# Health Scrutiny Committee

**Thursday 22nd January, 2015, at 6.00pm**
**In Committee Room 2 at the Council House, Priory Road, Dudley**

## Agenda - Public Session

**(Meeting open to the public and press)**

1. Apologies for absence.

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

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

4. To confirm and sign the minutes of the meeting held on 20th November, 2014 as a correct record.

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

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

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

6. Care Quality Commission Inspection Outcomes

7. Winter Pressures

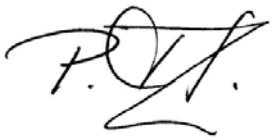
8. NHS Health Check Implementation

9. The Better Care Fund

10. Update on Urgent Care – Verbal Update

11. Responses to Questions

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



**Strategic Director (Resources and Transformation)**
**Dated: 14th January, 2015**

**Distribution:**

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

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

- The use of mobile devices or electronic facilities is permitted for the purposes of recording/reporting during the public session of the meeting. The use of any devices must not disrupt the meeting – Please turn off any ringtones or set your devices to silent.

- If you (or anyone you know) is attending the meeting and requires assistance to access the venue and/or its facilities, please notify the officer below in advance and we will do our best to help you.

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

- Elected Members can submit apologies by contacting the officer named below. The appointment of any Substitute Member(s) should be notified to Democratic Services at least one hour before the meeting starts.

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

# Minutes of the Health Scrutiny Committee

## Thursday 20th November, 2014 at 6.00 p.m.
## in Committee Room 2 at the Council House, Dudley

**Present**:-

Councillor C Hale (Chair)
Councillor N Barlow (Vice-Chair)
Councillors C Elcock, M Hanif, D Hemingsley, S Henley, K Jordan, M Roberts K Shakespeare, E Taylor and K Turner and J Emery

**Officers**

S Griffiths (Democratic Services Manager (Acting Lead Officer to the Committee), B Clifford (Interim Assistant Director for Adult Social Care), K Jackson (Interim Director of Public Health, M Johal (Democratic Services Officer – Directorate of Corporate Resources, D Lowndes (Assistant Director Culture and Leisure), I Newman (Treasurer – Corporate Finance), A Sangian (Senior Policy Analyst), R Sims (Assistant Director of Housing, Strategy and Private Sector) and J Vaughan (Head of Service, Directorate of Adult, Community and Housing Services)

**Also in Attendance**

Ms Liz Abbis – Dudley Group NHS Foundation Trust
Dr David Hegarty – Dudley Clinical Commissioning Group
Ms Laura Broster – Dudley Clinical Commissioning Group
Mr Jason Evans – Dudley Clinical Commissioning Group
Mr Neill Bucktin – Dudley Clinical Commissioning Group
Ms Marsha Ingram – Dudley and Walsall Mental Heath Trust
Ms Rosie Musson – Dudley and Walsall Mental Health Trust
Mr Paul Maubach – Dudley Clinical Commissioning Group

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20 **Declarations of Interest**

In accordance with the Members' Code of Conduct, a non-pecuniary interest was declared by Councillor K Turner in respect of any reference made to older people in view of him being the Chair and Director for Age Concern.

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21 **Apology for Absence**

An apology for absence from the meeting was submitted on behalf of P Bradbury (Healthwatch).

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22 **Appointment of Substitute Member**

It was reported that J Emery had been appointed to serve in place of P Bradbury for the meeting of this Committee only.

23 **Minutes**

**Resolved**

That the minutes of the meeting of the Health Scrutiny Committee held on 22nd September, 2014 be approved as a correct.

24 **Public Forum**

No issues were raised under this agenda item.

25 **Medium Term Financial Strategy**

A joint report of the Chief Executive, Treasurer and Interim Director of Public Health was submitted on the Medium Term Financial Strategy (MTFS) for 2017/18 with emphasis on proposals relating to the Committee's terms of reference. Items directly specific to this Committee were those relating to the proposed Public Health budget for 2015/16 as contained in paragraphs 25 to 27 of the report submitted.

Arising from the presentation of the report the following queries and comments were made by a Member:-

- That an increase in the Council Tax in the past would have generated additional income and the reason for the zero increase was questioned given the budgetary pressures.

- Reference was made to the savings to be made relating to health integration and the Mental Health Services and it was questioned whether the savings were realistic and achievable.

- Although it was acknowledged that savings were needed and were supported it was considered that it was important to continue and maintain Service Level Agreements for older people. There were progressively higher numbers of aging people, particularly those with dementia, and it was considered that resources should be targeted to detecting dementia as early prevention was a potential saving to the Local Authority.

In responding to the above the Treasurer stated that a freeze was a forecasting assumption rather than a recommended course of action. With regard to an increase in the Council Tax the Treasurer confirmed that the Local Authority had three options, namely: receiving the Council Tax Freeze Grant which was equivalent to a 1% increase, to increase Council Tax by up to 2% without the need to hold a referendum or to increase it above 2% by holding a referendum. It was pointed out that owing to the oddities in calculations relating to the Freeze Grant, the difference between a 1% grant and a 2% Council Tax increase was only around £0.75m though this would be ongoing in the base budget.

The Interim Assistant Director for Adult Social Care referred to older people and commented that there were a range of grants available and discussions were taking place with the Clinical Commissioning Group to improve the process given the increasing numbers of people with dementia.

**Resolved**

That the Cabinet's proposals for the Medium Term Financial Strategy to 2017/18, as set out in the report, and Appendices to the report, submitted be noted.

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26 **Quality Transfers of Care Between Hospital and Community Settings**

A joint report of the Director of Adult, Community and Housing Services and the Chief Accountable Officer was submitted on specific issues relating to delayed transfers of care, quality transfers of care between hospital and other settings, work being done in the health and social care economy to continually improve services and people's experience of transfer of care between hospital and other settings.

The Interim Assistant Director for Adult Social Care and the Chief Accountable Officer (Clinical Commissioning Group (CCG)) presented the report, and in doing so, made the following points:-

- Partnership was key between all agencies in ensuring that hospital discharge was a good experience and that the actions or inactions of one agency can affect the work of another

- That a number of initiatives were underway to address long-term and short-term issues, such as the development of a "discharge to assess" model and the need for more reliable, agreed information.

- That most discharges from hospital were done without the involvement of adult social care through the support of family or friends. The challenges referred to in the report were specifically about discharges where support from the Council and/or the CCG was required.

- The role of the CCG was to commission health care with a view to the Dudley Group Hospital Foundation Trust (DGHFT) providing the care.

- A review on quality transfers of care had been undertaken in conjunction with the Council, CCG and DGFT and following discussions an Action Plan had been produced. Work was currently being undertaken with a view to implementing the plans with the intent to improving the services which were being provided to the public. A copy of the Action Plan could be made available to Members, if required.

- Reference was made to the pie chart illustrating the degree of delays and it was commented that it was intended to gradually reduce these delays to zero. The issue was of multi-agency concern and efforts would be made jointly with a view to improving the quality of transfers.

- Arising from recent research it had demonstrated that 90% of people had benefited from a good experience and the remaining 10% had suffered varying levels of bad experiences.

Arising from the presentation of the report and in responding to Members' queries and comments, the Interim Assistant Director for Adult Social Care and the Chief Accountable Officer made the following points:-

- It was acknowledged that there had been some delays in discharging patients due to reasons such as the length of time taken by the pharmacy to dispense medication. Some of the delays had been associated with the technology used by the pharmacy, however, the computer systems had now been updated. The CCG were aware of other problems, such as the delays in "signing off" prescriptions by hospital doctors and had raised the matter with the Trust with a view to addressing the issue. However, it was pointed out that there was a rigorous process in place to ensure that correct medication was being dispensed and some delays were inevitable.

  It was stated that the number of staff employed and available at the pharmacy on a typical day was not known, however, Ms Abbis undertook to provide this information to Members. Insofar as whether there would be any reduction in staff given the budgetary constraints it was commented that any job losses would be achieved by natural wastage.

- In response to a query about the delays in Ambuline collecting patients from hospitals which subsequently resulted in delays to beds being released for other patients, it was acknowledged that there was a need for all organisations to communicate effectively and that improvements needed to be made. In relation to the arrangements that were in place to collect patients it was stated that Ambuline attempted to collect patients in geographic clusters, where this was not possible, individual patients would be collected.

- Comments about the excellent service offered at Tiled House for the elderly and that the service should be expanded were welcomed.

- The Chief Accountable Officer undertook to investigate the incidents as described by a Member in relation to the bad experiences of two patients. It was also suggested that any concerns should be raised with the hospital directly or the CCG for further investigations.

The Chair requested that information collated from the survey conducted by Healthwatch in gauging patient experiences upon being discharged be circulated to all Members of the Committee.

**Resolved**

That the information contained in the report submitted on quality transfers of care between hospital and community settings, be noted and that a further report be submitted to a future meeting of the Committee.

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27 **The Better Care Fund**

A report of the Chief Accountable Officer was submitted on the current position in relation to the Better Care Fund (BCF). The Better Care Fund Planning Template – Part 1 – Final Submission had also been circulated to Members of the Committee.

In presenting the report the Chief Accountable Officer explained that the BCF plan had been approved by the Health and Well Being Board. The integration model for Dudley involved various agencies comprising of a General Practitioner (GP), community nurse, mental health link worker, practice based pharmacist and a social care link worker with a view to combining and offering shared services. All agencies were working together with a view to improvements being made and the programme had now been extended to twelve practices with a view to rolling out to the rest of the Borough in due course.

Arising from the presentation of the report, and in responding to a query from a Member, it was stated that various events were being held with a view to addressing and engaging people, particularly young people, as Dudley had a high obesity rate.

The view of the adult social care service was sought and the Assistant Director for Adult Social Care stated that the service supported the direction described in the report, noting that further work was being done in relation to financial and technical issues.

**Resolved**

That the information contained in the report submitted on the position in relation to the Better Care Fund, be noted and that a further update report be submitted to the next meeting of the Committee.

28 **Dudley Group National Health Service Care Quality Commission Outcomes**

Ms Abbis, Dudley Group NHS Foundation Trust informed the Committee that there had been a delay and that the report was not as yet available.

A Member commented that she had been informed that Russells Hall Hospital had been placed on alert because of failings relating to their budget and delays in the Accident and Emergency Department and if issues were not addressed the Chief Executive could lose her position. In responding the Chief Accountable Officer referred to a historical matter about failings at the hospital and reported that discussions had, in the past, been held between the Trust and Monitor (the regulator) but that work had taken place to address the issues that had been highlighted. The Chief Accountable Officer stated that he was not aware of any other problems but he referred to the recent announcement of the resignation of the Chief Executive of Kettering over problems with emergency department performance which may have led to staff at some hospitals being concerned and fearful.

**Resolved**

That the report on the Dudley Group National Health Service Care Quality Commission Outcomes be submitted to a future meeting of the Committee.

29 **Mental Health Services Care Quality Commission Inspection**

Ms Ingram and Ms Musson, Dudley and Walsall Mental Heath Trust presented information on progress made on the Care Quality Commission inspection. A copy of the slides had previously been circulated to Members of the Committee.

Arising from the presentation, and in responding to Members' queries and comments, the following points were made:-

- The information relating to the query about the number of lay managers and associated gender mix was not known and would be circulated to Members of the Committee in due course.

- There was a limited service specifically for dealing with people suffering from eating disorders. There were two full time equivalent posts in place, however, specialist services could be accessed and referrals made, if required. It was further stated that it was unusual for a patient to visit their GP solely with an eating disorder and diagnosis was usually via generic assessment.

  Ms Ingram and Ms Musson undertook to circulate to Members of the Committee a response to the query on how long patients had to wait to be seen by a specialist when referred by the GP for an eating disorder and also subsequent waiting times before treatment commenced.

- A monthly matrix was published on the NHS Choices website detailing information on the working patterns. A regular monthly report on the workforce was also submitted to the Board with a view to comparing staffing levels on a national basis.

- A significant amount of work was being undertaken to improve staff morale. The Trust conducted regular "Friends and Family Test" which was an important tool to give staff the opportunity to provide feedback on their experience. A typical question asked of staff was whether they would recommend the Trust to their family and friends. It was commented that the survey was anonymous and that approximately 35% of staff had completed a form during the first quarter.

**Resolved**

That the information contained in the presentation on progress made on the Care Quality Commission inspection, be noted.

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30 **Clinical Commissioning Group: Birmingham, Black Country and Solihull Stroke Review – Programme Development**

Mr Maubach, Chief Accountable Officer (Clinical Commissioning Group) gave an oral update on the BBC and Solihull Stroke Review Programme Development.

The Chief Accountable Officer explained that a joint stroke review was being undertaken by all Clinical Commissioning Groups in the Black Country area and that there were currently six hospital trusts in the conurbation delivering hyper acute stroke services. Discussions had not concluded and further information could not be provided at this time for confidentiality reasons.

**Resolved**

That the information contained in the verbal update on the Birmingham and Black Country and Solihull Stroke Review Programme Development be noted and a report be submitted to a future meeting of the Committee.

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31 **Dudley Group NHS Foundation Trust: Patient Experience**

A report of the Dudley Group NHS Foundation Trust was submitted updating the Committee on the Trusts Patient Experience Strategy 2014-2017. The Strategy was attached as an Appendix to the report submitted.

Arising from the presentation of the report and in responding to a query, Ms Abiss reported that volunteers and nurses were available to assist vulnerable patients if they had difficulties in consuming their food. It was suggested that if people experienced any issues they should initially approach a member of staff, and if a satisfactory response was not forthcoming, then the matter should be referred to the Patient Advice and Liaison Service (PALS).

**Resolved**

That the information contained in the report and Appendix to the report submitted on the Dudley Group NHS Foundation Trust : Patient Experience, be noted.

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32 **Update on Urgent Care Development**

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

In presenting the oral report the Chief Accountable Officer stated that discussions to consider challenges and best solutions were still taking place, there were delays to the building but that the service would still be operational from 1st April, 2015. It was reported that "Malling Health" had been the successful tender and that all parties had been impressed by their culture and attitude and were of the opinion that they would work particularly and effectively well with GP's and patients.

Arising from the oral presentation, and in responding to Members' queries and comments, the following points were made:-

- The service would be in place and running from 1st April, 2015. However, there were delays to the building due to changes to the design and the requirement to submit a planning application.

- It was expected that the design of the service would free up capacity and therefore help to improve the quality of service to people and also help to reduce delays in ambulance turnaround.

- Discussions had been held around car parking and consideration was being given to expand the parking at the hospital and also the availability of buses to and from the hospital was being explored. It was pointed out that there were only eight car parking spaces at the current walk in centre.

- With regard to consultation rooms the Committee were informed that if the designated rooms to be located near the Accident and Emergency Department were not ready and available by 1st April, 2015, other rooms situated elsewhere in the hospital could be used.

- In relation to drawings or a model of the plans for the UCC the Chief Accountable Officer stated that it was intended to produce plans and that clear information would be publicised as it was imperative that members of the public were made aware of expectations.

  Ms Emery (Healthwatch) reported that once the UCC was operational they would undertake a survey with a view to collating information to gauge people's experiences.

The Chief Accountable Officer undertook to submit a report to the Chair to provide an update on discussions held with “Malling Health”. It was also requested that an update report be submitted to the meeting to be held in July, 2015 detailing information on performance, any associated problems particularly in relation to timescales and car parking together with information to be collated from the survey to be undertaken by Healthwatch.

**Resolved**

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

(2) That a further update report to include information on performance, problems encountered, particularly in relation to timescales and car parking, together with information collated from the survey by Healthwatch be submitted to the meeting of the Committee to be held in July, 2015.

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The meeting ended at 8.30 p.m.

CHAIR

Dudley Metropolitan Borough Council

**Agenda Item No. 6**

**Health Overview and Scrutiny Committee – 22 January 2015**

**Report of the Chief Executive, Paula Clark, The Dudley Group NHS Foundation Trust**

Care Quality Commission Inspection Outcomes

## 1.0 Purpose of Report

1.1 To advise the Committee of the outcomes of the Care Quality Commission hospital inspection of The Dudley Group NHS Foundation Trust, and the plans the Trust has in place to address the report.

## 2.0 Background

2.1 The Trust was inspected by the Care Quality Commission in March 2014. A number of areas for improvement were highlighted and it would be usual practice to provide an action plan.

2.2 However, the Trust asked for a review of the ratings during the summer and as a result there has been a considerable time lag from the point at which the Inspectors visited to the publication of the final report. As a result, the majority of areas for improvement have already been addressed and completed. Those which remain open are monitored by the Board and its Committees as areas of work on which the organisation was already sighted.

2.3 This paper therefore takes the Committee through each of the areas of concern raised by the CQC in March and provides information about the actions already taken. In those areas which remain open it signposts Board members to where progress is being monitored.

2.4 The majority of areas 30 out of 38 areas were rated Good. We are disappointed, therefore, that our overall rating for the Trust is Requires Improvement. The actions taken, and those in hand, address the requires improvement areas and the Areas for Improvement/Compliance Actions.

2.5 Children and young people, medical care, surgery, outpatients and end of life care all received an overall Good rating. Across all core services inspected, we have been rated **caring** and **effective**.

Chief Inspector of Hospitals, Professor Sir Mike Richards, believes we are not far off achieving a Good rating and he has confidence that we are addressing the issues highlighted by the inspection.

2.6 The CQC summary report is at Appendix 1.

## 3.0 Areas requiring improvement

### 3.1 Do Not Attempt Resuscitation Policy: Adherence, Training and Audit:

Although the Inspectors found good adherence to the policy on the wards they found two out of 17 notes with which they had concerns. Therefore the Trust has reacted by improving processes to provide full compliance.

DNAR is on the new ward round checklist/bundle that has been developed with one of our senior consultants. Ward clerks have been asked to ensure there is a copy in each patient's notes, and Matrons agreed to take on this responsibility. The completion and audit of process is in medical responsibility. For patients with an active DNAR in place where there are concerns about capacity, each ward sends a list on a daily basis to the Mental Health team to check and challenge as appropriate.

Training has been provided for medical staff by the Trust's legal advisors to ensure they are up to date with the latest legal guidance and advice. Further sessions are planned.

### 3.2 Emergency Department Flow

At the time of the visit in March the Trust was failing the 4 hour ED target and had done so for two successive quarters. Concerns were raised by the Inspectors about the responsiveness of the service given the delays being experienced by patients.

The Trust also failed Q1 but management arrangements have since been changed and performance has improved to be one of the best in the region and nationally. Focus on "pull" from the ED and improved processes on the wards has resulted in achievement of Q2 and Q3 in the face of huge pressure in the wider system.

The Trust has continued to participate in Emergency Care Intensive Support Team (ECIST) and the development of the frail elderly service with the CCG. Plans are also underway to host the Urgent Care Centre on site from April 2015 which will ensure patients are streamed appropriately thereby easing pressure on the main ED relieving capacity.

Performance of ED is monitored via both the Finance and Performance Committee and the Divisional Performance meetings.

### 3.3 Ophthalmology Clinic Provision

The pressure on the ophthalmology service is long standing. This has been for two reasons; firstly national shortage of consultants and secondly because of increasing demand as the population ages.

Work was already underway to address this prior to the Inspection and has continued since. Additional senior medical staff have been secured from overseas recruitment and a new Consultant has now been appointed who will start in March 2015.

The team are introducing three session days to create more capacity with the extended team. However as capacity comes on stream it is being taken up by increased demand.

Performance of this service is monitored by Finance and Performance in terms of slot availability and by the Divisional Performance meetings held monthly.

3.4 **Phlebotomy Capacity**

The Inspectors witnessed crowded clinics with patients waiting long periods and in some cases having to stand. This was unusual as most patients are seen quickly within a few minutes. However demand on the service continues to increase.

An additional waiting area has been provided at Corbett so that patients can be accommodated more comfortably if they do need to wait.

The recent decision to house the interim solution for the Urgent Care Centre in Outpatients on the Russells Hall site has created an opportunity to review the service there. We are considering how best to accommodate Phlebotomy services across our sites. Providing a convenient service off the main site and expanding capacity.

3.5 **Documentation for the Use of Compression Stockings**

During the inspection it came to light that the forms used for Venous Thrombo Embolism (VTE) assessment could be confusing for staff who were not familiar with them. The Inspectors were concerned that this could lead to patients who may need compression stockings not be given them potentially putting them at risk.

After the inspection all critical care patients were checked and they had all received either compression stockings or the appropriate VTE prevention treatment.

As a result of the Inspection findings the forms were changed during the summer.

3.6 **Incident Recording and Reporting**

The inspection found that in many areas this was good but there was some inconsistency. Although the Trust is one of the highest reporting trusts nationally it is recognised we can always do better. Therefore the governance team at both a corporate level and at a Divisional level have been working to embed best practice at all levels and in all areas.

3.7 **Staffing Level Reporting and Recording in Maternity**

This was an issue of reporting midwife to birth ratios rather than concerns about staffing levels. The Inspection team wanted to ensure clarity by the reporting of one measure in the unit so that there was good understanding of staffing levels on a daily basis. This has been actioned.

3.8 **Staffing Levels and Cover for Vacant Shifts**

The Inspection team were content that the Trust had the appropriate staffing levels in place but concerns were raised about the reliance on bank staff, many of whom were Trust staff, to fill vacant shifts.

In a difficult recruitment climate for qualified nurses, the Trust has continued to recruit and has undertaken another successful round of recruitment in Portugal. The latest round of recruitment has brought the Trust close to full establishment for qualified nurses. We are still actively recruiting to ensure that we are we are able to meet new vacancies as they arise through natural turnover.

The Trust plays a leading role in the Black Country Education and Training Council and the CE has a seat on the West Midlands Health Education Board. Therefore we are in a good position to influence training and education and have been successful in

getting increased training numbers and courses for sonographers and ODPs in addition to more nurse training places. Although this strategy will take three years to come to fruition with the new graduates, the Trust will continue its policy of recruiting abroad and in trying to make The Dudley Group the best place to work to attract local candidates in a difficult market.

Ward staffing levels are monitored daily and reported to the Board on a monthly basis under the Safer Staffing initiative and are available on the Trust website.

## 4.0 Areas of good practice the CQC highlighted in the report

4.1 The way we aim to meet individual needs of patients through for example the breakfast club within medical services to help stimulate patients and avoid isolation and also the pet therapy provided by Buster the dog.

4.2 The user engagement we have undertaken in development and launch of the learning disabilities strategy, which was praised by our patient's.

4.3 The smart phone app for antimicrobial prescribing captured the imagination of the inspectors as it allows prescribers to have the most up to date information at their fingertips.

4.4 Something that we already knew but is comforting to see within our report is the overriding view that we are very fortunate to have such caring staff here in Dudley who provide excellent care.

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**Paula Clark**
**Chief Executive**

Contact Officer: Liz Abbiss
Telephone: 01384 321013
Email: liz.abbiss@dgh.nhs.uk

# Dudley Group NHS Foundation Trust

## Quality Report

Russells Hall Hospital
Dudley, West Midlands
DY1 2HQ
Tel: 01384 456111
Website: www.dgh.nhs.uk

Date of inspection visit: 26 and 27 March 2014
Date of publication: 03/12/2014

This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

## Ratings

| | |
|---|---|
| Overall rating for this trust | Requires improvement |
| Are services at this trust safe? | Requires improvement |
| Are services at this trust effective? | Good |
| Are services at this trust caring? | Good |
| Are services at this trust responsive? | Requires improvement |
| Are services at this trust well-led? | Good |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We carried out this comprehensive inspection as part of the new hospital inspection programme and as a follow up to the Keogh review which took place in 2013. Of the 14 trusts inspected under the Keogh review for the quality and safety of their services, The Dudley Group NHS Foundation Trust was one of only three trusts that were not put into special measures. That review identified concerns regarding:

- governance arrangements
- the need to embed a culture of learning from incidents
- how the trust uses and reviews mortality data
- the system for bed management and patient flows
- embedding patient experience in the organisation's learning and strategy
- staffing levels and skills mix
- safety and equipment checks
- pressure ulcer care.

Before the inspection conducted in March 2014, the Trust was identified in CQC's intelligent monitoring system as a priority band 4 Trust. There are six bands within the monitoring system so this Trust had a relatively lower risk.

We noted that the trust's action plan to address the concerns following the Keogh review had been put into place and signed off.

Our inspection of The Dudley Group NHS Foundation Trust included Russells Hall Hospital, Corbett Outpatient Centre and Dudley Guest Outpatient Centre.

The announced inspection took place between 26 and 27 March 2014, and unannounced inspection visits took place in the two weeks following this visit.

Overall, this trust was found to require improvement, although we rated it good in terms of having caring staff, and effective services.

We saw much support for the trust, both from the public and from the local health economy.

We saw a trust that was a considerable way along its improvement journey and saw many areas of strong development. Whilst some of the core service areas within the trust required improvements in leadership, we found the executive team and the trust board had a clear focus on improvement and as such we rated this trust as good for its overall leadership.

The improvements required by the trust were within the grasp of the trust and its leaders. We were confident that these could be achieved quickly.Key findings related to the following:

- The trust's staff are seen as highly caring by many of the patients we spoke to and praised the staff for 'going the extra mile'.
- The trust's leadership team is seen as highly effective by the staff; and is recognised to be clearly in touch with the experience of patients and the work of the staff.
- Staff value the Dudley Group as a place to work and a team spirit is clearly evident.
- The trust has responded well to the Keogh review in 2013.
- There are a number of areas of good practice in the trust, which should be encouraged. Staff feel able to develop their own ideas and have confidence that the trust will support them.
- The emergency department (A&E) is busy and overstretched. There remain challenges in the flow of patients, but much of this relates to flow across the rest of the hospital. Only a small proportion relates to the emergency department itself.
- The trust does not always follow its own policy in relation to DNACPR (do not attempt resuscitation) notices.
- The ophthalmology clinics require review to ensure that all patients are followed up as required and that there is capacity for these clinics.
- The trust must review its capacity in phlebotomy clinics as this is seen as insufficient.

**Professor Sir Mike Richards**

Chief Inspector of Hospitals

# Summary of findings

## Background to Dudley Group NHS Foundation Trust

The Dudley Group NHS Foundation Trust is a medium sized hospital providing hospital and adult community services to the population of Dudley, Stourbridge and the surrounding towns and villages. Located in the heart of the Black Country area it covers a population of around 450,000 people in mainly urban areas.

The trust provides the full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands region. The trust also provides specialist adult community based care in patients' homes and in more than 40 centres in the Dudley Metropolitan Borough Council community.

The trust consists of one main hospital with two smaller outpatients centres that are run as one main unit. The hospital has around 687 beds. It sees around 105,000 inpatients; 500,000 outpatients and almost 100,000 attendances at A&E each year.

The area of Dudley is moderately deprived (83rd out of 326 local authorities where 1 is the most deprived). Life expectancy is worse than that expected within the England average.

The trust gained foundation trust status in October 2008, and was the first trust to do so in the area.

Through CQC's Intelligent Monitoring process this organisation was seen as a relatively low risk organisation. Professor Sir Bruce Keogh undertook a review of hospitals where the rate of mortality was greater than expected. The Dudley Group NHS Foundation Trust was one of 14 trusts reviewed in that process. It was one of only three that were not put into special measures following the review.

CQC has reviewed the trust on a number of areas and against all outcomes in the CQC outcomes framework. The trust has had seven inspections since registration. The trust was last reviewed on 30 July 2013. On all reviews the trust was found to be fully compliant.

## Our inspection team

Our inspection team was led by:

**Chair:** Mr Peter Lees, Medical Director, Faculty of Medical Leadership and Management

**Team Leader:** Tim Cooper, Head of Hospital Inspection, Care Quality Commission

The team of 40 included CQC inspectors, doctors and nurses with specialist skills and interests in the areas we inspected. There was a pharmacist inspector, people with skills and experience to look at safeguarding and care of vulnerable adults. At least two members of the team also held board level roles in other trusts and were therefore experienced in the wider organisational issues. We had both a junior doctor and a student nurse. Additionally we had two Experts by Experience (people with experience of using similar services who are able to talk to patients to gather their views) and two lay representatives.

The Patients Association was also part of our team to review how the trust handled complaints.

## How we carried out this inspection

To really understand a patient's experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical

# Summary of findings

commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Royal Colleges and the local Healthwatch.

We held two community focus groups in early March 2014 with voluntary and community organisations. The focus groups were organised in partnership with Raise, through CQC's Regional Voices Programme. They aim to listen to the views of people who may not always be heard.

We held two listening events, in Stourbridge and Dudley, on 25 March 2014, when people shared their views and experiences of The Dudley Group NHS Foundation Trust.

We carried out an announced inspection visit on 26 and 27 March 2014. We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses, junior doctors, consultants, midwives, student nurses, managers, administrative and clerical staff, physiotherapists, occupational therapists, pharmacists, domestic staff and porters. We also spoke with staff individually as requested.

We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' records of personal care and treatment.

We carried out several unannounced inspections in the two weeks following our inspection.

We are grateful to all the patients, carers, members of the public and staff for their honesty and open approach during this visit.

## What people who use the trust's services say

We spoke to two patient/community groups before the hospital inspection, which were arranged by CQC partners and held off-site. We also spoke to many patients and relatives during our inspection in each clinical area we visited. In the subsequent sections of this report we have detailed the comments as they relate to each service. However, the generic themes that emerged are:

People at the focus groups reported that they had challenges in accessing outpatients and often experienced delays in the service. People found most problems with the ophthalmology clinics.

We held two public listening events on 25 March for people of the Dudley and Stourbridge areas to join us in one-to-one discussions about their experiences, one in Stourbridge and one in Dudley. These meetings were well attended and the information shared with our inspectors informed the inspection.

People told us of areas where the care they had received was good and that they were pleased with that care; people also told us of times when (with complex clinical or social needs) they felt the service had let them down.

Letters handed to the CQC inspection team on the day of the visit were highly complimentary about the services that people had received.

### Management of complaints

During our visit, we were joined by colleagues from the Patients' Association who carried out a detailed review into the way the trust manages complaints.

Shortly before the inspection, the trust sent out 300 Patient Association complainant questionnaires. In spite of the tight timescales, there was a 13% response rate, and 38 questionnaires were returned and analysed.

Of those 38:

- 25 (65.8%) felt either dissatisfied or very dissatisfied with the response they had received;
- 8 (21%) were either satisfied or very satisfied;
- The majority felt that the Trust had told them the truth, either completely (6) or partially (16);
- Most found complaining to the Trust a stressful process, with 19 (50%) reporting that it was very stressful and 8 (21.1%) sometimes stressful;
- 18 respondents (47.4%) did not believe the response had explained how the Trust had taken action to prevent similar problems happening again;
- 20 (52.6%) felt that they had not been updated on changes made as a result of their complaint.

We saw evidence of very good practice resulting from the reflection that has already taken place in the trust as a result of the Keogh review. In particular complainants had

# Summary of findings

been invited to give feedback on their experience of the complaints process and what could be improved at the two Listening into Action events, attended by the Chief Executive and other members of the Executive Team. Events were held in December 2013 and March 2014 and some immediate changes were made to the process, including offering to meet complainants at the outset to clarify their concerns and providing clearer information in response letters about changes which have been made as a result of each complaint. We also saw evidence that the Medical Director had written to a complainant following a Listening into Action event, to tell them that he had personally met with a member of the medical staff whose behaviour had been complained about. He confirmed that the member of staff apologised for his behaviour and that he would be taking this up as part of his appraisal and attending further training around communication skills.

A positive culture of resolving issues on the ground before they become complaints was in evidence. In Critical Care / the Acute Medical Unit there appeared to be a clear process for escalating any concerns raised by patients which were not resolved immediately. We understand that if a concern is raised, nursing staff frequently phone a patient or relative back, write a letter or offer an immediate meeting. These are logged as concerns and staff reported that very few go on to become formal complaints. This early resolution of concerns by the staff involved is to be commended. Newly-introduced 'Huddle Boards' at ward level also offered the opportunity for immediate discussion of concerns and complaints, and feedback to ward teams about learning and action points.

A member of the Patient Experience Team also watched a video entitled 'My Promise to Emrys', in which a bereaved woman speaks about her late husband's experiences of poor care at the trust. The trust's Head of Customer Relations and Communications explained that this person had made a complaint to the trust and as a result had been invited to speak to the board and make the video about her husband. The short film is also used in staff induction and training. It highlights the importance of staff asking themselves the question: 'How would I like to be treated today?'

The use of these short films in both training and induction with staff is an example of excellent practice. We understand that the trust's induction training includes a session from the Governance department, which includes some information about responding to complaints. Customer care training is available as part of a package of non-mandatory staff development training, and some ward staff had attended that or sent members of their team. However, it appeared from speaking to ward staff that there is no ongoing training on effective complaints investigation. Nurses told us that they would welcome more training and opportunities to share good practice in complaints handling and learning from complaints, including what other areas are doing to address common issues.

# Summary of findings

## Our judgements about each of our five key questions

**Rating**

### Are services at this trust safe?

**Requires improvement**

Overall, we rated safety in the trust as requires improvement.

A serious incident known as a never event is classified as such because it is so serious that it should never happen. The trust previously reported two never events between December 2012 and January 2014.

The Strategic Executive Information System (STEIS) records serious incidents and never events. Serious incidents are those that require an investigation. Between December 2012 to January 2014, 168 serious incidents occurred at the trust. Between June 2012 and July 2013, the trust submitted 1,003 serious incident notifications.

During our inspection, we found the department staffed with medical and nursing staff in sufficient numbers to meet the needs of patients. We observed patients in the Minors and Majors areas being prioritised or triaged by a 'triage trained' nurse. This process ensured that the most appropriate plan of care was organised to meet their needs. Children were triaged in the separate paediatric department from 11am to 11pm. This meant that they were seen by specialist nurses and doctors during those hours.

We found that all of the areas we visited on the medical care directorate were clean and hygienic, which helped to protect patients from hospital-acquired infection. We saw that all areas were well maintained and free of clutter. In the 2013 NHS Staff Survey, the trust came in the top 20% of trusts nationally, regarding the proportion of staff stating that hand-washing materials were readily available ensuring people were protected from the spread of infection.

The proportion of patients risk assessed for venous thromboembolism (VTE) was within expectations but we found some concerns with the use of anti-embolism stockings in the critical care unit.

Some areas of the trust required improvement in aspects that we consider contribute to patient safety. In A&E we saw that space was an issue for the service and patients were waiting in corridors on a number of occasions. Staff were working under significant pressure. There was a plan for looking at capacity and flow across the acute trust and into the community.

In some areas we were concerned that not all staff understood the importance of incident reporting and the processes to use.

# Summary of findings

In maternity, historically the capacity of the service was stretched. A plan for managing this had been agreed with the Clinical Commissioning Group (who had limited the activity at the trust). In the event of staffing or patient capacity issues, the service would be suspended in accordance with the escalation policy.

In end of life care, we found that the systems for agreeing a DNACPR order (do not attempt resuscitation) for those patients at end of life were not always robust.

We found not all risks had all been identified or recorded onto the critical care risk register. The Medical High Dependency Unit (MHDU) was routinely staffed to less than the full capacity for the number of patients they could accommodate. We were concerned that the "flex" staffing arrangements in MHDU could place people at risk of unsafe care. We found that senior nurses were spending unreasonable amounts of time covering shifts with agency staff or the Trust's own temporary nurses.

We did however see elements of good practice including safety huddles; use of safety dashboards; antibiotic prescribing; clean clinical areas and good hand washing and hand hygiene.

**Are services at this trust effective?**

Good

The trust was delivering effective care.

Using CQC's Intelligent Monitoring data, the trust previously had a mortality alert as an outlier for skin and sub cutaneous tissue infections. At the time of our visit this had already been recognised by the trust and investigated. This issue was discussed with the medical director who felt that this related to small numbers within the data amplifying the concerns.

Current data shows that the trust's mortality has been reduced and it is no longer an outlier in national monitoring. The Medical Director had led work on resolving this through mortality review meetings and pathway redesign. The Medical Director showed strong leadership in resolving these concerns.

In maternity services, we saw that there were around 5,600 births during the previous year. This had now been limited to 4,900 by the commissioners as a way of managing capacity in the trust. The trust had a higher rate of elective caesarean and other forceps deliveries when compared with nationally. The trust's normal delivery rate was also slightly higher than that reported nationally. The trust's outcomes as judged by the maternity indicators were within expected limits for all of the indicators (i.e. Perinatal mortality Emergency caesarean sections Elective caesarean sections Neonatal readmissions and Puerperal sepsis).

# Summary of findings

In many areas the trust had good practice and audit to support its work and access to nurse specialists, where required, was available. We saw good use of clinical guidelines and competency training. Most staff we spoke to had personal development plans to improve their clinical skills and training.

In maternity however, we found that monitoring information on the dashboard was inaccurate. Additionally, not all audits carried an action plan, and not all audits undertaken were part of an agreed plan for the service.

We spoke with the relative of a patient who had chosen to take part in a government-funded treatment trial. They told us that the consultant had explained the benefits and limitations of this prior to commencing the treatment.

**Are services at this trust caring?**

Good

Overall we rated the caring aspects of services in the trust as 'good'.

Since April 2013, patients have been asked whether they would recommend hospital wards to their friends and family if they required similar care or treatment, the results of which have been used to formulate NHS Friends and Family Tests for Accident & Emergency and Inpatient admissions. The Inpatient FFT survey emphasises that the trust performed better than the England average during this period. The A&E FFT highlights that the trust was performing better than the England average for all four months, with the highest score being 73 in December. It also reflected that the most responses received were 1,071 in December.

The trust has performed 'worse than other trusts' nationally for 32 of the 69 questions asked in the 2012/13 Cancer Patient Experience Survey. It has also performed 'better than other trusts' for one other question in the survey (Patient has taken part in cancer research).

Analysis of data from CQC's Adult Inpatient Survey 2012 showed the trust had performed worse than expected on two areas of questioning: the emergency/A&E department and waiting to get to a bed on a ward.

Many patients were highly positive of the care they had received. Staff were praised by patients for being very committed. Individual examples where staff went 'over and above' what would be expected are set out in individual sections. However, we noted in many areas patients were extremely appreciative of the efforts of staff to meet their needs.

# Summary of findings

We saw good voluntary sector engagement and a strong sense of community feel. One of the trust's governors worked as a volunteer and we met him both in the governors meeting and also the following morning 'on duty' in the trust.

**Are services at this trust responsive?**

**Requires improvement**

Whilst many of the services provided a responsive approach to patient care, we felt a number of services required improvement. We could not be assured that services patients received would always respond to their needs.

We saw that the trust regularly breached the four-hour wait target for patients in A&E. The ability of the trust to respond to patients' needs by providing access to secondary care beds from A&E was limited. Patients were often delayed in accessing beds in the hospital.

We saw in some areas a delay in discharge related to challenges in accessing medication in a timely way.

We found delays in admission and the flow of patients through the organisation, meaning patients were taking longer to arrive on the appropriate ward than should have been the case. We saw a number of outliers on different wards (patients who were not on the ward they should have been due to bed shortages); this meant they were not always receiving care from the nursing and clinical team that would best meet their needs.

In some areas the physical space (eg Phlebotomy and A&E) was insufficient for the needs of the people using it.

However, we also noted areas where the trust was highly responsive to patients' needs. As example of this is a sonographer available on the surgical assessment unit and a holistic approach to fracture care.

We were told that the trust is undertaking an ambulatory care pilot scheme to ensure that it could improve the way it met the needs of patients coming in through A&E.

We saw good examples of how the trust protected vulnerable adults and applied safeguarding procedures.

The week before the inspection, the trust had held an international event at the hospital which had been coordinated by the hospital caterers association with dieticians from the trust and Interserve, the trust's catering company. As part of this event, new leaflets had been produced for patients on how to maintain good nutrition and hydration.

# Summary of findings

During our listening event and throughout our hospital visits we were told by patients and relatives that problems with car parking at the hospital caused much stress. They said they found it very difficult to park and that the costs for car parking were too high. They were, however, aware that a weekly car parking pass could be purchased at a reduced rate. A relative told us, “I find the parking very stressful. There is not enough parking and I have to drive round and round to find a space.”

**Are services at this trust well-led?**

Good

We saw strong leadership throughout the organisation.

The leadership of the Chief Executive was praised by many members of staff at all levels and the focus from the Executive Team on taking the organisation forwards. Both the Chief Executive and the board were visible and highly engaged. Staff we spoke to knew them by name and by sight. Staff spoke of the executive team doing shifts on the wards. One member of staff told us that following one shift, the Chief Executive saw and recognised some of the challenges the team faced, and the next day an order for a specific piece of equipment was approved. There was confidence among the staff that the board really understood the challenges and practices in the trust.

Overall, we rated the trust as good at trust wide level (reflecting the role of the executive team and the board). However, at a location level, well-led was rated as requires improvement.

The Chief Executive expressed a view of one single hospital on three sites; and this is certainly how many of the inspection team perceived it to work. There was a clear sense of team spirit throughout the whole trust.

We noted that the trust’s action plan to address the concerns following the Keogh review had been put into place and signed off as complete by Monitor.

The NHS Staff Survey 2013 saw the percentage of staff reporting good communication between senior management and staff as tending towards a ‘better than expected’ result. Throughout our inspection we were given many examples referring to the Chief Executive and their visibility and commitment to the organisation.

The trust had been reviewed as part of the Keogh mortality review. We saw a trust that understood what it needed to do to move the organisation forwards and had focused on meeting those requirements.

The trust’s performance was better than expected or tending towards better than expected for 13 of the 28 NHS 2013 Staff Survey

# Summary of findings

indicators. The trust was found to be performing well in regard to staff being satisfied in their jobs, staff being supported by immediate managers and staff stating that there was good communication between staff and senior managers

The trust's performance was worse than expected or tending towards worse than expected for 11 of the 28 NHS 2013 Staff Survey indicators. Key points from these indicators are the lack of effective team working, staff not feeling that their role makes a difference to patients, staff being able to contribute towards improvements at work and staff experiencing physical violence from other staff in the last 12 months.

The NHS staff survey 2013 saw the percentage of staff having a well-structured appraisal in the last 12 months within the top 20% of trusts nationally and the percentage of staff having received job-relevant training, learning or development as tending towards better than expected. Medical and nursing staff told us that they had regular opportunities to speak with their line managers.

A member of staff at Dudley Guest Hospital told us of "strong ties between the multidisciplinary team". Another told us they received six-weekly supervision and an annual appraisal.

The trust has taken part in all the audits it was eligible to participate in. The trust's performance against the five National Bowel Cancer Audit Project indicators was found to be within expectations. The trust was found to be performing better than expected for two of the five indicators in the Myocardial Ischaemia National Audit Project. The trust was found to be performing within expectations for all three of the Antenatal and Newborn Screening Education Audit indicators.

We saw good attention being paid to professional development and training. All staff we spoke to had received both an annual appraisal and a mid-year review. All staff felt that they had a development plan that was agreed and access to support in achieving it.

The trust has implemented a vision and values drive. Its clear message was contained in the three values 'Care' 'Respect' and 'Responsibility'. It was clear that staff understood these and were signed up to them.

In some areas we saw leadership that required some development. This included systems for sharing learning from incidents, workload in some teams and communication systems that were too cumbersome to be effective.

# Summary of findings

The NHS Staff Survey 2013 also saw the percentage of staff recommending the trust as a place to work or receive treatment as 'within expectations'. All the staff we spoke with over the two days, and at staff focus groups, were confident that if their relative were admitted to the trust they would receive good, safe care.

# Overview of ratings

## Our ratings for Russells Hall Hospital (including Corbett and Dudley Guest)

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Accident and emergency | Good | Not rated | Good | Requires improvement | Requires improvement | Requires improvement |
| Medical care | Good | Good | Good | Good | Good | Good |
| Surgery | Good | Good | Good | Good | Good | Good |
| Critical care | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |
| Maternity & family planning | Requires improvement | Good | Good | Good | Requires improvement | Requires improvement |
| Children & young people | Good | Good | Good | Good | Good | Good |
| End of life care | Requires improvement | Good | Good | Good | Good | Good |
| Outpatients | Good | Not rated | Good | Requires improvement | Good | Good |
| Overall | Requires improvement | Good | Good | Requires improvement | Requires improvement | Requires improvement |

## Our ratings for Dudley Group NHS Foundation Trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Overall trust | Requires improvement | Good | Good | Requires improvement | Good | Requires improvement |

### Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both Accident & Emergency and Outpatients.
2. The rating for overall trust for the well-led key question is different for the rating for well-led for the location. This reflects the inspection team's view of strong leadership from the executive team, trust board and the chief executive.

# Outstanding practice and areas for improvement

## Outstanding practice

### Good practice

- The breakfast club within medical services to meet patients psychological need and void isolation. Pet Therapy was also available on wards.
- There had been positive user engagement in developing the Trust strategy for patients with learning needs. This was welcomed by this patient group and their carers.
- The Trust had developed a smart-phone app for antibiotic prescribing. All staff have access to this, it ensures those prescribing antibiotics have access to the most up-to-date Trust information.
- There was strong engagement from the executive team at all levels and staff report an open door and open communication culture.
- In response to a previous criticism of the food provided by the hospital, the Trust held an 'international' event to improve food quality. Jointly hosted by dieticians, the Trusts catering team and Interserve (PFI partners). Following this new nutrition and hydration leaflets had been produced.
- Staff were highly praised by patients for their caring approach. Numerous examples were given were staff had 'gone the extra mile' and this was appreciated.
- Hot clinics (rapid access) were in place to fast track patients who need to be seen quickly in surgical areas.
- There was a sensory room in the children's ward for young babies and children with specific needs; this was seen as highly responsive to people's needs
- We identified some excellent practice that targeted patients' specific needs in an empathetic manner. This included the Eye Clinic Liaison Officer (ECLO) and the Care of Next Infant (CONI) programme in the outpatient clinic for children and young people.
- We saw staff respond positively and professionally to anxiety and aggression in individual patients.

## Areas for improvement

### Action the trust MUST take to improve

- The Trust must ensure that DNACPR orders are followed according to the Trust's policy and are reviewed regularly.
- The Trust must review its flow of patients from A&E through the hospital. There are challenges to patient flow that are preventing the service meeting needs of patients early in the pathway.
- The Trust must review its ophthalmology clinic provision to ensure patients' needs are met.
- The Trust must review its capacity in phlebotomy clinics at both Russells Hall and at Corbett Hospital.
- The Trust must review the documentation it uses for compression stockings on critical care unit; these reduce the risk of venous thrombo-embolism. The Trust must ensure that all patients who require these are given them and it is appropriately recorded.
- The Trust must review its incident recording and reporting. In many areas this is good, but this is not consistent across the organisation.
- The Trust must review its method of agreeing staffing levels in maternity so that only one figure is understood by the whole Trust.
- The Trust must ensure that staffing levels and cover for vacant shifts is satisfactory and does not place overreliance of staff who have already worked full shifts to cover these.

Agenda Item No. 7

**Health Overview and Scrutiny Committee – 22 January 2015**

**Report of the Head of Commissioning, Neill Bucktin, Dudley CCG and Paula Clark, Chief Executive, The Dudley Group NHS Foundation Trust**

# Winter Pressures

## 1.0 Purpose of Report

1.1 To advise the Committee of plans put in place to deal with demand in the health and social care system and performance during the winter period.

## 2.0 Background

2.1 In June 2014, NHS England made available additional resources to health and social care systems to support agreed "Operational Capacity and Resilience Plans" established by System Resilience Groups, consisting of Chief Executive/Director level representatives of the main health, social care and voluntary sector organisations in the local health and social care economy.

2.2 In Dudley, the Health and Social Care Leadership Group fulfills the role of the System Resilience Group and reports to the Health and Wellbeing Board. As Chairman of the Group, the CCG's Chief Executive Officer acts as the Accountable Officer for the use of the additional resources.

2.3 This report sets out the agreed plan for the use of additional monies made available to Dudley by NHS England via the System Resilience Group and also made available directly to Dudley Group NHS FT; and subsequent performance during recent weeks.

## 3.0 Resource Allocation

3.1 The schedule at Appendix 1 shows the breakdown of the use of additional monies. The Committee will note that these monies have been allocated across a range of schemes covering:-

- primary care
- community health services
- hospital services
- mental health services
- intermediate care
- social care

3.2 Expenditure and performance has been overseen by the Urgent Care Working Group, reporting to the System Resilience Group.

3.3 In addition, the System Resilience Group has in place an agreed action plan for improving system wide performance, as a result of advice received from the Emergency Care Intensive Support Team. This, alongside the additional resources was designed to create a sustainable system over the winter period and beyond.

## 4.0 System Performance

4.1 In recent weeks the system has been under significant pressure. This has been characterised by:-

- additional demand in primary care;
- additional demand in A and E, as a result of influenza A and respiratory conditions, predominantly for the frail elderly;
- delayed transfers of care;
- delays in intermediate care, in terms of patients waiting to be either allocated to a social worker or to be assessed by a social worker.

4.2 The attached graphs at Appendix 2 show Dudley Group NHS FT's performance in relation to the 4 hour target to see treat, admit or discharge 95% of patients in ED and describes in further detail the initiatives in place within The Dudley Group to support winter demands. Despite the significant pressure in the system, the quarterly and monthly target was met for the period ending 28th December, 2014. Quarter 3 data published by NHS England shows that 95% of DGNHSFT's 24,918 attendances were seen, treated, admitted or discharged within 4 hours.

4.3 This put The Dudley Group as 11$^{th}$ best district General Hospital in the country (only 13 trusts met the type 1 95% target in Q3) and the only Trust in the midlands to meet the target. In the same period of 2013/14 the Trust had 23,181 attendances (+1737). Since New Year's Eve performance has deteriorated. Within three days, the level, of breaches within A and E was the equivalent of what would be expected over a "normal" 3 week period. Appendix 3 gives more detail on the increase in demand upon emergency department services.

4.4 Primary care activity is best illustrated by activity at the Walk in Centre. The centre's usual planned level of activity is 3,289 attendances per month. December saw total attendances of 5,171.

4.5 The fundamental issue has been maintaining a suitable level of patient "flow" through the hospital and discharge to home; intermediate care; residential care or nursing home care. This has been hampered by a breakdown in the intermediate care system. As far as the latter is concerned, a significant number of patients have a length of stay beyond the expected 6 weeks, many of whom had not been allocated a social worker. Without adequate "flow" through the system, pressures in terms of hospital admissions become very difficult to manage. The table below shows the number of delays in both locations at three points during the period.

| Date | 25/12/2014 | 01/01/2015 | 08/01/2015 |
|---|---|---|---|
| **Acute Delays** | 87 | 76 | 70 |

**Non Acute Delays**

| Date | 25/12/2014 | 01/01/2015 | 08/01/2015 |
|---|---|---|---|
| Total Delays | 52 | 42 | 43 |
| Awaiting Allocation of social worker | 41 | 34 | 15 |
| Awaiting social care assessment | 7 | 5 | 20 |

**Neill Bucktin**
**Head of Commissioning, Dudley Clinical Commissioning Group**

**Paula Clark**
**Chief Executive,The Dudley Group NHS Foundation Trust**

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Appendix 1

# Winter Schemes 2014/15

| | Better Management of current Pathways/services | Value £ | Provider |
|---|---|---|---|
| 1 | Frail Elderly Assessment Unit | 259,600 | DGH |
| 2 | Extension of HALO cover | 21,000 | WMAS |
| | **Divert Pathway** | **Value £** | **Provider** |
| 3 | Social Care Urgent Response Service | 140,000 | DMBC |
| 4 | Falls First Response Service | 131,000 | DMBC |
| 5 | Urgent Care Streaming | 51,000 | DGH |
| 6 | Dudley Paramedic pathfinder | 20,000 | WMAS |
| 7 | Black country mental health car response service | 85,000 | WMAS |
| 8 | NHS 111 GP on calls pilot. | 14,000 | NHS 111 |
| 9 | Walk in centre Extended hours | 145,700 | Primecare |
| | **Better Discharges** | **Value £** | **Provider** |
| 10 | Care Home Select | 84,000 | Ind Sector |
| 11 | Discharge to Assess | 172,000 | DGH |
| 12 | Bed Management System | 28,600 | DMBC |
| 13 | Red Cross Patient Transport and Home Ready Initiative | 224,000 | Ind Sector |
| 14 | Trusted Assessor pilot | 29,300 | DGH |
| 15 | Increase in intermediate care capacity | 319,000 | Ind Sector |
| | **Consistency of Services Across 7 days** | **Value £** | **Provider** |
| 16 | Extension of DISCO OOH | 13,000 | DGH |
| 17 | Weekend Discharge ( 3 day team) | 78,000 | DGH |
| 18 | Increase in therapy support to intermediate care beds | 84,700 | DGH |
| 19 | 7 Day streaming for surgical assessment unit | 15,600 | DGH |
| 20 | Increase in intermediate care team capacity | 100,000 | CCG |
| | **Local Plans for Innovation** | **Value £** | **Provider** |
| 21 | Rapid Response Team | 1,000,000 | CCG |
| 22 | GP Locality Leads | 135,000 | CCG |
| 23 | Voluntary Sector Locality Link Workers | 388,000 | CCG |
| 24 | Social Prescribing Scheme | 126,000 | CCG |
| 25 | Mental Health Crisis Service | 654,000 | CCG/DWMH |
| | **Preventative** | **Value £** | **Provider** |
| 26 | Flu vaccination Campaign | N/A | CCG |
| | | | |

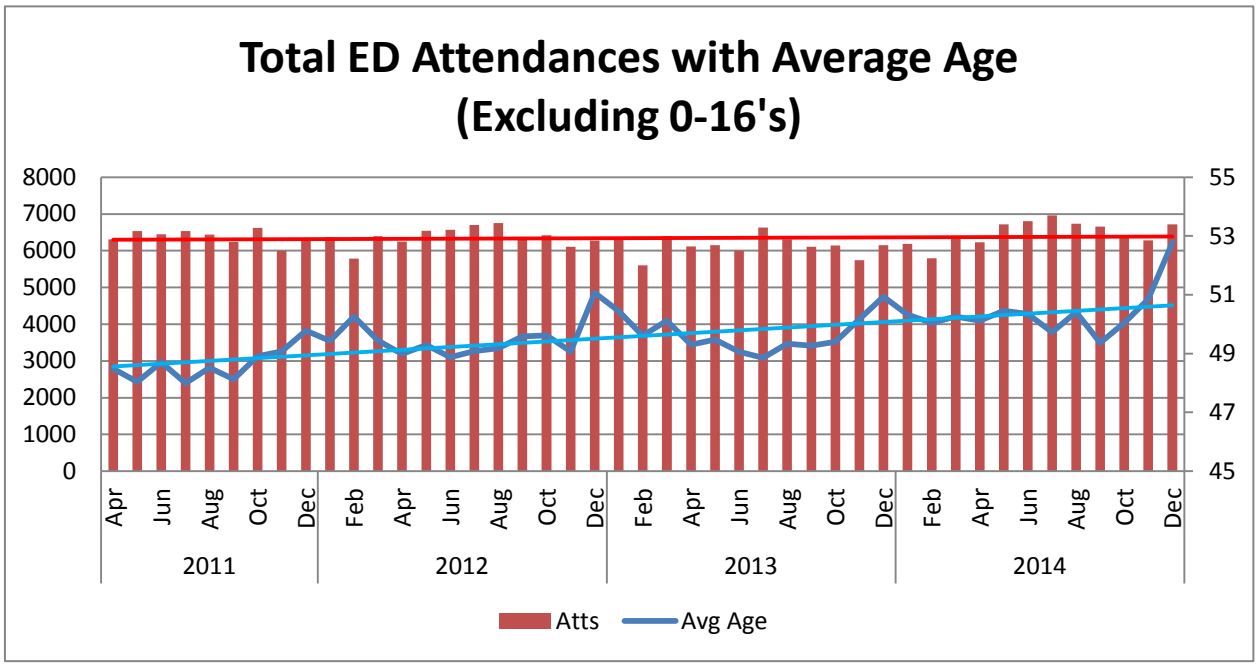
| | Additional A&E Monies Schemes | Value £ | Provider |
|---|---|---|---|
| **27** | Reconfiguration of acute medical unit | £821,594 | DGH |
| **28** | Wrap around services to support patient discharge from hospital | £151,000 | DGH |
| **29** | Spot Purchase | £200,000 | DGH |
| **30** | Increased Impact therapy support | £20,000 | DGH |
| **31** | Patient Trackers in ED | £151, 575 | DGH |
| **32** | Increased therapy into minors flow | £25,000 | DGH |
| **33** | Additional Dr Support to 7 day working | £58,293 | DGH |
| **34** | HIP attack | £35,000 | DGH |
| **35** | PAU extension to hours | £23,000 | DGH |
| **36** | Increased Portering Staff | £50,000 | DGH |
| **37** | Tri Agency Funding | £60,000 | DGH |

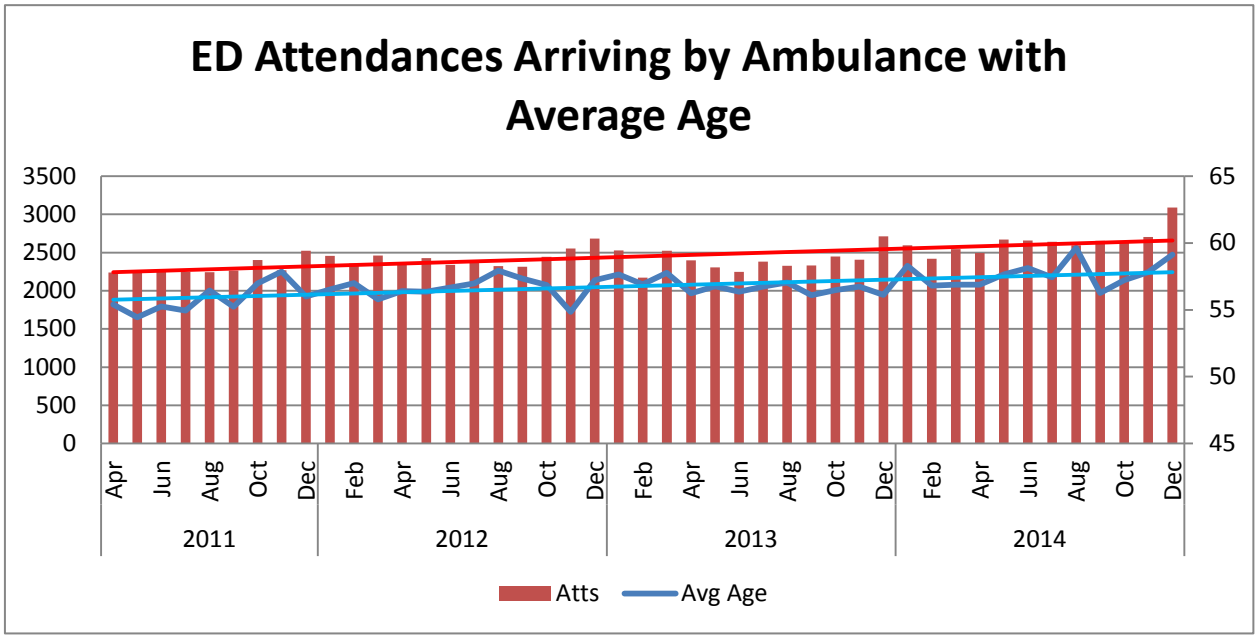
The Dudley Group NHS FT have used the funding to support winter demands on our services to :-

- have a GP supported by a nurse within the ED department to triage and treat patients with less urgent needs keeping the emergency department team free for the most poorly patients;
- instilled a single minded focus on capacity and flow across all our wards and the emergency department. This means all areas take responsibility for discharging patients in a timely manner to ensure we keep up with demand in ED. This includes treating weekends like weekdays and having discharge doctors, ward rounds, matrons and management on site;
- dedicated capacity hub which includes nurses, doctors and managers working together at regular intervals throughout the day to review current waits, patient volumes and how many discharges are due;
- site coordinators are a team of senior nurses who have overall responsibility for the coordinating of patient flow 24 hours per day. Using an escalation process to assist in managing pressures;
- improved use of the Discharge Lounge to facilitate early discharge;
- spot purchase beds to free up acute beds, to allow discharge of medically fit patients;
- discharge to Assess started from 5th January, as Pathway 1 has been rolled out to all wards and Pathway 2 commenced today. Ultimately this means that patients should not remain in a hospital bed unnecessarily;
- we are working with Care Home Select in the assisting of patients and families in finding suitable residential and nursing home care;
- we have increased the input from Red Cross, in the provision of an ambulance for front door patients and support with the discharge lounge.

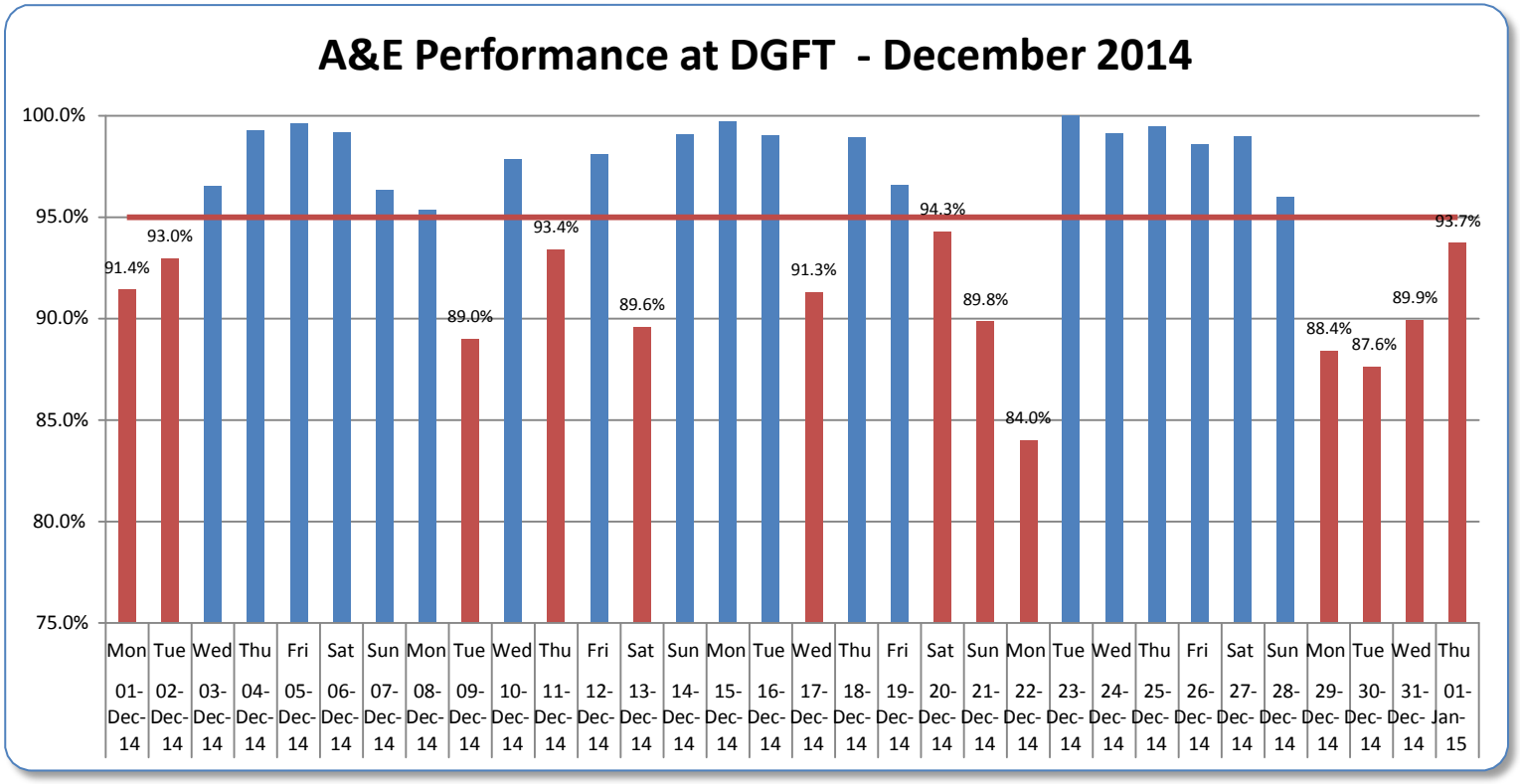
# A&E Performance DGFT

Appendix 2



# A&E Performance DGFT




The bar chart above shows A&E 4 hour wait performance at DGFT throughout December 2014. Despite some low achievement days the month was achieved (95.0%).

**Appendix 3**

**Russell's Hall Hospital ED information**

**Attendances**

| | | |
|---|---|---|
| December 2013 | 7944 | |
| December 2014 | 8672 (about 10% increase) | |
| January 2014 | Since 1st Jan to 7th Jan | 1543 |
| January 2015 | Since 1st Jan to 7th Jan | 1673 (8.5% increase) |

**Ambulances**

| | | |
|---|---|---|
| December 2013 | 2713 | |
| December 2014 | 3090 (14% increase) but 18% increase in year to date average | |
| 7th Jan 2014 | 75 | |
| 7th Jan 2015 | 102 (36% increase) | |
| OR ambulances Wednesday 8th Jan 2014 | 83 | Wednesday 7th Jan 2015 102 (23% increase) |

**Over 80s**

| | |
|---|---|
| December 2013 | 919 |
| December 2014 | 1201 (30% increase) |

**Majors**

| | |
|---|---|
| December 2013 | 5954 |
| December 2014 | 6577 (10% increase) |

**December achievement 95.23%** **Quarter achievement 95.04%**

**Delayed discharges**

At Jan 1st 2015 total of 507 days of delayed discharges for patient in 'red' status (29 patients medically fit and on sitrep).

**Admissions and Discharges (running total)**

| | Admissions | Discharges | |
|---|---|---|---|
| 01/01/2015 | 91 | 59 | -32 |
| 02/01/2015 | 84 | 98 | -18 |
| 03/01/2015 | 88 | 65 | -41 |
| 04/01/2015 | 84 | 65 | -60 |
| 05/01/2015 | 77 | 51 | -86 |
| 06/01/2015 | 97 | 121 | -62 |
| 07/01/2015 | 96 | 104 | -54 |
| 08/01/2015 | 90 | 104 | -40 |

Agenda Item No 8

**REPORT FROM DIRECTOR OF PUBLIC HEALTH**
**22ND January 2015**

## PURPOSE OF REPORT

1. This attached report gives an overview of the implementation of the national NHS health checks programme in Dudley Borough.

## BACKGROUND

2. The NHS Health Check Programme commenced in England in April 2009. The expectation was that each Public Health Department in England would commission a service which met the national specifications and work to meet targets set for performance.

3. The NHS Health Check was to be a service which specifically targets the primary prevention of vascular disease in people in the 40 to 74 year age group with no pre-existing vascular disease diagnosis. People are invited on a 5 year recall basis by GPs and by the Office of Public Health.

4. In Dudley the service is commissioned from all GPs, a number of pharmacies and is also provided in community settings and workplaces by an external provider and also the Office of Public Health staff.

5. The programme has now become a key indicator in the Public Health Outcomes Framework and requires each department to report quarterly on the Vital Signs targets. These targets are:
   - The number and percentage of eligible people who receive an invitation to have a Health Check
   - The number and percentage of people who have had a completed Health Check.

6. This data is reported as performance indicators against the Vital Signs benchmarks for the programme on a quarterly basis in the Spectrum returns for the Council. (PI730 and PI731).

## KEY ISSUES

7. The attached report gives an overview of
   - the current process of delivery of health checks in the borough and key performance trends benchmarked to all local authorities
   - key issues impacting on performance of the program and actions taken to increase uptake of the NHS health checks program in Dudley.

8. Dudley meets the invitations target, however the uptake of health checks does not meet the local target of 50% or the national aspirational target of 75%.

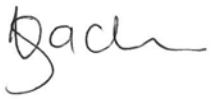
9. Dudley benchmarks as close to the national average in terms of uptake, although it must be noted there are issues with the robustness of the national data as some areas operate manual systems of data collection.

10. There have been a number of constraints that have impacted on performance of providers including software migrations within GP practices, provider on-site capacity issues, pharmacy activity being lower than expected and information governance issues.

11. Recovery plans have been put in place to mitigate constraints and increase uptake of the health checks programme. Quarter 3 data will be reviewed shortly.

**RECOMMENDATION**

12. It is recommended that the Health Overview and Scrutiny Committee note the performance, constraints and actions detailed in the attached report and support action to increase uptake.



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# NHS Health Check Implementation Briefing for the Health and Scrutiny Committee

22nd January 2015

Shelagh Cleary
Vascular Programme Manager

David Pitches
Consultant in Public Health

Office of Public Health
Dudley MBC

## 1. Background

The NHS Health Check Programme commenced in England in April 2009. The programme was set out in the Operating Framework for the NHS. The expectation was that each Public Health Department in England would commission a service which met the specifications within this document and work to meet targets set for performance. The NHS Health Check was to be a service which specifically targets the primary prevention of vascular disease in people in the 40 to 74 year age group with no pre-existing vascular disease diagnosis.

Guidance to support commissioners and providers was issued by the Department of Health to support the setting up of a service. This culminated in the landmark blueprint for the programme, Putting Prevention First. This guidance set out how the programme should be developed and what was expected from commissioners and providers.
The decision on how the programme was to be delivered locally was left largely to individual Public Health Departments to reflect their individual demography and specific needs.

The programme has now become a key indicator in the Public Health Outcomes Framework and requires each department to report quarterly on the Vital Signs targets. These targets are:

- The number and percentage of eligible people who receive an invitation to have a Health Check
- The number and percentage of people who have had a completed Health Check.

This data is reported as performance indicators against the Vital Signs benchmarks for the programme on a quarterly basis in the Spectrum returns (PI730 and PI731).

## 1.1 Eligibility

The programme stipulates that all those eligible (Table 1) should be invited for a Health Check every five years. Following the Health Check, all those assessed at high risk of vascular disease (≥20% risk in the next 10 years) exit the programme. Those at moderate or low risk receive a further invitation for a Health Check every five years. It is recommended to GP practices that they hold a register of those at high risk who quit the programme and offer them an annual review to reduce their risk.

**Table 1: Eligibility Criteria for Service Users of NHS Health Check Programme**

| Criterion | Inclusion | Exclusion |
|---|---|---|
| Age | Adults 40 – 74 years | |
| Gender | Males and females | |
| Medical history | | History of a vascular condition, i.e. heart disease, diabetes, stroke, kidney disease |
| Frequency | Every five years | NHS Health Check within past five years |

## 1.2 National data set

The national data set for the NHS Health Check programme sets out the clinical and behavioural aspects that are expected to be assessed and recorded to complete a full Health Check (Health and Social Care information Centre 2011). These mandatory requirements are shown in Table 2.

**Table 2: Clinical and lifestyle components comprising a full NHS Health Check**

| Clinical | Lifestyle * |
|---|---|
| Systolic blood pressure | Smoking status |
| Diastolic blood pressure | Physical activity status |
| Total cholesterol | Alcohol consumption assessment |
| Total cholesterol/high density lipid ratio | Ethnicity |
| Diabetes risk assessment | Age |
| Cardiovascular disease risk score | Family history of CVD |
| Body mass index | Dementia awareness |

*advice and referral to be given where appropriate

## 2. The Dudley Programme

The Dudley Programme commenced in April 2009. In the first year, risk stratification software was used to target those estimated to be at very high risk (≥ 30% risk of vascular disease in the next ten years) and offer them a Health Check. During this time, work commenced with a software company to develop a software solution to support the programme. The software (Informatica Clinical Audit Programme or iCAP) was commissioned and rolled out to all general practitioner (GP) provider sites along with a programme of clinical and software training. The software provides a standardised systematic process for:

- Invitation and recall ( by the GP and also by the Office of Public Health providing a back-up centralised invitation and recall)
- Data entry template and data set extraction
- Central auditing function
- Community version of the software to allow checks to be completed outside of GP surgeries, including web based push back of data collected during a Health Check into GP information systems.

The Dudley programme retains those assessed as high risk within the programme and places them on an annual recall. Also those assessed at high risk of diabetes are placed on annual review. The monthly invitations and recall in practices and at the central point include these annual reviews as well as the 5 yearly invitations.

## 3. NHS Health Check activity

The table below shows activity in Dudley over the last four years. The source of the data is the iCAP software which supports the programme. All invites and recalls and every individual element of the Health Check is given a special code (known as a Read code) into the GP information system and recorded in the patient's medical record. Unless all elements of the Health Check are completed, a Health Check will not be recorded as having been completed on the system and so cannot be counted in the data and will not be paid for.

National data from Public Health England (PHE) includes manual returns from some areas and so cannot be considered quite as robust. Also, uptake is calculated as the percentage of Health Checks completed against the number of invitations. Where areas

have a low invitation rate, the percentage uptake is hugely biased by this method of calculation. Some areas show 100 to more than 200% uptake. Therefore national data cannot be considered to be robust. In Dudley the targets for invitation are always met, indeed exceeded, and so this reflects a truer picture of activity. Also, expected invites and expected Health Checks activity is monitored at monthly points throughout the year as one-twelfth of the annual total denominator so that activity can be performance managed on a monthly basis. This method of data analysis if applied by the national team would remove limitations and give much more robust and comparable data.

Table 3 below show Dudley Vital Signs returns to PHE for the last four years against Vital Signs targets. Note that no target was set for 2010/11. This is also shown in Figures 1 and 2.

**Table 3: Summary of Dudley NHS Health Check activity**

| Financial Year | 2013/14 | 2012/13 | 2011/12 | 2010/11 |
|---|---|---|---|---|
| Vital Signs Total Cohort | 89291 | 92400 | 90000 | 92149 |
| Vital Signs Total Invitations | 19903 | 21627 | 16705 | 9587 |
| Vital Signs Target | 17858 | 18480 | 16200 | none |
| Invitations as a Percentage of Total Cohort | 22.3% | 23.4% | 18.6% | 10.4% |
| Invitations as a Percentage of Yearly Cohort | 100.6% | 117% | 103% | 53.3% |
| Vital Signs Completed Check Target | 8928 | 9240 | 7200 | none |
| Completed Checks | 7874 | 8974 | 7365 | 4342 |
| Completed Checks as a Percentage of Total Cohort | 8.8% | 9.7% | 8.1% | 4.8% |
| Uptake target | 50% | 50% | none | none |
| Completed Checks as a Percentage of Yearly Cohort | 39.8% | 48.5% | 44.5% | 24% |
| Completed Checks as a Percentage of Invited Cohort | 39.6% | 41.5% | 43% | 45% |

**Figure 1**

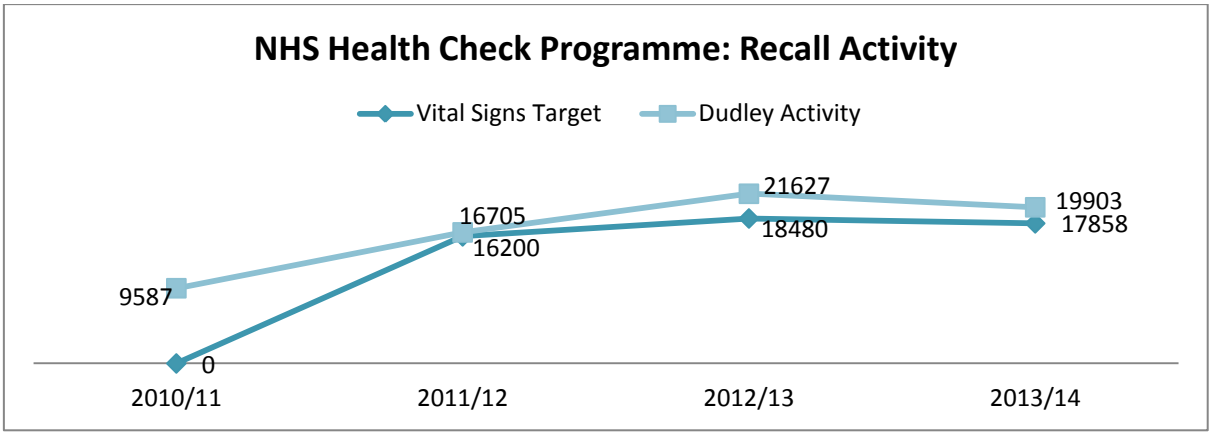
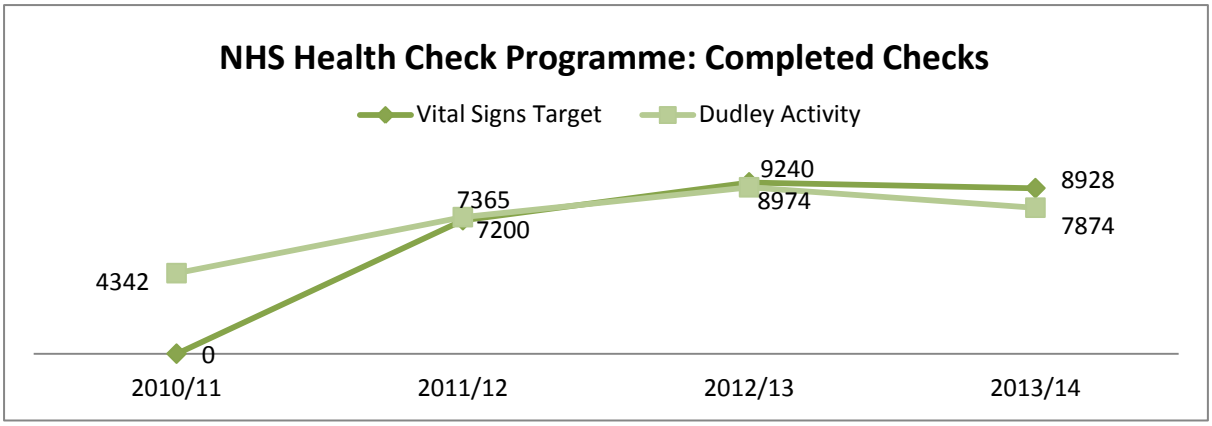



**Figure 2**




It is important to place the Dudley Health Checks in the context of the national program. PHE has set an "aspirational target" of 75% of the population receiving a Health Check but as can be seen from Figure 3, only a small minority of Local Authorities across England have achieved a 75% uptake amongst the population screened so far. It is important to bear in mind that because the Health Checks is a rolling five year program, and the current reporting period began in April 2014, only six quarters of a total of twenty quarters worth of data is available for comparison, and it is expected that only six out of twenty eligible people would have invited for a Health Check to the end of October 2014 (the latest available data).

The West Midlands is actually doing better on average than the national average for people receiving Health Checks so far, though despite this the regional performance

over the six quarters from April 2013 to October 2014 was that only 50.8% of people due a Health Check actually received one. Dudley's performance (43.2% of people due a Health Check actually received one) is not far short of the England average of 45.1%) during this time.

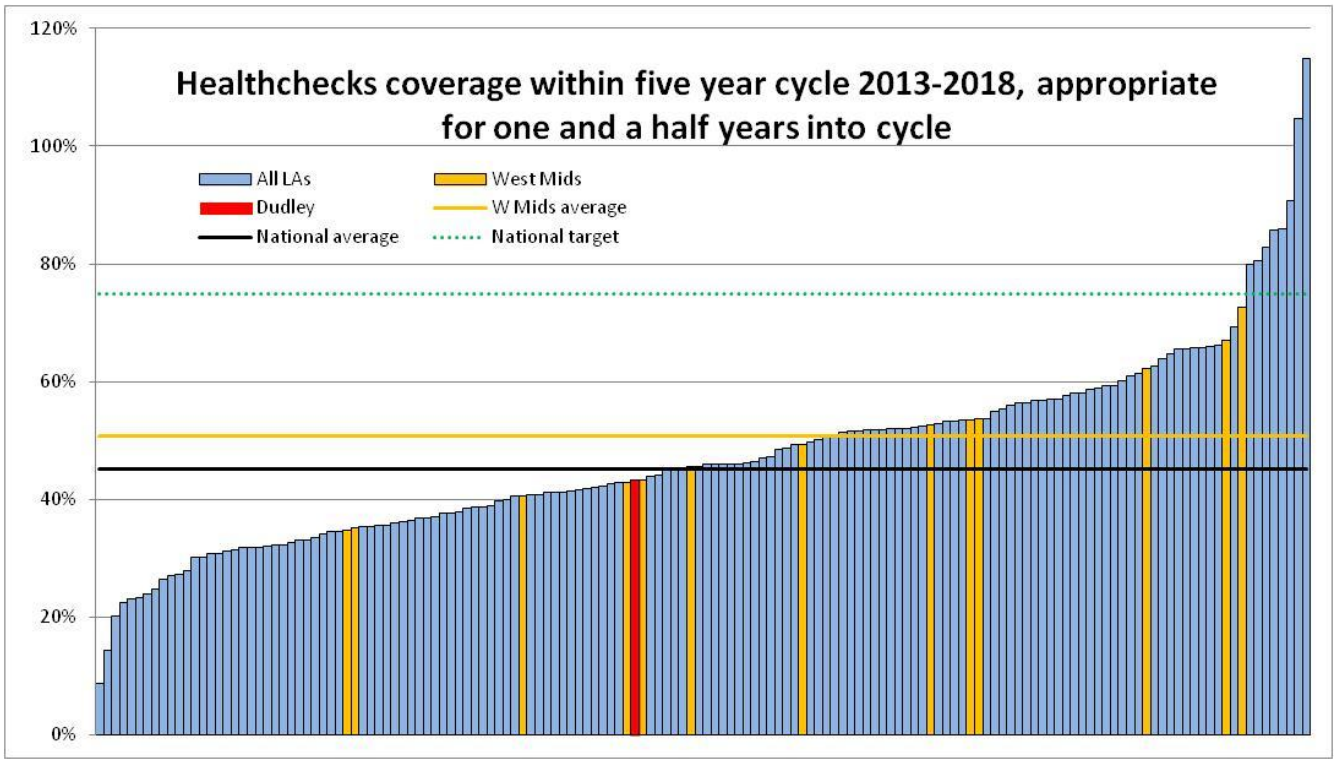



**Figure 3: National uptake of Health Checks, in comparison with Dudley and other West Midlands local authorities.**

Another way of looking at Dudley's performance is to compare where we are against the number of invitations offered. During the period April to October 2014, Figure 4 shows that the proportion of people eligible who actually had a Health Check was on a par with the national average, whilst the number of people invited was slightly, but not excessively, greater than 10% (during six months of a five year cycle, 10% of the eligible population should be invited). The grey bars show the proportion of people in each area who were invited but did not accept a Health Check, above and beyond the number eligible. In other words, whilst Dudley could increase the number of people having Health Checks simply by inviting more people, to do so without regard for the proportion of those inviting accepting a Health Check would be wasteful. Dudley has been offering appropriate numbers of Health Checks over the past two quarters.

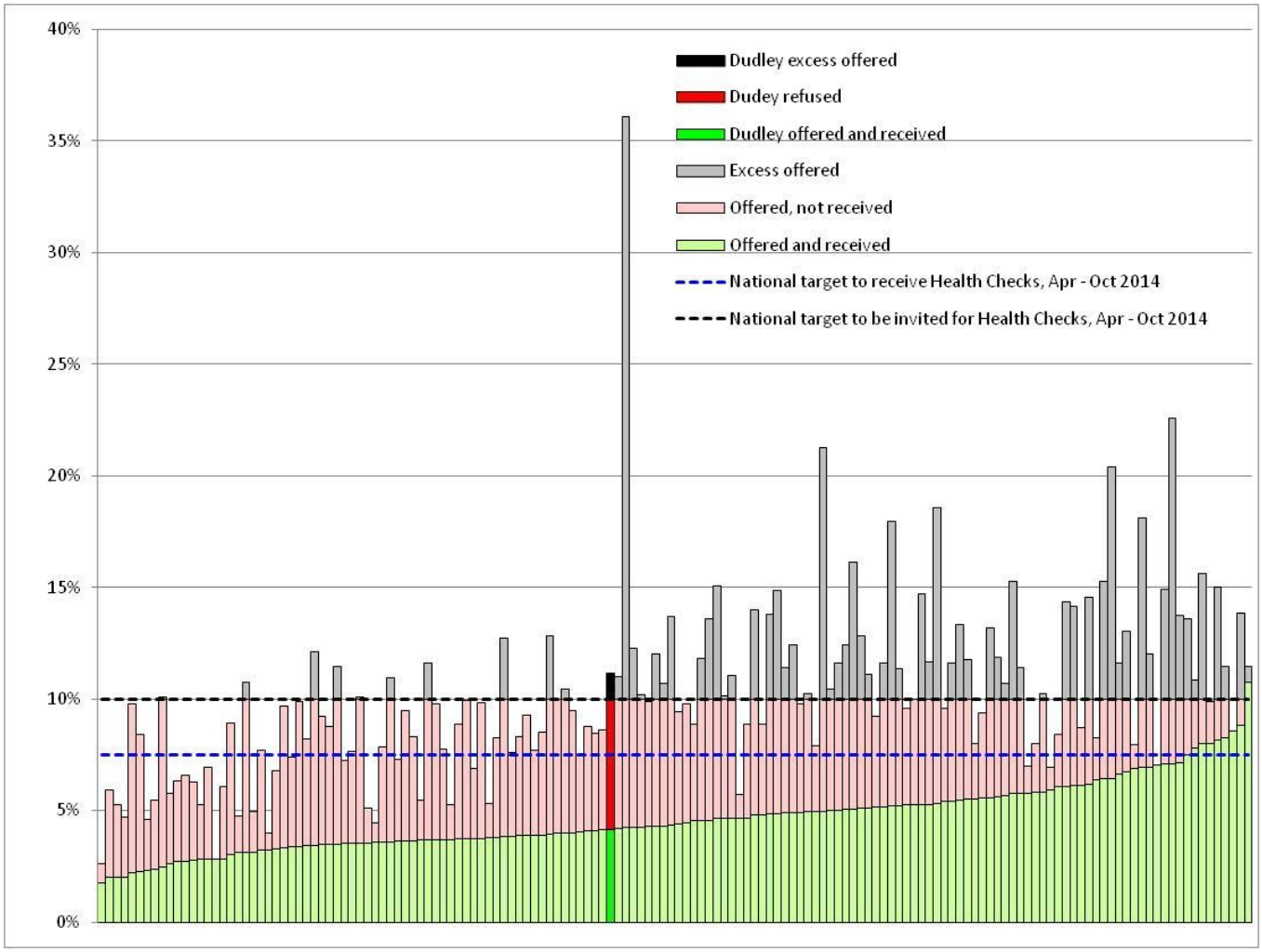



**Figure 4: Invitations and received Health Checks for Dudley during Q1 and Q2, 2014**

## 4. Constraints/Difficulties Affecting Performance

### 4.1 EMIS Web migration

In May 2011, one of the larger Dudley practices with a list size of 10% of the Dudley registered population, updated their computer systems to a system called EMIS Web. At that time there was no compatibility between EMIS Web and iCAP, and this was reported as an extreme risk to the project. Work commenced to develop a working interface but this was problematic. So much so, that this was not completed until September 2013. However in April 2013 the CCG recommended that all practices migrate their systems to EMIS Web. This created huge problems with data, and as the interface was not available, some practices ceased Health Check activity. The migration of all practices was only completed in November 2014. During the whole of this period, Health Check activity was severely affected and data was unreliable. Now that all practice systems have completed migration of their data to EMIS web and are communicating directly with iCAP, robust data is available. Therefore data from Q1 – Q3 of 2014-15 will have been affected, although, the Vascular Team has taken steps to ameliorate this as much as possible, as detailed later in this briefing.

### 4.2 Poor performance in some GP sites

Some GP sites were slow to commence Health Checks and also some practices had very little monthly activity. Steps taken by the Vascular Team are detailed in recovery plans.

### 4.3 Pharmacy activity was lower than expected

In January 2012, 38 Healthy Living pharmacies began to offer NHS Health Checks as an alternative to having a Health Check at the patient's GP surgery. To date there has been very little activity in this sector and some very slow starts. Currently only four pharmacies are achieving the target of eight checks a month on a regular basis, and indeed some pharmacies have completed no checks to date.

### 4.4 Information Governance Issues

In April 2013, Caldecott Guidance was revised. The guidance has always included the stipulation that no identifiable data should be submitted to third parties and continues to do so in the new guidance. Since Public Health are now part of the Local Authority and not the NHS, practices are viewing the Office of Public Health as a third party. The NHS Health Checks programme relies on identifiable data from practice systems to complete central recall and invitation. A data sharing agreement is included in the Public Health contract agreed with practices, but one practice has refused to share data, citing information governance law as the issue. Certain other practices are wary of an information governance breach. Although they continue to allow their information systems to communicate with iCAP, they do not currently permit the Vascular Team staff to visit the practice to participate in audit work, support, troubleshooting the system and performance management, effectively allowing no access to their systems.

## 5. Recovery Plans

### 5.1 EMIS Web

As there was a timetable available of migrations available from EMIS, the Vascular Team recommended that recall be completed ahead of time at each practice site to cover a few months after the migration date was set to begin and the system would not be available. In this way the people who would need to be contacted during this period would still be able to receive an invitation. Health Checks were advised to continue to be completed and saved on the icap software while the migration process was underway. The checks could then be synchronised with EMIS once migration was complete. This would enable activity to continue through the migration process. However, the uptake of these recommendations was not universal. Most practices ceased activity during migration, which in many cases, was unacceptably lengthy. The longest migration period was 29 weeks, the average being 13 weeks. Other actions taken included:

- Tracking of practices undergoing migration by the Vascular Team and Informatica to troubleshoot and support them through the process with the aim of reducing the time migration was taking. Tracking on a spreadsheet was

updated by both teams and discussed almost daily. Progress was reported and monitored through the monthly project meetings. It was reported as a risk to the project.

- Informatica commenced working directly with EMIS and assisting with migrations.
- The Vascular Team checked each site that completed migration before activity resumed to correct any anomalies caused by migration and ensure the system was functioning correctly.

## 5.2 Practice Plans to Increase Uptake

- The Vascular Team actively performance manage practice sites. Activity is monitored on a monthly basis against expected targets to achieve at least a 50% uptake. The 10 lowest performing practices are visited each month and offered support from the Vascular Team to increase uptake.
- The CCG use a 'scorecard' as a dashboard to monitor performance on several clinical indicators. Practices receive a red, silver, gold or platinum rating for each indicator and an overall rating. In April of 2014 work commenced to get NHS Health Check uptake rates included in the indicators for the scorecard. This was achieved in July and reporting began. Any practice who achieves a red rating for any indicator (< 50% achievement) receives a peer visit by the CCG and is expected to develop an action plan to improve performance. Practices keen to keep their overall rating have been contacting the Vascular Team since this time for support to increase their uptake. The Vascular Team have also liaised with the peer reviewers to offer practices support to increase their uptake.
- Where practices offer low numbers of Health Checks due to issues on site, e.g. staffing constraints, the Vascular Team offer to take over the service within the practice, supplying sessional workers to continue clinics until such time as the practice can resume their service. One recent case was Meadowbrook Surgery. This practice was in the bottom two performing practices and for many months did not complete any checks. The service was taken over by the Vascular Team for a period of four months, during which time models and systems were put in place and staff trained including front line reception and administration staff.

The practice has now resumed their service and since April 2014 have achieved an average 78% uptake rate and a 174% invitation rate of expected and have consistently achieved a platinum performance rating on the CCG scorecard.

- The Vascular Team have written two articles for the CCG monthly circulation GP Brief. This has included information on the scorecard, support available and information on the clinical evidence base. The articles also demonstrated the cost savings the NHS Health Check programme can be expected to deliver to practices and how it can assist in achieving reductions in premature death rates, emergency hospital attendance and hospital admissions.
- The Vascular Team have developed a NHS Health Check Clinical Outcomes audit. This is expected to show positive outcomes as a process of the Health Check programme. It will be shared with practices and will include recommendations for improving practice. The audit will then be published.
- The Vascular Team have been attending Practice Manager meetings and Practice Patient Participation Forums over the period that the programme has been running to ensure good communication with practices and patients and to raise the awareness of the programme.

### 5.3 Pharmacy Activity

The Vascular Team continued to support pharmacies in setting up and developing a Health Check service. Pharmacy intentions to develop the service have always and continue to be very positive, but have particular and unique challenges. The Vascular Team are currently completing a pharmacy audit to identify common themes within these challenges and work on the development of a pharmacy model for the Health Checks service.

### 5.4 General Measures to Support all Providers/ Improve Uptake

The following measures outline the actions taken to the increase the uptake of the NHS Health Checks programme to meet national targets and to increase public awareness and access to the programme.

- The Vascular Team have offered support to all providers throughout the duration of the programme. A helpline was set up in 2010 which directs providers to the Vascular Team, although all providers are given office and mobile numbers of the team and email addresses to allow contact on a 24/7 basis. Visits are made to troubleshoot problems on site.
- Clinical and software based training. These sessions have taken place in organised venues, in provider sites and on a 1:1 basis as required. Training continues as an ongoing programme for providers to offer refreshers and to train new members of staff. On average 19 half or one day training sessions are offered annually in organised local venues.
- In December 2013 the Vascular Team offered all providers a point of care testing machine (POCT) for providing blood results for cholesterol and glucose, which are core elements of a Health Check. POCT is currently available in 54 provider sites. Up to this point, all services users wishing to have a Health Check had to have a formal pathology lab fasting blood test. The offer of a POCT finger prick blood test enabled:
    - No blood test appointment needed before the Health Check appointment. Previously service users would need to have a blood test a week before their check to allow for results to be available to complete the check. For working people the blood test would most likely be done at Russell's Hall Hospital on a Saturday morning. The blood test and check can be completed in one appointment using POCT.
    - A non-fasting sample to be used.
    - Immediate results.

  Therefore, this enabled a fully opportunistic offer of a Health Check. As the eligible cohort for a Health Check includes mainly working people, this removes some of the barriers they may have come up against when deciding whether to have a Health Check.
- Over the period of the Health Check programme four marketing campaigns have been completed. The campaigns have included advertising on/in:
    - Newspapers
    - Local periodicals
    - Radio

    - Bus advertising
    - Council billboards
    - Car park tickets
- Marketing materials produced include posters, leaflets, badges, window stickers, bunting, pens, appointment cards etc.
- In April 2012 a Dudley Health Checks website was set up. The website raises awareness, outlines what happens during a check and informs the public how and where they may access a check including contact telephone numbers and addresses for all providers.

## 5.5 Actions Initiated by the Vascular Team

- Working with the Public Health Workplace Programme and Workplace Charter, the Vascular Team has been offering cholesterol testing, diabetes screening and NHS Health checks in workplaces. The workplace programme is currently running at two events a week.
- The Vascular Team also carry out local Health Check events with community groups at a current rate of two a month.
- The Vascular Team offer a fortnightly clinic at base to further increase access to Health Checks.
- Sessional workers have been commenced to assist with workplace and community events, Vascular Team clinics and practice service takeovers.
- A pilot of a community outreach service offering Health Checks to 'hard to reach' groups commenced in July 2014. This will run until March 2015 at which point it will be evaluated. The company involved in the pilot are offering checks in various community venues including domiciliary visits and places of worship where English is not the first language.
- The Vascular Team have provided a biannual session at the local Dudley Patient Forum to increase public awareness of the programme.
- NHS Health Checks Pathway was produced by the Vascular Team in 2012 to provide guidance to providers and contractors to cover the clinical elements of a Health Check. A Failsafe Pathway was also produced at this time to cover the logistics of the programme and provide quality assurance. A user guide for the

iCAP software has been developed by the Vascular Team to support the use of the Health Check software. All providers have received copies of these documents.

- A member of the Vascular Team attends CCG Implementation Group meetings for Vascular Long Term conditions, Diabetes, Stroke and Acute/Chronic Kidney disease. This is to provide prevention, identification, diagnostic guidance and support to the group and participate in service development. The prevention and identification arm of the LTC groups relies on the NHS Health Check programme as a major part of this work and the meetings provide an opportunity to discuss joint plans with the CCG.
- A member of the Vascular Team attends all regional and national meetings for the NHS Health Check programme. Local and national data is studied on an ongoing basis to monitor trends and intervene where necessary.
- In September 2014 a local network group was established between Dudley, Wolverhampton and Walsall Public Health Departments to share good practice and support regarding the NHS Health check programme.
- In October 2014 a member of the Vascular Team was invited by Warwick University to participate in proposed research which is developing a study on the uptake of the NHS Health Check programme.
- Focus group research is planned for early 2015 to gain patients' perspective of Health Checks and understand from service users what might encourage more people to take up offers of Health Checks.

### 5.6 Information Governance

- An initial meeting has taken place to discuss IG issues with the Caldecott Guardian for the CCG. Information and guidance was also sought from the Local Authority Caldecott Guardian. A further meeting is planned to work on an agreed way forward with the assistance of a third party information governance specialist and an IT specialist supporting the programme.
- Work is scheduled to develop a draft data sharing agreement between GP practices and Public Health as a joint piece of work between the Vascular Team and the Self Management Team who are also affected by this issue.

## Conclusion

In its first year and a half since Dudley MBC began running the Health Checks program, the rate of invitations and uptake of people accepting Health Checks has been roughly on a par with the national average, though slightly lower than the West Midlands regional average. Ongoing work is being undertaken to catch up where there were IT delays in 2013-14 and to increase the proportion of people choosing to accept their Health Checks invitation.

Further detailed information to support this briefing can be found in the NHS Health Check Programme Annual Reports, available by request from the Vascular Programme Manager, Office of Public Health.

The potential benefits if 75% of the population of Dudley accepted a Health Check when invited can be modelled and the impact on our local population is shown in Figure 5.

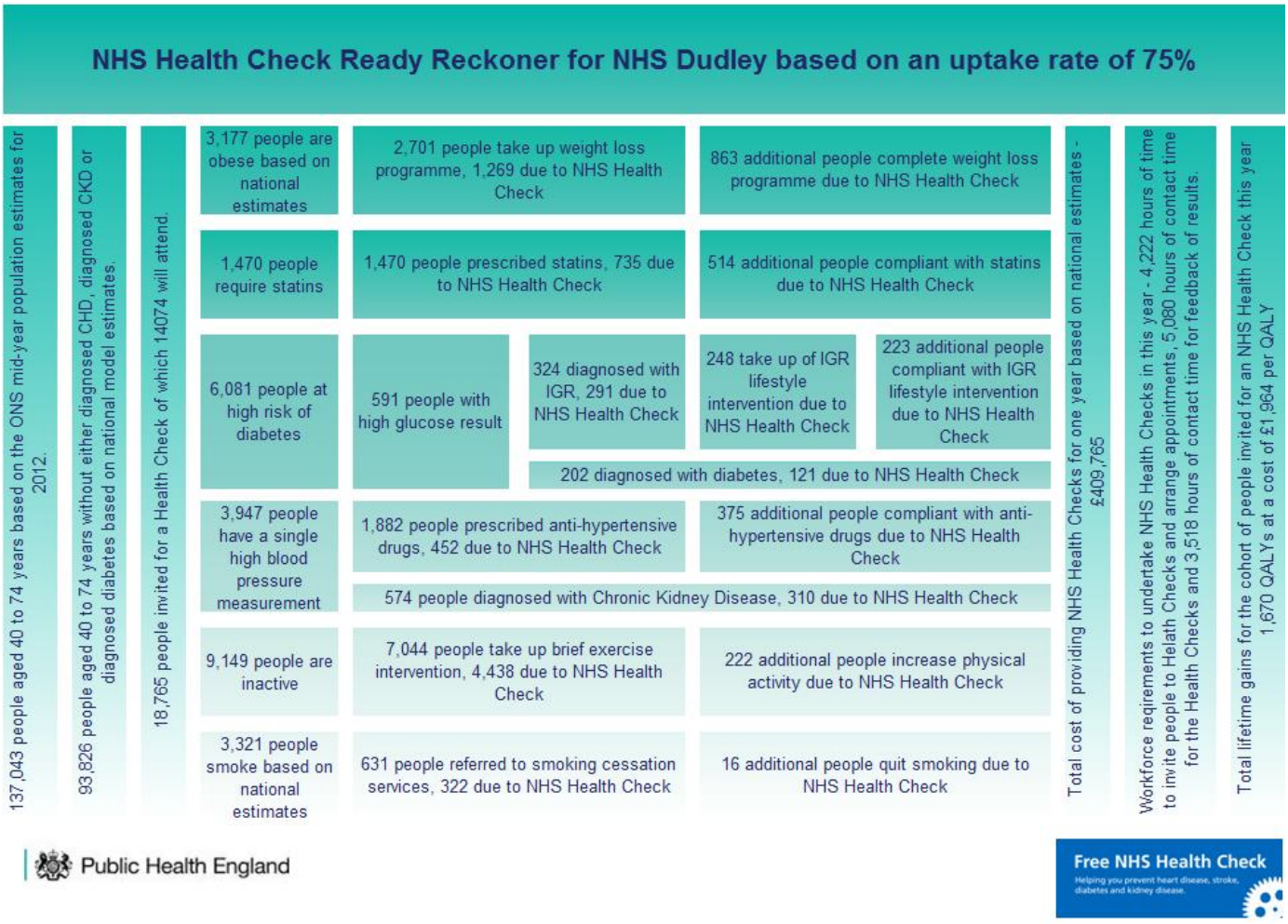



**Figure 5: Summary of potential benefits of Health Checks in Dudley**

Agenda Item No. 9

## Health Overview and Scrutiny Committee

## Report of the Chief Executive Officer, Dudley CCG

## Better Care Fund

### 1.0 BACKGROUND

1.1 The Committee will recall that the Better Care Fund (BCF) requires the CCG to establish a pooled budget, under Section 75 of the NHS Act 2006, with the Council, designed to support the integration of health and social care.

1.2 There are a number of key system wide performance metrics associated with this including:-

- reduction of emergency admissions (performance in relation to which has a direct bearing on releasing resources from the CCG);
- reduction of admissions to care homes;
- promotion of reablement;
- reduction in delayed transfers of care.

1.3 This has been viewed locally as a work-stream of our service integration programme which pre-dates the BCF. The main vehicle for our programme is the establishment of integrated, practice based teams and associated services including the Community Rapid Response Team.

1.4 The CCG and the Council are required to go through an assurance process in order to gain approval to what is ultimately the Health and Wellbeing Board's BCF Plan. A submission was made in September 2014 which was "approved with conditions". The main condition was related to the extent of our ambition to reduce the number of emergency admissions and a requirement to re-profile the planned reduction over a longer timeframe.

1.5 This report sets out:-

- the implications of this;
- the CCG's revised proposal in relation to the BCF Plan;
- the proposed arrangements for the Section 75 Agreement required to govern the pooled budget and the associated performance framework.

### 2.0 RE-PROFILED ACTIVITY PLAN

2.1 The required 15% reduction in emergency admissions presents the CCG and the Council with a financial challenge:-

- the ability of the CGG to pool funding is directly related to the freeing up of resources as a result of reducing emergency admissions, including those associated with the performance element of the BCF;

- this in turn affects the ability of the Council to protect adult social care - a national condition of the BCF.

2.2 The original submission was deemed ambitious to achieve the 15% reduction over 2 years, therefore it is proposed to reprofile the activity reduction over 4 years equating to 3.5% per annum.

2.3 The final outcome of the assurance process is expected in January.

**3.0 FINANCIAL PLAN**

3.1 The plan designed to address this, with the reduction in emergency activity phased over 4 years, is now based upon the pooling of £4.625m (£3.0m + £1.625m – see below) from the CCG to be managed within a total pooled budget of £69.548m (see 4.1 below). This is built up of two elements:-

- monies from the CCG baseline of £3.0m;
- performance fund of £1.625m (from the reduction in emergency admissions).

3.2 The £3.0m identified above is conditional upon the Council paying for excess bed day costs incurred by the CCG for patients medically fit for discharge from hospital.

**4.0 SECTION 75 AGREEMENT**

4.1 The proposed pooled budget, in total, is £69.548m. This has been constructed on the basis of identifying those services commissioned by both the Council and the CCG which contribute to the key performance metrics set out above. This is shown at Appendix 1.

4.2 Section 75 of the NHS Act 2006, enables CCGs and Councils to enter into agreements to:-

- create jointly managed teams of staff with associated secondment arrangements;
- enable one body to act as "lead commissioner" for a service;
- create pooled budgets.

It is the latter power that will be used in relation to the BCF.

4.3 There are two specific issues that such an agreement will need to address:-

- how the pooled budget will operate;
- how it will be governed.

**5.0 POOLED BUDGET**

5.1 The CCG needs to ensure that any risks associated with the pool are mitigated as well as ensuring that the budget facilitates the development of the service integration programme.

5.2 Therefore, the CCG's requirements for the Section 75 Agreement are:-

- budgetary management to be hosted by the CCG;
- all decisions in relation to investment or disinvestment of services in the pool to be taken jointly by the Joint Management Group (see below);
- any decisions in relation to service changes as part of 2015/16 budget setting (i.e. prior to the Agreement becoming operational on 1st April 2015) to be taken jointly;
- any negotiations within the Council on adult services' share of any corporate savings target to take place on a tripartite basis with CCG involvement;

- any benefits/risks arising from the operation of the pool to be distributed between the partners in proportion to their relative contributions to the pool;
- performance framework to be developed and maintained by the CCG.

## 6.0 JOINT MANAGEMENT GROUP

6.1 A Joint Management Group will be established with the following membership to oversee the arrangements described above. The membership is proposed as follows:-

**CCG**

- Chief Executive Officer
- Chief Finance and Operating Officer
- Head of Commissioning

**Council**

- Strategic Director, People's Services
- Chief Officer, Adult Social Care
- Finance Manager

**Chairmanship** - to be alternated on an annual basis

**Reporting arrangements** - reports to Health and Wellbeing Board

## 7.0 RECOMMENDATION

7.1 That the revised financial plan for the Better Care fund be noted.

7.2 That the proposed arrangements for the Section 75 Agreement and pooled budget be noted.

**Enclosed: Appendix 1**

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**Neill Bucktin**
**Head of Commissioning, Dudley CCG**

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| Scheme | Cost | Owner | team | PI | Area of Spend | Intervention | Stream2 |
|---|---|---|---|---|---|---|---|
| Community rapid response team (CRRT) - Health | £ 1,321,848.00 | CCG | CRRT | Avoidable Admissions | Community Health | CRRT | Crisis/Emergency |
| Community rapid response team (CRRT) - Social | £ 461,000.00 | CCG | CRRT | Avoidable Admissions | Social Care | CRRT | Crisis/Emergency |
| VW – 8 wards | £ 1,582,099.00 | DGoH | Virtual Ward | Avoidable Admissions | Community Health | MDTs | Crisis/Emergency |
| Care Home Nurse Practitioners | £ 159,005.00 | DGoH | Care Home Nurse Practitioners | Avoidable Admissions | Community Health | CRRT | Crisis/Emergency |
| Diabetes and Hypo rapid response service | £ 458,027.00 | DGoH | Diabetes and Hypo rapid response service | Avoidable Admissions | Community Health | MDTs | Crisis/Emergency |
| Heart failure | £ 589,533.88 | DGoH | Heart failure | Avoidable Admissions | Community Health | MDTs | Crisis/Emergency |
| Emergency Response Team | £ 507,020.00 | DMBC | CRRT | Avoidable Admissions | Social Care | CRRT | Crisis/Emergency |
| Falls Service | £ 197,330.00 | DMBC | Falls Service | Avoidable Admissions | Social Care | CRRT | Crisis/Emergency |
| Out of Hours | £ 281,310.00 | DMBC | CRRT | Avoidable Admissions | Social Care | CRRT | Crisis/Emergency |
| Virtual Ward | £ 37,000.00 | DMBC | Virtual Ward | Avoidable Admissions | Social Care | MDTs | Crisis/Emergency |
| Crisis Resolution/Home Treatment Team (CR/HT) | £ 3,049,647.00 | DWMHT | Crisis Resolution/Home Treatment Team (CR/HT) | Avoidable Admissions | Mental Health | MDTs | Crisis/Emergency |
| Early Access Service – adults | £ 656,159.00 | DWMHT | Early Access Service – adults | Avoidable Admissions | Mental Health | MDTs | Crisis/Emergency |
| Early Intervention in Psychosis | £ 567,178.00 | DWMHT | Early Intervention in Psychosis | Avoidable Admissions | Mental Health | MDTs | Crisis/Emergency |
| Tiled House | £ 1,846,000.00 | DMBC | Residential Intermediate Care | Delayed Days | Social Care | IC | Promoting Independence |
| Palliative Care - transition care | £ 69,790.00 | DMBC | Palliative Care - transition care | Delayed Days | Social Care | IC | Promoting Independence |
| Transition Team | £ 912,860.00 | DMBC | Transition Team | Delayed Days | Social Care | IC | Promoting Independence |
| Intermediate Care Support - Dr Plant | £ 61,934.00 | Other | Intermediate Care Support - Dr Plant | Delayed Days | Other | IC | Promoting Independence |
| Intermediate Care Team - Nursing | £ 114,086.00 | Other | Intermediate Care Team - Nursing | Delayed Days | Other | IC | Promoting Independence |
| Intermediate/Stepdown Care - Physiotherapists | £ 122,400.00 | Other | Intermediate/Stepdown Care - Physiotherapists | Delayed Days | Other | IC | Promoting Independence |
| Intermediate/Stepdown Care - Private Care Home (Bed days) | £ 2,703,000.00 | Other | Residential Intermediate Care | Delayed Days | Other | IC | Promoting Independence |
| Stepdown Cover - DGFT | £ 58,091.00 | Other | | Delayed Days | Other | IC | Promoting Independence |
| Access - single point of contact | £ 1,174,310.00 | DMBC | Adult Social Care Assessment | Reablement | Social Care | Access | Promoting Independence |
| Locality Based prevention hubs (including grants to vol orgs ) | £ 1,245,020.00 | DMBC | Community Voluntary Sector | Reablement | Social Care | Localities | Promoting Independence |
| Locality Based prevention hubs (including grants to vol orgs ) | £ 746,010.00 | DMBC | Community Voluntary Sector | Reablement | Social Care | Localities | Promoting Independence |
| Locality social work teams | £ 2,720,790.00 | DMBC | Adult Social Care Assessment | Reablement | Social Care | Localities | Promoting Independence |
| Acute Rehabilitation - Other | £ 1,262,890.00 | DGoH | Acute Rehabilitation | Reablement | Acute | Reablement | Promoting Independence |
| Acute Rehabilitation - Stroke | £ 822,368.00 | DGoH | Acute Rehabilitation | Reablement | Acute | Reablement | Promoting Independence |
| Acute Rehabilitation - T&O | £ 1,205,702.00 | DGoH | Acute Rehabilitation | Reablement | Acute | Reablement | Promoting Independence |
| Physiotherapy - MSK | £ 873,345.55 | DGoH | Physiotherapy - MSK | Reablement | Community Health | Reablement | Promoting Independence |
| Rehab Single Point of Access - Community Stroke Rehabilitation | £ 537,906.72 | DGoH | Rehab Single Point of Access | Reablement | Community Health | Reablement | Promoting Independence |
| Rehab Single Point of Access - OT Primary Care | £ 397,962.79 | DGoH | Rehab Single Point of Access | Reablement | Community Health | Reablement | Promoting Independence |
| Rehab Single Point of Access - Primary Care Neurology Team | £ 364,718.39 | DGoH | Rehab Single Point of Access | Reablement | Community Health | Reablement | Promoting Independence |
| Rehab Single Point of Access - Speech Therapy Adults | £ 202,817.29 | DGoH | Rehab Single Point of Access | Reablement | Community Health | Reablement | Promoting Independence |
| Step down - Occupational Therapy | £ 429,780.37 | DGoH | Residential Intermediate Care | Reablement | Community Health | Reablement | Promoting Independence |
| Step down - Physiotherapy | £ 200,273.66 | DGoH | Residential Intermediate Care | Reablement | Community Health | Reablement | Promoting Independence |
| Community Equipment Stores | £ 863,000.00 | DMBC | CES/OT | Reablement | Other | Reablement | Promoting Independence |
| LIT - Community Reablement | £ 438,800.00 | DMBC | START | Reablement | Social Care | Reablement | Promoting Independence |
| OT's | £ 1,164,630.00 | DMBC | CES/OT | Reablement | Social Care | Reablement | Promoting Independence |
| Russell Court - Residential Reablement | £ 1,467,370.00 | DMBC | START | Reablement | Social Care | Reablement | Promoting Independence |
| START - Community Reablement | £ 1,525,000.00 | DMBC | START | Reablement | Social Care | Reablement | Promoting Independence |
| Substance misuse | £ 192,000.00 | DMBC | Substance misuse | Reablement | Social Care | Reablement | Promoting Independence |
| Adults team – Community Recovery Service | £ 3,217,677.00 | DWMHT | Adults team – Community Recovery Service | Reablement | Mental Health | Reablement | Promoting Independence |
| Community Equipment Stores | £ 523,090.00 | Other | CES/OT | Reablement | Other | Reablement | Promoting Independence |
| GP over 75's | £ 1,571,000.00 | CCG | GP over 75's | Avoidable Admissions | Primary Care | MDTs | Crisis/Emergency |
| Joint Palliative care support team | £ 440,811.00 | DGoH | Joint Palliative care support team | Avoidable Admissions | Community Health | MDTs | Crisis/Emergency |
| Community OPAT and oncology | £ 548,080.00 | DGoH | Community OPAT and oncology | Avoidable Admissions | Community Health | MDTs | Crisis/Emergency |
| Continence | £ 1,169,343.00 | DGoH | Continence | Reablement | Community Health | MDTs | Promoting Independence |
| District nursing 16 teams – 15 teams and out of hours | £ 7,924,352.10 | DGoH | District nursing 16 teams – 15 teams and out of hours | Reablement | Community Health | MDTs | Promoting Independence |
| Macmillan nurses | £ 476,228.00 | DGoH | Macmillan nurses | Avoidable Admissions | Community Health | MDTs | Crisis/Emergency |
| Respiratory specialist nurses - Outpatient Firsts | £ 189,073.58 | DGoH | Respiratory specialist nurses | Avoidable Admissions | Community Health | MDTs | Crisis/Emergency |
| Respiratory specialist nurses - Outpatient Follow ups | £ 245,472.05 | DGoH | Respiratory specialist nurses | Avoidable Admissions | Community Health | MDTs | Crisis/Emergency |
| Tissue Viability - Leg Ulcer Clinic | £ 344,839.00 | DGoH | Tissue Viability - Leg Ulcer Clinic | Reablement | Community Health | MDTs | Promoting Independence |
| Direct payments | £ 1,586,000.00 | DMBC | Community Manitenance & Stabilisation | Res Care | Social Care | Personalised C&S | Maintenance and Stabilisation |
| Direct payments | £ 162,000.00 | DMBC | Community Manitenance & Stabilisation | Res Care | Social Care | Personalised C&S | Maintenance and Stabilisation |
| Direct payments | £ 1,164,840.00 | DMBC | Community Manitenance & Stabilisation | Res Care | Social Care | Personalised C&S | Maintenance and Stabilisation |
| Disabled Facilities Grants | £ 2,867,000.00 | DMBC | DFG | Res Care | Social Care | DFG | Maintenance and Stabilisation |
| Domiciliary Care | £ 6,955,740.00 | DMBC | Community Manitenance & Stabilisation | Res Care | Social Care | Personalised C&S | Maintenance and Stabilisation |
| Domiciliary Care | £ 1,018,000.00 | DMBC | Community Manitenance & Stabilisation | Res Care | Social Care | Personalised C&S | Maintenance and Stabilisation |
| Extra care housing | £ 865,000.00 | DMBC | EXCH | Res Care | Social Care | Personalised C&S | Maintenance and Stabilisation |
| Intermediate Care - DMBC (Packages of Care) | £ 560,000.00 | DMBC | Community Manitenance & Stabilisation | Res Care | Social Care | Personalised C&S | Maintenance and Stabilisation |
| Palliative Care - front end | £ 208,000.00 | DMBC | Community Manitenance & Stabilisation | Res Care | Social Care | MDTs | Maintenance and Stabilisation |
| Supported living | £ 795,000.00 | DMBC | Community Manitenance & Stabilisation | Res Care | Social Care | Personalised C&S | Maintenance and Stabilisation |
| Community mental health team for older people | £ 1,110,129.00 | DWMHT | Community mental health team for older people | Reablement | Mental Health | MDTs | Promoting Independence |
| Internal day care and Dementia Gateways | £ 1,825,000.00 | DMBC | Dementia care | z - Dementia Diagnosis | Social Care | Dementia care | Dementia Care |
| Specialist Dementia Nurses | £ 189,686.00 | Other | Dementia care | z - Dementia Diagnosis | Mental Health | Dementia care | Dementia Care |
| Total | £ 69,546,373 | | | | | | |
| Minus efficiencies | -£ 2,892,848 | | | | | | |
| BCF Total | £ 66,653,525 | | | | | | |

Agenda Item No. 11

**Health Scrutiny Committee – 22nd January 2015**

**Report of the Lead Officer to the Committee**

**Responses arising from previous Committee meetings**

## Purpose of Report

1. To consider updates and responses arising from previous presentations

## Background

2. Information requests from members regularly arise from scrutiny of planning development and delivery of services. Clearly some queries cannot be answered immediately with some prompting further investigation, or consultation, prior to being reported back to Committee.

3. To keep members updated, responses and resultant recommendations arising from previous reports are presented at appendix 1 for review.

## Finance

4. Costs linked to Council responsibilities will be met through existing resources.

## Law

5. Section 111 of the Local Government Act 1972 authorises the Council to do anything which is calculated to facilitate or is conducive or incidental to the exercise of any of its functions.

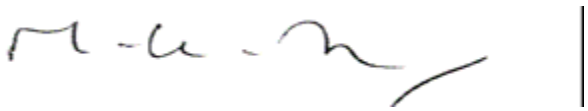
6. The Health and Social Care Act 2012 places the scrutiny of health, care and well-being services by local authority members onto a statutory footing.

## Equality Impact

7. Health Scrutiny can be seen as contributing to the equality agenda in the pursuit of improving care for all. This implies a challenge to ensure that services meet the needs of all sectors of the community to make this an even greater reality in Dudley.

**Recommendation**

8. Members endorse proposals presented at Appendix 1.



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**Mohammed Farooq – Assistant Director Corporate Resources**

**LEAD OFFICER FOR HEALTH SCRUTINY**

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Documents used in the preparation of this report:-

1. Minutes of January 2013 Committee.

Appendix 1

**Dudley Group of Hospitals (DGH)**

**Query**

Arising from a presentation relating to DGH's budget strategy members sought assurances that mechanisms were in-place to maintain safe and effective services particularly in the light of planned workforce reductions totalling 400. Separately, members requested staffing details specifically relating to pharmacy services.

**Response**

Pharmacy staffing

DGH has profiled pharmacy staffing based on average demand. We usually start the day with 9 staff (Pharmacists and Technicians). This is then varied throughout the day based on demand and we may have up to 15 members of staff in the dispensary at very busy times. It also has 22 members of pharmacy staff on the wards doing medication history, medicines reconciliation, screening, verifying and validating prescriptions of doctors as well as dealing with other medheicines management issues. Movement of pharmacy staff between ward and dispensary is managed daily based on need.

The pharmacy department have recently piloted a pharmacist prescribing of drugs to take away (TTA) on 2 wards which has demonstrated a reduction in the waiting time for ward drug dispensing by over 2hours. This is being rolled out to more wards over the winter period.

There are 20 other pharmacy staff who work in the Aseptic Technical Services Unit preparing cancer chemotherapy and some biological injections for patients. Some of the pharmacists in this Team run outpatient clinics for cancer patients.

There are 10 other Pharmacy staff who are employed in procurement and the distribution of medicines to the wards.

There are also 4 members of pharmacy staff in the Medicines Management, Medicines information, Antimicrobial Stewardship Team.

Reported 400 job cuts

The Dudley Group has taken the decision to impose strict vacancy controls to save £14 million on its pay costs to help it achieve financial stability.

Managers at the Trust have been told that vacant posts will only be approved in exceptional circumstances. The Trust aims to take out 400 posts over the

next two years. However, the Trust is still actively recruiting to essential frontline posts on wards and in the community.

Chief Executive Paula Clark said the Board's decision was not taken lightly but the Trust's turnaround plans were not delivering results fast enough.

"Our priority is always to provide high quality patient care as well as protecting our workforce and if we can get the vacancy controls right then we can reduce redundancies," said Paula.

"Pay is our biggest cost, making up 70 per cent of spend, and we know we cannot make the type of savings we need without looking at a reducing our spend on staffing," she added.

"We must ensure we maintain appropriate staffing levels to continue to deliver safe and effective care to our patients and our approach will be to minimise the impact on front line clinical areas."

The Trust has introduced a director-led vacancy control panel that will scrutinise every single request to fill a vacant post. All requests will be subject to a rigorous quality impact assessment and only those deemed necessary to maintain our high quality of care to patients will be approved.

**Proposal**

Members note the response outlined above and keep a watching brief on the development of the Trust's financial plan with the aim of maximising health outcomes across community groups.

**<u>Dudley Walsall Mental Health Trust (DWMH)</u>**

**Query**

Arising from the Trust's update against Care Quality Commission inspections actions members sought more information on waiting times relating to eating disorder services; and gender profile of Mental Health Act lay managers.

**Response**

Accessing Eating Disorder Services

It was acknowledged at the Committee that the Trust has very limited resources for this service. Furthermore, pathways aren't straightforward as people with eating disorders will often have and be under assessment for other mental health problems too. Urgent cases are seen within a very short time – within a day or two if required. However, for the last 12 months, the average waiting time to access this service was 31 days.

Mental Health Act Lay Managers – Gender split

The Trust was asked to return the gender split of our MHA Lay Managers. It currently has 20 individuals performing this role; 10 female and 10 male.

**Proposal**

Note contents and comment as appropriate.