DUDLEY HEALTH AND WELLBEING BOARD

TUESDAY 28TH JANUARY 2014

AT 3.00 PM
COMMITTEE ROOM 2
COUNCIL HOUSE
DUDLEY

If you (or anyone you know) is attending the meeting and requires assistance to access the venue and/or its facilities, could you please contact Democratic Services in advance and we will do our best to help you

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You can view information about Dudley MBC on www.dudley.gov.uk

health &wellbeing
looking after our borough

Dudley
Metropolitan Borough Council

IMPORTANT NOTICE

COUNCIL MEETINGS

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There is to be no smoking on the premises in line with national legislation. It is an offence to smoke in or on these premises.

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Please turn off your mobile phones and mobile communication devices during the meeting.

Thank you for your co-operation.

Directorate of Corporate Resources

Law **and Governance,** Council House, Priory Road, Dudley, West Midlands DY1 1HF
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www.dudley.gov.uk

Your ref:	Our ref:	Please ask for:	Telephone No.
	JJ/jj	Mr J Jablonski	815243

15th January, 2014

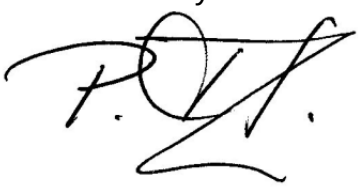
Dear Member

Dudley Health and Wellbeing Board

You are requested to attend a meeting of the Dudley Health and Wellbeing Board to be held on Tuesday, 28th January, 2014 at 3.00 pm in Committee Room 2, the Council House, Dudley to consider the business set out in the Agenda below.

The agenda is available on the Council's Website www.dudley.gov.uk and follow the links to Councillors in Dudley and Committee Management Information System.

Yours sincerely



Director of Corporate Resources

A G E N D A

1. APOLOGIES FOR ABSENCE

   To receive apologies for absence from the meeting

2. APPOINTMENT OF SUBSTITUTE MEMBERS (IF ANY)

   To report the names of any substitute members serving for this meeting.

3. DECLARATIONS OF INTEREST

   To receive Declarations of Interest in accordance with the Members' Code of Conduct

The attention of Members is drawn to the wording in the protocols regarding the general dispensation granted to Elected Members and the voting non-elected representative from requirements relating to other interests set out in the Members' Code of Conduct given the nature of the business to be transacted at meetings.

However, Members and the voting non-elected representative (and his potential substitutes) are required to disclose any disclosable pecuniary interests. In such circumstances, the voting Member would be required to withdraw from the meeting.

If Members have any queries regarding interests would they please contact the Director of Corporate Resources, Philip Tart, prior to the meeting.

4. MINUTES

To approved as a correct record and sign the minutes of the meeting of the Board held on 26th September, 2013 (copy herewith)

5. PERFORMANCE MONITORING ARRANGEMENTS AND CURRENT PERFORMANCE STATUS (PAGES 1 - 36)

To consider a joint report of Officers

6. HEALTH AND WELLBEING BOARD COMMUNITY ENGAGEMENT PRINCIPLES (PAGES 37 - 56)

To consider a report of a Senior Development Officer of Dudley CVS

7. UPDATE ON HEALTHWATCH DUDLEY PROGRESS AND ACTIVITY IN RELATION TO INTELLIGANCE GATHERING AND PUBLIC ENGAGEMENT (PAGES 57 - 65)

To consider a report of the Chief Officer of Healthwatch Dudley

8. UPDATE AND PRESENTATION ON STROKE RECONFIGURATION PROGRAMME

UPDATE - ATTACHED (PAGES 66 – 154)
PRESENTATION – TO FOLLOW

9. BETTER CARE FUND
To consider a joint report of Officers – TO FOLLOW

10. PRESENTATION ON DEVELOPMENT OF CLINICAL COMMISSIONING GROUP STRATEGIC PLAN - EVERYONE COUNTS – PLANNING FOR PATIENTS 2014/15 – 2018/19 (PAGES 155 - 169)

11. URGENT CARE CONSULTATION OUTCOME AND THE RECONFIGURATION OF URGENT CARE (PAGES 170 - 230)

To consider a report of the Chief Accountable Officer, Dudley Clinical Commissioning Group

12 CHARTERS (PAGES 231 - 236)

To note that the Board has signed up to

(i) Disabled Children's Charter for Health and Wellbeing Boards
(ii)Children and Young People's better health pledge

To note that the Council has signed up to

(iii) The Local Government Declaration on Tobacco Control

13. TO ANSWER QUESTIONS UNDER COUNCIL PROCEDURE RULE 11.8 (IF ANY)

MEMBERSHIP OF THE
BOARD

Councillors Branwood, Crumpton, Miller and S.Turner

Director of Adult, Community and Housing Services, Interim Director of Children's Services and Assistant Director of Planning and Environmental Health

Director of Public Health

Roger Clayton – Chair of Safeguarding Boards

Dudley GP Clinical Commissioning Group

Dr. D Hegarty, Dr S.Cartwright and Mr P Maubach

Alison Taylor – Local Area Team - NHS Commissioning Board – Lead Director for Dudley

Andy Gray – Dudley CVS CEO

tbc - Healthwatch Dudley

Chief Superintendent Johnson – West Midlands Police

OFFICER SUPPORT

Cc Brendan Clifford Assistant Director, Adult Social Care (DACHS)

Ian McGuff Assistant Director Quality and Partnership (Children's Services)

Mr N. Bucktin,Head of Partnership Commissioning.(CCG)

Ms K.Jackson, Consultant in Public Health (Office of Public Health)

DUDLEY HEALTH AND WELL-BEING BOARD

Thursday, 26th September, 2013 at 3.00 pm
in Committee Room 2, The Council House, Dudley

PRESENT:-

Councillor S. Turner (Chair)
Councillors Branwood and Harley
Director of Children's Services, Director of Public Health, Dr. D. Hegarty and Mr. P. Maubach - Dudley GP Clinical Commissioning Group; Alison Taylor, Local Area Team, NHS Commissioning Board, Mr. A. Gray - Dudley CVS CEO.

In Attendance

Assistant Director, Adult Social Care (Directorate of Adult, Community and Housing Services), Assistant Director (Quality and Partnership) and Assistant Director (Children and Families)(both Directorate of Children's Services), Mr. N. Bucktin, Head of Partnership Commissioning - Clinical Commissioning Group, Ms. K. Jackson, Consultant in Public Health (Office of Public Health) and Mr. J. Jablonski (Directorate of Corporate Resources)

Also in attendance

Mr. R. Cattell, Director of Operations, The Dudley Group NHS Foundation Trust (for Agenda Item No. 6)
Dr. Rob Dalziel - Healthwatch Dudley (for Agenda Item No. 13)

Observer

Councillor Foster

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9. APOLOGIES FOR ABSENCE

Apologies for absence from the meeting were submitted on behalf of Councillors Crumpton and Miller, Andrea Pope-Smith and Roger Clayton.

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10. APPOINTMENT OF SUBSTITUTE MEMBER

It was reported that Councillor Harley was serving in place of Councillor Miller for this meeting of the Board only.

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11. DECLARATIONS OF INTEREST

No member declared an interest in any matter to be considered at this meeting.

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12. MINUTES

Arising from consideration of the minutes, positive feedback on the conference held following the meeting of the Board on the 26th June, 2013 was reported on.

RESOLVED

That the minutes of the meeting of the Board held on the 26th June, 2013, be approved as a correct record and signed.

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13. MECHANISMS FOR THE BOARD TO BE ASSURED OF QUALITY AND SAFETY

A joint report of Officers was submitted on the new quality and safety assurance arrangements in the health and social care system and on a process for deciding how the Board could be assured that these processes were in place and were robust.

RESOLVED

(1) That the information contained in the report submitted, on mechanisms for the Board to be assured of quality and safety, with particular references to paragraphs 37-39 of the report submitted, be noted.

(2) That approval be given to the holding of an additional, short, development session to agree quality and safety role and mechanisms.

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14. CHANGE IN ORDER OF BUSINESS

Pursuant to Council Procedure Rule 13 (c), it was

RESOLVED

That agenda item no. 6 - Keogh Action Plan - be considered after agenda item nos. 7, 8 and 9.

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15. QUALITY AND SAFETY - UPDATE ON DUDLEY RESPONSE TO WINTERBOURNE VIEW REPORT

A joint report of the Director of Adult, Community and Housing Services and the Chief Officer, Dudley Clinical Commissioning Group was submitted updating the Board on developments relating to the response in Dudley to the implications of the Winterbourne View report.

RESOLVED

That the information contained in the report submitted, updating the Board on the response to the Winterbourne View report, in the context of its overall concern for Quality and Safety in the Borough and the services used by people in Dudley, be noted.

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16. THE ANNUAL REPORT OF THE DUDLEY SAFEGUARDING ADULTS BOARD 2012

A report of the Director of Adult, Community and Housing Services was submitted on the Annual Report of the Dudley Safeguarding Adults Board for 2012.

During his presentation of the content of the Annual Report, a copy of which was attached as an appendix to the report submitted, the Assistant Director, Adult Social Care, referred, in particular, to the reporting structure outlined in Appendix 1 to the Annual Report and to the decision to appoint a Joint Independent Chair to the Safeguarding Boards for both Children and Adult Services; the appointment having been made in May, 2013. The Chair, Roger Clayton, was a member of this Board and in respect of the Safeguarding Adults Board, would introduce a new element into the operation of the Board in terms of independence and challenge.

RESOLVED

That the information contained in the report, and Appendix to the report, submitted on the Annual Report of the Dudley Safeguarding Adults Board, 2012, be noted.

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17. THE ANNUAL REPORT, BUSINESS PLAN AND WORK PROGRAMME OF THE DUDLEY SAFEGUARDING CHILDREN'S BOARD

A report of the Director of Children's Services was submitted on the Annual Report, Business Plan and Work Programme of the Dudley Safeguarding Children's Board.

The Assistant Director, Quality and Partnership (Directorate of Children's Services), commented on the report and the copy of the Annual Report, Business Plan and Work Programme attached as an Appendix to the report submitted. He also referred to the reporting arrangements, as set out in the previous report and to the appointment of an Independent Chair of the Dudley Safeguarding Children's Board.

Arising from initial consideration of the report, and the Appendix to the report submitted, a number of comments were made relating, in particular, to the rising number of contacts that were reported and a query as to the key trend to focus on.

In response, it was reported that there was an upward trend and that neglect was the single biggest issue. Children's social care were currently supporting around 2,000 children .

In response to a query as to whether the strategy was to stop the increase or whether it was an inevitable consequence, it was reported that the trend was not inevitable and the spotlight work being done was cited in relation to this.

In response to a further query regarding the Mental Health Services for Adults and the need for an understanding of where children were considered in relation to that, it was considered that in relation to Mental Health Services it was not clear whether this Board had a focus on that aspect and whether the voice of the child was being heard in this context. It was suggested that this aspect be picked up in spotlight sessions and that issues arising therefrom should be reported back to this Board. It was also noted that as a result of intervention, greater needs were identified.

RESOLVED

That the information contained in the report, and Appendix to the report, submitted on the Annual Report, Business Plan and Work Programme of the Dudley Safeguarding Children's Board, be noted.

18. KEOGH ACTION PLAN

A report of the Chief Executive, the Dudley Group NHS Foundation Trust, was submitted on the Trust's response to the Keogh Review and an update on progress to date.

In the absence of the Chief Executive of the Trust, who was unable to attend the meeting, Richard Cattell, Director of Operations at the Trust commented on a number of the themes set out in the Keogh Investigation Action Plan - July, 2013, attached as an Appendix to the report submitted.

Arising from the presentation given, a number of comments were made and responses given with particular reference to:-

- That in response to the query regarding the number of action dates recorded as September/October, 2013 and whether the targets would be met, it was noted that an updated version of the Action Plan was to be submitted to the Trust's Board on the 3rd October, 2013, and that following the meeting of that Board an updated Action Plan would be shared with members of this Board. It was further commented that almost all the actions would be completed by the end of October. One aspect that would not be completed was the nursing care mix as the Trust was still working through this aspect using a nationally accredited tool, e.g. AUKUH, Safer Nursing Care tool.

- It was noted that the Clinical Commissioning Group were also monitoring the Trust's action on the Action Plan and were working with the Trust.

- Both Dudley Healthwatch and Dudley Clinical Commissioning Group commented that they had not yet had the opportunity to review with Dudley Group Foundation Trust their Patient Experience Strategy referred to at 17.1 of the Action Plan; and so this action was not yet completed.

- In relation to a query about the voice of the child, being heard in relation to the Action Plan, the Director of Operations undertook to respond to members of this Board on this aspect.

- A comment was made that overall the Trust's response to the Keogh Review was satisfactory.

RESOLVED

That the information contained in the report, and attached Keogh Investigation Action Plan - July, 2013, being the response of the Dudley Group NHS Foundation Trust to the Keogh Review that had been undertaken and the update on progress to date, be noted.

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19. DUDLEY CLINICAL COMMISSIONING GROUP PRIMARY CARE DEVELOPMENT STRATEGY

A report of the Chief Officer, Dudley Clinical Commissioning Group, was submitted presenting the final version of the Primary Care Development Strategy, as approved by the Clinical Commissioning Group's Governing Body. A copy of the Primary Care Development Strategy, 2013 was attached as an Appendix to the report submitted.

It was noted that the focus of the strategy was on developing local primary care and supporting GP practices to provide high quality services for patients. Dudley was the first Clinical Commissioning Group in the region to report on improving the quality of primary care.

Arising from the presentation given by the Chief Officer, Dudley Clinical Commissioning Group, it was noted that Dudley was one of the few areas where demand for A & E services was constant and it was considered that this was due to the support given to practices. It was further noted that the Area Team, NHS England were supportive of the approach set out in the model contained in the Strategy and that they would be using it across the area of the Area Team.

The fact that primary care in Dudley was being cited as an exemplar should give confidence to the Board.

There were, however, real challenges, for example, the demographics of the work force in that there was a higher percentage of aged, single or low handed practices in the Borough. However, the strategy attached to the report was a working document that needed to go forward to ensure sustainability in the provision of primary care.

Arising from the initial comments made, a number of points were raised and in response it was agreed that a role of good quality primary care was prevention and that there was a need for pro-active management and closer working relationships. The importance of IT systems in relation to this was cited and how to take quality per pound, so that this could be understood better. Issues of quality and how to ensure better services were provided as well as more pro-active steps being taken and the need for an infrastructure to make it work were also commented upon.

In relation to the approach being adopted, Dr. Dalziel indicated that Healthwatch were pleased with the content of the strategy and the approach adopted and were keen to monitor and evaluate issues, for example, those relating to access such as appointment times and access lines. They, therefore, wanted to see progress with thinking about how improvements could be made.

As regards access, work was being undertaken to support practices on this issue so that they could develop their own development plans. However, it was also reported that there was a 4% year on year increase in demand for access with no additional resources for practices, so clearly some practices had improved in delivering services. Responding to the increasing demand was, however, an on-going challenge.

A further issue was that some practices were able to earn more than others and so could provide more services than those whose contract value was lower. It was the case that some practices in the more deprived areas were the least well served. The issue of contract value was though one requiring a national decision and over time differences in funding practices had grown. This issue was, therefore, a complex one and might explain why some patients were more satisfied with access to services than others.

The issue of patient questionnaires was raised as one way in which to identify the quality that was obtained for each pound invested. In relation to the voice of young people on this aspect, it was considered that further work needed to be done in relation to engaging with young people.

In view of the comments made it was considered that specific research should be undertaken and that Children's Services would be happy to work with the Clinical Commissioning Group on gathering information to progress this. It was further noted that the voluntary sector had data which would be available for use.

RESOLVED

That the information contained in the report, and Appendix to the report, submitted on the final version of the Primary Care Development Strategy, 2013, that supports Dudley's "Joint Health and Wellbeing Strategy Wellbeing for Life - Our Plan for a Healthier Dudley Borough, 2013-2016" be noted.

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20. <u>TRANSFER OF RESOURCES TO DUDLEY MBC 2013/14 TO SUPPORT SOCIAL CARE AND THE HEALTH AND SOCIAL CARE INTERACTION TRANSFORMATION FUND</u>

A joint report of the Chief Officer, Dudley Clinical Commissioning Group, Director of Adult, Community and Housing Services and Director of Children's Services on the proposed use of resources to be transferred to Dudley MBC for the purposes of supporting social care in 2013/14 and on a national announcement of £3.8 billion of funding to ensure closer integration between health and social care, was submitted.

RESOLVED

(1) That the information contained in the report submitted on the proposed resource transfer of £5.589 million to Dudley MBC for the purposes of supporting social care in 2013/14, be approved and that NHS England be advised accordingly.

(2) That a further report be submitted for a future meeting of the Board on the use of the Health and Social Care Integration Transformation Fund.

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21. THE NHS BELONGS TO THE PEOPLE: A CALL TO ACTION

A report of Alison Taylor, Director of Finance, Birmingham, Solihull and the Black Country Area Team NHS England, was submitted on the document "The NHS Belongs to the People: A Call for Action", which was published by NHS England on the 11th July, 2013. A copy of the full paper was attached as Appendix 1 to the report submitted and set out the case for transformational change across the NHS.

Arising from the presentation of the report, and the Appendix to the report submitted, it was suggested that the document form part of a future spotlight session.

Regarding consultation on this and related issues, it was considered that there was a need to avoid over-consulting with the public and that one way that this could be achieved was for there to be a co-ordinated response to consultation undertaken.

In response to the points raised, it was noted that a report would be submitted to a future meeting of the Board on communication and engagement which should address the issues raised.

RESOLVED

That the information contained in the report, and Appendix to the report, submitted on the document entitled "The NHS Belongs to the People: A Call to Action" published by NHS England on the 11th July, 2013, be noted and that it be further noted that a report on communication and engagement with the people of Dudley would be submitted to a future meeting of the Board.

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22. UPDATE ON HEALTHWATCH DUDLEY PROGRESS

A report of the Chief Officer of Healthwatch Dudley was submitted updating the Board on Healthwatch Dudley progress.

As the Chief Officer was unable to attend the meeting, Dr. Rob Dalziel of Healthwatch was in attendance to present the report.

Arising from the presentation of the report, a number of questions were asked and in response to a particular question, it was noted that the question of the appointment of a Chair of Healthwatch Dudley had still to be finalised.

In respect of a further question as to why elected members were not being allowed to be members of the Healthwatch Board, it was noted that Healthwatch Dudley would be happy to revisit this issue and take some guidance.

RESOLVED

That the information contained in the report submitted, on an update on the work being progressed by Healthwatch Dudley, be noted.

The meeting ended at 4.50 p.m.

CHAIR

Agenda Item No. 5

DUDLEY HEALTH AND WELLBEING BOARD

28th JANUARY 2013

Joint Report of the Director of Public Health, Director of Adult, Community and Housing Services, Director of Children's Services, Director of the Urban Environment and the Chief Officer of the Dudley Clinical Commissioning Group

PERFORMANCE MONITORING ARANGEMENTS AND CURRENT PERFORMANCE STATUS

PURPOSE OF REPORT

1. This report
    a. gives an overview of proposed arrangements by which the Health and Wellbeing Board can monitor performance outcomes against national and local priorities for health and wellbeing
    b. provides an update for the Board of current progress in relation to national and local priorities and the implementation of Dudley Borough's Health and Wellbeing strategy.

2. The Dudley Health and Wellbeing Board (H&WBB) is required to agree the proposed performance monitoring arrangements and note the current performance status.

BACKGROUND

3. As system leader for the health and care system, the Health and Wellbeing Board requires a performance monitoring process that is light touch but also able to provide
    a. What impact it is having on the health and wellbeing of the people of Dudley borough.
    b. What progress is being made with the implementation of a Joint Health and Wellbeing Strategy and
    c. Able to provide a good understanding of how the H&WB Board is functioning

4. This includes the need to be able to identify good performance and where improvements need to be made, which may in turn be fed into the Joint Strategic Needs Assessment process and become local priorities for action.

5. Dudley Health and Wellbeing Board approved the Joint Health and Wellbeing Strategy in January 2013 setting out our five strategic priorities:-

a. **Making our neighbourhoods healthy** – by planning sustainable, healthy and safe environments and supporting the development of health enhancing assets in local communities.
b. **Making our lifestyles healthy** – by supporting people to have healthy lifestyles and working on areas which influence health inequalities, for instance, obesity, alcohol, smoking and the early detection of ill health
c. **Making our children healthy** – by supporting children and their families at all stages bur especially the early years; keeping them safe from harm and neglect, supporting the development of effective parenting skills and educating young people to avoid taking risks that might affect their health in the future
d. **Making our minds healthy** – by promoting mental health and wellbeing
e. **Making our services healthy** – by integrating health and care services to meet the changing Dudley borough demography, starting with urgent care

PROPOSED PERFORMANCE MONITORING ARRANGMENTS

6. Overarching performance outcomes frameworks for Public Health, Adult Social Care and the NHS have been set nationally. It is proposed to report performance status to the Board annually against these frameworks, using a system that organises all indicators according to Dudley borough's 5 local priorities and highlights where performance is below, similar or above the average performance for England. In year, it is proposed that the Health and Wellbeing Development Group monitor the outcomes frameworks on a quarterly basis and inform the Board of any additional performance outliers.

7. Where performance demonstrates a trend that is significantly below average, explanations will be provided from the lead Directorate/organisation where feasible.

8. Alongside the national perspective, it is proposed to report annually against a set of agreed local indicators and actions being undertaken to take forward the 5 priority areas set out in the Joint Health and Wellbeing strategy. These indictors may vary or be added to from year to year as identified challenges and actions change. It is proposed to use a similar process of progress commentary as described in 7 to highlight where performance is below target for each priority area.

9. Annual performance reporting needs to fit closely with the business and commissioning cycles of the local authority and clinical commissioning group.

10. In terms of assessing how the H&WB Board is functioning it is proposed that there is an annual appraisal process or Board health check, that makes use of available tool kits and peer review as made available.

CURRENT PERFORMANCE STATUS

Impact on Health and Wellbeing

11. The attached report – Health and Wellbeing Outcomes Frameworks details a dashboard of performance for Dudley as of January 2014, against the national indictor set for Public Health, Adult Social Care and the NHS, mapped against Dudley borough's five local priorities. Commentary explaining the variations significantly below the England average is provided in appendix 1.

Progress of the Joint Health and Wellbeing Strategy Priorities

12. During 2013/14, the Board is progressing the 5 priority areas through a series of spotlight events with key stakeholders, one for each priority area. Each spotlight focuses on specific challenging issues identified from the JSNA associated with the priority area and the event follows a process of diagnosing the issue, providing information on the key challenges and then stimulating the generation of ideas and action planning across partners. Outcomes and recommendations from the spotlight sessions are presented to the appropriate lead Commissioning Group or Board to agree key actions and performance indicators to take forward during 2013/14 and 2014/15.These collectively frame the implementation plan for the Health and Wellbeing Strategy.

13. To date, 4 of 5 spotlight sessions have been held:

    a. Making Our Services Healthy – focusing on Urgent Care: 18th June 2013
    b. Making Our Lifestyles Healthy- focusing on breastfeeding and alcohol: 19th July 2013
    c. Making Our Children Healthy- focusing on building resilience in children, young people and their parents: 10th October 2013
    d. Making Our Minds Healthy- focusing on depression and dementia: 14th November 2013

14. The final spotlight for 2013/14 on 'Making Our Neighbourhoods Healthy' is scheduled for February 6th 2014. It is proposed that this will focus on building community capacity, working with and facilitated by the Think Local Act Personal (TLAP) partnership, to test out a framework they are developing on this issue for Health and Wellbeing boards. This is part of the support being offered to Dudley borough following successful application to the TLAP 'Developing the Power of Strong Inclusive Communities' programme. The overall offer includes 6 days of facilitator time from Catherine Wilton. The H&WB Board will be able to use the draft TLAP framework to help it reflect on wider issues of how community capacity in Dudley borough will help support improving the health of residents and the quality of health and care services.

15. Progress to date is as follows:

    a. Urgent Care: The spotlight session was attended by Board members, Commissioners, Providers, and Councillors, and public and user input was incorporated from the Clinical Commissioning Group's health forum

event held prior to the spotlight session. An outcomes report has been produced and forwarded to the Urgent Care Working Group, who continue to coordinate work to redesign and improve urgent care provision. Key conclusions from this event were that the model of urgent and emergency care needed to be redesigned to simplify, reduce duplication and to take account of peoples default behaviour of attending A/E and that awareness of how to access the system was needed across all partners and the public. Since the spotlight event the CCG has carried out a public consultation process on a new service model for urgent care that reflects the comments made at both the spotlight event and the CCG Healthcare Forum. This is in line with the Joint Health and Wellbeing Strategy and the CCG's Primary Care Strategy, approved at the last meeting of the Board and is subject of a separate report to this meeting of the Board. Reducing hospital admissions and nursing home/residential home admissions will be a key performance requirement of the services to be funded through the Better Care Fund. Partners will be expected to agree a series of performance indicators linked to the Better Care Fund. This is the subject of a separate report on this agenda. It is suggested that the performance indicators developed for this purpose are used as a basis for assessing performance in relation to this Joint Health and Wellbeing Strategy priority. The current Urgent Care Working Group dashboard is detailed in appendix 2 for information. The spotlight event report will be available at www.allaboutdudley.info, where a topic page for the Health and Wellbeing Board is being set up.

b. Breast Feeding and Alcohol: The spotlight session included a similar range of stakeholders and also service users. Key discussions in relation to alcohol focused on the need to further educate and raise awareness on the health impacts from a younger age, the need to stimulate a cultural change towards alcohol, for health professionals to feel confident in raising the issue especially in primary care, and to have programmes that support people to use other coping strategies rather than alcohol. Key discussions in relation to breast feeding emphasised the need to develop strategies to gain its cultural acceptance, including with the health care profession. An outcomes report has been forwarded to the Strategic Breast Feeding Group who have agreed key actions and local indicators for improving breast feeding rates and to the Substance Misuse Implementation Group for inclusion in the alcohol strategy currently in development. Details are in Appendix 2. The full report will be available at www.allaboutdudley.info

c. Resilience of Children, Young people and Parents: The spotlight session focused specifically on the early years and 16 to 18 transition. As part of the process a consultation with young people is underway to further inform the outcomes from this spotlight. An outcomes report is currently being finalised for circulation to the Children's and Young People's Partnership Board for inclusion in their action plans. Key actions and indicators are included in appendix 2. Key outcomes from the discussion in relation to early years were the importance of building on the Time for Twos programme, targeting the most vulnerable children and their families. There was a view that there needed to be more joined up working for

transition through to the provision for 3 to 4 year olds. The family support worker role has been shown to have a significant effect and it was the view that this provision needs to be extended. There was unanimous agreement that the current work to develop parenting skills was critical and needed to be further developed to enable more families to benefit. The third major topic of discussion was the acknowledgement that early intervention was essential in order to support families in the development of resilience in their children. Key outcomes of the discussion for the 16-18 age group were firstly the need to commission a Mental Health Service for the 16 – 18 age group, whose needs are frequently not met in the transition from the Children's and Adolescent Mental Health Service to Adult Services. Secondly there was the recognition that all services should be young people friendly, and that there was a need to ensure that staff are trained to understand the issues around providing young person appropriate services. The third key outcome was the importance of ensuring that young people are empowered to contribute to the planning and development of services that meet their needs, through ensuring that their voice is heard. The full report will be available on www.allaboutdudley.info.

d. Depression and Dementia: This session involved stakeholders and service users who gave informative accounts of their experiences in using services. An appreciative inquiry technique was used to organise and develop participation and generate key areas for development. There was a strong emphasis in discussion of orienting the local system towards preventative interventions, developing a mental health friendly Dudley borough and a greater prominence of interventions that build/strengthen social capital. This theme links well to the final spotlight session on neighbourhoods and the proposed focus on the 'Think Local Act Personal' framework. The full report will be available at www.allaboutdudley.info. The report has been forwarded to the Mental Health Partnership Board for final development of key actions and local indicators for 2014/15 onwards.

16. A set of local indicators and actions will be developed for the neighbourhoods priority area following the spotlight event in February on the developing community capacity theme. To compliment these, a set of local indicators have been developed by the Department of Urban Environment in relation to the physical environment. These are detailed in appendix 2.

17. A process of evaluating the spotlight session approach is currently in progress in order to inform H&WBB work-plan developments for 2014/15.

18. The draft work-plan for 2014/15 will be brought to the H&WB Board in March 2014. Going forward, the Board may wish to consider the following issues for the 2014/15 work-plan:
    a. Reassurance that all issues are being addressed through the governance processes- such as groups working on specific issues e.g. obesity, health inequalities, older people, children etc
    b. Reassurance that all sections of the community have access to the H&WB Board,

c. The key priorities on which the H&WB Board wants to focus during 2014/15 relating to its purpose of overseeing integration, addressing health inequalities, improving health services and engagement.
d. Championing one key theme where the Board partnerships can make a real difference within Dudley borough.
e. Review the terms of reference and constitutional working of the Board in order to optimise its potential role and impact.

19. Appendix 2 details the collective local indicators, their status and the actions identified to date for the priority areas.

How the Board is Functioning

20. The Health and Wellbeing Board became fully functional in April 2013, so is in its first year of operation.

21. It is proposed to conduct an annual appraisal during 2014/15, to allow the Board some time to reflect on its responsibilities and embed working processes. The Board has applied to take part in the peer-review process being offered to Boards by the Local Government Association during this time period.

FINANCE

22. Any financial implications resulting from these proposals will be met within existing budget arrangements.

LAW

23. The statutory duties of the Health and Wellbeing Board are detailed in the Health and Social Care Act 2012 and related guidance.

EQUALITY IMPACT

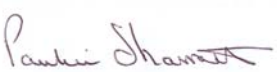
24. Improving equality and tackling health inequalities are key priorities of the Health and Wellbeing Board and will be discharged through implementation of the Board's Joint Health and Wellbeing Strategy. The establishment of the Dudley Health and Well-Being Board provides an opportunity to extend the influence of the Council in working more closely with partners, particularly GP and Clinical Commissioners, to consider equality issues through the work of the Board.

RECOMMENDATION

25. That the Dudley Health and Well-Being Board agree the performance monitoring arrangements and note the current performance status for Dudley borough.

Valerie A Little
Director of Public Health

Andrea Pope- Smith
Director – DACHS



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Appendix 1: Supporting Commentary for Indicators Signficantly Below the England Average (Accompanies the Outcomes Frameworks Report)

Indicator	Lead	Priority	Commentary
Under 75s mortality from liver disease, and Under 75s mortality from liver disease that is considered preventable	Public Health	Overarching	The misuse of alcohol impacts significantly on this indicator. Locally alcohol admissions are now on the decrease but it will take 10 to 15 years for this improvement to have an impact on liver disease rates. Tackling alcohol misuse remains a local priority has been a focus of a Health and Wellbeing Board Spotlight event. Local indicators and actions are being set within an alcohol strategy for Dudley borough, and local delivery is being led by the multi-agency Substance Misuse Group.
Potential Years of Life Lost from causes considered amenable to healthcare (females) 2012	All	Overarching	This indicator gives an overall general view on the quality of local health care. Causes considered amenable to health care are those from which premature deaths should not occur in the presence of timely and effective health care and cover all disease areas such as infectious disease through to cancers and CVD and injuries during surgery/medical care, and so reflects the clinical pathways of across the health and care system. Work on service integration and urgent care should contribute to a reduction.
One-year survival from lung cancer 2005-09 (%)	All	Overarching	This indicator gives a general overview and encourages measures across the whole clinical pathway such as prevention, early and accurate diagnosis, optimal pharmacotherapy, physical interventions, prompt access to specialist cancer care, structured hospital admission and appropriate provision of home care. In terms of prevention Dudley delivers a range of stop smoking services and tobacco control programmes which are undergoing scrutiny by the health overview and scrutiny committee. This indicator is being reviewed and will be replaced by an indicator that brings together 1 year survival rates from all cancers rather than just lung cancer. The CCGs strategic plan, to be submitted in march 2014 will set out further information and actions against this indicator.
Children in Poverty (%)	Children's Directorate	Children	This reduced between 2010 and 2011 but is still above the England average. In order to continue to reduce this figure there needs to be a more co-ordinated approach across agencies to address the underlying economic factors that contribute to childhood poverty.
Good development at age 5 2012 (%)	Children's Directorate	Children	2013 figures suggest an improvement for Dudley bringing it almost to the England average.
Pupil absence 2011-12 (%)	Children's Directorate	Children	Currently the national average is 5.3 and Dudley is 5.5, but this is only state funded maintained schools. Local calculations including academy schools for the same period indicate an absence of 5.1% (which would be better than the national average). NB Absence data is more useful when broken down into authorised absence eg sickness, holidays, (of which Dudley is on a par with the

			national average) and unauthorised absence of which Dudley is higher.
16-18 year olds NEET (%)	Children's Directorate	Children	The number has decreased since this 2012 figure to 5.8% at the end of December 2013 – level with the national average.
Year R excess weight (%) and Year 6 excess weight (%)	Public Health	Children	Overall, the prevalence of children who are overweight or obese in Dudley at reception year age and year 6 has stabilised since 2006/7, but remains higher than England prevalence. Dudley's strategy to reduce obesity has been refreshed and a new 5 year action plan to 2017 is being implemented. New areas of work include an emphasis on environmental changes e.g. planning guidance for health, implementation of the food-dudes programme in all primary and special schools and the development of an early years health charter for PVI nurseries. For more information, the strategy and health needs assessment are on www.allaboutdudley.info
Breastfeeding initiation (%) and Breastfeeding at 6-8 weeks (%)	Public Health	Lifestyles	The number of mothers breast feeding and the duration they breast feed for is on the increase in Dudley, but remains well below the England average. Improving this rate is a key priority for Dudley and has been a focus of a Health and Wellbeing Board Spotlight event. Local indicators and actions have been set, and local delivery is being led by the Strategic Breast-Feeding Group.
Maternal smoking prevalence (%)	Public Health	Lifestyles	This is a key priority for Dudley, and Dudley's tobacco control programme is currently being scrutinised by the Overview and Scrutiny Committee for Health. The report is due for publication early 2014 and will inform the updating of Dudley's Tobacco Control strategy and 5 year action plan. Key issues to be addressed regarding maternal smoking prevalence will be included.
Excess weight in adults (2006-2008)	Public Health	Lifestyles	This benchmark for Dudley is currently based on estimates from the National Health Survey for England for levels of obesity (body mass index (BMI) of 30 or more). In future, local estimates will be taken from the active people's survey and include those classified as overweight and obese (BMI 25 or more). Reducing obesity is a key priority for Dudley, a strategy has been in place since 2005, which has improved provision of prevention activity and treatment programmes. This has recently been refreshed with a target to halt the rise in adult obesity and an updated 5 year action plan. For more information, the strategy and health needs assessment are on www.allaboutdudley.info.
Adults classified as physically active (150mins/week) and classed as inactive	Public Health	Lifestyles	Local surveys suggest an increase in people taking enough exercise in Dudley over the last 5 years, however levels remain low when compared to England. Getting more people more active more often remains a local challenge, with a key focus on meeting the recommendations outlined within the 2012 obesity HNA, working in line with the national Sport England strategy to draw down funding targeting the 14+ population. Work is also on-going to develop supportive environments, with the development of the Green Space Strategy, the completion of the Planning for Health SPD and the emerging Active Travel Strategy. This year will also see the development of a new Physical Activity Strategy, Playing Pitch Strategy and Facilities Strategy.
Breast screening coverage age 53-70	Public Health	Lifestyles	A number of activities have been delivered across Dudley borough, throughout 2011-2013, to raise awareness and increase the uptake of breast cancer screening and tackle cancer inequalities. Life

			is Precious Campaign raises awareness of cancer screening amongst the minority ethnic community and utilises the creative arts. The project has engaged with over 100 community members who have become local Community Health Champions (CHC) who are sharing the cancer screening message. Targeted Breast Screening Campaigns, by area, are run in concert with the rotational call for screening including a local poster campaign entitled 'Put it in Your Diary' to promote the importance of breast screening and motivate women aged 50-70 to attend for screening. GPs are encouraged to promote beast screening in their practices. 'Be aware-show you care' campaign is an inclusive campaign to support hairdressers and beauticians to raise awareness of cancer and screening. A number of borough-wide community events have also been held targeted at those electoral wards where uptake is low to raise awareness of cancer prevention and breast screening. National Breast Cancer Awareness Month is supported across the patch. Community engagement work carried out in Dudley borough has recognised several factors contributing to low performance, such as lack of access to service, particularly for those that work and transport issues, other reasons are: perceptions of not being at risk, lack of awareness and information. Confusion amongst women due to the national media focus on risks of false positives in screening may also be having an effect.
NHS Health check take up	Public Health	Lifestyles	Uptake of health checks in Dudley is lower than the England average. There are national data recording issues that impact on this benchmark, and local operational issues involving software migration have had a particular negative impact during 2013/14. However uptake is low, and plans are in place to address it which include tackling poor performing providers, piloting point of care testing for bloods so that the check can be delivered in one appointment, and delivering public campaigns to raise awareness and trigger public uptake of the check.
Access to eye screening- uptake	Public Health	Lifestyles	Local uptake of diabetic eye screening has increased over the last 3 years, and by 3% to 76% during 2012/13, but it remains below the England average. Uptake has been identified as an area for action by Public Health and a workshop is planned with key partners to look at how uptake can be improved.
Self-harm rate 2011-12	Public Health	Healthy Minds	The increase in self harm has been recognised and a local survey is taking place with service providers and focus groups to understand the local profile of self harmers with a view to implementing specific interventions for identified at risk groups.
Wellbeing Measures: how satisfied are you , how worthwhile is your life, how happy are you	Public Health	Healthy Minds	These subjective indicators are reflective of concepts related to overall physical and mental health. More specifically , these concepts can be aligned to mental wellbeing (feeling good and functioning well) and are typically influenced by a range of individual, social, and structural determinants. Currently in Dudley Borough we have a Mental Health Promotion action plan (2010-2013) devised by the Public Mental Health Programme. The action plan aims to address the multiple factors relating to mental health and wellbeing locally; supporting the current national mental health strategy

(2011/12) %			(this action plan is currently being refreshed). The five ways to wellbeing (nef,2008) is promoted locally through resources such as "*Road to wellbeing*" a self help resource available free of charge across Dudley Borough. A Small Grants Fund Programme is in place, providing funding for initiatives to improve mental wellbeing across the community, voluntary and statutory organisations. Asset Based health promotion pilot project is currently being developed which aims to identify protective factors that support health and wellbeing at a local level, enhancing quality and longevity of life through focusing on the resources (such as social capital) that promote self-esteem and the coping abilities of individuals and communities. Workplace health programmes are also piloting wellbeing sessions for staff.
Adults receiving secondary mental health services living independently at the time of their most recent assessment 2011-12 (%) and living independently, with or without support 2012-13 (%)	DACHS	Healthy Minds	Dudley's position was low for 2010/11 as well as 2011/12 and it is a key priority. The Personalisation programme and more effective joint working with the Dudley and Walsall Mental Health Trust is increasing supported living and enabling more people to live independently. The assertive reviewing process has enabled more people to be recovered or supported into living independently.
Proportion of adults in contact with secondary mental health services in paid employment	DACHS	Healthy Minds	The Dudley and Walsall Mental Health Trust is focussing on this as part of its recovery and outcomes framework. Increased efforts to help people achieve their employment aspirations and support them to get jobs is being overseen by the Personalisation programme. Focussing on the quality of providers that support people through Place and Train approaches will improve the performance of this measure.
Age-standardised rate of emergency hospital admissions for violence per 100,000	Safe & Sound Board	Healthy Neighbourhoods	WM Police data shows that Dudley is the best performer in the WM police force area in terms of violence with injury. When compared with similar groups Dudley is 3rd out of 15 with a rate of 7.9 offences per 1,000. However, not all injuries caused by violence are reported to the police, and this may be reflected in the higher figures seen by hospitals. In the last 3 years there has also been improved recording and reporting of injuries caused by violence in the A&E setting and this may then be reflected in the numbers recorded as injury by violence resulting in emergency admissions.
Households that are in fuel poverty (%)	Public Health	Healthy Neighbourhoods	The methodology used to calculate this indicator has altered, giving Dudley a lower level than by the previous method, where March 2013 submissions were 26,615 (20.9%). Under the new definition of fuel poverty (August 2013), some households are now no longer considered fuel poor and are therefore no longer eligible for government support, despite their incomes being significantly

			strained by energy costs. High levels of fuel poverty may be explained by housing conditions:-lack of central heating, a pre-1945 social housing stock which is energy inefficient, poor standards in the private rented sector, high numbers of elderly households (38.2%) which account for 60% households in fuel poverty in the private sector; also low incomes:- 60% of households earn below the national average income of £25,900, 28% of households earn below £10,000, 41% of households are in receipt of financial support and 50.9% are considered economically vulnerable; Welfare reform - in Dudley, the financial loss per working age adult is £473 per year an escalating energy prices. A draft fuel poverty strategy has been developed with an action plan to address fuel poverty, including a range of technical improvements to housing stock to increase the energy efficiency of households. A stock condition survey of council-owned dwellings will help target future investment and attract the maximum Energy Company Obligation (ECO) funding into the borough. A Private Sector Renewal Strategy is also planned and will include actions to improve housing stock in the private rented sector and the wider private sector. Dudley's Winter Warmth Service is now in its 3rd year and supports the most vulnerable households to access a tailored package of support to enable them to stay warm and well. Other initiatives are in place to tackle low household income (through Housing Support), to tackle high energy prices (through the collective switching initiative and advice on switching tariffs/ energy providers), and to help change behaviour (through the Energy Advice Line, and the Winter Warmth Service).
Recorded diabetes 2011-12 (%)	CCG/NHS England	Healthy Services	Type 2 diabetes (90% of diagnosed cases) can be prevented or delayed by lifestyle changes (exercise, weight loss, healthy eating) and earlier detection of diabetes followed by effective treatment reduces the risk of developing diabetic complications. Dudley has a higher recorded prevalence than England, so is benchmarked red, however this should be interpreted as positive as it means Dudley is identifying and treating diabetes more rigorously. Dudley's expected prevalence for diabetes is modelled at 8% for 2011 so we have 25% undiagnosed diabetes in Dudley. Actual prevalence against expected prevalence is a better indicator. Work continues to identify undiagnosed diabetes through the diabetes local enhanced GP service and NHS health checks service.
Emergency hospital admissions for injuries due to falls in persons aged 65 and over, and in persons aged 80 and over (2011-12)	Public Health	Healthy Services	Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. being a major precipitant of people moving from their own home to long-term nursing or residential care. Interventions for recently retired and active older people are likely to be different in provision and uptake for frailer older people. Locally, an evidence based integrated falls pathway, with single point of referral for those at risk of falls has been implemented in quarter 3 of 2013 and a review of the falls service being undertaken to identify areas of priority and development .

Emergency admissions for acute conditions that should not normally require hospital admission	CCG	Services	To be addressed through the implementation of the CCG's proposed urgent care model.
Access to GP services	CCG	Healthy Services	To be addressed through the implementation of the CCG's proposed urgent care model.
Incidence of medication errors causing serious harm 2012-13 Q1&2	Public Health/CCG	Healthy Services	This indicator is by provider organisation per 100,000 population, and so relates to data from RHH The numerator is small and the denominator large, so the best and the worst across England for this period ranges only between 0 and 0.3. All serious incidents are monitored by quarterly clinical quality review meetings between commissioner and provider. Root cause analysis is undertaken to investigate the incident, rectify and prevent re-occurance.
PPV vaccination coverage (over 65s)	Public Health	Healthy Services	Although slightly below the England average for pneumococcal vaccination, Dudley is showing an upward trend rising from 67.2% during 2010/11 to 67.8% (2011/12) and was at 69.4% at March 2013. National comparison for mach 2013 is not currently available.
Flu vaccination coverage (over 65s)	Public Health	Healthy Services	Flu vaccine coverage has been slightly but significantly below the England average for the last 3 years, including 2012/3 – Dudley 72.2% and national 73.4%. Dudley has set up a local flu vaccine monitoring group working collaboratively with stakeholders to increase the coverage, including running a series of local health promotional activities to encourage uptake.
Preventable Sight Loss- Certifications	Public Health	Healthy Services	The numbers are small, so caution must be applied in interpreting the data, however, Dudley was significantly lower than the England average in 2010/11 but significantly higher in 2011/12. Prevention of sight loss helps people maintain independent lives and reduce needs for social care support. Research by the Royal National Institute for Blind People (RNIB) suggests that 50% of the cases of blindness and serious sight loss could be prevented if detected and treated in time and can be influenced by improving the take-up of sight tests in the general population. Risk of sight loss is heavily influenced by health inequalities, including ethnicity, deprivation and age. Sight loss can increase the risk of depression, falls and hip fractures, loss of independence and living in poverty. This indicator has been identified for action by Public Health and a programme of work is being planned for 2014/15.
Permanent admissions to residential and nursing homes of	DACHS	Healthy Services	In the current financial year, the Council has increased its presence at the hospital to 7 day working to eliminate the need for Dudley Group of Hospitals spot purchasing. This should reduce the numbers of people going into residential and nursing care and also eliminate inappropriate placements. A Memorandum of Agreement is being revised to ensure better processes and clarity

older people, per 100,000 population 2012-13 (Rate per 100,000 population)			of targets around hospital discharges. A joint Panel to consider residential and care at home placements is to be introduced to ensure all options have been considered before residential or nursing care placement is sought.
The proportion of people who use services who feel safe 2012-13 (%)	DACHS	Healthy Services	This measure is sourced from the annual Adult Social Care Survey. A total of 2156 clients were surveyed with a response rate of 36.2%. In 2012/13 a total of 766 clients responded to this question of which 513 expressed that they felt as safe as they wanted. A range of initiatives have been developed which may help increase the performance of this measure: Safeguarding training has been developed with West Midlands Care Association to raise standards in commissioned services across the borough. £25K funding has been received from ADASS to develop on-line regional safeguarding package. Priorities for action arising from the Winterbourne View are focussing on: the number of repeat referrals in establishments, to ensure Advocacy services were engaged with the Board and through the Deprivation of liberties, to explore with Commissioners of LD services the types of restraint training across agencies and to bring the partners of Safeguarding to account within the Board by the production of reports and case studies to the Board

Appendix 2: Local Indicators and Actions Health and Wellbeing Strategy Implementation Plan 2013/14- 2014/15

HEALTHY SERVICES :URGENT CARE DASHBOARD															
Item	**Indicator**	**Target**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**YTD Performance**	**RAG**	**Consequences of Breach**	**Penalty for Month**	**YTD Penalties**
1	A&E 4 Hour Waits	95%	91%	96%	96%	97%	96%	97%	92%	94%	**94.9%**		2% of revenue derived from the provision of the locally defined service line in the month of the under achievement.	£ -	£ -
2	Trolley Waits in A & E	Any trolley wait > 12 hours	0	0	0	0	0	0	0	0	**0**		£1,000 per breach	£ -	£ -
3	Ambulance Handover between 30mins & 60mins	Target 15m, Threshold =30m	379	211	247	201	182	205	401		**1826**		£200 per patient waiting over 30 minutes	£ 80,200	£ 365,200
4	Ambulance Handover > 60mins	Target 15m, Threshold =60m	53	15	9	12	9	23	55		**176**		£1,000 per patient waiting over 60 minutes	£ 55,000	£ 176,000
5	Category A Red 1 Response	75.0%	73.0%	81.5%	95.8%	87.5%	89.7%	82.1%	81.5%		**84.4%**		Monthly witholding of 2% of the actual monthly contract value with an end of year reconciliation	Year End	Year End
6	Category A Red 2 Response	75.0%	69.4%	78.0%	78.5%	73.0%	75.1%	72.6%	73.3%		**74.3%**		As Above	Year End	Year End
7	Category A 19 Minute Response	95.0%	99.1%	99.2%	98.8%	99.0%	98.8%	98.6%	99.1%		**98.9%**		As Above	Year End	Year End
8	Ambulance Crew Readiness (a)	Target 15m, Threshold =30m	67	36	11	12	12	12	13		**163**		£20 per event where > 30 minutes	£ -	£ -
9	Ambulance Crew Readiness (b)	Target 15m, Threshold =60m	2	1	0	0	0	0	0		**3**		£100 per event where > 60 minutes	£ -	£ -

Notes

1. The Contractual Performance month is currently June 2013 (all validated data submitted). Where data is available for July this is included.

2. Ambulance Handover penalties for >30minutes have to date been waived due to inaccuracy of Ambulance Service data and clinical concerns regarding motivating Providers to cohort patients and increase trolley waits in A&E in order to meet this target.

3. RAG rating key

 Both month and YTD figures meet or exceed the target

 Either the month or the YTD figure has failed to meet the target

 Both the month and the YTD figures fail to meet the target

HEALTHY LIFESTYLES: BREAST FEEDING

Key Actions and Indicators:

Priority	Notes	Lead	Local Indicator	Timescale
Development of Borough Wide-Marketing Plan /Strategy	This priority will capture a number of the points raised regarding better communication, promotion, awareness and positive press interests etc.	OPH	Marketing / promotion plan developed using social marketing approaches.	August 2014
Ongoing development of the volunteer buddy programme.	Volunteer Buddies to be integrated into Office of Public Health volunteer programme.	OPH	Annually train 30 buddies. Recruitment of 90% of trained buddies on volunteer programme.	
GP Engagement	Identify GP Champions. Online GP training made available to all GP's.	CCG	20 % (50) of Dudley GP's trained (250) – need to get actual GP numbers in Dudley.	March 2015
Multidisciplinary co-ordinated approach to provision of Antenatal support to pregnant mothers		OPH /BCPFT/DGHFT	100% of Dudley pregnant women offered antenatal support (at 34 weeks)	March 2016
Maintain UNICEF		OPH	UNICEF accreditation level 3 achieved	

Stage 3 in hospital and achieve stage 3 in community		/BCPFT/DGHFT	2014/15	
Mainstreaming community buddies in health visiting teams			Each Health Visiting team to have one wte buddy. 90% of women who are breastfeeding on discharge have contact with buddy.	

HEALTHY LIFESTYLES: ALCOHOL

Key Indicators:

Ref	Performance Indicator	Last year out-turn 2012/13	Target 2013/14
	Alcohol related admissions to hospital per 100,000	2144/100,000	2293/100,000
	Alcohol treatment services: Numbers in alcohol treatment services Number of successful completions Re-presentations within 6 months Numbers waiting >3 weeks to start treatment		 Target >900 Target 45% Target <10% Target <8%

Key Actions

Action	Lead	Completion date
Development of an alcohol strategy and action plan for Dudley borough	Substance Misuse team	March 2015

HEALTHY CHILDREN – EARLY YEARS

Key Actions for commissioners

Action for Commissioners	Lead	Completion date
• The importance of building on the Time for Twos programme, targeting the most vulnerable children		

and their families, joined up working for transition through to the provision for 3 to 4 year olds is required. Extend the key worker role which been shown to have a significant impact.	**TBC**	**TBC**
• Further develop parenting skills opportunities to enable more families to benefit.	**TBC**	**TBC**
• Focus on early intervention to support families in the development of resilience in their children	**TBC**	**TBC**

HEALTHY CHILDREN- 16 TO 18 TRANSITION

Key Actions for Commissioners

Action for Commissioners	Lead	Completion date
• Commission a Mental Health Service for the 16 – 18 age group, whose needs are frequently not met in the transition from the Children's and Adolescent Mental Health Service to Adult Services.	**TBC**	**TBC**
• Put in place plans to encourage all services to be young people friendly, and train staff to understand the issues around providing young person appropriate services.	**TBC**	**TBC**
• Ensure young people are empowered to contribute to the planning and development of services that meet their needs, through ensuring that their voice is heard.	**TBC**	**TBC**

HEALTHY NEIGHBOURHOODS

Key Indicators:

Ref	Performance Indicator	Last year out-turn	Target
	Adult participation in sport and active recreation (1X30 minutes per week)	27.8% (2012)	N/A
	Improved street and environmental cleanliness (National indicator 195) a: litter b:detritus c:Graffiti d:fly-posting)	 3.3% 6.3% 1.3% 0.1%	 3.3% (2014/15) 5.7% 1.3% 0%

	Gross affordable housing completions (Core Output Indicator HOU3)	312 (49% of gross completions (2011/12)	Between yrs 2006-2026) 2479 affordable dwellings (15% of gross completions) (116 /year)
	Increase in cycle use of monitored routes (LOI TRAN4a)	14,272 (2012/13)	1% increase in cycling
	Implementation of missing links and overcoming barriers identified in sub regional cycle network map (LOITRAN4b)	10 new links via healthy towns project – 7.26km (2012)	N/A

HEALTH AND WELLBEING PRIORITIES -OUTCOMES FRAMEWORKS

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

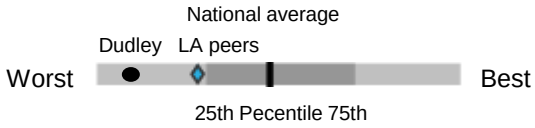
Source

Public Health outcomes framework

NHS outcomes framework

Adult social care outcomes framework

Spine chart explanation:



Domain	Indicator		Local Numerator	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Overarching	0.1i males	Male healthy life expectancy at birth 2009-11 (Years)		62.1	63.2	55.0		70.3
	0.1i females	Female healthy life expectancy at birth 2009-11 (Years)		63.6	64.2	54.1		72.1
	0.1ii males	Male life expectancy at birth 2009-11 (Years)		78.7	78.9	73.8		83.0
	0.1ii females	Female life expectancy at birth 2009-11 (Years)		82.8	82.9	79.3		86.4
	0.2iii males	SII in life expectancy at birth for males within each English upper tier local authority, based on local deprivation deciles of LSOAs 2009-11 (Ratio)		9.4		16.4		0.0
	0.2iii females	SII in life expectancy at birth for females within each English upper tier local authority, based on local deprivation deciles of LSOAs 2009-11 (Ratio)		6.6		13.3		0.0
	0.2iv males	Indication of overall life expectancy for each local authority 2009-11 (Number)		-0.2	0.0	-5.1		3.0
	0.2iv males	Indication of overall life expectancy for each local authority 2009-11 (Number)		-0.1	0.0	0.0		3.2
	0.2v	SII in healthy life expectancy at birth based on national deprivation deciles of LSOAs within England (Ratio)						0.0
	1bi	Life expectancy at 75, males 2009-11 (Years)		11.2	11.4	10.0		13.8
	1bii	Life expectancy at 75, females 2009-11 (Years)		13.2	13.2	11.5		15.7
	4.3	Mortality rate from causes considered preventable 2009-11 (Rate per 100,000 population)	1782	153.2	146.1	264.2		100.7
	4.4i	Mortality rate from all cardiovascular diseases (including heart diseases and stroke) in persons less than 75 years of age 2009-11 (Rate per 100,000 population)	688	61.0	60.9	113.3		39.5

HEALTH AND WELLBEING PRIORITIES -OUTCOMES FRAMEWORKS

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

Source

Public Health outcomes framework

NHS outcomes framework

Adult social care outcomes framework

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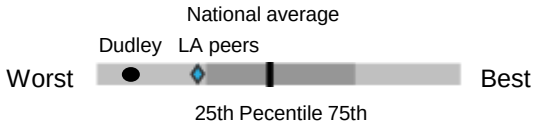

Domain	Indicator		Local Numerator	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Overarching	1.1	Under 75 mortality rate from cardiovascular disease 2012 (Rate per 100,000 population)		53.6	56.0	94.0		25.5
	4.4ii	Mortality rate from all cardiovascular diseases (including heart disease and stroke) that is considered preventable in persons less than 75 years of age 2009-11 (Rate per 100,000 population)	480	42.7	40.6	75.1		23.0
	4.5i	Mortality rate from all cancers for persons in persons less than 75 years of age 2009-11 (Rate per 100,000 population)	1250	111.4	108.1	153.2		84.0
	4.5ii	Mortality rate from all cancers that is considered preventable in persons less than 75 years of age 2009-11 (Rate per 100,000 population)	738	65.5	61.9	98.1		45.2
	4.6i	Mortality rate from liver disease in persons less than 75 years of age 2009-11 (Rate per 100,000 population)	200	20.3	14.4	39.3		7.5
	1.3	Under 75 mortality rate from liver disease 2012 (Rate per 100,000 population)		22.6	14.2	33.3		4.0
	4.6ii	Mortality rate from liver disease that is considered preventable in persons less than 75 years of age 2009-11 (Rate per 100,000 population)	186	19.0	12.7	37.0		7.5
	4.7i	Mortality rate from respiratory diseases in persons less than 75 years of age 2009-11 (Rate per 100,000 population)	286	24.0	23.4	62.0		13.7
	1.2	Under 75 mortality rate from respiratory disease 2012 (Rate per 100,000 population)		20.5	22.6	55.2		5.2
	4.7ii	Mortality rate from respiratory diseases that is considered preventable in persons less than 75 years of age 2009-11 (Rate per 100,000 population)	129	10.5	11.6	28.6		5.3
	4.8	Mortality rate from communicable diseases 2009-11 (Rate per 100,000 population)	517	29.1	29.9	54.9		22.0
	4.14i	Emergency admissions for fractured neck of femur in persons aged 65 and over 2011-12 (Rate per 100,000 population)		466.2	457.2	599.5		337.9

HEALTH AND WELLBEING PRIORITIES -OUTCOMES FRAMEWORKS

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Adult social care outcomes framework

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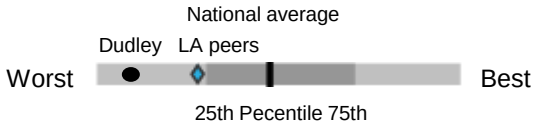

Domain	Indicator		Local Numerator	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Overarching	4.14ii	Emergency admissions for fractured neck of femur in persons aged 65-79 2011-12 (Rate per 100,000 population)		216.8	222.2	346.7		135.7
	4.14iii	Emergency admissions for fractured neck of femur in persons aged 80 and over 2011-12 (Rate per 100,000 population)		1588.9	1514.6	2020.8		993.3
	4.15i	Excess winter deaths all ages 2010-11 (Ratio)	222	24.8	17.0	34.0		0.0
	3.5ii	Incidence of Tuberculosis 2010-12 (Rate per 100,000 population)		10.5	15.1	112.3		0.0
	1a males	Potential Years of Life Lost from causes considered amenable to healthcare (males) 2012 (Rate per 100,000 population)		2139.5	2200.5	5266.7		0.0
	1a females	Potential Years of Life Lost from causes considered amenable to healthcare (females) 2012 (Rate per 100,000 population)		1879.5	1810.7	2873.2		455.2
	1.4i	One-year survival from colorectal cancer 2005-09 (%)		77.1	74.5	66.7		77.1
	1.4ii	Five-year survival from colorectal cancer 2001-05 (%)		52.1	54.9	44.6		58.1
	1.4iii	One-year survival from breast cancer 2005-09 (%)		94.4	95.8	93.7		98.2
	1.4iv	Five-year survival from breast cancer 2001-05 (%)		81.8	82.0	77.1		86.1
	1.4v	One-year survival from lung cancer 2005-09 (%)		24.9	31.0	23.3		35.5
	1.4vi	Five-year survival from lung cancer 2001-05 (%)		6.7		5.6		8.1

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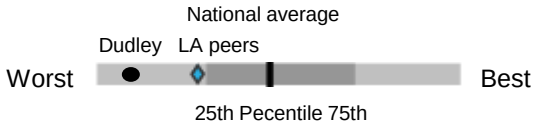

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Overarching	1.4vii	Under 75 mortality rate from cancer 2012 (Rate per 100,000 population)		113.7	105.3	160.3		72.9
	1.7	Premature mortality for people with a learning disability (TBC)						
Healthy Children	1.1	Children in poverty 2011 (%)	13095	22.8	20.6	43.6		2.8
	1.2	Good development at age 5 2012 (%)	2152	60.0	64.0	51.0		78.0
	1.3	Pupil absence 2011-12 (%)		5.3	5.1	6.7		2.0
	1.4	First time entrants to the youth justice system 2012 (Rate per 100,000 population)		403.3	537.0	1426.6		150.7
	1.5	16-18 year olds not in education, employment or training 2012 (%)		6.6	5.8	10.5		0.0
	2.8	Emotional well-being of looked after children 2011-12 (Score out of 40)		12.7	13.8	9.5		20.1
	2.1	Low birth weight of term babies 2011 (%)		3.4	2.8	5.3		0.0
	4.1	Infant mortality 2009-11 (Rate per 1,000 live births)	45	4.0	4.3	8.0		2.3
	1.6i	Infant mortality 2010 (Rate per 1,000 live births)		4.5	4.2	10.0		0.0
	1.6ii	Neonatal mortality and stillbirths 2010 (Rate per 1,000 live births and stillbirths)		9.2	8.0	16.1		4.0

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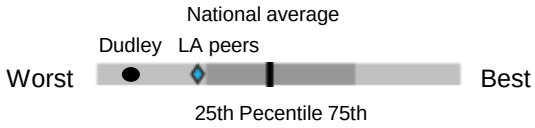

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Healthy Children	5.5	Admission of full term babies to neonatal care 2010 (%)	114	3.3	5.1	57.1		0.8
	3.2	Emergency admissions for children with Lower Respiratory Tract Infections (LRTIs) 2012-13 Q4 (Rate per 100,000 population)		112.7	89.6	208.7		18.1
	5.6	Incidence of harm to children due to 'failure to monitor' (Number)						
	4.8	Children and young people's experience of healthcare (TBC)						
	2.6i	Proportion of children aged 4-5 classified as overweight or obese 2011-12 (%)	867	24.7	22.6	30.0		0.0
	2.6ii	Proportion of children aged 10-11 classified as overweight or obese 2011-12 (%)	1294	38.4	33.9	42.8		0.0
	4.2	Tooth decay in children aged 5 2011-12 (%)		0.6	0.9	2.1		0.0
	2.7i	Hospital admissions caused by unintentional and deliberate injuries in children (aged 0-14 years) 2011-12 (Rate per 10,000 population)	618	111.6	118.2	211.4		68.7
	2.7ii	Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15-24) 2011-12 (Rate per 10,000 population)	586	154.4	144.7	278.7		71.6
	3.2ii	Chlamydia diagnoses - CTAD Data 2012 (Rate per 100,000 population)	275	724.5	1979.1	6131.9		702.8
	2.4	Under 18 conceptions 2011 (Rate per 1,000 female population aged 15-17)		35.6	30.7	58.1		0.0
	3.3i (1yr olds)	Hepatitis B vaccination coverage (one year olds) 2011-12 (%)	4	100.0		0.0		100.0

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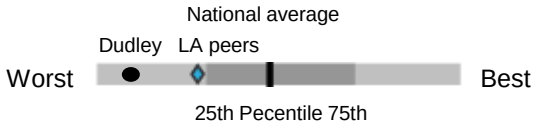

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Healthy Children	3.3i (2yr olds)	Hepatitis B vaccination coverage (two year olds) 2011-12 (%)	6	100.0		2.6		100.0
	3.3ii	BCG vaccination coverage (aged under 1 year) 2011-12 (%)	518	100.0	96.5	2.1		100.0
	3.3iii	DTaP/IPV/Hib vaccination coverage (one and two year olds) 2013-14 Q2 (%)	1877	98.3	94.9	79.9		99.0
	3.3iv	MenC vaccination coverage (one year olds) 2011-12 (%)	3484	96.5	93.9	81.4		98.6
	3.3v	PCV vaccination coverage (one year olds) 2011-12 (%)	3490	96.6	94.2	83.8		98.6
	3.3vi	Hib/MenC booster vaccination coverage (two and five year olds) 2012-13 Q4 (%)	1703	94.6	92.4	77.3		98.1
	3.3vii	PCV booster vaccination coverage (two year olds) 2011-12 (%)	3508	95.2	91.5	74.7		97.0
	3.3viii	MMR vaccination coverage for one dose (two year olds) 2011-12 (%)	3478	94.4	91.2	78.7		97.2
	3.3ix	MMR vaccination coverage for one dose (five year olds) 2011-12 (%)	3301	95.5	92.9	79.8		98.0
	3.3x	MMR vaccination coverage for two doses (five year olds) 2011-12 (%)	3098	89.6	86.0	69.7		95.3
	3.3xi	Td/IPV booster vaccination coverage (13-18 year olds) 2011-12 (%)	2893	12.1	11.4	2.7		24.7
	3.3xii	HPV vaccination coverage (females 12-13 year olds) 2011-12 (%)	1586	90.7	86.8	62.3		97.2

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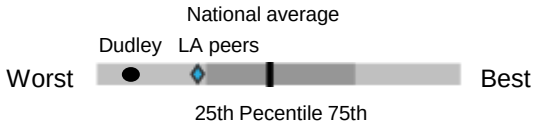

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Healthy Lifestyles	2.2i	Breastfeeding initiation 2011-12 (%)	2112	57.2	74.0	41.8		94.3
	2.2ii	Breastfeeding prevalence at 6-8 weeks after birth 2011-12 (%)	1040	28.8	47.2	19.7		82.8
	2.3	Smoking status at time of delivery 2011-12 (%)	574	15.5	13.2	29.7		2.9
	2.14	Smoking prevalence - adults 2011-12 (%)	250	19.1	20.0	41.7		13.2
	2.12	Excess weight in adults 2006-08 (%)		27.7	24.2	30.7		13.9
	2.13i	Proportion of adults achieving at least 150 minutes of physical activity per week in accordance with UK CMO recommended guidelines on physical activity 2012 (%)		48.4	56.0	43.8		68.5
	2.13ii	Proportion of adults classified as "inactive" 2012 (%)		37.7	28.5	40.2		18.2
	2.18	Alcohol-related admissions to hospital 2012-13 Q4 (Rate per 100,000 population)	2338	556.6	495.1	818.8		235.9
	2.20i	The percentage of women in a population eligible for breast screening at a given point in time who were screened adequately within a specified period 2013 (%)	25493	75.1	76.3	58.2		84.5
	2.20ii	The percentage of women in a population eligible for cervical screening at a given point in time who were screened adequately within a specified period 2013 (%)	56548	73.8	73.9	58.6		83.2
	2.22i	Percentage of eligible population who are offered an NHS health check 2012-13 (%)	21627	23.4	16.5	0.7		42.5
	2.22ii	Percentage of eligible population offered an NHS Health Check who received an NHS Health Check 2012-13 (%)	8974	41.5	49.1	7.7		100.0

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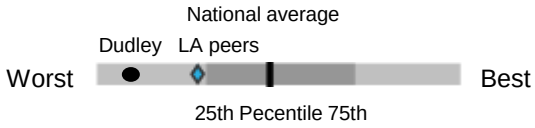

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Healthy Lifestyl	2.21vii	The percentage of those offered screening for diabetic eye screening who attend a digital screening event 2011-12 (%)	10320	72.9	80.9	66.7		95.0
Healthy Minds	2.10	Self-harm 2011-12 (Rate per 100,000 population)	684	234.3	207.9	542.4		51.2
	4.10	Suicide rate 2009-11 (Rate per 100,000 population)		6.5	7.9	13.9		4.3
	4.9	Excess under 75 mortality in adults with serious mental illness 2010-11 (Rate per 100,000 population)		965.4	921.2	1863.2		210.4
	2.23i	The percentage of respondents scoring 0-6 to the question "Overall, how satisfied are you with your life nowadays?" 2011-12 (%)		30.5	24.3	30.5		14.6
	2.23ii	The percentage of respondents scoring 0-6 to the question "Overall, to what extent do you feel the things you do in your life are worthwhile?" 2011-12 (%)		25.2	20.1	25.4		12.8
	2.23iii	The percentage of respondents who answered 0-6 to the question "Overall, how happy did you feel yesterday?" 2011-12 (%)		33.5	29.0	36.6		19.2
	2.23iv	The percentage of respondents scoring 4-10 to the question "Overall, how anxious did you feel yesterday?" 2011-12 (%)		38.5	40.1	48.3		34.4
	2	Health related quality of life for people with long-term conditions 2012/13 (Number)		0.7	0.7	0.6		0.8
	2.4	Health-related quality of life for carers 2012-13 (Number)		0.8	0.8	0.7		0.9
	1.6ii	Percentage of adults receiving secondary mental health services living independently at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting 2011-12 (%)	965	48.4	54.6	2.9		91.7
	1.8iii	Gap between employment rate of those with mental illness and overall employment rate (%)						

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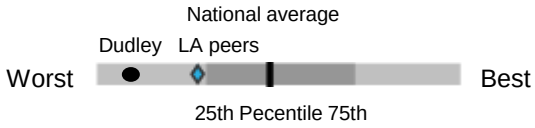

Domain	Indicator		Local Numerator	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Healthy Minds	1F	Proportion of adults in contact with secondary mental health services in paid employment 2012-13 (%)	55	3.4	7.7	1.0		20.3
	1.6i	Percentage of adults with a learning disability who are known to the council, who are recorded as living in their own home or with their family 2011-12 (%)		76.8	70.0	0.0		93.8
	1H	Proportion of adults in contact with secondary mental health services living independently, with or without support 2012-13 (%)	520	32.3	59.3	4.7		94.0
	2.6i	Estimated diagnosis rate for people with dementia (%)			48.7			
	2.6ii	Effectiveness of dementia post-diagnosis care in sustaining independence and improving quality of life (TBC)						
	4.7	Patient experience of community mental health services 2013 (Score out of 100)		87.6	85.8	80.9		90.9
Healthy Neighbourhoods	1.10	Killed and seriously injured casualties on England's roads 2010-12 (Rate per 100,000 population)	283	30.1	40.5	665.6		0.0
	3.1	Fraction of mortality attributable to particulate air pollution 2011 (%)		5.3	5.4	8.9		3.0
	1.16	Utilisation of outdoor space for exercise/health reasons 2012-13 (%)		14.3	15.3	0.0		41.2
	3.6	Public sector organisations with a board approved sustainable development management plan 2011-12 (%)	3	60.0	84.1	20.0		100.0
	1.12ii	Rate of violence against the person offences based on police recorded crime data 2012-13 (Rate per 1,000 population)	2157	6.9	10.6	69.9		4.1
	1.12i	Emergency hospital admissions for violence 2009-10/2011-12 (Rate per 100,000 population)	659	78.4	67.7	213.5		0.0

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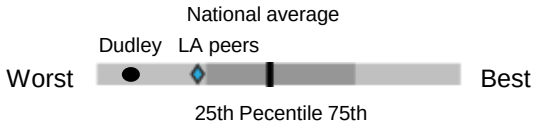

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Healthy Neighbourhoods	1.12iii	Sexual Violence 2011-12 (%)	240	0.8	1.0	3.0		0.3
	1.13i	The percentage of offenders who re-offend from a rolling 12 month cohort 2010 (%)	620	22.8	26.8	36.3		17.3
	1.13ii	The average number of re-offences committed per offender from a rolling 12 month cohort 2010 (Mean average)	1668	0.6	0.8	1.2		0.4
	1.14i	Number of complaints per year per local authority about noise 2011-12 (Rate per 1,000 population)	1528	4.9	7.5	116.0		1.4
	1.15i	Homelessness acceptances 2012-13 (Rate per 1,000 households)	171	1.3	2.4	11.4		0.0
	1.15ii	Households in temporary accommodation 2012-13 (Rate per 1,000 households)	55	0.4	2.4	33.2		0.0
	1.17	Fuel poverty 2011 (%)	16668	12.8	10.9	18.0		2.5
Healthy Services	2.17	Recorded diabetes 2011-12 (%)	15670	6.2	5.8	8.0		2.7
	4.11	Emergency readmissions within 30 days of discharge from hospital 2010-11 (%)		11.7	11.8	13.8		8.1
	2.15i	Successful completion of drug treatment for opiates 2012 (%)	89	9.2	8.2	0.0		17.6
	2.15ii	Successful completion of drug treatment for non-opiates 2012 (%)	80	44.0	40.2	0.0		68.4
	2.24i	Emergency hospital admissions for injuries due to falls in persons aged 65 and over 2011-12 (Rate per 100,000 population)	1380	1825.7	1664.8	2985.3		0.0

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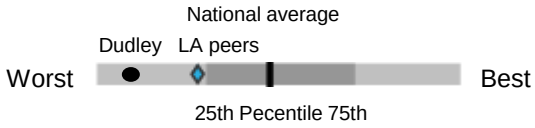

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Healthy Services	2.24ii	Emergency hospital admissions for injuries due to falls in persons aged 65 to 79 2011-12 (Rate per 100,000 population)	416	906.0	940.5	1725.8		0.0
	2.24iii	Emergency hospital admissions for injuries due to falls in persons aged 80 and over 2011-12 (Rate per 100,000 population)	964	5964.2	4923.9	8965.4		0.0
	2.3i	Unplanned hospitalisation for chronic ambulatory care sensitive conditions 2012-13 Q4 (Rate per 100,000 population)		220.2	205.5	423.4		43.5
	2.3ii	Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s 2012-13 Q1 (Rate per 100,000 population)		94.5	77.0	196.8		11.4
	3a	Emergency admissions for acute conditions that should not usually require hospital admission 2012-13 (Rate per 100,000 population)		420.4	314.9	588.7		73.2
	3b	Emergency readmissions within 30 days of discharge from hospital 2011-12 (%)		11.8	11.8	14.5		8.9
	3.1i	Total health gain as assessed by patients for elective procedures - Unilateral Hip Replacements 2011-12 (Health score)		0.4	0.4	0.3		0.5
	3.1ii	Total health gain as assessed by patients for elective procedures - Unilateral Knee Replacements 2011-12 (Health score)		0.3	0.3	0.2		0.4
	3.1iii	Total health gain as assessed by patients for elective procedures - Groin Hernia Surgery 2011-12 (Health score)		0.0	0.1	0.0		0.1
	3.1iv	Total health gain as assessed by patients for elective procedures - Varicose Vein Surgery 2011-12 (Health score)		0.1	0.1	0.1		0.2
	3.1v	Total health gain as assessed by patients for elective procedures - Psychological Therapies (Health score)						
	3.3	Proportion of people who recover from major trauma (Adjusted odds)						

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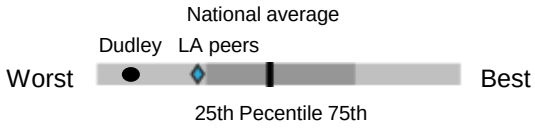

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Healthy Services	3.4	Proportion of stroke patients reporting an improvement in activity/lifestyle on the Modified Rankin Scale at 6 months (Score out of 6)						
	3.5i	The proportion of patients with a fragility fracture recovering to their previous levels of mobility at 30 days (%)			21.7			
	3.5ii	The proportion of patients with a fragility fracture recovering to their previous levels of mobility at 120 days (%)			47.3			
	3.6i	The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation 2011-12 (%)	199	87.3	82.7	56.9		100.0
	4ai	Patient experience of primary care - GP services 2012-13 (Score out of 100)	4663	85.5	86.7	74.1		92.6
	4aii	Patient experience of primary care - GP out of hours services 2012-13 (Score out of 100)	412	66.6	70.2	54.5		82.8
	4aiii	Patient experience of primary care - NHS dental services 2012-13 (Score out of 100)	1626	89.2	84.0	73.4		92.9
	4b	Patient experience of hospital care 2012-13 (Score out of 100)		73.4	76.5	68.0		88.2
	4ci	Friends and Family Test - A&E Oct-13 (Score between -100 and 100)		61.0		-11.0		93.0
	4cii	Friends and Family Test - Inpatients Oct-13 (Score between -100 and 100)		76.0	71.0	41.0		100.0
	4.1	Patient experience of outpatient services 2011 (Score out of 100)		77.4	79.5	71.0		88.5
	4.2	Responsiveness to in-patients' personal needs 2012-13 (Score out of 100)		64.9	68.1	57.4		84.4

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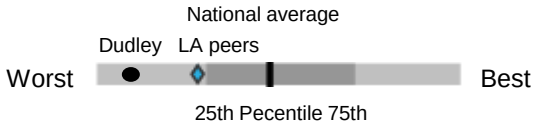


Domain	Indicator		Local Numerator	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Healthy Services	4.3	Patient experience of accident and emergency services 2012 (Score out of 100)		78.5	79.1	0.0		86.6
	4.4i	Access to GP services 2012-13 (%)	3932	73.3	76.3	59.3		86.8
	4.4ii	Access to NHS dental services 2012-13 (%)	1751	95.9	93.0	83.0		97.4
	4.5	Women's experience of maternity services 2010 (Score out of 100)		77.1	77.0	74.4		80.5
	4.6	Bereaved carers' views on the quality of care in the last 3 months of life (%)						
	4.9	People's experience of integrated care (TBC)						
	5a	Patient safety incidents reported 2012-13 Q1&2 (Rate per 100 admissions)	4049	7.5		24.6		2.0
	5b	Safety incidents involving severe harm or death 2012-13 Q1&2 (Rate per 100 admissions)	41	0.1		0.3		0.0
	5c	Hospital deaths attributable to problems in care (TBC)						
	5.1	Incidence of healthcare-related venous thromboembolism (Rate per 100,000 population)						
	5.2i	Incidence of healthcare associated infection: MRSA bacteraemia 2012-13 (Number)		2.0		18.0		0.0
	5.2ii	Incidence of healthcare associated infection: C. Difficile 2012-13 (Number)		106.0		269.0		12.0

HEALTH AND WELLBEING PRIORITIES -OUTCOMES FRAMEWORKS

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

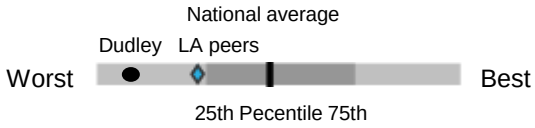
Source

Public Health outcomes framework

NHS outcomes framework

Adult social care outcomes framework

Spine chart explanation:



Domain	Indicator		Local Numerator	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Healthy Services	5.3	Incidence of newly-acquired category 2,3 and 4 pressure ulcers (%)						
	5.4	Incidence of medication errors causing serious harm 2012-13 Q1&2 (Rate per 100 admissions)	41	0.1	0.0	0.3		0.0
	3.3xiii	PPV vaccination coverage (over 65s) 2011-12 (%)	40661	67.8	68.3	52.8		76.6
	3.3xiv	Flu vaccination coverage (over 65s) 2011-12 (%)	44105	73.2	74.0	64.8		81.5
	3.3xv	Flu vaccination coverage (at risk individuals from age six months to under 65 years) 2011-12 (%)	16326	52.2	51.6	43.4		66.3
	3.4	People presenting with HIV at a late stage of infection 2009-11 (%)	11	36.7	50.0	75.0		0.0
	3.5i	Proportion of patients who successfully complete treatment for tuberculosis 2012 (%)		74.3	82.8	22.6		100.0
	4.12i	Crude rate of sight loss due to Age-related Macular Degeneration (AMD) in persons aged 65 years and over 2011-12 (Rate per 100,000 population)	79	134.8	110.5	225.2		12.8
	4.12ii	Crude rate of sight loss due to glaucoma in persons aged 40 years and over 2011-12 (Rate per 100,000 population)	15	9.2	12.8	34.5		3.0
	4.12iv	Crude rate of sight loss certifications 2011-12 (Rate per 100,000 population)	164	52.4	44.5	82.5		5.1
	2.1	Proportion of people feeling supported to manage their condition 2012-13 (%)		69.5	69.3	55.3		79.2
	1.8i	Gap between employment rate of those with long-term health conditions and overall employment rate 2012 (%)		4.7	7.1	21.7		-5.3

HEALTH AND WELLBEING PRIORITIES -OUTCOMES FRAMEWORKS

- Significantly better than England average
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Public Health outcomes framework

NHS outcomes framework

Adult social care outcomes framework

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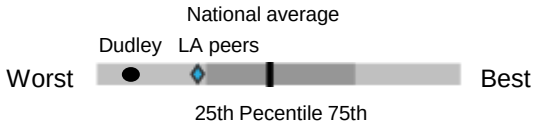

Domain	Indicator		Local Numerator	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Healthy Services	1.8ii	Gap between employment rate of those with learning difficulty/disability and overall employment rate. 2011-12 (%)		65.7	63.2	73.1		40.2
	1G	Proportion of adults with a learning disability who live in their own home or with their family 2012-13 (%)	495	70.0	73.5	32.6		96.6
	1E	Proportion of adults with learning disabilities in paid employment 2012-13 (%)	50	6.8	7.0	0.6		23.1
	1A	Social care related quality of life 2012-13 (Score out of 24)		19.0	18.8	17.6		19.9
	1B	The proportion of people who use services who have control over their daily life 2012-13 (%)		74.8	76.1	64.8		86.5
	1Ci	Proportion of people using social care who receive self-directed support 2012-13 (%)	4100	68.0	55.5	7.4		96.2
	1Cii	Proportion of people using social care who receive direct payments 2012-13 (%)	1185	19.7	16.5	4.2		45.5
	1D	Carer-reported quality of life 2012-13 (Score out of 12)	355	8.3	8.1	6.6		9.8
	1I	Proportion of people who use services and their carers, who reported that they had as much social contact as they would like (%)	0	0.0	0.0	0.0		0.0
	2Ai	Permanent admissions to residential and nursing homes of younger people, per 100,000 population 2012-13 (Rate per 100,000 population)	35	19.4	15.0	51.7		3.9
	2Aii	Permanent admissions to residential and nursing homes of older people, per 100,000 population 2012-13 (Rate per 100,000 population)	475	783.0	697.2	1376.3		138.3
	2Bi	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services 2012-13 (%)	220	87.4	81.4	53.7		98.1

HEALTH AND WELLBEING PRIORITIES -OUTCOMES FRAMEWORKS

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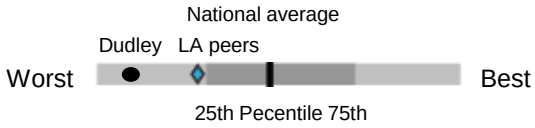

Domain	Indicator		Local Numerator	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Healthy Services	2Bii / NHS 3.6ii	The proportion of older people aged 65 and over offered reablement services following discharge from hospital. 2021-13 (%)*	255	2.8	3.2	0.4		25.4
	2Ci	Delayed transfers of care from hospital per 100,000 population 2012-13 (Rate per 100,000 population)	21	8.5	9.5	27.1		1.1
	2Cii	Delayed transfers of care from hospital attributable to adult social care services per 100,000 population 2012-13 (Rate per 100,000 population)	14	5.7	3.3	12.8		0.3
	2D	The outcomes of short-term services: sequel to service (%)		0.0	0.0	0.0		0.0
	2E	The effectiveness of reablement services (TBC)	0	0.0	0.0	0.0		0.0
	2F	Dementia - a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life (TBC)		0.0	0.0	0.0		0.0
	3A	Overall satisfaction of people who use services with their care and support 2012-13 (%)		61.2	64.1	48.0		73.9
	3B	Overall satisfaction of carers with social services 2012-13 (%)	155	45.9	42.7	25.8		65.4
	3C	The proportion of carers who report that they have been included or consulted in discussion about the person they care for 2012-13 (%)	215	74.5	72.9	55.0		100.0
	3D	The proportion of people who use services and carers who find it easy to find information about services 2012-13 (%)		73.2	71.4	51.9		83.0
	3E	Improving people's experience of integrated care (TBC)		0.0	0.0	0.0		0.0
	4A	The proportion of people who use services who feel safe 2012-13 (%)		62.6	65.1	49.6		77.8

HEALTH AND WELLBEING PRIORITIES -OUTCOMES FRAMEWORKS

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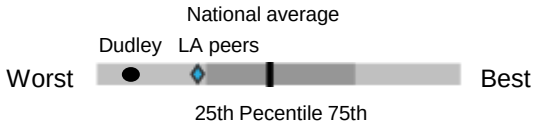


Domain	Indicator		Local Numerator	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Healthy Services	4B	The proportion of people who use services who say that those services have made them feel safe and secure 2012-13 (%)		76.4	78.1	57.5		93.0
	4C	Proportion of completed safeguarding referrals where people report that they feel safe (%)						

Notes * This indicator (ASC 2Bii and NHS 3.6ii) is identical and therefore has only been included once on the HWBB outcomes framework

Agenda Item No.6

DUDLEY HEALTH AND WELLBEING BOARD

28th JANUARY 2013

Report of a Senior Development Officer of Dudley CVS prepared on behalf of the Health and Wellbeing Board Development Group

HEALTH AND WELLBEING BOARD COMMUNITY ENGAGEMENT PRINCIPLES

PURPOSE OF REPORT

1. This report
   a. provides a summary of findings from interviews with Dudley Health and Wellbeing Board members in relation to engagement
   b. proposes principles in relation to involvement and engagement.

2. The Dudley Health and Wellbeing Board (H&WBB) is invited to consider the principles to guide processes and practice in relation to the engagement and involvement of local people in the commissioning and provision of services and in the realisation of vision, aspirations and priorities in Dudley's Health and Wellbeing Strategy.

BACKGROUND

3. Engaging patients and the public in the commissioning and provision of services is recognised as best practice and is also a statutory requirement under the Health and Social Care Act (2012).

4. The Health and Wellbeing Board Development Group has delivered activity on behalf of the board in relation to the Conference and Spotlight events, and is developing work around performance management, quality assurance and some of the national programmes which Dudley Health and Wellbeing Board are involved in, such as Think Local Act Personal's Strong Inclusive Communities Project. In relation to these engagement and involvement (and communications) have emerged as a priority for action.

5. Interviews have been carried out with 10 board members to date, and an Interim Report (see Appendix) brings together their perspectives in relation to engaging and involving individuals and communities and

   a. local practice and resources
   b. responsibilities of board members

c. sharing knowledge and learning
d. understanding the impact of engagement and involvement.

6. The insights offered by board members paint a picture of the current context in Dudley borough in relation to current performance in relation to engaging and involving people, some examples of practice which can be shared and learned from, attitudes and aspirations in relation to engagement and the resources available locally to make improvements.

7. Board members articulated in detail some local strengths and good practice in relation to engagement and involvement and also the difficulties and complexities faced. There is an appetite among many to shift towards more asset based approaches, such as co-production.

8. There was widespread recognition of collective responsibility in relation to engagement and involvement, though often limited awareness of practice in other organisations, which impacts on assurance and understanding of the impact of engagement, which many acknowledged were complex issues. Accessible communication and concerns in relation to the formality of board meetings were raised independently in a number of discussions.

PROPOSED PRINCIPLES

9. Dudley Health and Wellbeing Board has already articulated seven principles which inform the delivery of the vision in Dudley's Health and Wellbeing Strategy. One of these is:

we will work in empowering ways, appreciating the potential of individuals and their communities to maintain and sustain health and wellbeing and the contribution they can make to shaping and delivering services.

10. It is suggested that the above principle should underpin engagement and involvement activities, and in addition the following principles be used to guide engagement and involvement:
    a. **Engagement is the business and responsibility of every board member**
    b. **There will be different types and levels of appropriate engagement, depending on the situation**
    c. **Engagement activities should be based on evidence of what works**
    d. **We will open ourselves to learning about the reach, impact and effectiveness of our engagement**

FINANCE

11. Any financial implications resulting from these proposals will be met within existing budget arrangements.

LAW

12. Engaging patients and the public in the commissioning and provision of services is recognised as best practice and is also a statutory requirement under the Health and Social Care Act (2012). The statutory duties of the Health and Wellbeing Board are detailed in the Health and Social Care Act 2012 and related guidance.

EQUALITY IMPACT

13. Improving equality and tackling health inequalities are key priorities of the Health and Wellbeing Board and will be discharged through implementation of the Board's Joint Health and Wellbeing Strategy, including related engagement and involvement activities.

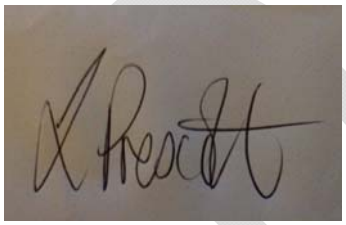
RECOMMENDATION

14. That the Dudley Health and Wellbeing Board discuss the proposed principles in relation to community engagement.

15. That the Dudley Health and Wellbeing Board Development Group develop plans which support the board to undertake responsibilities in relation to engagement and involvement and address the issues raised by board members which are highlighted in the appended report.

APPENDIX

Engaging Together? *towards a collective approach to involving individuals and communities led by Dudley Health and Wellbeing Board*, Interim Report, 2 January 2014



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Dudley CVS

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Engaging Together?

Towards a collective approach to involving individuals and communities led by Dudley Health and Wellbeing Board

Draft Interim Report

Prepared by Lorna Prescott for Dudley Health and Wellbeing Board on behalf of the Health and Wellbeing Board Development Group

2 January 2014

Engaging Together?

towards a collective approach to involving individuals and communities led by Dudley Health and Wellbeing Board

Summary

This interim report brings together perspectives from members of Dudley Health and Wellbeing Board in relation to engaging and involving individuals and communities and

- local practice and resources
- responsibilities of board members
- sharing knowledge and learning
- understanding the impact of engagement and involvement.

The insights offered by board members paint a picture of the current context in Dudley borough in relation to current performance in relation to engaging and involving people, some examples of practice which can be shared and learned from, attitudes and aspirations in relation to engagement and the resources available locally to make improvements.

Board members articulated in detail some local strengths and good practice in relation to engagement and involvement and also the difficulties and complexities faced. There is an appetite among many to shift towards more asset based approaches, such as co-production.

Healthwatch Dudley has quickly established itself as a resource in relation to engagement and involvement, though some board members didn't know what the role of Healthwatch is.

There was widespread recognition of collective responsibility in relation to engagement and involvement, though often limited awareness of practice in other organisations, which impacts on assurance and understanding of the impact of engagement, which many acknowledged were complex issues. Accessible communication and concerns in relation to the formality of board meetings were raised independently in a number of discussions.

In section 5 of this interim report some principles are suggested specifically in relation to engagement and involvement.

- Engagement is the business and responsibility of every board member
- There will be different types and levels of appropriate engagement, depending on the situation
- Engagement activities should be based on evidence of what works
- We will open ourselves to learning about the reach, impact and effectiveness of our engagement

It is intended that these and the issues highlighted through the discussions with board members will be used by the Board and it's Development Group to adapt and develop frameworks, resources and plans in relation to engagement, building on what we already have across partner organisations.

Please note: It was not in the scope this activity to develop agreed definitions or terminology in relation to engagement of involvement, nor the people involved (patients, people who access services, carers, individuals, residents, citizens, communities etc.).

1. Introduction

> The Health and Social Care Act 2012 establishes health and wellbeing boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members will collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more joined-up services from the NHS and local councils in the future.[1]
>
> Engaging patients and the public in the commissioning and provision of services is recognised as best practice and is also a statutory requirement under the Health and Social Care Act (2012).[2]

In April 2013 Dudley's Health and Wellbeing Board became responsible for the health and wellbeing of all Dudley residents. The board members are from:

- Dudley Council (including cabinet members)
- Dudley Council's Office of Public Health
- Dudley Clinical Commissioning Group
- Healthwatch Dudley
- Dudley Council for Voluntary Service
- West Midlands Police
- NHS Commissioning Board (Birmingham and Black Country Area Commissioning Team)

Further details and board papers are available at http://bit.ly/cmisdudleyhwb

A Development Group comprising officers from the public and voluntary sectors has evolved from a group which undertook editorial responsibilities for the writing of Dudley's Health & Wellbeing Strategy in early 2013. The Development Group has been supporting the work of the board in relation to:

- board events - a conference in June and 5 spotlight events with stakeholders focusing on each of the priorities in Dudley's Health & Wellbeing Strategy
- board meetings - agenda setting, shaping and writing board papers
- quality assurance
- performance outcomes
- opportunities for support from national programmes (e.g. the Local Government Association's system leadership programme and Think Local Act Personal's Strong Inclusive Communities Project)

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1. From the Local Government Association website (http://www.local.gov.uk/health/-/journal_content/56/10180/3510973/ARTICLE)
2. From an NHS Confederation publication (http://www.nhsconfed.org/Publications/Documents/patient-public-engagement.pdf)

Following reflection on the conference in June and acknowledgment of key public events and activities organised by members of the health and wellbeing board, communications and engagement were added to the agenda of the Development Group. A meeting for stakeholders wider than those in the Development Group was convened in September 2013 to generate ideas and opportunities for a yearly communications and engagement plan. Some thoughts on developing a strategy and plan were circulated in a paper in advance of the meeting, highlighting Dudley's joint empowering approach to engaging communities developed in 2007-9 through the work of Dudley Community Partnership. Support for practitioners has been a notable success to date in putting the approach into action, through **engaging together** training sessions and community engagement network events.

Following the session in September and other discussions in relation to the Health and Wellbeing Board's system leadership work with Robin Douglas, the Development Group suggested that instead of a developing a strategy for engagement, the board could agree some principles in relation to engagement and be supported to identify and put in place processes to help ensure that practice aligns with the principles and the aspirations and vision in Dudley's Health & Wellbeing Strategy.

It was agreed that one-to-one or small group discussions with Dudley Health & Wellbeing Board members would be offered, to explore different perspectives on engagement, consider draft principles, and elicit examples of useful practice and developments to share between stakeholders.

Methodology

A discussion guide loosely covering four broad themes and some suggested principles in relation to engagement and involvement was developed. The themes weren't made explicit during the discussions, though the questions used related to engaging and involving individuals and communities and:

- local practice and resources
- responsibilities of board members
- sharing knowledge and learning
- understanding the impact of engagement and involvement.

A key source for questions in the discussion guide was Patient and public engagement: a practical guide for health and wellbeing boards (November 2012) developed by the National Learning Network for health and wellbeing boards.

Board members were invited by email to take part in one-to-one or small group discussions, and offered a range of appointment times on which a member of the Development Group could meet them at their office or another suitable venue. Lorna Prescott took on the role of 'interviewer' in all of the discussions (other Development Group members were invited to join sessions but were unable to).

Some of the discussions involved running through most or all of the questions in the discussion guide in an interview style process, while in other discussions the board members took more of a lead and shared ideas and information which felt relevant to them, with a few questions from the discussion guide being selected and drawn on as prompts by the interviewer.

The first round of discussions took place between 21 November and 17 December 2013 with 10 board members and 2 Development Group members. (See Appendix 1.) A further round of appointments are being offered in January 2014 to the remaining 6 board members.


"PEOPLE WILL FORGET
WHAT YOU SAID,
PEOPLE WILL FORGET
WHAT YOU DID,
BUT PEOPLE WILL
NEVER FORGET
HOW YOU
MADE THEM FEEL."
MAYA ANGELOU

2. Local practice and resources

Strengths in Dudley borough in relation to engaging and involving individuals and communities which board members identified included:

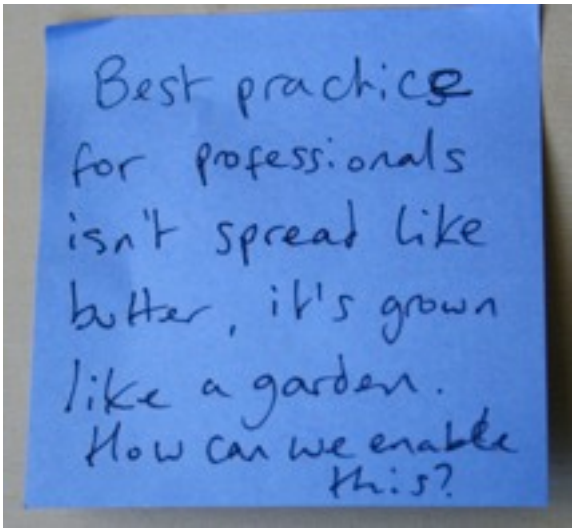
- A strong tradition of engagement, there is a lot of engagement and involvement going on.
- We put a lot of effort in to engagement and have a genuine commitment to it.
- People in Dudley borough are engagable! (in other areas they not as keen to engage).
- People get on well together across the Health and Wellbeing board and know each other.
- Health and wellbeing board spotlight sessions.
- CCG work on clinical pathways and commissioning.
- Healthwatch Dudley is "far more advanced than in other areas, with a good infrastructure".

Most of Dudley's Health and Wellbeing Board members have robust examples of engagement activity in their organisation or directorate, although they feel effective engagement isn't yet fully embedded across the commissioning and/or delivery of all of their services. Areas in which improvement has been noted include:

- Sharing learning beyond immediate teams so that can be used more widely.
- Increased action as a result of outcomes of engagement.
- Deliberate efforts to engage young people, older people, disabled people etc.

Priorities for improving and/or embedding engagement within organisations include:

- Getting better at feedback.
- Putting things in to a language that people can understand (a learning and development issue).
- Co-production around clinically commissioned Public Health services
- Increasing coverage of Patient Participation Groups in GP surgeries to 100%, then them working effectively across localities and being able to articulate health needs effectively.
- Systems of reporting that genuinely provide understanding of an individual's own perspective on the care they have been given
- Embracing and using technology - social messaging and social media is part of the Police's strategy
- Making commissioning practice more consistent



Issues identified by board members in relation to engagement across the borough were:

- Engagement and involvement isn't joined up, people are getting fed up.
- We aren't feeding back across the piece.
- We don't all know about the engagement we are doing.
- We need clarity against priorities and we need to engage against all of them, and not just with the usual suspects. Engagement of children and young people is an area for development.
- Organisational change breaks the chains of things we've built. We don't make effective use of what we have from communities - we use it once and not again. We should look to see if existing work is still relevant.

Some types of involvement discussed

Individual involvement

Engaging individual members of the public in their own health and care through shared decision-making and giving them more choice and control over how, when and where they are treated – helping to deliver "no decision about me without me".

Collective involvement

Engaging the public, and groups with common health conditions or care issues, to help get services right for them. Involving the public and patients in decisions about the planning, design and reconfiguration of health services; proactively as design partners and reactively through effective consultation.

Co-production

Working collaboratively with local communities from different geographical areas, communities of interest and seldom heard groups to ensure their views are integral in the commissioning, design, delivery and evaluation of services.

The above are from Patient and public engagement: a practical guide for health and wellbeing boards

The **co-production of public services** has been defined in a variety of ways - e.g. "co-production means delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours" (new economics foundation) or "the public sector and citizens making better use of each other's assets and resources to achieve better outcomes and improved efficiency" (Governance International). source: wikipedia

There is a lot of interest in co-production among Dudley's Health and Wellbeing board member organisations, with an understanding that other types of engagement and involvement are also needed, depending on the circumstances.

"Co-production is increasingly the most important type of engagement for Dudley CCG."

"We need co-production and mutual responsibilities and leadership between organisations in the system."

"We should work with public, rather than for them. The public need to be recognised used as full partners. 99% of healthcare is delivered by an individual to themselves."

"We do a lot of collective involvement. Co-production… I'm not so familiar with. It will be challenging to do it meaningfully."

"We should share and join up the engagement process, through distributed leadership."

There was widespread recognition of resources we can draw on in Dudley borough to support engagement, including joined-up resources across the health and wellbeing system. A number of board members mentioned Healthwatch Dudley specifically, in relation to working together.

When asked about training or support available to those undertaking engagement, many board members interviewed pointed towards support offered to their own officers through internal training or to role models in their teams and external champions they are supporting. The Police are arranging for their front line officers to be trained through Public Health to increase their ability to support the delivery of health and wellbeing outcomes and signposting to health and wellbeing services.

Half of those interviewed made reference to engaging together training and support (see below). Elected members on the board seemed less informed about any training and support available, which officers involved in engaging together had also identified and are seeking to address.

engaging together is an empowering approach to engaging communities developed in Dudley borough by people responsible for community engagement.

A group of 6 officers from Dudley's public and voluntary sectors have continued to build on work developed by a wider multi-agency group between 2007 and 2009. Over the last four years the group has developed 13 different training courses and workshops and delivered them (free of charge) to over 400 officers and volunteers. Community Engagement Network events are held three times a year. Over 300 people have taken part in these since January 2010. The network events are an opportunity for learning about local practice, groups and organisations, discussing the implications of changes in legislation (e.g. the Localism Act) and testing out ideas for future training courses (e.g. using social media in community engagement).

Training courses include:

- Understanding Engagement
- Public Consultation Tools
- Introduction to Survey Design
- Introduction to Running Focus Groups
- Introduction to Presentation Skills
- Communicating with communities in empowering ways
- Introduction to Facilitation Skills
- Working in Inclusive Ways
- Partnership Working
- Reflective Practice

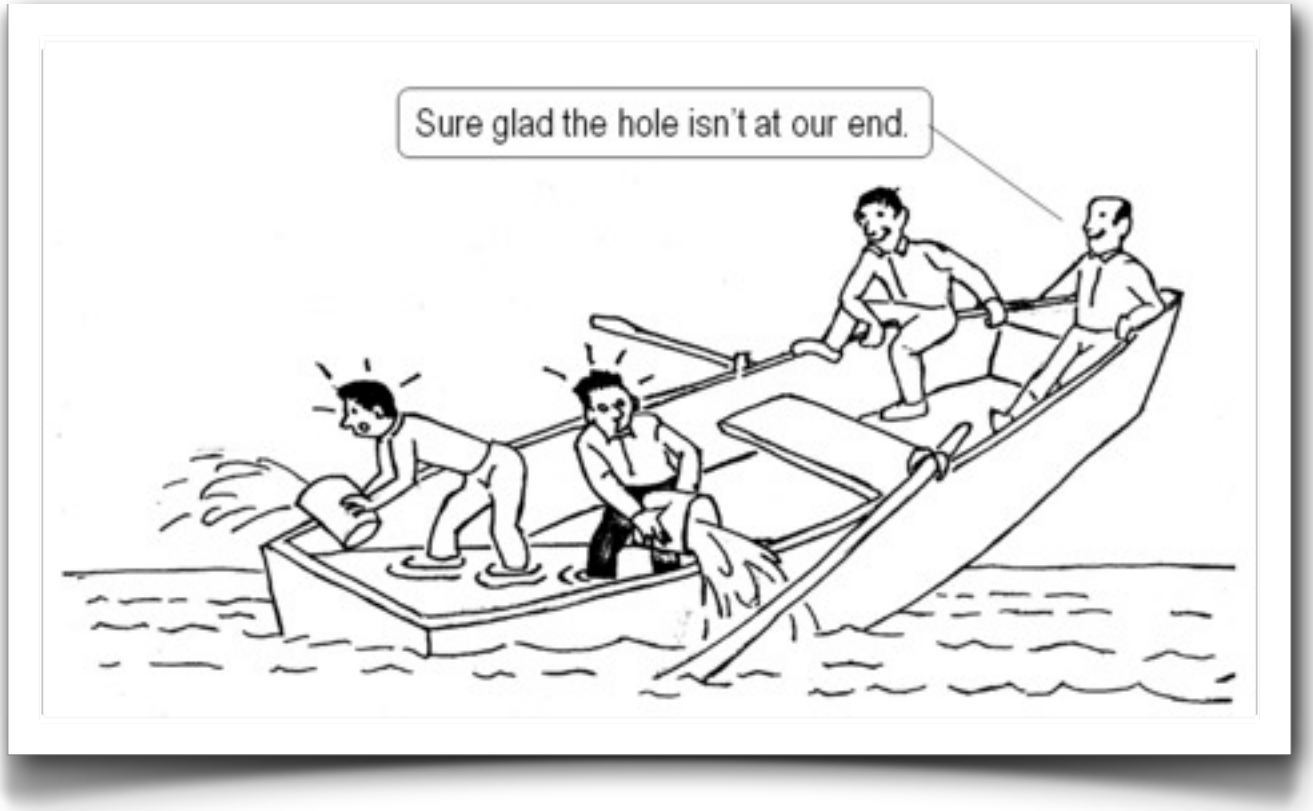
Online modules will be developed in 2014, and new courses added in relation to using social media in community engagement. Community Engagement Network events will continue to address current issues and ideas in relation to community engagement. Training and support to be developed with and for commissioners is also being discussed, a community of practice around social care and engagement will be initiated in 2014, and work around co-production is being taken forward.

It is estimated that organisations in Dudley have saved over £35,000 in training costs by this training and support being developed and delivered locally.

3. Responsibilities of board members

Board members were asked which member or members of Dudley Health & Wellbeing Board they feel have responsibility for community (patient and public) engagement.

The response which most board members ultimately gave was 'all board members'. Healthwatch Dudley was mentioned specifically a number of times, often before other partners were mentioned by name. Alison Taylor from the NHS England Area Team highlighted that while responsibility sits with all board members, for some it rests with them more directly than for others: "engagement isn't in my portfolio, someone else in the Area Team has responsibility for it".



When asked about they see Healthwatch Dudley fitting in to local engagement structures, a few board members said they didn't know much about Healthwatch. Those who had a view said:

"Healthwatch has a leadership role, but it's not all down to them. It will be dangerous if they see themselves as the voice of the people. What we hear has to be joined up. Healthwatch has a fundamental role in joining up voices, challenge, as well as bring forward what people see as solutions."

"It's a delicate balance, they have got to maintain and be seen to maintain an independent view, it's really important for their credibility. I see Healthwatch doing some independent work, and supporting other work or doing joint work on other occasions."

"They are a crucial and should be a thorn in our side. They need to ask the right questions and do a bit of probing."

Most board members were aware that the board has a legal duty to involve the local community, including people living in different geographical areas, communities of interest and seldom heard groups, when undertaking JSNAs and the Joint Health and Wellbeing Strategy.

In relation to steps taken to date to engage all parts of the local community in service planning and delivery, including seldom heard groups, children and young people, one board member said:

**"There is too much of an assumption that specialists are doing that.
We haven't tested how robust our approach is of reaching hard to reach.
We don't know where things are funneled.
The role of board members is not listening to people ourselves, but testing that they are being listened to and asking 'so what?' "**

A number of board members feel that to date there hasn't been sufficient time built in for effective, co-ordinated engagement to take place in relation to issues addressed by the board. However they are aware of a few examples, primarily highlighting work in their own organisation or directorate, of good practice, tools and approaches used to engage and involve individuals and communities:

"In Children's Services we have work around the Voice of the Child, the new OFSTED framework, school councils, youth parliament, and the children in care council."

"What the police do is pretty well developed, I'd be happy to share it, we could possibly ask more questions in our regular feeling the difference survey."

"The You Said, We Did approach, and the Local Account for adult social care."

"The asset based work in JSNA and Public Health work are examples, also insight work as well as engagement. You don't need dialogue all the time. Insight work helps you with the why and and how, formal consultation and coproduction helps with the what."

"There are good things happening, for example the evening and lunchtime sessions that Dudley CCG are doing in relation to the Urgent Care consultation, and questionnaire Healthwatch are doing at the Walk in Centre."

3. Sharing knowledge and learning

Board members were asked about ways that learning within and between member organisations could be shared to promote best practice in engagement and to ensure agreed priorities and service design, planning and delivery are influenced by the voices of local people. A combination of board meetings, development sessions or additional sessions (e.g. spotlight events), toolkits and sub-groups were suggested.

Board members are accustomed to attending and participating in partnership meetings, and most reported feeling able to contribute, and being comfortable "in that sort of group". It was felt by some that that the sharing of knowledge and learning depended on members bringing experiences to the board, and the agenda being shaped to encourage it. This could include having an agenda item for Healthwatch to feed back under, and perhaps including patient/public stories at board meetings. It was highlighted that learning together demands members to be open about how they do things.

However a barrier to both contributing community views and engaging people in the work of the board was articulated by a board member as follows:

"The formality of board meetings is a really big problem. It offers little opportunity to capitalise on intelligence around the table - the information people hold. I feel like a passive recipient of information, and there are no defined actions. There is a real case for the board to look at making meetings less formal to release some of that information and expertise. We might be able to open opportunities for engagement by working in a different way."

It was identified that board members are each at different stages and come at things from different frames of reference and agendas. It was therefore felt that development sessions were still important. The spotlight events were mentioned by a number of board members: "I find them useful, to see the extra stuff people do that I wouldn't have imagined. Engagement, which is as much social oriented as clinical. I've learned a lot and it has given me ideas about linking up in terms of engagement though the board." It was also identified that "the spotlight events are really useful, but have a shelf life". A couple of board members suggested arrangements which would include people from local communities and people who use services in reference or sub-groups.

Issues in relation to communication, language and jargon were raised:

"We should be talking together more and listening together more and making it simple. I find the health service speak in a different language - and we probably do as a council."

"The fact it is constituted board doesn't mean to say all reports have to be written in the way that democratic services request. Wouldn't it be good if they were all in Easy Read as a baseline? If the Health and Wellbeing Board is accountable to the public it needs to be in a language that is useful."

Some board members feel they don't know much at all about other partners practice. Others have identified specific areas they want to learn more about from each other.

4. Understanding the impact of engagement and involvement

Board members articulated difficulties inherent in provision of assurance that effective engagement which makes a difference is taking place in relation to their own organisation and to the work of the board.

It was acknowledged that as new board, to date there has been little feedback in relation to engagement, or a full commissioning cycle. It could be useful if written reports included an assessment of engagement activity, yet a problem is that "you want evidence, not just a statement". One board member felt that: "We would need to know that each constituent agency or sections represented had got processes in place and that there was way of demonstrating impact in relation to what they put resources into. So we need a process that enables us to see that member organisations are not only engaging and co-producing around commissioning plans, but also that delivery is being monitored through contracts and where appropriate the providers are engaging."

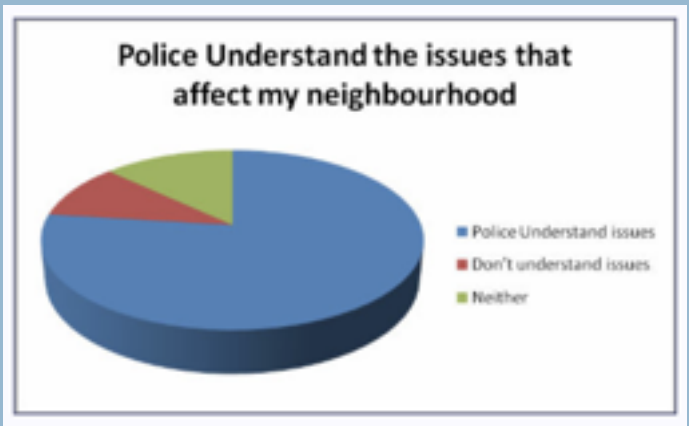
The messiness / complexity was acknowledged, however a board member suggested that ongoing development of insights being drawn together through the JSNA might begin to help. Trust between partners was also mentioned in relation to assurance.

Satisfaction surveys, such as the Feeling the Difference survey used by the West Midlands Police can help to offer assurance in relation to engagement activity.

Feeling the Difference

The West Midlands Police website explains that the Police rely on the views of residents across the force area to tell then how they are doing and they we can improve. Feedback from residents is collected in a survey called **'Feeling the Difference'.** This survey has been conducted since April 2004 by an independent research company and collects feedback from 16,800 people each year. [Over 1000 of those are residents of Dudley borough].

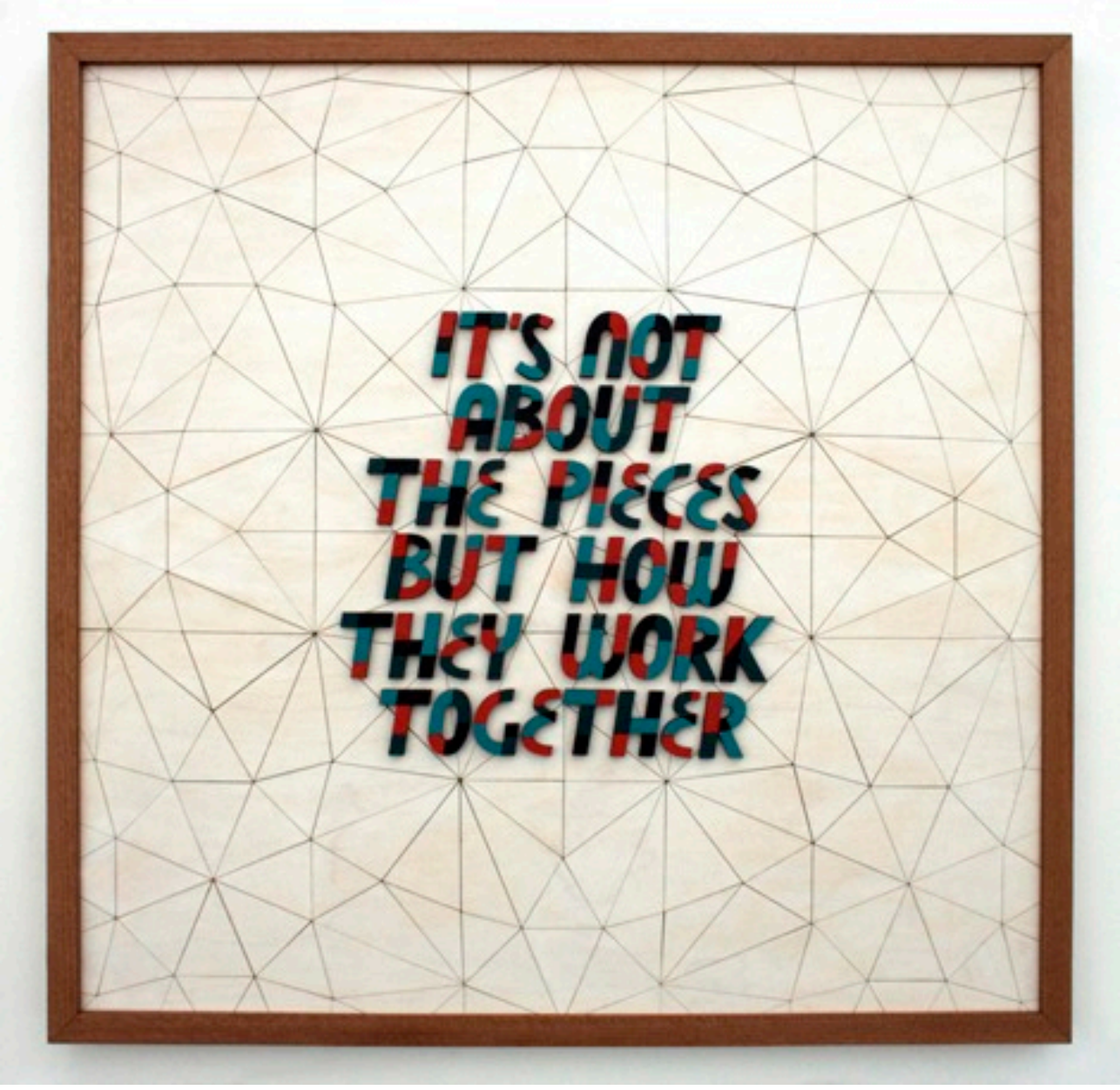
One of the performance indicators which a question is asked in relation to is that the Police works hard to engage local residents, and another asks about the strength of relations between people in your neighbourhood and the police.



It was important to some board members to hear community voices at the board "directly, not sanitised for the board". Reports from Healthwatch Dudley and patient representatives were suggested, as was involving young people with a role to ask questions, including about engagement.

In the future the board should be in a position to evidence that engagement has influenced decision-making and contributed to improved local health and wellbeing outcomes. Ways that this could be done which were suggested by board members included:

- Satisfaction surveys/tests
- You told us this, we did that
- Demonstrating the impact of voice through the Joint Strategic Needs Assessment
- Tracing priorities back to what people said, and feeding back when activity has taken place (e.g. on a website)
- Documentary: videos and full accounts of activity and what it has told us
- An annual Local Account style report




EVERYONE
WELCOME!
EXHIBITION
FREE PIE
& CONVERSATION

5. Proposed principles for engagement and involvement

Dudley Health and Wellbeing Board has already articulated seven principles which inform the delivery of the vision in Dudley's Health and Wellbeing Strategy. One of these is:

we will work in empowering ways, appreciating the potential of individuals and their communities to maintain and sustain health and wellbeing and the contribution they can make to shaping and delivering services.

It is suggested that this principle should underpin engagement and involvement activities, and in addition the following principles be used to guide engagement and involvement:

Engagement is the business and responsibility of every board member

Engagement is the business of every board member and collectively the board has responsibility to ensure effective engagement is embedded within its day-to-day business and is taking place through the commissioning and delivery of services.

Activity and issues should be routinely screened by the board in terms of engagement implications and required actions, the board's capability (and the capability of their partners) to involve local people, and local communities' interest and capability to be involved.

There will be different types and levels of appropriate engagement, depending on the situation

The board needs a consistent and rigorous mechanism by which it can assess the form that engagement should take as each new issue arises, and to evaluate its success.

Engagement activities should be based on evidence of what works

There are a variety of traditional and innovative ways to connect with the local community, including those people who may be from seldom heard groups. Consideration should be given to the most appropriate methodology and medium for engaging the particular target group concerned. It is important that individuals and communities receive feedback on how engagement activities have influenced the development of board policy, priorities and actions.

We will open ourselves to learning about the reach, impact and effectiveness of our engagement

All engagement activity needs to be evaluated, and the learning collected used to plan and develop future engagement. Any evaluation undertaken should actively involve the key audience for the engagement activity concerned.

Appendix 1
Participating Health & Wellbeing Board members

(21 November 2013 - 2 January 2014)

Alison Taylor
Andrea Pope-Smith
Cllr Turner
Cllr Miller
Ian McGuff
Pauline Sharratt
Paul Maubach
Stuart Johnson
Sue Holmyard
Valerie Little

Participating Development Group members interviewed

Brendan Clifford
Neill Bucktin

(NB. Views from the above two interviews have not been included in this Interim Report. They will be discussed by the Development Group in January.)

Outstanding interviews to be arranged with

Andy Gray (booked 8 January 2014)
Jayne Emery (possibly 7 January 2014)
Dr Heggarty
Roger Clayton
Cllr Branwood
Cllr Crumpton (omitted from original list of contacts)

Image credits

Maya Angelou quote from http://tbwork.tumblr.com/post/30742121855

Photograph of post-it with "Best practice for professionals isn't spread like butter, it's grown like a garden. How can we enable this?" from Social Innovation Camp's Flickr images http://www.flickr.com/photos/sicamp/

Cartoon of boat, uncredited, from blog post: http://leadinganswers.typepad.com/leading_answers/2007/12/the-doi-made-to.html

"It's not about the pieces, but how they work together" from http://tbwork.tumblr.com/post/55360495220 source http://www.acejet170.typepad.com

Everyone Welcome sign from Tessy Britton's Flickr images http://www.flickr.com/photos/tessybritton/

Agenda Item No. 7

DUDLEY HEALTH AND WELL-BEING BOARD 28TH JANUARY 2014

Report of the Chief Officer of Healthwatch Dudley

Update on Healthwatch Dudley progress and activity in relation to intelligence gathering and public engagement

Purpose of Report

1. To update the Board on Healthwatch Dudley (HWD) progress.

Background

2. All Councils were required to establish a Local Healthwatch organisation (LHW) by April 1st 2013. Local Healthwatch is the consumer champion for health and social care. The establishment of LHW is of particular relevance to the Health and Wellbeing Board, how the Board and Local Healthwatch interact with each other will have a direct influence on improving outcomes for local communities and people who use services.

Healthwatch Dudley

3. Dudley Council for Voluntary Service (DCVS) commenced delivery of Healthwatch Dudley (HWD) on 1st April. The following outlines key areas of progress made by HWD up to the end of December 2013:

Board Recruitment

4. Following a successful assessed workshop on the 11th September 2013, seven board members were recruited. 6 meetings have taken place along with an away day to develop terms of reference and establish priorities.

5. In addition, the role of Chair was advertised. The interview process involved facilitating a focus group with individuals representing communities within the Dudley borough, giving a presentation and a formal interview. Pam Bradbury was the successful candidate. Board profiles can be found at: http://healthwatchdudley.co.uk/meet-the-board/

Urgent Care Consultation

6. As part of Dudley CCG Urgent Care Consultation, HWD undertook a questionnaire survey in Russells Hall Hospital Accident and Emergency and the Holly Hall Walk in Centre over seven days, between 8.00am and 8.00pm, from Friday 29 November to Thursday 5 December 2013. Twenty fully trained volunteers supported HWD staff in each centre covering four hour slots and approaching

individuals using the facilities and asking for their help to complete the questionnaire survey. Over the seven days, 1,074 people were approached and 943 completed the survey.

7. The questions were designed to get opinion and information on use of primary care services and why people were in A&E or the Walk in Centre. No personal details were collected and confidentiality was ensured to the extent that only aggregated data would be used in reports and individuals anonymity would be maintained.

8. The data will be analysed and a full report of findings produced by the end of January. A head-line summary will be produced for the CCG Board meeting on 9th January 2014.

Information Points

9. Organisations from across Dudley borough have come together to provide a new network of Information and support for local communities. Information points will be in locations around Dudley borough, where local people already visit, get information or services.

10. Information points will be staffed by information champions. An information Champion is a member of staff, community leader or a volunteer from an organisation, who already supports local people to access community information. They might provide signposting to health, preventative wellbeing, or social care services, local charities, or help people to understand where to go for benefits or debt advice.

11. The Network will consist of people who work in prominent community locations, volunteer for groups that provide essential local services, or are involved with a local centre or lead an activity. Joining the network will give people access to training and tools, that will help them to point people in the right direction. An extra level of training and support will follow for organisations that want to give more enhanced support, such as more specialised signposting around money management, health or benefits.

12. The support given to local people at Dudley Information points will create more resilient communities by preventing people from getting into crisis situations.

13. The Community Information Network is a partnership of local organisations operating within Dudley borough and a joint communications strategy has been produced to reflect promotion and purpose of the new network.

14. A launch event took place in Brierley Hill in November which was attended by over 50 local people. Representation included strategic partners, local charities and community groups wishing to become information points and champions.

15. Further network meetings have taken place, 43 information points have been confirmed and 51 information champions are awaiting training that will take place in the New Year.

Adult Social Care Local Account

16. HWD was invited to bring together local people, with a wide range of experiences to comment on the production of the Dudley adult social care Local Account or annual report.

17. Over the last few months, HWD has brought together three groups of people, to provide feedback on various drafts of the report. The group had a direct say on the presentation,they said no to information being given in complicated formats and championed the use of clear language. The group scrutinised the report's content and asked for explanations if they felt that enough detail hadn't been included. Finally, they shared their views about major challenges they felt would be faced in the delivery of adult social care services in the year ahead.

18. Involvement in the workshops was diverse and included 22 people (including officers) with experience of physical disability, neurological conditions, sight loss, drug and alcohol addiction, being a carer, learning disability, personal budgets and issues that affect older people.

19. One group member who has Multiple Sclerosis said, "I might not be able to walk for great distances but I can listen and share my experiences of local services. I was delighted when I was asked to be involved, as it felt fantastic to get the chance for my voice to be heard. Being involved in this way not only keeps my mind active, it makes me feel stronger and more alive."

Professor Sir Bruce Keogh Review

20. Following the Keogh Review at Dudley Group NHS Foundation Trust, there were three key urgent actions identified that HWD were especially concerned about:
    - The shortfalls in learning from serious incidents and complaints
    - The complaints process not being fit for purpose
    - Adequately responding to the patients needs.

21. In December, a meeting took place with Paula Clark, Chief Executive, Liz Abbiss, Head of Communications and Patient Experience and Paul Maubach, Chief Accountable Officer, Dudley CCG to discuss and consider the hospital's patient engagement strategy and action programme. Suggestions were made and the programme will be regularly reviewed.

22. In January, a meeting will take place with the PALS/Complaints Department to review the improvements that have been made so far and through representing the views of local people make recommendations on how they can be further improved.

CQC Inspection of Dudley and Walsall Mental Health Partnership NHS Trust

23. The CQC is currently undertaking a radical review of how it regulates and inspects health and social care services. It is about to do the first testing of its new approach for large complex mental health and community health providers. Dudley and Walsall Mental Health Partnership NHS Trust is due to be expected on 24th February 2014

24. The new inspections will involve larger inspection teams including clinical and other experts, and members of the public. The CQC want to make better use of information and evidence from partners, including HWD, to help identify any current issues or concerns, specific lines of enquiry and any additional services which they may look at during their inspection of the trust.

25. HWD is holding a listening event on 8th January 2014 to gather the views and experiences from people who access services or care for someone who does, to include in its feedback to the CQC to help them plan their inspection.

Enter and View

26. Members of the HWD team have now undertaken Enter and View training from HW England. DMBC Learning and Development has agreed to produce and deliver some bespoke safeguarding training as part of the training package, we have developed for our volunteers. This will be delivered during the next couple of months.

MiR/Carers Event

27. On Friday 29th November a Carers Rights Day Event was held at Insight House in Brierley Hill. HWD organised an engagement exercise where the question was asked, 'What does a carers' information pathway look like to you and what do you need at each stage of your journey. A report from the activity can be viewed here: http://makingitrealindudley.org/wp-content/uploads/2013/12/Carers-Rights-Day-feedback.pdf

Networking and Board Representation

28. The HWD team has continued to build relationships with strategic partners within the Dudley borough promoting the importance and value of HWD.

Networking – National

- Voluntary Sector Studies Network Conference, Sheffield
- HW England Chief Executives Network
- HW Communications Network – London
- Patient Opinion HW training event – London
- Meeting with HW England Board member to discuss establishing a researchers' Community of Practice that has been agreed by HW England and will be formed early 2014.

Networking – Regional

- DMBC Local Account x 3 – engagement events
- Dudley Voices for Choice – engagement re accessible HW literature
- Engaging Communities Staffordshire (contract holders for HW Staffs) meeting
- Healthwatch England regional network meetings
- Healthwatch Black Country chief officer meetings
- Improving and protecting health and wellbeing in the West Midlands – Making new public health systems work - Birmingham

- Local Government Association / Healthwatch Conference on outcomes & impact framework tool
- Migrant Health Forum – Birmingham
- NHS England - Improving GP Practice
- NHS England – met with local area team to establish relationships and discuss future engagement
- NHS England – met with finance director who has a seat on Dudley Health & Wellbeing board
- West Midlands Fire Service – meeting with Partnership Officer to discuss joint working & engagement opportunities
- West Midlands Strategic Clinical Network and Senate Event – Development of West Midland Patient and Public Voice Strategy
- West Midlands Regional Safeguarding Adults Conference, Solihull

Networking – Local

- Black Country Partnership meeting with membership officer
- Carers in Partnership – Meeting with Nigel Hayden
- Chris Kelly MP and Cllr Patrick Harley
- Dudley Health and Well Being Board Spotlight Event – Building resilience in children, young people and their parents
- Mental Health Personalisation
- Patient Experience
- Patient Opportunity Panel
- Planning For Personalisation Meetings and Event
- RNIB meeting with campaigns officer to identify future joint working opportunities
- Queens Cross – Disability in action – Michelle Hill

Public events / presentations / engagement activities

- Beacon Centre conference on future of sight loss – presence
- Black Country Neurological Alliance AGM – presentation & engagement activity
- Black Country Partnership Lighthouse event – presence
- Building Health Partnerships event - presence
- Carers Network update and follow-up 2014 event – presentation & engagement
- CCG Healthcare Forum – urgent care – presence
- CCG Healthcare Forum – older people - presence
- Dudley CIL - Dudley Wood Learning Event – stall
- Dudley CVS Volunteer Awards – support with planning & delivery
- Dudley & Walsall Mental Health Partnership NHS Trust AGM - presence
- DGOH - Volunteer recruitment fayre – stall
- DGoH Patient Focus Group to discuss governance – facilitated by Deloittes - meetings
- DMBC Local Account reference group events - engagement
- Dudley Volunteer Organisers Network - presentation
- Get Connected to Heath and Wellbeing Himley event - stall
- Health & Wellbeing board – spotlight event on children's services - presence
- Healthwatch volunteer induction sessions x 3
- Healthwatch focus group of local people & stakeholders to support chair recruitment
- Insight House Volunteer recruitment fayre – stall

- Information points related meetings x 8 – network / communications / information etc
- Information points – co-ordinated joint launch event
- Living well feeling safe – network meeting
- Living well feeling safe event – Wall Heath – stall
- Low Vision Event - Beacon Centre
- Me Myself and I dementia support group - presence
- MIND - Mental health what is a crisis to you event - presence
- Making it real Carers Event – organised engagement activity
- Making it real Your Support, Your Care, Your Way / Beacon Centre - presence
- Social Media Surgeries – jointly facilitated four events in Dudley & Stourbridge
- St Thomas's Community Network AGM – presence
- Thomas Pocklington - sight loss event – stall
- Woodhouse Court & Miles Court sheltered housing - engagement
- Woodside Day Centre User Forum – presentation
- Wychbury Medical Practice Patient Panel Group - Presentation

Representation

- Carers Services task and finish group
- Clinical Commission Group (CCG) board
- CCG Communications & Engagement group
- CCG Primary Care implantation group
- CCG urgent care task & finish group
- Dudley independent health advocacy service steering group
- Dudley Safeguarding Adults Board
- Health and Well Being Board
- Health Scrutiny Committee
- Healthcare Forum
- Making It Real Board
- NHS England Quality Surveillance Group

Other activity / relationship building

- CCG virtual ward commissioning meeting to discuss reconfiguration of services
- CQC compliance manager meetings
- DACHS advocacy - development meeting
- Dudley Group of Hospitals – meeting with Chief Executive & Chief Accountable Officer from CCG to discuss development of patient experience programme following Keogh review
- Dudley outcomes commissioning workshop to discuss future criteria
- DMBC Safeguarding Training - Meeting with Sarah Roper
- Healthwatch governance - meeting with DMBC DACHS partners and Cllr Stuart Turner, Health & Wellbeing Board Chair to discuss
- Health & wellbeing board development / representation meeting facilitated by Regional Action West Midlands
- JSNA - Met with Dudley resident living with MS to prepare case study
- Queens Award for Voluntary Service - Supported Atlantic House Recovery In Progress Team and the Dudley Pain Relief Support Group with the nomination process
- Safe and Sound Coseley meeting

- Support Association for Mental Health (SAMH) - Met with volunteers to discuss how their experiences can be shared with Healthwatch Dudley
- Volunteers – three meetings with potential volunteers to discuss their greater involvement with Healthwatch Dudley

Engagement Statistics

29. During the last four months, in addition to the many engagement activities undertaken by HWD, over 40 enquiries have been received from the public with the majority being directly from someone who accesses services and of a negative sentiment. The greatest number of enquiries related to primary care/GPs closely followed by inpatient care and mental health services. Where appropriate enquirers were signposted to organisations complaints processes.

Social networking and connecting

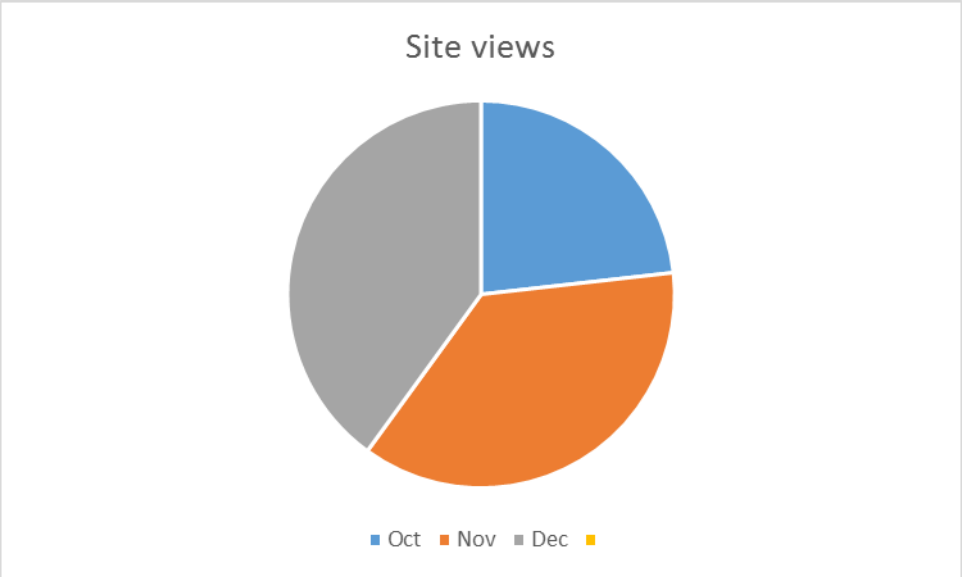
30.

- **17** new subscribers to the Healthwatch Dudley mailing list
- **154** signed up to the Healthwatch Dudley mailing list in total

- **85** new followers on Twitter
- **619** total followers on Twitter

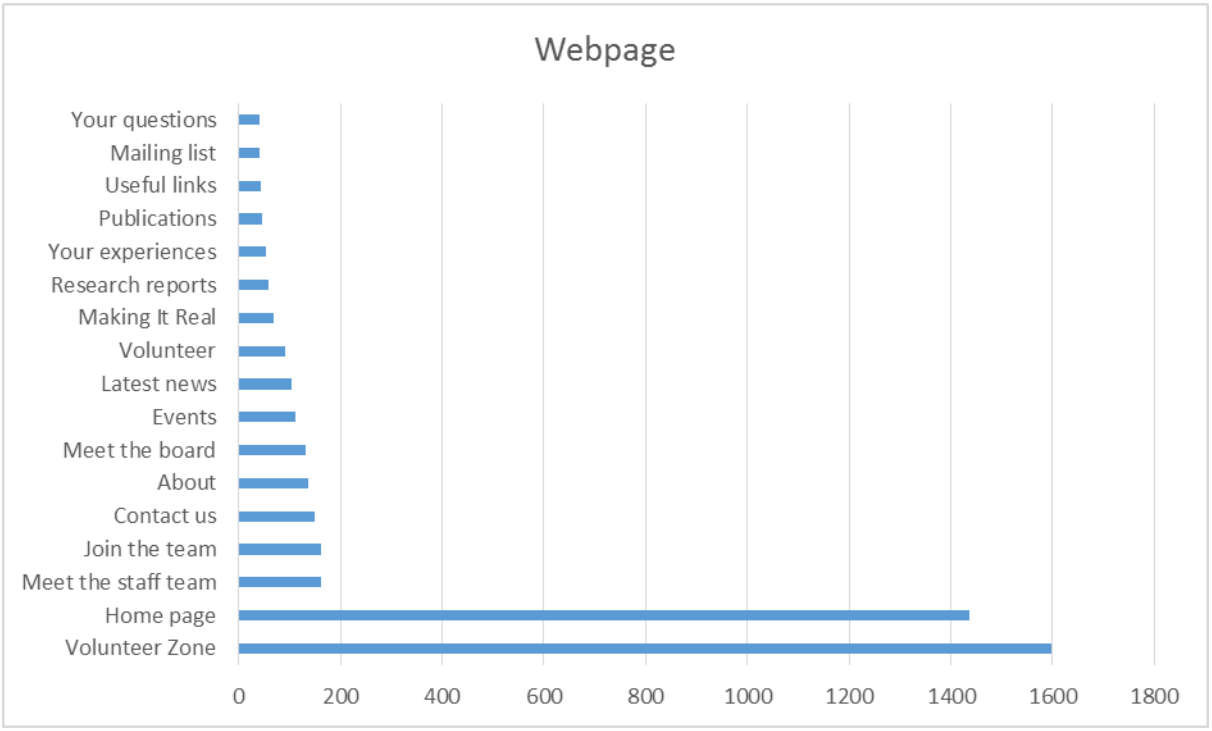
Website hits

Month	Site Views
October	1069
November	1695
December	1842
Total	**4606**



An average of 50 hits per day.

Webpage	Site Views
Volunteer Zone	1597
Home page	1437
Meet the staff team	162
Join the team	161
Contact us	149
About	137
Meet the board	132
Events	112
Latest news	105
Volunteer	91
Making It Real	68
Research reports	59
Your experiences	53
Publications	47
Useful links	43
Mailing list	42
Your questions	40



Please note the additional web visits to the Volunteer Zone in December were as a result of volunteers and staff accessing a link to the Urgent Care online survey contained in a private area of the site.

Finance

31. Local Healthwatch is funded by the Government and primarily through Department of Health.

    The contract runs for a 3 year period subject to the Governments on-going funding of the Healthwatch programme.

Law

32. As outlined within the Health & Social Care Act 2012, Local Authorities have a statutory duty to support and establish local Healthwatch in their area.

Recommendation

33. It is recommended that the Dudley Health and Well-being Board note the work being progressed by Healthwatch Dudley.

Jayne Emery
Chief Officer of Healthwatch Dudley

Contact Officer: Jayne Emery
Chief Officer, Healthwatch Dudley
Telephone: 03000 111 001
Email: jayne@healthwatchdudley.co.uk

Update on Stroke Reconfiguration Programme
Birmingham, Solihull and Black Country

1. Purpose

To provide an overview of the Birmingham, Solihull and Black Country Stroke reconfiguration Programme. The programme aims to draw together work undertaken to date by the Midlands and East Stroke Review and seeks to understand if there is a need to reconfigure local stroke services to deliver improved patient outcomes.

2. Overview

Stroke is a major cause of death with 40,000 deaths in England; 12,000 in NHS Midlands & East region alone (2009). Over the past few years work has taken place at a national and regional level to improve stroke services. In 2010, the West Midlands Regional Quality Review Service led a review process in co-ordination with the West Midlands Cardiac and Stroke Networks. The purpose of the review was to assess compliance with the WMQRS (West Midlands Quality Review Service) quality standards for acute stroke and Transient Ischaemic Attacks (TIA) and to train future reviewers. The review team included a Stroke Consultant, Stroke Nurse, an Allied Health Professional and members of WMQRS and the Stroke Network. The process consisted of site visits and discussions with a multidisciplinary team. The outputs of the assessment process were used to inform the quality of care that was being delivered by each provider and to assess the capability of providers to deliver 24/7 thrombolysis and other stroke services.

The review process showed that there was significant variation in the quality of care provided across the region. The Midlands and East Strategic Health Authority was still concerned about the model / configuration for stroke services and in January 2012 launched a clinically led comprehensive review of stroke across the region, to identify options that would improve outcomes by improving mortality, reduce chances of long term disability and improve patient experience.

The regional review evidenced a best practice specification that all Hyper Acute Stroke Units (HASUs) should achieve if they are to provide optimum care to patients. HASUs are the specialist departments that deliver care in the first 72 hours post stroke. This best practice centred on the timeliness of response and required 24/7 consultants on call as well as access to rapid scanning and thrombolysis services. This specification recommended that HASUs see a minimum of 600 confirmed stroke patients per year to improve clinical quality, by enabling clinicians to treat enough patients to maintain their skills. National and regional evidence also indicates that if patients have access to larger units they have a reduced risk of morbidity, reduced chance of long term disability and quicker access to thrombolysis services.

The regional review recognised that strong collaborative work and clear governance arrangements were required to take this work forward at a local level during 2013/14. The seven CCGs in Birmingham, Solihull and the Black Country have now joined together to launch this local review to take forward these regional recommendations.

At the time of the regional review there were six hospital trusts in the conurbation delivering nine Hyper Acute Stroke Units. Since this time a public consultation took place in Sandwell and West Birmingham to configure stroke services at Sandwell General Hospital, resulting in eight HASU sites across the area. There are further plans to move to six sites with a public consultation taking place at Heart of England Foundation Trust, considering the options of moving HASU services from both Solihull and Good Hope hospitals to the Heartland site. If the consultation recommendations are approved this would result in 6 HASU sites across the area.

There is evidence to suggest that changing the specification of the stroke care pathway in Birmingham, Solihull and the Black Country could lead to improved outcomes for patients. This review will consider improvements across the whole stroke patient journey from prevention to hospital stroke care to rehabilitation services. However, a key part of this review relates to the Hyper Acute Stroke Units. This review seeks to identify if six hyper acute sites is appropriate for the area and if they can deliver the necessary improvements to patient care. As part of this work, Clinical Commissioning Groups (CCGs) will consider a number of factors including travel time, quality of care, workforce and patient experience. This review will consider these factors to determine the recommended number of HASU sites for the area. No decision has been made, and the review may determine that six sites is the most appropriate configuration for local stroke services.

Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG) is leading the Birmingham and Black Country Stroke Reconfiguration Programme on behalf of all seven CCGs. SWB CCG will have overall responsibility for the delivery of the programme and will host the Stroke CCG Programme Board to provide a strategic steer. The decision on the future placement of Hyper Acute and Acute Stroke Centres will sit with the individual CCG Governing Bodies; the role of the Programme Board will be to advise and recommend the preferred model for Hyper Acute Stroke Units.

Our aim is for all stroke patients to receive high quality Specialist Consultant support 24/7. Working with clinicians, providers, patients and stakeholders we hope to agree a recommended model (number of HASUs) across the area. This work will need to consider clinical evidence, impact on neighbouring areas and current services.

3. Programme Scope

3.1 Provider and CCG Landscape

The review of stroke services is in relation to the following provider Trusts:

- Birmingham Community Healthcare NHS Trust
- Heart of England NHS Foundation Trust
- Royal Wolverhampton Hospitals NHS Trust
- Sandwell and West Birmingham NHS Trust
- The Dudley Group NHS Foundation Trust
- University Hospitals Birmingham NHS Trust
- Walsall Healthcare NHS Trust
- West Midlands Ambulance Trust

These are respectively commissioned by:

- Birmingham Cross City Clinical Commissioning Group
- Birmingham South Central Clinical Commissioning Group
- Dudley Clinical Commissioning Group
- Sandwell and West Birmingham Clinical Commissioning Group
- Solihull Clinical Commissioning Group
- Walsall Clinical Commissioning Group
- Wolverhampton Clinical Commissioning Group

The population for the programme will require a solution that takes in Birmingham, Solihull and the Black Country. Therefore the work will focus on the:

- Population registered with GPs within the boundaries of the seven CCGs of Birmingham and Black Country (BBC)
- People who live within the seven CCGs boundaries, but who are not registered with a GP
- People who access emergency health care services within Birmingham, Solihull and the Black Country either on an ad hoc basis, or based upon the traditional referral flow (catchments of acute organisations)

3.2 Clinical scope

The regional Midlands and East best practice service specification divides the pathway into eight phases and specifies the standards to be achieved in each (Appendix 1 – Midlands & East Service Specification). These are:

- Primary prevention
- Pre-hospital
- Acute phase
    - Hyper-acute stroke unit (HASU) services
    - Acute stroke (ASU) services
    - Transient Ischaemic Attack (TIA) services
    - Tertiary care (i.e vascular and neurology care)
- In-hospital rehabilitation
- Community rehabilitation
- Long term care and support
- Secondary prevention
- End of Life

3.3 Outside scope

Tertiary care (neuro-surgical referral) and strokes occurring in children are both outside the direct scope of the programme.

3.4 Interdependencies:

The programme will take into consideration a number of interdependences, these include:

- Accident and Emergency Services
- Intensive and Critical care
- General Medicine
- Geriatric Medicine
- Radiology
- Neurology services
- Vascular surgery
- Voluntary sector
- Lifestyle interventions
- Geographical Boundaries

4. Programme Vision and Outcomes:

4.1 Vision

The programme's vision is to prioritise stroke care and to develop a clinically driven model for local stroke provision. The overall aim is to ensure a uniformly high treatment standard for stroke patients, irrespective of where in the Birmingham, Solihull and Black Country they suffer their stroke.

4.2 Outcomes

- Reduction in stroke mortality rates
- Reduction in average length of stay
- Reduction in stroke re-admissions
- Achievement of 90% of patients able to stay on a dedicated stroke ward
- Increase in the percentage of patients receiving thrombolysis treatment
- Achievement of diagnosis and treatment for high risk TIA within 24hrs
- Increase in the number of patients discharged to their normal place of residency

4.3 High Level Criteria:

In determining the optimum configuration of local stroke services, the CCG will prioritise the below criteria:

a) Quality of Services

Definition: Quality and continuity of care for stroke patients across the pathway. This also covers clinical critical mass which is the minimum throughput of patients to be maintained in order to ensure quality of service. It takes account of the number of patients required for an acute stroke service provider to be clinically effective, based on incidence and population.

Outcome: High standard of quality in the stroke system leading to improved patient outcomes. Regional evidence shows that improving outcomes for patients is dependent on a step-change in the quality and continuity of care across the stroke pathway.

b) Workforce including Innovation and Research & Development

Definition: Providers are able to attract and retain the best healthcare professionals, and invest in them via an accredited training and development programme, as well as rotating staff

appropriately across the pathway. This includes delivering quality education and training for staff and continuous improvement through innovation and research.

Outcome: Optimum workforce to support stroke patients

c) Access

Definition: Maximum time taken for a stroke patient to be assessed at the point of arrival and treated within a HASU thereby helping improve quality and reduce health inequalities. Ambulance travel time is not the only consideration, as this criteria will also look at accessibility by public transport, impact on family and carers and patient experience.

Outcome: A stroke patient should be able to access a HASU that delivers access to high quality care. The access heading will also consider access to a HASU within a maximum of 30 minutes (by an ambulance with a blue light), this element will be picked up from West Midlands Ambulance Service returns. Patients and visitors will have access to local ASU and TIA services.

d) Ease of Delivery

Definition: Assess how the acute stroke service provider can improve substantially from current provision. Also covers implementation of infrastructure, capacity and feasibility of acute stroke service providers.

Outcome: Continued quality service to stroke patients.

e) Improved Strategic Fit

Definition: The ability of providers to work effectively with neighbouring providers. Networks will need to provide adequate coverage of the entire Birmingham, Solihull and Black Country population.

Outcome: Optimum service to stroke patients supporting collaborative capability across the Cardiovascular Network, providers, local authorities, voluntary sector and CCGs.

f) Cost and Affordability

Definition: The balance between impact on patient outcomes with the incremental cost of providing the new acute stroke services in a particular configuration. There are many competing priorities in Birmingham, Solihull and Black Country and the financial impact of the proposed changes for stroke must be evaluated against the impact on the overall healthcare system.

Outcome: Affordability of service within the current financial envelope ensuring high quality services can be safely provided.

4.4 Co-ordinating Commissioner Role

SWB CCG in conjunction with the Cardiovascular Network Team, will ensure that specifications for the service reflect the agreed guidelines and protocols developed through the Birmingham, Solihull and Black Country area. SWB CCG will ensure performance management arrangements for the programme are robust; clinical and financial risks are assessed and managed; and that robust and transparent arrangements are in place for the consideration of service developments against agreed priorities. It is important to recognise that the local performance management of services will continue to sit with each individual CCG.

SWB CCG will develop a shared central team to work on behalf of all the CCGs as the accountable bodies, working through the Programme Board, using the under spend identified in Cardiovascular Network resources (2012/13) to support and coordinate the programme for a time limited period (April 2013 up to March 2015).

5. Approach and Next Steps

It is recognised that each of the phases within the services specification will have a number of specific standards to be delivered and so will need to be treated as a specific project, with clear timescales and distinct actions and responsibilities. However it is intended these will all form part of an overall interlinked programme of work, with oversight by the Birmingham, Solihull and Black Country CCG Stroke Programme Board, which will ensure overall connectivity and that an integrated pathway of care is in place. For further information please refer to Appendix 2 (Programme Brief), Appendix 3 (Programme Board Terms of Reference).

The programme will be designed into the following project specific strands as follows:

5.1 Hyper Acute Project:

This strand will support an options appraisal for future hyper acute and acute phase sector configuration. It is recognised that this will be complex and will therefore require the most capacity and focus. This phase includes:-

- Pre-Hospital Phase
- Hyper-acute stroke services
- Acute stroke services
- TIA services

As above, it is also recognised that the programme will require a solution that takes into account Birmingham, Solihull and the Black Country and also acknowledges other neighbouring health economies.

In addition the review will need to consider the whole patient pathway and the interface between the acute phase and the rehabilitation phase, and the rehabilitation and long term care phases.

5.2 Non Hyper Acute Projects:

This review will consider the whole patient journey, not just Hyper Acute Stroke Units. Working with lead representatives in each CCG and with provider organisations the review seeks to understand current stroke service provision within other stroke services against the standards and criteria set out in the regional best practice service specification. The role of the programme team will be to support the gap analysis and recommendation to achieve best practice for the prevention, acute, rehabilitation, community and end of life phases of the pathway.

- Inpatient and Community Rehabilitation Project
- Long Term Care Project
- End of Life Project
- Prevention Framework Project

CCGs should ensure that they can support the evaluation and gap analysis of the above stroke pathway phases and to receive the recommendation from the individual projects. Respective funding for local service change will need to be agreed with each individual CCG and the respective provider.

6. Stages of Reconfiguration:

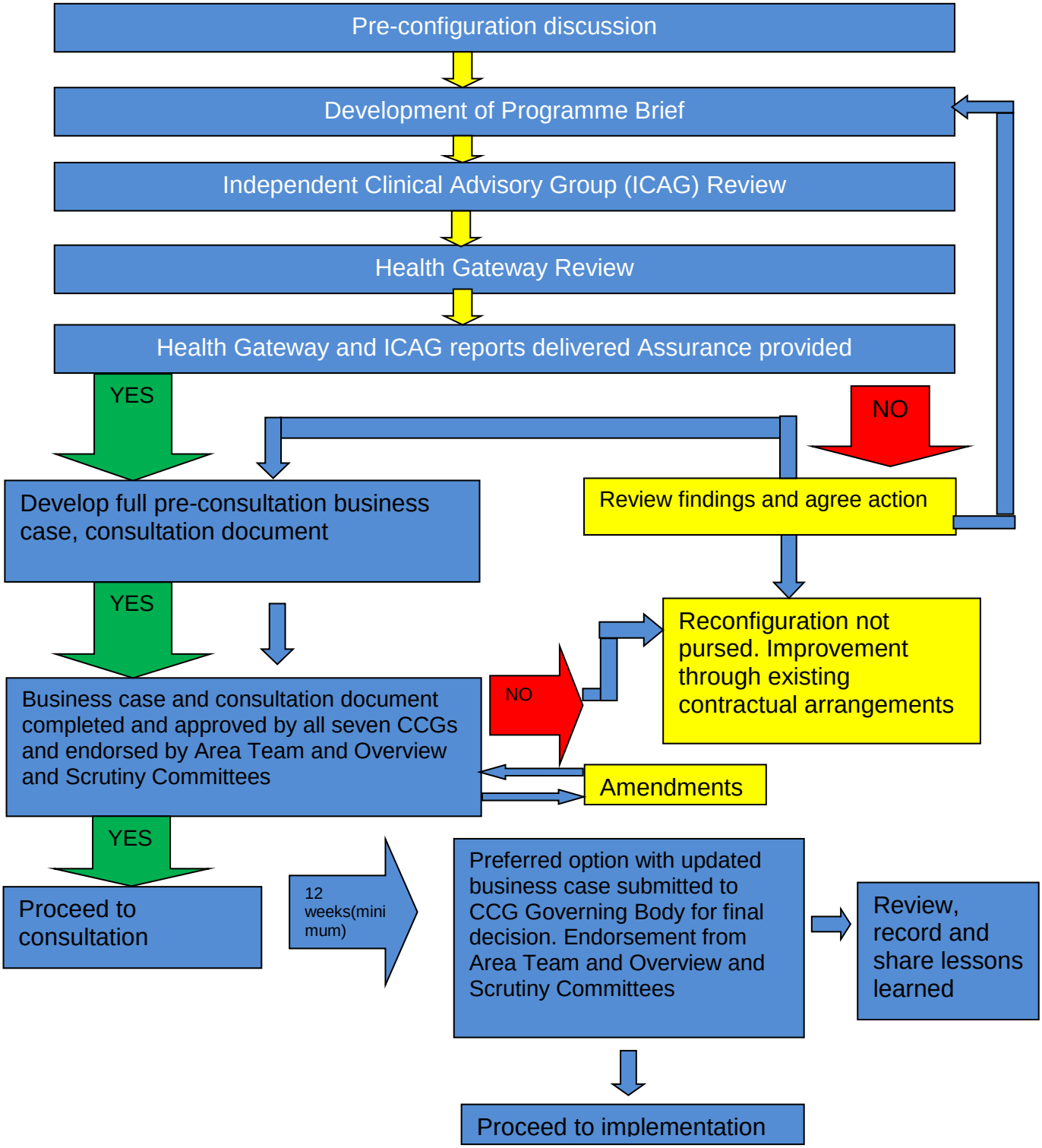
The Birmingham Solihull and Black Country Stroke CCGs will not support the Stroke programme to proceed to the next stage in the reconfiguration scheme without the successful completion of the following three stages of reconfiguration:

The pre-consultation process: including developing a robust clinical case for change and holding extensive dialogue with a wide range of stakeholders including OSCs, Health and Well-Being Boards and Councils, the public, their representatives, patients, carers, clinicians and NHS staff.

The consultation process: managing the consultation process, producing documentation and ensuring that statutory requirements to consult the public, healthcare professionals and other statutory bodies (including Overview and Scrutiny Committees) are met.

The post-consultation process: decision making process including sign-off with appropriate bodies and managing any subsequent reviews or challenges.

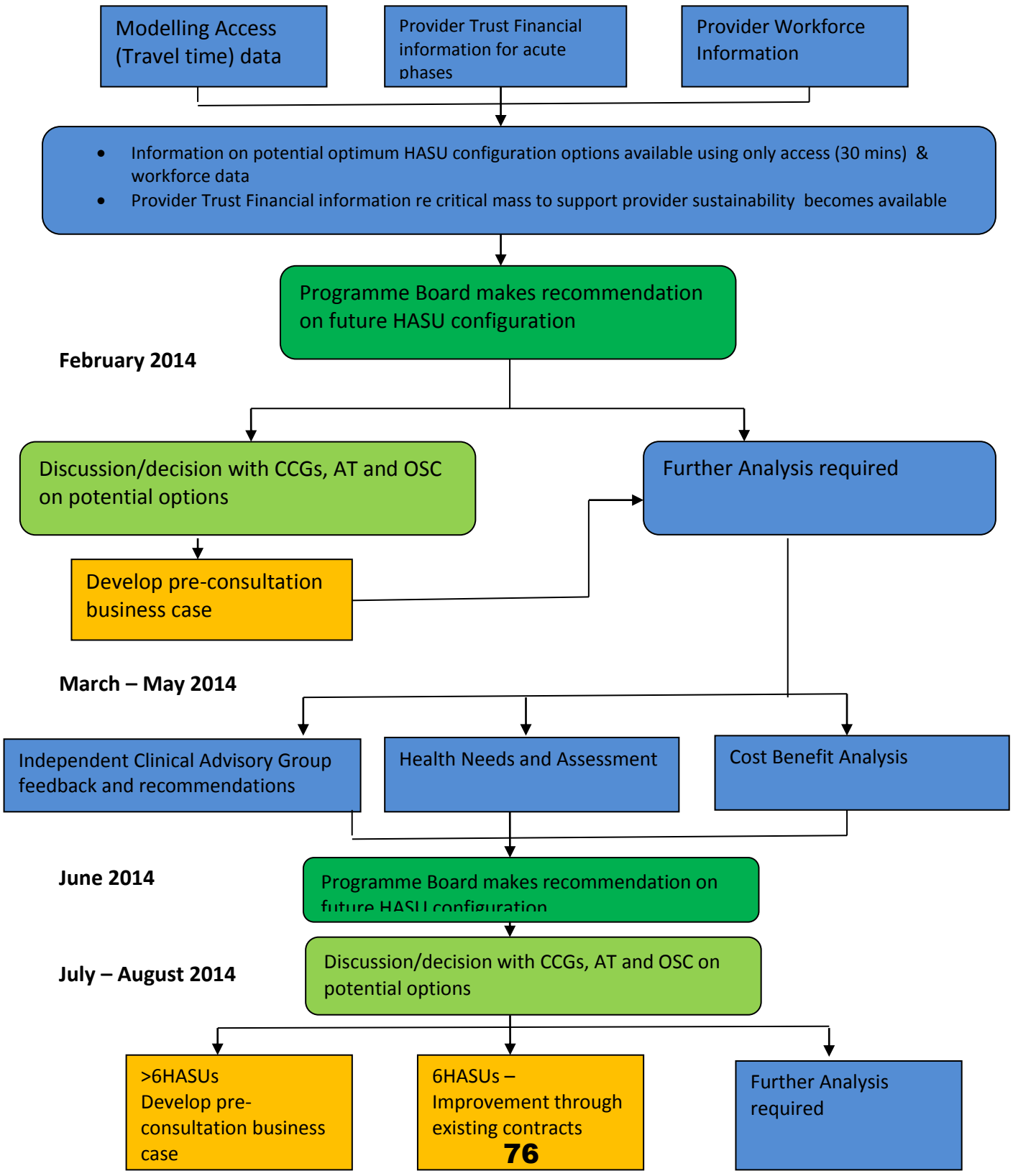
Stages of Reconfiguration:



7. Decision Framework

It is anticipated that the Programme Board will reach a recommendation on the future hyper acute service configuration by July/August 2014. The following process will be followed to reach an agreement across key stakeholders:

7.1 Key Decision points:



7.2 High Level Project Milestones:

	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Scoping	√															
Activity Modelling	√	√	√													
Financial Modelling	√	√	√													
Public Health data	√	√	√	√												
Provider Submissions			√	√												
Independent Expert Advisory Group					√											
Cost Benefit Analysis					√	√										
Recommendation PB							√									
Decision 7 CCGs								√	√							
Public Consultation										√	√	√				

8. Update on Programme Review Progress:

8.1 Programme Sub Groups

A number of sub groups have been organised to deliver the stroke review, these include:

- Modelling task group(developing options)
- Finance sub group (considering the financial cost of the different options and developing a financial model that support s the patient journey)
- Communications and engagement sub group
- Public Health Sub Group (developing the Health Needs Assessment)
- Local Clinical Advisory Group (advising on Clinical Quality Standards and performance Metrics)
- Independent Clinical Advisory Group (assessing the options to ensure that proposed options meet the clinical quality requirements)

These groups will meet regularly, reporting to the Stroke Programme Board. Ultimately, the decisions will be made by each individual CCG's Governing Body. This Programme Board has been set up to help facilitate work over this large area; however any decisions will be made by each local CCG. This final decision will need to be endorsed by Overview and Scrutiny Committees and the NHS England Area Team leads.

8.3 Patient Advisory Group

A Patient Advisory Group with patient representatives from each of the CCG areas has been established; the first meeting took place on Wednesday 18 December,. The Programme will work closely with this group throughout the review to ensure that patient views are at the heart of any commissioning decisions. The Programme will also be carrying out wider patient and stakeholder engagement over the coming months; however this group will meet regularly to help give assurance to the programme board.

8.4 Independent Clinical Advisory Group

An Independent Clinical Advisory Group (ICAG) has been established; chaired by Professor Tony Rudd National Clinical Director for Stroke NHS England. The Group will use the Midland and East service specification as an evidence based best practice specification for the whole stroke pathway, to guide the service in being clear about what needs to be provided to achieve a step change improvement in outcome. The ICAG will support the option appraisal process ensuring that future HASU options can deliver high quality sustainable services. ICAG has a strong membership, with a combination of national expertise, and experience in the major review and implementation of improvement to stroke services.

9. Future Updates

The Programme will issue monthly updates to all stakeholders. Confidential detailed reports for the key decision points will be sent to CCGs, Area Team and Overview and Scrutiny Committees. Organisations will be asked to sign both the Confidentially Agreement and complete the Conflict of Interest documentation; the confidential reports should under no circumstance be shared in the public arena as this would breach the procurement regulation of confidentiality for any future HASU service configuration. It is important to note that the responsibility for maintaining confidentially lies with the receiving organisation.

An update will come back to Health and Wellbeing Boards to inform on progress with the review and on the pre consultation business case if options are identified to change services.

10. Recommendation

The Health & Wellbeing Board is asked to:

a) Note and endorse the programme scope & approach including governance arrangements, (please refer to programme brief)
b) Note that their primary points of contact are their local commissioners, supported by Sandwell & West Birmingham CCG
c) Note that if consultation is required this will be determined in September 2014; proposals will be subject to a period of formal consultation

NHS Midlands and East

NHS Midlands and East

Stroke Services Specification

Version Control

Version No.	Date	Authors/ Editors	To be reviewed by	Status
v1.0	01 June 2012	Tim Lawrence, Laura Dendy	External Expert Advisory Group (EEAG)	1st Draft
v2.0	14 June 2012	Tim Lawrence, Laura Dendy	EEAG, Stroke Network Directors, Project Board	2nd Draft
v2.3	21 June 2012	Tim Lawrence, Laura Dendy	EEAG	3rd Draft
v2.6	22 June 2012	Tony Rudd, Tim Lawrence	Damian Jenkinson	4th Draft
v2.7	25 June 2012	Tim Lawrence, Laura Dendy	EEAG, Stroke Network Clinical Leads	5th Draft
v2.8	28 June 2012	Tim Lawrence	Damian Jenkinson	6th Draft
v3.0	29 June 2012	EEAG	N/A	Final

Version 3.0

1. Introduction and Purpose

1.1 Purpose

The following Service Specification document sets out the criteria,as recommended by the External Expert Advisory Group,that different parts of the stroke pathway needto meet to deliver high quality care to patients and achieve the step change improvement sought by the Midlands and East StrokeReview. These are the expected standards commissioners should adopt when commissioning stroke care services.

This service specification has been developed by the External Expert Advisory Group (EEAG)in consultation with stakeholders, including Stroke Networks, clinical staff working in stroke and other associated services, commissioners and patients and carers who have experienced NHS services. The document aims to build on clinical best practice and provide clarity on the system requirements for stroke services without prescribing the service model to be adopted locally.

1.2 Overview

The National Stroke Strategy (2007) provides the foundation for defining stroke services and outlines what is needed to create the most effective stroke services in England. The strategy identifies major stages in the stroke patient's pathway and stresses a need to reorganise the way in which stroke services are delivered, from prevention through to support for those who have experienced a stroke.

A whole pathway approach to the provision of stroke services is crucial to maximising the clinical outcomes for patients, the resultant quality of life and their experience of stroke services. The first 72 hours of care is vital to ensure the optimum clinical outcome for stroke survivors. This needs to be underpinned by an effective whole system pathway for assessment, discharge and repatriation to local stroke services, subsequent rehabilitation and longer term support.

Improving outcomes in stroke services is core to the NHS Midlands and East's ambitions to provide access to the highest quality services. Although there have been significant improvements in stroke services across the Midlands and East region over the last three years, there remains scope for further improvement; demonstrated by the gap between the regions' performance as measured against the national Integrated Performance Measures.

1.3 Midlands and East Vision for Stroke Services

Midlands and East want to achieve a step change improvement in the quality of stroke and TIA services and outcomes. The overarching vision for stroke services across the area is to ensure that all patients who experience a stroke have access to high quality acute care 24/7 and high quality life after stroke rehabilitation as part of a stroke pathway focused on providing patient and carer centric care, empowerment and facilitation of self-management leading to meaningful participation in daily life.

1.4 Objectives and Expected Outcomes

The objectives are to:

- Provide a fully integrated, end-to-end stroke service for NHS Midlands and East.
- Implement the recommendations of the National Stroke Strategy.

- Meet the service standards and specifications set by the Royal College of Physicians and NICE guidelines.
- Ensure that stroke services deliver:
  - Improved clinical outcomes e.g. reduced mortality
  - Improved quality of life outcomes e.g. reduced level of disability following a stroke
  - An excellent patient and carer experience e.g. experience across the whole pathway and including improved access
- Ensure equity of service provision, outcomes and experience across the region

In meeting the above objectives, the expected outcomes will be that any patient presenting with acute stroke symptoms will receive the most appropriate care for their condition. Placing patients on the correct pathway (TIA, hyperacute or acute) will maximise the likelihood of best possible outcomes and allow NHS Midlands and East to use resources effectively within the local area. The specific performance standards are listed in each section, but the general expected outcomes are:

- Improved outcomes of stroke patients, by reducing the levels of death and disability following a stroke
- Reduced length of stay of stroke patients in bed based services
- Improved patient experience and to enhance recovery following a stroke through long term support and follow up
- A service that is sustainable and provides good value for money through effective use of resources
- Access to the services and the quality of care provided is equitable across the region.
- Provide high quality specialist stroke professional development

1.5 Evidence Base

Stroke is the third biggest killer in England and the main cause of adult disability - Stroke killed more than 40,000 people in 2009 in England and over 12,000 in NHS Midlands and East. Around two thirds of people will survive their stroke, but half of stroke survivors are left with long term disability and dependent on others for everyday activities.

Stroke care costs the NHS and the economy about £8 billion a year – about £3 billion in direct costs to the NHS[1], £2.4 billion in informal care costs (costs of nursing home care and care borne by the patients' families) and £1.8 billion in income lost to mortality and morbidity and benefit payments.

This service specification is based upon a comprehensive and current evidence base and agreed best practice, including:

- *National Stroke Strategy* (2007) Department of Health.
- *National Clinical Guidelines for Stroke* (2012) Royal College of Physicians
- *Quality Standards Programme: Stroke* (2010) National Institute for Clinical Excellence.
- *Stroke Service Standards* (2010) British Association of Stroke Physicians
- *Quality and Outcomes Framework for 2012/13* (2011) NHS Employers.
- *The NHS Outcomes Framework 2012/13* (2011) Department of Health.
- *A Public Health Outcomes Framework for England 2013-2016* (2012) Department of Health.
- *The 2012/13 Adult Social Care Outcomes Framework* (2012) Department of Health
- *Supporting Life after stroke* (2011) Care Quality Commission

[1] NAO (2010) *Progressing in improving stroke care* report

2. Service Specification

The service specification is divided into phases of the care pathway for stroke patients:

This document is structured according to the stroke pathway phases below. In addition, expectations that apply across the whole pathway are described at the outset.

A. **Primary prevention**
B. **Pre-hospital**
C. **Acute phase**
    i. *Hyper Acute Stroke care*
    ii. *Acute Stroke care (including in-hospital rehabilitation services)*
    iii. *Transient Ischaemic Attack (TIA) services*
    iv. *Tertiary care services (e.g. neuro and vascular surgery referrals)*
D. **Community rehabilitation**
    i. *Early Supported Discharge (ESD)*
    ii. *Stroke specialist community rehabilitation*
E. **Long term care and support**
F. **Secondary prevention**
G. **End of life**

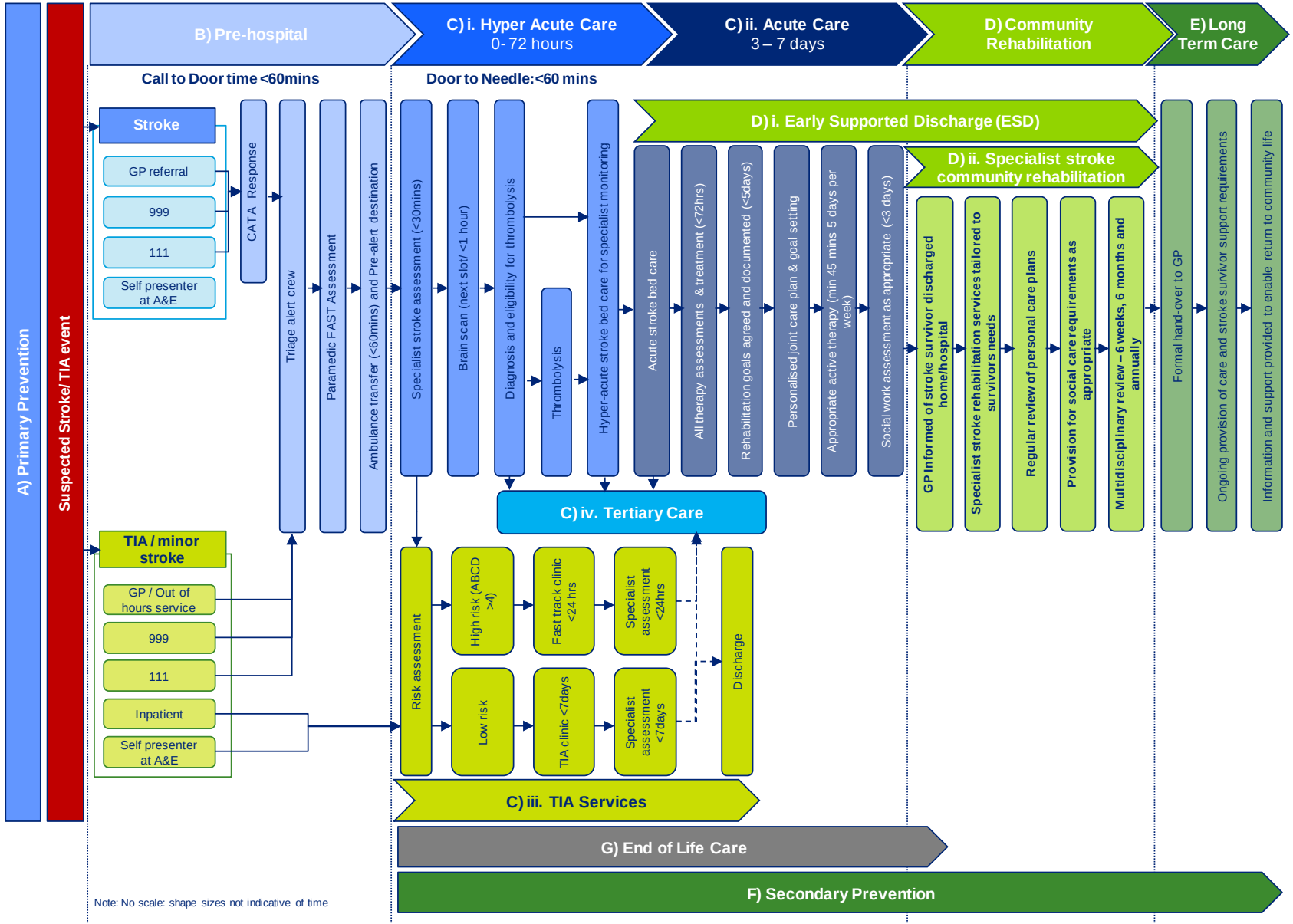
The specification divides the expected outcomes into three time windows – within 6 months, 6-12 months and 18 months or beyond. These are the expectation based on starting implementation following the Midlands and East SHA decision at the end of March 2013, therefore within 6 months would be by end of September 2013.

The performance standards specified for each pathway stage are defined according to the data definitions of the stated data collection audit (e.g. ASI, SSNAP, QOF etc.)

The diagram overleaf summaries the pathway according to the patient movement across the phases since they are not necessarily linear and not all phases or services are applicable to all patients.

2. Service Specification

Summary stroke pathway diagram:



2. Expectations across the whole stroke pathway

Across the entire pathway stroke care must be underpinned by several universally applicable components – to improve the quality of care e.g. communications; to improve patient experience of stroke services; and to ensure the step change improvement being sought in stroke care can be achieved e.g. data collection. These elements that apply across the whole pathway are described in this section.

1. Patient Experience

- Patients and their carers are informed throughout the care pathway on a regular and timely basis of:
  - Their prognosis and situation
  - What is likely to happen to them next e.g. how soon they will be seen, frequency of contact, contact information for the new team, how goals will be carried over
  - Who is taking care of them and who is responsible for their care
  - What they need to be doing to facilitate their care and recovery e.g. advice and information about exercises or other activities that they can practice independently
- Patients and carers are able to access information provided to them i.e. provided in an appropriate format/ medium, and in relevant community languages other than English; and that is specific to the phase of recovery and their needs at that time.
- Patients and carers receive instruction and guidance regarding any prescriptions – verbally and supported by written information
- Families and carers are actively involved in day to day care, rehabilitation and decisions about the planning and delivery of their care
- Patients are directed to relevant voluntary service organisations
- The service has in place a process for incorporating patient/ carer feedback into quality improvement service developments

2. Engagement and Communications

- Awareness raising activities are proactive and ongoing e.g. FAST awareness across primary care, care homes and providers and the general public.
- Providers of stroke services are actively engaged with their local stroke network/s e.g. to ensure that each stroke unit is linked to a regional neurosciences centre for emergency review of local brain imaging
- Clinical teams proactively communicate between themselves and with anyone who takes over responsibility for a patients care, while the processes used to manage care involve all relevant people and support seamless transitions between services along the pathway
- Clinical team members communicate regularlywith patients and carers in appropriate ways for their condition and needs
- Formal links exist with patient and carer organisations e.g. local users' forum, Stroke Association Group, community stroke clubs.

3. Data Transfer and Information Sharing

- Accurate and explicit records of patients are recorded and shared using agreed protocols between all hospital, community and social care practitioners and individuals in a timely way

4. Data Collection and Monitoring

- All organisations should report historical Sentinel metrics where available and required
- All organisations should submit data for the DH stroke and TIA IPMRs
- All clinical services take responsibility for all aspects of data collection, keeping stroke register, and participating in national stroke audit(SSNAP) either directly of via upload of equivalent local data that enables comparison with regional and national peers)
- A sustainable system of coding for stroke patients is in place.
- Local guidance should be in place to support the collection of data between community and across service providers
- All organisations will need to develop a robust system for collection and validation of reliable and accurate stroke data with a lead responsible individual to approve and sign off the data. This may involve investment in data systems and personnel to avoid the burden of data collection responsibility on clinical staff.
- An assessment of patient and carer experience across the stroke pathway is required at regular intervals. This information should be used to inform the improvement of local services and results submitted to inform commissioners on the progress in improving patient experience.

5. Innovation and Research & Development

- To be part of a research network, have a dedicated stroke research lead and actively participate in research (e.g. On the role of interventional radiology in treatment of acute ischaemic stroke or whether the increased intensity of therapy result in improved outcomes)
- Work with Stroke Research Networks
- Be open to performing and participating in national and international trials

2. A) Primary Prevention

Lack of awareness of stroke and TIA – lifestyle causes, risk factors, prevention and symptoms – can be a significant challenge to the realisation of a successful outcome for someone whogoes on to experience a stroke or TIA. A proactive approach by all healthcare professionals to recognise patients at risk of stroke or TIA and subsequent mitigation against those risks will support the minimisation of stroke or TIAs.

	Immediate
Service Outcomes	Primary care and other health care professionals (e.g. opticians, ophthalmologists) are effective in: • Identifying patients at risk of stroke or TIA • Identifying atrial fibrillation and reducing the risk of stroke e.g. through anticoagulation • Promoting the "Know your Pulse" campaign and other national/ regional campaigns • Advising at risk patients of lifestyle choices and treatments to minimise risk of stroke and TIA • Advising and educating patients on how to identify symptoms of stroke and TIA to enable effective early intervention/ treatment • Ensuring patient attendance at vascular health check programme and regular long term condition reviews as appropriate
	Social care staff in domiciliary care, care homes and day centres, together with personal assistants purchased through Direct Payments are: • Effectively trained in the signs of stroke and TIA and aware of the consequences of delay • Able to recognise when a referral to emergency care is needed, and able to contact such services quickly • Able to reassure service users whilst the emergency services are en-route
	Members of the public are able to recognise and identify the main symptoms of stroke and TIA and know it needs to be treated as an emergency.[2] Local health economy, including voluntary organisations communicates basic information to patients on the symptoms, emergency treatment, risk factors, lifestyle factors and treatments.
Performance Standards	No metrics are proposed for monitoring. It is expected that local systems will performance manage primary prevention according to NICE guidelines on atrial fibrillation and anticoagulation. There are a large number of performance standards in the QOF and ASI that should be supported.

Delivering a step change in Primary Prevention is not the focus for the Midlands and East Stroke Review. However it is an important component of the stroke pathway and thus included at high-level for completeness to ensure it is recognised as part of a pathway wide approach to managing stroke.

[2] National Stroke Strategy Quality Markers – QM1: Awareness Raising

2. B) Pre-Hospital Phase

A fast response to stroke reduces the risk of mortality and disability – “Time is Brain”. The identification of potential stroke and TIA patients and their timely admission to an appropriate stroke centre is acritical stage of the care pathway. Promotion amongst healthcare professionals, the public and carers of stroke symptom awareness (e.g. FAST) that prompt emergency treatment can improve health outcomes through timely access to stroke care and specialist treatments such as thrombolysis, which must be administered within a few hours of the onset of symptoms.

	Immediate Requirements		Long term (>18months)
	<6 months	6-12 months	
Service Outcomes	**Clinical assessment by ambulance staff:** Patients with suspected acute stroke (or sudden onset of neurological symptoms) are screened using a validated tool[3] to diagnose stroke or assess TIA risk[4]. • All patients with suspected acute stroke are immediately transferred by ambulance to a hospital with facilities to manage hyper acute stroke (to include FAST positive or where stroke is suspected by paramedics even if FAST negative). • Higher risk TIA (ABCD2 score >3, on anticoagulation or with crescendo TIA[5]) is treated as an emergency, being at greater and imminent risk of stroke, undergoes specialist assessment within 24 hours of presentation to healthcare professional.[6] • All suspected stroke patients are assessed and managed in accordance with best clinical practice and monitored for atrial fibrillation and other dysrrhythmias[7].		
	Ambulance transfer to hospital: Ambulance service transfer to the appropriate stroke centre within 60mins, ideally within 30 mins(from scene to hospital). Local areas may choose to set more challenging targets as their geography permits • All patients with suspected acute stroke are immediately transferred by ambulance to a stroke centre offeringhyper acute stroke services[8]		

[3] Note: Many valid tools exist and this specification does not specify which one should be used, though some suggestions are made
[4] NICE Quality Standards – Quality Statement 1; National Stroke Strategy Quality Markers – QM8: Assessment
[5] Crescendo TIA is defined as two or more TIAs in one week
[6] RCP2012 – 4.2.1C & D; low risk TIA should receive specialist assessment as soon as possible, but definitely within one week of onset of symptoms
[7] RCP2012 – 4.1.1.1F,G & H
[8] National Stroke Strategy Quality Markers – QM7: Urgent Response

2. B) Pre-Hospital Phase

	• Suspected stroke cases are assigned "Category A" 999 response (and meet Category A ambulance service standards – 2 man, 4 wheel response with the ability to transport patient). • The Ambulance Paramedic service links with the receiving hospital when they have a suspected stroke patient[9], providing a system of pre-alert to enable potential stroke patients (FAST positive) to be met on arrival. • Action plans are in place to improve ambulance response and on-scene times.			
Education & Training	All ambulance and triage staff follow best practice clinical guidelines in the recognition of and handling of stroke patients' e.g. FAST, ABCD2 • All Ambulance crews and paramedics are trained in stroke recognition using validated tools (e.g. FAST) • Stroke experience is included in paramedic training and staff able to prepare patient appropriately for admission to hyper acute stroke service according to agreed protocols. • Communication training provided to help manage patients with aphasia • Ongoing stroke specific training is included as part of Continuous Professional Development (CPD)		• Ambulance service has an established method of obtaining and implementing new guidance for stroke care	• Ambulance service participates in local Stroke Research Network trials and studies
Workforce	• There is sufficient and appropriate stroke skilled capacity in the ambulance service to provide the service to the required population to the defined performance standards. • There is an identified clinical lead for stroke within the ambulance service • Skill mix supports supervision of junior and trainee ambulance personnel			
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Percentage of suspected stroke patients transferred by ambulance where a validated tool (e.g. FAST) was used to determine stroke (SSNAP)	100%		
	2. Percentage of patients admitted to hyper acute services within 4 hoursof symptom onset (SSNAP)		60%	
	3. Percentage of FAST positive patients with a 'call to door' time <60 mins(SSNAP)	90%	95%	

[9] BASP Stroke Service Stanadards 1.1

2. C) i. Hyper acute stroke care

Hyper acute services provide expert specialist clinical assessment, rapid imaging and the ability to deliver intravenous thrombolysis 24/7, typically for no longer than 72 hours after admission. These services may be in a specialist Hyper Acute Stroke Unit (HASU) or as a dedicated area on a stroke unit. At least 600 stroke patient admissions per year are typically required to provide sufficient patient volumes to make a hyper acute stroke service clinically sustainable, to maintain expertise and to ensure good clinical outcomes.People with acute stroke will receive an early multidisciplinary assessment, including swallow screening and, for those that continue to need it, have prompt access to high-quality stroke care.

	Immediate		Long term (>18months)
	<6 months	6-12 months	
Service Outcomes	**Clinical assessment:** All patients (including self/ GP referrals) with suspected stroke are admitted to a hospital with a hyper acute services and seen immediately by stroke team to receive immediate structured assessment by the appropriately trained staff in a consultant led teamto determine likely diagnosis and suitability for thrombolysis and ongoing care needs[10]: • Hyper acute service alerted prior to patient arrival (where appropriate) • Hyper acute service has sufficient capacity for all stroke admissions • Patients are seen and assessed by a member of the specialist stroke team without delay and within 30 minutes of arrival • Patients diagnosed with stroke receive early multidisciplinary assessment: ○ Eligibility for thrombolysis ○ Need for immediate brain imaging ○ Swallow screening (within 4 hours of admission[11]) with ongoing management plan for provision of adequate nutrition.Patients who fail swallow screen to be assessed by Speech and Language Therapist within 24 hours ○ Assessment for malnutrition and need for nasogastric tube or gastrostomy within 24 hours of admission[12] ○ Protocols for assessment and management ofother causes of stroke: intracerebral haemorrhage, subarachnoid haemorrhage, acute arterial dissection, cerebral venous thrombosis[13]		

[10]National Stroke Strategy Quality Markers –QM8: Assessment; NICE Quality Standards – Quality Statement 3
[11]NICE Quality Standards – Quality Standard 4
[12] RCP2012 – 4.17
[13] RCP2012– 4.7-4.9

2. C) i. Hyper acute stroke care

	○ Patients with ischaemic stroke or TIA found to be in atrial fibrillation should be anticoagulated (once intracranial bleeding excluded by imaging) at the discretion of the prescriber, but no later than 14 days from the onset[14] • Patients with stroke are assessed and managed by stroke nursing staff and at least one member of the specialist rehabilitation team within 24 hours of admission to hospital[15] • Ensure all patients with stroke are given an antiplatelet (e.g. aspirin 300mg) immediatelyafter scanningunless contraindicated[16] • Diagnosis discussed with patient and carer and plan of care clearly written in patient notes		
	Thrombolysis: Thrombolysis can be provided 24/7 to confirmed stroke patients with an appropriate protocol in place to screen patients against the medical criteria for thrombolysis: • Appropriate stroke patients, identified as potentially eligible for thrombolysis treatment, to be scanned within next available CT slot • Appropriate stroke patients to be scanned and receive thrombolysis, ideally within30minsand certainlywithin 60 minsof admission (door to needle time)[17]. • Thrombolysis should be conducted within the criteria specified within the RCP National clinical guidelines for stroke 2012		
	Monitoring: Protocols or pathways in place that ensure appropriate monitoring of stroke patients in the hyper acute phase of care: • All hyper acute patients should be monitored according to a protocol post stroke for 24 hours and then according to patients needs.[18] • Any thrombolysed patient should be closely monitored by stroke-trained staff according to a protocol for the first 24 - 72 hours post-thrombolysis in a monitored bed.		

[14] RCP2012 – 4.10.1C
[15] NICE Quality Standards – Quality Statement 5
[16] RCP 2012 – 4.6.1J-L
[17] BASP Stroke Service Standards 1.4
[18] Physiological monitoring and maintenance of hemostasis is recommended in RCP 2012 – 4.12

2. C) i. Hyper acute stroke care

	• All conscious patients admitted with suspected acute stroke are mobilised out of bed on the day of admission unless contraindicatedwith frequent opportunity to practice functional activities with a trained healthcare professional[19] • Mixed gender wards may be used for critical or highly specialised care in line with DH guidelines for mixed sex accommodation		
	Access to support services: Hyper acute services haveonsite access to the following support services and clinical interpretation: • Brain imaging (MRI and CT)– patients are scanned in the next scan slot within usual working hours, and within a maximum of 60 minutes of request out-of-hours with skilled radiological and clinical interpretation being available 24/7[20] • Carotid imaging (e.g. ultrasound, MRA, CTA), within 24 hours[21] Access (onsite or via clear pathway) is also available to tertiary care services with clear protocols to provide: • Neurosurgery • Vascular surgery		
	Repatriation/ Patient transfer: • If patient transfer is required from hyper acute to acute care services appropriate pathway protocols are in place and followed. • A system is in place to reduce delays in patient transfers.		
Education & Training	Hyper acuteservice staff have comprehensive knowledge of the stroke pathway: • Clinical staff assessing stroke admissions are trained in thrombolysis and interpretation of brain imaging • In-house multidisciplinary team stroke training programmes provided. • External stroke training available • Stroke physicians and non-medical specialist/ expert practitioners attend BASP thrombolysis training		

[19] BASP Stroke Service Standards – 3.7
[20] National Stroke Strategy Quality Markers –QM8: Assessment; NICE Quality Standards – Quality Standard 2;BASP Stroke Service Standards – 2.1
[21] RCP2012 – 4.4.1 C; BASP Stroke Service Standards – 2.2

2. C) i. Hyper acute stroke care

	• Communication training provided to help manage patients with aphasia. • All staff aware of the Mental Capacity Act and its implications • Specific education and training is developed and provided in accordance with the Stroke-Specific Education Framework		
Workforce	**Consultant Stroke Specialist led:** Access to consultant stroke specialist[22]decision making for all hyper acute stroke related issues, including thrombolysis 24/7: • In person or via telemedicine[23] • Sustainable on-call consultant with stroke training rota (no more than1:6) • At least daily consultant stroke specialist rounds, 7 days a week		
	Multidisciplinary Team: Hyper acute services have a sufficient multi-disciplinary team on rota to provide service outcomes with an identified consultant stroke specialist clinical lead: • 24/7 availability of appropriately trained staff for assessment of all patients, including thrombolysis eligibility assessment • Specialist stroke nursing is available for the care and monitoring of all hyper acute service patients • Meet at least once per week to exchange information about individual patients[24]		

[22] A stroke specialist is defined as a healthcare professional with the necessary knowledge and skills in managing people with stroke, usually evidenced by having a relevant further qualification and keeping up-to-date through CPD; it does not require the person to exclusively see people with stroke (RCP 2012 – 3.2)
[23]Telemedicine with telephone and video, with a local specialist stroke nurse (and IT support and regular audits for quality) can be used as an alternative to face-to-face with a stroke specialist (RCP 2012 – 3.4)
[24] RCP2012 – 3.2.1F

2. C) i. Hyper acute stroke care

	Staffing Numbers Hyper acute services provide minimum staffing ratios[25] of: • 6 BASP thrombolysis trained physicians on a rota 24/7 • 2.9 WTE nurses per bed to comply with 80:20 trained vs. untrained skill mix • 0.73 WTE Physiotherapist per 5 beds (respiratory &neuro) • 0.68 WTE Occupational Therapist per 5 beds • 0.68 WTE S&LT per 10 beds • Access to social worker			
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Percentage of all stroke patients admitted to hyper acute unit within 4 hours of arrival to hospital (SSNAP)	90%		
	2. Percentage of patients seen and assessed within 30mins of admission by a specialist in stroke (SSNAP)	90%	95%	
	3. Percentage of appropriate patients having thrombolysis within 60 mins of entry (door to needle time) (SSNAP)	85%	90%	95%
	4. Percentage of appropriate patients having thrombolysis within 45 mins of entry (door to needle time) (SSNAP)			90%
	5. Percentage of appropriate patients having thrombolysis within 30 mins of entry (door to needle time) (SSNAP)			50%
	6. Percentage of stroke patients, identified as ineligible for thrombolysis, scanned within 12 hours of admission (SSNAP)	95%		
	7. Percentage of all conscious stroke patients to receive a swallow screen within 4 hours of admission (SSNAP)	100%		
	8. Percentage of patients who fail swallow screen that are assessed by Speech and Language Therapist within 24 hours (SSNAP)	100%		

[25] RCP 2012 – 3.3

2. C) i. Hyper acute stroke care

	9. Proportion of patients with stroke assessed and managed by stroke nursing staff and at least one member of the MDT within 24 hours of admission to hospital (SSNAP)	80%		
	10. Percentage of all stroke admissions thrombolysed (SSNAP)	10%	15%	20%
	11. Percentage of patients who spend at least 90% of their time on a stroke unit (SSNAP)	80%		90%
	12. Carotid imaging performed within 24 hours for patients suitable for carotid endarterectomy	70%	80%	90%

2. C) ii. Acute stroke care

Acute stroke care immediately follows the hyper-acute phase, usually after first 72 hours after admission. Acute stroke care services provide continuing specialist day and night care, with daily multidisciplinary care, continued access to stroke trained consultant care, access to physiological monitoring and access to urgent imaging as required.In-hospital rehabilitation should begin immediately after a person has had a stroke. Rehabilitation services should continue for as long as required, to ensure the best recovery and the minimisation of any disabilities[26] though these are likely to extend beyond time in-hospital (see section D). Rehabilitation goals should be agreed between the multidisciplinary team and stroke patients and carers.

	Immediate		Long term (>18months)
	<6 months	6-12 months	
Service Outcomes	**Acute stroke care:** All stroke patients should have access to high quality stroke care and spend the majority of their time in hospital under specialist stroke care: • Patients have access to a stroke trained nurse at all times • Protocol in place for the promotion of bladder and bowel continence including a policy to avoid urinary catheters[27] and prevention of pressure sores • Daily consultant or specialist registrar ward rounds at least 5 days a week • Protocols are in place for receiving and discharging patients 7 days a week in a timely manner • All patients with stroke have access to a designated stroke rehabilitation services[28] whether in an acute stroke bed or on a specialist rehabilitation unit in hospital. • All patients to be mobilised out of bed on day of admission unless contra-indicated and offered frequent opportunity to practice functional activities with a trained healthcare professional[29]. Rehabilitation commences as soon as possible following admission into the acute stroke pathway. • Social work assessment as soon as possible and within a maximum of 3 days from referral, if appropriate		• Stroke trained MDT available 7 days a week

[26]National Stroke Strategy Quality Markers – QM10: High-quality specialist rehabilitation
[27]BASP Stroke Service Standards – 3.8
[28]BASP Stroke Service Standards – 4.1; NICE Quality Standards – Quality Standard 6
[29]BASP Stroke Service Standards – 3.7

2. C) ii. Acute stroke care

	Access to support services: Acute stroke services have access (not necessarily onsite) to the following support services and clinical interpretation: • Brain imaging (MRI and CT)[30] • Carotid imaging (including ultrasound, MRA, CTA) • Based on carotid imaging/stenosis, CEA should be undertaken as soon as possible and within 7 days[31] of symptoms Access is also available to tertiary care services (onsite or offsite with clear protocols) to provide: • Neuro surgery • Vascular surgery		
	Rehabilitation planning in hospital: Rehabilitation programmes are built around the individual needs with patient agreed goals: • Patients assessed by specialist rehab team within 72hours, with documented multidisciplinary goals agreed within 5 days[32]) • Personal care plan which is patient-centred, goal-led and implemented from admission. The expected date of discharge will be planned and worked towardsand plans shared with patient and carers • Multidisciplinary meetings at least once a week to plan patient care		
	Rehabilitation services available: Rehabilitation services that provide specialist stroke care 5 days a week: • Assessment by specialist therapists (Physiotherapist, occupational therapist, speech and language therapist) within 72 hours of admission[33] • Stroke survivors offered required active therapy at a level appropriate for obtaining rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it (target for 45 mins per discipline, 5	• Access to a service capable of appropriately managing mood, behaviour or cognitive disturbance following a stroke • A dysphagia	• Rehabilitation services that provide specialist stroke care 7 days a week

[30] Brain imaging should be performed immediately (ideally the next imaging sot and definitely within 1 hour) for people with acute stroke if several conditions apply, else as soon as possible and at most within 24 hours (RCP2012 – 4.5.1A&B)
[31] RCP2012 – 4.4.1C
[32] RCP2012 – 3.2.1
[33] NICE Quality Standards – Quality Standard 10

2. C) ii. Acute stroke care

	days a week)[34] • Identification of cognitive and perceptual problems within 7 days via a cognitive and psychological assessment using a validated screening tool for all patients by appropriate therapist • Screening of all patients to identify mood disturbance and cognitive impairment prior to discharge or within 6 weeks[35] • Specialised neuro-rehabilitation services e.g. spasticity, orthotics, continence, driving, vocational etc. prior to discharge[36] • Stroke survivors with continued loss of bladder control 2 weeks after diagnosis are reassessed and agree an ongoing treatment plan involving both patients and carers[37] • Comprehensive secondary prevention advice and treatment[38] is provided	management service is available including Percutaneous Endoscopic Gastrostomy (PEG)	
	Preparation for discharge: • Planning for care after discharge undertaken with stroke patients and their carer/s at as soon as possible to enable domiciliary care support and adaptations to be arranged in good time and in context of pre-admission status and family/ carer support available • Protocols are in place to ensure patients and families are fully informed and participate in the process of transfer of care • Discharge planning protocols ensures information handover with clear direction for community rehabilitation requirements, discharge destination (e.g. home, care home) with full participation of the ESD/ community rehabilitation team • Stroke survivors receive advice and support to enable a return to previous level of activities • A formal discharge summary report should be shared with the referrer, GP and stroke survivor (if requested) within 7 days of discharge		

[34]BASP Stroke Service Standards – 3.10, 3.11, 3.12, 4.4, 4.5, 4.6; NICE Quality Standards – Quality Standard 7; RCP 2012 – 3.14.1A
[35]RCP 2012 – 3.2.1 H
[36]BASP Stroke Service Standards – 4.10
[37]RCP 2012 3.2.1G; NICE Quality Standards – Quality Standard 8
[38]BASP Stroke Service Standards – 4.17

2. C) ii. Acute stroke care

Education & Training	All staff of the MDT are knowledgeable of the care standards and protocols of the stroke pathway: • In-house and external training provided, with staff released for training as required, including a stroke specific in-house induction training programme. • Staff skill mix supports supervision of junior and trainee personnel • All registered nursing staff in stroke units trained in urinary bowel continence • Specific education and training is developed and provided in accordance with the Stroke-Specific Education Framework or recognised competency framework. • Health and social care professionals should ensure that they are up to date with the current guidance from the DVLA • Staff are aware of the Mental Capacity Act and it implications • Communication training provided to help manage patients with aphasia.		• The practice development team incorporates stroke in education and training plans
Workforce	**Acute Stroke Services** Sufficient capacity to provide the service to the performance standards set: • Consultant specialist stroke physician available 5 days a week • Consultant to see all new patients on the next working day following admission and provide 5 day a week consultant review • Provide a means for a consultant review of a deteriorating patient out-of-hours • 24/7 provision of stroke trained nurses • Identified clinical leads (i.e. one A&E Clinical Stroke Lead and one Radiology Stroke Lead)		• 7 day provision of stroke trained multidisciplinary therapists • Regular stroke physician to input into the review and medical management of patients[39]

[39]BASP Stroke Service Standards – 4.3

2. C) ii. Acute stroke care

	Staffing numbers: Acute and rehabilitation services should have a multidisciplinary team comprising of[40]: ○ Nurses: 1.35 WTE per bed (65:35 trained to untrained skill mix) ○ Physiotherapists: 0.84 WTE per 5 beds ○ Occupational Therapists: 0.81 WTE per 5 beds ○ Speech & Language Therapists: 0.81 WTE per 10 beds ○ Psychologists ○ Dieticians ○ Social workers • Access is available to a range of additional professionals including those in: ○ Clinical Psychology ○ Oral health ○ Orthoptics ○ Orthotics ○ Pharmacy Note: where combined stroke units are used, it is expected that beds are designated as hyperacute and acute, then staffed according to the hyper acute service and acute service standards outlined.			
Other	**Equipment and Aids:** • All equipment and aids (e.g. wheelchairs, continence equipment etc) should be reviewed and ordered before discharge		• Open referral system in social services for assessments of home adaptations and equipment needs	
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Percentage of patients with agreed rehabilitation goals within 5 days of admission with appropriately formatted copy of goals given to them (SSNAP)	80%		
	2. Percentage of appropriate patients weighed (or alternative weight estimate if weighting not appropriate) within 72 hours of admission to acute stroke care (SSNAP)	100%		

[40] RCP 2012 – 3.3

2. C) ii. Acute stroke care

	3. Percentage of incontinent patients having continence management plan within 7 days of admission (SSNAP)	80%		
	4. Percentage of appropriate patients to receive an occupational therapy assessment within 72 hours of admission to acute stroke care (SSNAP)	95%		Within 24 hours – 95%
	5. Percentage of appropriate patients to receive physiotherapy assessment and treatment within 72 hours of admission to acute stroke care (SSNAP)	95%		Within 24 hours – 95%
	6. Percentage of appropriate patients to receive speech and language assessment and treatment within 72 hours of admission to acute stroke care (SSNAP)	95%		Within 24 hours – 95%
	7. Percentage of appropriate patients receiving 5 x45min face-to-face sessions per week each of occupational therapy as necessary[41] (SSNAP)	80%		
	8. Percentage of appropriate patients receiving 5 x45min face-to-face sessions per week each of speech and language therapy as necessary[41] (SSNAP)	80%		
	9. Percentage of appropriate patients receiving 5 x45min face-to-face sessions per week each of physiotherapy as necessary[41](SSNAP)	80%		
	10. Percentage of patients receiving cognitive/ perceptual screening within six weeks if required (SSNAP)	85%		
	11. Percentage of patients receiving a continence assessment before discharge (SSNAP)	100%		
	12. Percentage of appropriate patients and carers provided with joint care plan on discharge from hospital (ASI 7)	100%		

[41] NICE Quality Standards – Quality Standard 7

2. C) iii. TIA services

The risk of a stroke is high following a TIA – approximately 10 to 20 percent of patients who have a TIAwill go on to have a stroke within seven days. Specific TIA services provide rapid diagnostic assessment and access to specialist care for high risk patients thereby lowering the risk of a subsequent stroke.

	Immediate		Long term (>18months)
	<6 months	6-12 months	
Service Outcomes	**TIA identification:** • TIA patients are risk stratified using the ABCD2 score • All TIA patients will be referred to a TIA service (accepting direct referral from primary care and A&E)		

	TIA Service:
	Specific TIA service is provided for those identified with TIA:
	• Access 7 days a week, 365 days a year.
	• The TIA service has both the facilities to diagnose and treat people with confirmed TIA, plus the facilities to identify and appropriately manage (which may include onward referral) people with conditions mimicking TIA
	• High risk patients[42] must receive specialist assessment and investigation within 24 hours of presenting to a healthcare professional and be started on an antiplatelet (e.g. aspirin) and a statin immediately[43]
	• TIA service has access to:
	  ○ Blood tests
	  ○ ECG
	  ○ Brain scan (if vascular territory or pathology uncertain) – MRI DWI is preferred mode of imaging; urgently in high risk and within one week in low risk TIA
	  ○ Completion of carotid imaging (where indicated)
	  ○ Referral for carotid surgery[44] where indicated, which should be undertaken within 7 days of onset of TIA[45]
	  ○ Provision of aspirin, clopidogrel orstatins as appropriate
	  ○ Control of blood pressure		

[42] High risk TIA is defined as ABCD score of 4 or above or crescendo TIA (two or more TIAs in one week)
[43] RCP 2012 – 4.2.1C&D
[44] Carotid endarterectomy is the recommended procedure, with less routine indications for carotid angioplasty or stenting (RCP2012 – 4.4.1 L)
[45] RCP 2012 – 4.4.1 C

2. C) iii. TIA services

	○ Information and advice provided regarding stroke risk and secondary prevention • Lower risk TIA patients should receive specialist assessment as soon as possible, but definitely within one week of symptoms[46]			
Education & Training	• Specialist stroke practitioner assessing TIA patients have training, skills and competence in the diagnosis and management of TIA. This should be consistent with the UK Forum for Stroke Training[47] • Education and training for primary care staff in recognition and management of TIA patients • Specific education and training is developed and provided in accordance with the Stroke-Specific Education Framework or recognised competency framework.			
Workforce	• The service should be led by a specialist stroke consultant and provided by a specialist in vascular services with access to the consultant lead or specialist stroke nurse with appropriate specialist competency (where appropriate)			
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. TIA cases with a higher risk of stroke who are assessed and treated within 24 hours of presenting to a healthcare professional (ASI 5/ IPMR)	70%		
	2. Number of people who are referred as having a TIA who are at higher risk of stroke (IPMR)	70%		

[46] RCP 2012 – 4.2.1 E
[47] http://www.ukstrokeforum.org/

2. C) iv. Tertiary Care

Specialist neurosurgical and vascular procedures are sometimes necessary to prevent further damage following a stroke, or prevent stroke altogether. Effective and timely referrals are necessary to ensure that patients suffering a stroke receive the most appropriate care as quickly as possible to improve their long term outcome.

	Immediate Requirements		Long term Requirements (>18months)
	<6 months	6-12 months	

Service Outcomes	**Access to tertiary services:**
	Surgical services are provided as early as possible through early recognition of the need for surgical intervention:
	• All patients with a suspected non-disabling stroke or TIA have urgent access to comprehensive neurovascular services[48] . Neurovascular services include:
	  ○ Neurosurgical services
	  ○ Vascular surgical services
	• Access to tertiary services may be on site or off-site. For offsite services, clear protocols must be in place for a commissioned pathway of care.		

	Neuro surgical services There are relatively few indications for neurosurgical intervention in patients with stroke; however specific cases of stroke may require urgent management.For example: • Cases of middle cerebral infarction should be referred within 24 hours and treated (e.g. decompressivehemicraniotomy) within 48 hours[49]. • Treatment for aneurysm (endovascular embolisation or surgical clipping) should be available within 48 hours[50]		
	Vascular surgical services: • Carotid intervention (e.g. carotid endarterectomy) for recently symptomatic severe carotid stenosis should be regarded as an emergency procedure in patients who are neurologically stable, and be performed within 7 days of a TIA or minor stroke[51]		• High risk TIA[42] that require carotid endarterectomy are admitted for urgent investigation and surgery within 48 hours

[48] BASP Stroke Service Standards – 5.1; National Stroke Strategy Quality Markers –QM 9: Stroke Treatment
[49] RCP2012 – 4.6.1N
[50] RCP2012 – 4.8.1C
[51] National Stroke Strategy Quality Markers –QM 6: TIA and Minor Stroke Treatment; BASP Stroke Service Standards – 3.16; Also note: The use of carotid artery stenting (CAS) was reviewed by NICE/RCP; however, no evidence (no RCT) for early stenting was found on which to base a recommendation [RCP 2012 – 6.4.2; NICE CG68 1.2.1]

2. C) iv. Tertiary Care

Education and Training	• Staff trained to recognise when specialist referral is required			
Workforce	• Stroke physicians input to the multi-disciplinary management of appropriate cases			
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Percentage of patients receivingcarotid surgery within 7 days of symptom onset that triggered referral (UK Carotid Interventions Audit)	95%		

2. D) i.Early Supported Discharge (ESD)

Early supported discharge (ESD) enables appropriate stroke survivors to leave hospital 'early' through the provision of intense rehabilitation in the community at a similar level to the care provided in hospital. An ESD team of nurses, therapists, doctors and social care staff work collaboratively as a team and with patient and families, providing intensive rehabilitation at home for up to 6 weeks, thereby reducing the risk of re-admission into hospital for stroke related problems and increasing independence and quality of life with support the carer and family.

	Immediate Requirements		Long term Requirements (>18months)
	<6 months	6-12 months	
Service Outcomes	**ESD service:** ESD team should be stroke specific and sufficiently able to commence treatment within 24 hours of discharge: • Rapid response, same day ESD service provided 5 days a week at a stroke survivors place of residence to facilitate timely discharge from hospital setting for a period of up to 6 weeks. • Stroke survivors offered required active therapy, (target of 45 mins per discipline, 5 days a week) to an intensity equivalent to in hospital rehabilitation, but reflective of individual patient needs and goals • Single point of contact provided to patients, carer and families(into rehab) • Carers are appropriately educated and trained to recognise common causes of illness that result in avoidable admissions e.g. constipation, urinary tract infection (into rehab) • Collaboration with health and social services, the independent and third sectors to enable to stroke survivor to develop a greater quality of life and independence (in all or generic) • Access is provided to community rehabilitation services/ long term care provision following ESD if required.		• 7 days a week ESD service
Education & Training	• Specific education and training is developed and provided in accordance with the Stroke-Specific Education Framework		

2. D) i.Early Supported Discharge (ESD)

Workforce	• A stroke ESD multidisciplinary team composition should include as a minimum (WTE per 100 cases per year[52]):
	  ○ Occupational Therapy (1)
	  ○ Physiotherapy (1)
	  ○ Speech and Language Therapy (0.4)
	• The stroke ESD team has access to support from:
	  ○ Stroke physician (0.1)
	  ○ Nurse (0- 1.2)
	  ○ Social worker (0- 0.5)
	  ○ Rehabilitation assistants (0.25)
	  ○ Clinical Psychology
	  ○ Dieticians
	  ○ Orthotics
	  ○ Orthoptics
	• There are coordinated stroke skilled ESD teams working in partnership with local authorities and other health and third sector providers
	• ESD team meets weekly as a minimum to plan and manage patient care			

Other	**Equipment and Aids:** • All equipment and aids (e.g. wheelchairs, continence equipment) should be reviewed and ordered during ESD service		• Open referral system in social services for assessments of home adaptations and equipment needs	
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Percentage of stroke survivors supported by a stroke skilled Early Supported Discharge team (ASI 9)	40%		
	*2. Percentage appropriate stroke survivors whose treatment programme started within one working day of release from hospital**	80%	100%	

**Requires a separate data collection exercise. These metrics are believed to be important components of the care pathway, but at the moment there is not a existing data source to provide a standard means of collection and thus would require local collection.*

[52] East Midlands ESD Service Specification

2. D) ii.Stroke Specialist Community Rehabilitation

Stroke survivors' rehabilitation will continue after the initial time spent in acute in-hospital rehabilitation, out into the community. These servicesenable stroke survivors develop a greater quality of life and independence following stroke. Patients will access community rehabilitation servicesfollowing standard discharge from a stroke unit or following ESD. Community stroke rehabilitation services includes the transfer of care from hospital to home and time at home provided through collaboration with health and social services, the independent and third sectors.

	Immediate Requirements		Long term Requirements (>18months)
	<6 months	6-12 months	
Service Outcomes	A range of services are in place and easily accessible to support the individual long-term needs of individuals, their carer/s and families[53], encouraging self-management where appropriate. Comprehensive social care is provided to all patients and their carers that need it • Single point of contact provided when patients leave hospital • All stroke survivors discharged from hospital who have residual stroke-related problems are followed up within 72 hours by specialist stroke rehabilitation services for assessment and ongoing management[54] • Any stroke survivors referred to a social worker will receive an assessment within 72 hours of receipt of the referral • Goals incorporated into a personalised care plan that allows the patient to take ownership of their rehabilitation and reviewed regularly (every 4-6 weeks) with the patient throughout the treatment period. • Active therapy at a level appropriate for obtaining rehabilitation goals for as long as they are continuing to benefit from the therapy and are able to tolerate it[55] (target for 45 mins per discipline, 5 days a week[56]) • The GP and other relevant community services are informed that a stroke survivor has been discharged home or to another hospital prior to discharge. • Age appropriate provision made for the social care requirements of stroke survivor prior to discharge, e.g. domestic tasks (such as shopping and	• Training in self-management, goal setting and problem solving skills is available[60]	

[53]National Stroke Strategy Quality Markers –QM13: Long term care and support; Adult Social Care Outcomes Framework
[54] RCP2012 – 3.8.1A
[55] BASP Standards – 3.10, 3.11, 3.12; 4.4, 4.5, 4.6; NICE Quality Standards – Quality Standard 7
[56]RCP 2012 – 3.14.1A
[60] Royal College of Physicians Stroke Guidelines; London commissioning guidelines

laundry)
- Adult social services provide advice on aids and adaptations to daily living
- Review of home environment, usually by a home visit by an occupational therapist, to adapt to patient needs where patient remains dependent in some activities[57]
- A carers assessment should be completed for each carer with links to carer support groups made and family support organisations and followed up
- Specialist stroke rehabilitation, support and any appropriate management plans will address the following issues either directly or by seamless onward referral where required[58]:
  - Mobility and movement (including exercise programmes, gait retraining, mobility aids and orthotics)
  - Upper limb rehabilitation
  - Management of spasticity and tone
  - Sensory impairment screening and sensory discrimination training
  - Falls prevention (including assessment of bone health, progressive balance training and aids)
  - Cognitive rehabilitation (including addressing impairment in attention, memory, spatial awareness,perception, praxis and executive function)
  - Communication(including aphasia support twice weekly during the first 20 weeks, techniques or aids for dysarthria and apraxia, information about local groups)
  - Everyday activities including provision of daily living aids and equipment (e.g. dressing, washing, meal preparation)
  - Emotional and psychosocial issues (e.g. depression, adjustment difficulties, changes in self-esteem or efficacy, emotionalism)
  - Swallowing (including swallowing rehab, maintenance of oral and dental hygiene, nasograstric tube feeding, gastrostomy)
  - Skin integrity (i.e. pressure care and positioning)
  - Nutrition (including specialist nutritional assessment, nutritional support)Visual disturbance
  - Continence (bladder and bowel)
  - Social interaction, relationships and sexualfunctioning (including

[57] RCP 2012 – 3.8.1 D
[58] RCP 2012 – 6.4 to 6.46

	psychosocial management or medications) ○ Pain (assessed regularly using validated score, referred to specialist where indicated) ○ Home assessment (including need for larger scale equipment or adaptation) ○ Return to work (including referral to specialist in employment or vocational rehabilitation) ○ Driving ○ Financial management and accessing benefits • Community leisure and exercise classes are available and promoted to stroke survivors, who are then supported to attend • Stroke survivors are aware of and offered options to promote wellbeing, including peer-led support groups, engagement in community activities and professional psychological therapies including IAPT and community mental health services • Telephone counselling support available for three months[59]		
Education & Training	• Specific education and training is developed and provided in accordance with the Stroke-Specific Education Framework • Staff are aware of the Mental Capacity Act and it implications • Carers receive training in care, for example, moving, handling and dressing; receive written information on management plan and point of contact for stroke information		
Workforce	• There are established stroke skilled, multidisciplinary community rehabilitation teams. Composition of the team should include as a minimum: ○ Physiotherapist ○ Occupational therapist ○ Speech and language therapist ○ Community nursing (as appropriate) ○ Social care ○ Rehabilitation assistants ○ Clinical psychology (as appropriate) • The community rehabilitation team has access to support from: ○ GP ○ Dieticians		

[59] RCP2012 – 3.8.1C

2. D) ii.Stroke Specialist Community Rehabilitation

	○ Orthotics ○ Orthoptics ○ Vocational rehabilitation • Initial assessment of the stroke patient is carried out by a qualified professional (some of the care may be delivered by rehabilitation assistants under the supervision of a qualified therapist)			
Other	**Equipment and Aids:** • All equipment and aids (e.g. wheelchairs, continence equipment etc) necessary to ensure a safe environment should be available at discharge and appropriate training provided to stroke survivors and carers.		• Open referral system in social services for assessments of home adaptations and equipment needs	
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Percentage of appropriate patients and carers with joint care plans on discharge from hospital (ASI 7/ SSNAP)	85%	95%	100%
	*2. Percentage of stroke survivors contacted by a member of community rehabilitation team within one working day and assessed within 72 hours**	80%	90%	100%
	3. Percentage appropriate stroke survivors whose treatment programme started within 7 days where agreed as part of care plan (SSNAP)	80%	100%	
	*4. Percentage of stroke patients that are reviewed six weeks after leaving hospital**	95%		

**Requires a separate data collection exercise. These metrics are believed to be important components of the care pathway, but at the moment there is not a existing data source to provide a standard means of collection and thus would require local collection.*

2. E) Long term care

Stroke survivors and their carers should be enabled to live a full life in the community[61] over the medium and long term (>3 months). Support is required from local services to ensure appropriate, tailored support is provided to assist re-integration into the community and maximise the quality of life experienced by stroke survivors, their carer/s and families.

	Immediate Requirements		Long term Requirements (>18months)
	<6 months	6-12 months	
Service Outcomes	**Provision of information and support for stroke survivors, carers and families:** • Ongoing physical, speech and language, continence and other required therapiesare provided where clinically appropriate to meet patient needs • Carers of stroke survivors with stroke are provided with a named point of contact for stroke information, written information about the stroke survivors diagnosis and personal care plan, and sufficient practical training to enable them to provide care[62] • Carers are provided with clear guidance on how to find help if problems develop	• All eligible users of social care services should have access to a personal budget	• Carers have the opportunity to access long-term emotional and practical support though peer support groups facilitated by charitable or voluntary groups
	Regular review and needs assessment: • The patient and family will be aware of their single named point of contact • All stroke survivors receive a review and onward referral to appropriate MDT members at six weeks, six months, 12 months and then annually that facilitates a clear pathway back to further specialist review, risk factor screening, advice, information, support and rehabilitation where required, is provided[63]. • Information from reviews should be shared across the entire team involved in delivering care to the stroke survivor, including with the stroke survivor themselves and their GP. • Stroke survivors and their carers are enabled to participate in paid, supported and voluntary employment[64]		

[61] National Stroke Strategy Quality Markers –QM15: Participation in community life
[62] NICE Quality Standards – Quality Standard 11
[63] National Stroke Strategy Quality Markers –QM3: Information, advice and support, QM 14: Assessment and review
[64] National Stroke Strategy Quality Markers –QM 16: Return to work

2. E) Long term care

Education & Training	• Staff seeing stroke survivors know where to go to obtain information on other local services, charities in the area and how the stroke survivor may access financial, emotional, social, and vocational support. • Staff are aware of the Mental Capacity Act and it implications • Health and social care professionals should ensure that they are up to date with the current guidance from the DVLA • Care home staff should be familiar with stroke care strategies and options (including physical, physchological and social), and the needs and aspirations of those in their care • Staff have the details of the local IAPT service so that those that need it can access the service • Carers involved with the care management process from the outset, and encouraged to participate in an educational programme (on stroke, care and management, prevention)		• Service should include staff with expertise and competence in assessing, treating and monitoring people with behavioural and cognitive disturbance	
Workforce	• Staff working in long term care should have access to support and guidance from stroke skilled staff			
Performance Standards		**<6months**	**6-12 Months**	**>18 months**
	1. Proportion of stroke patients that are reviewed six months after leaving hospital (ASI 8/ SSNAP)	95%		
	2. Percentage of stroke survivors that received psychological support for mood, behaviour or cognitive disturbance within six months(ASI 6/ SSNAP)	40%	50%	60%
	3. Percentage of patients with Barthel score recorded at discharge (SSNAP)	100%		
	4. Percentage of patients with Modified Rankin score at discharge (SSNAP)	100%		

2. F) Secondary Prevention

Healthy lifestyles and management of specific risk factors reduce the risk of an initial stroke and the risk of a subsequent stroke[65]. For those who have already had a stroke or TIA, prevention advice is even more important. This means assessing individuals for their risk factors and giving them information about possible strategies to modify their lifestyle that can reduce their risk. GPs need to actively manage these conditions in line with national guidelines.

	Immediate		Long term (>18months)
	<6 months	6-12 months	
Service Outcomes	**Assessment:** After stroke, stroke survivors and their carers need to be offered a review from primary care services[66] of their health, social care and secondary prevention needs: • All stroke survivors with a stroke will have their risk factors assessed as soon as possible and certainly within one week[67]; documented and a personal care plan for secondary prevention as part of the stroke team's assessment which is passed onto primary care • Monitored regularly in primary care on a yearly basis at minimum	• Protocols in place for stroke survivors education for secondary prevention of stroke encouraging better compliance with end result of reduced recurrent stroke	
	Monitoring: This specification does not attempt to define all risk factors (see RCP National clinical guidelines 2012), though significant risk factors and assessment include the following: • Managing hypertension so systolic blood pressure is below 130 mmHg; treatment should be initiated prior to discharge or at two weeks[68] • Anticoagulation (e.g. Warfarin) for individuals with atrial fibrillationand where not contraindicated; prescribed before discharge or plans to anti-coagulate as out-patient which ever aligns with guidelines to administer 2 weeks following stroke onset • All patients with ischaemic stroke, not in atrial fibrillation, to have anti-platelets medication unless contraindicated • All patient who have had an ischaemic stroke or TIA should be offered a statin drug unless contraindicated[69] • Smoking cessation, alcohol, tailored exercise programmes and healthy		

[65] National Stroke Strategy Quality Markers –QM2: Managing risk
[66] National Stroke Strategy Quality Markers –QM 14: Assessment and review
[67] RCP2012 – 5.1.1A
[68] RCP2012 – 5.4.1D. Note: For non-admitted patients requiring blood pressure treatment, treatment should be stated at the first clinic visit
[69] RCP2012 – 5.6.1A

2. F) Secondary Prevention

	lifestyle advice for all stroke/TIA survivors.		
	Risk management: Risk factors, including hypertension, obesity, high cholesterol, atrial fibrillation and diabetes, are managed according to clinical guidelines, and appropriate action is taken to reduce overall vascular risk[70] • Participating GPs produce and maintain a register of patients who have had a stroke or TIA, forming a suite of indicators to provide quality of care[77] • Measures for secondary prevention introduced as soon as the diagnosis is confirmed, including discussion of individual risk factors • Information and advice strategies to ensure that clear, consistent, culturally sensitive messages are being given to those who have had a stroke, their families and those at high risk • Practices can produce a register of patients with stroke or TIA[71]		
	Information and advice: Those at risk of stroke and stroke survivors are assessed for and given information about risk factors and lifestyle management issues (exercise, smoking, diet, weight and alcohol), and are advised and supported in possible strategies to modify their lifestyle and risk factors[70] • Stroke survivors given named contact to help them plan and manage their long-term care[72] • Meet individual needs, tailoring for a variety of ages, ethnicities and lifestyles • Access to leaflets in variety of formats (i.e. different languages, large print, braille, dysphasia friendly)		
Education & Training	• All primary care professionals maintain and update their knowledge of national guidelines and implement them in practice, targeting high risk patient groups[70]		
Performance		**<6months**	**6-12 Months**	**>18 months**

[70] National Stroke Strategy Quality Markers – QM2: Managing Risk
[71] Quality and Outcomes Framework: Stroke 1
[72] Care Quality Commission: Supporting Life After Stroke

2. F) Secondary Prevention

Standards	1. Percentage of patients with stroke or TIA who smoke whose notes record smoking status within the previous 15 months[73] (QOF)	90%		
	2. Percentage of patients with a history of TIA or stroke in whom the last blood pressure reading (measured in the previous 15 months) is 150/90 or less[74] (QOF)	70%		
	3. Percentage of patients with a TIA or stroke who have a record of total cholesterol in the last 15 months[75] (QOF)	90%		
	4. Percentage of patients with TIA or stroke who last measured total cholesterol (measured in the previous 15 months) is 5 mmol/L or less[76] (QOF)	60%		
	5. Percentage of patients with stroke or TIA who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months[77] (QOF)	90%		
	6. Percentage of patients presenting with stroke with new or previously diagnosed atrial fibrillation who are anti-coagulated on discharge. (ASI 1)	60%	70%	80%

[73] QOF Smoking 3
[74] QOF Stroke 6
[75] QOF Stroke 7
[76] QOF Stroke 8
[77] QOF Smoking 4

G) End of Life care

Stroke is the UK's third biggest killer[78]. Patients with stroke may enter the End of Life pathway at many stages of the Stroke Pathway, in different care settings. Clear decisions will indicate when a patient's prognosis means that an end of life pathway is appropriate. It is important that this decision is made by the appropriate skilled and experienced individual, taking account of the needs and choices of the patient, carer and family.

	Immediate		Long term (>18months)
	<6 months	6-12 months	
Service Outcomes	**End of life care:** • Decision to enter a patient into an end of life pathway should be taken by an appropriate and experienced individual, taking account of the needs and wishes of the patient, carer and family[79] • Patients and carer offered opportunity to be discharged home for end of life care • Palliative and End of Life care will be provided in line with clinical practice guidance and the local service specification for End of Life care. This may include referral to specialist palliative care services. • The Liverpool Care Pathway for the dying should be used to care for people in the last days or hours of life to deliver high quality care during this phase[79].	• Patients considered to be in the last 12 months of life are recommended for inclusion on the GP's GSF register	
Education & Training	• Preferred Priorities for Care (PPC) document shared with all health and social care staff involved in their care • Application of the 'Gold standards framework' to enable identification of appropriate patients and their care, and the Liverpool Care Pathway • Communication training provided to support practitioners in conversations about end of life care		
Workforce	• Patients receiving end of life care do so from a workforce with appropriate skills and experience in all care settings[79]		

Performance Standards	**<6months**	**6-12 Months**	**>18 months**
1. Percentage mortality of stroke patients at 1 month following a stroke (SSNAP)	N/A		

[78] Stroke Association Manifesto 2010-2015
[79] National Stroke Strategy Quality Markers – QM 11: End of Life care

G) End of Life care

	2. Percentage mortality of stroke patients at 6 months following a stroke (SSNAP)	N/A		
	3. Percentage mortality of stroke patients one year following a stroke (SSNAP)	N/A		
	No explicit performance measures are included for End of Life care services, though it is expected that the National Quality Markers for End of Life care are met, with data collected to support achievement.			

Stroke Services Reconfiguration Programme Brief

Birmingham, Solihull and Black Country

January 2014

Contents:

1. Purpose

To provide an overview of the Birmingham, Solihull and Black Country Stroke reconfiguration Programme. The programme aims to draw together work undertaken to date by the Midlands and East Stroke Review and seeks to understand if there is a need to reconfigure local stroke services to deliver better patient outcomes.

2. Context

In 2010, the West Midlands Regional Quality Review Service led a review process in co-ordination with the West Midlands Cardiac and Stroke Networks. The purpose of the review was to assess compliance with the WMQRS (West Midlands Quality Review Service) quality standards for acute stroke and Transient Ischaemic Attacks (TIA) and to train future reviewers. The review team included a Stroke Consultant, Stroke Nurse, an Allied Health Professional and members of WMQRS and the Stroke Network. The process consisted of site visits and discussions with a multidisciplinary team. The outputs of the assessment process were used to inform the quality of care that was being delivered by each provider and to assess the capability of providers to deliver 24/7 thrombolysis and other stroke services.

The review process showed that there was significant variation in the quality of care that is provided across the region. The West Midlands Strategic Health Authority was still concerned about the model / configuration for stroke services in the region. In January 2012 the NHS across the Midlands and East approved a clinically led comprehensive review of stroke across the region, to identify options that would improve outcomes by improving mortality, reduce chances of long term disability and improve patient experience.

The Midlands and East Stroke Review for the Birmingham, Solihull and Black Country area concluded that there are six hospital trusts, which deliver nine Hyper Acute Stroke Units (HASU). Hyper Acute Stroke Units provide specialist stroke care in the first 72 hours after the stroke. The regional review recognised that strong collaborative work and clear governance arrangements were required to take this work forward at a local level during 2013/14 and considered a range of options from three to six HASU sites, all of which required local appraisal. Since this time a public consultation took place in Sandwell and West Birmingham to configure stroke services at Sandwell General Hospital, resulting in 8 HASU sites across the area. There are further plans to move to six sites with a public consultation taking place at Heart of England Foundation Trust, considering the options of moving HASU services from both the Solihull and Good Hope site to the Heartland location.

There is evidence to suggest that changing the specification of the stroke care pathway in Birmingham, Solihull and the Black Country could lead to improved outcomes for patients. An important part of this pathway relates to the hyper acute stroke units. This review will look at whether six hyper acute sites is appropriate for the area and if they can deliver the necessary improvements to patient care. Analysis of travel times suggests that it may be feasible to move to between three and six sites, with patients able to be conveyed to hospital within the recommended 30 minutes. However Clinical Commissioning Groups (CCGs) are clear that other factors such as quality of care, workforce and patient experience also need to be considered. This review will consider these factors to determine the recommended number

of HASU sites for the area. No decision has been made, and the review may determine that six sites are the most appropriate configuration for stroke services.

The evidence suggests that there is a minimum specification that all hyper acute stroke units should achieve if they are to provide optimal care to patients. This centres on the timeliness of response and requires 24/7 consultants on call, as well as access to rapid scanning and thrombolysis services. This specification recommends that HASUs see a minimum of 600 confirmed stroke patients per year to improve clinical quality, by enabling clinicians to treat enough patients to maintain their skills. National and regional evidence also indicates that if patients have access to larger units they have a reduced risk of morbidity, reduced chance of long term disability and quicker access to thrombolysis services.

Sandwell and West Birmingham Clinical Commissioning Group (SWB CCG) is leading the Birmingham and Black Country Stroke Reconfiguration Programme. SWB CCG will have overall responsibility for the delivery of the programme and will host the Stroke CCG Programme Board to provide the strategic steer for the programme. The decision on the future placement of hyperacute and acute stroke centres will sit with the respective CCG Governing Bodies; the role of the programme board will be to advise and recommend the preferred model for hyper acute stroke units.

The focus of the review is to assess if there is a need to reconfigure hyper acute stroke units to deliver improved clinical outcomes for patients. Our aim is for all stroke patients to receive high quality specialist consultant support 24/7. Working with clinicians, providers, patients and stakeholders we hope to agree a recommended model (number of HASUs) across the area. This work will need to consider clinical evidence, impact on neighbouring areas and current services.

3. Programme Scope

3.1 Provider & CCG Landscape

The intended reconfiguration of services is in relation to the following provider Trusts;

Birmingham Community Healthcare NHS Trust
Heart of England NHS Foundation Trust
Royal Wolverhampton Hospitals NHS Trust
Sandwell and West Birmingham NHS Trust
The Dudley Group NHS Foundation Trust
University Hospitals Birmingham NHS Trust
Walsall Healthcare NHS Trust
West Midlands Ambulance Trust

These are respectively commissioned by;

Birmingham Cross City Clinical Commissioning Group
Birmingham South Central Clinical Commissioning Group
Dudley Clinical Commissioning Group
Sandwell and West Birmingham Clinical Commissioning Group

Solihull Clinical Commissioning Group
Walsall Clinical Commissioning Group
Wolverhampton Clinical Commissioning Group

The population for the programme will require a solution that takes in Birmingham, Solihull and the Black Country. Therefore the work will focus on the:-

- Population registered with GPs within the boundaries of the seven CCGs of Birmingham and Black Country (BBC)
- People who live within the seven CCGs boundaries, but who are not registered with a GP
- People who access emergency health care services within Birmingham, Solihull and the Black Country either on an ad hoc basis, or based upon the traditional referral flow (catchments of acute organisations)

3.2 Clinical scope

The Midlands and East Service Specification divides the pathway into eight phases and specifies the standards to be achieved in each (Appendix 1). These are:-

- Primary prevention
- Pre-hospital
- Acute phase
    - Hyper-acute stroke unit (HASU) services
    - Acute stroke (ASU) services
    - Transient Ischaemic Attack (TIA) services
    - Tertiary care (i.e vascular and neurology care)
- In-hospital rehabilitation
- Community rehabilitation
- Long term care and support
- Secondary prevention
- End of Life

3.3 Outside scope:

Tertiary care (neuro-surgical referral) and strokes occurring in children are both outside the direct scope of the programme.

3.4 Interdependencies:

To understand the above services, a wider number of interdependences will require consideration, these include:

- Accident and Emergency Services
- Intensive and Critical care
- General Medicine
- Geriatric Medicine
- Radiology

- Neurology services
- Vascular surgery
- Voluntary sector
- Lifestyle interventions
- Geographical Boundaries

4. Programme Vision and Outcomes:

4.1 Vision

The vision for stroke services is to prioritise stroke as a focus condition for the adoption of a clinically-driven and clinically-owned model of care. The overall aim is to ensure a uniformly high treatment standard for stroke patients, irrespective of where in the Birmingham, Solihull and Black Country they suffered their stroke.

4.2 Outcomes

- Reduction in stroke mortality rates
- Reduction in average length of stay
- Reduction in stroke re-admissions
- Achievement of 90% stay on stroke ward
- Increase in the percentage of patients receiving thrombolysis
- Achievement of diagnosis and treatment for high risk TIA within 24hrs
- Increase in the number of patients discharged to their normal place of residency

4.3 Co-ordinating Commissioner Role

SWB CCG in conjunction with the Cardiovascular Network Team, will ensure that specifications for the service reflect the agreed guidelines and protocols developed through the Birmingham, Solihull and Black Country area. SWB CCG will ensure performance management arrangements for the programme are robust; clinical and financial risks are assessed and managed; and that robust and transparent arrangements are in place for the consideration of service developments against agreed priorities. It is important to recognise that the local performance management of services will continue to sit with each individual CCG.

SWB CCG will develop a shared central team to work on behalf of all the CCGs as the accountable bodies, working through the Programme Board, using the under spend identified in Cardiovascular Network resources (2012/13) to support and coordinate the programme for a time limited period (April 2013 up to March 2015).

5. Approach and Next Steps

It is recognised that each of the phases with the services specification will have a number of specific standards to be delivered and so will need to be treated as a specific project, with clear timescales and distinct actions and responsibilities. However it is intended these will all form part of an overall interlinked programme of work, with oversight by the Birmingham, Solihull and Black Country CCG

Stroke Project Board, which will ensure overall connectivity and that an integrated pathway of care is in place.

The programme will be designed into the following project specific strands as follows:

5.1 Hyperacute Project:

This strand will support an options appraisal for future hyper acute and acute phase sector configuration. It is recognised that this will be complex and will therefore require the most capacity and focus. This phase includes:-

- Pre-Hospital Phase
- Hyper-acute stroke services
- Acute stroke services
- TIA services

As above, it is also recognised that the programme will require a solution that takes in both Birmingham and the Black Country and also acknowledges other neighbouring economies. In addition managing the interface between the acute phase and the rehabilitation phase, and the rehabilitation and long term care phases may also provide challenges.

5.2 Non Hyper-Acute Projects:

Working with lead CCG representatives and with the respective provider organisation the review seeks to understand current stroke service provision against the standards and criteria set out in the best practice service specification. The role of the programme team will be to support the gap analysis and recommendation to achieve best practice for the prevention, acute, rehabilitation, community and end of life phases of the pathway.

- Inpatient and Community Rehabilitation Project:
- Long Term Care Project
- End of Life Project
- Prevention Framework Project

CCGs should ensure that they can support the evaluation and gap analysis of the above stroke pathway phases and to receive the recommendation from the individual projects. Respective funding for local service change will need to be agreed with each individual CCG and respective provider.

5.3 Programme Deliverables:

The Programme will support the development of the following deliverables in order to successfully complete the programme:

- Providing submissions to the Area Team at given points on progress and also to confirm the intentions on future delivery.
- A decision making framework agreed across all CCGs to support a robust decision making process
- Mapping of current service delivery and gaps for all phases

- The construction of a Project Initiation Document /phased implementation plans for each section of the pathway including a risk management framework
- An Options Appraisal for future acute sector configuration
- Cost benefit analysis to support recommendation of optimum configuration
- A Communication and Engagement Plan with expected schedules identified for both internal and external engagement and communication of project progress to key stakeholders including Overview and Scrutiny Committees and the public
- A Resource Plan including an appraisal of current and likely future service costs, and a recommended locally agreed reimbursement system, that contains:-
    - Details of all current payments to trusts for stroke services (in scope)
    - Details of current service costs (incl fixed and staff costs)
    - Recommendations for a revised reimbursement system, based on an unbundled Payment by result tariff to support the financial sustainability of the proposed HASU options
- A completed Health Needs Assessment and Equality Impact Assessment
- Relevant consultation process undertaken within relevant legislative guidance and defined outcomes achieved
- Commissioning intentions for subsequent year(s)
- Agreement of KPIs and monitoring framework for each CCG
- Plan of action for all issues raised during the review
- Review closure and handover

6. **Procurement Strategy:**

Taking into account the legal advice, if a decision to reduce HASU centres is reached the Programme Board will recommend service reconfiguration to reduce HASU centres with a procurement process based on competition open to all providers. The timetable for this will be published once a decision has been made on the optimum number of HASU centres.

The clinical requirements of the hyper-acute stroke service are that:

- It must be provided in an acute setting which has intensive care facilities and specialist stroke clinicians; and
- That there are time limits for patients to be transferred to the provider by the Ambulance Trust.

If the CCGs decide that it is essential that these two conditions are met for these services, “all potential provider” will mean only NHS Acute Trusts which can be reached within the required time limits.

If the Programme Board reaches a decision endorsed by the seven CCGs, AT and OSC that six HASU centres are retained, this can be dealt with by way of variation of their existing specificationsas part of the usual annual contracting round. There is no need for any competitive process because it falls within the usual process for dealing with services which can only be provided by local Acute NHS Trusts. As there would not be decision to choose between those Trusts but continuing to work with all of them, there would be no change from current commissioning practice.

7. Stakeholder Engagement

To support the achievement of the programme it is necessary to clarify the components of the system and assign appropriate roles according to the tasks to be undertaken to oversee and provide assurance. The table below highlights the key stakeholder groups which we can identify as immediately critical to the project:

7.1 Key Stakeholders

Role	Body/Group
Lead	CCG Chairs and Accountable Officer Stroke Programme Board
Assure	CCGs Acute Stroke Providers Community Stroke providers WMAS Social Care providers CCG Governing Bodies
Deliver	All Stroke Providers
Oversee	Cardiovascular Network Area Team CCG Lead Commissioner Clinical Reference Groups
Check/Challenge	Directors of Commissioning Directors of Finance Directors of Public Health Provider Director of operations Clinical Reference Group
Support/Enable	Cardiovascular Network Leads Voluntary Sector
Consult/Engage	Health and Well-Being Boards Overview and Scrutiny HealthWatch The Public Providers

7.2 Stakeholder Engagement

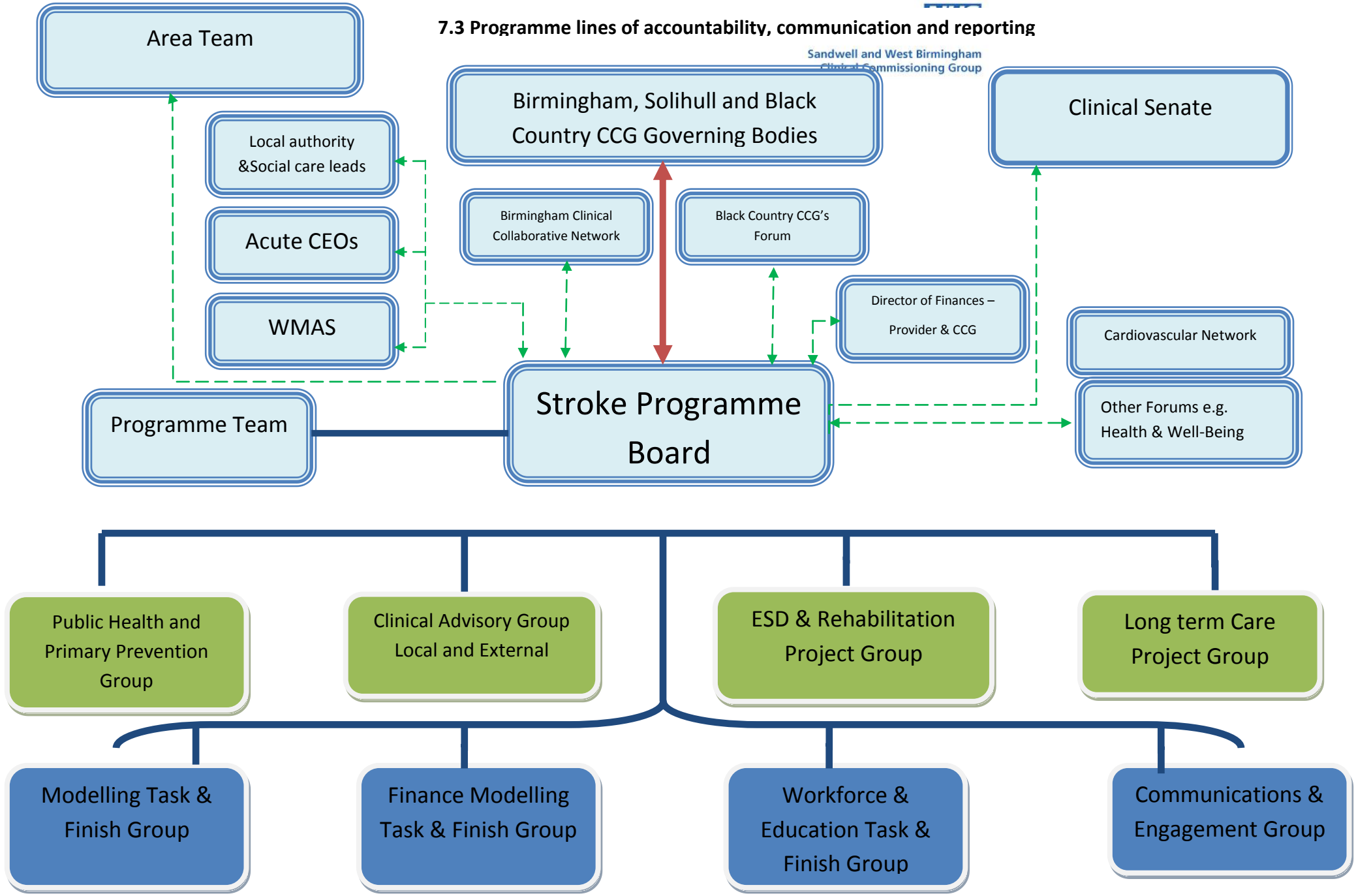
Key Stakeholders	Engagement	Role	Communications
CCGs	Stroke Programme Board CCG Governing Bodies CCG local stroke meetings	Actively shape the development of the local system proposal according to local commissioning intentions and health economics. As commissioners, take the lead in the preparation of and consultation on reconfiguration proposals. Accountable for the final decision on optimum HASU configuration	CCC Chairs Accountable Officers Directors of Commissioning Chief Financial Officer Clinical Leads CCG members
Providers	Provider Events 1:1 meetings Stroke Programme Sub-groups Ad-hoc communication	Work with commissioners to develop case for change, pre-consultation business case and consultation documentation and to take forward implementation. In collaboration with other providers as part of a local system, develop proposals and plans for how services will meet the standards set out in the regional best practice stroke service specification. Responsible for service change and improving quality of stroke services	CEOs Director of Operations Finance Directors Consultant Clinical lead Divisional Manager Stroke Coordinator Nursing and therapy leads
Cardiovascular Network	Stroke Programme Board Stroke Programme Sub-groups Ad-hoc communication	Provide oversight of the service from a West Midlands perspective and expert challenge the achievement of key milestones. The Network to provide advice to the system in support of the strategic development of stroke services in line with recommendations contained within the National Stroke Strategy, Royal College Physicians and National Institute for Health and Care Excellence guidance.	Clinical leads Management leads

Stroke Programme Board	Board meetings Ad-hoc communication	Provides overall direction and management of the project Takes major decisions for the project and make recommendations for approval for CCGs Accountable to the CCGs for the success of the programme Identifies and manages risks to project delivery and escalates issues to the Programme Board Co-ordinate and develop local system proposals on the future service provision in order to achieve the stroke service specification. Ensure cross boundary issues are explored and resolution sought with neighbouring areas/ stroke networks. Engage and seek support from local stakeholders in relation to these proposals via both pre-consultation and formal consultation. Make a clear recommendation to the CCGs and Area Team on the future system change to be implemented.	Refer to SPB TORs
Clinical Senate	West Midlands Clinical Senate meeting	This forum will provide advice on the clinical configuration for hyper and acute reconfiguration and the respective services specification for quality improvement and sustainability.	Clinical senate members
Independent Clinical Advisory Group	Sub-group developed using the framework of the EEAG TORs	This group will provide clinical input to the programme from a wide range of clinical areas involved in stroke and will approve the clinical aspects of the projects deliverables and act as a clinical advocate for the project. Provides clinical input to the programme from the wide range of clinical areas involved in stroke Approves the clinical aspects of the programmes deliverables Feeds in views and insights between the project and the programme board Acts as clinical advocates for the programme Provide endorsement to deliverables produced by the programme	Refer to TORs

		Each member of the Clinical Expert Panel is responsible for representing the opinions and needs of their specialist clinical area to ensure that the programme/projects achieve the best clinical outcome for patients.	
Local Clinical Advisory Group	Local Sub-group developed	Provide specialist clinical views Provide advice to inform the programme/ project outcomes, criteria and provider submission template. Provide clinical views and consultation forum on local clinical pathways where appropriate, for Primary Prevention, Hyper Acute Stroke Units, Early Supported Discharge, Rehabilitation and End of Life Care to ensure that services developed as part of the Stroke Programme are developed in accordance with best practice and clinical quality guidelines.	Refer to TORs
Area Team	Stroke Programme Board Ad-hoc meetings	Ensure that CCGs develop proposals for reconfiguration that are robust and fit for purpose (in line with the legal framework and current guidance)and that commissioners carry out consultations appropriately Will be consulted and informed of the clinical configuration for hyper and acute reconfiguration and the respective services specification for quality improvement and sustainability.	Area team members
Health and Well-Being Boards / Overview Scrutiny Committee	Communication and engagement plan to be developed	Scrutinise the planning, provision and operation of health services. Ensure that NHS organisations are held to account for their decisions on behalf of the people they serve. To provide insight and guidance in the development of new services. To ensure all groups are treated equally.	To be agreed
Patient and Public	Communication and engagement plan to be	To provide insight and guidance in the development of new services.	To be agreed

	developed		
Secretary of State (SofS)	To be agreed if required	Power to endorse or reject proposals referred by the OSC to ensure the effective provision of comprehensive health services in accordance with the NHS Act 2006.	If required
Independent Reconfiguration Panel (IRP)	To be agreed if required	Advises the SofS on proposals that have been contested locally	If required

7.3 Programme lines of accountability, communication and reporting



7.4 Programme Team membership

Role	Lead	Designation
Chair	Dr Nick Harding	Chair Sandwell and West Birmingham CCG
Deputy Chair	Dr Helen Hibbs	Wolverhampton CCG Accountable officer
Programme Sponsor	Andy Williams	Accountable Officer Sandwell and West Birmingham CCG
Finance Management lead	James Green	Chief Financial Officer Sandwell and West Birmingham CCG
Finance Clinical lead	Dr Helen Hibbs	Wolverhampton CCG Accountable Officer
Modelling Management lead	Matt Ward	West Midlands Ambulance Trust
Modelling Clinical lead	Dr Helen Hibbs	Wolverhampton CCG Accountable officer
Primary Prevention and Public Health lead	Jyoti Arti	Deputy Director of Public Health – Sandwell Local Authority
Primary Prevention and Public Health Clinical lead &	Dr Nick Harding	Chair Sandwell and West Birmingham CCG
Communications and Engagement Lead	Jayne Salter-Scott	Senior Commissioning Engagement lead Sandwell and West Birmingham
Communication Lead	Jenny Fullard	Communication and Engagement Lead Central Midlands CSU
Communications and Engagement Clinical Lead	Dr Nick Harding	Chair Sandwell and West Birmingham CCG
Independent Clinical Advisory Group	Dr Raj Mohan	Clinical lead Walsall CCG
Procurement Advisor	Alan Turrell	Head of Contracting and Procurement Walsall CCG
Procurement Leads	Mike Evans and Gary Hemer	Senior Procurement and Contracting Manager Central Midlands CSU
Analytical Support	Steve Wyatt	Central Midlands CSU
Cost Benefit Analysis	To be agreed	TBC
Programme Director	Nighat Hussain	Sandwell and West Birmingham CCG
Senior Programme Manager	Liz Green	Sandwell and West Birmingham CCG
Project Programme Officer	Stephanie Green	Sandwell and West Birmingham CCG

7.5 High Level Project Milestones and outputs:

	Dec 13	Jan 14	Feb 14	Mar 14	Apr 14	May 14	Jun 14	Jul 14	Aug 14	Sep 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15
Scoping	√															
Activity Modelling	√	√	√													
Financial Modelling	√	√	√													
Public Health data	√	√	√	√												
Provider Submissions			√	√												
Independent Expert Advisory Group					√											
Cost Benefit Analysis					√	√										
Recommendation PB							√									
Decision 7 CCGs								√	√							
Public Consultation										√	√	√				

8. Assurance Process:

The reconfiguration assurance process describes the approach by which proposals for major stroke service change will be supported by the Birmingham Solihull and Black Country CCGs and how they will reviewed by the Birmingham, Solihull and Black Country Area Team and Overview and Scrutiny Committees to ensure they meet all the requirements.

The Birmingham Solihull and Black Country Stroke CCGs will not support the Stroke programme to proceed to the next stage in the reconfiguration scheme without the successful completion of the following three stages of reconfiguration:

8.1 Consultation Phase

The pre-consultation process: including developing a robust clinical case for change and holding extensive dialogue with a wide range of stakeholders including OSCs, Health and Well-Being Boards and Councils , the public, their representatives, patients, carers, clinicians and NHS staff.

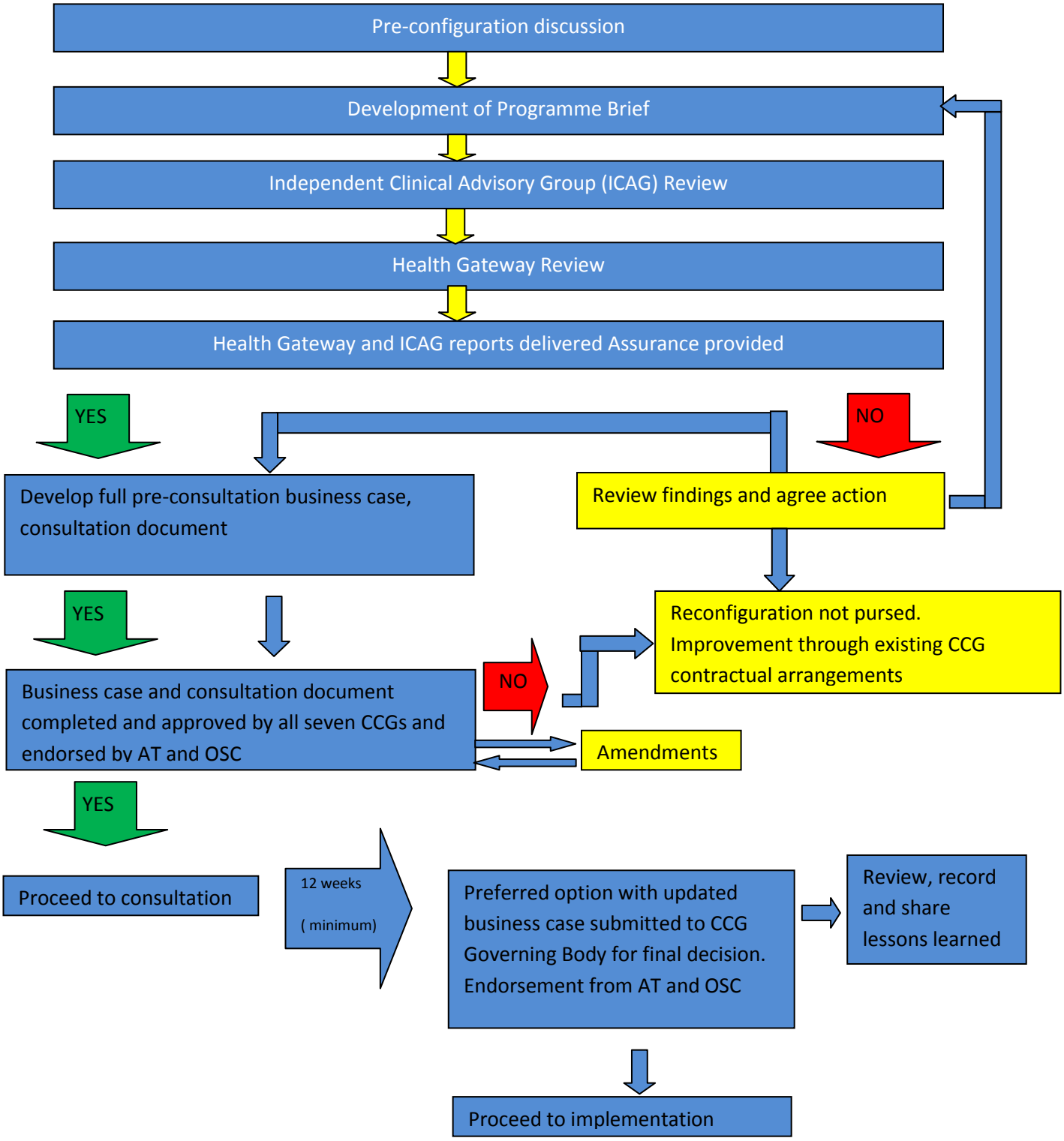
The consultation process: managing the consultation process, producing documentation and ensuring that statutory requirements to consult the public, healthcare professionals and other statutory bodies (including Overview and Scrutiny Committees) are met.

The post-consultation process: decision making process including sign-off with appropriate bodies and managing any subsequent reviews or challenges.

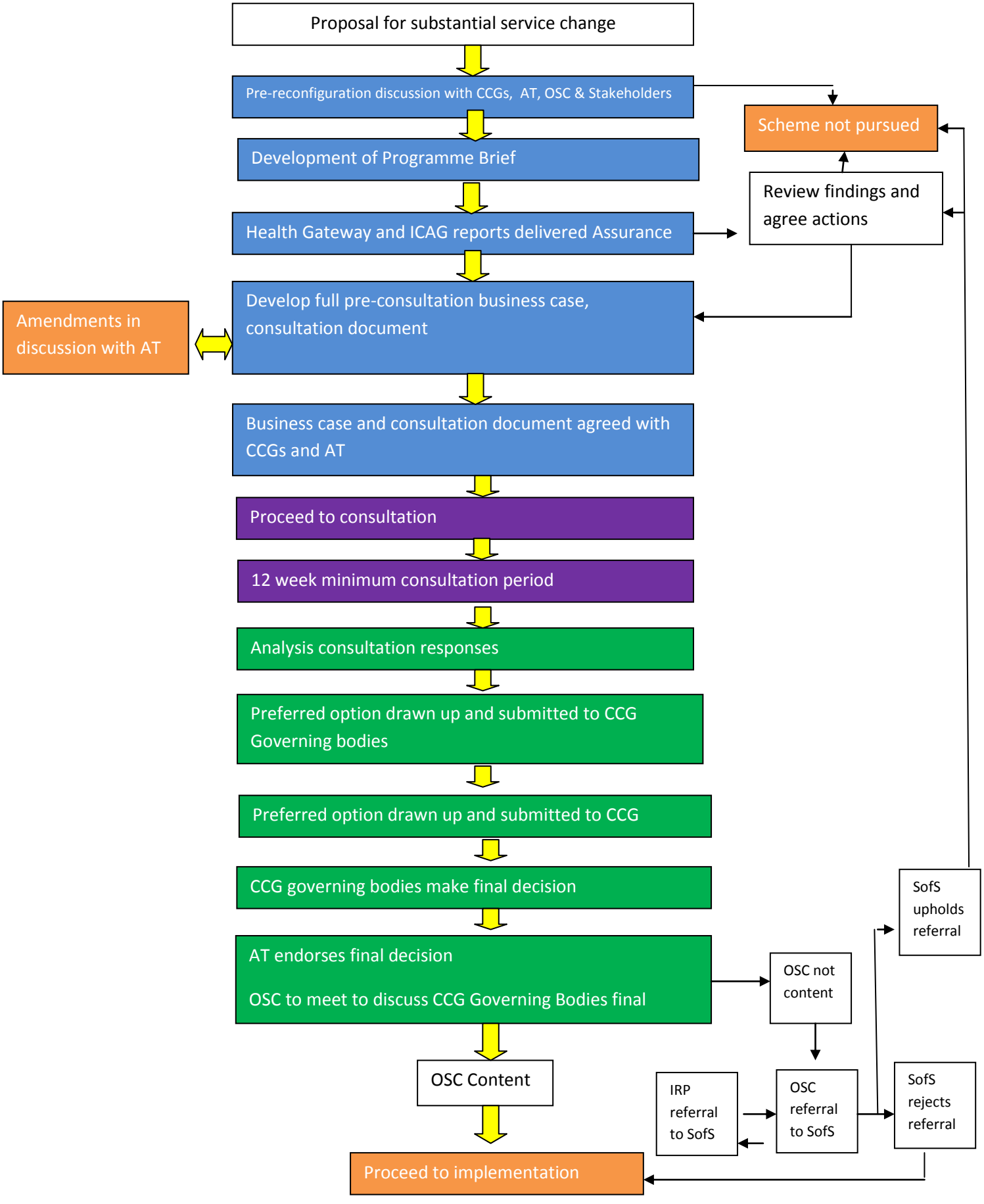
Designation Decision and Configuration Implementation -

Implementation of the configuration of stroke services and optimal care pathways will be informed by the outcome of consultation on the configurations for service delivery and occur from December 2014.

It is anticipated that the Programme Board will reach a recommendation on the future hyper-acute service configuration by July/August 2014. The following process will be followed to reach an agreement across key stakeholders:

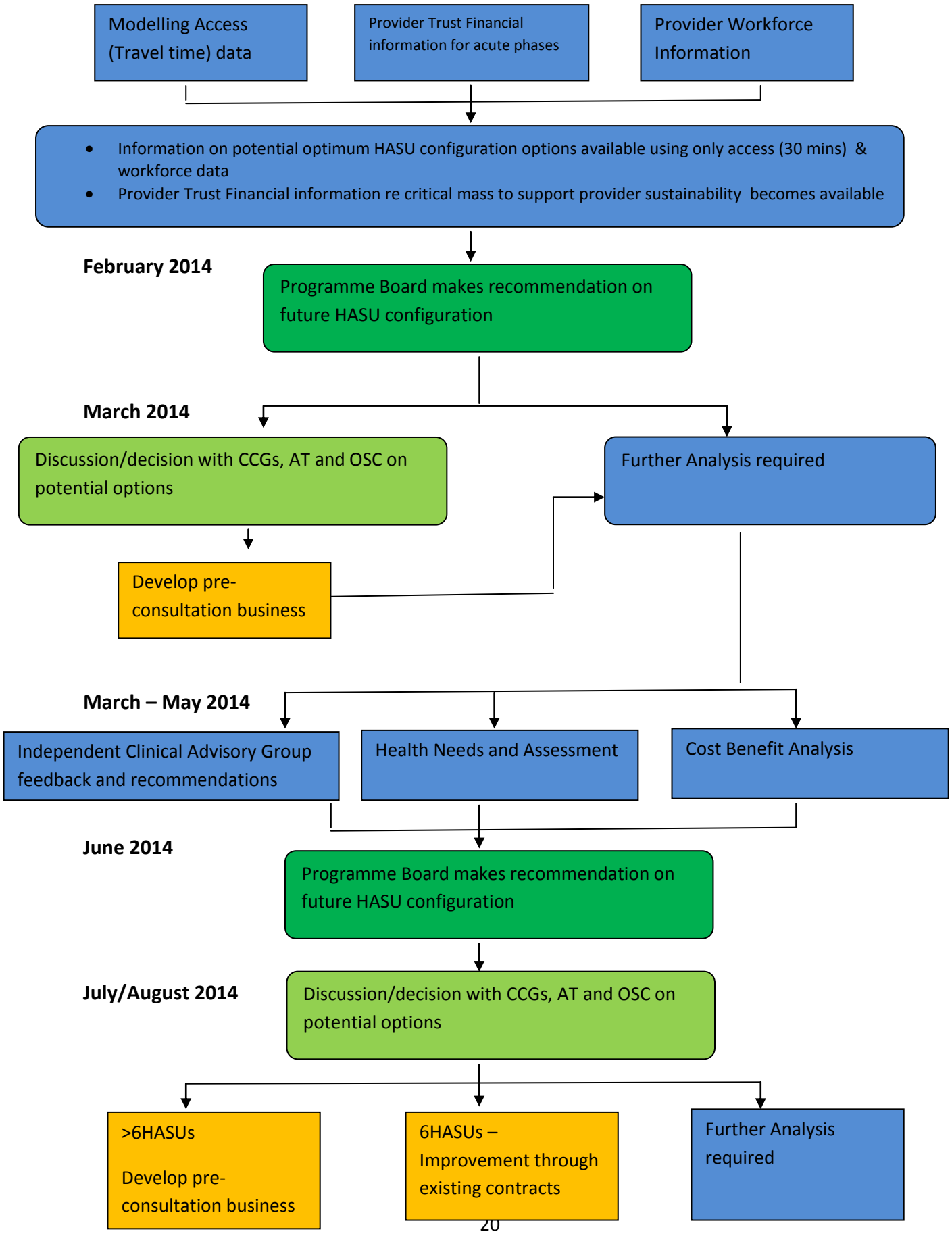


8.2 Overview of the reconfiguration/consultation process:



8.3 Key Decision Points:

January – February 2014



9. Communication Plan:

If the preferred option is a reduction of the number of HASU centres for stroke services, then a formal patient and public consultation process would be undertaken. The following narrative highlights the different phases of stakeholder and patient & public engagement that the programme will follow.

9.1 Engagement Phase (pre-consultation)

9.1.1 Phase 1

Identify and agree key stakeholders

Objective for engagement (pre-consultation) phase to consult on:

- Share Principles of Decision Making
- Develop and agree framework to be applied to Option Appraisal process

9.1.2 Phase 2

To ensure that stakeholders are consulted on Option Appraisal process. To also ensure that Stakeholders fully engaged in pre-consultation process

a) Providers:
- Providers signed up to option appraisal process

b) CCGs
- CCGs engaged through Programme Board

c) Patient and Public:
- Patients, carers and their representatives are engaged through the establishment of a Patient Advisory Group
- Patient representatives participating in Programme Board and Option Appraisal Panel

9.1.3 Phase 3

Outcome of Option Appraisal process feedback to stakeholders and used to inform formal consultation documentation and plans.

9.1.4 Engagement Phase (formal consultation) Phase 4

Formal Consultation launched

9.2 Role of Patient Advisory Group

- Consult Principles of Decision Making
- Consult on Option Appraisal process (OAP)
- Representative on Programme Board
- Representative on OAP
- Participation in Impact Assessment (EQiA) Workshop

- Part of assurance process for the Programme Board around:
  - Equality Analysis Process
  - Consultation Plan and Consultation Documentation

10. Affordability

It is perfectly legitimate for CCG decisions to take into account affordability, given the limited resources available and the requirement to break even. There is also an express duty on CCGs to exercise their functions effectively, efficiently and economically (section 14Q, NHS Act 2006) and this should also be taken into account. The best approach is to be clear about this issue from the outset, so as to ensure transparency.

In addition, if the programme makes a recommendation to reduce HASU centres it is likely to be appropriate to consider including an affordability ceiling in the tender documents following the options appraisal. The programme will use the cost of the current service, the financial sub-group will support the analysis to demonstrate that the affordability ceiling is appropriate, supported by a clear audit trail that shows how this figure was calculated. NHS rules on agreeing prices for services where there is no mandatory tariff are also clear that prices should, among other things, are fair.

Finally, if a decision is made not to reconfigure the services because the options are unaffordable, the Programme Board will ensure that the reasons for the decision are fully documented so as to demonstrate that the decision is robust.

11. Option Appraisal Process:

11.1 Optimum HASU configuration

It is important to acknowledge that HASU configuration below three HASUs will not be considered for two reasons. The first critical mass from London and Manchester suggest that stroke activity volumes of 1300 and population coverage of one million provide optimum financial viability. The second is that the bed capacity requirements required for anything less than 3 HASUs would provide significant pressure on current services and require significant investment. Further validation will be supported by Trust clinical and financial submissions.

Financial Advice on volume of activity to support critical mass:

The financial sub-group will provide evidence from provider returns to support the optimum configuration to achieve financial critical mass to ensure provider financial stability. Overall financial landscape will be demonstrated using the current Pbr and local tariff to define the most cost-effective option.

Decision on optimum configuration:

The information above will be populated as demonstrated below to support the Optimum HASU configuration decision:

	Option 6	Option (s) 5	Option (s)4	Option (s)3
Meets 30minutes access travel time				
Meets Health Needs				
Cost affordability / Affordability				
Optimum configuration				

11.2 Option Appraisal Principles:

The Stroke Programme Board has agreed a period of consultation/market engagement with the six current providers to obtain information (non- financial & financial) to understand better the capability and capacity of providers to deliver current and future activity models. This information will be presented to the Independent Clinical Advisory Group Panel to review and recommend the most appropriate model that meets the clinical, financial and demographic solution for the Birmingham, Solihull & Black Country CCGs. The process will be carried out with a robust framework to ensure confidentiality is maintained and under no circumstances will any provider submission response be discussed with another provider or providers.

The current stage of the option appraisal process asks providers to put forward evidence of their capacity and capability to deliver current service and supporting information to provide increased level of stroke activity to support a high quality HASU in line with the Midlands and East Service Specification.

The future configuration model assumes that irrespective of any HASU configuration change all current providers will retain the provision of Stroke Acute, Outpatient TIA, Inpatient and community rehabilitation, long term care services and end of life care. The joint provider and CCGs modelling sub-group will determine the length of stay for the acute and community phase and recommend the optimum hand-off points.

<u>Provider submissions are not required to address how the West Midlands Ambulance Service will support stroke services, or the triage protocol to be used.</u>

Should the decision be taken to reduce the number of HASU centres, there is an expectation that HASU stroke services to be operational in 2016. It is recognised that the proposed acute stroke service providers may not currently have the infrastructure in place to meet the requirements for increased level of activity from the outset. Therefore, as part of the provider submissions process, providers will be asked to provide evidence of requirements already met, and estimates for when the remaining requirements could be achieved.

High level plans for meeting those requirements not already met, within maximum specified timeframes will be required including, where applicable the proposed funding streams and other 'deliverability' factors.

11.2.1 Use of Provider Submissions in the Option appraisal process:

As part of the options appraisal, the programme is engaging with providers to obtain information which will help to inform the decision as to the future configuration of stroke services in the Birmingham, Solihull and the Black Country. The information gathered will be used to assess current service provision and to test the feasibility of the proposed future configurations.

Each provider submission will be reviewed to understand the capability and capacity of providers to deliver current and proposed activity models. This will inform an analysis as to the most appropriate model to meet the clinical, financial and demographic solution for the Birmingham, Solihull & Black Country CCGs.

Areas for Review of Provider Submission Evaluation
Quality of Services
Workforce including Innovation and Research& Development
Access
Ease of Delivery
Improved Strategic fit
Cost and affordability

The definition of the headings is described below:

a) **Quality of Services**

Definition: Quality and continuity of care for stroke patients across the pathway. This also covers clinical critical mass which is the minimum throughput of patients to be maintained in order to ensure quality of service. It takes account of the number of patients required for an acute stroke service provider to be clinically effective, based on incidence and population.

Outcome: High level of quality for the stroke system improving patients' outcomes. Improving patients' outcomes is dependent on a step-change in the quality and continuity of care across the stroke pathway.

b) **Workforce including Innovation and Research& Development**

Definition: Heading covers workforce issues (attracting and retaining the best healthcare professionals, and investing in them via an accredited training and development programme, as well as rotating staff appropriately across the pathway and between similar care settings) and patient experience. This includes delivering quality education and training for staff and for the improvement to continue through innovation and research.

Outcome: Optimum workforce to support stroke patients.

c) Access

Definition: Maximum time taken for a stroke patient to be assessed at the point of arrival and treated within a HASU thereby helping improve quality and reduce health inequalities. Also considers accessibility by public transport to, HASU, ASU and TIA services.

Outcome: A stroke patient should be able to access a HASU that delivers access to high quality care. The access heading will also consider access to a HASU within a maximum of 30 minutes (by an ambulance with a blue light), this element will be picked up from WMAS returns. Patients and visitors will have access to local ASU and TIA services.

d) Ease of Delivery

Definition: The need for the acute stroke service provider to improve substantially from where it is now. Also covers implementation of infrastructure, capacity and feasibility of acute stroke service providers.

Outcome: Continued quality service to stroke patients.

e) Improved Strategic Fit

Definition: The ability of providers to work effectively with neighbouring providers. Networks will need to provide adequate coverage of the entire Birmingham, Solihull and Black Country population, whereby a simple system will be easier to manage.

Outcome: Optimum service to stroke patients supporting collaborative capability across Network, Providers, Local Authority, Voluntary Sector and CCGs.

f) Cost and Affordability

Definition: The balance between impact on patient outcomes with the incremental cost of providing the new acute stroke services in a particular configuration. There are many competing priorities in Birmingham, Solihull and Black Country and the financial impact of

the proposed changes for stroke must be evaluated against the impact on the overall healthcare system.

Outcome: Affordability of service within the current financial envelope ensuring high quality services can be safely provided.

11.2.2 The Review Process

Provider submissions will be reviewed as part of the option appraisal process. In reviewing the information received, provider submissions will be treated as confidential and will not be disclosed to other providers.

The provider submission review process will be co-ordinated by the Stroke Programme Board comprising members of the Independent Clinical Advisory Group and led by the National Stroke Clinical Lead.

The review of submissions will be undertaken by a review panel comprising clinicians and NHS senior management that are not associated with any Birmingham, Solihull and Black Country Acute Trusts.

It should be noted that the provider submissions will only be used to inform the options appraisal for future service configuration and not to assess and score individual providers against each other. Any assessment of the relative merits of individual providers will only take place as part of any procurement process which may flow from this options appraisal and would not take into account any information provided at this engagement stage.

11.2.3 Option Appraisal Process:

The option appraisal process will be carried out in line with the following methodology, which will support an evaluation method measuring quality and price. All six headings will have an equal score of out of a 100 and this will be distributed evenly within the subheadings of each area. The options with the highest score representing the most economically advantageous option.

Areas for Review of Provider Submission Evaluation	Score
Quality of Services	16.7
Workforce including Innovation and Research& Development	16.7
Access	16.7
Ease of Delivery	16.7
Improved Strategic fit	16.7
Cost and Affordability	16.7

Total	100

The questions that are to be answered by provider templates will be scored as follows:-

Score	Definition
5	Meets the standard exactly and demonstrates innovation.
4	Meets the standard exactly
3	Meets the standard in most aspects
2	Fails to meet the standard in most aspects
1	Fails to meet the standard
0	No response submitted

The scores will be summarised for each options as follows:

	Option 6	**Option (s)5**	**Option (s) 4**	**Option (s)3**
Quality of Services				
Workforce including Innovation and Research& Development				
Access				
Ease of Delivery				
Improved Strategic fit				
Cost and Affordability				
Total weighting for each option				

11.2.4 Timetable for change:

If a decision is made to reduce the number of HASU centres it is anticipated that the proposed new services will go-live from 2016, with a step-change in the quality of service being delivered from the outset and commitment to an implementation plan achieve the requirements detailed under the option appraisal headings (above) within the first 18 months.

The Programme Board will take into consideration potential timeframes for service change when considering the recommendation for future service configuration and reserve the right to change the go-live date based on the information submitted by providers.

A long list of possible configurations will then be reduced to a short list through analysis of how individual configurations compare against the factors outlined above. The short listing will be conducted by a panel of representatives from the Independent Clinical Advisory

Group, who will generate a recommendation to take forward to the Stroke Project Board. The Stroke Project Board will then approve the recommendation and issue it to the Birmingham, Solihull and Black Country CCGs to agree future stroke service provision.

In September 2014, it is anticipated that a shortlist of provider configurations will be brought to a public consultation. The decision on which configuration options will be included in the consultation will then be communicated to providers. The final decision on which configuration will be designated will be taken in December 2014 following the public consultation. Any decision to reduce the number of HASU centres will be followed by a competitive procurement tender process.

11.2.5 Procurement Tender Process:

Key Milestones	Approx No. of Working Days
Issue Advert / Invitations	
PQQ Expressions of Interest Invited	
PQQ Expression of Interest Returned	10
PQQ Evaluation	10
PQQ Shortlist	
PQQ Standstill Period/debriefs	5
ITT/final proposal invited	
ITT/final proposal returned	20(max)
ITT Evaluations commence	25
Contract Award Recommendation	10
Contract Award Approved (eg Board)	5
ITT Standstill period	5
Contract Award	
Mobilisation (inc any TUPE issues)	85
Service Commencement Date	

Key

PQQ = Pre-qualification Questionnaire
ITT = Initiation To Tender
w/c = Week Commencing

N.B. all dates and no of days are approximate at this stage.

12. Cost-Benefit Analysis:

The cost-benefit analysis will support CCGs to make a decision on the optimum configuration of HASUs. Key objectives will be:

- Provide the cost-benefit of the option appraisal configuration to demonstrate the marginal cost-benefit of each configuration;
- Provide a return on investment for each of the configurations from six HASU sites to a minimum of three sites.

12.1 Development of an Economic Model

An economic model will be developed based on the outcomes of the options appraisal carried out by the programme board. It is anticipated that this will provide a number of scenarios which can be included in the economic modelling. The model will calculate the costs of the different options identified for HASU provision and will allow the benefits of HASU treatment to be modelled. The benefits of reconfiguration of HASU provision will be identified through the literature review but the key metrics are likely to include:

- Reduction in length of hospital stay;
- Improved mortality rates;
- Reduction in future event rates.

If data is available the model will seek to understand the potential effect of changes on aspects such as mortality and health-related quality of life, then these benefits will be calculated in terms of quality adjusted life years (QALYs). These benefits can then be monetised by applying a value per QALY, based on the range used by the National Institute for Health and Care Excellence (NICE), which uses a threshold value of between £20,000 and £30,000 per QALY.

In modelling the costs, the key metrics are likely to include:

- Staffing costs;
- Hospital bed occupancy;
- Costs of drugs and procedures, e.g. thrombolysis.

Activity data for patients will be gathered where possible from local systems. If local data is unavailable, data will be extracted from the Hospital Episode Statistics (HES) database, held by the Health and Social Care Information Centre. Data will be gathered from care providers where possible so that local variations in cost can be accounted for. Where data is unavailable, it will be extracted from publicly available national sources such as NHS Reference Costs, Payment by Results Tariffs, Unit costs of Health and Social Care, the Drug Tariff and the British National Formulary, as applicable.

An additional consideration for each of the options will be the cost of patient repatriation. For each of the options, the additional number of patient journeys that would need to be

made to repatriate patients from the HASU to their local hospital will be calculated. This will be done on the assumption that repatriation will be to a patient's local hospital rather than to their home address and unit costs of ambulance or patient transport journeys will be used to provide estimated costs.

12.2 Cost-benefit analysis of optimal HASU services configuration

Once the economic model is constructed, it will be used to estimate the costs and benefits for each of the options. The return on investment will be calculated for each option and presented in short, medium and longer-term scenarios. Demographic and epidemiological data from local and national sources will be used to project the costs and benefits forward into future years. Relevant discount rates and net present values will be used to make those estimates, adhering to the requirements of the Green Book.[1]

The model will present the user with additional components to test the 'uncertainty' of the parameter values used. For example, one-way and two-way sensitivity analysis will be conducted around the key parameter values such as costs and activity rates. This will be used to explore the sensitivity of the findings for each of the options.

13. High Level Risks & Challenges

As part of the process to date a number of key challenges & risks have been identified that will need to be worked through as part of the detailed discussions in order to support determination of the final preferred delivery model and also ensure that delivery is sustainable.

Key Risk and Challenges Include:

A. Case for changes:

The case for change needs to be revisited to understand the current quality of services and the gap to meet the best practice service specification; this may delay the option appraisal process due to the time it will take to carry out a comprehensive review.

B. Modelling Framework:

The programme no longer has access to the Deloittes' model and recruiting this may take a significant amount of time thus causing a delay in carrying out the option appraisal process.

C. Financial impact:

- It is recognised that the current 6 trusts have not achieved a 100% of the Stroke Best Practice tariff payment, initial analysis shows that this could lead to a cost pressure of 4.5 million to CCGs
- A reduction in sites could introduce an additional costs in ambulance conveyance and repatriation cost to local hospital sites for the acute care episode

[1] The Green Book: Appraisal and Evaluation in Central Government. HM Treasury, 2011.

- There is a risk that CCGs may not be able to collectively agree a mechanism where cost pressure are shared across the 7CCGs
- If the optimum configuration is to reduce HASU sites and this leads to an introduction of a cost pressure that CCGS are unable to support. CCGs will need to demonstrate a robust process if they decide collectively not to go ahead with the reconfiguration.

D. Service Outcomes & Performance Standards

- General concern has been raised regarding the achievability of a number of the standards, particularly without a step-increase in resources and also because of the reliance that this would place systems not within a provider's control.
- In particular it is felt that a burden of work would be likely to move to out of hours e.g. scanning, which again would require a step-increase in resources to fund this premium rate activity which is not recognised at present.
- A reduction in HASU sites may have an adverse impact on other clinical areas such as A&E, General Medicine, Geriatric Medicine, Neurology and Radiology

E. Workforce

The staffing levels required to achieve the expected performance standards are likely to require significant investment and recruitment of additional staff in each area.

Key Risks

A number of interdependencies exist which will impact on successful delivery of the programme. In particular failure to agree a revised resourcing mechanism will present a high level of risk to sustainability and affordability of any new models of care, and will also impact on the ability to agree the final configuration of the hyper-acute delivery. Delivery of the pathway is also heavily reliant on provider collaboration.

Terms of Reference for Stroke Programme Board:

PURPOSE

The Stroke Programme Board takes an overarching strategic view of the development of stroke services across the Birmingham, Solihull and Black Country to achieve a step change improvement in the quality of stroke services.

ACCOUNTABILITY

The Stroke Review Programme Board is accountable to the Birmingham, Solihull and Black Country CCGs.

Expected Outcomes

- To ensure that all people living in Birmingham, Solihull and Black Country who have had a Stroke have access to high quality Stroke Services at all stages in the pathway, including longer term quality of life
- To oversee the programme governance and structure to ensure that the overall purpose is achieved and to report progress to the Birmingham, Solihull and Black Country CCGs and Area Team
- Ensure equitable provision of services and a seamless transition in care across the whole patient journey.
- To ensure that cross boundary resources and patient flows are built in options for future delivery.
- To ensure that there is sufficient resource to support the communications and engagement implications of the project
- To proactively engage with commissioners
- To receive monthly updates from the Project Management Office and to resolve any issues causing delay in the set milestones.
- Identify and share common risks and ensure mitigation against these.
- To facilities dialogue with lead clinicians from network Stroke Advisory Groups at key times during the project
- To receive the recommendations of the Independent Clinical Advisory Group
- To agree the implementation plan to take forward the recommendations.

Clinical Outcomes of programme:

- Reduction mortality rates
- Reduction in average length of stay
- Reduction in Stroke re-admissions
- Achievement of 90% stay on Stroke Unit
- Achievement of diagnosis and treatment for high risk TIA within 24hrs
- Increase in % of patients receiving thrombolysis
- Increase in the number of patients discharged to their normal place of residency

Core Membership

- Programme Board Chair – SWB CCG Chair
- SWB CCG – Accountable Officer
- CCG Clinical leads
- A representative from CCG Accountable Officers/Directors of Commissioning /CCG Finance leads
- Area Team representative
- Public health leads
- West Midlands Cardiovascular Network Clinical Lead
- West Midlands Cardiovascular Network Director or nominated lead
- West Midlands Ambulance Trust lead
- Communication and engagement lead
- Project Director – SWB CCG
- Contracting and Procurement Adviser (to be confirmed)
- Stroke Association
- National Clinical Director for Stroke NHS England
- Local authority/ Social care
- Senior Research Associate – representative of the NIHR HS&DR national evaluation of stroke service reconfiguration (non-participating observer)
- Others as appropriate

The above list is not exhaustive and others may be invited or co-opted to attend the Board as required if applicable.

Invitations may be extended to any appropriate personnel to attend and provide evidence, information or expert advice to the Board.

Core/voting members may be asked to nominate a deputy, who has full authority to act on behalf of the core/voting member, to attend the Board in their place (if applicable)

Secretary:

The Stroke Programme Director with administrative support will be responsible for managing the Board and for drawing the Boards attention to best practice, national guidance and other relevant documents, as appropriate.

- The Board secretary will be responsible for
- Preparation of the agenda in conjunction with the Chairman and CCG Accountable Officer
- Minuting the proceedings and resolutions of all meetings of the Boards, including recording the names of those present and in attendance. Minutes shall be circulated promptly to all members of the Board
- Keeping a record of matters arising and issues to be carried forward
- Advising the Board on pertinent areas

Sub Groups

The following sub-groups will formally report to the Programme Board, and each chair will be a member of the Board supported by a dedicated clinical lead:

- Modelling Group
- Public Health and Primary Prevention Group
- Financial Modelling Group
- Clinical Advisory Group
- Communications and Engagement Group

Quorum

- The Programme Stroke Board will be considered quorate if the:
  - Chair/Vice Chair
  - Minimum of 3 clinicians across all 7 CCGs
  - Public health lead
  - Communication& Engagement lead
  - West Midlands Cardiovascular Network Clinical Lead
  - West Midlands Cardiovascular Network Director or nominated lead
  - Programme Director

- If a quorate member of the Board should be required to leave prior to the conclusion of the meeting, the chair should confirm that the meeting is still quorate or not. If the meeting is no longer quorate, it may continue but decisions will have to be ratified at the next meeting.

- A duly convened meeting of the Board at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Board.

- The Board may on occasion take a decision by email provided that:
  - The decision taken is by quorum of the Board as laid down in its Terms of Reference
  - If the decision is one which requires a vote, it shall be at the discretion of the Chair to decide whether use of email is appropriate
  - The decision is reported to the next meeting and is minuted
  - The e-mails reflecting the decision are copied to all members of the Board are printed, appended to the minutes and are retained on file.

Frequency and notice of meetings

- The Board shall meet on a bi-monthly basis on a minimum of 6 occasions per financial year. Additional formal or informal meetings may be arranged and convened by the Chair.

- Meeting papers will be sent out 7 days (5 working days) in advance of the meeting

Relationship with the CCG Governing Body

The will be directly accountable to the Birmingham, Solihull and Black Country CCG Governing Bodies.

- CCG representatives shall report formally to respective CCG Governing Bodies on the key points arising from its proceedings after each meeting.

- The Board shall make whatever recommendations it deems appropriate on any area within its remit where action or improvement is needed.

- The Board minutes shall be formally recorded and submitted to the CCG Governing Body according to the respective Boards reporting cycle.

Policy and best practice

- The Board will use best practice and policy guidance to inform the stroke transformation programme and to deliver its business.

Conduct of the Board

- If any member has an interest, pecuniary or otherwise, in any matter, and is present at the meeting at which the matter is under discussion, he/she must declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the matter has been completed.

- The Chair must invite members to declare any interests at the start of each meeting. This will be a specific agenda item. In addition, members may declare an interest at any time during the meeting.

- Any declarations will be recorded by the minute taker.

- If the Chair declares a conflict of interest, the Vice-Chair will chair that part of the meeting. If both the Chair and Vice-Chair declare an interest, an appropriate member will chair that part of the meeting.

- Wherever a conflict of interest may be perceived, the matter must always be resolved in favour of the public interest rather than the individual member.

- All members and those attending/participating in meetings will be expected to adhere to the Seven Principles of Public Life.

These Terms of reference were agreed by the Stroke Programme Board on the 17th December 2013 and approved by the CCG governing bodies (to be confirmed) they are due for review in March 2014.

Appendix 1

THE NOLAN SEVEN PRINCIPLES OF PUBLIC LIFE

SELFLESSNESS

Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

INTEGRITY

Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

OBJECTIVITY

In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

ACCOUNTABILITY

Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

OPENNESS

Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

HONESTY

Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

LEADERSHIP

Holders of public office should promote and support these principles by leadership and example.

Thinking Differently

NHS

Dudley Clinical Commissioning Group

Everyone Counts – Planning for Patients 2014/15 – 2018/19

Five Domains

- Prevent premature death
- Best quality of life for people with long term conditions
- Quick and successful recovery following ill health
- Great patient experience
- Keep patients safe and protect from avoidable harm

Seven Ambitions…

- Additional years of life for people with treatable mental/physical health conditions
- Improving quality of life for people with long term conditions
- Reducing time spent in hospital through integrated care in the community
- Increasing number of older people living independently at home

Seven Ambitions continued…

- Increasing the number of people having a positive experience of hospital care
- Increasing the number of people having a positive experience of care outside hospital, in general practice and the community
- Eliminating avoidable deaths in hospital

Three Important Measures

- Improving health – commissioning for prevention and tackling the wider determinants of health
- Reducing health inequalities – better care and services for the most vulnerable
- Parity of esteem – for physical and mental health problems

Local Leadership

- CCG is the local leader of the NHS
- Working closely with Health and Wellbeing Board partners
- Local authority role in terms of social care and the broader determinants of health

Transformation and Sustainability
6 Service Models

- 15% Reduction in emergency activity required
- Citizen involvement and patient empowerment
- Primary care provided at scale
- Modern integrated care
- High quality urgent and emergency care
- Step change in productive elective care
- Specialised services in centres of excellence
- Plans to be tested against these characteristics

Essential System Characteristics

- Quality – Francis, Winterbourne View, patient experience, staff satisfaction, seven day services, safeguarding
- Access – minority groups, general practice, NHS Constitution standards
- Innovation – improved outcomes through research
- Value for Money - £30 billion funding gap by 2020/21

Planning Fundamentals

- Move from incremental to transformational addressing the financial gap
- Costed plan for outcome ambitions
- 5 year plan to deliver the six service models
- 2 year detailed operational plan
- Explicit plan for financial gap including risks/mitigations
- Bold, developed in partnership, locally led,
- Reflect Health and Wellbeing Board Priorities

Alignment to Existing Plan

- Existing objectives – reduce health inequalities, deliver best outcomes, improve quality and safety
- Our strategic intent - planned care, urgent care, re-ablement care, preventative care and a focus on vulnerable groups
- Close alignment to national priorities

Commissioning Intentions

- Planned Care – pathway efficiency and value outcomes
- Urgent Care – New Urgent Care Centre and Frail Elderly model
- Reablement Care – Aligned CCG & MBC capacity plans aimed at reducing dependency
- Proactive Care – Integrated Primary, Community and Social Care Services demonstrating value to patients
- Primary Care Strategy – Empowering our localities, leading the integration
- Patient Engagement – Developing PPGs and mutualist approach

Joint Health and Wellbeing Strategy Alignment

- Making our neighbourhoods healthy – citizen involvement, tackling the wider determinants of health
- Making our lifestyles healthy – improving health and prevention
- Making our children healthy – tackling health inequalities
- Making our minds healthy – parity of esteem
- Making our services healthy – improving urgent care, integration, quality, safety and the patient experience

Quality Premium

- Reducing years lost through causes amenable to healthcare, including local priority for premature mortality
- Improving access to psychological therapies
- Reducing avoidable emergency admissions
- Addressing issues from 13/14 Friends and Family Test
- Improved reporting of medication related safety incidents
- Further priority based on Joint Health and Wellbeing Strategy

Financial Planning Assumptions

- Allocation growth of 2.14%
- Better Care Fund additional £12m in 15/16
- Extra 0.5% non-recurrent reserve to find
- 1% “Call to Action” reserve
- Control Total remains at 1.5%
- Running cost reduction 10% in 15/16
- Net increase in QIPP target of £2m in 14/15
- QIPP target rises by £13m in 15/16

Better Care Fund Plan

- Joint plan to be agreed by CCG and local authority with involvement of providers
- Approved by Health and Wellbeing Board
- Must set out expected outcomes, benefits and risk management of NHS services – 15% emergency activity reduction
- 14/15 - £1,100 million – Section 256 transfer
- 15/16 – further £1.9billion from CCG funding – Section 75 pooled budget

Agenda Item No. 11

Dudley Health and Wellbeing Board

Report of the Chief Accountable Officer, Dudley Clinical Commissioning Grouop

Urgent Care Consultation Outcome and the Reconfiguration of Urgent Care

Purpose of Report

1. To advise the Board of the outcome of the CCG's consultation process in relation to the future clinical model for urgent care in Dudley.

2. To consider the CCG's final proposals for urgent care, in the light of the consultation exercise.

Background

3. As the Board will be aware, the CCG ran a consultation process on urgent care from 1st October 2013 – 24th December 2013.

4. Attached as appendices are two reports considered by the CCG at its Board meeting on 9th January 2014. The first setting out an over view of the consultation process and the feedback received, the second setting out the CCG's proposed clinical mode for urgent care, in the light of the outcome of the consultation process.

5. The recommendations in both reports have now been approved by the CCG. This matter will be the subject of a separate report to the Health Overview and Scrutiny Committee on 23rd January 2013 and there are specific recommendations that the CCG wishes to make to this Board as set out below.

Finance

6. The premise of the proposal is that it will be revenue neutral. However, there are capital costs associated with the development of an urgent care centre. The ability to provide improved access to GPs will be dependent upon support from NHS England as the commissioner of primary care services and moving towards "scenario 5" (see report on proposed service model)

Law

7. The consultation process was conducted in accordance with the CCG's statutory duty to consult, as set out in Section 14Z2 of the NHS Act 2006.

Equality Impact

8. As a result of these proposals, access for all groups to routine general practice will be enhanced.

Recommendation

8. It is recommended that the Board:-

- note the consultation process carried out by the CCG and its outcome;
- note the recommendations on the future configuration of urgent care as approved by the CCG in the light of the public consultation process;
- invite NHS England, as a partner on the Board, with contractual responsibility for access to general practice, to demonstrate how they intend to improve this in Dudley;
- support joint commissioning as a means of addressing this issue;
- approve the CCG's proposals for the future configuration of urgent care.

……..
Paul Maubach
Chief Accountable Officer, Dudley Clinical Commissioning Group

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DUDLEY CLINICAL COMMISSIONING GROUP BOARD

Date of Report: 9th January 2014
Report: Urgent Care Consultation Outcome
Agenda item No: 8.1

TITLE OF REPORT:	Urgent Care Consultation Outcome
PURPOSE OF REPORT:	To provide Board members with an overview of consultation activities undertaken and assure them that the CCG has fulfilled its statutory obligations to properly consult on proposed changes to the urgent care system To provide a summary of feedback received
AUTHOR OF REPORT:	Richard Haynes, Interim Head of Communications and Engagement
MANAGEMENT LEAD:	Richard Haynes, Interim Head of Communications and Engagement
CLINICAL LEAD:	Dr Steve Mann
KEY POINTS:	• The consultation ran from 1 October to 24 December 2013 • It generated a considerable amount of interest and comment • Key themes to emerge are summarised in this report and will be used to inform the development of future services (see separate report on Urgent Care Reconfiguration)
RECOMMENDATION:	Board members are asked to note the consultation activities set out above by way of assurance that the CCG has fulfilled its statutory obligations to properly consult on proposed changes to the urgent care system Members are also asked to note the feedback received and take it into account when agreeing next steps in developing an improved urgent care system for the people of Dudley
FINANCIAL IMPLICATIONS:	Costs of the consultation exercise were met from the communications and engagement budget
WHAT ENGAGEMENT HAS TAKEN PLACE:	The report covers a wide range of engagement activities, before and during the consultation as well as outlining next steps on communication and engagement to support the delivery of improvements to urgent care in Dudley
ACTION REQUIRED:	Decision Approval ✓ Assurance

INTRODUCTION

This report focusses on the formal consultation carried out by NHS Dudley Clinical Commissioning Group between 1 October and 24 December 2013 on proposed changes to the local urgent care system.

It summarises the background to, and context of, the consultation, the steps taken by the CCG in the pre-consultation period and the activities carried out during the consultation period. It also sets out some of the key issues to be raised by individuals and groups who responded to the consultation.

Given the very short time between the end of the consultation period and the production of this report, it is suggested that further detailed analysis of the consultation feedback be included as part of the development of any specification or performance criteria for future developments on urgent care in Dudley.

The purpose of this report is to:

- Provide Board members with an overview of consultation activities undertaken by way of assurance that that the CCG has fulfilled its statutory obligations to properly consult on proposed changes to the urgent care system

- Provide Board members with a summary of feedback received from the consultation

REPORT

Background and Context

The decision to begin a consultation on urgent care was prompted by the imminent (March 2014) need to retender the current contracts for the Holly Hall walk-In Centre and Out of Hours GP Service.

Against a background of: Growing pressure on A&E; increasing demand for primary care services; concerns over the recently launched 111 telephone service and the restructuring of the NHS as a result of the Health and Social Care Act, a decision was made to use the ending of these contracts as an opportunity to take a wider look at urgent care services in Dudley.

To allow time for these complex matters to be considered in detail and discussed with the local population, the contract was extended by a further six months (to the end of September 2014) pending the outcome of a public consultation and further analysis of service requirements and patient flows.

The CCG's Statutory Duties in Regard to Involvement and Consultation

The legal duty to consult

The law requires NHS bodies to engage with members of the public before making decisions on changes to health services. Currently, separate sections of the NHS Act apply to CCGs and to other organisations.

CCGs are governed by section 14Z2 of the NHS Act 2006, which states:

> (1) This section applies in relation to any health services which are, or are to be, provided pursuant to arrangements made by a clinical commissioning group in the exercise of its functions ("commissioning arrangements").

(2) The clinical commissioning group must make arrangements to secure that individuals to whom the services are being or may be provided are involved (whether by being consulted or provided with information or in other ways):

(a) in the planning of the commissioning arrangements by the group,

(b) in the development and consideration of proposals by the group for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals or the range of health services available to them, and

(c) in decisions of the group affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

There are two other relevant aspects to section 14Z2. Subsection 3 requires all CCGs to include in their constitution a description of their public engagement arrangements and a statement of the principles that they will follow in when implementing them. Subsection 4 empowers NHS England to publish guidance on compliance with this section, which CCGs must have regard to.

The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 deal with the statutory duty to consult a local authority, and the powers of the local authority to report to the Secretary of State if it is not satisfied with the CCG's proposals or consultation. The regulations came into effect on 1 April 2013.

Section 23 in Part 4 of these regulations requires a CCG *to consult a local authority when it has under consideration any proposal:*

- *for a substantial development of the health service in the area of the local authority; or*
- *for a substantial variation in the provision of such service.*[1]

[1] Substantial variation is not defined, but ultimately the OSC will decide if it cannot reach agreement with the CCG; so early discussion with the OSC should be helpful

Guidance

The most recent guidance on consultations for the NHS was published in September 2013 by NHS England, and is called Transforming Participation in Health and Care.

The guidance sets out a number of suggested features of public participation. The information provided should be of good quality, and in a number of different formats to ensure that it reaches the intended target. There should be a range of opportunities for participation, which could include online surveys and dedicated local events, as well as work through voluntary and community sector organisations. Patients and the public should be involved from the initial planning stages of service redesign, and special efforts should be made to reach out to diverse communities.

Pre-Consultation Activity and Other Relevant Work

Following its formal establishment in April 2013, the CCG was involved in a number of important pieces of work to support its vision of working with partner organisations to improve health outcomes and reduce health inequalities for the people of Dudley.

This work influenced in a number of important ways the consultation on urgent care, and it is for that reason they are included in this report.

Primary Care Strategy

The CCG's Primary Care Development Strategy (approved by the Board in July 2013) aims to support local GP practices to further improve the quality of primary care. As a clinically-led membership organisation, Dudley CCG is uniquely placed to deliver change and improvement in primary care. The strategy aims to build on this opportunity, whilst acknowledging the freedoms and restrictions of the new NHS arrangements for the direct commissioning of primary care.

The priorities set out in this strategy are based on:

- What member practices told us about their key concerns and how these should be addressed
- What patients and our local communities told us about their current primary care services
- The CCG's agreed strategic aims and priorities (and those of Dudley's Health and Wellbeing Strategy)
- The national 'must do's' and performance management requirements.

The biggest single issue raised by patients and members of the public during the development of the strategy was access to GP appointments – in particular same day appointments – and telephone access to practices. The strategy also recognises the positive impact that improved primary care access can have on reducing pressures on the urgent care system.

Dudley CCG Healthcare Forum – June 2013

The CCG dedicated this meeting of its regular public forum to discuss views and perspectives on urgent care in Dudley.

The main feedback that we received at this event was as follows:

- There was a suspicion about the quality of; and lack of confidence in; the NHS 111 system
- Concerns were expressed about needing immediate advice/reassurance for ill children
- There was a perception that if an ambulance takes you to A&E you get seen quicker
- Some people need a point of contact for reassurance which could often be all that is needed to avoid them feeling the need to dial 999
- There was a desire for improved access to primary care outside of routine work hours
- There was an expressed preference to simplify the number of points of access and the signposting to services
- To have a system that gave more effective triaging so there is more right care, at the right place, at right time
- There should be patient education at an early age on how to use the urgent care services and there should be 24/7 access to health advice

Health and Wellbeing Board 'Spotlight on Urgent Care' – June 2013

The Health and Wellbeing Board has produced a Health and Wellbeing Strategy for Dudley Borough with five strategic priorities:

- Making our services healthy
- Making our lifestyle healthy
- Making our children healthy
- Making our minds healthy
- Making our neighbourhoods healthy.

The Board agreed to hold five 'spotlight' sessions, involving Board members and other stakeholders, throughout 2013/14, to stimulate fresh thinking in these areas, generate ideas and maximise the added value from integrated approaches and partnership working.

On 18 June 2013, the first spotlight session was held on 'urgent and emergency care. Feedback from the Healthcare Forum event mentioned above was incorporated into discussions at the Spotlight Event.

Outcomes from the Spotlight Event included agreement on a set of key principles relating to a good urgent care system, including:

- A joined up, coordinated and seamless system, fluid- no 'bottle necks'
- A simple system-no confusion for the public (or professionals) of what to do, who to call or where to go

- Safe, responsive and high quality

One of the solutions identified was to work to simplify the urgent care system, reduce duplication and develop a system which responded to patients' 'default behaviour.' Specific proposals included "co-locate the walk in centre, with the emergency department."

Engagement with Members

One of the key differences between the CCG and the Primary Care Trust (PCT) which preceded it is that the CCG is a membership organisation, led by the GPs who comprise its membership.

That clinical leadership was reflected by the development of the proposals through discussion at a series of events for GPs – a round of locality meetings (GPs grouped together by geographical location) followed by a CCG-wide Members' meeting in September.

Views expressed at these meetings gave clear guidance to the CCG management team that members did not feel the current walk-in centre arrangements offered the best service to patients during normal working hours.

The majority of GPs were in favour of relocating walk-in services and co-locating them with the emergency department at Russell's Hall, in line with the proposals from the Health and Wellbeing Board's Spotlight Event referred to above. They were also supportive of investment to improve access to primary care during core working hours, in line with the objectives of the CCG's Primary Care Strategy.

Reports to Health Scrutiny Committee

An initial report was presented to Dudley Borough Council's Health Scrutiny Committee on 25 September 2013, ahead of the launch of the consultation. CCG Chief Officer Paul Maubach and Dr Steve Mann, clinical lead for urgent care, were present to answer members' questions directly.

THE CONSULTATION

The consultation was launched on 1 October 2013 with an end date of 24 December.

Consultation document

A 12 page full colour consultation document was produced by the CCG's communications and engagement team. The consultation form was available in hard copy and electronic versions as well as an 'easy read' version. It included a freepost response form.

An estimated 5,000 hard copies were sent out by the CCG during the consultation period through a wide range of distribution channels including: GP Practices; healthcare centres; Dudley HealthCare forum members; Halesowen Older People Forum; Dudley Youth Council; Dudley and Stourbridge College; Dudley Age Concern; Dudley Carers Forum and numerous other health and other community groups.

By the closing date of the Consultation (24 December) the CCG had received a total of 1390 completed forms

Online Survey

An online survey, using Survey Monkey software was available through the CCG website throughout the consultation

By the closing date of the Consultation (24 December) the CCG had received a total of 1388 responses to this survey.

Meetings

Over the course of the consultation GPs and senior managers from the CCG had attended more than 40 meetings of local patient, service user and community groups to talk about the proposals and hear first-hand what local people think of them.

Total attendance at these meetings was more than 1,000 people

Drop In Sessions

As well as actively seeking invitations to local organisations, the CCG also hosted its own series of drop-in sessions, at GP practices or other community locations, as follows:

- 17 October ,12pm to 2pm – Sedgley Ladies Walk
- 7 November, 12pm to 2pm – Worcester Street Surgery
- 15 November, 12pm to 2pm – Halesowen Library
- 28 November, 12pm to 2pm – Brierley Hill Health and Social Care Centre
- 30 November, 12pm to 4pm – Insight House, Pearson Street, Brierley Hill
- 12 December, 12pm to 2pm – Dudley Council Plus, Dudley
- 12 December, 6.30pm to 8pm – Stourbridge Town Hall
- 17 December, 6.30pm to 8pm – Main Hall, Dudley College, Dudley

The evening sessions in December were added to the original programme in response to concerns raised during the consultation (from Health Scrutiny Committee members amongst others) that it would be better to offer meetings at different times of the day.

Despite publicising these sessions widely (including a series of paid for newspaper adverts), attendance was not as good as at the other community group meetings, although discussions were generally very productive and produced useful insights. This is consistent with experience in other consultation exercises.

Healthcare Forum: Members of the Healthcare Forum were given an update on the urgent care consultation at their meeting on 3 December. Members present noted that they had previously called for a more simplified system of urgent care and responded positively to the proposals in the consultation.

Website and Social Media

All the consultation materials were made available via a dedicated section of our website www.dudleyccg.nhs.uk and we also used our social media platforms (Facebook and Twitter) to broaden the range of opportunities that local people had to take part in the conversation about what they want from their urgent care services.

In addition, we hosted two live 'webchats' – one with urgent care clinical lead Dr Steve Mann and one with Chief Officer Paul Maubach.

'Feet on the Street'

Feet on the Street is the name for our regular 'vox pop' videos, recorded in local communities by our in-house engagement team. The team took to the streets twice during the consultation period to produce two separate short films to capture views on urgent care services and our consultation.

These films were screened at the CCG's Board meetings in October and December and they were also used at members meetings and the meetings of the Task and Finish Group.

Media Coverage

We issued a series of proactive press releases during the consultation period as well as responding reactively to a number of media inquiries as well as arranging for coverage in the local talking newspaper.

There was significant media interest in our plans, with front page coverage in the Express and Star on the launch of the consultation, and a number of follow-up pieces elsewhere in the local media.

We also used paid-for advertising in the local press to raise awareness of the drop-in sessions

Report to Health Scrutiny Committee

An update report was presented to the Health Scrutiny Committee meeting on7 November 2013. CCG Chief Officer Paul Maubach attended the meeting to answer members' questions directly.

Task and Finish Group

A Task and Finish group was established with invited representatives from the CCG, Healthwatch, Dudley CVS, local Patient Participation Groups (PPGs), Dudley Council and Dudley Group's public governors.

The group met twice during the consultation period and identified a number of key issues which have been fed into the key themes and issues set out below.

Healthwatch Survey

Healthwatch Dudley were commissioned to carry out a targeted research exercise talking to service users at Russell's Hall A&E and the Walk-In Centre in November.

Over a period of seven days, from 29 November – 5 December, space of a week, Healthwatch volunteers spoke to more than 900 people about their experiences and their reasons for choosing the service they were using.

Many of the themes which emerged during these interviews are also reflected in the key themes and issues set out below, but given the very targeted and specific nature of this piece of work, a copy of their initial report is also attached as Appendix 1.

The report (p18) identifies a significant number of patients using the Walk-In Centre to fill "a gap in doctors surgery provision" with the majority of patients surveyed agreeing that a doctors' surgery could have helped them with the issue which had brought them to the Walk-In Centre. Given the possible scenarios we have been modelling, it is also interesting to note that in response to a specific question, "449 patients said they would be happy to be referred back to a doctors' surgery for treatment after assessment…" (p5)

Independent evaluation

Shortly after the midpoint of the consultation, we commissioned an independent evaluation of the consultation activities and materials to provide assurance that the process was robust and inclusive.

The review was carried out by Richard Miles, a highly experienced consultant who has worked on both NHS consultations and with Scrutiny Committees. His review included 1-1 interviews with key clinicians and CCG managers as well as an in-depth review of the consultation activities and supporting materials.

His conclusion supported our view that up to the end of the consultation period we had fulfilled our statutory obligations on consultation and involvement, while also reflecting both the challenge that we faced in developing and communicating a detailed vision for the future of urgent care services during the consultation period, rather than having a clearly defined service model set out at the beginning of the consultation period; and the challenge that we now face in pursuing a service improvement for the people of Dudley that addresses concerns expressed during the consultation, and overcomes the constraints of different funding streams for primary care services.

Petitions

We are aware of two separate petitions, both protesting against the 'closure' of walk-In Centre services.

A petition against the closure of the walk-in centre has also been launched by Natasha Millward, Labour's prospective parliamentary candidate for Dudley South. That petition is still live and can be seen on-line at http://www.natashamillward.org.uk/keep_our_walk_in_petition Ian Austin MP (Labour, Dudley North), and Pat McFadden MP (Lab, Wolverhampton South-East) have also been promoting this petition.

At the time of writing this report (7 January) the petition had 747 signatures.

On 16 December, Chris Kelly MP (conservative, Dudley South) petitioned the House of Commons, as follows: "The Petition of residents of Dudley South, Declares that the Petitioners believe that proposed closure of the Dudley Borough Walk-in Centre at Holly Hall Clinic, 174 Stourbridge Road, Dudley DY1 2ER, by Dudley Clinical Commissioning Group should not go ahead; further that the Petitioners believe that, with its 08:00 to 20:00 opening hours, seven days a week, the walk-in centre currently provides a vital out-of-hours service for hardworking people in the Dudley Borough and the wider Black Country, especially on weekday evenings and at weekends; further that the Petitioners believe that the accessibility of the walk-in centre service contributes significantly to a reduction in the number of Accident and Emergency visits which reduces pressure on local A&E services such as those at Russell's Hall Hospital.
The Petitioners therefore request that the House of Commons urges the Government to urge Dudley Clinical Commissioning Group to keep the Dudley Borough Walk-in Centre open."

This petition will be sent to the Department of Health, which will be required to make observations on it that will be posted in Hansard.

Next Steps

Subject to the outcome of discussions at this Board meeting, we will take an update on the Consultation to the next meeting of the Health Scrutiny Committee on 23 January.

Following that, our proposals for the new service, will go the Health and Wellbeing Board for endorsement on 28 January.

We will then hold a public feedback event on 13 February to offer everyone who has taken part in the consultation exercise an opportunity to hear what we are proposing to do as a result of what they have told us.

The information received during the Consultation will be used to support the development of the specification and procurement process for any future service. (See also the report to this meeting of the Board on Urgent Care Reconfiguration)

Key Themes and Issues Raised During Consultation

From the thousands of responses to set questions and 'free text' submissions received, a number of themes and issues emerged at a very early stage and were topics of consistent interest and discussion throughout the consultation. They are summarised below.

How would a perfect Urgent Care service work for you? The survey asked respondents to consider how a perfect urgent care service would work for them. This was an optional question. It should be noted that 'urgent care' meant different things to different people – but by far the most common issue raised was people's desire to be seen, or given advice, quickly when they had an urgent need. This point was reinforced at many of the drop-in sessions and other meetings

A significant number of people also used this question as an opportunity to question the need for change, which is consistent with the point below (but should also be read in context with the clear and strong demand for improved access to GP services)

Need for Change: Approximately 45% of respondents expressed the view that there was no need to change the current urgent care system (against 30% who felt there was a need for change and 25% who were unsure). In terms of support for our proposals, just over 49% agreed or strongly agreed with them, while just under 51% disagreed or strongly disagreed.

Proposal to relocate services from Holly Hall: Of those who questioned the need for change, a significant number of responses praised the quality of services provided at Holly Hall and questioned whether 'closing' the Walk-In Centre would improve healthcare locally. A number of respondents stated that any replacement service should be at least as good as that which is currently provided.

Respondents also highlighted the convenience and accessibility of Holly Hall.

Problems with primary care access was another key factor for those who opposed change. Comments included ‘service is important when it is impossible to get access to own GP’ and ‘waiting times to see a GP will get worse.’ Many people expressed concerns about GPs’ ability to manage an increased caseload resulting from the changes.

Proposals for an Urgent Care Centre: Throughout the consultation period we were challenged very robustly to explain how the ‘Urgent Care Centre’ mentioned in the consultation document would work in practice. Frequently asked questions included location, opening hours, range of services on offer, staffing numbers and skill mix and whether or not staff at the new centre would have access to patient’s medical records.

Proposal to co-locate Urgent Care Centre with Emergency Department at Russell’s Hall: A key issue here was concerns about increased pressure on parking at Russell’s Hall and the cost of parking for patients and visitors. A number of people pointed out that parking at Holly Hall is free.

A further concern was the risk of increasing pressure on services at Russell’s Hall, particularly A&E, by directing more patients to the site.

Improved Access to GPs: Access to primary care was one of the most frequently raised issues in consultation responses and at meetings. The consultation form posed a specific question (Question 5) inviting people to select, from a list, three services which they felt would most improve healthcare services in Dudley and the top four most popular choices all related to GP services, as follows:

- Local GPs to open at weekends (68% of all respondents)
- Local GPs to offer walk-in appointments (58% of all respondents)
- Local GPs to open earlier/later (55% of all respondents)
- More urgent appointments at GP services (34% of all respondents)

Questions were raised at a number of meetings as to whether the CCG actually had the power to influence GP opening times, as the contracts are held by NHS England following the restructuring of the NHS in 2013.

Other issues:
A number of respondents queried how our proposals would impact on patients who are not registered with GPs.

A point made in many forums was the need for local people to have somewhere to turn for advice or reassurance at any time of the day or night, either over the phone or face to face. This issue was a general concern but expressed particularly strongly by those caring for young children. Many

respondents were aware of the 111 service but there were mixed views about the effectiveness of the service in its current form, with some users expressing genuine satisfaction but others voicing reservations about the quality of the advice provided.

Another concern that was raised regularly was the lack of specific provision in the urgent care system for patients with mental health issues.

Following discussions with a number of public and patient groups, the CCG was also urged to do more to raise awareness of what has already been achieved locally in terms of improving access to primary care.

CONCLUSION

This consultation took a considerable amount of time and effort to plan and deliver. The timing of the consultation, and the way the possible service scenarios developed during the consultation period added to the challenge. Members of the CCG's Communications and Engagement team, senior managers and clinical colleagues have all made a valuable and much appreciated contribution and found themselves in the midst of some robust exchanges of views.

We would also like to express our thanks to everyone who took the time and trouble to complete a consultation form, come to an event or share their views with us. (We have sent out this week invitations to all contributors whose details we have, asking them to come to our feedback event next month.)

RECOMMENDATION

Board members are asked to note the consultation activities set out above by way of assurance that the CCG has fulfilled its statutory obligations to properly consult on proposed changes to the urgent care system

Members are also asked to note the feedback received and take it into account when agreeing next steps in developing an improved urgent care system for the people of Dudley

APPENDICES

Appendix 1 – Healthwatch Dudley report
Appendix 2 – Summary of responses from partner organisations and other correspondence including contact from MPs

Richard Haynes
Interim Head of Communications and Engagement
8 January 2014

Dudley Clinical Commissioning Group Urgent Care Consultations

Questionnaire Survey
Dudley Borough Walk-in Centre
Russells Hall Hospital Accident and Emergency

First Report

Healthwatch Dudley

January 2014

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Acknowledgements
Healthwatch Dudley would like to thank everyone who helped with the questionnaire survey at Dudley Borough Walk-in Centre and Russells Hall Hospital Accident and Emergency including staff, patients and volunteer helpers.

Summary

Healthwatch Dudley undertook a questionnaire survey at the Dudley Borough Walk-in Centre and Russells Hall Hospital Accident and Emergency on behalf of the Dudley Clinical Commissioning Group (DCCG) as part of its review of Urgent Care services. In total 943 patients (or their representatives) participated in the questionnaire survey that included 395 male and 417 female patients where there sex was known. In turn, the ethnicity of 829 patients was recorded with the majority, 677 patients, being British. Information was obtained that showed 839 patients indicated that they were registered with a doctors surgery and 546 patients indicated that they travelled straight to the Walk-in Centre or Accident and Emergency without getting any medical advice. Patterns in the numbers of patients coming to the Dudley Borough Walk-in Centre and the Russells Hall Hospital Accident and Emergency from different surgeries are shown for 630 patients. When patients were asked about whether they had tried to contact a doctors surgery before coming to the Walk-in Centre or Accident and Emergency 847 patients gave details and 487 of them said they had not tried to contact a doctors surgery. When patients who had obtained medical advice (320 in number) were asked how they were referred on to the Walk-in Centre or Accident and Emergency 98 said they had been referred by a doctors surgery.

Patients were concerned about the proposal to close the Walk-in Centre which is popular and fills a gap in primary care service provision (especially for patients unable to get an appointment at a doctors surgery). Any new facility to replace the Walk-in Centre would need to consider patient issues relating to its location and accessibility, the types of services provided, and car parking issues. It is a mixed picture regarding patient perceptions of whether a doctors surgery could have helped them if they had been able to get an appointment and in terms of patients past experience of getting into a doctors surgery. Nevertheless, 449 patients said they would be happy to be referred back to a doctors surgery for treatment after assessment at the Walk-in Centre or Accident and Emergency. Meanwhile, there is a demand from particular patients groups for seven day opening of doctors' surgeries, longer opening hours, shorter waiting times for appointments, and more same day appointments. Questions arise about how to get patients who are using the Walk-in Centre and where it is appropriate Accident and Emergency to use doctors surgeries and avoid simply shifting patients around without dealing with underlying problems around access to doctors' surgeries.

Introduction

Healthwatch Dudley undertook a questionnaire survey at Russells Hall Hospital Accident and Emergency and the Dudley Borough Walk-in Centre over a period of seven days between Friday 29 November and Thursday 5 December 2013. It was undertaken on behalf of the Dudley Clinical Commissioning Group (DCCG) as part of their review of Urgent Care services and consultations taking place between 17 October and 24 December 2013 on proposals to improve the design of primary and community urgent care services, out-of-hours services and close the Walk-in Centre

and provide a different service based at the Russells Hall Hospital site. Walk-in Centre opening times are from 8.00am to 8.00pm on Tuesday, Wednesday and Thursday and from 8.00am to 10.00pm on Friday, Saturday, Sunday and Monday. Questionnaire survey sessions were from 8.00am to 8.00pm (with an extension to 10.00pm at Accident and Emergency on Tuesday, Wednesday, and Thursday to assess any impact of changed Walk-in Centre opening times on demand for Accident and Emergency services). There were four Healthwatch Dudley members of staff and fifteen volunteer helpers who had attended an induction event to learn more about the project involved in undertaking the questionnaire survey work. At each questionnaire survey location there was a Healthwatch Dudley member of staff and either one or two volunteers covering four hour questionnaire survey interview sessions. Their role was to approach patients in each of the facilities and ask them for their help to answer some questions (designed to take up no more than five minutes of their time) on why they were using the Walk-in Centre or Accident and Emergency.

In the main computer tablets and Survey Monkey online questionnaire survey software were used to collect patient responses to questions (and sometimes the responses of a representative to questions on a patient's behalf in instances where, for example, they were an infant or young child). Some paper questionnaire surveys were completed at times when WiFi internet access to the online questionnaire survey was problematic or an interviewer was not comfortable using a computer tablet. No patient medical details were collected and confidentiality was ensured to the extent that only aggregated patient information would be used in any report and patient anonymity would be maintained. All questions were optional to answer (except for the question to get a patient's consent to continue with the questionnaire survey). There were closed questions (requiring a yes or no response) that sometimes directed the interviewer to another relevant part of the questionnaire survey, questions requiring one or more boxes to be ticked from a list, and questions requiring a response on a scale of 1 to 6 where 1 is strongly disagree and 6 is strongly agree with a particular statement. In addition, there were some questions on patient gender, age, ethnicity, home address post code, and work arrangements. Patients also had the opportunity to make any other comments. Finally, non-response rates were recorded where a patient declined to continue with the questionnaire survey or an interviewer decided that it was not appropriate to continue with a questionnaire survey. The aim was to produce a summary report for the DCCG board meeting scheduled to be held on the 9 January 2014.

Descriptive Information

At the Walk-in Centre and Accident and Emergency a total of 1,074 patients (or their representatives) were approached and asked for their help to answer some questions on why they were using the facility. After this initial contact 943 patients (or their representatives) agreed to take part in the questionnaire survey. In terms of non-response there were 131 patients (or their representatives) that declined to participate in the questionnaire survey. A breakdown of the participants at each

location shows that at Accident and Emergency there were 459 participants and at the Walk-in Centre there were 440 participants (with 44 participants where there was no interview location recorded).

At the two study locations there were a total of 395 male and 417 female patients, one transgender patient, and 130 patients where their sex was not recorded. The question on age was answered by 819 patients with 280 being aged 15 or under, 113 aged 65 or over (see Figure 1 to 4 below)

Figure 1: Participants at the Walk-in Centre

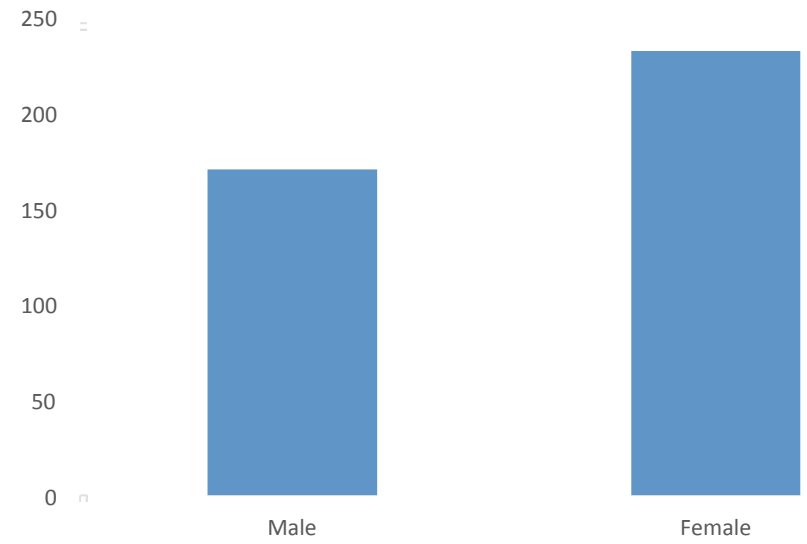


Figure 2: Age

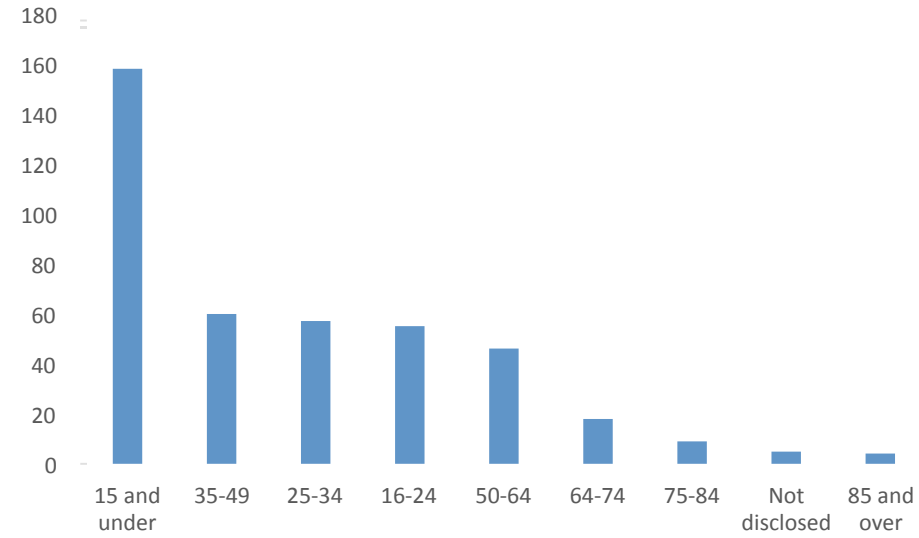


Figure 3: Participants at Accident and Emergency

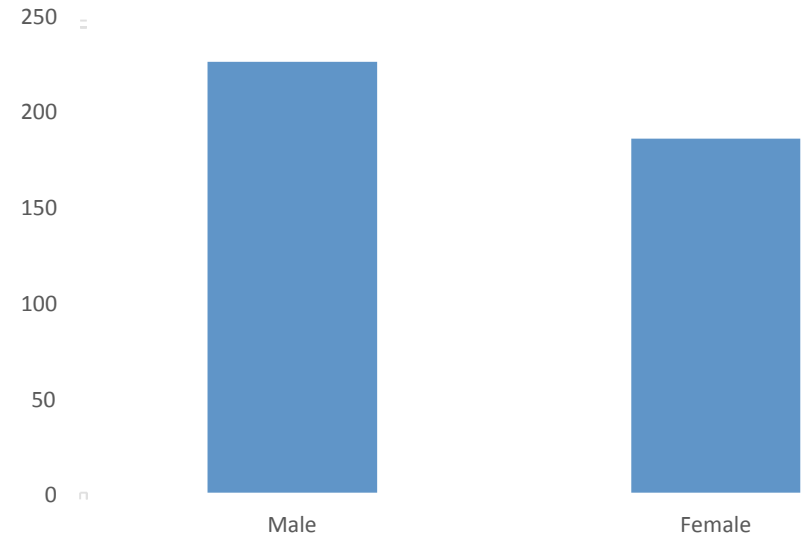
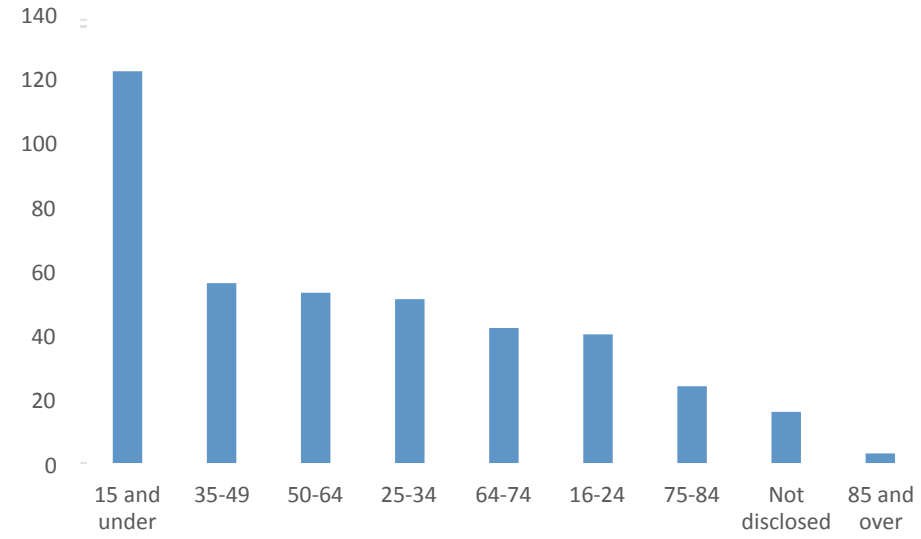


Figure 4: Age



In turn, 829 patients ethnicity was recorded with 677 being British and smaller numbers from White and Black Caribbean, Indian, and Pakistani ethnic groups. Information on the working patterns (or not) of 809 patients was recorded. For 480 patients the question was not applicable because they were an infant or young person, not in employment, or retired. For the other patients the majority, 250 of them, said they worked days. There was information on 883 patients on how they travelled to the Walk-in Centre or Accident and Emergency. Of these patients 622 travelled in their own or a family car, 110 got a lift from someone, 47 came by bus, 34 came by taxi, 35 came by ambulance, and 29 came on foot.

Information on seeking medical advice before attending the Walk-in Centre or Accident and Emergency was collected for 859 patients. The figures show that 546 patients travelled straight to the Walk-in Centre or Accident and Emergency without

first seeking medical advice and 310 patients travelled to the Walk-in Centre or Accident and Emergency after first seeking medical advice.

Doctors Surgery Access Issues

Information was obtained on 868 patients regarding registration with a doctors surgery. It shows that 839 patients were registered with a doctors surgery. On arrival times, information was collected on 881 patients across the Walk-in Centre and Accident and Emergency study locations. Sample graphs show that a number of patients are using the facilities even when doctors surgeries are open (see figures 5 to 8 below).

Figure 5: Arrivals at the Walk-in Centre (Friday 29 November)

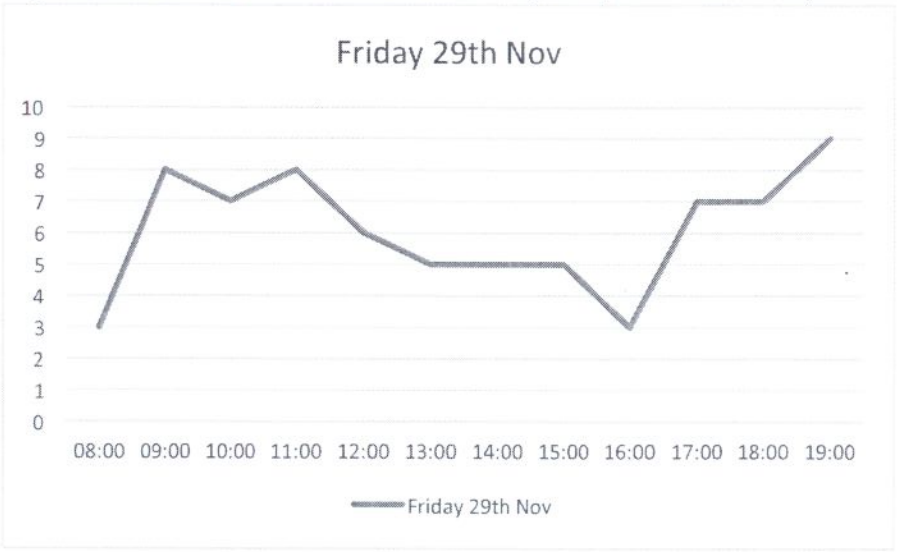


Figure 6: Arrivals at the Walk-in centre (Saturday 30 November)

Figure 7: Arrivals at Accident and Emergency (Friday 29 November)

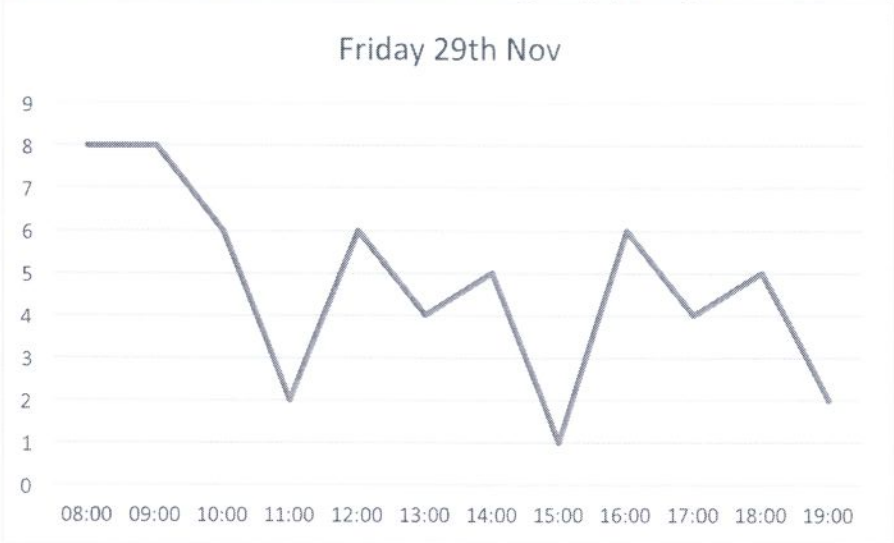


Figure 8: Arrivals at Accident and Emergency (Saturday 30 November)

Patient and surgery information

Patterns in the numbers of patients coming to the Walk-in Centre and Accident and Emergency from different surgeries was collected on 630 people about whom the name of the doctors surgery that they used was known (see Figures 9 and 10 below).

Figure 9: Patient doctors surgery (Walk-in Centre)

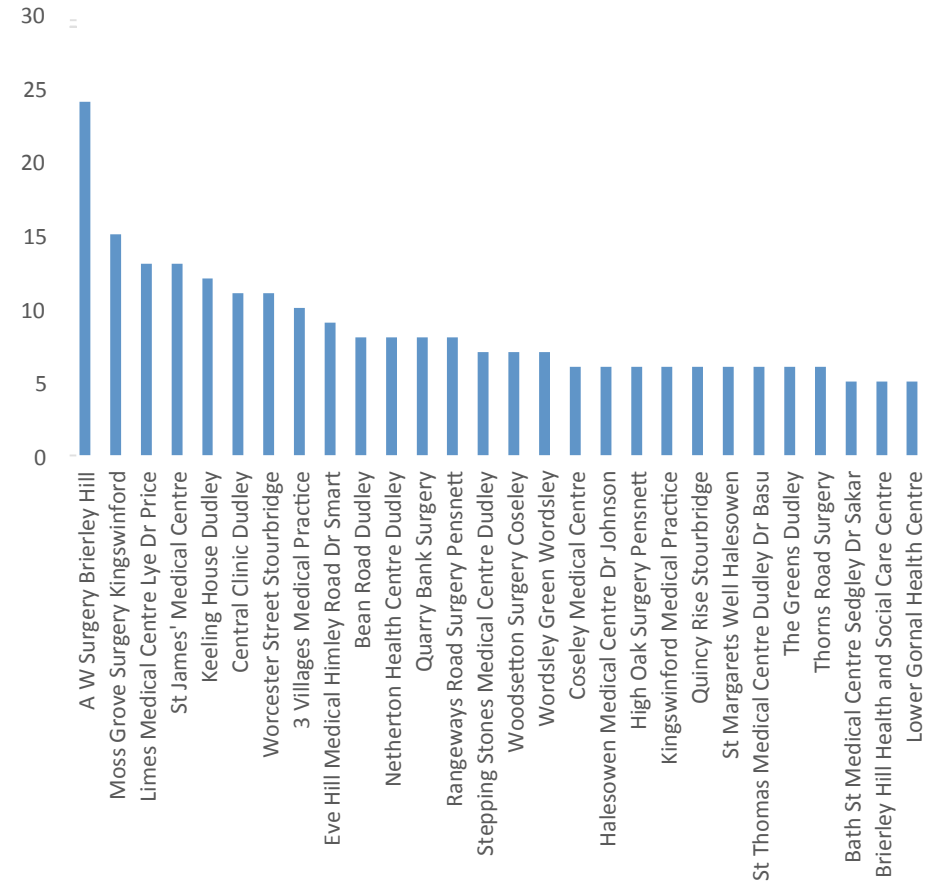
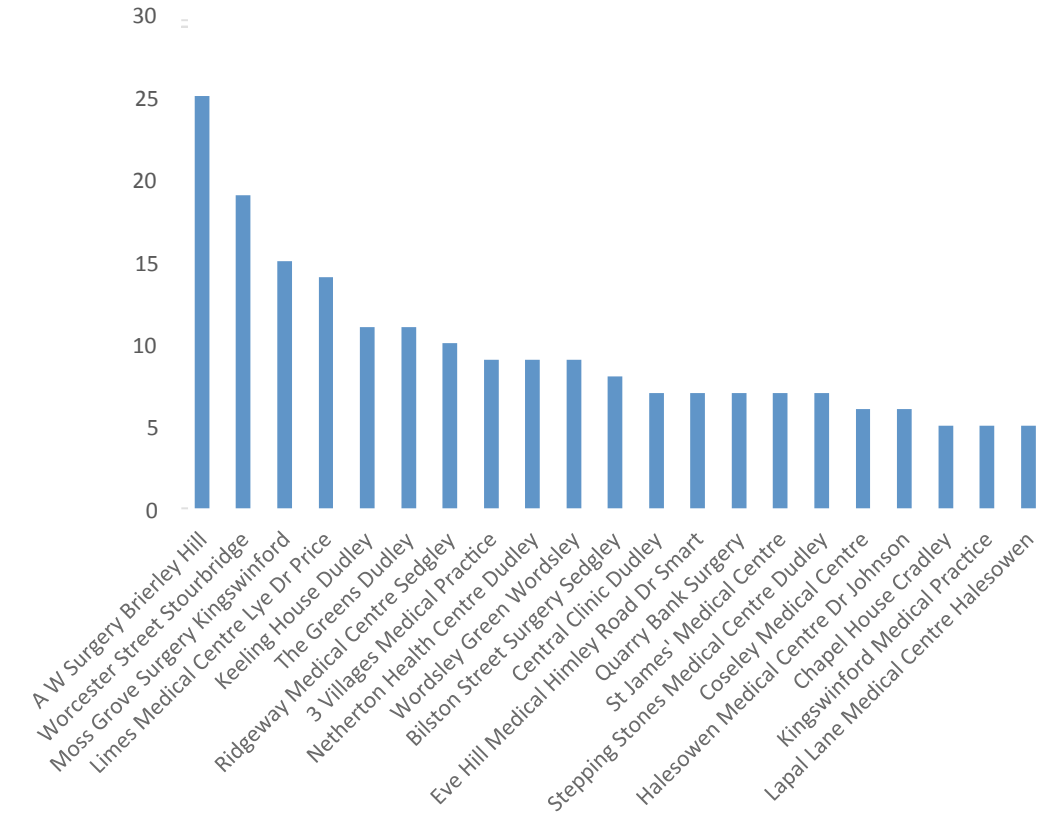


Figure 10: Patient doctors surgery (Accident and Emergency)



In turn, it was possible to collect information on 740 patients about their home address postcode (see Figure 11 below).

Figure 11: Patient home address postcode (Walk-in Centre)

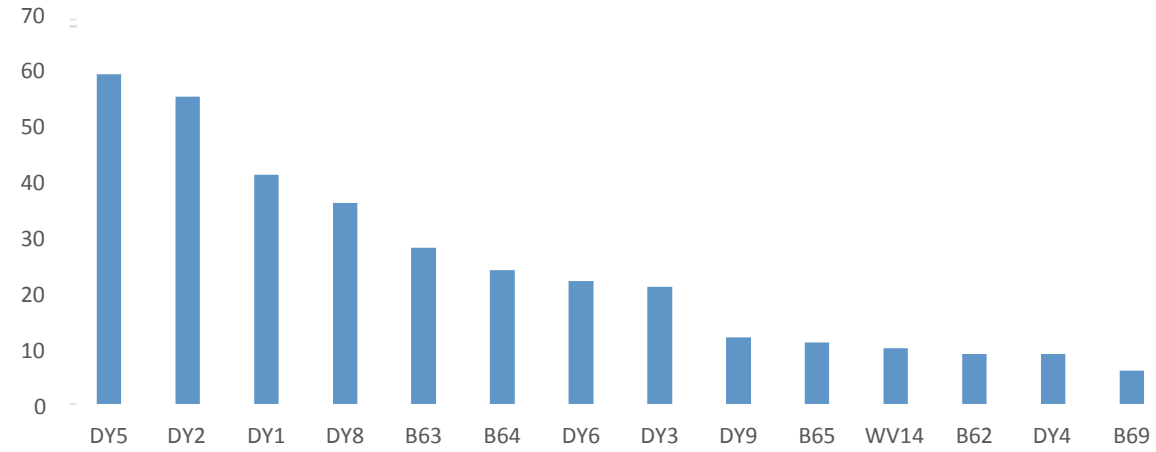
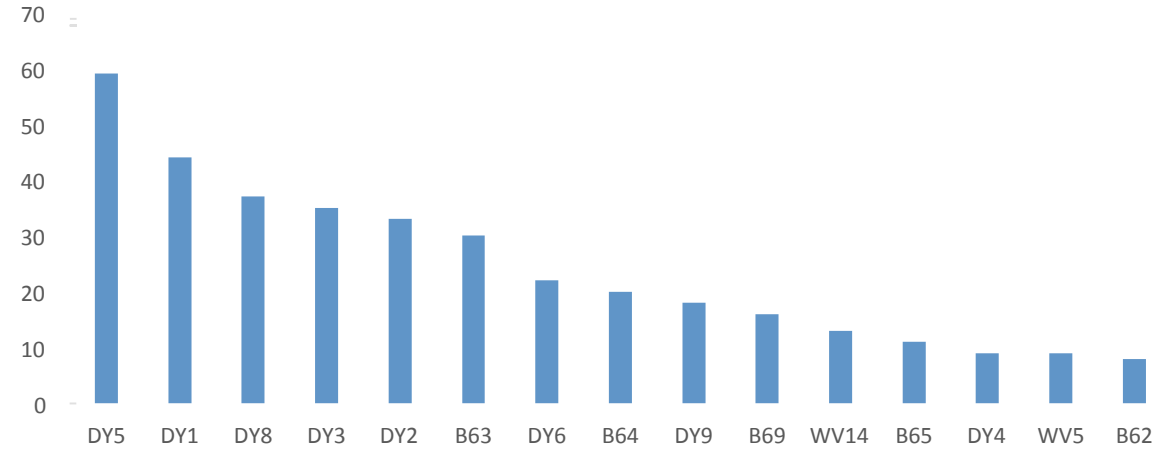


Figure 12: Patient home address postcode (Accident and Emergency)



Getting medical advice

When patients who had obtained medical advice (320 in number) were asked how they were referred on to the Walk-in Centre or Accident and Emergency 98 said they had been referred by a doctors surgery. A total of 117 patients were referred on by a pharmacy, a work, leisure facility or school based first aider, community nurse or health visitor. There were 56 patients who had been referred on by the NHS 111 telephone advice line, and 19 patients who were taken to a facility by the ambulance service (see figures 13 and 14 below).

Figure 13: Patient referrals (Walk-in Centre)

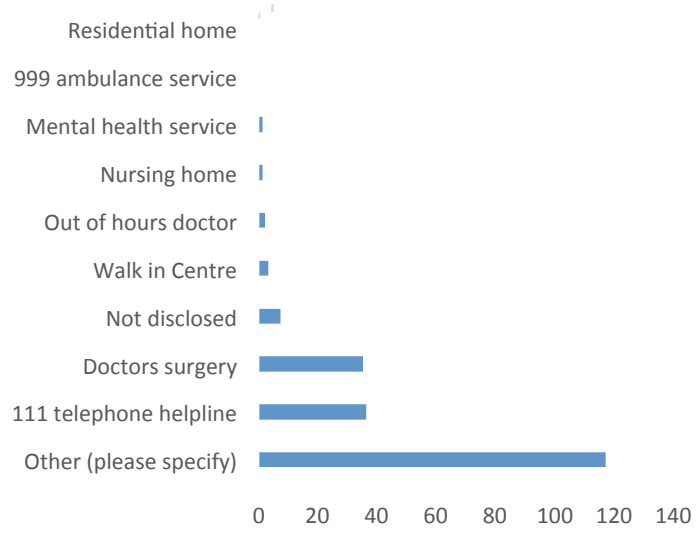
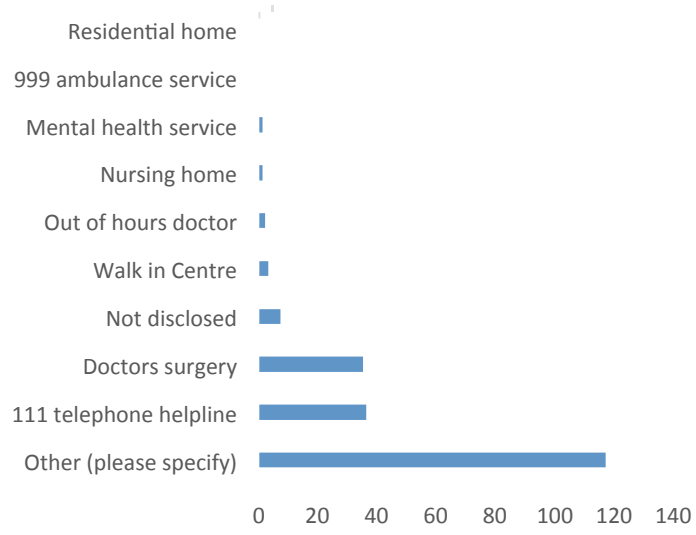


Figure 14: Patient referrals (Accident and Emergency)



When patients were asked about whether they had tried to contact a doctors surgery before coming to the Walk-in Centre or Accident and Emergency there were details provided for 847 patients. The information collected shows that for 487 patients no attempt had been made to contact a doctors surgery and for 356 patients there had been an attempt to contact a doctor's surgery (see Figures 15 and 16 below).

Figure 15: Contact with a doctors surgery (Walk-in Centre)

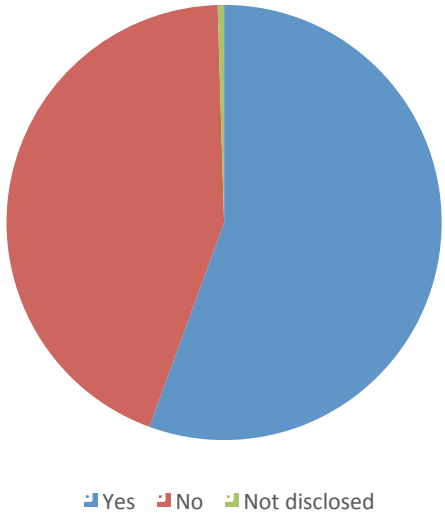
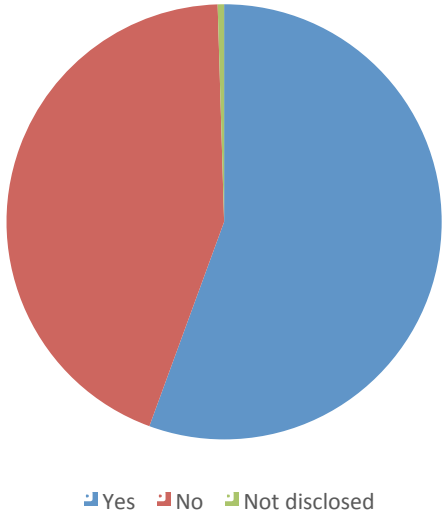


Figure 16: Contact with a doctors surgery (Accident and Emergency)



A question on the outcome for patients following an attempt to contact a doctors surgery show that for the 362 patients that details were collected there were 222 patients that were not able to get a suitable appointment. Other issues include the doctors surgery being closed (36 patients), and not being able to get through on the telephone (16 patients). There were 10 patients who had been to a doctor's surgery but wanted another opinion, 6 patients who had had an appointment but wanted to be seen sooner, and 3 patients who were not able to get the help they wanted from a surgery reception (see Figures 17 and 18 below).

Figure 17: Doctors surgery contact outcomes (Walk-in Centre)

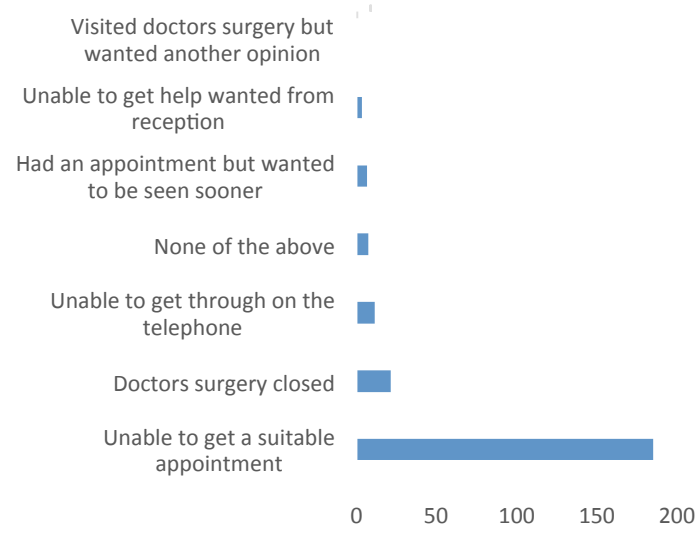
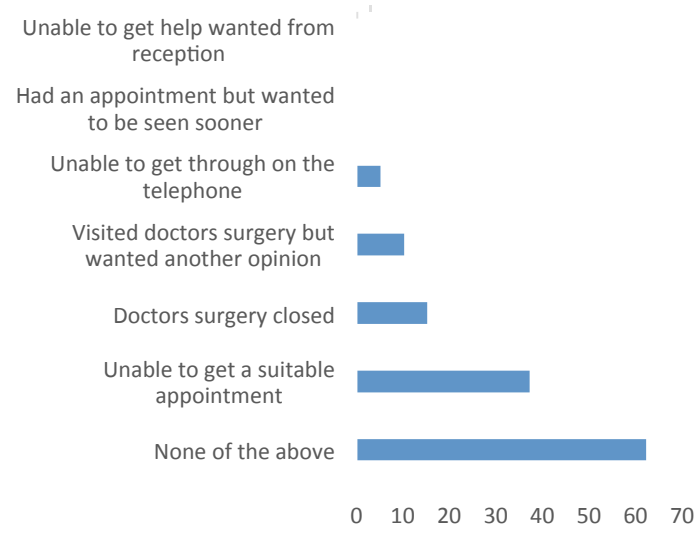


Figure 18: Doctors surgery contact outcomes (Accident and Emergency)



Views and experiences

[There were] thirty-nine people in the telephone queue … difficult to get an appointment … used Walk-in Centre. Appointments hard to get… Called twice for an emergency appointment but couldn't get in, baby has a chest infection … if the Walk-in Centre closes where will people go? Came to the Walk-in Centre with the same problem two weeks ago, can only get an appointment with GP three days in advance, prefer to be seen at Walk-in Centre … Can never get an appointment, only one doctor and only works three days each week … Can't plan illness, no appointments for same day at GP … Child ill … it took one and a half hours to get through on the phone to GP, Walk-in Centre provides excellent service. Couldn't get an appointment for another week, can't get appointments for children either so usually go straight to Walk-in Centre … Lots of people will be lost without Walk-in

Centre … Walk-in Centre is convenient … Walk-in Centre is fantastic my kids and grand kids use it regularly … Walk-in Centre is very valuable we have used it, don't know what people will do without them.

Why patients are using services

Where no attempt to contact a doctors surgery had occurred prior to attending the Walk-in Centre or Accident and Emergency information collected on 412 patients giving one or more reasons shows that for many it was because it was known that the surgery was closed or there was a feeling that it was a medical emergency situation (see Figures 19 and 20 below).

Figure 19: No prior contact with a doctors surgery (Walk in Centre)

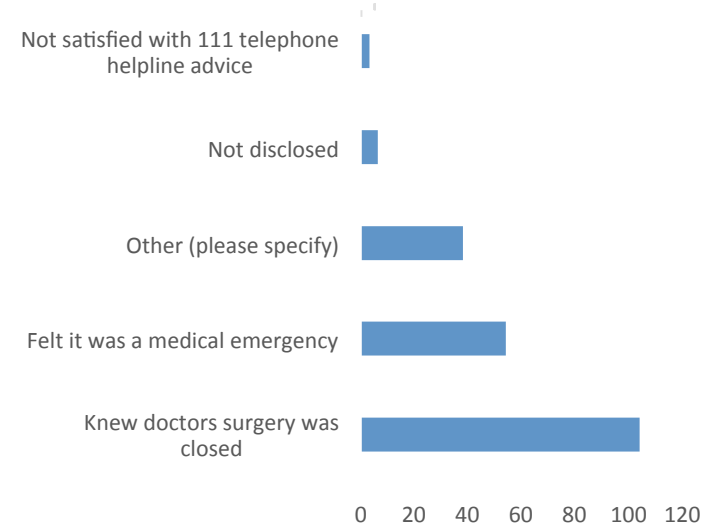
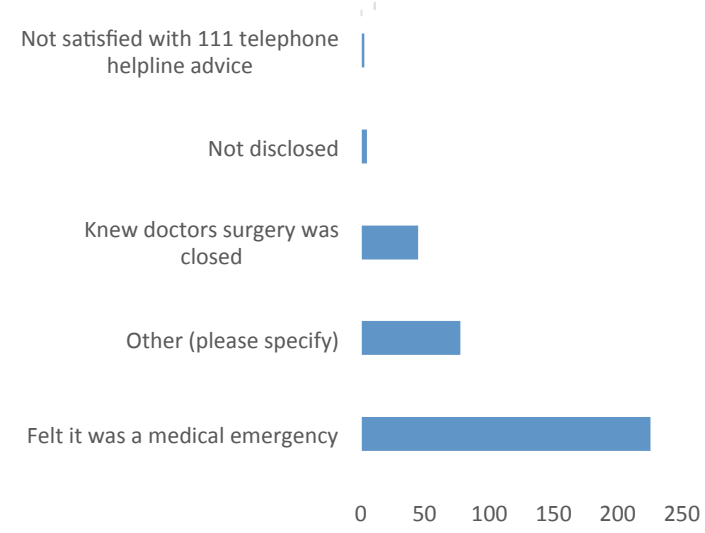


Figure 20: No prior contact with a doctors surgery (Accident and Emergency)



Dudley Borough Walk-in Centre and Patient Concerns

There is a demand for Walk-in Centre services (and opening hours have recently been extended). There is some evidence of people going to Accident and Emergency when the Walk-in Centre reaches capacity and it seems there is some extra burden placed on Accident and Emergency due to the way that some patients are not able to effectively access doctors surgery services.

- Patients are worried by the proposal to close the Walk in Centre
- The Walk in Centre is popular and the number of patients using it each year continues to grow
- A gap in doctors surgery service provision is being filled by the Walk in Centre (when people cannot get into doctors surgeries)
- Any new facility to replace the Walk-in Centre would need to consider location, accessibility, service provision and parking issues.

What patients want

Of 822 patients for whom information about the helpfulness of a doctors surgery was obtained (on a scale of 1 to 6 where 1 is strongly disagree and 6 is strongly disagree) 411 patients were at level 5 or 6 towards the strongly disagree end of the scale and 322 patients were at level 1 and 2 towards the strongly agree end of the scale. A breakdown of the data for the two study locations is provided in Figures 21 and 22 below.

Figure 21: Could a doctors surgery have helped (Walk-in Centre)

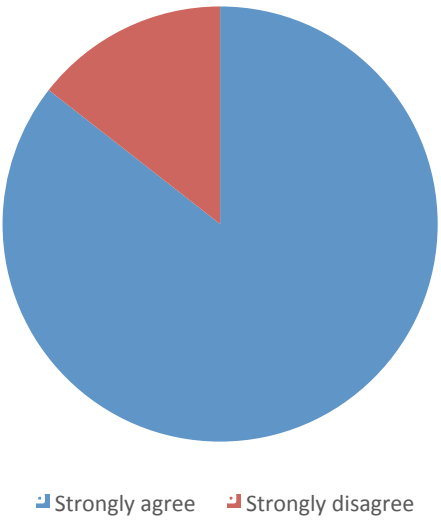
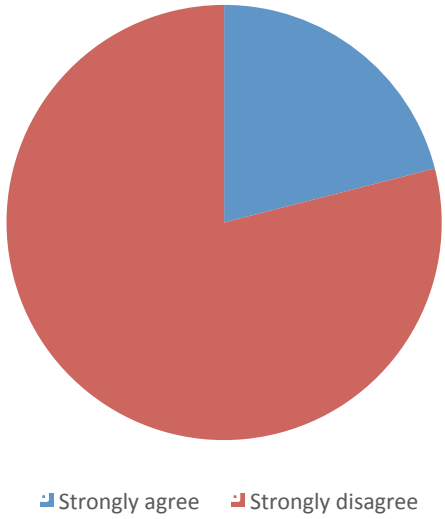


Figure 22: Could a doctors surgery have helped (Accident and Emergency)



On a question about past experience of getting into a doctors surgery the information collected on 819 patients shows that there were 309 patients at level 5 and 6 strongly agree that past experience of getting into a doctors surgery had been satisfactory and 301 patients on level 1 and 2 strongly disagree that past experience of getting into a doctors surgery had been satisfactory. A breakdown of the information on past experience of getting into a doctors surgery for the two study locations is provided in Figures 23 and 24 below.

Figure 23: Satisfaction getting into a doctors surgery (Walk-in Centre)

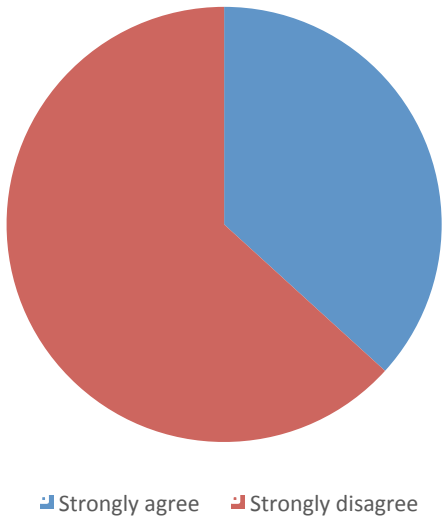
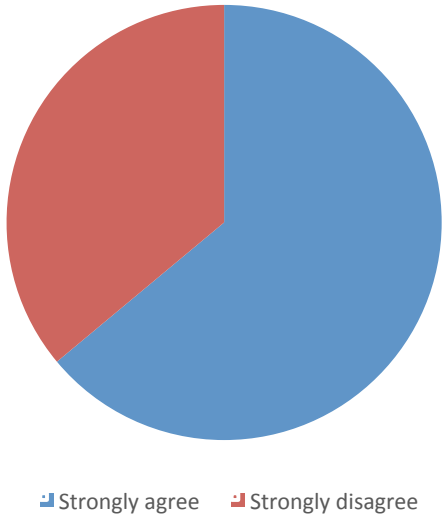


Figure 24: Satisfaction getting into a doctors surgery (Accident and Emergency)



On happiness to go back to a doctors surgery for treatment after assessment at the Walk in Centre or Accident and Emergency there were response for 809 patients. Of these response 449 patients were at levels 5 and 6 strongly agree and 190 were at levels 1 and 2 strongly disagree.

Questions for Dudley Clinical Commissioning Group

There are patient access to doctors surgery issues that are widespread and even impact on patients who can get appointments but are not necessarily happy about the length of time it takes to get to see a doctor. Being unable to get a suitable appointment at the doctors' surgery is a significant issue for many patients. In addition, there are particular issues in getting access to a doctors surgery affecting infants and young people.

- How would any replacement facility for the Walk-in Centre be combined with plans to reduce the difficulties that some groups of patients experience getting access to a doctors surgery?
- How would any replacement facility for the Walk-in Centre avoid simply shifting patients around without dealing with underlying problems around access to doctors' surgeries?
- Would any replacement facility for the Walk-in Centre put more pressure on Accident and Emergency if access to doctors' surgeries did not change?
- Would it be better to retain the Walk-in Centre service and try to make changes in dealing with the patient access doctors' surgeries issues?

Conclusions

The questionnaire survey provides valuable initial insights on the views and concerns of patients using the Dudley Borough Walk-in Centre and Russells Hall

Hospital Accident and Emergency. It shows that there is a gap in doctors surgery provision that is being filled by the Walk-in Centre. Information on a representative group of 943 patients was collected and many were keen to talk about their experiences of getting access to a doctors surgery and the future of the Walk-in Centre. A number of patients were fearful about what people would do if the Walk-in Centre was closed and there was much elaboration on peoples difficulties getting access to a doctors surgery and in particular suitable appointments without having to wait days or in a few instances weeks. Patients also had concerns about getting access to primary care services when doctors surgeries were not open in the evenings and at weekends. And some patients said they were unable to easily get time off of work for available doctors surgery appointments, they had infants and young children and found it difficult to get access to a doctors surgery when they needed to, or they were older people that sometimes needed to access a doctors surgery at short notice and this was not always possible. Consideration will need to be given to the question of doctors surgeries opening at weekends and for longer in the evenings as well as making it easier for patients to get access to doctors surgery services, waiting less time to see a doctor and able to more easily get a same day appointment. Any plan for a new medical facility at the Russells Hall Hospital site intended to replace the Walk-in Centre would need to include a clear strategy to deal with these patient access to doctors surgery services to prevent just simply shifting patients around and not getting more back into using doctors surgeries as their first port of call when they need medical help.

INTRODUCTION

This appendix summarises responses received to our Urgent Care Consultation from key partner organisations and other examples of correspondence received. The amount of feedback received was considerable and although we are not able to list every respondent by name we are grateful to them all for their contributions, which will continue to inform the development of urgent care services.

Dudley Group NHS Foundation Trust

Fully supportive of improvements to health and social care that ensure that the residents of Dudley are cared for in the right place, at the right time, by the right provider.

Extremely supportive of an increase in capacity in GP availability for patients who currently attend the Walk in Centre (WIC) or our Emergency Department (ED) as these are provided more locally and the GP is often the best informed and most aware of current care issues. Would expect that this may lead to a reduction in demand.

Supportive of better 24 hours a day and 7 days a week support for patients in need of urgent health care through an easier to navigate urgent care centre.

Would like CCG to ensure that ALL patients are able to consistently access care in their area of Dudley. A collaborative approach to a co-located, Urgent Care Hub/model will ensure streaming of patients through to the right service. The streaming process at first point of contact will serve to educate patients and professionals in how appropriate access to services in the borough can be made. Easier choice will help to manage demand.

For the urgent care centre to operate effectively it will need collaborative working across ambulance services. health and social care, 7 day access to GP services.

Dudley Group is committed to solving urgent care issues by providing a communication hub with access to all health and social care, reduce non-elective admissions by 15%, allowing ED to focus on those needing urgent care, working collaboratively, providing better community based acute services.

Challenges -providing a hub from the Russells Hall Hospital site for ease of access for Dudley residents requires considerable capital investment and a long term commitment to such a model would be a pre-requisite.

Dudley Health and Wellbeing Board

Councillor Stuart Turner, Chair of the Dudley Health and Wellbeing Board, has indicated that he is unable to offer his support for our proposals because of two concerns.

The first relates to a need for further clarity on the location and opening hours of evening and weekend primary care services. The second is a concern about a lack of detailed information regarding patient flows and increased primary care access.

West Midlands Ambulance Service

WIC provision - the urgent care centre located alongside the emergency department will make it quicker and easier for clinicians as there have been historic issues in regards to whether the WIC accepts certain types of patients transported there. Will allow for appropriate triage but needs a single triage system so no duplication of handover or two queues for ambulance staff. Co-location of services will reduce confusion for patients.

GP out of hours service - imperative our WMAS clinical staff have direct line access to a GP on the telephone to enable quicker agreement of treatment plan for patients to enable quicker release of ambulance resources and ambulance availability for further patients.

Overall Primary and Community Urgent Care - the redesign of services needs to provide services that compliment and support patients 24/7. For example, if it is deemed after triage not appropriate for ED or the urgent care centre but still requires another service, then there needs to be a safety net service that can capture this group of patients in the out of hours period such as rapid response team. The service could be expanded to include other groups of patients in addition to the elderly. This will help to ensure patients are treated in the right place, at the right time.

There is a need to community based services to ensure that they are simplified as to who delivers what, when and how, then make this available in the directory of services or through the urgent care centre.
IT connectivity - it is vital there is an IT strategy that will allow all the IT systems to link up between the different Trust's/healthcare providers in the borough to assist in a seamless approach to patient care.

Correspondence from MPs

During the consultation period we received correspondence from Ian Austin MP and Chris Kelly MP, both raising issues relating to their respective petitions which are mentioned in the report. Margot James MP also wrote to raise concerns about accessibility of the Russell's Hall site (an issue which was raised by other respondents and is reflected in the main themes of the feedback).

Dudley Local Pharmaceutical Committee

The LPC was broadly supportive of our proposals but keen to stress the valuable role that community pharmacists can play in easing pressure on the urgent care system by, for example: Supporting patients with long term conditions; Urgent repeat prescription dispensing and wider provision of influenza vaccination.

The LPC also commented on the 111 service, specifically with regard to a need to improve signposting to community pharmacy.

Dudley Black Country Neurological Alliance (BCNA)

The BCNA undertook consultations with healthcare professionals, service users and carers through one to one interviews, emails and a workshop co facilitated by Dudley CCG. Their feedback highlights a range of issues affecting patients with neurological conditions.

DUDLEY CLINICAL COMMISSIONING GROUP BOARD

Date of Report: 9th January 2013
Report: Proposal for the reconfiguration of Urgent Care
Agenda item No: 8.2

TITLE OF REPORT:	Proposal for the reconfiguration of Urgent Care
PURPOSE OF REPORT:	The purpose of this report is to define the context and future options now available to Dudley CCG Board in regards to urgent care in Dudley. This paper builds on the comprehensive consultation process undertaken by the CCG, evaluates possible future service models and recommends the most robust and cost effective way forward.
AUTHOR OF REPORT:	Jason Evans – Commissioning Manager for Urgent Care
MANAGEMENT LEAD:	Paul Maubach – Chief Accountable Officer
CLINICAL LEAD:	Dr Steve Mann – Clinical Lead for Urgent Care
KEY POINTS:	• The current contracts for the Walk-in-Centre and Out-of-Hours contacts come to an end in September 2014. • The commissioning of new contracts provides an opportunity for Dudley CCG to adopt national guidance, fall in line with the CCG Primary Care Strategy and respond to the needs of local patients by re-designing these services into a simpler and more cost effective urgent care pathway. • The Board are asked to consider the 12 recommendations of this paper.
RECOMMENDATIONS:	**Recommendation 1:** that Board note the reconfiguration of Dudley urgent care system is in line with nation guidance and best practice; furthermore it falls in line with Dudley CCG Primary Care Strategy and they Dudley Health and Wellbeing Board June recommendations on urgent care. **Recommendation 2:** that the Board approve the rationale and evidence base to redesign the urgent care pathway for Dudley and as a minimum move to adopting scenario 3; thereby developing an integrated UCC on the Russells Hall NHS Trust site, adjacent to ED **Recommendation 3:** Our proposal in response to the issues raised by the public about the walk-in services is therefore two-fold: • Firstly, the ability to walk-in and obtain an assessment; especially at evenings and weekends; should be maintained. • Secondly, the out-of-hours service should be integrated into the walk-in service as part of the urgent care centre to create a new 24/7 service – thus extending the availability beyond the current arrangements. **Recommendation 4:** Our original proposal, in response to the issues raised in the consultation, should be modified to include bookable appointments at the urgent care centre and so reduce the impact to the public on the costs of parking at Russell's Hall. **Recommendation 5**: The CCG Board will therefore need to obtain assurance at a future meeting, as part of the procurement process, that the specification enhances the quality of the service to take account of the issues raised about Paediatrics, Mental Health and unregistered patients.

	Recommendation 6: The CCG Board should note that our IT strategy will enable further improvements to the connectivity and access to medical records in the future. **Recommendation 7:** The Board should report our conclusions to the Health and Wellbeing Board and seek endorsement for our planned way forward. **Recommendation 8:** Our Board is asked to: • confirm that it should be part of our strategic plan to develop joint commissioning arrangements [for GP services] with NHS England. • encourage Dudley Health & Wellbeing Board to invite NHS England, as a partner on the Board with the contractual responsibility for GP Access, to demonstrate how they intend to improve this in Dudley. • ask Dudley Health & Wellbeing Board to support joint commissioning between the CCG and NHS England as a key opportunity for addressing this issue. **Recommendation 9:** Our Board is asked to note: • that the current development support arrangements that we have put in place for GPs, have made, and continue to make, an important contribution to improving access to GPs but will be insufficient longer-term both; without additional resources and without working with the public to change patterns of behaviour and expectation. • that the risk of GP access deteriorating would place unmanageable pressures on walk-in services **Recommendation 10:** Our Board is asked to approve that we should encourage the development of PPGs with all practices and ensure future plans on improving access require their input **Recommendation 11:** Our Board is asked to confirm that the newly commissioned urgent care centre is initially designed to accommodate the planning assumptions in scenario 3; but should incorporate the flexibility to move to scenario 5 **Recommendation 12**: approve that we commence the development of the service specification to produce a detailed proposal at the March Board meeting, at which point we will also have received the feedback from the Health and Wellbeing Board.
FINANCIAL IMPLICATIONS:	This premise of this proposal is that it will be financially neutral. However, there would be capital costs associated with the establishment of the UCC and the ability to provide funding to improve GP access will be dependent on two things: firstly that support is available from NHS England and secondly moving towards scenario 5.
WHAT ENGAGEMENT HAS TAKEN PLACE:	Extensive stakeholder, patient and public engagement has been undertaken – See Urgent Care Consultation Outcomes Report (Agenda item 8.1)
ACTION REQUIRED:	✓ Approval ✓ Decision Assurance

DUDLEY CLINICAL COMMISSIONING GROUP BOARD – 9th JANUARY 2014
PROPOSAL FOR THE RECONFIGURATION OF URGENT CARE IN THE BOROUGH OF DUDLEY

CONTENTS

1. INTRODUCTION

The purpose of this report is to define the context and future options now available to Dudley CCG Board in regards to urgent care in Dudley. This paper builds on the comprehensive consultation process undertaken by the CCG, evaluates possible future service models and recommends the most robust and cost effective way forward.

In line with the vision of the CCG Board, current national recommendations on urgent care and the findings of the recent consultation process, this paper will recommend the procurement of an Urgent Care Centre (UCC) located on the Russells Hall NHS Trust site, adjacent to the Emergency Department (ED). A service outline for the proposed UCC is also included in section 6 of this paper which provides an overview of the key elements of the proposed new service. Twelve recommendations are offered for The Board to consider at the end of the paper.

2. REPORT

The principles underpinning the redesign of the unscheduled and urgent care in Dudley is affirmed by many resent national publications and urgent care analysis. The NHS England publication 'High quality care for all now and for future generations: Transforming Urgent and Emergency Care Services in England (Revised November 2013)', asserts that "the diverse nature of urgent care services causes confusion amongst patients and healthcare professionals." It further states that "this confused picture can cause the lack of standardised clinical practice amongst differing services and a lack of clear information given to patients" and that "this variation can cause a delay in access to appropriate treatment, multiple contacts with different clinicians and ultimately a poor experience for the patient."

The Royal College of Physicians publication in June 2013 'Urgent and emergency care – a prescription for the future' also identified ten priorities for action by commissioners. Alongside recommendations for acute trusts the report stated there should be:

- Effective and simplified alternatives to hospital admission across seven days
- The promotion of greater collaboration within the hospital and beyond to manage emergency patients

- The commissioning and planning emergency care services that focus on ambulatory emergency care, setting out which admissions are avoidable, and what proportion should be more appropriately managed in the community.

Significantly these best practice approaches and principles are reaffirmed in the Keogh review 'Transforming Urgent Care Services in England (November 2013)'. In summary the review recommended from the extensive public, clinical and commissioner engagement undertaken that there was clear evidence base for:

> *The co-location of community-based urgent care services in coordinated Urgent Care Centres. These will be locally specified to meet local need, but should consistently use the "Urgent Care Centre" name, to replace the multitude of confusing terms that are available at present. Urgent Care Centres may provide access to walk-in minor illness and minor injury services, and will be part of the wider community primary care service including out-of–hours GP services. Considering all local facilities in this way will mean that networks will need to examine the extent of duplication or gaps in service offered by all of these facilities currently. Urgent Care Centres may also be advantaged by co-location with hospital services, particularly in urban areas.*

At a more local level the redesign of urgent care has been a core component of the CCG's Primary Care Strategy and also a focus of Dudley Health and Wellbeing Board. In June 2013 the first 'Spotlight Event' was held with the Health and Wellbeing Board on 'urgent and emergency care'. Outcomes from the event included agreement on a set of key principles relating to what a future urgent care system might include. The principles were as follows:

- A joined up, coordinated and seamless system, fluid- no 'bottle necks'
- A simple system-no confusion for the public (or professionals) of what to do, who to call or where to go
- Safe, responsive and high quality

One of the solutions the event delegates identified was to work to simplify the urgent care system, reduce duplication and develop a system which responded to patients' 'default behaviour.' Specific proposals from the event included "co-locate the walk in centre, with the emergency department."

Furthermore, prior to starting this public consultation, our GPs reviewed the current arrangements and concluded that a co-located and integrated urgent care centre would provide the clinically most appropriate and safest service for patients (both simplifying the service and as a result resolving the existing risk of patients self-presenting to the wrong service). Our GPs also concluded that this new arrangement should be developed in conjunction with improving weekday access to general practice in order to ensure as many patients as possible are able to appropriately attend their local practice as the service best able to meet their needs.

3. CURRENT SERVICE CONFIGERATION

As a result of overwhelming national and local support for change the CCG has sought to develop a vision forward. The recent CCG urgent care consultation confirms that for some patients there is a fragmented and confusing model of urgent care in Dudley. The current configuration of unscheduled care in Dudley is as follows:

Provider	Contracted service	Service provided	Location	Hours
Primecare	Walk in Centre	Primary Care	Holly Hall Clinic	08:00 to 20:00 Mon – Friday (08:00 to 10:00 seven days a week throughout Winter Pressures
Primecare	Out of Hours service	Primary Care	Holly Hall Clinic	18:30 to 08:00 and 24 hours on Saturday to Sunday and Bank Holidays
49 Dudley GPs	Primary Care	Primary Care	Locations across the whole borough	Core hours between 8am-6.30pm on weekdays, varies by practice
Dudley Group of Hospitals NHS FT	Accident and Emergency services	Primary Care and Major cases	Russells Hall Hospital	24 hours a day 365 days a year

4. SCENARIO DETAIL AND ESTIMATED ACTIVITY LEVELS

The following section offers detail and estimated activity levels for five possible scenarios. These have been developed in response to the consultation and in response to a steer from the chair of the Health and Wellbeing Board in order to help illustrate how the issues raised both before and during the consultation will or will not be resolved in different circumstances. These scenarios are as follows:

Scenario 1 - 'Do nothing' and simply re-commission the walk-in-centre and out-of-hours contracts in their existing form at their current sites.

Scenario 2 - re-commission the walk-in-centre and out-of-hours contracts in their existing form but specify in the contract that the service must be provided from the Russells Hall NHS Trust site adjacent to ED.

Scenario 3 - Commission a 24/7 UCC combining out-of-hours provision, provided from the Russells Hall NHS Trust site adjacent to ED.

Scenario 4 - Commission a 24/7 UCC combining out-of-hours provision, provided from the Russells Hall NHS Trust site adjacent to ED. Invest in GP in-hours access which would result in some patients (10%) changing their current behaviour to preference GP services – but don't redirect them to those services.

Scenario 5 - Commission a 24/7 UCC combining out-of-hours provision, provided from the Russells Hall NHS Trust site adjacent to ED. Invest in GP in-hours access and include arrangements to redirect all non-urgent cases from the UCC back to their own registered GP practice.

Scenario 5 reflects the vision that was proposed in the urgent care consultation as this incorporates:

- the development of an integrated Urgent Care Centre;
- the active triage of patients at the UCC both into the emergency department, into urgent primary care at the centre, or back to the patients' practice or other appropriate services;
- improving GP access to see more patients during the day on week-days

The follow tables summarises the current levels of activity and how these levels may change dependant on the five scenarios:

Scenario 1	In Hours / Weekday		OOH		
	Urgent	Non Urgent	Urgent	Non Urgent	Total
Walk in Centre	1,626	24,409	1,550	23,259	50,844
Out of Hours Service			1,005	19,635	20,640
A&E	11,447	28,682	18,427	38,981	97,537
Total	13,073	53,091	20,982	81,875	169,021
Assumes current service configeration remains (Do nothing and re-commission existing serivces)					

Scenario 2	In Hours / Weekday		OOH		
	Urgent	Non Urgent	Urgent	Non Urgent	Total
Walk in Centre	1,626	24,409	1,550	23,259	50,844
Out of Hours Service			1,005	19,635	20,640
A&E	11,447	28,682	18,427	38,981	97,537
Total	13,073	53,091	20,982	81,875	169,021
Assumes current Service configuration remains but is moved to Russells Hall NHS Trust site					

Scenario 3	In Hours / Weekday		OOH		
	Urgent	Non Urgent	Urgent	Non Urgent	Total
Urgent Care Centre	8,629	28,061	14,122	50,409	101,221
A&E	4,444	25,030	6,860	31,466	67,800
Total	13,073	53,091	20,982	81,875	169,021
Assumes all Primary Care A&E cases are managed by the Urgent Care Centre					

Scenario 4	In Hours / Weekday		OOH		
	Urgent	Non Urgent	Urgent	Non Urgent	Total
Urgent Care Centre	7,766	25,255	14,122	50,409	97,552
A&E	4,444	25,030	6,860	31,466	67,800
Total	12,210	50,285	20,982	81,875	165,352
Assumes 10% of in-hours cases previously using the UCC, use GP services					

Scenario 5	In Hours / Weekday		OOH		
	Urgent	Non Urgent	Urgent	Non Urgent	Total
Urgent Care Centre	7,766	842	14,122	1,512	24,242
A&E	4,444	25,030	6,860	31,466	67,800
Total	12,210	25,872	20,982	32,978	92,042
Assumes all non-urgent redirected except for unregistered patients					

5. HOW THESE SCENARIOS REFLECT THE PUBLIC CONSULTATION

The pre-consultation and subsequent consultation identified several issues that need to be considered in redesigning the services.

5.1 MOVING FROM SCENARIO ONE TO SCENARIO THREE

5.1.1 Proposed co-location and integration of walk-in, out-of-hours and A&E services

The first key component of our consultation was to recommend that we close the existing walk-in service and create a new integrated urgent care centre at the Russell's Hall site. To demonstrate the implications of this change: scenario one assumes no change; scenario two assumes merely locating the services on the same site but without any redesign; and scenario three models the impact of creating an integrated service.

There is a clear steer both from national guidance and from our own local assessments that this proposal (ie: scenario three) is the most clinically appropriate thing to do and will provide a better service for our population.

In the public consultation very clear concerns were expressed that people do not want to see a deterioration in the accessibility that the walk-in service provides (see next section) however no-one provided any challenge or counter argument to the national guidance or to our own prior assessment that this change would be the most clinically appropriate thing to do.

There were three concerns that were raised about the transfer of the service to the Russell's Hall site.

Firstly, a concern that the co-location would create added pressure on the existing A&E services. This concern is however, unfounded. In fact it will reduce the pressure on the emergency department. This is because a significant number of patients who self-present and are currently treated at the A&E merely have a primary care need. Therefore these patients would be triaged by the Urgent Care Service and seen by the primary care service. The model (comparing scenario three to scenario one) shows that an integrated service would therefore significantly reduce the numbers of patients who would need to be seen by the A&E. The change is also supported by Dudley Group FT as significantly improving the way the services would operate.

Secondly a few individuals queried whether Russell's Hall is more accessible than Holly Hall. But in fact the hospital site is much better served by public transport and the two locations are very close – only 7 minutes walk apart.

Thirdly a concern that was consistently raised in many meetings, and in individual responses is the cost of parking at Russell's Hall.

So the first issue that we have to consider is whether the concerns about the cost of parking at the site outweigh the clinical benefits, national guidance and local assessment that creating an integrated service would provide. i.e: That scenario three is better than scenario one.

For completeness, we have included scenario two, but in fact this provides none of the benefits of scenario three together with the pain of parking costs.

Recommendation 1: that Board note the reconfiguration of Dudley urgent care system is in line with nation guidance and best practice; furthermore it falls in line with Dudley CCG Primary Care Strategy and they Dudley Health and Wellbeing Board June recommendations on urgent care.

Recommendation 2: that the Board approve the rationale and evidence base to redesign the urgent care pathway for Dudley and as a minimum move to adopting scenario 3; thereby developing an integrated UCC on the Russells Hall NHS Trust site, adjacent to ED

5.1.2 Accessibility of walk-in services and primary care out-of-hours services

These two existing services are contracted for separately; albeit provided by the same organisation. The pre-consultation public survey results for the out-of-hours services indicated that it provides poor levels of patient satisfaction. In contrast the public survey and subsequent feedback from the public consultation for the current walk-in service demonstrates very high levels of patient satisfaction.

It is clear that people like the ease of use of the walk-in service and there are lessons to be learnt from this in the provision of the out-of-hours service. However the walk-in service currently only operates from 8am-8pm (extended to 10pm over the winter period).

It is important to note that, with the creation of an urgent care centre, there would have to be the provision of a 24/7 service because the centre would have to be able to triage patients between A&E and the urgent Primary Service.

Recommendation 3: Our proposal in response to the issues raised by the public is therefore two-fold:

- Firstly, the ability to walk-in and obtain an assessment; especially at evenings and weekends; should be maintained.
- Secondly, the out-of-hours service should be integrated into the walk-in service as part of the urgent care centre to create a new 24/7 service – thus extending the availability beyond the current arrangements.

This would then provide a significant enhancement to the way the current services are provided.

5.1.3 Providing telephone advice and booking

There has been a clearly expressed preference that people would like to be able to access reliable telephone advice that can provide reassurance and/or direct them to the most appropriate service. In particular, parents with ill children would find this extremely helpful. This endorses the need for NHS 111 and the service that they already provide.

NHS 111 is now fully in place but the feedback from the consultation reveals a lack of confidence in the current service. It is unclear whether this is informed through practical experience or whether this is perception or lack of awareness.

In our consultation we proposed that people should be able to phone 111 for advice or to make an urgent appointment with their local GP the next day. However, we could modify this concept to enable the 111 service to make appointments for patients at the urgent care centre. The front desk of the urgent care centre would triage all walk-in patients: into providing advice, into the primary care component of the service, or into the emergency department. So the telephone service could triage patients in the same way and either solely provide advice, make direct appointments for patients if needed into the primary care component of the service; or advise on the need to go to the emergency department.

This aspect of the telephone service with bookable appointments would have three distinct benefits:

- Patients who don't need either primary care or emergency care would not have to go to the urgent care centre at all;
- Patients who get a booked appointment would then not have to wait in the way they would if they walked-in to the centre; and so would spend considerably less time at the centre;
- Both of these outcomes would either avoid, or significantly reduce the time spent at Russell's Hall and would therefore substantially mitigate against the cost of parking at the site.

Recommendation 4:
Our original proposal, in response to the issues raised in the consultation, should be modified to include bookable appointments at the urgent care centre and so reduce the impact to the public on the costs of parking at Russell's Hall.

5.1.4 Improving the quality of the walk-in and OOH services

There are some important issues which have been identified in this process which will need to be addressed, regardless of where and how the services are provided

- A disproportionately high proportion of cases are paediatrics – so it will be important to ensure that any new service is tailored to meet this need.
- Concerns have been raised about the timeliness and accessibility to mental health services as part of these arrangements
- The service will need to provide urgent care to unregistered patients – but also actively encourage those patients to register with a GP

These are issues which will need to be addressed as part of the development of the specification for a new service. A more detailed analysis of the Healthwatch interviews will also help to inform the specification.

Recommendation 5: The CCG Board will therefore need to obtain assurance at a future meeting, as part of the procurement process, that the specification enhances the quality of the service to take account of these issues.

5.1.5 Improving connectivity and access to medical records

Another concern expressed by both our GPs and by the public is that current A&E, WIC and OOH services do not have access to full patient records. This is one of the reasons why there is a clear preference for people to access their GP rather than a WIC service because they will be seen by a service that knows them and has their full medical history.

An additional consequence is also that the A&E, WIC and OOH services are necessarily less efficient than GP services because the former have to undertake consultations which include taking information from the patient that would otherwise be readily available to the latter on their medical records.

Our IT strategies will help to improve this situation over the next few years. It is our preferred intention to migrate all GPs over to using the same system. Once this is achieved it would then be possible to provide integrated access to the GP records to the other urgent care services – and so improve the efficiency and effectiveness of those services.

Recommendation 6: The CCG Board should note that our IT strategy will enable further improvements to the connectivity and access to medical records in the future.

5.1.6 Overall assessment on creating an integrated Urgent Care Centre

It is our view that the establishment of an Urgent Care Centre as a replacement for the existing walk-in and out-of-hours services is an essential requirement to improving the provision of urgent care in Dudley and that this is consistent with Dudley Health and Wellbeing Board's strategic vision.

Recommendation 7: The Board should report our conclusions to the Health and Wellbeing Board and seek endorsement for our planned way forward.

5.2 MOVING FROM SCENARIO THREE TO SCENARIO FIVE

5.2.1 The importance of good GP access

The overwhelmingly most significant issue raised both before and during the public consultation was around the public's preference for improved GP access; tempered with scepticism as to whether this can be achieved.

Our consultation included in the vision our belief that the individual's own GP is the best 'navigator' for their health needs and care. They hold the records and have all of the medical history on which to make the safest healthcare decisions.

Our model proposed that local GPs should be the first place that they go for urgent care and that they should get all of their basic health care at the local surgery during week days. We also identified that this would need additional GP appointments during week days, at the expense of providing a walk-in service during week days.

Our model also proposed that the new urgent care service should be available to provide the walk-in and out-of hours care when the local GP service is closed.

Scenario three assumes that either no attempt is made to improve GP access or that the attempt to improve access does not deliver any reduction in demand for the Urgent Care Centre.

Scenario four assumes that we improve GP access but that we do not direct people to use those service as a first choice, and so reductions in the use of the UCC are limited to public behavioural change.

Scenario five assumes that we improve GP access and that we also direct people to use the most appropriate service so that the maximum benefits in matching need to service are achieved.

The importance of good access to GP services cannot be underestimated. The current walk-in-centre represents a tiny proportion (less than 3%) of the total number of primary care appointments that are available across Dudley borough. The vast majority of the service is provided by our GPs and only a very small proportion of patients either choose, or feel they have no choice other than to use, the existing walk-in service.

We should therefore recognise the current success of GP services and we should perhaps consider that the biggest risk to urgent care delivery is not: can we improve GP access further? But what if current pressures on GP services result in a shift in demand to walk-in services?

A 1% reduction in availability of GP services could create a 33% increase in demand for walk-in services. Whereas a 50% reduction in walk-in capacity would create only a 1.5% pressure on GP practices. So there is an obvious risk, that a failure to support improving GP access may actually result in undeliverable pressures on the walk-in service.

It is therefore encouraging that the public feedback from the consultation places a much greater importance on the need to support GP access, rather than on the need to rely upon walk-in services; and this therefore supports the need to move away from scenario three towards scenario five.

However public feedback from the consultation both supports and challenges our proposals on improving GP access:

How does it support our proposals?

There is a clear public preference for more same-day appointments in General Practice and for more flexibility on booking when you can see your GP (eg: in two or three days' time, rather than having to choose between an emergency or weeks in advance).

There is also clear evidence from those who use the existing walk-in service that they would be happy to see their own GP if they could.

And there is also clear evidence that people would be happy to be redirected to see their own GP if they could access the service and that people should use services appropriately and not abuse the system – which supports the move from Scenario 4 to Scenario 5.

How does it challenge our proposals?

There is a clear public preference for more early and late opening for GP services and for weekend opening of GP services. This in effect, therefore asks for us to take our plans well beyond what we are currently proposing. However we do raise these issues as part of the longer-term considerations in our primary care strategy.

There is also a clear public scepticism, particularly expressed by local councillors, that we won't be able to improve GP access because the CCG does not have the contractual responsibility for this – NHS England does.

How does this affect the priority for this in our proposals?

No-one was saying that the objective to improve GP access was not relevant or that we should not be aiming to try and do something to support it.

There was overwhelming agreement that this should be our most important priority out of all the issues identified during the consultation.

5.2.2 Can we improve GP access?

The role of NHS England and the CCG

NHS England has the contractual responsibility for GP access. Therefore NHS England will have to consider the outcome of this consultation and consider how it will address the issues that have been raised.

It is therefore reasonable for the public to raise concerns about the extent to which Dudley CCG can address the issues of GP access in isolation, without cooperation from NHS England.

However, Dudley CCG is working in partnership with NHS England and we have already established some joint arrangements together - both with the establishment of a joint performance review group; with NHS England membership on the CCG's Primary Care Development Committee; and with shared endorsement of our primary care strategy through the Health and Wellbeing Board.

There is nevertheless, as a consequence of the national reforms, a disconnect between the CCG responsibility for funding walk-in services (in-hours) and the NHSE responsibility for funding GP services (in-hours). To some extent, the rising pressure on the former could be considered as consequentially arising from the commissioning failure by the latter – ie: NHSE's failure to adequately address access results in more people using walk-in services when they would rather see their own GP.

This challenge could be better addressed by further improved integration between the CCG and NHS England on how we commission these comparable and interconnected services.

In addition, the CCG holds the responsibility for quality improvement in general practice. However whilst our CCG has extensive support arrangements in place for working with our practices; our effectiveness in achieving these aims is inevitably partially hindered by the limitations on how we can invest resources.

This limitation could also be better addressed by improved integration between the CCG and NHS England – so we should be seeking to bring our improvement responsibilities for these services, together with NHSE's contractual responsibilities for these services, into a more formalised joint commissioning arrangement.

Current evidence for improving GP access

The public are saying that GP access is the single most important quality issue arising from this consultation; and so given our responsibilities, we have already been undertaking work with our practices to support improvements.

Dudley CCG has been providing a wide range of development support to practices since its inception. This support is detailed in the Primary Care Strategy and it is our view that this has helped practices to meet the year-on-year rise in demand without the need for additional resources. This is evidenced by the fact that demand for A&E services has not risen over the last few years.

In addition, Dudley CCG invited all practices to work with the Primary Care Foundation, funded with non-recurrent resources, to review their current access arrangements and there has been 100% take up from our practices to do this. As a result of this work, practices are already looking at how they can make improvements and are sharing their experiences with each other in our locality meetings. This will be brought together over the next 2 months to set out the opportunities and existing improvements that are already being made.

Two case study examples are illustrated below.

Practice case study one:
An online service for booking appointments and requesting repeat prescriptions

In late 2013, the practice set in train a number of improvements that will help reduce the number of calls coming in and free receptionists to pick up the telephone when they do. For a start, patients can now book appointments and request repeat prescriptions online.

The online services will help increase the accessibility of the practice, by reducing the number of calls and increasing the capacity to answer them.

Practice case study two:
Regular review of the calls coming into the practice and the appointments available means the practice can flex to meet changing demand

The focus of the practice is on making sure the practice can respond quickly to changing demand by looking in detail at the appointment requests coming in.
The change is not just in the volume of calls to the surgery but also for the type of appointments people need. Sometimes there is a surge in demand for same day appointments; other times more people are looking for regular appointments to discuss an on-going health issue. For example, Mondays and Thursdays have proven to be high demand days for same day appointments so on those days, the practice now allocates more slots to same day appointments.
By looking in detail at the demand, the practice can make more of the types of appointments available when people need them. The practice team aims to smooth the peaks and troughs making for a better patient experience and a better working environment.

These demonstrate the commitment of GPs in Dudley to respond to the challenges on access. They also show; though innovative working; that it is possible to make some improvements with modest investment and without having to expand the number of existing appointments.

However, some of these changes will have already been implemented by other practices so it would be incorrect to assume that this is the answer to solving all access issues. Each practice will need to be considered separately; a one-size-fits all approach won't work; and it would be naïve to assume that the current levels of increasing demand can continue to be met both; without additional resources and without working with the public to change patterns of behaviour and expectation.

<u>Reviewing access with each practice.</u>

Access to GPs is variable (there are 49 practices) and that variability is determined by both how the practices work and also by what their patients expect from their practice. Each practice supports a different population with different needs and has a different level of funding from NHS England to meet that need.

We have also heard from the public through the consultation that some people speak very highly of their practice and have no difficulties in accessing services (and the vast majority of people get their services from their GP); other people make a choice to sometimes use their practice and at other times use the walk-in service; some people over-use the service and will repeat attendance at all available services; whilst other people are not happy with their GP service and consequently choose to go to the walk-in centre.

So how should we define good access and how should we determine what is required for each practice.

Our view is that whilst there are some important themes that will be consistent between practices 'what does good access look like' is a question that should be answered between the practice and their patients; and both the CCG and NHS England should be actively supporting this. There is a mutual responsibility that should be shared:

- by the public to not use services inappropriately and so create unnecessary demand;
- between the practice and their patients to understand what good access means for them;
- between the practices the commissioners and the population to ensure there is sufficient capacity and capability in total to meet overall need.

So a key component to improving access is to include the public in that process. We are addressing this by

- prioritising the development of the practice participation groups (PPGs);
- supporting the groups to work with their practices on these issues;
- and including representation from those groups to inform our overall planning for the services

Out of the 49 practices we now have 33 PPGs established, with a further 8 practices wanting to set one up. It would add real strength to the role of these PPGs if it was made a requirement that any future investment in improving access with practices should be developed with PPGs.

5.3 How the modelled scenarios reflect the issues raised by the consultation

The table below summarises how the scenarios reflect the issues raised through the consultation.

Issue	Scenario 1	Scenario 2	Scenario 3	Scenario 4	Scenario 5
National Policy Issues					
Is service model consistent with principles set out in NHSE 'High Quality Care' document?	No	No	Yes	Yes	Yes
Is service model consistent with Keogh proposals in 'Transforming Urgent Care'?	No	No	Yes	Yes	Yes
Is service model consistent with recommendations from Royal College of Physicians	No	No	Yes	Yes	Yes

Local Issues					
Is it consistent with proposals to improve and simplify urgent care locally set out by HWBB?	No	No (because although co-located, not simplified)	Yes	Yes	Yes
Is it consistent with views of CCG's GP membership and clinical leaders about urgent care?	No	No	Partly (addresses co-location but not improving GP access)	Partly (addresses co-location but limits amount of investment in improved GP access)	Yes
Is it consistent with the aims of the CCG's Primary Care Strategy?	No	No	No	Yes	Yes
Issues Raised During Consultation					
Does it meet public requirements for a good quality service?	Dependent on contract specification	Dependent on contract specification	Dependent on contract specification	Dependent on contract specification	Dependent on contract specification
Does it provide a service for patients who are not registered with a GP?	Yes	Yes	Yes	Yes	Yes
Does it support improvements to GP access during weekday day times?	No	No	No	Yes	Yes
Does this reduce the pressure on GP services?	No	No	No	No	No
Does this avoid increasing the burden on GPs?	Yes	Yes	Yes	No (unless extra funding available)	No (unless extra funding available)
Does this release savings for reinvestment in GP services?	No	No	No	Partly (subject to agreement from NHS England)	Yes (subject to agreement from NHS England)
Does this reduce pressure on ED?	No	No	Yes	Yes	Yes
Does this support an affordable option for longer opening hours for walk-in services?	No	No	Yes	Yes	Yes
Is parking free?	Yes	No	No	No	No
Will the site be better serviced by public transport	No	Yes	Yes	Yes	Yes

Will this improve access to patient's own GP outside normal working hours (i.e. at evenings and weekends)?	No	No	No	No	No
Will it support provision of more help and advice by telephone?	Yes - Subject to appropriate use of 111	Yes- Subject to appropriate use of 111	Yes - Subject to appropriate use of 111	Yes - Subject to appropriate use of 111	Yes -Subject to appropriate use of 111
Does this support improvements to other services (for example mental health)?	Dependent on contract specification	Dependent on contract specification	Dependent on contract specification	Dependent on contract specification	Dependent on contract specification
Does this encourage more appropriate use of urgent care services?	No	No	Partly (simplifies choice)	Partly (simplifies choice)	Yes (simplifies choice and directs patients to most appropriate treatment)

5.4 Conclusions

There are actions that we can take to improve access to general practice and therefore enable a movement from scenario three to scenario five.

However this is challenging!

The public challenge and scepticism on achieving improvements is therefore reasonable. So it would be prudent to ensure that any newly commissioned urgent care centre is initially designed to accommodate the planning assumptions in scenario 3; but should incorporate the flexibility to move to scenario 5 as sufficient improvements in GP access are realised.

Recommendation 8: Our Board is asked to:

- confirm that it should be part of our strategic plan to develop joint commissioning arrangements [for GP services] with NHS England.
- encourage Dudley Health & Wellbeing Board to invite NHS England, as a partner on the Board with the contractual responsibility for GP Access, to demonstrate how they intend to improve this in Dudley.
- ask Dudley Health & Wellbeing Board to support joint commissioning between the CCG and NHS England as a key opportunity for addressing this issue.

Recommendation 9: Our Board is asked to note:

- that the current development support arrangements that we have put in place have made, and continue to make, an important contribution to improving access to GPs but will be insufficient longer-term both; without additional resources and without working with the public to change patterns of behaviour and expectation;
- that the risk of GP access deteriorating would place unmanageable pressures on walk-in services

Recommendation 10: Our Board is asked to approve that we should encourage the development of PPGs with all practices and ensure future plans on improving access require their input

Recommendation 11: Our Board is asked to confirm that the newly commissioned urgent care centre is initially designed to accommodate the planning assumptions in scenario 3; but should incorporate the flexibility to move to scenario 5

6. DRAFT SERIVCE OUTLINE FOR DUDLEY UCC

Should the Board choose scenario 3, moving to scenario 5 over time, the follow sections offer a useful outline definition and service specification of the proposed Urgent Care Centre (UCC). The purpose of the UCC could usefully be defined as:

> *To develop a coherent 24/7 urgent care service in the Borough of Dudley that makes sense to patients when they have to make choices about their care. This will provide streaming / triage for the front door of ED, if required urgent medical care with a clinical professional and a seamless relationship with 111.*

6.1 UCC Aims

Draft service aims for the UCC is offered below and would require the following service requirements:

- An Urgent Care Centre (UCC) providing a primary care triage service through bookable appointments 24 hours a day, 7 days a week.
- The delivery of a seamless interface between 111 (currently provided by WMAS), face-to-face streaming / triage and consultations with a clinical professional during the in-hours and out-of-hour's period.

6.2 UCC Objectives

A provider would be commissioned to deliver the best standards of health care that meets the patients need or perceived need through consistent assessment via a 'primary care triage' model of service. Upon entering the triage system a patient will be referred back to their GP, provided with advice, booked into a face-to-face clinical consultation at the UCC or directed to the ED. This service would be available in the UCC 24 hours a day 7 days a week. There would be 3 main routes into the service by patients:

1. They walk into the UCC and if appropriate are offered a booked appointment.
2. They call 111 (In-hours and Out-of-Hours) and if appropriate are offered a bookable appointment with an Advanced Nurse Practitioner (ANP) or General Practitioner (GP) at the UCC.
3. They are referred by another local provider such as ED (where blue light patients have been identified as not being appropriate for ED), WMAS non-urgent ambulance or a local GP.

6.3 Draft UCC Service Outline

The UCC would provide a consistent 24/7 assessment of patients who are booked into an appointment for the service by 111. The majority of these bookable appointments would be outside of GP core hours. Ambulatory patients would also be seen who may have accessed the service by walking into the centre and are very ill but do not require 999 services.

For ambulatory patients the UCC address patient's needs or perceived needs by face-to-face initial assessment by the triage 'reception and registration' facility. A trained receptionist (this model is in operation in Walsall UCC) gives appropriate response to the patient's perceived need. Following this initial visual assessment and if the patient is sufficiently ill they are offered an appointment at the UCC with an ANP or GP. At this clinical assessment patients are again triaged and may follow one of the following routes, based on clinical risk:

- Seen, treated and discharged
- Booked for diagnostic and imaging services
- Held for further observation
- Streamed to another Trust service i.e. plastering facility and subsequently to an outpatient's clinic e.g. fracture clinic
- Streamed to the Emergency Department
- Transferred to another Healthcare provider, which could include their own GP
- Signposted to Rapid Response Service
- Signposted to a local Pharmacy

6.4 Accessibility/acceptability

The UCC will act as a single point of access for all self-presenting cases at Russells Hall Hospital ED through a common reception gateway. Appropriate cases may also be diverted to the service by WMAS, ED or community based providers. The inclusion criteria for the UCC could be as follows:

Presentation	In Hours	Out of Hours
Registered with Local GP	Urgent - UCC see and treat	Urgent - UCC see and treat
	Non urgent - Refer back to own GP or Advise on self-treatment	Assessed as Non urgent - Refer back to own GP
Not registered with Local GP (out of area, regionally / nationally)	Urgent - UCC see and treat	Urgent - UCC see and treat
	Non urgent - Refer back to own GP or Advise on self-treatment	Assessed as Non urgent - Refer back to own GP
Not Registered with any GP	UCC see and treat - Signpost to practice near place of residence if local	UCC see & treat - Signpost to practice near place of residence if local

This description is consistent with scenario 5. The is only one difference in this model between scenario 5 and scenarios 3 and 4; namely: in scenarios 3 and 4 all non-urgent cases requiring a GP would be seen by the UCC rather than redirected back to their own GP.

The Out-of-Hours period is defined as 18:30 – 08:00 hours, Monday –Thursday and 18:30hrs Friday – 08:00 Monday at weekends plus bank holidays.

The In-hours period is defined as 0801 – 1829 hours Monday- Friday (excluding bank holidays)

6.5 Out of Scope

Dental Services would be out of the scope of the service unless a patient had protracted dental bleeding, trauma or swelling to the face i.e. rapidly spreading infection; these patients may be seen in the UCC or immediately be streamed to ED.

6.6 Service Delivery

There are five service elements to the UCC and Out of Hours provision that would need to be commissioned and coordinated as summarised below:

1) Initial **self-presentation** of patients in the UCC is met by face-to-face triage by a receptionist. The receptionist undertakes a primary assessment using a visual and question based assessment formulary. The receptionist then streams the patient to an appropriate service i.e. back to their own GP, a booked appointment in the UCC or if sufficiently serious direct referral to ED.

2) **Face to face consultation and treatment** - In hours and Out-of-Hours patients at the UCC are booked an appointment via 111 or the UCC receptionist for a face-to-face consultation conducted by an ANP or GP. A clinician would offer treatment, including assessment, diagnosis, treatment or treatment plan, onward referral, follow-up, or discharge and prescribing of medicines as required.

3) Initial access to Out-of-Hours services and associated **call handling** will be provided by 111. There would need to be a seamless approach between 111 and the UCC. An effective relationship between the two would ensure the 111 system would:

   a. Enable filtering out of unnecessary referrals to the UCC according to agreed prioritisation and referral protocols.
   b. Continue to provide a real-time local information and advice service to signpost patients to other services (e.g. local pharmacies etc.) and direct patients to their GP as required.
   c. Identify and fast-tracks potentially life-threatening conditions to WMAS via 999.

4) 111 provide the Out-of-hours **assessment and advice** service via a telephone assessment service through trained health care professionals. On the patients request or if deemed necessary 111 would:

   - Offer a definite clinical assessment of the patient needs conducted by an appropriately trained clinician working to an agreed clinical protocol (e.g. if not a GP) and within a defined clinical governance framework agreed by the CCG.
   - Offer a course of treatment which may include:
     - Advice on self-management.
     - A telephone consultation providing advice on self-care.
     - A booked invitation to attend the UCC for a face-to-face consultation with a clinician
     - A home visit planned for a face to face consultation with a clinician
     - Advice to patients to contact their own GP during the opening hours of their GP surgery.
     - Referral to another service i.e. Rapid response, Social services, Community Nursing, Mental Health, Dentistry, Local Authority Services etc.
     - Onward referral to another out-of-hours, urgent or emergency service.

- o Advice to patient to contact their local Walk in Centre (if not patient of Dudley GP practice) where these are available.

5) 111 provide the current out-of-hours **home visiting** service which receives its workload from the telephone assessment service. 111 will continue to provide a home (home is considered to be where the patient normally resides and may be a care home) visiting service to all patients whom, in the reasonable opinion of the telephone assessment service, and in the light of the patient's medical condition and/or significantly difficult social circumstances (being "functionally housebound"), it would not be reasonable to expect to be able to travel to the UCC.

6.7 Premises for Urgent Care Centre and Out-Of-Hours Service

The UCC will be located on the Russells Hall NHS Trust site, adjacent to ED. 111 call handling and telephone triage elements of the service are located on a separate site and provided by WMAS.

7. PROCUREMENT IMPLICATIONS

A significant amount of work still needs to be undertaken to define the model, produce a detailed service specification and determine the type of service contract to be used if scenarios 3-5 are agreed.

The procurement procedure for this tender will be the restricted procedure, an advert will be placed in Supply2Health and a pre-qualification process will be undertaken to devise a shortlist of potential bidders to be taken forward to the final invitation to tender stage.

Dudley CCG should consider tendering the new service for a period of not less than three years and preferably for up to five years, as implementation of the new service may require significant capital expenditure to secure suitable premises on the Russells Hall NHS Trust site and clinical and non-clinical equipment. An initial contract term of up to five year will enable the successful provider or Prime Contractor to recoup any capital expenditure invested in the service.

A contract term of up to five years will also provide assurance to Dudley Group of Hospitals NHS Trust as landlords of the OOH site of Dudley CCG's commitment to support a viable site for the UCC.

7.1 Timescales for procurement

The procurement of the service (with agreement of the Board) will need to ensure that a contract is awarded by the 1st October 2014 and allowing three months for the mobilisation of the service.

This affords very little time for delay in determining the detailed service specification and so this process should begin as soon as possible. The development of the specification will need to include appropriate provider, patient and public representation. This will need to establish key performance standards and use both the issues identified in this report as well as further detailed analysis that can be taken from the Healthwatch questionnaires.

Recommendation 12: The Board is asked to approve that we commence the development of the service specification to produce a detailed proposal at the March Board meeting, at which point we will also have received the feedback from the Health and Wellbeing Board.

9. CONCLUSION

The case for the redesign of unscheduled care services remains strong. This paper represents the rational and draft service outline in which to define the vision to redesign urgent care in Dudley into a coherent, viable and safe future service provision. It is acknowledged that the draft service outline will require significant expansion, clinical scrutiny and refinement to enable a full service specification to be finalised in preparation for the procurement process.

10. RECOMMENDATIONS

Recommendation 1: that Board note the reconfiguration of Dudley urgent care system is in line with nation guidance and best practice; furthermore it falls in line with Dudley CCG Primary Care Strategy and they Dudley Health and Wellbeing Board June recommendations on urgent care.

Recommendation 2: that the Board approve the rationale and evidence base to redesign the urgent care pathway for Dudley and as a minimum move to adopting scenario 3; thereby developing an integrated UCC on the Russells Hall NHS Trust site, adjacent to ED

Recommendation 3: Our proposal in response to the issues raised by the public about the walk-in services is therefore two-fold:

- Firstly, the ability to walk-in and obtain an assessment; especially at evenings and weekends; should be maintained.
- Secondly, the out-of-hours service should be integrated into the walk-in service as part of the urgent care centre to create a new 24/7 service – thus extending the availability beyond the current arrangements.

Recommendation 4:
Our original proposal, in response to the issues raised in the consultation, should be modified to include bookable appointments at the urgent care centre and so reduce the impact to the public on the costs of parking at Russell's Hall.

Recommendation 5: The CCG Board will therefore need to obtain assurance at a future meeting, as part of the procurement process, that the specification enhances the quality of the service to take account of the issues raised about Paediatrics, Mental Health and unregistered patients.

Recommendation 6: The CCG Board should note that our IT strategy will enable further improvements to the connectivity and access to medical records in the future.

Recommendation 7: The Board should report our conclusions to the Health and Wellbeing Board and seek endorsement for our planned way forward.

Recommendation 8: Our Board is asked to:

- confirm that it should be part of our strategic plan to develop joint commissioning arrangements [for GP services] with NHS England.
- encourage Dudley Health & Wellbeing Board to invite NHS England, as a partner on the Board with the contractual responsibility for GP Access, to demonstrate how they intend to improve this in Dudley.
- ask Dudley Health & Wellbeing Board to support joint commissioning between the CCG and NHS England as a key opportunity for addressing this issue.

Recommendation 9: Our Board is asked to note:

- that the current development support arrangements that we have put in place have made, and continue to make, an important contribution to improving access to GPs but will be insufficient longer-term both; without additional resources and without working with the public to change patterns of behaviour and expectation;
- that the risk of GP access deteriorating would place unmanageable pressures on walk-in services

Recommendation 10: Our Board is asked to approve that we should encourage the development of PPGs with all practices and ensure future plans on improving access require their input

Recommendation 11: Our Board is asked to confirm that the newly commissioned urgent care centre is initially designed to accommodate the planning assumptions in scenario 3; but should incorporate the flexibility to move to scenario 5

Recommendation 12: approve that we commence the development of the service specification to produce a detailed proposal at the March Board meeting, at which point we will also have received the feedback from the Health and Wellbeing Board.

Jason Evans
Commissioning Manager – Urgent Care
8th January 2014

Disabled Children's Charter
for Health and Wellbeing Boards

The Dudley Metropolitan Borough Council **Health and Wellbeing Board** is committed to improving the quality of life and outcomes experienced by disabled children, young people and their families, including children and young people with special educational needs and health conditions. We will work together in partnership with disabled children and young people, and their families to improve universal and specialised services, and ensure they receive the support they need, when they need it. Disabled children and young people will be supported to fulfil their potential and achieve their aspirations and the needs of the family will be met so that they can lead ordinary lives.

By [date within 1 year of signing the Charter] our Health and Wellbeing Board will provide evidence that:

1. We have **detailed and accurate information** on the disabled children and young people living in our area, and provide public information on how we plan to meet their needs
2. We **engage directly with disabled children and young people** and their participation is embedded in the work of our Health and Wellbeing Board
3. We **engage directly with parent carers** of disabled children and young people and their participation is embedded in the work of our Health and Wellbeing Board
4. We set **clear strategic outcomes** for our partners to meet in relation to disabled children, young people and their families, monitor progress towards achieving them and hold each other to account
5. We **promote early intervention** and support for smooth transitions between children and adult services for disabled children and young people
6. We work with key partners to **strengthen integration** between health, social care and education services, and with services provided by wider partners
7. We provide **cohesive governance** and leadership across the disabled children and young people's agenda by linking effectively with key partners

Signed by ..... **Date** 10 October 2013

Position: Chair of Health and Wellbeing Board.

For guidance on meeting these commitments, please read the accompanying document: Why sign the Charter?

every disabled child matters

Every Disabled Child Matters (EDCM) is the campaign to get rights and justice for every disabled child. It has been set up by four leading organisations working with disabled children and their families – Contact a Family, the Council for Disabled Children, Mencap and the Special Educational Consortium. EDCM is hosted by the National Children's Bureau, Charity registration number: 258825.

The Children's Trust, Tadworth is a national charity providing specialist services to disabled children and young people across the UK. These services include rehabilitation and support for children with acquired brain injury, expert nursing care for children with complex health needs, and residential education for pupils with profound and multiple learning difficulties at The School for Profound Education. Charity registration number: 288018. Find out more about the work of The Children's Trust, Tadworth at www.thechildrenstrust.org.uk

The Children's Trust Tadworth
For children with multiple disabilities

Better health outcomes for children and young people

Our pledge

> “The foundations for virtually every aspect of human development – physical, intellectual, and emotional – are laid in early childhood.”
>
> **(Marmot)**

Children and young people growing up in England today are healthier than they ever have been before. Health care and social changes have had dramatic impacts. Previously common killer diseases are now rare. More children with serious illnesses and disabilities are surviving into adulthood and the infant mortality rate has fallen to less than a quarter of what it was at the beginning of the 1960s.

But international comparisons and worrying long-term trends demonstrate there is room for improvement, with poor health outcomes for too many children and young people compared with other countries. A smaller group of more vulnerable children – such as looked after children – suffer much worse outcomes. The variation in outcomes and quality of healthcare for children and young people is unacceptable. The clear evidence that pregnancy and the earliest years are critical to the future health and wellbeing of children and adults and that evidence-based early interventions can have significant positive impacts does not always inform how services are commissioned.

The need for improvement is not new; numerous reports have highlighted the issues. Individual initiatives have led to improvements in specific areas, but have not resulted in the system wide changes required to improve outcomes. What is new is the opportunity to ensure the focus on outcomes in the new health and care system includes children and young people clearly and explicitly, from conception through to adulthood.

We are committed to improving the health outcomes of our children and young people so that they become amongst the best in the world.

System-wide change is required to achieve this and each part of the system, at each level, has a vital contribution to make. To this end we pledge to work in partnership, both locally and nationally, with children, young people and their families.

Our shared ambitions are that:

1. Children, young people and their families will be at the heart of decision-making, with the health outcomes that matter most to them taking priority.

2. Services, from pregnancy through to adolescence and beyond, will be high quality, evidence based and safe, delivered at the right time, in the right place, by a properly planned, educated and trained workforce.

3. Good mental and physical health and early interventions, including for children and young people with long term conditions, will be of equal importance to caring for those who become acutely unwell.

4. Services will be integrated and care will be coordinated around the individual, with an optimal experience of transition to adult services for those young people who require ongoing health and care in adult life.

5. There will be clear leadership, accountability and assurance and organisations will work in partnership for the benefit of children and young people.

We all have a part to play in promoting the importance of the health of our children and young people.

Through our joint commitment and efforts we are determined to:

- **reduce child deaths** through evidence based public health measures and by providing the right care at the right time;
- **prevent ill health for children and young people and improve their opportunities for better long-term health** by supporting families to look after their children, when they need it, and helping children and young people and their families to prioritise healthy behaviour;
- **improve the mental health of our children and young people** by promoting resilience and mental wellbeing and providing early and effective evidence based treatment for those who need it;
- **support and protect the most vulnerable** by focusing on the social determinants of health and providing better support to the groups that have the worst health **outcomes**;
- **provide better care for children and young people with long term conditions and disability** and increase life expectancy of those with life limiting conditions.

Because

- **the all-cause mortality rate for children aged 0 – 14 years has moved from the average to amongst the worst in Europe**[1]
- **26% of children's deaths showed 'identifiable failure in the child's direct care'**[2]
- **more than 8 out of 10 adults who have ever smoked regularly started before 19**[3]
- **more than 30% of 2 to 15 year olds are overweight or obese**[4]
- **half of life time mental illness starts by the age of 14**[5]
- **nearly half of looked after children have a mental health disorder and two thirds have at least one physical health complaint**[6]
- **about 75% of hospital admissions of children with asthma could have been prevented in primary care**[7]

Building momentum

At national level a new **Children and Young People's Health Outcomes Board**, led by the Chief Medical Officer, will bring together key system leaders in child health to provide a sustained focus and scrutiny on improving outcomes across the whole child health system.

A new **Children and Young People's Health Outcomes Forum** will provide both ongoing expertise in child health and offer constructive challenge to the next phase of this work. The Forum will hold an annual summit involving the CMO to monitor progress on child health outcomes and make recommendations for their improvement.

The Children and Young People's Health Outcomes Forum report and system response can be found at **http://www.dh.gov.uk/health/2012/07/cyp-report/**

For the very first time, everyone across the health and care system is determined to play their part in improving health outcomes for children and young people.

1 Wolfe I, Cass H,Thompson MJ et al. Improving child health services in the UK: insights from Europe and their implications for the NHS reforms. BMJ 2011; 342:d1277
2 CEMACH report 2008
3 Healthy Lives, Healthy People – our strategy for public health in England. Department of Health (2010)
4 Health Survey for England 2010
5 Kessler R, Angermeyer M, Anthony J et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry 2007 Oct; 6(3):168-76
6 DfE Outcomes for children looked after as at 31 March 2012
7 Asthma UK. Wish you were here – England (2008).

Local Government Declaration on Tobacco Control

We acknowledge that:

- Smoking is the single greatest cause of premature death and disease in our communities;
- Reducing smoking in our communities significantly increases household incomes and benefits the local economy;
- Reducing smoking amongst the most disadvantaged in our communities is the single most important means of reducing health inequalities;
- Smoking is an addiction largely taken up by children and young people, two thirds of smokers start before the age of 18;
- Smoking is an epidemic created and sustained by the tobacco industry, which promotes uptake of smoking to replace the 80,000 people its products kill in England every year; and
- The illicit trade in tobacco funds the activities of organised criminal gangs and gives children access to cheap tobacco.

As local leaders in public health we welcome the:

- Opportunity for local government to lead local action to tackle smoking and secure the health, welfare, social, economic and environmental benefits that come from reducing smoking prevalence;
- Commitment by the government to live up to its obligations as a party to the World Health Organization's Framework Convention on Tobacco Control (FCTC) and in particular to protect the development of public health policy from the vested interests of the tobacco industry; and
- Endorsement of this declaration by the Department of Health, Public Health England and professional bodies.

We commit our Council from this date …….....to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use;
- Participate in local and regional networks for support;
- Support the government in taking action at national level to help local authorities reduce smoking prevalence and health inequalities in our communities;
- Protect our tobacco control work from the commercial and vested interests of the tobacco industry by not accepting any partnerships, payments, gifts and services, monetary or in kind or research funding offered by the tobacco industry to officials or employees;
- Monitor the progress of our plans against our commitments and publish the results; and
- Publicly declare our commitment to reducing smoking in our communities by joining the Smokefree Action Coalition, the alliance of organisations working to reduce the harm caused by tobacco.

Signatories

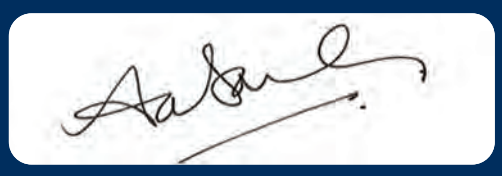
Leader of Council

Chief Executive

Director of Public Health

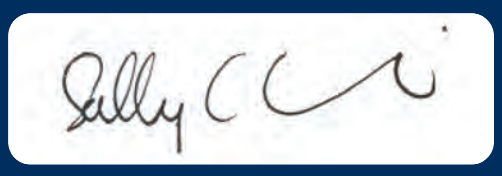
Endorsed by

Anna Soubry, Public Health Minister, Department of Health

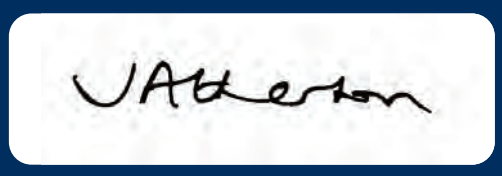


Duncan Selbie, Chief Executive, Public Health England

Professor Dame Sally Davies, Chief Medical Officer, Department of Health



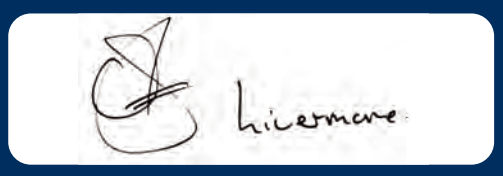
Dr Janet Atherton, President, Association of Directors of Public Health



Dr Lindsey Davies, President, UK Faculty of Public Health

Graham Jukes, Chief Executive, Chartered Institute of Environmental Health

Leon Livermore, Chief Executive, Trading Standards Institute



Department of Health | Public Health England | Association of Directors of Public Health | Faculty of Public Health | Chartered Institute of Environmental Health | ts trading standards institute