		**745**
NHS Health Checks Programme (prescribed function)		**560**
Health Protection - communicable disease	262	
Health Protection - LA role (prescribed function)	263	
Health Protection Programme total		**525**
Mental Health Promotion Programme		**485**
Nutrition & Oral Health Promotion Programme		**435**
Long Term Conditions Self Management Programme		**268**

	£'000	£'000
Other PH Programmes (e.g. cancer awareness, falls prevention)		**473**
New Projects (parenting, diabetic eye screening, reduction in self harm)		**184**
Children's Centres (non-recurring use of reserves)		**420**
Overheads - central establishment charge	300	
Overheads - rent ,rates, service charge, cleaning	118	
Overheads - utilities, computer equipment, insurance etc	97	
Overheads total		**515**
Total Spend		**19,595**
Reserve funding		**(621)**
Total Public Health Grant funded		**18,974**
Estimated Opening Reserves 1.4.2015		1,713
Reserves use		(621)
Estimated Closing Reserves 31.3.2016		**1,092**

Agenda Item No. 7

Dudley Clinical Commissioning Group

Report of the Director of Adult, Community and Housing Services and the Chief Accountable Officer, Dudley CCG

Quality Transfers of Care between Hospital and community settings

Purpose of Report

1. To advise the Health Scrutiny Committee on issues relating to:
   - quality transfers of care between hospital and other settings,
   - work being done in the health and social care economy to continually improve our services and people's experience of transfer of care between hospital and other settings
   - specific issues relating to delayed transfers of care.

Background

Quality transfers of care between hospital and other settings

2. Admission to hospital can be an anxiety-provoking experience for anyone requiring treatment or physical investigation as well as those who actively care or are concerned about them.

3. It is a priority for organisations working in the health and social care economy in Dudley to ensure that when people develop care needs, the support they receive is appropriate and takes place in the most appropriate setting depending on their circumstances.

4. All health and care agencies are committed to upholding best practice by treating people with dignity, respect and ensuring a quality service is provided. Promoting the independence of people and acknowledging the strengths they bring to their own situation are key underpinning practices which support a quality service. Amongst other mechanisms for these practices, health and care agencies bring together their agency commitment to quality and dignity in service provision through their partnership as members of the Dudley Safeguarding Adults Board.

5. The overwhelming majority of people who are admitted to hospital and are discharged back home to the care of their GP do so with support from their family or friends. The care and concern of their family or friends generally gives people the best chance of making a full recovery and regaining independence as soon as possible.

6. A smaller number of people require support and care from health and social care services on the transfer of their care from the hospital to other settings in community, residential or nursing care homes. These instances can range from fairly straight-forward arrangements such as re-starting a package of care which a person had before their admission to hospital to more complex arrangements in starting a new service or admission to a care home environment.

Work being done in the health and social care economy to continually improve services and people's experience of transfer of care between hospital and other settings

7. Work being done in the health and social care economy to improve services and people's experience is influenced by factors, amongst others, which include:

    - More people living longer
    - More people living with long-term conditions
    - Rising public expectations
    - Improved medical and care technologies
    - Need for greater efficiency in context of reduced resources
    - policy to promote independence, choice and support informal carers;
    - Specific policies aimed at addressing avoidable hospital admissions i.e. the Better Care Fund

8. People whose care needs are more complex need staff from different agencies to work together as partners serving the same person in the hospital setting. For example, Dudley Adult Social Care provide:
    - A Hospital Access Team of four Social Workers and a five Community Care Supervisors. One Social Worker and one Community Care Supervisor work in the Emergency Department to support attempts to divert people from Hospital care where appropriate. The remainder of the team work on the Wards. This team works across a time-span from 08:00 - 22:00 with support from other parts of Adult Social Care such as care staff who respond to emergencies in community settings
    - A seven-day service has been provided since January 2014
    - Specialist Safeguarding Social Workers for safeguarding work for people admitted to Hospital. The thresholds for adult safeguarding are actively monitored by the team to ensure that best use is made of expensive hospital beds.

9. Dudley CCG staff are also in attendance at the Hospital to support assessments for Intermediate Care or Continuing Health Care. On a Tuesday, Thursday, Saturday and Sunday, the Intermediate Care work is covered by the Council's Hospital Access Team.

10. Voluntary organisations also contribute e.g. the Red Cross Society work with some people on discharge from Hospital

11. Private organisations such as "Care Home Select" have been commissioned by the Hospital to support transfers to care homes.

12. Within the hospital, a "Discharge Impact Team" meeting of a multi-disciplinary team meet twice daily to discuss the latest situation of the patients on their list. The status for each patient should be agreed at this meeting and it is recorded on a database called the "Disco" (Discharge Co-ordinators) database. This database is important because its output is used for reporting Dudley's performance to national systems.

13. To avoid hospital admission where possible, a broad range of activity is being undertaken under the heading of the Better Care Fund to support people to stay in the place where they live – at home or in a care environment such as a care home – rather than be admitted to hospital where avoidable and safe to do so. Actions include:

- Development of a Community Rapid Response Team under clinical oversight to strengthen options for alternatives to admission to hospital, including dialogue with West Midlands Ambulance Service;

- The development of a new Urgent Care Centre based at the Hospital will support work to "triage" patients more effectively, supporting efforts to avoid hospital admission as appropriate

- Promoting a more locality-based approach through more integrated working with GP practices and other services e.g. mental health and adult social care;

- Broadening of preventative services still further so that people respond to the need to maximise their own health and well-being

- Re-organisation of adult social care services on a "Customer Journey" model to reflect the way in which people generally may need support and care;

- Working with West Midlands Care Home Association to up-date protocols for discharge from hospital back to the care home environment

- A "Discharge To Assess" model which creates three "pathways" for people to (1) return home where safe to do so; (2) reablement; (3) provision of continuing healthcare.

- The commissioning of work to resolve long-standing challenges about management information system which inform the analysis and decision-making process used to show the activities of all partners relating to hospital discharges.

14. A separate report is on the Agenda for the Committee's consideration but in the context of this Report, the Committee may wish to be reminded that the reduction in emergency admissions to hospital is now the sole determinant of access to the performance element of the Better Care Fund.

15. With regard to the experience of transfer of care between hospital and other settings, a legal framework was set for this through the *Community Care (Delayed Discharges etc.) Act 2003* which was enacted in 2004 and has been updated as appropriate by the *Care Act 2014.*

16. The aim of this law and subsequent guidance / definitions, has been to improve people's experience by better "flow" through the whole system, supporting people to:

- avoid hospital admission where an equally effective alternative can be provided;
- be re-directed from hospital where an equally effective alternative can be provided
- if admitted, experience effective discharge from hospital where each partner agency exercises their responsibility to ensure the best onward provision of care and support from hospital.

Specific issues relating to delayed transfers of care

17. Ensuring a good experience for the person requiring a transfer of care can be a complex process involving the resources and actions of, amongst others:

    - the person who is in hospital, their family, informal carers,
    - public sector agencies such as
        - Dudley Council Adult Social Care Services,
        - Dudley Group NHS Foundation Trust,
        - Dudley Clinical Commissioning Group
        - Dudley Walsall Mental HealthTrust
        - Care or Nursing Homes, and
    - other specialist providers dependant on individual circumstances

18. Monitoring transfers of care is one way of measuring how effectively organisations are working together to facilitate the timely transfer of patients from hospital and so improve a person's experience. The issue of transfers of care is also complex because of the definitions and information requirements needed. For instance, delayed transfers of care are commonly defined as follows:

    A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.

    A patient is ready for transfer when:
    (a) a clinical decision has been made that the patient is ready for transfer
    AND
    (b) a multi-disciplinary team decision has been made that the patient is ready for transfer*
    AND
    (c) the patient is safe to discharge/transfer.

    (*A multi-disciplinary team in this context includes nursing and other health and social care professionals, caring for that patient in an acute setting.)

19. There is an expectation that delays to transfers of care will be minimised through the following steps:-

    - discharge planning begins on admission to hospital or in the early stages of recovery;
    - there are no built-in delays in the process of deciding that a person will no longer benefit from acute care and is safe to be transferred to a non-acute (including community and mental health) setting;
    - that the NHS and social care will jointly review policies and protocols around discharge, including handling of choice of accommodation; and have systems and processes for assessment, safe transfer and placement, as part of their capacity planning

- these steps should be guided by good professional practice and safe, person-centred transfers. Although an acute ward is not appropriate once an acute episode is over, joint planning is needed to ensure that appropriate care is available in other settings.

Reasons for delays in transfers of care

20. Relevant guidance takes account of the fact that the reasons for delays in transfer of care may be various. Categories for reasons for delay have been established by the Department of Health as shown in the Table below. Using the categories shown in this Table, both the number of patients whose transfer of care is delayed (a) and the number of days delayed within the month (b) are subdivided by the reasons for delay: A patient should only be counted in ONE category of delay ad this category should be the one most appropriately describing their reason for delay and total numbers allocated to reasons for delay should equal the number of patients delayed.

	Attributable to NHS	Attributable to Social Care	Attributable to both
A. Awaiting completion of assessment	✓	✓	✓
B. Awaiting public funding	✓	✓	✓
C. Awaiting further non-acute (including community and mental health) NHS care (including intermediate care, rehabilitation services etc)	✓	×	×
D i). Awaiting residential home placement or availability	✓	✓	×
D ii). Awaiting nursing home placement or availability	✓	✓	✓
E. Awaiting care package in own home	✓	✓	✓
F. Awaiting community equipment and adaptations	✓	✓	✓
G. Patient or Family choice	✓	✓	×
H. Disputes	✓	✓	×
I. Housing – patients not covered by NHS and Community Care Act	✓	×	×

Monitoring delays

21. Using a national monthly Situation Report (SITREP) collected through a system known as UNIFY, data is collected on:
    - the number of patients delayed on the last Thursday of each month and
    - the total delayed days during the month for all patients delayed throughout the month.

22. Data is :
- shown at provider organisation level, (NHS Trusts, NHS Foundation Trusts and Clinical Commissioning Groups)
- shown by Local Authority that is responsible for each patient delayed.
- split by the agency responsible for delay (NHS, social care or both), type of care that the patient receives (acute or non-acute) and reason for delay.

23. The Table above also shows which reasons can be attributed to NHS, social care and both. On the other hand, the delayed days for a given patient can be split across the reasons for the delay. For example, if the total length of delay is 10 days, the first two days were due to waiting for the assessment to be completed and the following eight days were due to waiting for a nursing home placement, then the delayed days will be split across reason A and Dii.

The Situation in Dudley

24. At the time of writing this report, the SITREP data submitted to UNIFY covered September2014. This gives the following figures for Dudley Council of the number of patients whose transfer of care has been delayed (figures for Birmingham, Walsall and Wolverhampton are also included for comparative purposes:)

Local Authority	NHS	Social Care	Both	Total number of patients
Dudley	9	18	2	29
Birmingham	103	88	0	191
Walsall	7	5	5	17
Wolverhampton	12	8	3	23

25. These figures reflect the patients falling within the strictly defined SITREP categories. However, it is recognised across the health and social care economy that SITREP figures alone do not reflect the full scale of the challenge we face in Dudley, because there may be significantly higher numbers of patients in hospital who are medically fit for discharge but not included in these figures. In this context, it is important to note that people's health may vary in terms of medical fitness for discharge. As an example, the council does not deem patients 'safe' for discharge until a social care assessment has been completed because the public are entitled by law to an assessment by the Council. While the number of patients in this category varies on a daily basis, there can be occasions when 20-30 patients are considered safe for discharge in the view of their clinicians but unable to leave hospital until a social care assessment has been carried out.

26. Flow through the system is also dependent upon the availability of community based beds for people stepped down from acute services. These are also subject to delayed transfers of care. At the time of preparing this report, 45 community bed delays are attributable to social care. 35 are awaiting an assessment by a social worker.

27. In addition delayed transfers of care impact on the ability of the hospital to deal with patients in the Emergency Department (ED) and in turn this is reflected in performance in relation to the 4 hour ED wait target. This requires 95% of patients to be either discharged, transferred or admitted within 4 hours of their arrival. Year to date performance is illustrated in Appendix 1.

28. There are occasions, however, when partners dispute the figures used as referred to earlier in this report. The current SITREP definition of a dispute is as follows;

"*This should be used only to record disputes between statutory agencies, either concerning responsibility for the patient's onward care, or concerning an aspect of the discharge decision, e.g. readiness for discharge or appropriateness of the care package.*

*Disputes may **not** be recorded as the responsibility of both agencies. NHS bodies and councils are expected to operate within a culture of problem solving and partnership, where formal dispute is a last resort*."

29. Evidence shows that the reason for the vast majority of Dudley delays on the SITREP, for the period April to August 2014 is "dispute." This recognition has spurred partners to clarify the practice and management information processes through a project to review and agreed a defined way forward which avoids this occurring. The Council has also agreed to work with the Department of Health as part of a regional Sector Led Improvement approach to improve the current situation.

External Review

30. To help all partners update their understanding and plans of the challenges they face across the whole system, the Department of Health's Emergency Care Intensive Support Team have carried out a review of the operation of the Dudley urgent care system. Their work has been presented to the multi-agency System Resilience Group. It covers a range of factors about the way in which the whole emergency care system works which are the responsibility of all agencies, the Dudley Group, Dudley CCG and the Council's adult social care function.

31. The System Resilience Group has now agreed an Action Plan designed to address all issues of flows through the system. The allocation of additional resources from NHS England to the Dudley Health and Social Care Economy to manage winter pressures will be dependent upon completing a number of required actions.

32. The Emergency Care Improvement Support Team returned to Dudley in early September in order to carry out further work in relation to primary care, nursing homes, mental health and the West Midlands Ambulance Service, with a view to identifying any other system blockages. Any required actions will be built into the existing agreed action plan.

33. Relevant actions designed to reduce delays are attached as Appendix 2. Some significant actions, including the removal of weekly funding panels, remain outstanding.

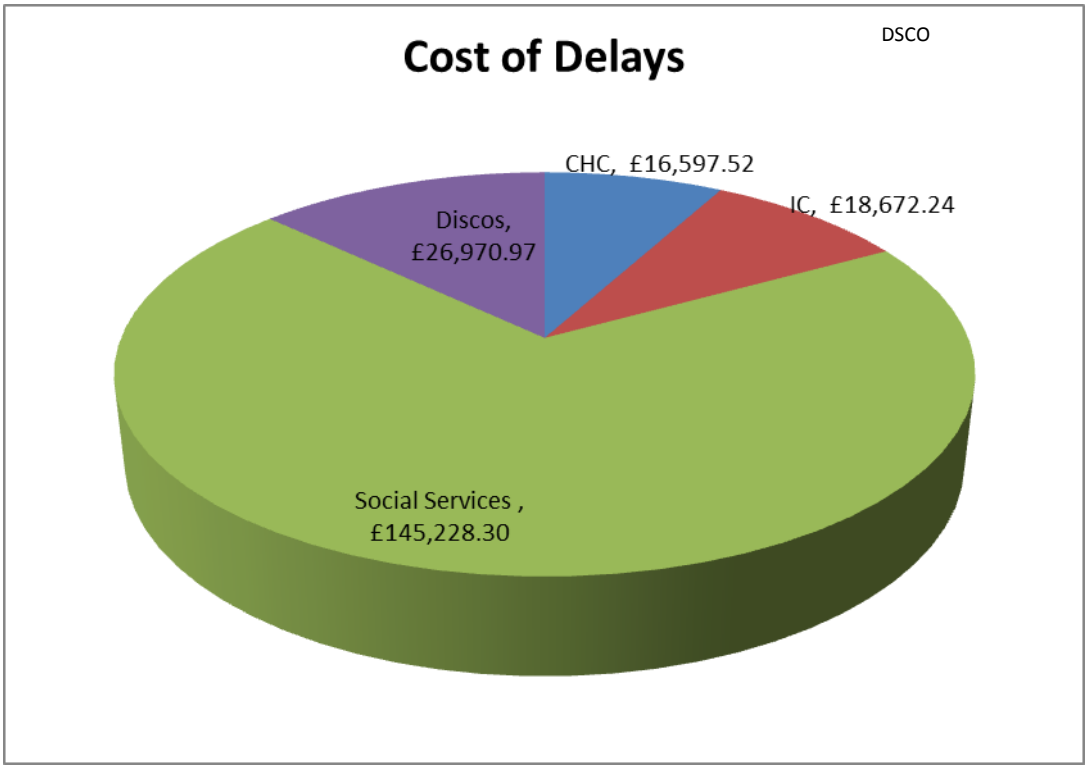
Finance

34. Work is being done to ensure that the information systems used by all agencies are more reliable for all partners to have confidence in analyses made and actions planned based on those analyses. This will support improved efficiency of the system and improved experience by people. All agencies have views about the costs of delays or the processes to their agencies and they are working to ensure that the information sources are more consistent so that view can be reconciled and appropriate actions taken.

35. The CCG has carried out a retrospective analysis of the delays taking place in May 2014, both in terms of the cause of the delay and the associated cost to the CCG. At the time the review was undertaken, the reason for the delay was agreed and none were in dispute.

36. The pie charts below indicate that the majority of delays (70%) were attributable to social care, based on current CCG analysis, at a total cost to the CCG for the month of £145,228, an annual equivalent of £1,742,736.

This data and outcome is currently being challenged and scutinised by the Local Authority so that we can achieve a shared agreement



CHC = NHS Continuing Healthcare
IC = Intermediate Care
DISCO = Dudley Group NHS FT discharge co-ordinators

Law

37. The legal and government guidance framework to manage issues connected to delayed discharges is set through:

- The *Community Care (Delayed Discharges etc.) Act 2003* which was enacted in 2004
- Delayed Discharges (England) Regulations 2003
- Health Service Circular 2003/009
- Delayed Discharges (Continuing Care) Directions 2013
- Monthly Delayed Transfer of Care Satraps: Definitions and Guidance Version 1.07 (last updated 8 April 2013)
- *Care Act 2014*

Equality Impact

38. Transfers of care will need to be made equally for all people. People's needs will vary according to their health and assessments should take account of all relevant factors at the point of transfer from hospital.

Recommendation

39. That the Committee note and comment on
    - issues connected to quality transfers of care between hospital and other settings,
    - work being done in the health and social care economy to continually improve our services and people's experience of transfer of care between hospital and other settings
    - specific issues relating to delayed transfers of care

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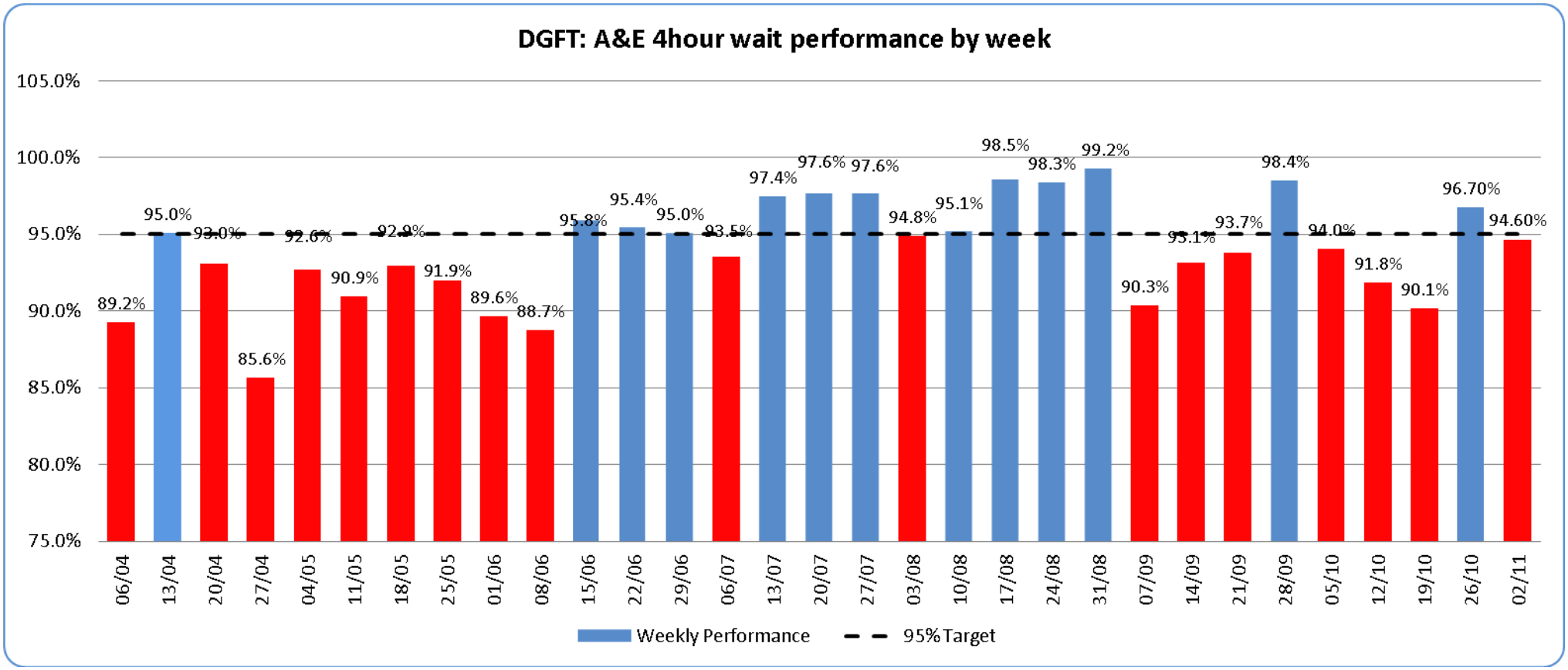
Background Papers

More detailed definitions, guidance and the most up to date national statistics are available from the NHS England website at http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

APPENDIX 1


DGFT: A&E 4hour wait performance by week
105.0%
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
89.2%
95.0%
93.0%
85.6%
92.6%
90.9%
92.9%
91.9%
89.6%
88.7%
95.8%
95.4%
95.0%
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17/08
24/08
31/08
07/09
14/09
21/09
28/09
05/10
12/10
19/10
26/10
02/11
Weekly Performance
95% Target

APPENDIX 2

Delayed Transfers of Care

Extract from Emergency Care Intensive Support Team Action Plan

Area No	Area	Scheme Description	Lead	ECIST suggested key performance indicators	Start Date	Current status of scheme eg: date implemented, key milestones, date for full implementation	RAG Red= not yet started Amber partially implemented % Green fully implemented	Mitigation actions to progress/ comments
1	**Improve the discharge process**	Reduce variation in medical models across inpatient ward areas. Provide a consistent model for provision of ward and board rounds. Implement clinical criteria for discharge with expected discharge dates. Review existing internal professional standards in relation to DTOC. Set internal professional standards with associated escalation for diagnostic tests.	Jon Scott	Number of Discharges taking place each day. Meeting the 4 hour standard.	Oct-14	Some work underway internally.	**Partially Complete**	Mark as complete when D2A live and weekly panel meetings are increased.
2	**Reduce the level of DTOC**	There is a need to reduce delays for community services and partner organisations. Internal length of stay review is completed for all patients in beds over 7 days for both acute and community	Brendan Clifford / Jon Scott / Paul Maubach	Number of Discharges taking place each day. Meeting the 4 hour standard.	Oct-14	Planning and roll-out of D2A model will significantly reduce DTOC issues. Discharge to Assessment workshop agreed for 18th September. LA to review its Panel decision making process. 08.10.14 S Lackenby confirmed that twice weekly panel meetings will commence immediately.	**Partially Complete**	Mark as complete when D2A live and weekly panel meetings are increased. 08.10.14 D Fitton to at UCWG on 22.10.14 re DTOC/EMS Levels - Trigger 14.
3	**Discharge Lounge**	Recommend that the discharge lounge is ring fenced and not used as a contingency for inpatients.	Jon Scott	Discharge lounge used for its primary function and no longer compromised due to inappropriate use.	Aug-14	Ring fence policy issued.	**Complete**	N/a
4	**Weekly panel decisions**	Improvement access to continuing Healthcare panel.	Brendan Clifford	Remove reliance on weekly continuing care assessment panels. Increase frequency of sign-off and agreement of funding decisions. **ECIST Recommendation**: replace weekly panels with 'real time' decision making system.	Oct-14	Currently weekly panel still in place although some decisions are made outside of this meeting. Review of Panel (LA) is to take place early September with the aim of allowing decisions making for placements available across the working week.	**Partially Complete**	Need confirmation of revision of this practice. Proposal ready within the next few weeks. 24.09.14 B Clifford & J Scott to meet on 29.09.14 to discuss this issue. A pope-Smith to write to DGFT with full update. 08.10.14 S Lackenby confirmed twice weekly panel meetings will commence immediately.
5	**Discharge to Assess Model**	Launch Discharge to Assess model.		Pay attention to: medical model for complex medical patients who are clinically stable. Consider using a memorandum of agreement to help clarify governance arrangements across the system. Ensure that optimum use is made of home based assessment pathways. Importance of therapy input in this model - flexibility between acute and community teams required.			**Partially Complete**	

Agenda Item No.8

Health Scrutiny Committee

Report of the Chief Accountable Officer, Dudley CCG

The Better Care Fund (BCF)

1.0 Purpose of Report

1.1 To update the Committee on the current position in relation to the Better Care Fund (BCF).

2.0 Background

2.1 At its last meeting the Committee received a report on the BCF. The Committee will recall that, at that time, The BCF Plan was awaiting formal sign off by the Health and Wellbeing Board and would be subject to a national assurance process.

2.2 The BCF Plan (a copy of which is attached as Appendix 1) was approved by the Health and Wellbeing Board at its meeting on 30th September 2014.

2.3 Following an assurance process, the BCF Plan has been assessed as "approved with conditions". The main condition relates to the planned reduction in emergency admissions and whether this is achievable. Further work is now taking place to assess what the potential scenarios may be in relation to this before a resubmission is made. An action plan setting out how we will review the plan has to be submitted by 14th November and it is anticipated that a resubmission will be made by early December.

2.4 The Committee will note that the annexes to the BCF Plan set out the main schemes to be implemented with the intention of reducing admissions to secondary care and enabling the associated financial plan to balance. These are at varying stages of development but there is a clear imperative to implement these as rapidly as possible if the target level of admission reduction is to be achieved. Work is taking place to review current progress and ensure the appropriate programme management arrangements are in place for successful delivery.

2.5 The Committee will recall that the performance element of the BCF (£5.9m) is based purely on delivering the required reduction in emergency admissions. This requires close performance monitoring in order to manage the associated risk to both the CCG and the Council. Other performance indicators, such as the level of admissions to residential/nursing home care and delayed transfers of care, are important to the overall success of the health and social care system. Therefore, these will feature in a more comprehensive performance framework which will be reported to the Health and Wellbeing Board.

3.0 Finance

3.1 The respective contributions to the BCF are set out in the Appendix. In particular, the issue of how risk will be managed between the CCG and the Council is addressed.

4.0 Law

4.1 The pooled budget to be used to facilitate the creation of the BCF will be created using powers contained in Section 75 of the NHS Act 2006.

5.0 Equality Impact

5.1 The integrated services model that underpins the BCF is designed specifically to respond to health inequalities identified in the Joint Strategic Needs Assessment and the CCG's Operational Plan.

6.0 Recommendation

6.1 That the position in relation to The Better Care Fund be noted

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The Dudley Group NHS
NHS Foundation Trust

Agenda item 12

Dudley Health Scrutiny Committee – 20th November 2014

The Dudley Group NHS Foundation Trust
Patient Experience

1.0 Purpose of Report

This document is presented to update the committee on The Dudley Group NHS Foundation Trust Patient Experience Strategy. The committee received the full patient experience strategy in February 2014 however as the committee has changed since then it is again attached at Appendix 1 for information. The committee requested further updates be brought back to the committee on progress.

2.0 Patient Experience Strategy – Appendix 1

The Dudley Group NHS Foundation Trust has systematically been collecting patient feedback for some years now and using this data to drive improvements. Data is collected from a variety of routes (around 20,000 pieces of feedback in 2013/14, and growing), for example:

- Complaints
- PALS queries
- Compliments
- National Survey programme
- Local real-time surveys programme
- Departmental surveys
- Listening events
- Patient panels
- The Friends and Family Test
- NHS Choices/patient opinion/other online methods

The Trust used all of this information as well as some dedicated engagement with patients and partner organisations in order to inform the strategy and associated actions.

One of its core strategic objectives is to *provide the best possible patient experience,* in an organisation *where people matter.* The Trust values of *care, respect, responsibility* underpin all of the work within the strategy and are the basis upon which we want to build our patient experience.

We will achieve this by achieving the following strategic goals:

- Mobilising the workforce with a passion for getting things right for patients every time
- Creating an environment that provides the facilities expected in 21st C healthcare and which aids treatment and or/recovery

- Providing good clinical outcomes and effective processes so that patients feel involved, valued and informed

Translated into three key areas below.

The strategy can be seen at Appendix 1.

3.0 Patient Experience Actions update – appendix 2

Since approval of the strategy the Trust have introduced an executive led steering group for Patient Experience chaired by the Chief Executive to ensure service improvements and best practice are shared across the Trust.

In the first two quarters of 2014/15 the Trust have prioritised improving our food offering to patients with our providers Interserve through a complete menu. This is a result of patients consistently telling us this is the number one area for improvement see graph at foot of appendix 2. The menu trial was conducted on four wards during September 2014 with both patients and staff choosing their preferred dishes to go on the menu. Governors, public and Board members will be giving the final feedback on the new menu before it is implemented across the Trust in the New Year.

Alongside the complete menu review the Trust have implemented some immediate changes to the existing menus which have been well received by patients. The sandwiches have been improved with better bread and specialist fillings, nourishing soup and chip trials have been conducted and additional training on food preparation and customer service.

Interserve has undertaken additional training for their staff, and have produced a manual for each ward covering laying out the food trolleys, standard dress, plug in points for the trolley, standardised ward kitchen layouts.

Interserve are also investing in new food trolleys which will resolve any temperature issues we may have.

Appendix 2 shows the last two quarters action plan summary reports highlighting other patient experience improvement actions. The Trust Board, Clinical Quality, Safety and Patient Experience (CQSPE) sub Committee receive this report each quarter to track progress against the more detailed action plans which are developed and monitored at the Patient Experience Group.

4.0 Equality Impact

The Dudley Group NHS Foundation Trust is committed to ensuring that as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

5.0 Recommendation

6.1 That the committee receive this report for information

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Head of Communications and Patient Experience
The Dudley Group NHS Foundation Trust
……..

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APPENDIX 1

THE DUDLEY GROUP NHS FOUNDATION TRUST

PATIENT EXPERIENCE STRATEGY 2014 - 2017

1. INTRODUCTION

The Trust is committed to providing patient-centred services that meet the health needs of the communities it serves. One of its core strategic objectives is to *provide the best possible patient experience,* in an organisation *where people matter.* The Trust values of *care, respect, responsibility* underpin all of the work within this strategy and are the basis upon which we want to build our patient experience.

We will achieve this by achieving the following strategic goals:

- Mobilising the workforce with a passion for getting things right for patients every time
- Creating an environment that provides the facilities expected in 21st C healthcare and which aids treatment and or/recovery
- Providing good clinical outcomes and effective processes so that patients feel involved, valued and informed

Translated into three key areas below.

2. STATEMENT OF INTENT/PURPOSE

This strategy sets out The Dudley Group NHS Foundation Trust (the Trust) commitment to continuously improving our patients' experience of our services.

It aims to set out how the Trust will raise the standards and set expectations of patient, family and carer experience. It provides guidance to support further development of patient experience and public involvement within the Trust, and aims to ensure that Trust plans are driven by patient priorities wherever possible, both locally and across the wider health community.

It sets out the main responsibilities and systems the Trust will use to make changes and monitor progress towards our vision of being *a highly regarded healthcare provider for the Black Country and West Midlands, offering a range of closely integrated acute and community based services, driven by the philosophy that people matter*.

In order to do this successfully, patients, carers, the public and other stakeholders need to be involved in planning, delivering and monitoring of services. This is alongside the need and right for patients and carers to be involved in decisions about their healthcare at a personal level.

3. SCOPE

This strategy applies to the whole Trust. This strategy has been developed following thorough research of this fast paced evolving topic and in depth analysis of our own and national patient experience benchmarks. A public and stakeholder listening event helped shape this strategy and the strategies of our commissioners were also taken into account.

It also outlines work already underway with our commissioners, along with local patient group Healthwatch, and key areas all organisations want to further develop work, to improve the patient experience across the health economy.

It is important to recognise in the current financial climate the Trust will not be able to do some things that patients have said they would like to see such as making parking free or bedside TVs at all beds. Consequently this may have an impact on patients' views of our services. Therefore it is vital we manage expectations whilst we tackle as many of those things patients wish to see changed that are in our gift.

4. DEFINITIONS

The Kings Fund in 2008 described patient experience as follows
" Patients' experience of hospital is intrinsically difficult to grasp. It is richly textured and complex. By definition subjective, the experience is such that no one else can know how it works from one moment to the next, how different aspects of the experience (the process of care, the manner in which it is delivered, the environment in which it occurs, the physical sense of the place) come together, or what they mean for this particular person at this particular moment in their life."

A patient's direct experience of specific aspects of treatment or care
NQB SECRETARIAT (2011, p2)

This definition is further expanded to include the elements listed under the section entitled NHS Patient Experience Framework 2011/12 see appendix 1 for further background and definitions of patient experience and the national context.

5. DUTIES (RESPONSIBILITIES)

The Trust Executive lead for Patient Experience is the Chief Executive supported by the Communications and Patient Experience Team.

The Non Executive lead for patient experience is the Chair of the Clinical Quality Safety and Patient Experience Committee (CQSPE). This Board Committee takes the lead for patient experience within the Trust and elements of it are monitored regularly directly by Board, for example the Friends and Family Test and real time surveys. The Board also receive a patient story at each meeting.

The Patient Experience Group will report to the CQSPE and ensure operational implementation of this strategy and action plans for patient experience improvements.

This strategy is intrinsically linked to the Staff Engagement Strategy which is also led by the Chief Executive and Communications Team. This is because a large number of research studies have shown that organisations with high levels of staff engagement achieve better quality standards, more innovation, increased

productivity and better customer service. Therefore the Staff Engagement Strategy reinforces the fact good patient experience is the responsibility of every member of staff, based on the vision of creating an environment *where people matter* through treating everyone with *care, respect and responsibility* by living the Trust values.

6. STRATEGY

6.1 OVERVIEW OF PROCESS

The failings at Mid Staffordshire Hospitals NHS Foundation Trust and other more recent NHS care failures have signalled a new era for patient voice and how trusts can make improvements as a result of proactively gathering and using patient feedback. The Trust currently gathers over 10,000 pieces of patient feedback each year is therefore well placed to meet the challenges posed by this new environment.

As an integrated service provider the Trust has real opportunities to ensure seamless services for patients thereby helping to provide the best possible patient experience from door to door. The Trust has the desire to be amongst the very best for patient experience, consistently scoring in the top 20 per cent of Trusts in national surveys being the long term aim.

Dudley Clinical Commissioning Group and patient group Healthwatch have worked with the Trust in the development of this strategy, with all organisations sharing a desire to focus attention on system wide key themes which affect patient experience such as:-

- Handover of care
- Communications between professionals and organisations
- Managing vulnerable people through transition

Listening events with the public and complainants have been held to further develop the patient experience improvement actions all of which are designed to fulfil the intent of the strategy. These will be delivered through time-lined, measurable action plans which will be updated each year and reviewed along with the strategy in 2017.

6.2 Mobilising the workforce with a passion for getting things right for patients every time

We will inspire all our staff to provide the best possible experience every time for every patient through effective recruitment, training and management processes. This will enable everyone to take responsibility for their actions and the experience of their patients, their carers and families.

By 2017 we will:

- Have reduced the numbers of complaints that cite staff behaviours or attitudes as their cause
- Have patients rate the Trust amongst the top performers in the NHS (as measured by national patient surveys upper quartile)
- Have consistently high levels of patient's recommending the Trust to friends and family (as measured by the Friends and Family Test)
- Continue and further develop ways to involve patients in their care throughout their journey to help understanding of what they can expect from their healthcare services.
- Developed our workforce to excel at customer service delivered with care, compassion and empathy.

Action:
The staff engagement strategy defines actions we will take to engage our workforce to deliver the best possible patient care through our clinical strategy, the patient experience strategy focuses on ensuring we pick up the focus on customer care from the patient's perspective not the Trust's.

- Hold regular listening events with public and patients to ensure our action plans are relevant and evolving with the Trust.
- Further develop the complaints process to ensure when it does go wrong patients receive the best possible outcome
- Ensure ownership of patient feedback both good and bad across all service and clinical levels empowering staff to make changes
- Ensure every ward/ department has patient feedback
- Work alongside the Nursing Directorate in the delivery of their strategy "The Way We Care"

6.3 Creating an environment that provides the facilities expected in 21st C healthcare and which aids treatment and/or recovery

The Trust is developing an Estates Strategy which deals specifically with ensuring our excellent facilities remain as such and we take opportunities to provide services in the best possible clinically appropriate environment. This strategy will therefore focus on ensuring patients have a way to make suggestions for improvements to the environment and that a process is in place to monitor patient comments about environmental topics and ensure a system for improvements is in place. Patient feedback on care of their holistic needs will also be monitored for improvement.

By 2017 we will:

- Continue to have some of the most up to date estate and facilities in the NHS which are fit for purpose
- Develop facilities and support services that centre around our patients needs involving them in development and improvements, ensuring patient feedback forms part of any estates and facilities reconfiguration or development
- Value the diversity of our population and provide facilities that make it easy for all people to navigate and to get around

Action:
Patient opinion and experience should always be taken in to consideration when planning and designing new facilities and service redesign.

- Deliver annual programme of patient panels to tackle priority areas for improvement
- Continue to report estates issues highlighted in patient feedback
- Continue to focus on improvements to hotel services with our PFI partners

6.4 Providing good clinical outcomes and effective processes so that patients feel involved, valued and informed

The Trust's Clinical strategy sets out clearly the clinical priorities for the Trust while the Quality strategy states the key performance measures for the quality of those services. This strategy outlines how we will deliver better outcomes with less money whilst also continuing to improve our patients' experiences of our services. We will

make patient feedback part of valued core performance information which drives service improvements from patients' perspectives

By 2017 we will:

- Further develop shared decision making tools and embed across the clinical services to ensure there is "*no decision about me without me"* widely embraced throughout the Trust
- Have a systematic approach to collecting patient experience data ensuring we learn from both good and bad feedback and demonstrate how practice has changed.
- Develop and embed key performance indicators for patient experience ensuring they have equal weight alongside the financial and clinical safety and quality ones from ward to Board level.

Action:

- Communicate clearly Shared Decision Making tools across the Trust
- Develop and implement action plans in response to national and local patient experience feedback monitored through the Patient Experience Group
- Continue to publish results to our patients and public of the Friends and Family test and further develop 'You said we did' approach to feedback of changes made.

7. TRAINING/SUPPORT

Guidance and training is offered to staff as requested for implementation of the Friends and Family Test system and where concerns are raised about particular issues advice is given on what training is available to support development.

The patient experience team work closely with wards/departments to ensure they understand the role they all play in improving patient experience.

Training and Development are working to further develop Customer Care Ambassador and Customer Care training programmes.

8. PROCESS FOR MONITORING COMPLIANCE

Patient feedback is evaluated and monitored at all levels across the Trust and this strategy sets out specific measures and checks to ensure it remains a key focus for the Trust. The CQSPE committee will continue to receive regular reports on all the forms of patient feedback the Trust uses to ensure the action plans remain on track and monitor progress.

9. EQUALITY IMPACT ASSESSMENT

The Dudley Group NHS Foundation Trust is committed to ensuring that as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

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11. **MONITORING THE EFFECTIVENESS OF THIS STRATEGY**

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
PE Quality priorities	Trust Board	Audit PE database Reports	Quarterly	Quarterly report to CQSPE	Identify actions required and delegate individuals to take forward	Communications department to determine appropriate methods of communication dependent upon target audience
PE CQUIN targets	Trust Board	Reports National/ local surveys	Annual and quarterly	Quarterly report to CQSPE and quarterly CCG joint quality review meeting	Identify actions required and delegate individuals to take forward	Communications department to determine appropriate methods of communication dependent upon target audience
National patient surveys	Trust Board	Reports Survey	As per national programme of surveys	As required following publication of results nationally to CQSPE	Patient Experience Group to deliver action plan Deputy Head of Communications and Patient Experience	Communications department to determine appropriate methods of communication dependent upon target audience
Friends and family test	Trust Board	Reports	Monthly	Monthly to CQSPE and Board Externally reported on UNIFY	Patient Experience Group and Deputy Head of Communications and Patient Experience	Communications department to determine appropriate methods of communication dependent upon target audience

APPENDIX 1 (to the Patient Experience Strategy)

Background and key guidance

This strategy provides an important focus for the organisation and has facilitated the commitment of the Trust Board. There has been a plethora of national documents, initiatives and guidance which have highlighted the need to focus on measuring and improving patient, family and carer experience. For most, experiences of care are mixed and patient stories will often describe variability in the experience of care across the Trust and the NHS as a whole. Nationally the NHS has not made significant progress in the area of service experience and there is a need for more concerted effort to be made by all staff.

There is much learning in relation to clinical effectiveness and safety, our understanding of what matters to patients in relation to their experience of healthcare and how it can be improved is still evolving. Despite the NHS gathering a lot of data in relation to patients' experiences of our services there
is little hard evidence on how best to make that data into real quality improvements. Studies have seen improvements where there is systematic collection of patient experience feedback.

The **NHS Constitution (2010)** promotes 'high quality care for all' and clearly signposts patients, public and staff to their responsibilities and rights whilst reiterating the enduring principles and values of the NHS. Its importance has recently been reinforced through the report into Mid Staffordshire Hospitals. There has never been a more important or pertinent time in the history of the NHS to focus on delivering good patient experiences every time. The **Health Act 2010** saw the introduction of a legal obligation on Trusts to take the NHS constitution into account in all their decisions and actions.

The **Equality Act 2010** replaces all previous anti-discrimination legislation, and includes a public sector equality duty requiring public bodies to have due regard to the need to eliminate discrimination and to advance equality of opportunity and foster good relations between people who share certain protected characteristics and those who do not. The protected characteristics are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The Act provides an important legal framework which should improve the experience of all patients using NHS services.

Despite these policy initiatives, there is evidence to suggest that further work is needed to deliver the best possible experience for users of NHS services. The Government signalled in its White Paper **'Equity and excellence: liberating the NHS'** (2010) that more emphasis needs to be placed on improving patients' experience of NHS care. It focused on generic patient experiences and is relevant for all people who use adult NHS services in England and Wales. The aim of this paper was to provide the NHS with clear guidance on the components of a good patient experience. The guidance provided the evidence and the direction for creating sustainable change that will result in an NHS cultural shift towards a truly person-centred service.

Equity and excellence: Liberating the NHS placed a greater emphasis on Involvement of patients and public, putting patients and public first through the following measures:

- Shared decision making**: *nothing about me without me.***

- An NHS information revolution: much more public information about safety, effectiveness and experience.
- Specific public information on every NHS Trust's performance and clinical outcomes.
- Strengthening the collective voice of patients by *HealthWatch England,* a new independent consumer statutory body, coming into force in April 2013.

Outcome 1 of the ***Essential Standards of Quality and Safety*** (Care Quality Commission/CQC) is a key standard for patient experience.

The ***NHS Outcomes Framework*** is structured around five domains, which set out the high level national outcomes that the NHS should be aiming to improve. Domain 4 provides indicators to ensure that people have a positive experience of care.

The purpose of the *NHS Outcomes Framework* is to provide a national level overview of how well the NHS in performing, to provide an accountability mechanism between the Secretary of State for Health and the *NHS Commissioning Board* and to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change culture and behaviour.

In February 2012 the NHS National Quality Board (NQB) published the ***NHS Patient Experience Framework*****,** agreed by the National Quality Board in October 2011, (see below), based on the *Picker Institute Framework* and can be the starting point to explore the patient experience in a particular service. A team of staff involved with a service might want to focus on one or two dimensions and look at improvements in those areas. Once the team has decided what kind of service they are striving to deliver, they can outline the types of behaviour that would be expected from staff to make this happen.

NHS Patient Experience Framework 2011/12:

Respect of patient-centred values, preferences, and expressed needs including: cultural issues; the dignity, privacy and independence of patients and service users; an awareness of quality-of-life issues; and shared decision making.

1. **Coordination and integration of care** across health and social care system.
2. **Information, communication, and education** on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care and health promotion.
3. **Physical comfort** including pain management, help with activities of daily living, and clean and comfortable surroundings.
4. **Emotional support** and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances.
5. **Welcoming the involvement of family and friends**, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as care-givers.
6. **Transition and continuity** as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions.
7. **Access to care** with attention for example, to time spent waiting for admission or time between admission and placement in a room in an in-patient setting, and waiting time for an appointment or visit in the out-patient, primary care or social care setting.

The **National Institute for Health and Clinical Excellence (NICE 2012)** have condensed the 65 recommendations contained in their Patient Experience Clinical Guideline into 14 quality statements.

No.	Quality statements
1.	Patients are treated with dignity, kindness, compassion, courtesy, respect, understanding and honesty.
2.	Patients experience effective interactions with staff who have demonstrated competency in relevant communication skills.
3.	Patients are introduced to all healthcare professionals involved in their care, and are made aware of the roles and responsibilities of the members of the healthcare team.
4.	Patients have opportunities to discuss their health beliefs, concerns and preferences to inform their individualised care.
5.	Patients are supported by healthcare professionals to understand relevant treatment options, including benefits, risks and potential consequences.
6.	Patients are actively involved in shared decision making and supported by healthcare professionals to make fully informed choices about investigations, treatment and care that reflect what is important to them.
7.	Patients are made aware that they have the right to choose, accept or decline treatment and these decisions are respected and supported.
8.	Patients are made aware that they can ask for a second opinion.
9.	Patients experience care that is tailored to their needs and personal preferences, taking into account their circumstances, their ability to access services and their coexisting conditions.
10.	Patients have their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety.
11.	Patients experience continuity of care delivered, whenever possible, by the same healthcare professional or team throughout a single episode of care.
12.	Patients experience coordinated care with clear and accurate information exchange between relevant health and social care professionals.
13.	Patients' preferences for sharing information with their partner, family members and/or carers are established, respected and reviewed throughout their care.
14.	Patients are made aware of who to contact, how to contact them and when to make contact about their ongoing healthcare needs.

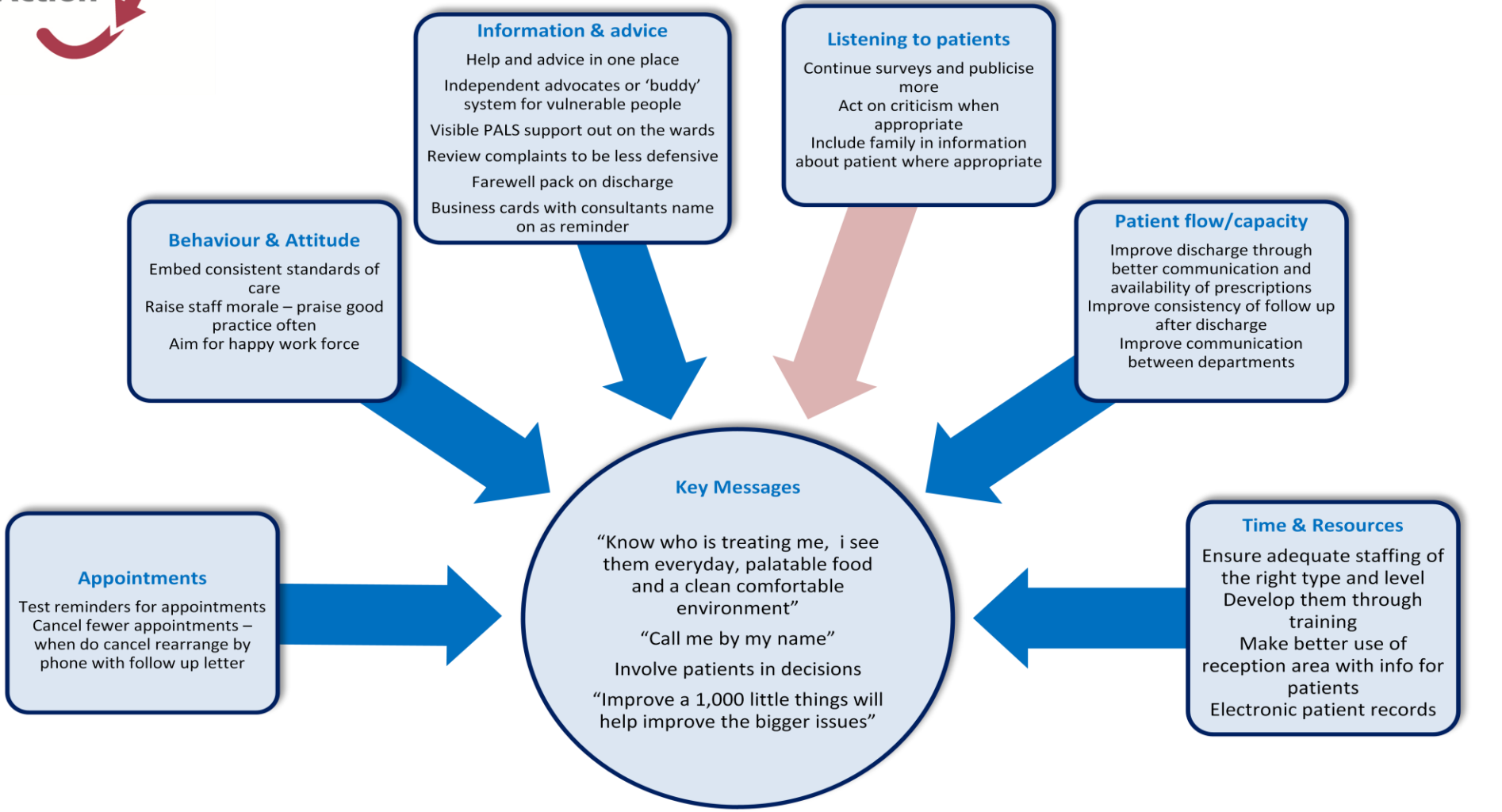
November 2012 saw the publication of the first **Mandate** between Government and the NHS Commissioning Board setting out the ambitions for the Health Service for the next two years.

The objectives in this mandate focus on those areas identified as being of greatest importance to people and one of the five areas to make improvements is ensuring people have a positive experience of care. It sets an objective and therefore importance to ensure all patients can give feedback on their care via the Friends and Family Test so that people can tell which wards, A&E departments, maternity units and hospitals are providing the best care.

Appendix 2 (to the Patient Experience Strategy) - Listening into Action feedback

Patient Experience LiA- what people want

The Dudley Group NHS
NHS Foundation Trust



Here is your feedback from the Patient Experience LiA conversation showing the main themes and top features you'd like to see

Communications Team

Patient Experience Actions update

Appendix 2

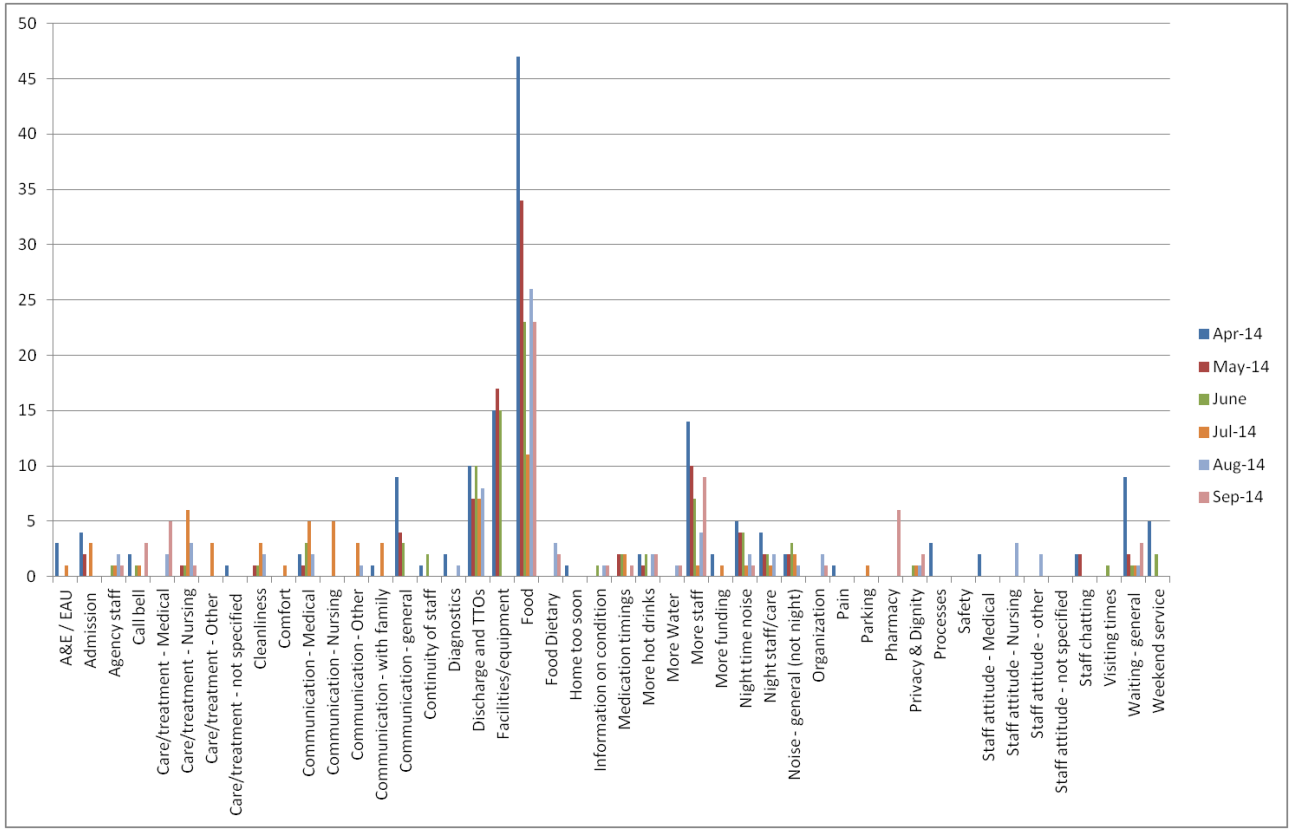
Actions taken in Quarter 1 2014/15			**Patient Experience Summary Action Plan 2014-2017** *(interactions between the organisation and its patients; a blend of physical performance and emotions evoked measured against customer expectations across journey touchpoints)*		
		Theme	**Key actions**	**Lead director**	**Monitoring**
•Staff Friends and Family Test implemented. •Entries made to Nursing Times, Nursing Standard, Patient Safety and Care and HSJ awards. •2014 Committed to Excellence launched - over 200 entries so far •Investigating signing up to NHS Sport and Physical Activity Challenge or instigating Trust own. •Initial scope for customer care programme drawn up and awaiting director approval. •Customer care training now included on novice, fundamental skills, graduate and international nurse programmes. •Customer Care Ambassador programme relaunched - ideas generated for a refresh including expectations of ambassadors. •Staff engagement reporting system established via Workforce and Staff Engagement Committee. •Values based questions introduced at the beginning of all interviews. •Vision and values incorporated into all training delivered by Learning and Development team, whatever the level of type of training.	1		Drive improvements in customer service and staff engagement to improve patient experience	Chief Executive	Workforce and Staff Engagement Committee
•Staff survey improved score for engagement now marginally below national average parital question on FFT will be used throughout the year to monitor	2		Review the existing culture of the organisation and put plans in place to establish a positive culture to improve patient experience	Chief Executive	Workforce and Staff Engagement Committee
•Volunteers' week celebrated with thank you postcards from staff to volunteers displayed at sites, along with a poster campaign •Regular volunteer recruitment events held •Volunteer policy updated and placed on Hub •Newly recruited volunteers received induction and assigned to wards •38 new mealtime volunteers recruited and first training session undertaken	3		Develop the role of volunteers	Chief Executive	PEG
Volunteer strategy drafted but awaiting further work					
•Annual PLACE Assessment undertaken •Market testing programme underway and to include patient involvement where appropriate •PFI-related patient experience feedback reporting process implemented •Menu review undertaken and timelines being drawn up for piloting and public testing. •Chips being trialled at all mealtimes •EPAC, GI and 1st floor POD works complete •Feasibility works for hybrid theatre undertaken and handed over to surgery for a business plan •Agreement from Highways Agency for improved signage at Guest Hospital •Additional mugs on order •Shop trolley re-started with ward rota publicised	4		Ensure our facilities and equipment meet the needs of our patients in terms of access, comfort, dignity and experience	Director of Operations	Diversity Management Committee PEG
•Charity bid being drawn up for soft close bins, and night time protocol under development •No progress on number plate recognition for car parking as Interserve has not yet agreed a partner. Interim arrangement in place for large adapted vehicles to park. •2nd floor pod works delayed due to compliance issues - work now underway •Trust IT progressing wifi project for patient/public access					
•Discharge lounge environment works variation received - needs consultation with ward staff on exact requirements.					
•CE update verbal and video ongoing •Turnaround events held with Chief Executive/Director to start staff engagement •Extensive staff communications in build up to CQC visit with positive responses •Nurse staffing data now on website and NHS Choices •Annual Report/Quality Report prepared and laid before Parliament •Your Trust magazine published •Successful Carers' week held with take the time tea event for visitors •Interpreting/translation awareness campaign developed	5		Improve communication: Internal - ensure staff know goals and how we are doing External - build reputation, confidence and service knowledge Patients/carers - ensure patients and carers are kept informed with consistent information and joined up care	Chief Executive/Director of Nursing/ Head of HR	Trust Board

•New Welcome to the Ward leaflets introduced for Surgical Assessment Unit and Paediatrics •Bedside folders introduced into Maternity •3 cancer information display stands erected - 1 in main reception, 2 at second floor near Georgina Unit •Noticeboard information reviewed and refreshed •Ongoing new and updated leaflets - particular focus on cancer and diagnostics •Commenced marking out of date leaflets as 'under review' on the Hub (as per policies)	6		Ensure that appropriate information is available to help patients understand their treatment options, risks and benefits and to keep them informed	Chief Executive	PEG
•Patient experience results now included in directorate performance reviews •Strong links forged with Healthwatch and Health Overview and Scrutiny Committee •LiA included in Service Improvement meetings •Business case policy updated and now includes non-financial appraisal with patient experience cited as an example •Patient stories presented at Board and PEG •Key patient experience metrics displayed on ward huddle boards •Complaint responses updated to include recommended changes from Keogh and subsequent Deloitte reviews •Patient Experience Group introduced •FFT RAG rating updated for 2014/15 •System set up for patients to feedback directly to us via our website and get a response if required •Text messaging reminder service implemented for outpatients •Mystery Patient Programme started in outpatients •National ED survey underway •National cancer survey underay •PALS office now part of Communications and Patient Experience team	7		Implement a service improvement framework to ensure that patient feedback drives improvement and processes are built around our patients - inlcuding links to Service Improvement and local improvement toolkit		Transformation PEG Council of Governors

Actions taken in Quarter 2 2014/15			**Patient Experience Summary Action Plan 2014-2017** *(interactions between the organisation and its patients; a blend of physical performance and emotions evoked measured against customer expectations across journey touch points)*		
		Theme	**Key actions**	**Lead director**	**Monitoring**
•Staff Friends and Family Test implemented. •Entries made to EHealth insider awards for mortality tracking system - finalist news communicated. •2014 Committed to Excellence delivered - successful event with over entries. Hello myname is campaign launched at the event to help promote excellent communications with patients and colleagues across the Trust. •Work underway with Action Heart on Sport and Physical Activity Challenge for staff. •Customer Care Ambassador programme first two training sessions complete to develop ambassadors skills further. • Gifts for longest serving long service awards procured with charitable funds from local glass sculptor.	1		Drive improvements in customer service and staff engagement to improve patient experience	Chief Executive	Workforce and Staff Engagement Committee
•First two quarters FFT results reported to NHS E in line with national guidance •Highlights and lowlights of staff survey 2013 communicated more widely throughout organisation and plan in place to continue throughout 2014/15, ongoing work.	2		Review the existing culture of the organisation and put plans in place to establish a positive culture to improve patient experience	Chief Executive	Workforce and Staff Engagement Committee
Volunteer strategy drafted but awaiting further work	3		Develop the role of volunteers	Chief Executive	PEG
•Annual PLACE Assessment results received and communicated - improved results •Additional mugs received on all wards	4		Ensure our facilities and equipment meet the needs of our patients in terms of access, comfort, dignity and experience	Director of Operations	Diversity Management Committee PEG
•New gowns sourced by PFI provider, samples received awaiting Trust confirmation of order •Discharge lounge works halted on C8 as proposal to move to A2.					

•CE update ongoing. •Monthly Live chat with Chief Executive launched. •Recommendation of the Trust by patients included on NHS Choices comparison page. •Roll out of Interpreting/translation awareness campaign underway. •Huddle boards have key staff on duty that day/night as well as other key patient experience information.	5		Improve communication: <u>Internal</u> - ensure staff know goals and how we are doing <u>External</u> - build reputation, confidence and service knowledge <u>Patients/carers</u> - ensure patients and carers are kept informed with consistent information and joined up care	Chief Executive Director of Nursing Medical Director Associate Director of IT	Trust Board
•Ongoing new and updated leaflets •Commenced marking out of date leaflets as 'under review' on the Hub (as per policies) • Welcome to the ward leaflets review underway for sustainable model • Awareness campaign developed and implemented to ensure staff know how to access patient information •Audit of patient information to identify any service gaps complete including cross matching all information on hub, website and patient information database. •Learning disabilities lead has software to produce Easy Read leaflets	6		Ensure that appropriate information is available to help patients understand their treatment options, risks and benefits and to keep them informed	Chief Executive	PEG
•Patient stories presented at Board and PEG •Patient stories included for doctors' learning at medical directorate audit meeting •New real-time surveys implemented: updated inpatient, maternity and bereavement •National inpatient survey data collection complete - awaiting results •Update reporting rotas following restructure •Mystery Patient Programme underway •National ED survey data collection complete •Appointment letters have been reviewed by a dedicated Task & Finish Group .	7		Implement a service improvement framework to ensure that patient feedback drives improvement and processes are built around our patients - including links to Service Improvement and local improvement toolkit	Director of Strategy and Performance / Chief Executive	Transformation PEG Council of Governors

What could be improved – FFT Q1 and 2 2014/15



In the first two quarters of 2014/15 we received 2288 comments from our acute inpatients using the Friends and Family Test. The majority of comments were positive. The remaining comments are assigned to one of 46 categories as detailed in the above chart. The top five most frequently received comments where patients say we should make improvements are:

Food 268
Facilities and equipment 94
More Staff 76
Discharge and TTO's 69
Communication 32