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Healthy Staffordshire Select Committee

Tuesday, 19 March 2019
10.00 am
Oak Room, County Buildings, Stafford

NB. Members are requested to ensure that their Laptops/Tablets are fully charged before the meeting

John Tradewell
Director of Corporate Services
11 March 2019

A G E N D A

PART ONE

1. **Apologies**

2. **Declarations of Interest**

3. **Minutes of the last meeting held on 4 February 2019** (Pages 1 - 8)

4. **Proposal for the Provision of an Integrated stroke service at University Hospitals of Derby and Burton** (Pages 9 - 40)

   Report of the Clinical Commissioning Group

5. **Cancer Services and the STP Cancer Transformation Plan 2019/20** (Pages 41 - 56)

   Report of the Clinical Commissioing Group

6. **Progress update on Palliative and End of Life Care** (Pages 57 - 64)

   Report of the Clinical Commissioing Group

7. **Excluded and Restricted Procedures (including Hearing Aids)** (Pages 65 - 68)

   Report of the Clinical Commissioing Group

8. **District and Borough Health Scrutiny Activity** (Pages 69 - 72)

   Report of the Scrutiny and Support Manager

9. **Healthy Staffordshire Select Committee Work Programme 2018/19** (Pages 73 - 82)

Report of the Scrutiny and Support Manager

10. **Exclusion of the Public**

The Chairman to move:-

That the public be excluded from the meeting for the following items of business which involve the likely disclosure of exempt information as defined in the paragraphs Part 1 of Schedule 12A Local Government Act 1972 (as amended) indicated below.

Membership

Charlotte Atkins	Johnny McMahon (Chairman)
Deb Baker	Paul Northcott (Vice-Chairman)
Jessica Cooper	Jeremy Oates
Janet Eagland	Kath Perry
Ann Edgeller	Jeremy Pert
Richard Ford	Bernard Peters
Phil Hewitt	Carolyn Trowbridge
Barbara Hughes	Ross Ward
Alan Johnson	Ian Wilkes
Janet Johnson	Victoria Wilson
Dave Jones	

Note for Members of the Press and Public

Scrutiny and Support Manager: Nick Pountney Tel: (01785) 276153

Minutes of the Healthy Staffordshire Select Committee Meeting held on 4 February 2019

Present: Johnny McMahon (Chairman)

Attendance

Charlotte Atkins	Jeremy Oates
Deb Baker	Kath Perry
Ann Edgeller	Jeremy Pert
Phil Hewitt	Bernard Peters
Barbara Hughes	Carolyn Trowbridge
Janet Johnson	Ross Ward
Dave Jones	Victoria Wilson
Paul Northcott (Vice-Chairman)	

Apologies: Janet Eagland and Alan Johnson

PART ONE

The Chairman welcomed Jackie Owen the Staffordshire Healthwatch Manager who would now be attending meetings as a non-voting observer. He also welcomed Councillor J Oates to the Committee.

54. Declarations of Interest

There were no declarations of interest made at the meeting.

55. Minutes of the last meeting held on 3 December 2018

A Member asked if any information had been received which the Committee had requested at previous meetings. The Scrutiny and Support Manager agreed to chase the information and forward it onto the Committee as soon as possible.

RESOLVED: That the Minutes of the meeting held on 3 December 2018 be received as a correct record and signed by the Chairman.

56. Discharge to Assess

The Committee considered a joint report of the Director of Health and Care and the Accountable Officer, Staffordshire Clinical Commissioning Groups (CCGs).

The Director of Health and Care, Mr R Harling and the Senior Commissioning Manager for Staffordshire CCGs, Ms Gemma Smith attended the meeting to present the report and answer questions.

The Director of Health and Care summarised the report and informed the Committee that there had been both a national and local move to get people out of hospital and cared for in their own homes or in their local communities. There was national best practise on how this could be achieved and 'Discharge to Assess' was one of the models of care suggested. It was explained that the model required the following services and functions:

- A **'Track and Triage'** service to accept complex referrals from the wards, determine whether they need ongoing reablement and support, determine the most appropriate setting [home or bed], and make the necessary arrangements to put interim care in place.
- **Home First** services to provide reablement and support at home**.** These include intermediate care, palliative care, night sitting and reablement.
- **Community beds** for people who are unable to return home for interim care**.** These require a **Trusted Assessor** function to enable timely transfers, as well as **GP and rehabilitation cover** to ensure active therapy and avoid deconditioning.
- **Active management** of Home First services and community beds to ensure that people move on.

The Discharge to Assess model had been working in the North of the County for approximately 12 months and had seen reductions of delayed discharges of 50 %. This model of care now needed to be rolled out to the rest of the County. Critical to the rolling out was the development of the track and triage service and the CCG's have to commission an additional 4200 hours per week of reablement Home First services.

Discharge to Assess to support Queens and Good Hope hospitals remained under development and there were ongoing issues with Delayed Transfers of Care (DTOC). The position was however, was getting better and it was hoped that the following developments would see significant improvement:

- Home First,
- commissioned hours increasing
- an agreement of funding and,
- the development of standard opening procedures for transfer of people from Queens and Good Hope into Community beds at Robert Peel and Samuel Johnson hospitals.

Discharge to Assess to support County Hospital was close to maturity. Support for Walsall Manor, New Cross and Russell's Hall hospitals remained under development. Improvements to date include the County Council commissioning an additional 732 hours reablement Home First services per week, and New Cross hospital using non-recurrent funding form the Better Care Fund (BCF). There had also been a modernisation of the Track and Triage service to manage Community beds in care homes in the South of the County.

The Director of Health and Care informed the Committee that there was still a delay in getting people home from New Cross and Cannock Hospital. The Senior Commissioning Manager explained that roll out of improved services would continue to take place prior to Winter 2019 and joint commissioning of services between the CCGs and Social Care should improve discharge rates.

A Member of the Committee asked what the targets were for the South of the County; were they SMART and how would they be monitored. They also asked a question on the Disabled Facilities Grants and if they were available from three sources; what is being done to ensure that these were being coordinated and the funds spent wisely. In response, it was explained that there were targets set through the commissioning process e.g. a specific number of beds available in the South. It was then for the providers to supply these and have the support services such as staff to run them. Assurance was given that targets and contracts were closely monitored. Disabled Facilities Grants was a priority for the partnerships.

The outcomes and savings from the Discharge to Assess model were requested. It was explained that the data collected may not be in the same as previously so may not provide a reliable comparison, and that it is difficult to make accurate estimates of savings.

A question was asked on the level of preparation before elective surgery to plan for an early discharge post surgery. In response, the Committee was informed that there was early discharge planning, but more can be done and organisations where learning all the time.

Several questions were asked on the recruitment and retention of care workers. It was explained that providers try to incentivise with training packages, wages and retention bonuses, the Council could encourage and facilitate these but could not offer them directly because they are not Council employees. The Sustainability Transformation Plan (STP) was looking at ways to improve recruitment and retention in the longer term, including working with schools and colleges for future planning. Further questions were asked on the encouragement given to young people to become the care provision.

The quality of care homes was questioned, particularly with the increase in demand for good quality beds that may be commissioned by the CCG following the North Staffordshire consultation proposals: how could a higher quality of care and appropriate capacity and levels of staffing be assured? The Committee was reminded that the outcomes of the consultation could not be pre-empted, but work was already underway to improve standards. The procurement and letting of contracts would include long term monitoring and quality assurance. The Chairman reminded the Committee that the Joint Staffordshire and Stoke on Trent Health Scrutiny Committee was due to meet on the 13 February and the 11 March 2019.

A Member asked how aspirational the 80/20 (80% of discharges for acute hospitals which should be simple and timely and 20% complex and requiring further support) and 70/30 (70% should receive reablement and support at home with fewer than 30% requiring a community bed) targets were and how close we were to meeting these. In response to the question, it was explained that the 80/20 and 70/30 were based on current practice and aspiration. Royal Stoke was running at 82/18 and approximately 70/30 with the County Hospital having higher proportions of complex and bed based discharges. The figures reflect local demographics and frailty as well as clinical practice and risk management.

Home First services were having a positive effect on delayed discharge figures in the South of the County. Members requested information on the numbers of admissions to each of the out of county hospitals from the South of the County for both planned and urgent care.

RESOLVED: That the following information be requested:

a) The outcomes and savings from Discharge to Assess.
b) Numbers of admissions to each of the out of county hospitals from the South of the County for both planned and urgent care, and the numbers of delayed discharges for each of the out of county hospitals.

57. University Hospitals of Derby and Burton - update

Tosca Fairchild-Moyo, Director of Governance and Communications and Mike Carr, Divisional Manager of University Hospitals of Derby and Burton (UHDB) gave a presentation to the Committee on the recent merger of the two hospitals and the progress being made towards integrating services to benefit patients. The presentation also covered information on the Cancer performance targets which the Committee had requested at the Accountability session in July 2018.

The presentation covered:

- The story so far – the 'Big Conversation'; investing in maternity services; Joint Advisory Group (JAG) accreditation; and increased capacity over winter.
- The Merger principles – Sustaining clinical services at Queens Hospital Burton: Developing tertiary (specialist) services at Royal Derby; and Making the best use of community hospitals in Lichfield, Tamworth and Derby.
- Six clinical deep dives – Cardiology, Trauma and Outpatients, Stroke, Renal, Urology (Cancer) and Radiology.
- Next stages – A further six deep dives into Ophthalmology, Dermatology, Gynaecology, Vascular Surgery, Critical Care and Head and neck.
- The development on the Outwood's site (Queens Hospital) and the capital funding of £21.88m received from the Department of Health and Social Care.
- Cancer performance – the 62 day cancer referral standard remained a challenging target.

Following the presentation, a Member asked how much choice a GP had when referring patients to hospitals and speed at which information was transferred between Community Hospitals and Acute hospitals. In response Members were informed that a new digital website was being developed and one aspect of this incorporated more choice for GP's and patients. It was acknowledged that integrated communication between the community and acute hospitals was a particular issue and was a valid concern which officers would take back to the trust.

A Member felt that transport between Burton and Derby Hospitals was problematic for some patients. A bus service between both sites was in place and car parking was increasing with an additional 517 parking spaces on the Derby site provided for staff with further car parking development planned for the Burton site which would facilitate additional spaces for patients.

A question was asked on the cancer service and screening for cancers such as prostate cancer and how this was a challenge to get people to take up screening. Imaginative ways were already happening led by Miss Shah – Consultant Urologist and this had been covered nationally in the press such as attending football matches to carry out screening.

A Member asked how the hospitals were managing their financial deficit, and how they were managing recruitment and retention of staff. In response, it was agreed that the deficit was very challenging, and services were being reviewed all the time to ensure that services were operating as efficiently as possible. The STPs for both Derbyshire and Staffordshire were also working together to drive efficiency. With regard to recruitment/retention and budget pressures, it was explained that during the merger, there had been no redundancies with all staff finding a position in the new organisation and the Hospitals were continually recruiting into all posts. The Committee were pleased to hear this and asked if they could have sight of the Trusts financial plan, for information.

A Member noted that the development strategies employed by UHDB were very different to that of the Staffordshire Hospitals. For example, UHDB were increasing Accident and Emergencies capacity; additional car parking; increasing modular wards to accommodate more patients through the winter. There also seemed to be a move to repatriate patients in areas such as Cardiology which nationally, was moving to specialist centres as opposed to local provision. In response, the Director of Governance and Communications informed Members that emphasis was on quality care close to home and that activity levels were planned with Commissioners, but its delivery was affected, and challenged by any actual attendances which were quite high and delayed transfers of care. It was felt that the move to repatriate specialisms was a question for the Medical Director.

The Committee was informed that one of the main areas of concern for UHDB in relation to the 4 hour emergency target was the 12 hour breaches for mental health patients as one patient that could not be transferred from UHDB to a more appropriate service provider could result in a whole ward being closed and used by that one patient, dependant on safety/care issues. The Committee requested more information on how this was being managed with the Midlands Partnership Foundation Trust.

A Member asked if information could be shared to demonstrate real patient benefit that had been delivered because of the merger. The Director of Governance & Communications gave an example of the significant positive outcomes for patients with Acute Kidney Injury (AKI) and agreed to share the data that had been shared with UHDB's Council of Governors

The Chairman thanked officers for attending the meeting and their informative presentation.

RESOLVED: That the following information/action be requested:

a) It was acknowledged that integrated communication between the community and acute hospitals was a particular issue and was a valid concern which officers would take back to the Trust.

b) The Committee asked if they could have sight of the Trusts financial plan, for information.
c) The rationale behind the move to repatriate specialism services.
d) More information on how patients with mental health issues were being managed in order to transfer them to the most appropriate service provider.
e) Data relating to the AKI outcomes to be shared with the Committee.

58. District and Borough Health Scrutiny Activity

The Scrutiny and Support Manager presented the report which outlined the activity the Borough and District Councils since the last meeting.

It was reported the at the last meeting of the Cannock Chase District Councils Health Committee they had received presentations on Healthy lifestyles and Public Health. Clarity was requested on the duties of both the District/Boroughs and the County Council when carrying out Health Scrutiny. It was explained if an item concerned one Borough/District alone, then that local authority was able to look at it. If an issue had a wider detrimental effect, then the County Council would consider it.

The Committee were informed that at Lichfield District Councils last meeting, the items of business were Rough Sleepers and the prevention and support offered to them.

The South Staffordshire District Council Member explained that their Committee had received presentations from the South Staffordshire CCG and the Well Being Clinic.

The Stafford Borough Council representative added to the information in the report by informing the Committee that during a recent Planning Development application for approximately 1,500 new homes, the CCG had failed to respond on health implications or considerations.

The Committee acknowledged a Planning Authority could not legally require Health to respond and there was no statutory requirement to consult with Health on planning applications under 500 houses, but it was felt that in order to plan effectively for the populations wellbeing, Health partners should have an input and therefore legislation should be changed to require a response. There was also concern that any planning conditions that are added to permissions can be removed by way of challenge at appeal if they fail to meet the tests set out by the Government in the Planning Practice Guidance Note.

It was felt that Local Authorities need to look at health from a collective viewpoint as development size or number of properties add up and have considerable impact on health. The County Councils infrastructure plan was also in the process of being developed and it was hoped that health was a part of this.

There was also a discussion on whether raising the item at a meeting of the Chief Executives and Leaders Forum could help to ensure that health implications are considered and on whether District and Borough Councillors could add pressure on Planning Committees when applications come before them at a local level.

The representative from Tamworth Borough Council informed the Committee that their last meeting had contained a presentation from the University Hospital of Derby and Burton. The next meeting would be considering Mental Health issues; the First Response Service and GP provision across the Borough.

RESOLVED:

a) That the Chairman write to the Secretary of State for Communities and Local Government explaining that Scrutiny Committees are powerless to scrutinise the wider determinants of health if Health Partners are not a statutory consultee when dealing with planning applications.
b) That the Chairman write to District and Borough Councils to ensure that they are considering Health implications with the same level of importance as for example, highway observations.
c) That the Chief Executive and Leaders Forum be approached to ensure that they are considering Health implications with the same level of importance as for example, highway observations.

59. Healthy Staffordshire Select Committee Work Programme 2018/19

The Scrutiny and Support Manager presented the Committee Work Programme report. The dates for the two Joint Scrutiny Committee meetings with Stoke on Trent City Council were confirmed as 13 February at 10am and 11 March at 2pm.

At a previous meeting the issue of the mobile Breast screening clinic in Tamworth was discussed and the Scrutiny and Support Manager had secured a response from NHS England. The Chair asked Members if the removal of screening facilities was an issue is other areas of the County. It was agreed that more information on the removal of screening facilities throughout the County was needed.

RESOLVED:

a) That the work Programme be approved.
b) That the Scrutiny and Support Officer write to NHS England to establish if Breast Screening facilities in the County are reducing.

Chairman

Local Members' Interest

Staffordshire County Council Health Select Committee – 19 March 2019

Proposal for the Provision of an Integrated stroke service at University Hospitals of Derby and Burton

Recommendation/s

1.) Staffordshire Health Select Committee is invited to:

1.1) Consider the proposal for an integrated stroke pathway at the University Hospitals of Derby and Burton as outlined within the body of this report.

1.2) Consider whether, as defined in section 242 of the NHS Act 2006 (as amended) the proposals amount to a substantive variation in service delivery and as such, to advise whether patients, public and stakeholders should be involved in the development and consideration of change.

Summary

2.) Staffordshire Health Select Committee is invited to:

2.1) Consider the proposal for an integrated stroke pathway at the University Hospitals of Derby and Burton as outlined within the body of this report.

2.2) In accordance with the NHS Act 2006 Sec244 (as amended), and expanded further by the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013, the Clinical Commissioning Group (CCG) of East Staffordshire requests that the Healthy Staffordshire Select Committee receives the information and determines whether it considers that the proposals outlined are considered to be a substantive variation.

If so, Under Section 242(1B) of the NHS Act (2006), the CCGs will make the necessary arrangements to ensure that the public and our patients are informed, involved and consulted in the:

- planning the provision of services
- development and consideration of proposals for change in the way services are provided
- any decisions to be made affecting the operation of services

2.3) The comments of the Select Committee will be reported to the Trust Board and the CCG Governing Body. This will inform of any changes to the reconfiguration of the stroke pathway prior to the desired implementation date in September 2019.

Report

3.) Background

3.1) In line with the national direction of travel to concentrate specialist services, the provision of high quality stroke care formed part of the Full Business Case (FBC) and Patient Benefit Case (PBC) for the proposed merger of Burton Hospitals Foundation Trust and Derby Teaching Hospitals into the University Hospitals of Derby & Burton NHS Foundation Trust (UHDB).

3.2) The CCG are aware of its statutory duty that states that regulations under the Health and Social Care Act 2001 created duties on the NHS which require the NHS to: Provide information about the planning, provision and operation of health services as reasonably required by local authorities to enable them to carry out health scrutiny; to consult on any proposed substantial developments or variations in the provision the health service. Further guidance is available here

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/324965/Local_authority_health_scrutiny.pdf

3.3) The Full Business Case for the merger, which was approved by NHS Improvement (NHSI) and the Competitions & Marketing Authority (CMA) in March 2018, set out the proposal to deliver a centralised service model for Stroke at the Royal Derby Hospital (RDH) site, via a seven day hyper acute stroke unit (HASU) for the first 72 hours of care. After this time, patients will either be discharged or repatriated where relevant to local facilities (for acute and rehabilitation care (equivalent care to that currently provided).

3.4) Improving outcomes for patients with long term conditions, including stroke, is a key priority for the CCG, as outlined in the CCG's Delivery of Change Plan 2012 - 2016 and its Improving Lives Programme.

3.5) Over a time period of 4 years there has been an option explored of centralising hyper-acute stroke services at RDH, allowing an equitable service based on nationally agreed best practice with patients returning to Queens Hospital Burton (QHB) and local community bases for their acute care and rehabilitation.

3.6) This proposal was part of the UHDB financial sustainability plan, however no final decisions have been made about changes to stroke services

3.7) The national trend, led by London Acute Trusts, is towards fewer, larger stroke sites. Delivering services to the local population of Derby and Burton in line with this model would ensure that UHDB, is able to future proof the expected increase in minimum numbers of stroke patients based on national assumption profiles.

3.8) The proposal has been discussed at various committees and was supported subject to the QIA's and EIA's being completed (please see section 13).

- The Staffordshire Sustainability and Transformation Board on the 11th October 2018
- Tamworth, Lichfield and Burntwood Joint Locality Board on 13th November 2018
- East Staffordshire CCG GP Steering Group 20th November 2018
- South East Staffordshire and Seisdon Divisional Committee on the 28th November 2018
- University Hospitals of Derby & Burton NHS Foundation Trust Board at their meeting on the 4th of December 2018
- East Staffordshire Patient Board on the 11th December 2018

- East Staffordshire Governing Body 10th January 2019 (As host commissioner on the BHFT contract)

4.) The Current Model of Delivery

4.1) Currently, both RDH and QHB provide hyper-acute stroke care, acute stroke care and stroke rehabilitation services on site. Both sites also currently provide Transient Ischaemic Attack (TIA) clinics.

4.2) QHB admits a much smaller number of stroke patients per year than RDH.

4.3) RDH currently delivers a stroke service to the population of Derbyshire, inclusive of a 7 day hyper acute stroke service and high risk 7 day TIA service.

4.4) QHB Stroke services are delivered to patients from East Staffordshire, South East Staffordshire and the Swadlincote area of Southern Derbyshire. This is inclusive of a hyper acute stroke service and a 5 day TIA service.

5.) Case for change

5.1) According to the National Stroke Strategy, key changes in stroke care have contributed to a reduction in the chances of a patient dying within 10 years of having a stroke, from a 71% chance in 2006 to a 67% chance in 2010. For example, based on the National Stroke Strategy, the London Stroke Model (which is the model used for the Derby & Burton proposal) was developed to look at care throughout the stroke service, including the establishment of Hyper-Acute Stroke Units (HASUs), with the treatment of patients taking place in fewer specialist HASUs, Acute Stroke Units (ASUs), and being provided with improved Early Supported Discharge. This reduction is largely due to improved co-ordination in stroke care, more patients receiving thrombolysis when needed, and more patients receiving scans within 24 hours of admission to hospital, so that the optimum treatment and care can start as soon as possible. This approach would be supported through the UHDB combined cross site model.

5.2) The Sentinel Stroke National Audit Programme (SSNAP) has highlighted that hyper-acute stroke services are more likely to be clinically effective if they are admitting between 600 and 1500 cases per year.

5.3) QHB site admits fewer than 500 hyper acute stroke unit (HASU) patients a year (405 in 2017/18. 393 patients in 2016/17, and 410 patients in 2015/16). This is below the national best practice minimum of 600, meaning stroke doctors and nurses in some of our units risk becoming deskilled.

5.4) There is evidence to show that stroke patients treated at hospitals which provide 24/7 specialist stroke consultant-delivered care have lower mortality rates and lower rates of long term disability post stroke event.

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

5.6) The Sentinel Stroke National Audit Programme (SSNAP) also notes that larger services are more likely to be financially viable, with a typical breakeven point of approximately 900 admissions per year (on the assumption that all patients were eligible for the best practice

tariff). NHS England's 7 Day Services Clinical Guidance also notes these findings in relation to larger facilities.

5.7) QHB has a higher than expected mortality for confirmed strokes, with a Summary Hospital-level Mortality Indicator (SHMI) of 1.21 which implies 20 per cent more deaths than expected.

5.8) Centralisation of clinical services is a nationally recognised service model for delivery of stroke services. This model ensures clinical sustainability and quality care for patients.

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

6.) The Proposed Future Model

6.1) The proposed future model is that hyper-acute stroke medicine will be delivered via a centralised service model at the RDH site, and a single referral point for TIA will be established, allowing for a seven day service for all patients currently in RDH or QHB catchment.

6.2) The proposal is for all hyper acute, mimic stroke and weekend TIA patients to be treated at RDH rather than QHB.

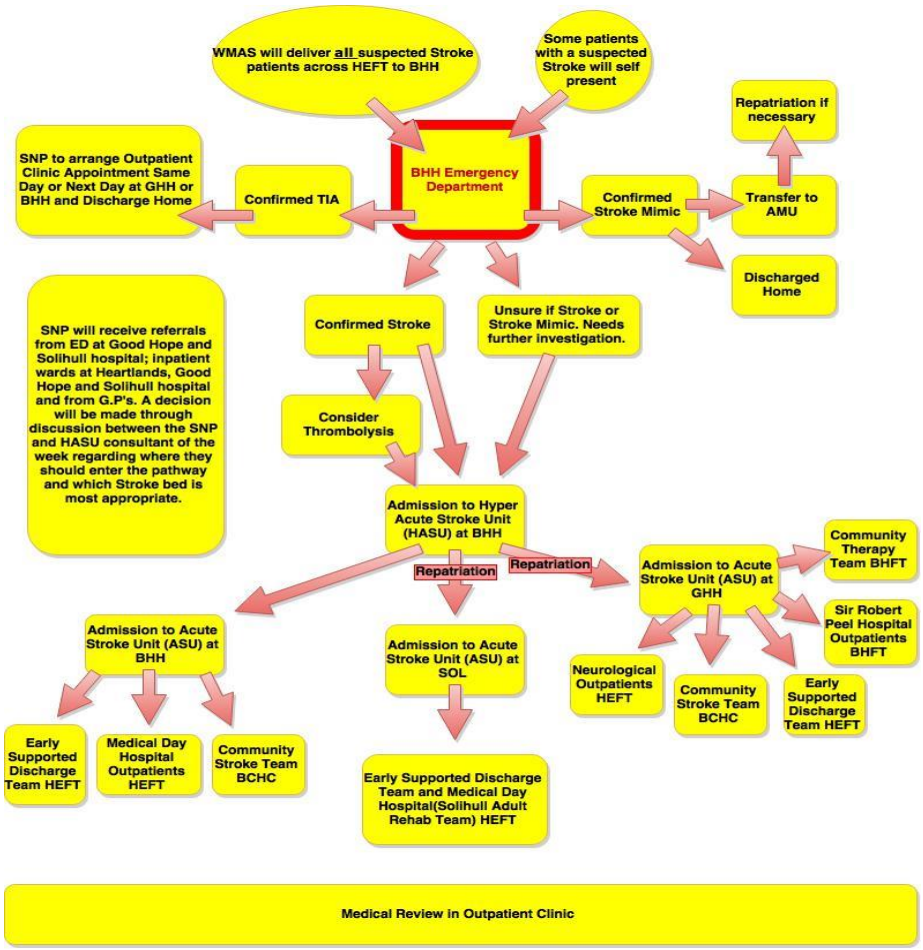
6.3) The proposed change to the patient pathway is as follows:

- All Hyper Acute (first 72 hours of care) patients would be treated at RDH and then stepped back down to QHB for acute care, rehabilitation and discharge to community services or care closer to home.
- Rehabilitation programmes following stroke would remain the same as they are currently
- All mimic stroke patients would be seen in derby and treated and discharged from Derby.
- All TIAs that present at the weekend would be treated at RDH and discharged to community or follow up care at QHB.
- Follow up clinics for Burton patients, post stroke or TIA would be provided at QHB.
- New treatment regimens for stroke patients, for example thrombectomy, would be supported by the RDH, but will mean patients follow a defined clinical pathway and this may include treatment at a very specialist hospital.
- West Midlands Ambulance Service (WMAS) and East Midlands Ambulance Service (EMAS) – the ambulance services that bring patients to QHB and RDH – have been engaged and are supportive in principle of the new hyper acute pathway and the requirement for conveyance to the Derby site as the acute/hyper site.

6.4) To Note

- There are a number of details which will need to be further modelled and planned prior to delivering this change with partner organisations looking at patient flow and the impact on contracts within the Stroke pathway.
- Discussions with East Midlands Ambulance Service and West Midlands Ambulance Service have been ongoing prior to and during the merger transaction.
- Modelling in relation to the changes to ambulance services for patients residing in North West Leicestershire to transport hyper acute stroke patients is currently taking place.

- Travel between sites (for purposes of repatriation to Queen's site for hyper acute patients, typically 72 hours post-stroke) will be via Patient Transport Service providers. A separate workstream is focussing on Patient Transport providers.
- Modelling has been completed for South East Staffordshire patients which does indicate that there is a hyper acute stroke unit at Birmingham Heartlands Foundation Trust (BHFT) with repatriation to an acute unit at Good Hope. This is where Burntwood, Lichfield and Tamworth patients will be transported to if they are not going to UHDB, a decision that will be made by the ambulance crew. The pathway is similar to that being proposed by UHDB.



7.) Benefits of Proposed Model

7.1) The benefits to patients, the local health care system and staff have been considered by UHDB as part of the proposal and are presented as follows:

7.2) Benefits identified for hyper acute patients include; reduced mortality rates, improved quality of life, reduced length of stay, and for the TIA patients reduced mortality and morbidity rates and improved quality of life.

7.3) The proposed model will secure the sustainability of local stroke services for all patients. Without this change to the stroke pathway, the long term viability of the current stroke pathway to the Burton population is exposed from a patient quality of care and performance perspective.

7.4) From a clinical perspective, there will be a joint on call rota and an investment in consultant medical, nursing and therapy staff in order to create capacity for an increased number of patients at Royal Derby Hospital

7.5) The same and equitable seven day service will be delivered to Burton patient population which is now provided to the Derby patient population at the RDH site.

7.6) RDH would continue to provide a seven day stroke consultant delivered service which will be available for patients across the merged Trust. This includes consultant stroke physician, delivered thrombolysis and ward rounds seven days per week which QHB is not currently able to deliver with its current consultant numbers.

7.7) In addition, RDH delivers a seven day TIA service and QHB patients will be able to access this at weekends, expanding the seven-day TIA service to the whole population of the merged Trust.

8.) Engagement undertaken to Date

8.1) During the Acute Trust merger consultation process, Engaging Communities Staffordshire (ECS) were commissioned to take this work forward on behalf of both Trusts. ECS is an independent, not-for-profit, community Interest Company that works to give the public a voice in the way services are delivered. The Engaging Communities work had a broad focus regarding the proposed merger of Burton and Derby Hospitals.

8.2) A number of workshops for patient representatives took place. The focus was to give the patient representatives a broad overview and discussion of what their role as patient representatives may involve.

8.3) This included a workshop which took place 20th September 2017 where patient representatives had initial discussions with clinicians representing the 6 clinical review areas, including Stroke. Patient representatives were recruited to become involved in the stroke clinical review.

8.4) The purpose of the workshop was to give the patient representatives updates on the collaboration and to hear more about each review area from clinicians. 23 patients attended the event; along with over 20 clinicians representing both Trusts.

8.5) Clinicians representing both Trusts led table discussions around clinical pathways including Stroke. The aim of the discussions was to give an overview of the clinical reviews; any key themes/issues that have emerged or been discussed; the vision for the service and patient benefits– to start to give the patient representatives an insight into the process and flavour of the discussions. It was also an opportunity for them to ask questions; to give their views; and to start to talk to them about their future involvement as patient representatives.

9.) Feedback

9.1) The Majority of the conversation was around the pathway and logistics of hyper acute stroke patients initially going to Derby (first 72 hours) and then receiving after care at Burton (if from the Burton/East Staffs area).

Discussion themes also included:

- The importance of high quality aftercare including community rehabilitation. The CCG will look at current provision available.
- Concerns around staffing with the current nurse shortage and recruitment. The model

would allow for an increase in staff capacity for an increased number of patients.

- Integration of the two staff teams. The model would allow for an increase in staff capacity for an increased number of patients.
- Financial savings: The sustainability and viability of stroke services will be secured under the proposed model.
- Higher quality services for patients. All patients would receive equitable care in a 'centre of excellence' as near to their homes as possible.
- Ambulance services and communication of where to take patients will be vital. Talks are underway with the ambulance provider ooking at the modelling.

9.2) Feedback has been taken into consideration as part of the proposals. The outputs of the events held were all taken into account when designing the proposed pathway alongside the Midlands & East Stroke Strategy and the national picture and feedback from the London Model. The Integration Stroke workstream project group has two patient representatives in attendance who have advised on patient engagement and their views on the further design of the proposed model.

10.) **Staff Engagement**

10.1) A full and detailed consultation process has been followed with the Staff both before, during and post transactional merger.

11.) **Wider engagement**

11.1) Wider engagement has been held by UHDB regarding experiences of patients of the Trust as part of the merger process; and raising awareness of the Burton Derby Collaboration this has included:

- A series of around 30 events between May 2017 and July 2018 have focused on the collaboration focusing on the seldom heard and those with protected characteristics.
- Individual meetings with member of the LGBTQ, Polish and Muslim communities; and with Staffordshire ASSIST who support with sensory impairment.
- Burton youth Forum members have received regular updates regarding the proposed merger with members of the Senior Executive Team attending meetings to give an opportunity for members to ask any questions.

To note: this has not been specific to Stroke provision but part of the wider engagement on the merger.

Link to Trust's or Shared Strategic Objectives –

12.) Improved health and wellbeing

12.1) The proposed changes, alongside the changes to TIA provision, will, drive a number of significant patient benefits:

• Reduced mortality rates for hyper acute stroke patients in the QHB patient population;
• Improved quality of life for surviving hyper acute stroke patients in the QHB patient population;
• Reduced length of stay overall for hyper acute stroke patients in the QHB patient population;
• Reduced mortality and morbidity rates for TIA patients in the QHB patient population
• Improved quality of life for TIA patients in the QHB patient population

Link to Other Overview and Scrutiny Activity

13.) UHDB attended the meeting of the Healthy Staffordshire Select Committee on 1st December 2017 where the proposal for the Strategic Collaboration between Burton Hospitals NHS Foundation Trust and Derby Teaching Hospitals NHS Foundation Trust - Outline Business case was reported.

14.) Community Impact

14.1) Within the Trust Business plan and working with the West Midlands Ambulance team there will be an in depth piece of work undertaken looking at conveyancing times and community impact which will form part of the full business case and options.

14.2) There has been a stage 1 Equality Impact Assessment led by ESCCG (Appendix 1) which has advised a Stage 2 Equality Impact Assessment is required. Advice from the OSC meeting will inform the basis for consultation and engagement including any Community Impact required.

14.3) ESCCG are submitting a paper to the Local Equality Advisory Forum on 20 March 2019. The forum is a group of people who represent communities with protect and inform our decision making. The group also includes representatives from vulnerable communities such as the homeless and asylum seekers and refugees and it includes people who can help us to think more broadly about how we can reduce health inequalities. Feedback received will form part of the EIRA stage 2 assessment and will inform the basis for any further engagement and consultation required including clinical pathway redesign.

14.4) UHDB has completed the Quality Impact Assessment (QIA) (Appendix 2) that was signed off by the Trust's Quality Review Group on 21 February 2019. All impacts were assessed as either positive or neutral and this has therefore not triggered a requirement for a stage 2 QIA. The QIA will be submitted to the CCG's Care Quality Review Meeting (that includes UHDB) on 6 March for information only.

Contact Officer

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Appendices/Background papers

Appendix 1 Equality Impact Assessment Stage 1
Appendix 2 UHDB Quality Impact Assessment

Equality Impact and Risk Assessments

Stroke pathway reconfiguration

East Staffordshire CCG

Current Status
Stage 2 Required

Review Date
16/05/2018

Person Responsible
Emily Davies

Service
Stroke

Service Area
Hyper acute Stroke

Project Lead

Name:	davies, emily
Email:	emily.davies@northstaffs.nhs.uk
Phone:	01283507167

Explanation

Reconfiguration of the Stroke pathway at University Hospital of Derby and Burton Hospitals is a key part of the merger business case, approved on the 1st July 2018. This relates to movement of the hyper acute element (first 72 hours of the pathway) from Queens Hospital Burton to Royal Derby Hospital. The Clinical Commissioning Group (CCG) was supportive of the merger for clinical and financial sustainability reasons and stroke services were identified as a key area of focus for the CCG in 2012 due to the need to improve patient outcomes and sustainability of services.

Assessment

Equality Impact

1	**Does this issue plan to withdraw a service, activity or presence?**	✔
No as the Hyper Acute Service will still exist, however it will be delivered at a different site. The Hyper acute element will be moved from QHB to Derby Royal. To note: patients may see this as a withdrawal/lack of presence locally as the services will be provided but somewhere else which could involve more travel		
2	**Does this issue plan to reduce a service, activity or presence?**	✔
No not applicable To note: patients may see this as a withdrawal/lack of presence locally as the services will be provided but somewhere else which could involve more travel		
3	**Does this issue plan to introduce or increase a charge for Service?**	✔
No no charge to the patient This is an NHS service which is free at the point of use for all UK residents from 'cradle to the grave'.		
4	**Does this issue plan to make a change to a commissioned service?**	✖
The hyper acute element of the pathway will be delivered from a different location. The service will move from QHB to Derby Royal. The acute and rehabilitation pathway will continue to be delivered as per current arrangements at QHB and in the community. The ESCCG rationale for the change is to drive improvements in patient outcomes. The plan is part of the planned merger between BHFT and DHTFT to drive clinical and financial sustainability.		
5	**Does this issue plan to introduce, review or change a policy, strategy or procedure?**	✖
There will be changes to the patient pathway which may result in other reviews of the service and changes		

6	**Does this issue plan to introduce a new service or activity?**	✔
No however see question 1 &5 (same service but hyper acute delivered from a different location)		
7	**Is this primarily about improving access to, or delivery of a service?**	✖
Yes the reconfiguration of the service will deliver improvements to patient outcomes including: - reduced mortality rates for hyper acute stroke patients in the BHFT patient population; - increased quality of life for surviving hyper acute stroke patients in the BHFT patient population; - reduced length of stay overall for hyper acute stroke patients in the BHFT patient population; - reduced mortality and morbidity rates for TIA patients in the BHFT patient population; and - increased quality of life for TIA patients in the BHFT patient population		
8	**Does this affect Employees or levels of training for those who will be delivering the service?**	✖
Yes. DTHFT staff currently provide and will continue to provide a seven day stroke consultant delivered service which will be available for patients across the merged Trust. This includes consultant stroke physician led thrombolysis and ward rounds seven days per week which BHFT is not currently able to deliver with its current consultant numbers. In addition, DTHFT delivers a seven day TIA service and QHB patients will be able to access this at weekends, expanding the seven-day TIA service to the whole population of the merged Trust. A further WTE stroke consultant will be recruited post-merger to assist with the additional patients that are brought in to RDH from the BHFT catchment area.		
9	**Does this issue affect Service users?**	✖
Yes the hyper acute element of the pathway eg. first 72 hours of care will be delivered at Derby Royal Hospital instead of QHB. This will also impact on family and carers. The CCG will be seeking views and opinions on impact. Targeted engagement will be planned and implemented with protected and seldom heard groups in the next stage.		

10	**Can you foresee a negative impact on any Protected Characteristic Group(s)?** *If YES please state what these could be.*	✔
No not at this point in time. However, targeted engagement will be planned and implemented with protected and seldom heard groups in the next stage will be planned with E&I BP and Comms and Engagement Lead.		

Equality Risk

11	**Have you got any general intelligence (research, consultation, etc.)?** *If YES please list any related documents.*	✔
Yes - SSNAP Audit Report Royal College of Physicians (2016), 'Sentinel Stroke National Audit Program (SSNAP): Acute organisational audit report', November, p. 40. https://www.strokeaudit.org/Documents/National/Clinical/AugNov2016/AugNov2016-PublicReport.aspx As part of the merger DTHFT and BHFT are reviewing sustainability of services across a number of pathways including stroke.		
12	**Have you got any specific intelligence (research, consultation, etc.)?** *If YES please list any related documents.*	✔
Yes - SSNAP Audit Report Royal College of Physicians (2016), 'Sentinel Stroke National Audit Program (SSNAP): Acute organisational audit report', November, p. 40. https://www.strokeaudit.org/Documents/National/Clinical/AugNov2016/AugNov2016-PublicReport.aspx		
13	**Have you taken specialist advice? (Legal, E&I Team, etc).** *If YES please state.*	✔
E&IBP and Comms and Engagement Lead (MLCSU)		
14	**Have you considered your Public Sector Equality Duty?** *Please provide a rationale.*	✔

East Staffs CCG are committed as approved within the governance process, to implementing the Equality Impact and Risk Assessment scrutiny process in all key healthcare changes for equitable patient outcomes. This involves showing evidence of taking 'due regard' i.e. prompting our deliberate thought and consideration of people from groups protected by the Equality Act 2010 (and H&SC Act 2012 - health inclusion groups - where there are local concerns) in all our planning and decision and in a timely way to follow due process. This has been achieved to date, through the completion of a Stage 1 EI&RA and will be continued in the more detailed stage 2.

15	**Do you plan to publish your information?** *Include any "Decision Reports"*	✔

Published via Governing Body Papers and on CCG website

16	**Can you minimise any negative effect?** *Please state how.*	✖

Not clear on any negative impact at this stage. Negative effect can be minimised by seeking the views of local service users, protected and seldom heard groups and where possible showing careful consideration and mitigating any negative issues raised through this process.

17	**Do you have any supporting evidence?** *If YES please list the documents.*	✔

Detail re: governing body papers

18	**Have you/will you engage with affected staff and users on these proposals?**	✔

We will be undertaking targeted engagement for ES and SES patients and carers.

Human Rights Impact

19	**Will the policy/decision or refusal to treat result in the death of a person?**	✔

no n/a		
20	**Will the policy/decision lead to degrading or inhuman treatment?**	✔
no n/a		
21	**Will the policy/decision limit a person's liberty?**	✔
no n/a		
22	**Will the policy/decision interfere with a person's right to respect for private and family life?**	✔
Query impact re: travel times This is currently being compiled by the Trust and West Midlands Ambulance Service and neighboring CCGs. The findings will be part of the considerations during the consultation and engagement phase.		
23	**Will the policy/decision result in unlawful discrimination?**	✔
no n/a		
24	**Will the policy/decision limit a person's right to security?**	✔
no n/a		
25	**Will the policy/decision breach the positive obligation to protect human rights?**	✔
no n/a		
26	**Will the policy/decision limit a person's right to a fair trial (assessment, interview or investgation)?**	✔
no n/a		

27	**Will the policy/decision interfere with a person's right to participate in life?**	
no n/a		

Stage 2 Details

Equality Policies

No files uploaded

Equality Other

No files uploaded

Human Rights

No files uploaded

Additional Files

No files uploaded

Comments

Assessment Comment

Reconfiguration of the Stroke pathway at University Hospital of Derby and Burton Hospitals is a key part of the merger business case, approved on the 1st July 2018. This relates to movement of The CCG considers reconfiguration of Stroke services important in order to improve patient outcomes and experience which fits with its overarching Improving Lives Strategy. The merger of DTHFT and BHFT provides an opportunity to consider how this can be achieved through the reconfiguration of the pathway.
22/10/2018
Fernando, Fleur

Approval Comment

QA check 1 J Allen 210818: Please complete front sheet with explanation of why you are doing what you are doing now. Please state abbreviations in full once for each. Please add URL to Q11 &12. Q14 please add suggested text e-mailed. Q22: Query impact re: travel times - please state impacts re travel time from reconfigured service. Please ask colleague to complete peer review as above. JA submitted in error. Still to be completed eg as above. thank you (141018) Peer review completed by Fleur Fernando Senior Commissioner 221018. Confirmed accuracy of content and critical friend appropriate challenge made. No changes resulted in this stage 1. Stage 2 required to be fully completed ahead of any senior committee decisions being made.
22/10/2018
Allen, Julia

Stage 2 Comment

No comment saved

Last Activation Comment

No comment saved

Last Deactivation Comment

No comment saved

Quality Impact Assessment
Summary

North Derbyshire Clinical Commissioning Group
Erewash Clinical Commissioning Group
Hardwick Clinical Commissioning Group
Southern Derbyshire Clinical Commissioning Group

Project Title:	**Integrated Stroke Pathway**		
Project Lead:	Sophie Hunter		
Project Manager (if applicable):	Jane Docksey		
Project Sponsor/SRO:	Jenny Deakin / James Hender		
Date QIA completed	16.1.19	**Completed by:**	Sophie Hunter/ Jenny Deakin
QIA panel recommendation:			

QIA Panel Comments

Project Overview

Current Service

Derby Based Services

In 2018 the service currently delivered consists of a 34 bedded ward, including a four bedded HDU and 30 acute stroke beds, access to 24 hour/day CT scan and Consultant led thrombolysis, via telemedicine out of hours. The service operates seven days a week and provides Consultant led ward rounds and a 7 day high risk TIA service supported by Consultants and Clinical Nurse Specialists. The service also has a 21 bedded stroke rehabilitation ward and investment from Commissioners has seen the expansion of early supported stroke discharge service, (ESSD), to incorporate the whole of Southern Derbyshire.

The Trust is a teaching hospital and the stroke service already has two academic Consultant posts within the team with an active programme of research. In challenging recruitment times, hospitals which are demonstrably embracing new techniques and are expanding through investment are likely to be more successful in recruiting and retaining high calibre staff across all disciplines.

Burton Based Services

Hyper acute service

The Burton Site provides a 24/7 365 day a year thrombolysis service from the Queen's Hospital site. All patients admitted to Queen's Hospital with suspected stroke are assessed using nationally recognised criteria and thrombolysed as appropriate. Between the hours of 9am -5pm Monday to Friday the service is led by the Stroke Coordinator with Consultant support and dedicated Stroke Registrars. The dedicated stroke registrar post is currently vacant but is due to be filled imminently. Out of hours the service is led by the on call medical registrar with telemedicine support for imaging interpretation by consultants based at Burton on a bi-weekly rota. All on call medical registrars have received thrombolysis training as part of their rotation.

The service is supported by a dedicated stroke unit on ward 8 with 21 beds (within a 27 bedded ward). 6 of the beds have the facility for external monitoring of patients' hourly neurological observations, in line with national guidance, and patients are monitored for the first 72 hours of their pathway. Nursing staff on the ward are trained with a stroke competency package and have received thrombolysis specific training via a dedicated thrombolysis simulation day.

The unit has 5 days a week ward rounds which are consultant led and has 7 days a week therapy cover (5 days a week dedicated stroke specialist therapists) and has access to dedicated speech therapy, dietician and orthoptist. Specialist nursing support is provided by the stroke coordinator.

Acute Service

After the first 72 hours patients are stepped down from the hyper acute monitoring beds and are considered for transfer to rehabilitation at community hospitals if they still need to be inpatients and for discharge to the community teams if they are medically fit for discharge. East Staffs has a combined ESD and community stroke service with limited capacity to take patients early after their stroke due to the lack of a community speech therapy and the lack of access to a care component to support patients discharged into the community with a disability. Therefore the numbers of patients discharged to the community with ESD is very low overall. South East Staffs has no community ESD service and all patients from this area are transferred to community hospitals for rehabilitation.

TIA Service

The TIA service has high risk clinics which run 5 days a week and aim to see patients referred within 24 hours of first contact and a low risk clinic on a Thursday morning which sees patients within 7 days of first contact. The service has dedicated carotid ultrasound support on weekdays and there is facility for CT angiogram for patients who present over the weekend. Patients requiring a vascular opinion are referred to a weekly clinic provided by University Hospitals of North Midlands (UHNM).

Rehabilitation Service

Traditionally Queen's hospital had a commissioned rehabilitation service based out of the Queen's site and both Tamworth and Lichfield community hospital sites. The lack of community led facilities for disabled stroke patients has resulted in patients having to remain with the acute Trust rehabilitation.

Planned Changes

Specifically, the following changes are proposed to the way stroke services currently operate at RDH and QHB:

• Hyper acute stroke patients will no longer be treated at Queen's site and instead hyper acute stroke care for the merged Trust's population will be provided at the Derby site. Paramedics will transfer patients from the combined catchment area directly to the RDH emergency department.

• Confirmed hyper acute stroke patients from the Burton catchment will be admitted into Derby site hyper acute stroke unit (HASU) for the first 72 hours of their care. After this time, patients will either be discharged or repatriated where relevant to local facilities (including the sites currently within QHB) for acute and rehabilitation care (equivalent care as they currently receive).

• It is planned that all consultants would participate on an equal basis in the out-of-hours hyper acute rota. However, where necessary advice could be sought from the consultant covering Derby site (where seven day ward rounds are the standard). It is unlikely that there will be sufficient staffing post-merger to allow a seven day stroke consultant ward round on the Queen's site immediately after the merger; instead, if out of hours advice is necessary, this will be sought from the consultant covering Derby site, where seven day ward rounds will continue to be in place. Where appropriate, for instance patients who have a stroke whilst they are inpatients at Queens Hospital, a transfer to the Derby site will be arranged following initial advice from the on-call stroke consultant.

• West Midlands Ambulance Service (WMAS) and East Midlands Ambulance Service (EMAS) – the ambulance services that bring patients to QHB and RDH – have been engaged and are supportive of the new hyper acute services and the requirement for conveyance to the Derby site as the acute/hyper acute site. Travel between sites (for purposes of repatriation to Queen's site for hyper acute patients, typically 72 hours post-stroke) will be via PTS providers.

• A single referral point will be set up for all suspected TIAs. On weekends, patients for the Queen's site will be directed to the Derby site so that they can access a seven day TIA clinic. On weekdays, patients will continue to be treated at the TIA clinic at Queen's site which will continue to operate five days per week.

• QHB TIA patients who attend the RDH TIA clinics at the weekend will receive follow up care at the most appropriate centre for the patient. It is planned that there will be a single referral process for all TIA clinics.

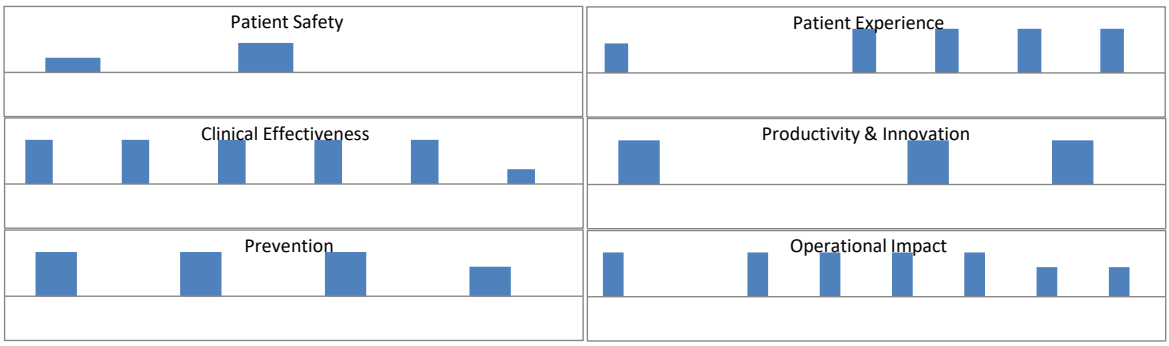
• Rehabilitation and therapy cover will be provided seven days a week at both Burton and Derby sites.

Future Services

For the current QHB patient populations, the changes set out above to the configuration of stroke services means a number of tangible changes in terms of the services they receive:
• Hyper acute patients that would otherwise have been admitted to Queen's site will receive treatment for up to 72 hours in a HASU with seven day consultant presence at Derby site. This compares to the current service at QHB where hyper acute patients presenting and admitting at the weekend are cared for by the medical on-call consultant. This change will specifically improve current QHB's performance in domains 2 and 4 of the SSNAP quality domains. Overall, these changes will mean that QHB's hyper acute patients will receive a service which is far more consistent with NICE clinical guidelines.
• Stroke beds on the Queen's site will be ring-fenced, to ensure capacity and appropriate location for stroke patients repatriated from Derby site after 72 hours. The merged Trust will provide an equitable offer for the post-72 hour period across the Derby and Burton sites.
• Hyper acute patients that otherwise would have been admitted to QHB will be provided with access to an Intermittent Pneumatic Compression ('IPC') device as a first prevention against VTE, where relevant. IPC devices are currently in the process of being introduced at Burton and will very soon be in use on the stroke unit to ensure an equitable service.
• TIA patients that otherwise would have presented over the weekend at QHB will be able to access preventative treatment within 24 hours in contrast to current practice of waiting until Monday. This means that TIA patients in the QHB catchment area will be provided with a service which is compliant with NICE clinical guidelines.
• 24/7 consultant cover is provided at RDH to deliver thrombolysis and specialist assessment. The QHB consultants would join the current out of hours rota.
In addition, patients at RDH will benefit from extended weekend services for physiotherapy and occupational therapy. At present, QHB provides stroke trained physiotherapy and occupational therapy services during the week and stroke patients see general physio/occupational therapists on the weekend. RDH stroke patients are seen six days a week by stroke trained physio/occupational therapists, and one day a week by general physio/occupational therapists. Post-merger, weekend patients at RDH (who would otherwise be at QHB) will benefit from the service from additional therapists. Hyper-acute patients in RDH would receive stroke specific therapy input at the weekend. These changes have been designed to drive a number of significant patient benefits.

Summary

	Questions Answered	*Questions NOT Answered*	Positive Scores	Neutral Scores	Negative Scores
Patient Safety	3	*0*	2	1	0
Patient Experience	7	*0*	5	2	0
Clinical Effectiveness	6	*0*	6	0	0
Productivity & Innovat	4	*0*	3	1	0
Prevention	4	*0*	4	0	0
Operational Impact	8	*0*	7	1	0
WHOLE PROJECT	32	*0*	27	5	0



RISK LEVEL

NO Risk

No negative scores for any of the criteria

No further action required

POST MITIGATION (MODERATED) RISK LEVEL

NO Risk

JUSTIFICATION FOR MODERATED RISK LEVEL

Quality Impact Assessment

Stage 1

NHS

North Derbyshire Clinical Commissioning Group
Erewash Clinical Commissioning Group
Hardwick Clinical Commissioning Group
Southern Derbyshire Clinical Commissioning Group

Domain	Criteria		Answer (select from picklist)	Score	Rationale
Patient Safety	Q1	Is there an impact on avoidable harm / incidents?	Reduction of harm/incidents possible	+ 1	** Summary Hospital-level Mortality Indicator (SHMI) data shows that the mortality rate for hyper-acute stroke patients at BHFT is above the level that would be expected based on
	Q2	Is there an Impact on Health Care Associated Infection (HCAI)?	Reduction of HCAI likely	+ 2	By reducing patient Length of Stay the assoicated risk of HCAI is reduced. Similar improvements observed elsewhere (London) - patient benefit: reduced time in hospital
	Q3	How will the reporting of safeguarding incidents be affected?	No impact on safeguarding	+ 0	UHDB has harmonised all safeguarding policies and electronic reporting tools
Patient Experience	Q4	Is there an impact on patient experience (complaints / PALS)?	Improved patient experience likely (decrease in complaints)	+ 2	** The redesign Stroke pathway will provide clinically effective care in line with national clinical guidelines and strategies. It needs to be acknowledged that relatives and carers of
	Q5	Is there an impact on consent and confidentiality?	no impact on consent and confidentiality	+ 0	All Trust employees undergo the same full training on consent and confidentiality. Changes to this service will not see a negative impact
	Q6	Is there an impact on informed choice and involvement in care planning?	No effect on choice and involvement in care planning	+ 0	** Patients will be admitted into a dedicated Hyperacute Stroke Units (HASU) under the new model as per national strategy. As per current care pathways patients will be involved in
	Q7	Is there an impact on personalised care?	Increase in personalised care and involvement expected	+ 3	Clinical care, and resultant patient outcomes, will be delivered for all patients (BHFT and DTHFT) thus maintaining the standards currently seen at DTHFT.
	Q8	Is there an impact on quality of the environment for patients?	Improved quality of patient environment expected	+ 3	Patients will be admitted onto a dedicated HASU which is resourced specifically for hyperacute stroke patients.
	Q9	Has there been involvement of patients / carers in project development?	There has been full patient / carer involvement	+ 3	A series of patient involvement events were held during the Trust merger processes. Patient representatives have attended the specific stroke workstream meetings and have
	Q10	Have lessons learned from patient experience been used to develop scheme?	Lessons learned from patient experience have been fully utilised	+ 3	Patient representatives are part of the core members of the monthly Stroke Operational Group (SOG)
Clinical Effectiveness	Q11	Has evidence based practice been utilised?	Project fully developed using EBP	+ 3	**In line with the national direction of travel to concentrate specialist services, the provision of high quality stroke care forms the basis of the Full Business Case (FBC) and Patient Benefit
	Q12	Does the project have clinical leadership / engagement?	Clinical leader / engagement in place	+ 3	Dr James Scott, Consultant Stroke Physician is the clinical lead, supported by Dr Magnus Harrison, Executive Medical Director UHDB
	Q13	How does the project reduce variations / improve consistency in care?	Reduction in variation / improvement in consistency expected	+ 3	Clinical care, and resultant patient outcomes, will be delivered for all patients (BHFT and DTHFT) thus maintaining the standards currently seen at DTHFT.
	Q14	Will quality metrics that measure outcomes be used to measure success?	Quality metrics in place that will identify success	+ 3	SSNAP 10 key indicators will be used as per nationally reported outcome measures
	Q15	Does the project improve NICE compliant treatment?	Improvement in NICE compliant treatment expected	+ 3	The changes represent a continuation in NICE compliant treatment
	Q16	How will the project impact on re-admission?	Decrease in re-admission rates possible	+ 1	Patients will experience more timely care in the hyperacute phase which will result in improved outcomes with associated possiblilty of reduced readmissions
Productivity & Innovation	Q17	Does the project help to eliminate inefficiency and waste?	Improved efficiency / reduction in wasted expected	+ 3	Centralised specialist dedicated service will create efficiencies on one site of the Trust providing hyperacute care
	Q18	Does the project support low carbon pathways (i.e. Reduced emissions)	Not applicable	+ 0	
	Q19	Will the project help to improve provider performance?	Improvement in provider performance is expected	+ 3	** BHFT also has a higher than expected mortality for confirmed strokes, with an SHMI of 1.21 which implies 20 per cent more deaths than expected. Fewer deaths among the
	Q20	Will the project improve care pathways?	Improvement in care pathways expected	+ 3	The reconfiguration of stroke services at UHDB will deliver a service that will be clinically sustainable with improved clinical outcomes.
Prevention	Q21	Will the project promote people to stay well?	Promotion of wellness expected	+ 3	Improved clinical outcomes
	Q22	Will the project promote self care for long term conditions?	Promotion of self care for LTC expected	+ 3	As above
	Q23	Will the project help reduce health inequalities?	Reduced health inequalities expected	+ 3	Equitable access to hyperacute stroke services for the communities served by UHDB

	Q24	Will the project prevent people dying prematurely?	Reduction in people dying prematurely likely	+ 2	The reduced likelihood of a subsequent stroke after TIA represents a significant benefit
Operational Impact	Q25	Will staff have relevant capability, knowledge and skills?	All staff will have the relevant capability and knowledge	+ 3	** As per training and professional roles, all staff delivering care will be trained and qualified appropriate to the role undertaken to ensure quality of care to stroke
	Q26	Will this project impact upon the level of violence & aggression experienced by patients, service users and staff?	Not applicable	+ 0	
	Q27	Could there be impact on service reputation / media coverage	Positive impact on service reputation / media coverage expected	+ 3	**Improved reputation evidenced by improved clinical outcomes and equitable access There may be a possible increase in complaints due to patients and carers potentially having
	Q28	Does the project affect effective support in the community?	Improved effective support in the community expected	+ 3	Patient supported to receive Right Care, Right time, Right place care
	Q29	Does the project impact on waiting times?	Improved waiting times expected	+ 3	Improved accessability to TIA weekend clinics will result in improvements in SSNAP outcome 9
	Q30	Are staff engaged in the scheme?	All staff are engaged	+ 3	** Multidisciplinary team are members of the Stroke workstream project group. Focus on Stroke integration throughout merger staff engagement highlighting improved patient
	Q31	Any impact on staff (e.g. terms and conditions, base change, role change etc.)?	Positive impact expected	+ 2	Development opportunites will be made available to staff
	Q32	Any impact on any other services or stakeholders including Primary Care?	Positive impact expected	+ 2	Improved patient outcomes should result in a healthier patient population across all CCG localities

RISK LEVEL

NO Risk

No negative scores for any of the criteria

No further action required

Quality Impact Assessment

Stage 2 Assessment

NHS

North Derbyshire Clinical Commissioning Group
Erewash Clinical Commissioning Group
Hardwick Clinical Commissioning Group
Southern Derbyshire Clinical Commissioning Group

	Question		Answer	Score	Stage 2 required?	What are the issues?	How will they be mitigated?	When can this be completed by?	Who will complete it?
Patient Safety	Q1	Is there an impact on avoidable harm / incidents?	Reduction of harm/incidents possible	+ 1	NO				
	Q2	Is there an Impact on Health Care Associated Infection (HCAI)?	Reduction of HCAI likely	+ 2	NO				
	Q3	How will the reporting of safeguarding incidents be affected?	No impact on safeguarding	+ 0	NO				
Patient Experience	Q4	Is there an impact on patient experience (complaints / PALS)?	Improved patient experience likely (decrease in complaints)	+ 2	NO				
	Q5	Is there an impact on consent and confidentiality?	no impact on consent and confidentiality	+ 0	NO				
	Q6	Is there an impact on informed choice and involvement in care planning?	No effect on choice and involvement in care planning	+ 0	NO				
	Q7	Is there an impact on personalised care?	Increase in personalised care and involvement expected	+ 3	NO				
	Q8	Is there an impact on quality of the environment for patients?	Improved quality of patient environment expected	+ 3	NO				
	Q9	Has there been involvement of patients / carers in project development?	There has been full patient / carer involvement	+ 3	NO				
	Q10	Have lessons learned from patient experience been used to develop scheme?	Lessons learned from patient experience have been fully utilised	+ 3	NO				
Clinical Effectiveness	Q11	Has evidence based practice been utilised?	Project fully developed using EBP	+ 3	NO				
	Q12	Does the project have clinical leadership / engagement?	Clinical leader / engagement in place	+ 3	NO				
	Q13	How does the project reduce variations / improve consistency in care?	Reduction in variation / improvement in consistency expected	+ 3	NO				
	Q14	Will quality metrics that measure outcomes be used to measure success?	Quality metrics in place that will identify success	+ 3	NO				
	Q15	Does the project improve NICE compliant treatment?	Improvement in NICE compliant treatment expected	+ 3	NO				
	Q16	How will the project impact on re-admission?	Decrease in re-admission rates possible	+ 1	NO				
Productivity & Innovation	Q17	Does the project help to eliminate inefficiency and waste?	Improved efficiency / reduction in wasted expected	+ 3	NO				
	Q18	Does the project support low carbon pathways (i.e. Reduced emissions)	Not applicable	+ 0	NO				
	Q19	Will the project help to improve provider performance?	Improvement in provider performance is expected	+ 3	NO				
	Q20	Will the project improve care pathways?	Improvement in care pathways expected	+ 3	NO				
Prevention	Q21	Will the project promote people to stay well?	Promotion of wellness expected	+ 3	NO				
	Q22	Will the project promote self care for long term conditions?	Promotion of self care for LTC expected	+ 3	NO				
	Q23	Will the project help reduce health inequalities?	Reduced health inequalities expected	+ 3	NO				
	Q24	Will the project prevent people dying prematurely?	Reduction in people dying prematurely likely	+ 2	NO				
	Q25	Will staff have relevant capability, knowledge and skills?	All staff will have the relevant capability and knowledge	+ 3	NO				
	Q26	Will this project impact upon the level of violence & aggression experienced by patients, service users and staff?	Not applicable	+ 0	NO				

Operational Impact	Q27	Could there be impact on service reputation / media coverage	Positive impact on service reputation / media coverage expected	+ 3	NO				
	Q28	Does the project affect effective support in the community?	Improved effective support in the community expected	+ 3	NO				
	Q29	Does the project impact on waiting times?	Improved waiting times expected	+ 3	NO				
	Q30	Are staff engaged in the scheme?	All staff are engaged	+ 3	NO				
	Q31	Any impact on staff (e.g. terms and conditions, base change, role change etc.)?	Positive impact expected	+ 2	NO				
	Q32	Any impact on any other services or stakeholders?	Positive impact expected	+ 2	NO				

STROKE QIA SUPPORTING EVIDENCE

(Q11 & Q13) Access to Services:
Post implementation of the redesigned Stroke pathway for UHDB patients, ensuring timely access to Hyperacute Stroke Services for the populations of East Staffs CCG and South East Staffs CCG is a key quality indicator.

Currently patients residing in East Staffs CCG and associate commissioning areas of Southern Derbyshire CCG, and South East Staffs CCG exhibiting symptoms of stroke are conveyed to and cared for by Queens Hospital Burton. It is acknowledged that there is a small cohort of patients from the South East Staffs locality whose conveyance travel time will increase due to centralising the HASU at Royal Derby (table below). However, it also needs to be acknowledged this patient population is able to access Hyperacute Stroke services from other Acute providers, currently commissioned by the CCGs within nationally recognised best practice travel conveyance times will continue to exist.

Rationale:
The Full Business Case (FBC) and the Patient Benefit Case (PBC) for the merger of Royal Derby Hospital and Queens Hospital Burton into the newly formed University Hospitals of Derby & Burton (UHDB), and national opinion as expressed by the National Director for Stroke, is that the threshold for a viable HASU is 600 admissions per year. Historically BHFT, and the now QHB are only partially compliant with the specifications for Hyper acute stroke services (NHS Midlands & East specification). It was therefore reasonably concluded, and expressed within that the stroke services for QHB could not continue in its current form.

Centralisation of hyper-acute stroke care is demonstrated to improve health outcomes, including mortality, by increasing thrombolysis rates, and possibly through the concentration of expertise and treatment of higher volumes of patients. Current national KPIs for patients receiving thrombolysis are within 4 hours of incident. The slightly extended travel conveyance times will not increase so significantly this 4 hour window is impacted on.

The redesigned pathway relocating HASU exclusively to the RDH site is also key in ensuring a further number of opportunities to improve access to interventions related to stroke, its diagnosis and related interventions such as vascular procedures. On admission to RDH the patient will have access to flow through scan and CT, a 24/7 Stroke physician and access to on site vascular teams.

WMAS & EMAS have been a key stakeholder in the wider merger consultation process and continues to be engaged in the proposed changes to the Stroke pathway.

As virtually all users of the new UHDB service will be conveyed to hospital by ambulance under blue light conditions, patients will be able to readily access the service offered in all acute providers commissioned by ESCCG & SESCCG, with UHDB RDH site being the identified HASU.

There is, however, likely to be some increased travel distance for some relatives and friends of the patient in accessing Royal Derby to visit the patient, depending on where they live in relation to the geographical location of the hospital, and in the majority of cases, it would be for an average of 3 days duration, where after the patient would be conveyed to either their place of residence to receive reablement services or, if medically unfit, receive in-patient rehabilitation in their local area, closer to home: Queens Hospital Burton, London Road, Sir Robert Peel, Tamworth or Samuel Johnson Lichfield.

All subsequent patient transfers post 3 days (or sooner if clinically appropriate and safe) will be subject to clinically led assessment and via a patient repatriation policy.

(Q11) Has evidence based practice been utilised?

Evidence 1

As part of the NHS England 7 day services, a number specialist services – including stroke thrombolysis - are expected to meet the four priority clinical standards. RDH already complies with all four priority standards in stroke medicine.

(https://www.england.nhs.uk/wp-content/uploads/2017/09/seven-day-service-clinical-standards-september-2017.pdf)

Professor Sir Bruce Keogh, the NHS Medical Director, supported by the Academy of Medical Royal Colleges, identified four of these standards which if met would be most likely to have the greatest impact on reducing variation in mortality risk.

These Priority Clinical Standards are:

- **Standard 2: Time to Consultant Review**
- **Standard 5: Access to Diagnostics**
- **Standard 6: Access to Consultant-directed Interventions**
- **Standard 8: On-going Review**

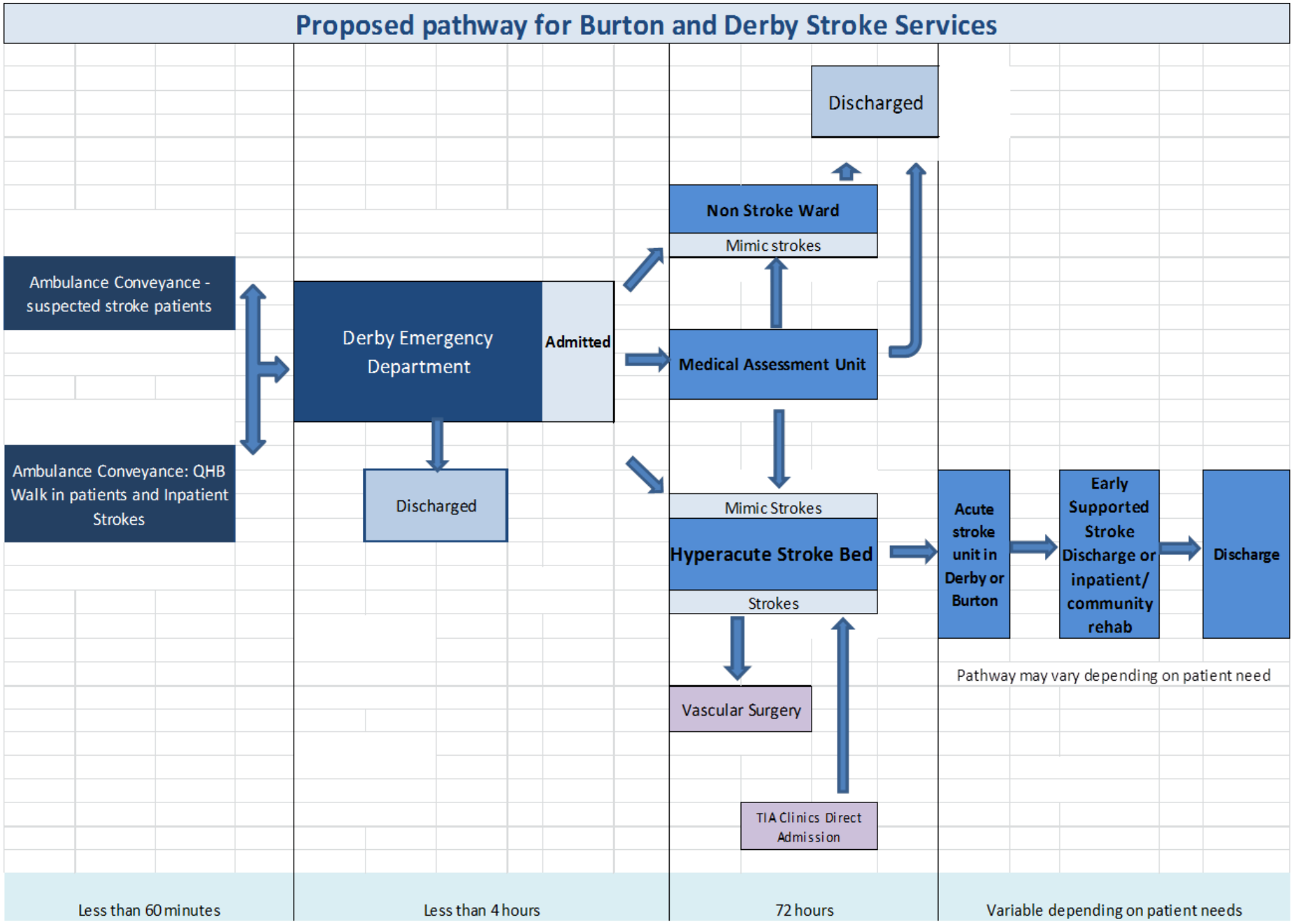
Evidence 2

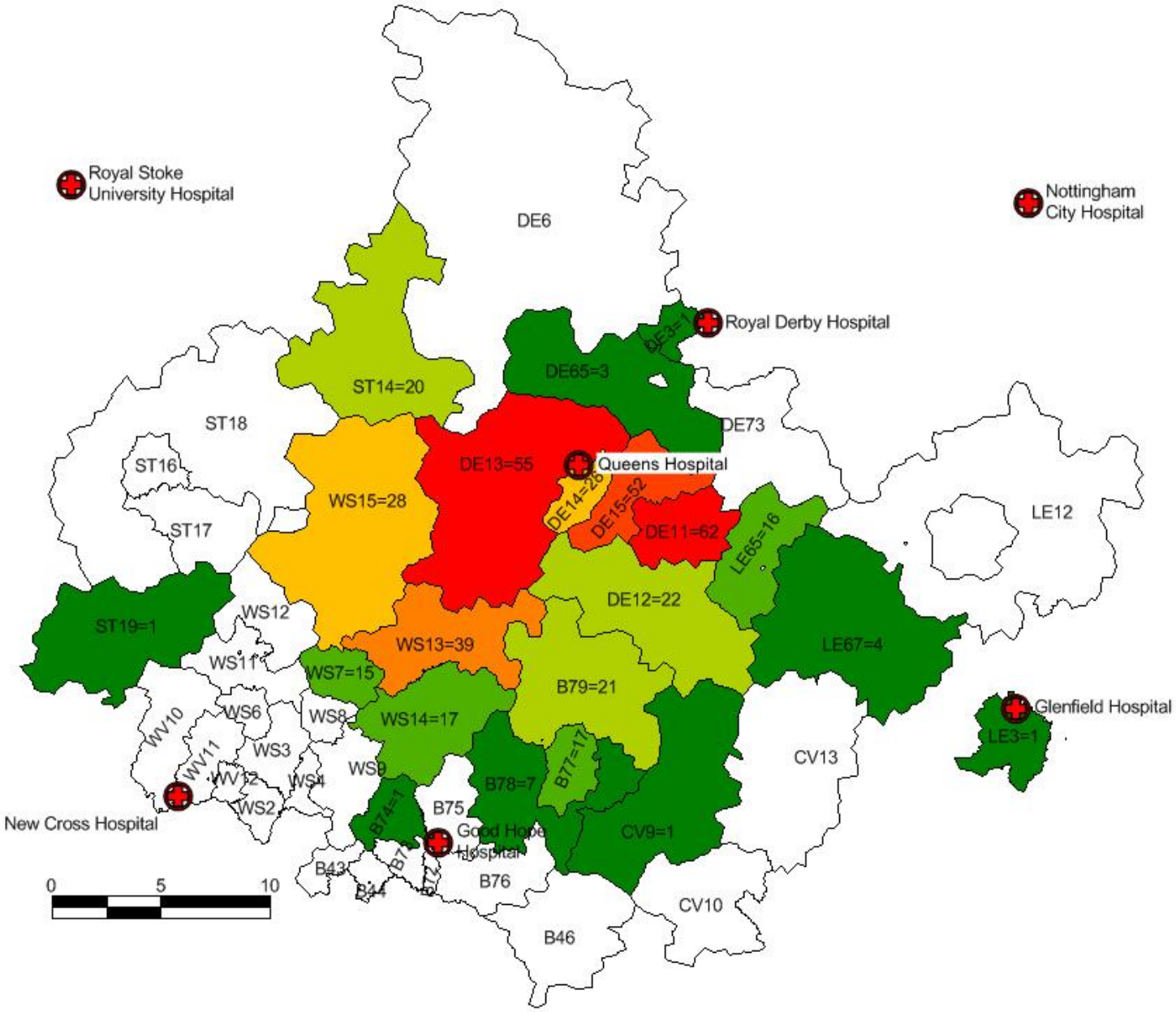
The challenges faced by BHFT's Stroke service were recognised by ESCCG in its Delivery of Change Plan for 2012 – 2016. This plan included a Commissioning intention to develop appropriate stroke models of care for the East Staffordshire area.
(http://www.eaststaffsbc.gov.uk/sites/default/files/docs/planning/planningpolicy/lpevidence/health/EastStaffsBoroughDeliveryofChangePlan2012-16.pdf)

WMAS Emergency Transports from Staffordshire to Royal Derby & Burton (by originating postcode area)								
	Destination							
	ROYAL DERBY HOSPITAL			QUEENS HOSPITAL BURTON				
Postcode Area	Transport Count	Avg Dur Left Scene to At Hosp	Avg Dur Left Scene to At Hosp (hh:mm:ss)	Transport Count	**Stroke Transport Count (Based on 6%)**	Avg Dur Left Scene to At Hosp	Avg Dur Left Scene to At Hosp (hh:mm:ss)	**Minutes Difference between traveling to RDH vs QHB**
DE13	414	1,224.90	00:20:25	4,994	**300**	639.9	00:10:40	00:09:45
ST14	255	1,816.90	00:30:17	1,942	**117**	1,631.60	00:27:12	00:03:05
DE6	213	2,135.00	00:35:35	198	**12**	1,245.40	00:20:45	00:14:50
DE14	153	1,179.60	00:19:40	5,493	**330**	473.9	00:07:54	00:11:46
DE15	99	1,464.10	00:24:24	2,901	**174**	735.8	00:12:16	00:12:08
WS13	94	1,826.50	00:30:26	4,476	**269**	1,495.20	00:24:55	00:05:31
ST10	46	2,674.10	00:44:34	12	**1**	2,344.20	00:39:04	00:05:30
WS15	35	2,056.10	00:34:16	2,335	**140**	1,972.90	00:32:53	00:01:23
WS14	31	1,808.50	00:30:08	998	**60**	1,538.90	00:25:39	00:04:29
WS7	18	2,455.70	00:40:56	1,331	**80**	2,085.10	00:34:45	00:06:11
SK17	15	3,418.00	00:56:58				00:00:00	-
ST13	13	2,949.90	00:49:10				00:00:00	-
B79	13	1,858.40	00:30:58	645	**39**	1,821.70	00:30:22	00:00:36
B77	6	3,090.50	00:51:31	387	**23**	2,105.70	00:35:06	00:16:25
B78	6	2,198.30	00:36:38	297	**18**	1,940.60	00:32:21	00:04:17
SK11	1	3,511.00	00:58:31				00:00:00	-
ST11	1	1,831.00	00:30:31				00:00:00	-
ST15	1	2,396.00	00:39:56				00:00:00	-
ST4	1	2,059.00	00:34:19				00:00:00	-
ST16			00:00:00	2	**0**	3,602.50	00:00:00	-
ST17			00:00:00	2	**0**	2,314.50	00:38:34	-
ST18			00:00:00	19	**1**	2,550.90	00:42:31	-
WS11			00:00:00	22	**1**	2,137.20	00:35:37	-
WS12			00:00:00	24	**1**	2,350.30	00:39:10	-
WS9			00:00:00	1	**0**	1,896.00	00:31:36	-
N/V	1	1,186.00	00:19:46	54	**3**	1,022.20	00:17:02	00:02:44
Grand Total	**1,416**	**1,676.60**	**00:27:57**	**26,133**	**1,568**	**1,139.30**	**00:18:59**	**00:08:58**

The average ~9 minute difference between the 2 sites is relatively small. The hub and spoke models in London and Manchester have shown improved outcomes (and they will have had the same issues with increased transportation time from further afield) – i.e. this change in model is backed up by evidence and guidance.

Also please note outlier postcodes such as SK11 from which only 1 patient was taken to RDH is likely to skew data to make time taken to RDH seem artificially higher, thus, making the actual travel time differences even smaller.


Proposed pathway for Burton and Derby Stroke Services
Ambulance Conveyance - suspected stroke patients
Ambulance Conveyance: QHB Walk in patients and Inpatient Strokes
Derby Emergency Department
Admitted
Discharged
Discharged
Non Stroke Ward
Mimic strokes
Medical Assessment Unit
Mimic Strokes
Hyperacute Stroke Bed
Strokes
Vascular Surgery
TIA Clinics Direct Admission
Acute stroke unit in Derby or Burton
Early Supported Stroke Discharge or inpatient/ community rehab
Discharge
Pathway may vary depending on patient need
Less than 60 minutes
Less than 4 hours
72 hours
Variable depending on patient needs


Royal Stoke University Hospital
Nottingham City Hospital
Royal Derby Hospital
Queens Hospital
Glenfield Hospital
New Cross Hospital
Good Hope Hospital
DE6
DE3=1
DE65=3
ST14=20
ST18
DE73
ST16
DE13=55
DE14=28
DE15=52
DE11=62
WS15=28
ST17
LE12
LE65=16
DE12=22
ST19=1
WS12
WS13=39
LE67=4
WS11
WS7=15
B79=21
WS14=17
WV10
WS6
WS8
LE3=1
WS3
WV11
WS9
B78=7
B77=17
CV13
WV12
WS4
WS2
B74=1
B75
CV9=1
B43
B76
CV10
B44
B46
0
5
10

Local Members' Interest
n/a

Healthy Staffordshire Select Committee – 19 March 2019

Staffordshire and Stoke-on-Trent Sustainability and Transformation Programme (STP)

Progress Update on Cancer Services and the STP Cancer Transformation Plan for 2019/2020

Recommendation

1. Members are asked to consider and comment on the content and to have an understanding of the current key issues with cancer services and the STP approach to improving cancer services.

Summary

2. This report provides an outline of the key priorities for improving cancer services across the Staffordshire and Stoke –on-Trent STP during 2019/2020. To provide context the report has some summary information covering current cancer performance. It also includes the specific objectives and measureable outcomes set out within our transformation plan.

3. Our 2019/2020 transformation plan demonstrates that across the STP we have taken a proactive approach to improving cancer services and although we absolutely must focus on delivering cancer performance and national cancer targets, as the committee will see our plan includes ensuring that the residents of our STP will benefit from implementation of national best practice as well as significant local innovations.

Transformation and Improvement of Cancer Services across Staffordshire and Stoke-on-Trent Sustainability and Transformation Programme.

Background

4. In 2017 The Staffordshire Transforming Cancer and End of Life Service (TCEOL) programme came to an end. The cancer service programme was halted, when at the end of the bid evaluation stage, no bidder was able to meet the minimum criteria set by the programme. The details of the programme and decision to close is without awarding a contract has previously been reported to the Scrutiny Committee.

5. Following this, the Staffordshire and Stoke-on-Trent CCGs governing bodies agreed that STP wide ambitions to improve cancer services should be taken forward through the Staffordshire and Stoke-on-Trent Sustainability and Transformation Programme (STP).

6. Transformation of Cancer Services is now part of our STP Planned Care work stream and falls under a unified Planned Care and Cancer Board.

7. On a wider footprint, the Staffordshire and Stoke-on-Trent STP is part of the West Midlands Cancer Alliance (WMCA). Our STP has been fortunate enough to benefit from over £1m of transformation funding and in addition significant funding from Macmillan to be used to support people living with and beyond cancer.

8. The purpose of this report is to provide an update on recent developments and improvements in cancer services across out STP, our plans and ambitions for making bets use of the transformation funding and other support we have received. We will also outline some of the challenges cancer services are likely to face in the next few years and how we plan to address these challenges.

Changes to Cancer Service Providers during 2018/2019.

9. In 2017/2018 the four largest cancer service providers for residents of Staffordshire and Stoke-on-Trent were University Hospitals North Midlands (UHNM), Royal Wolverhampton Hospitals Trust, Heart of England Foundation Trust and Burton Hospitals Foundation Trust. During 2018 / 2019 there have been changes to two of those organisations. Heart of England Foundation Trust is now part of University Hospitals Birmingham and Burton Hospitals Foundation Trust is now part of University of Derby and Burton Hospitals NHS Foundation Trust.

10. Although these changes have taken place, GPs continue to refer patients they suspect may have cancer in exactly the same way, and the vast majority of patients are being seen in the same unit. All four of the main NHS Trusts seeing patients from Staffordshire with cancer now offer specialist cancer services which mean fewer of our residents will need onward referrals after initial tests ae complete. For example a patient seen in

Burton who formerly might have had to be referred onward into Derby are now already under the care of the larger UHDB team an that extra referral step with the potential delay is no longer required. In addition the cancer services for Staffordshire patients can be more resilient and the larger Trusts and large specialist teams are less vulnerable to either sudden surges in demand or loss of critical staff. Our GPs are not reporting any concerns since this organisation change took place.

Cancer Commissioning

11. The arrangements for commissioning cancer services are multi-layered.

12. Where patients are suspected of having cancer, outpatients appointments and initial diagnostic tests are commissioned by clinical commissioning groups.

13. Most elements of chemotherapy (including the selection of and payment for the anticancer drugs) is commissioned as part of the specialised services commissioning.

14. Radiotherapy for cancer patients is commissioned by NHS England in line with a national policy.

15. Surgery and post treatment follow up for common types of cancer such as breast cancer is commissioned by CCGs.

16. For rarer types of cancer, the whole cancer pathway is commissioned by NHS England.

17. This can seem complex however it ensures that the more specialist services are planned at a larger scale and that CCGs are protected from natural fluctuations in number so very high cost treatments. At the same time the CCGs are fully involved in commissioning the services for the more common cancer types where local consideration can be crucial to ensuring excellent patient experience.

18. The Staffordshire and Stoke-on-Trent STP cancer and Planned Care Board is able to maintain an overview of the cancer services for the whole population.

Cancer Performance

Current Targets

19. Cancer service performance is monitored against a series of targets. These have been in place nationally for several years and they are used to identify potential deteriorations and drive improvements.

20. The key national targets are:

21. **Two week wait** – The time between referral by a GP and patient first being seen Recent performance is shown below (Figure 1)

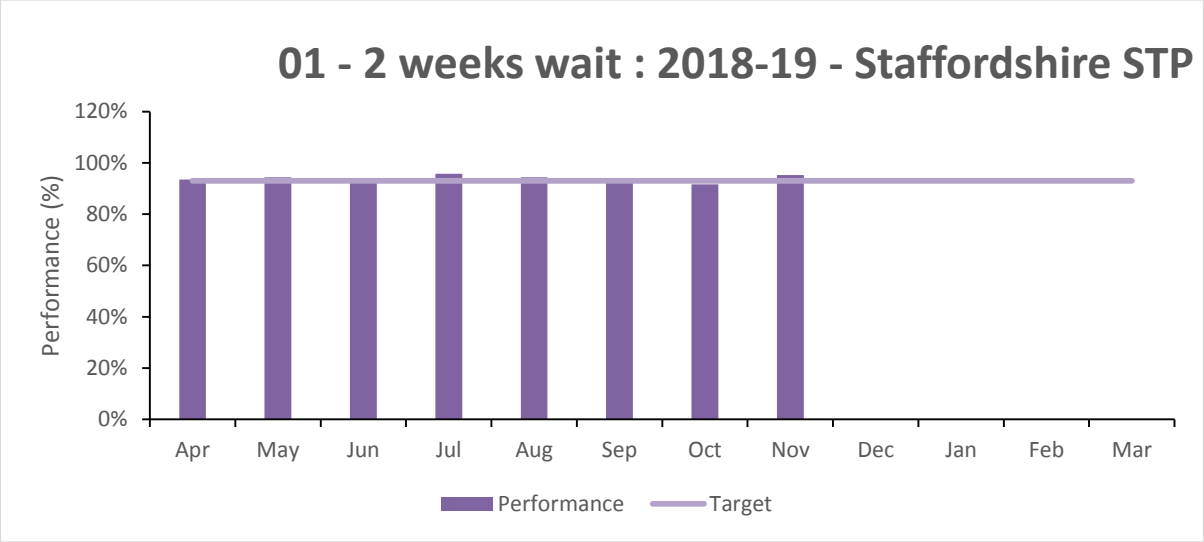


Figure 1 Two Week Wait Performance as an STP.

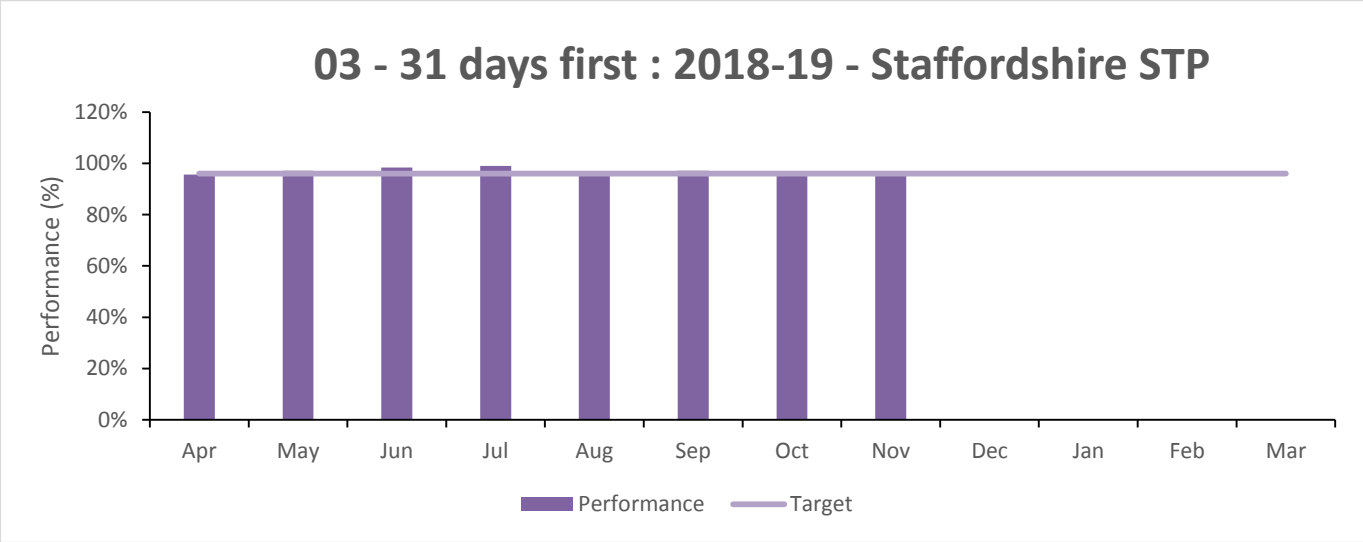
22. In previous years this target has been problematic to deliver, however our provider have taken decisive action to deliver and sustain improvements.

23. For example UHNM cancer bureau aims to offer as many patients as possible a first appointment 7 days after referral. This is not always possible but it gives sufficient resilience to the system to ensure the minority of patients who choose to delay their first appointment will not lead to breaches.

24. There are still blips in achieving this target but providers are able to recognise deteriorating performance and address rapidly.

25. **31 day** – The time between decisions that patient needs cancer treatment and the treatment starting. This target is monitored for each type of cancer treatment, surgery, chemotherapy and radiotherapy.

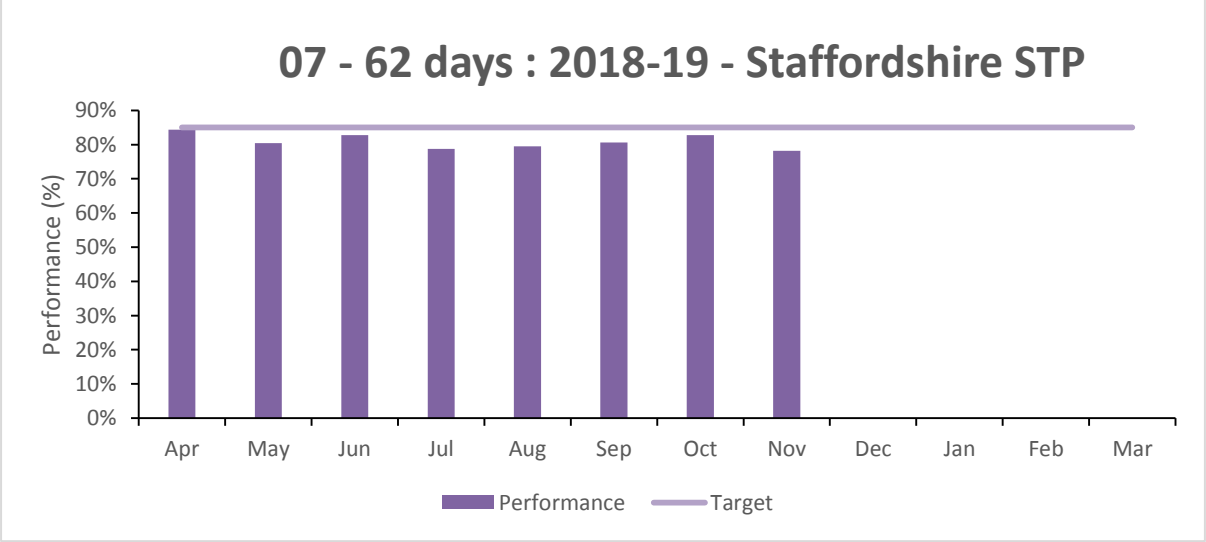
26. Recent performance for first treatment is shown below (Figure 2)



27. *Figure 2 - 31 day performance (From decision to treat to treatment starting with 31 days) as an STP.*

28. This target has also seen a reasonable level of achievement across Staffordshire in 18/19, deteriorations are rapidly resolved.

29. 62 day – The time between referral into cancer services and the treatment starting. Recent performance for first treatment is shown below (Figure 3)



30. Figure 3 – 62 day performance (Time from referral to treatment starting within 62 days) as an STP.

31. Across the whole of Staffordshire but also regionally and nationally, the 62 day target have proved the most problematic to achieve and maintain.

32. All of our main providers have identified detailed improvement plans and taken robust action to deliver improvements. Although Staffordshire is not yet able to deliver sustained achievement, Our STP and in particular University Hospital North Midlands has for the last 12 months performed better than forecast. This is important because the 62 day performance was nationally linked to some of the transformation funding available and in part thanks to the Staffordshire performance the West Midlands Cancer Alliance (WMCA) and Staffordshire STP managed to secure additional transformation funding. The funding allocated to us and how it will be used is detailed later in this report.

Key Actions taken to support improvement of 62 day performance across the STP

33. Regular performance review conference calls involving providers, commissioners, NHS England and WMCA at which provider improvement plans are reviewed in detail.

34. Increasing numbers of pathway coordinators or trackers employed by Trusts, helping support patients along the pathway, eliminating delays and prioritising access to services.

35. Putting target pathway timings in place to ensure patients are able to progress through the cancer pathways as quickly as possible.

36. For example at UNHM, the Trust is aiming to increase the numbers of patients offered a first appointment within 7 days of referral and is aiming to get the results of tests back within 7 days at the latest.

37. Across Staffordshire increasing numbers of patients are benefitting from a “one stop shop service”, so for example people referred with symptoms of breast cancer will receive multiple tests and see more than one professional in one appointment and will know whether they have breast cancer much sooner.

38. People referred for Chest X-Rays were lung cancer is a possibility are often being offered a CT scan date in no more than 3 days if cancer remains a possibility after the chest x. Over the next 12 months increasing numbers will hopefully be able to have the CT scan on the same day.

The biggest challenge’s to achieving the 62 day performance across 62 day performance across the STP

39. The single biggest challenge is increasing demand. Across our STP, the numbers of referrals of people suspected of having cancer is at an all-time high. In January one local Trust reported its weekly referrals as being highest ever recorded in January 2019

but this was then exceeded again in 2 of the following 3 weeks. Across the STP all providers are reporting a 20 – 30% increase in year on year referral numbers.

40. A further challenge is that as improvements are made to diagnostic pathways, services are increasing reliant upon staff with specialist skills. Locally we are addressing this by looking at how we best used clinical professionals and ensuring people have the right training. For example across Staffordshire we have more non-medical staff in post trained to carry out endoscopy which is one of the diagnostics tests relevant to cancer under most pressure. We also have increase numbers of radiographers trained to report on X-Rays.

41. As we aim to improve services however pressure on staff groups will increase. For example although we have more radiographers able to report on x-rays, only those staff specifically trained in recognising possible lung cancer report on chest x-rays where such cancer is suspected.

42. This means that cancer services across Staffordshire remain vulnerable to loss of critical staff.

Stage at Diagnosis.

43. How advanced a cancer is when it is detected has a great deal of impact on how treatable it is a what the prognosis will be for the patient. Cancers are typically reported as being stage 1 – 4 at diagnosis with stage 4 being the most advanced disease where the cancer has spreads to other organs. Nationally this is monitored by using the proportion of cancer diagnosed at stage 1 and stage 2.

44. Across Staffordshire our stage at diagnosis for the last two years is as follows:

	% of cancers diagnosed at stages 1 and 2 in 2016	**% of cancers diagnosed at stages 1 and 2 in 2017**
NHS Cannock Chase CCG	53.0%	54.2%
NHS East Staffordshire CCG	46.5%	47.7%
NHS North Staffordshire CCG	50.4%	50.7%
NHS South East Staffs and Seisdon Peninsular CCG	59.7%	49.9%
NHS Stafford and Surrounds CCG	54.8%	54.7%
NHS Stoke on Trent CCG	51.2%	47.7%

45. As readers will note, the latest data relates to 2017 because unfortunately there is a very long delay in validating the data for this indicator at a national level. This means

that the actions we are taking at the moment to increase the proportion of patients diagnosed at stage 1 and 2 will not start to show in the results until early 2021.

Changes required to improve Stage at Diagnosis.

The following actions are seen as key in driving improvements.

46. Increasing uptake of national screening programmes

47. There are 3 national cancer screening programmes. Breast cancer, Bowel Cancer and Cervical Cancer. These programmes are designed to identify cancer before symptoms arise and over many years have ensured that large numbers of people across Staffordshire have been able to access cancer effective treatment at an early stage.

48. Unfortunately across the UK and nationally we have not been seeing as many people attend for screening as we would hope. Locally we have looked at possible reasons for this,

49. There is some evidence that there are cultural or local community issues. For example in Burton a small number of areas in the town centre have a particularly low rate of screening uptake. There is an ongoing piece of work, involving communities in Burton looking at how we can address these issues. For example one suggestion being explored is that holding cervical screening sessions in child friendly locations might make it easier for people with young children to attend.

50. Low participation in cervical screening triggered has particular concerns. Women are enrolled in cervical screening in their 20s and evidence suggests that women who attend their first appointment are more likely to stay in the programme.

51. Recently the CCGs have participated in a campaign to promote cervical screening, targeted at younger women and involving social media. This includes a really informative interview with a local GP.

52. Awareness of cancer symptoms in the community.

53. In order to make improvements to stage at diagnosis on a large scale across the whole population, we will need to ensure that a greater proportion of patients experiencing symptoms go to see their GP. Unfortunately cancer at an early stage can cause very mild symptoms are even no symptoms at all and many people will be reluctant to go to their GP with what seem to be trivial complaints either because they don't want to bother the GP or because they have very busy lives and don't see the symptoms as being important, or both.

54. As a set of CCGs we participate in national and regional campaigns to raise awareness of cancer warning signs. We also work with public health colleagues to support the work they do in this area.

55. Regular updates for GPs on signs and symptoms that should trigger early referral.

56. Over the last few years and through 2019/202 some of the GP protected learning time has been dedicated to increasing awareness the clinical signs that might indicate cancer and require immediate referral.

Signs that actions are making a difference.

57. 4 years ago, the conversion rate for cancer referrals was between 8 and 10% across Staffordshire. The conversion rate is the proportion of patient referred who are found to have cancer. It was suggested nationally that the aspiration should be to reach an optimum conversion rate of about 3% by 2021.

58. Conversion rate data like stage at diagnosis takes a long time to validate however invalidated data suggests a conversion rate at present across our STP is close to 5%. This is a helpful early indicator that we will see meaningful improvements in stage at diagnosis over the next few years.

New national targets

59. As we better understand the what makes the greatest difference in improving cancer services, targets are changing and evolving. Over 2019 and 2020, new targets are being developed.

28 Day target

60. This target will be in shadow form from April 2019 and is expected to be fully embedded from April 2020.

61. It specifies that 95% of people referred with suspected cancer will be given a confirmation either that they don't have cancer or that there is cancer present within 28 days. It will complement but not replace the 2week to first appointment target.

62. This target has been introduced in response to overwhelming evidence that for patients, finding out whether or not they have cancer quickly is at least as important as having that first appointment quickly and then waiting for results.

<u>Benefits</u>

63. This target will support Trusts in improving the way in which they communicate with patients about the results of their tests. It recognises that even for people who do not

have cancer, by making sure they get that good news quickly, providers can allay anxiety and give reassurance to patients.

Long Term Stage at Diagnosis.

64. Nationally the NHS has been set a challenge to ensure that by 2028, 75% of cancer will be diagnosed at stage 1 or 2.

65. This is part of the NHS long term plans and will be extremely challenging. We know that a significant number of patients with some types of cancer won't experience any symptoms when their cancer is at an early stage. It is likely that in order to meet this long term challenge there will need to be a whole series of national and local initiatives, potentially including:

- Cancer diagnostic centres
- More national screening programmes
- Changing (lowering) the criteria for referral into diagnostic services
- Health Checks for well people
- Continuing and expanding the community symptom awareness programmes
- Planning for large increases in diagnostic activity.

66. Work nationally and regionally on planning for how this target will be addressed is underway now.

Our Cancer Transformation Programme for 2019 / 2020

67. Staffordshire and Stoke-on-Trent STP has a detailed cancer improvement programme in place running through to March 2020 and in some case longer, underpinned by regional transformation funding from the West Midlands Cancer Alliance and recently approved by the Alliance. As well as WMCA funded transformation, the programme includes some Staffordshire developed initiatives.

68. This report summarises the priorities, actions, anticipated benefits and risks of this programme.

Priorities

69. Our priorities for transformation of cancer services through to March 2020 are as follows:

70. Increasing early detection of cancer, reducing level of cancer not detected until the patient is seen in A&E and increasing number of patients with cancer detected at stage one and two.

71. This work stream will aim to increase community awareness, improve screening uptake and ensure the most appropriate patients are referred promptly by GPs.

72. Participate in the roll out of a revised national bowel screening test (FIT) which is easier for people to carry out and will have higher uptake rate and better accuracy than the current test.
73. Implementing and embedding national best practice pathways for lung cancer, prostate cancer, colorectal cancer and upper GI cancer (stomach and oesophagus; [gullet]).

74. The best practiced pathways will ensure that patients receive consistently the most clinically appropriate evidence based diagnostic tests and treatment *at the optimum time* maximising the number of patients who get their diagnosis with 28 days and minimising he number of patients who treatment starts within 62 days.

75. Developing a pathway to enable people who are frail or unwell but who are suspected of having bowel cancer, to be referred by the their GP directly for scans instead of having an outpatient appointment that will almost certainly determine that that the patient is not fit enough to have an endoscopy and be referred for the scan in any case.

76. Developing a pathway for people who have unexplained weight loss but who don't meet the criteria for any particular cancer type, to be referred by the their GP directly for scans that are able to detect more than one cancer type without needing an outpatient appointment first.

77. The two initiatives above will include service specification being developed and will require commissioner and provider agreement in line with other CCG commissioning priorities.

78. Ensuring people with women at risk of inherited breast cancer are automatically recalled for annual mammograms across the whole STP.

79. Patients whose family history and genetic testing shows they are greater risk of breast cancer are offered annual mammograms. In some parts of Staffordshire this relied on manual referral's made by GPs. This programme which is 75% complete will ensure that patients will be automatically invited by the screening centre every year without the GP needing to make a referral.

80. Piloting a programme to identify and offer CT scans to patients at highest risk fo lung cancer before they experience any symptoms.

81. Nationally there have been a number of programmes where patients at highest risk of lung cancer have an opportunity to be assessed and if appropriate offered at CT scan. Internationally evidence shows that programme like this have the potential to make the biggest possible difference to lung cancer survival. Staffordshire and Stoke-on-Trent

STP is set to be the first site to pilot this type of screening in the West Midlands and the first patients will be seen in April 2019.

82. Participating in the West Midlands Wide roll out of digitisation and networking of pathology services.

83. This programme will ensure that test results will be available all across the network and that doctors in one hospital can be confident that they will have access to the necessary pathology information at the point they see patients who have been referred from other or had tests at other hospitals. It will speed up pathways and reduce need for repeat tests.

84. Implementing risk stratified follow ups for patients with breast cancer, prostate cancer and colorectal cancer.

85. This work stream will identify those patients who following successful cancer treatment have extremely low risk of developing cancer again. Instead of such patient attending for regular face to face follow up with limited clinical value, the patients will be offered the chance to participate in supported self-management which ensures that they do need to attend hospital unnecessarily but have easy and rapid access to services if they do experience any worrying symptoms. It will also allow providers to make best use of clinical resources.

86. Implement best practice programmes and holistic services for people living with or beyond cancer in the community.

87. This work stream will ensure that a high proportion of cancer patients benefit from a holistic needs assessment whilst still under the care of the hospital and that GP will receive a detailed treatment summary in line with best practice. This will ensure that the patients are able to access recovery plans in the community and will help address the isolation and lack of support that some patient report, once their treatment is finished.

Transformation Investment

88. Many of these work streams are supported by investment of over one million pounds into he Staffordshire and Stoke-on-Trent STP by the West Midlands Cancer Alliance. Transformation Funding for 2019 / 2020 has not yet been agreed nationally but our STP is hoping that its achievements in 2018/2019 will ensure a similar level of investment next year.

Transformation Objectives.

89. The table below sets out our objectives and deliverable outcomes.

Objectives	Outcomes
Increasing the proportion of cancers diagnosed at an earlier stage (Stage 1 or 2) and reducing the number of people whose cancer is diagnosed in an emergency health care setting such as A&E	4% increase in proportion of cancer diagnosed at stage 1 or 2 by Q4 2020/2021 (Compared with 2016 benchmark)
	3% fewer cancer diagnosed following emergency presentation by Q4 2020/2021 (Compared with 2016 benchmark).
Increasing the number of people with the most common cancers (lung, prostate, lower GI, upper GI) whose diagnosis and treatment is in line with evidence based best practice pathways.	Best Practice pathways developed and agreed by 31 March 2019
	Best practice pathways fully implemented by 31 March 2020
	95% of patients within each of these pathways receive confirmation of diagnosis within 28 days of referral by Q1 2020/2021
	85% of patients within each of these pathways commence treatment within 62 days sustainably by Q4 2019/2020.
Increasing the proportion of cancer patients whose follow up is through supported self-management, reducing routine follow ups that are clinically unnecessary. (breast, prostate, lower GI).	Risk Stratified Follow Up pathway for patients with breast cancer developed and starting to be implemented by 31 March 2019
	40% of breast cancer patients benefit from self-managed follow up pathway by 31 March 2020
	70% of breast cancer patients benefit from self-managed follow up pathway by 31 March 2021
	Risk Stratified Follow Up pathway for patients with prostate and colorectal cancer implemented From July 2019 (prostate) and December 2019 (colorectal)
	40% of prostate cancer and 30% of colorectal cancer patients benefit from self-managed follow up pathway by 31 March 2021
Increasing the proportion of cancer patients who benefit from holistic needs assessments and are able to access recovery plans.	Participation in Burton Active Recovery Programme. This will be offered to all cancer patients in East Staffordshire during Q3 and Q4 18/19
	Completion of Holistic Needs Assessment for 80% of cancer patients diagnosed with cancer in Q4 18/19
	40% of cancer patients will receive a treatment summary. (Treatment completed in Q4 20/21)
	Cancer Care Reviews completed within 12 months of diagnosis for 20% of patients diagnosed with cancer in Q4 19/20
Develop Pilot Scale implementation of respiratory health checks and low dose CT scanning for people in selected practices in Stoke-on-Trent at high risk of developing lung cancer.	Test of concept and evaluation of delivery models for lung cancer screening. Evaluation complete by 31 March 2020.
	Networking and shared learning from other lung cancer screening pilot sites in England.
	Increase proportion of people participating in pilot with lung cancer whose cancer is diagnosed at stage 1 and 2 and whose cancer is treatable at time

	of diagnosis.
	Develop options for roll out of lung cancer screening across Staffordshire.
Patient Experience will be monitored, through provider patient experience surveys and also the annual national cancer patient experience survey.	Year on year improvement in patient key experience ratings in national cancer patient experience survey. (Note that due to reporting lag, improvements will be 12 – 18 months after improvement initiatives are in place.
	Patient experience results at provider level as well as other patient feedback will be fed into the STP cancer transformation steering group.
Radiotherapy Networks	Staffordshire and Stoke-on-Trent STP recognises the importance of the development of the radio therapy networks. The STP will request periodic updates from the network oversight group and will offer the group the opportunity to request support from the STP.
Embedding the Digitisation of Pathology Networks initiative, with UHNM becoming a designated hub.	Staffordshire and Stoke-on-Trent STP will closely monitor the implementation of this initiative. The steering will reach out to the "spoke" organisations working with UHNM to verify that suitable and arrangements are in place and working effectively during roll out / mobilisation period and beyond.

Key Risks and Mitigation – Balancing Priorities

90. It is very clear from all the data that there is one key risk we need to consider. The risk is that competing priorities may adversely affect the ability to deliver the desired outcomes. need to be balanced.

91. Diagnosing cancer at an earlier stage can be improved through initiatives like increasing screening uptake and GP support and education but to deliver improvements on the scale envisaged in the national NHS long term plan will require a very significant increase in the number of people referred into service, and a reduction in conversion rate to below the current optimum of 3%. This will require an increase in the clinical resource required particularly in the diagnostic part of the pathway.

92. This in turn will put pressure on the service to sustainably start cancer treatment with 62 days and to deliver the other outcomes listed above in a timely way.

93. The key mitigation is that at all parts of the cancer pathway provider have robust operational oversight and control., They will be supported in this by CCGs and by regulators and the West Midlands cancer Alliance.

94. It will be necessary to balance improvement initiatives and ensure improvements that impact on resources are implemented incrementally.

Conclusions

95. Across the Staffordshire and Stoke-on-Trent STP 2019 /2020 may well be a milestone year for cancer services. Numerous improvement actions have been implemented in the last few years have been embedded but many of these have been driven in a reactive way, aiming to address deterioration in performance.

96. Performance will remain critical in 2019/2020 and beyond but the improvement programme outlined in this paper includes a coherent and proactive approach to improving cancer services across our STP.

97. The priorities for 2019/2020 inevitably mean other parts of the overall cancer service pathway are not being supported by inward investment. Clearly in the currently financial climate it is not possible to address everything at once and the STP is confident that the priorities within out current plan and the right ones for our population at this point in time. The way in which Cancer Alliance investment is allocated is to some extent based on past performance and as a STP we can hope that successful delivery of our 2019/2020 programme will bring support and funding into Staffordshire and enable us to address other priority areas in future years.

Link to Trust's or Shared Strategic Objectives

98. *This paper links to the Staffordshire and Stoke on Trent STP priories and to the work streams within the STP Planned Care and Cancer Programme.*

Link to Other Overview and Scrutiny Activity

N/A – This is an update report from the STP

Community Impact

N/A

Local Members' Interest

Healthy Staffordshire Select Committee – 19 March 2019

Staffordshire and Stoke-on-Trent STP - Progress Update on Palliative and End of life Care

Recommendation/s

1. Members are asked to consider and comment on the content of the report.

Report

1. **Background**

1.1. A decision was made in June 2017 to cease the Staffordshire & Stoke-on-Trent End of Life Procurement (the procurement covered Stafford and Surrounds, Cannock Chase, Stoke-on-Trent and North Staffordshire CCGs).

1.2. Following this decision it was agreed that an End of Life (EOL) Programme Board would be established to take forward the palliative and End of Life priorities across all of Staffordshire and Stoke-on-Trent.

1.3. The End of Life Care Ambitions provide a national palliative and end of life care framework for local action. This guidance was used to develop the priorities for the EOL Programme Board work streams. In addition to this the West Midlands Clinical Senate published a blueprint for Palliative and End of Life Care in September 2018 (appendix 1).

1.4.This paper provides an overview of progress to date against the blue print and actions outlined from the Staffordshire CQC local area review.

2. **End of Life Programme Board**

2.1. The system-wide EOL Board has been in place for approximately 12 months and is part of the STP Enhanced Primary and Community Care Programme, sitting alongside work to develop integrated and primary care.

2.2. The programme has a full governance structure with a CEO-level SRO, an Executive-level Programme Director, clinical leads from primary and secondary care and programme management support.

2.3.Following on from the publication of the West Midlands Strategy Unit's report on Palliative and End of Life Care in the West Midlands, the STP EOL Programme Board commissioned the CSU Strategy Unit to run a more detailed report on the hospital usage of patients in their last 12 months of life (split by CCG). The report

indicated that two of the 6 CCGs had higher than average non-elective admissions in comparison to their peers for patients who were within the frail elderly or respiratory condition categories.

2.4. In spring 2018, Staffordshire and Stoke-on-Trent STP were approached by Social Finance to submit an application to the Government Life Chances fund to accelerate the plans the End of Life Programme Board had developed; unfortunately, the bid was unsuccessful.

2.5. The Programme board has identified the priorities for 2018/19 which are outlined in the EOL plan on a page (appendix 2).

2.6. The main areas of work we have undertaken to date are outlined in the next section.

3. Palliative Care Registers

3.1. To support the increase coverage of palliative care register the STP reviewed the size of registers and supported practices with the inclusion of palliative and EOL care identification within the GP Membership scheme and Quality Improvement Framework.

3.2. To support this, the EOL GP Macmillan leads provided practices with guidance on how to identify those patients who would be in the last 12 months of life and ensured practices were using the appropriate template on the GP systems to record patient information. To further support this, education and training has been delivered within the CCG localities at both a GP and practice nurse level.

3.3. Through the development of the Integrated Care Teams, MPFT, Tamworth Network of GPs and St Giles Hospice have developed a standard operating framework to further support the identification of EOL/frail elderly patients. It is proposed that this is cascaded across Primary Care Networks.

3.4. We have recently recruited to the Primary Care Nurse Facilitator roles (funded via Macmillan Cancer Care). These posts will support practices with identification and implementation of the new QI metrics within the GP contract.

4. Electronic Palliative Care Co-ordination System

4.1. To support the development of the Electronic Palliative Care Co-ordination System (EPaCCs) a working group was established to review the minimum data set and a decision was made in conjunction with the Digital Work stream of the STP (and support of the STP Clinical Leaders Group) that the EOL template would be the priority template when the Integrated Care Record is implemented later in 2019.

4.2. In addition, the four adult hospices have undertaken an options appraisal of alternative clinical systems and the digital requirements to ensure they are able to connect to the ICR, as their current clinical system of CrossCare in not compatible with the NHS Spine. One of the four hospices has made the decision to move to EMIS as their clinical system which will be in place by April 2019.

5. Admission avoidance

5.1.A number of admission avoidance schemes have been implemented during 2018/19 which has supported the reduction of non-elective admissions to hospital from patient in their own home or care home.

5.2.The schemes have ranged from low level intervention and education programmes to high level multi-agency schemes. The schemes ensure that end of life outcome measures are included within service specifications such as the High Intensity User Scheme, Integrated Care Teams and District Nursing Specification. These schemes are monitoring via the QIPP programmes within the CCGS.

5.3.We have undertaken a review of the palliative care co-ordination service which supports the North of the County and are in the process of revising the service specification in line with the development of the Integrated Care Teams and hospice service provision.

6.Care Homes

6.1.Across the STP we have implemented schemes to support patients in nursing and residential homes to reduce A&E admissions and support resident to maintain care in their own care home during periods of deterioration, illness and to help support those residents on their choice of place of death.

6.2.The schemes have introduced documentation which could be shared across agencies including Respect, DNACPR and ceilings of care. Quality end of life care training covering communication and comfort skills and last days of life care has also been delivered.

7.Children and young people

7.1.We have representation from the Children's hospices on the STP EOL programme Board who provide regular updates from the West Midlands-wide Network. We are currently awaiting further guidance regarding the Children's Hospice Grant proposals set out within the NHS Long-term plan.

8.Voluntary sector engagement

8.1.NHSE have provided £70k funding to Support Staffordshire and the three South Staffordshire Hospices to develop the South Staffordshire EOL Action alliance, which brings together c.20 voluntary sector organisations such as Men's lunch clubs, Citizens Advice Bureau, Bereavement Charities to facilitate conversations on death dying and advanced care planning.

8.2.A series of workshops and training sessions for the wider voluntary sector and public are planned for March 2019.The Alliance have looked at the Frome model for Community connectors and community development workers and are mapping out what services are currently available.

9.Further support required

9.1. The STP have requested further support from the Clinical Senate in undertaking both the demand and capacity planning for end of life care and the implementation of the peer review of community specialist palliative care.

10. Outcomes of the Staffordshire CQC Local Area Review

10.1. The Staffordshire CQC local area review outlined a number of actions in relation to end of life care and an action plan has been developed. The action to agree pathways with Hospices is been taken forward through a shared governance group which includes, hospice, community, primary care and acute sector partners.

10.2. The metrics to measure performance have been agreed through the group and the programme board and a business case is in development which will outline the resources required to support implementation.

10.3. The impact of the revised pathways for end of life care will be monitored via the end of life programme board.

11. Summary

11.1. Through the End of Life Programme Board, partners continue to take forward actions to deliver the priorities for end of life care, ensuring that the quality of care is maintained whilst implementing new models of care and pathways.

Appendices/Background papers

1. NHS England West Midlands Commissioning Blueprint STP/ICS in palliative and End of life care v0.7 September 2018/19
2. EOL Plan on a page

Plan on a page: End of Life

Our vision for Staffordshire and Stoke on Trent is to provide affordable care built and given locally around communities of 30-70,000 people.

By doing this, services will be tailored to local need and, supported by less complicated locality and county wide arrangements, will allow us to give joined up care to people close to or in their own homes, with less need to go to hospital.

Overview

- The End of Life Programme covers a population of over 1.1m people registered with GPs across six CCGs, two acute hospitals, two mental health providers and one community provider. In addition for EOL care we have four adult hospices and two children's hospices. There are two local authorities.
- Our system is experiencing increasing pressure, our modelling and financial challenges clearly shows that we need to reduce our cost base, improve our sustainability and enhance our offer to the public.
- We have identified priorities for change, underpinned by transformational enablers, which together will help us to address our financial gap by 2020/21. In years one and two we will progress key initiatives to lay the foundations of our STP over the next 5 years.
- All of our plans are and will be built on collaborative relationships and consensus amongst our system leaders which we will continue to develop to ensure the success of our STP, and which provide the foundations for an integrated health and social care system in the future.

six initiatives on which we will focus in 2017/18-18/19

1. We will develop a revised specification for care co-ordination across Staffordshire (inc. identification, co-ordination and MDT working)
2. We will implement ePACCS in conjunction with the development of the Staffordshire wide ICR solution
3. We will develop a Staffordshire wide approach to the implementation of the enhanced health in care homes framework
4. We will review EOL documentation across organisations to ensure consistency in care planning for patients at EOL and ease of handover between organisations
5. We will develop an End of Life Voluntary Sector Alliance
6. We will review community and hospice based services related to rapid response/admission avoidance/early discharge processes which are consistent with the development of Integrated Care Teams

Six priorities on which we will focus in 2017/18-18/19

- P1 We will increase the proportion of people identified as approaching end of life at an early stage and prioritise the management of their care
- P2 We will improve Care Planning and Recording of Preferred Place of care/death.
- P3 We will improve the level and consistency of co-ordination of care
- P4 We will improve the quality and experience for end of life care.
- P5 We will review the delivery of Education and Training across the workforce .
- P6 We will commission services to meet need based upon a robust clinical evidence base.

An underpinning programme of transformational enablers includes:

- Becoming a system with a collective focus on the whole population and their physical mental health and social care needs.
- Developing communities and social networks so that people have the skills and confidence to take responsibility for their own health and care in their communities.
- Developing the workforce across our system so that it is able to delivery our new models of care.
- Using technology to enable patients and our workforce to improve wellbeing, care, outcomes and efficiency.
- Redevelop our estate to ensure patients have services closer to home.
- A compelling, owned and agreed vision for the future of the primary can community care model for Staffordshire 2016-2021.
- Review the existing, and proposed clustering of GP practices in order to facilitate how these new clusters will work to deliver against the 10 high impact changes.

The XXX system will spend c£1XXXon health and social care in 2016/17

- Although there are modest increases in funding over the period to 2020/21, demand will far outstrip these increases if we do nothing.
- We have assumed health providers can continue to make efficiency savings of X% pa, and demand can be mitigated by X% pa. This is in line with historic levels of achievement. Including broader efficiencies from Social Care will deliver about £XXXm by 2020/21.
- Offer high level financial elements.

West Midlands STP/ICS Palliative & End of Life Care Blueprint: 2018/19, what you need to know this year.

Enabling patients to have choice at the end of their lives, and experience great care and outcomes is important for all people, regardless of age or condition. Strategic and operational planning for great care and outcomes may also help you to make best use of your healthcare budget. The following information should help guide your leadership team when considering high quality and cost-effective interventions in palliative and end of life care.

This http://endoflifecareambitions.org.uk/ is the national palliative and end of life care framework for local action. It is for all people, of all ages, with all conditions and in all care settings; a detailed self-assessment tool is also available at ENGLAND.endoflifecare@nhs.net. Both help population level strategic and operational planning.

There are quality and cost-effective approaches in palliative and end of life care including this Public Health England Tool and Report http://www.endoflifecare-intelligence.org.uk/resources/publications/costeffectivecomm and NHS RightCare Long-Term Condition Scenarios, comparing common sub-optimal but typical scenarios against ideal pathways Katie's story: Colorectal Cancer – full narrative and Sarah's story: Parkinson's – full narrative and https://www.england.nhs.uk/publication/getting-the-dementia-pathway-right/ also available: 'how to' commission specialist-level care guidance https://www.england.nhs.uk/resources/resources-for-ccgs/#palliative

Your local NHS RightCare Delivery Partner https://www.england.nhs.uk/rightcare/how-can-we-help-you/delivery-partners/ may be interested in exploring your 'opportunities' with you, by highlighting data and 'opportunities' from https://www.england.nhs.uk/rightcare/products/ltc/; additional mechanisms for monitoring 'patient reported outcome measures' in supportive and palliative care also exist. The CCG IAF now includes *Metric 105c: the percentage of deaths with three or more emergency admissions in last three months of life,* both trend and comparator data.

To see how your CCG/STP locality measures up to others in the West Midlands, view the in-depth West Midlands reports and recommendations, below and overleaf, created with you and your STP/ICS in mind, at: http://www.strategyunitwm.nhs.uk/publications/palliative-and-end-life-care-west-midlands and https://www.strategyunitwm.nhs.uk/publications/palliative-and-end-life-care-report-children-and-young-people and https://www.strategyunit.co.uk/publications/status-electronic-palliative-care-coordination-systems-west-midlands

Did you know that interventions to enable great palliative care may also help you to address some of your other commissioning/planning priorities? Your bespoke national 'STP Data Pack' will detail how, and also contain further information about cost-effectiveness and quality tools; please request yours here ENGLAND.endoflifecare@nhs.net

'Patients, citizens and the Government have said all this really matters. Find out more at:
https://www.gov.uk/government/publications/choice-in-end-of-life-care-government-response
http://www.ncpc.org.uk/news/every-moment-counts-new-vision-coordinated-care-people-near-end-life-calls-brave-conversations

There is also a useful repository of nationally-available information from The National Palliative and End of Life Care Partnership at: http://endoflifecareambitions.org.uk/resources/

If you need strategic clinical leadership advice, please ask your clinical lead or STP clinical group chair to contact local expert our clinical director at NHS England West Midlands, Dr Joanne Bowen england.eolnetwork@nhs.net or joanne.bowen2@nhs.net

The National End of Life Care Team, Personalised Care Group, NHS England is led by National Clinical Director for End of Life Care, Professor Bee Wee. The team can be contacted at ENGLAND.endoflifecare@nhs.net

STP/ICS Recommendations *'at a glance'* condensed from longer reports/publications:

Six National 'Ambitions': 1. Each person is seen as an individual 2. Each person gets fair access to care 3. Maximising comfort and wellbeing 4. Care is coordinated 5. All staff are prepared to care 6. Each community is prepared to help *Supported by 8 Foundations* http://endoflifecareambitions.org.uk/resources/	**Six Point 'Choice Commitment'; people at end of life should be able to:** 1. Have honest discussions with care professionals about their needs and preferences 2. Make informed choices about their care 3. Develop and document a personalised care plan 4. Discuss their personalised care plans with care professionals 5. Involve their family, carers and those important to them in all aspects of their care as much as they want 6. Know who to contact for help and advice at any time https://www.gov.uk/government/publications/choice-in-end-of-life-care-government-response
Six WM STP/ICS Recommendations – 'all ages': 1. Establish demand & capacity plans for EoLC. 2. Jointly commission a peer review of community specialist palliative care. 3. Increase the coverage of palliative care registers. 4. Identify & avoid non-beneficial acute sector treatments in the last 12 months of life. 5. Jointly commission a review of the status of shared electronic records including EPaCCS. 6. Ensure that acute hospital trusts have a lay member on the Trust Board with responsibility for end of life care & at least one EoL Care Facilitator. http://www.strategyunitwm.nhs.uk/publications/palliative-and-end-life-care-west-midlands	**Six WM STP/ICS Bespoke Recommendations:** 1. Out of hospital provision of palliative and end of life care. 2. Greater service coordination & integration. 3. The number of consultants in palliative medicine. 4. The balance of consultant time spent in hospital & other settings. 5. The cost of acute hospital usage in the last 12 months of life. 6. Plans to improve hospital-based end of life care. *Find out which one pertains to your STP* http://www.strategyunitwm.nhs.uk/publications/palliative-and-end-life-care-west-midlands
Six WM STP Recommendations '0-25 Years': 1. Improve the identification of children & young people with life-limiting and life-threatening conditions & associated short or long term palliative care needs. 2. Profile all current paediatric palliative care services, including current commissioning & funding arrangements. 3. Improve communication between tertiary, secondary & primary care & voluntary sector organisations; increase the inclusion of children and young people in primary care palliative care registers, & improve communication and support for families at transition. 4. Work closely with urgent and emergency care & critical care to identify opportunity for improved palliative care & improve access to Advance Care Planning www.cypacp.uk 5. Embed the six NICE quality standards for end of life care for infants, children & young people across community & acute settings https://www.nice.org.uk/guidance/qs160/chapter/Quality-statements 6. Ensure board level representative with responsibility for palliative & end of life care in all acute and community NHS trusts & commissioning organisations https://www.strategyunitwm.nhs.uk/publications/palliative-and-end-life-care-report-children-and-young-people	**Six WM STP Public Health Recommendations:** 1. Encourage routine inequality data collection. 2. Review cause of hospital admissions at end of life. 3. STP review of services, workforce and non-acute beds. 4. Patient & public engagement & feedback. 5. Define criterion of admission to provider care. 6. Further work on advance care plans. The full public health inequalities report is available from NHS England West Midlands, Dr Joanne Bowen england.eolnetwork@nhs.net or joanne.bowen2@nhs.net

Excluded and Restricted Procedures (including Hearing Aids)– Alignment and Consultation

19 March 2019

Background

The Clinical Commissioning Groups (CCGs) have a process for prioritising the use of the resources available to commission healthcare in across the six Staffordshire and Stoke on Trent CCG. This is set out in the Policy on the Prioritisation of Healthcare Resources.

The CCG has a group known as the Clinical Priorities Advisory Group (CPAG), which is a subcommittee of the Governing Board. The group considers interventions and services which are referred from the CCG's commissioning team. This may be because there is a recognised unmet need and the CCG wishes to identify the best interventions to invest in or, as is the reason in this case, because there is a view that a services need to be reviewed.

CPAG undertakes the ranking of healthcare interventions using a scoring system of criteria based on the Portsmouth Scorecard. Interventions are scored by the group against 8 criteria that include; the magnitude of overall health benefit, where it looks at issues such as how far the intervention or service extends life and how far it improves quality of life, the strength of the evidence supporting the assessment of benefit which is assessed using the same categories adopted by NICE and the cost-effectiveness - which is best expressed as a cost for the gain of one quality adjusted life year.

This final score is reported to the CCG Strategic Commissioning team. No decision is made by CPAG about whether a service should or should not be commissioned. As the policy explains there is a threshold score, and interventions scoring below the threshold will not be considered by the CCG for new investment and where already commissioned, current eligibility criteria will be subject to review.

Context

As described, the CCG has a robust process for prioritising the services and treatments it commissions.

Introducing excluded or restricted criteria for any intervention are difficult decisions to make, which is why the CCG has a clinically-led prioritisation process. Inevitably, this will result in some services scoring below the threshold for investment, but the CCG has to ensure that it operates within its defined budget and achieves financial balance.

The CCGs currently have three excluded and restricted procedures policies across Staffordshire and Stoke on Trent including a number of differing commissioning policies (e.g. hearing aids, Assisted Conception). The CCG also has a number of interventions that have been scored at the CCGs Clinical Priorities Advisory Group (CPAG) that require further action and review.

The Commissioning teams have previously reviewed all interventions that had been scored at CPAG and began work on the alignment of their commissioning policies, including introducing restricted or excluded criteria for interventions that scored below the threshold for commissioning set by the CCGs and developing commissioning policies for interventions that scored within the threshold for commissioning.

Interventions were identified as either requiring a wording amendment only that did not significantly change existing criteria, amendments or additions to existing policy that required clinical engagement only and amendments or additions to existing policy that required public engagement/consultation due to the nature of the interventions that were being reviewed.

A large proportion of amendments were agreed across Staffordshire and Stoke on Trent and implemented within the excluded and restricted procedures policies, however the CCGs were unable to reach a joint consensus on a number of areas that meant we were unable to fully align our policies. These include;

- Assisted conception
- Hearing aids for non-complex hearing loss
- Male and female sterilisation
- Breast Augmentation and reconstruction
- Removal of excess skin following significant weight loss

Following the alignment of the management structure, a further piece of work is being undertaken to align our policies and ensure all areas that have been scored at the CCGs CPAG are reviewed and actioned. It is recognised that a number of these areas, including those listed above, will require formal consultation to gain public, patient and stakeholder involvement in the decision making process and ensure an aligned approach is taken across all CCGs.

This was discussed at the Joint Strategic Commissioning Committee on 16 January 2019 where it was recommended that the CCGs undertake a formal consultation for the areas listed above recognising that this would need to take place after the purdah period and local elections.

The recommendation to undertake a formal consultation for the areas listed above was approved at the Cannock Chase Clinical Commissioning Group, South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group and Stafford and Surrounds Clinical Commissioning Group Governing Body Meeting in Common on 31 January 2019.

The recommendation to undertake a formal consultation for the areas listed above was approved at the North Staffordshire Clinical Commissioning Group and Stoke-on Trent Clinical Commissioning Group Governing Body meeting in Common on 05 March 2019.

The recommendation to undertake a formal consultation for the areas listed above was approved at the East Staffordshire Clinical Commissioning Group Governing Body meeting on 07 March 2019.

Next Steps

Indicative milestones for this piece of work are as follows;

January-March 2019

- Finalise review of differences across the CCGs excluded and restricted procedures policy and identify all interventions that have been scored at CPAG that require further action
- Identify appropriate action required for interventions requiring review of current criteria and possible amendment or inclusion within current policies. These may be subject to;
    - internal approval only e.g. where a wording amendment does not significantly change existing criteria
    - clinical engagement to support any changes to clinical criteria or the commissioning of a new service
    - inclusion in formal consultation as any changes to current commissioning arrangements have been identified as requiring public, patient and stakeholder involvement

April-May 2019

- Development of Consultation plan
- Complete quality and equality impact assessment

June 2019

- Consultation plan presented to Joint Strategic Commissioning Committee for approval

July 2019

- Consultation plan presented to Governing boards for approval

August-September 2019

- Enter formal 12 week consultation

Local Members' Interest
N/A

Healthy Staffordshire Select Committee – 19 March 2019

District and Borough Health Scrutiny Activity

Recommendation

1. That the report be received, and consideration given to any matters arising, as required.

Report of the Scrutiny and Support Manager

Background

2. The Health and Social Care Act 2001 confers on local authorities with social services functions powers to undertake scrutiny of health matters. The County Council currently have responsibility for social services functions but, to manage health scrutiny more effectively, they have agreed with the eight District/Borough Councils in the County to operate joint working arrangements.

3. Each District/Borough Council has a committee dealing with health scrutiny matters that have a specifically local theme. The Healthy Staffordshire Select Committee will continue to deal with matters that impact on the whole or large parts of the County.

4. The following is a summary of the health scrutiny activity which has been undertaken at the District/Borough Council level since the beginning of their municipal year.

Cannock Chase District Council

5. The Wellbeing Scrutiny Committee met on 29 January and again on 04 March. Items considered focussed on the 2018-19 Committee Review of Obesity in the District and the actions taken to address it. In these meetings the Committee:
   - Received and considered a presentation from Staffordshire Public Health which outlined the role of public health and the current actions and programmes aimed at tackling obesity in the District;
   - Received and considered a presentation from Inspiring Healthy Lifestyles (the Council's Leisure provider) which outlined various programmes and initiatives being pursued in the District to encourage increased physical activity and healthy lifestyle choices;
   - Received local Healthwatch updates;
   - Reviewed progress with the main work programme item of a review into obesity levels in the District.

East Staffordshire Borough Council

6. A verbal update will be given at the meeting.

Lichfield District Council

7. A verbal update will be given at the meeting.

Newcastle-under-Lyme Borough Council

8. On 4 March Staffordshire Police updated and busted myths surrounding the drug Monkey Dust. The local CCGs consulted members on the future of Local Health Services in North Staffordshire and members discussed analysis from the Active Lives Children's Survey.

South Staffordshire District Council

9. The next meeting will be held on 11th June

Stafford Borough Council

10. The next meeting of Committee is due to be held on **Tuesday 12 March 2019** during which the following items are due to be discussed:-
    - **Healthy Staffordshire Select Committee** – a report back on the previous meeting of the Healthy Staffordshire Select Committee held on 4 February 2019.
    - **Health in All Policies – A Progress Update** – a report updating the Committee on the progress of the integration of the Health in All Policies strategy throughout Stafford Borough Council
    - **Performance Reporting 2018-21** - a report outlining the performance and financial monitoring of those services within the remit of the Scrutiny Committee for the quarter 3 period ending 31 December 2018
    - **Work Programme** – a report outlining the Committee's Work Programme for meetings up to March 2020.

    The next scheduled meeting of the Committee is due to be held on **9 July 2019**. The Chairman will be able to provide a verbal update at the meeting.

Staffordshire Moorlands District Council

11. The SMDC Health O&S Panel met on 13th February 2019. Members received a presentation on the Future of Local Health Services in Northern in Staffordshire and had the opportunity to make comments and ask questions relating to this consultation. The Panel also heard about Myalgic Encephalomyelitis (ME) from patients with the condition and how a support group had been set up in Meerbrook. Representatives from Changes Health and Wellbeing were also in attendance at the meeting to inform the Panel of the work carried out by the organisation in relation to mental health.

Tamworth Borough Council

12. The Committee met on the 27 February 2019 and discussed GP provision and New Member support.

Appendices/Background papers (i) email from Cannock Chase 5 March 2019 (ii) email from Stafford Borough Council 11 March 2019; (iii) email from Newcastle Under Lyme Borough Council 7 March 2019 (iv) email from Staffordshire Moorlands District Council 5 March 2019 (v) email from Tamworth Borough Council 6 March 2019. (vi) email from

South Staffordshire 4 March 2019 (vii) email from Lichfield District Council none. (viii) email from East Staffs Borough Council None.

Contact Officers

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WORK PROGRAMME – 19 March 2019
Healthy Staffordshire Select Committee 2018/19

This document sets out the work programme for the Healthy Staffordshire Select Committee for 2018/19.

The Healthy Staffordshire Select Committee is responsible for:

- Scrutiny of matters relating to the planning, provision and operation of health services in the Authority's area, including public health, in accordance with regulations made under the Health and Social Care Act 2001 and subsequent guidance.
- Scrutiny of the Council's work to achieve its priorities that Staffordshire is a place where people live longer, healthier and fulfilling lives and In Staffordshire's communities people are able to live independent and safe lives, supported where this is required (adults).

Link to Council's Strategic Plan Outcomes and Priorities
Be healthier and more independent
A joined up approach to **Health, Care and Wellness** that encourages people to take responsibility for their own health and plan for their future, so that we can support those who really need it.

We review our work programme from time to time. Sometimes we change it - if something comes up during the year that we think we should investigate as a priority. Our work results in recommendations for NHS organisations in the county, the County Council and sometimes other organisations about how what they do can be improved, for the benefit of the people and communities of Staffordshire.
Councillor Johnny McMahon
Chair of the Healthy Staffordshire Select Committee

If you would like to know more about our work programme, please get in touch with Nick Pountney, Scrutiny and Support Manager on 01785 276153 or nicholas.pountney@staffordshire.gov.uk

In Staffordshire, the arrangements for health scrutiny have been set up to include the county's eight District and Borough Councils. The Healthy Staffordshire Select Committee is made up of elected County Councilors and one Councillor from each District or Borough Council. In turn, one County Councillor from the Committee sits on each District or Borough Council overview and scrutiny committee dealing with health scrutiny. The Healthy Staffordshire Select Committee concentrates on scrutinising health matters that concern the whole or large parts of the county. The District and Borough Council committees focus on scrutinising health matters of local concern within their area.

Work Programme 2018-19

Date	Topic	Background/Outcomes
Committee Meetings, Reviews and Consultations		
		Background	Outcomes from Meeting
11 June 2018	Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership (STP) - Update Simon Whitehouse - Chief Executive Lead Manager and Lead Clinician	January Select Committee - STP thematic approach	Further detail on the following workstreams was requested • Workforce • Intermediate Care • Mental Health Services • The financial position • Engagement process • Visit to a locality hub
	Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership (STP) - Urgent and Emergency Care Simon Whitehouse - Chief Executive Lead Manager and Lead Clinician	January Select Committee - STP thematic approach	• Winter Care Plan requested to Committee. • Information on the role of the Ambulance service in the UEC. • Evidence on technology not marginaliseing vulnerable membes of the community
9 July 2018	Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership (STP) - Mental Health Simon Whitehouse - Chief Executive Lead Manager and Lead Clinician	STP workstream - report requested at 11 June meeting	The Committee asked for more information on: • The place based approach and the impact this is making on patients and service users. • Quality of life and the approach to long term conditions and mental health. • Information on the research surrounding social media and possible services to support treatment for these affected by it. • Workforce recruitment and retention.
	Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership (STP) - Prevention Simon Whitehouse - Chief Executive Lead Manager and Lead Clinician	January Select Committee - STP thematic approach	STP be recommended to : • Committee monitor improvement of healthy life expectancy. • Talk to Borough and Districts to see what information thy hold. • Diet and food be included in the preention programme
	Adult Learning Disability Community 2022 Cabinet Member for Health Care and Wellbeing - Alan White	Pre-decision scrutiny. Due at Cabinet - 18 July 2018	Cabinet recommended to: • Develop a mechanism for engagement with carers • Develop system of accreditation for providers of non statutorily regulated services • How does this programme relate to NHS continuing Healthcare • Be mindful of carers and the effect of the changes
13 August	Staffordshire and Stoke-on-Trent	January Select	The Committee made the following recommendations:

2018	Sustainability and Transformation Partnership (STP) - Workforce Simon Whitehouse - Chief Executive Lead Manager and Lead Clinician	Committee - STP thematic approach	a) The East of the County and Stoke on Trent had unique challenges and services need to be tailored to their specific needs. b) The work stream needs to ensure that the work force is future proof and can cater for the demands of changing populations. c) The Committee would like to see evidence of the individual organisations being able to adapt to their individual and differing demands and issues. d) The Committee would like to see evidence of redundancy numbers being reduced.
	Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership (STP) - Enhanced Primary and Community Care Simon Whitehouse - Chief Executive Lead Manager and Lead Clinician	January Select Committee - STP thematic approach	That the Committee request the following: a) Evidence that the STP is letting go of control to the Integrated Care Team localities to deliver services to meet their local need. b) That at a future meeting when this item is being considered, a practising GP be invited to attend, to offer their views on the programme c) Information on the public awareness campaign and how that will be delivered.
17 September 2018	Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership (STP) - Planned Care Simon Whitehouse - Chief Executive Lead Manager and Lead Clinician	January Select Committee - STP thematic approach	That the STP provide the following information to the Committee: a) A breakdown of the Cancer treatment targets for the whole of Staffordshire b) The Voluntary Sector Commissioning Contract time line and how this would be measured in terms of outcomes. c) Results of the Collaboration piece and evidence to substantiate it. d) Workforce update which would be looked at through the STP work streams e) Integrated Care and Technology Strategy
	Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership (STP) - Estates Simon Whitehouse - Chief Executive Lead Manager and Lead Clinician	January Select Committee - STP thematic approach	That the STP provide the following information to the Committee: a) The savings to the Extra Care budget. b) Information requested on transport analysis for the Codsall site requested by the local member be sent directly. c) The timescales for the next proposed 20 estates projects.
WOLVER-HAMPTON **23 October 2018 12.30pm**	Wolverhampton Health Scrutiny Panel – Royal Wolverhampton NHS Trust – Scrutiny of Mortality rates	Result of an increase in mortality rates	Minutes to follow
29 October 2018	Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership (STP) - Update on issues that have arisen from Scrutiny. Sir Neil McKay – Chairman and Simon Whitehouse - Chief Executive.	Requested at January Select committee	The update was noted and the Committee would discuss the future STP scrutiny requirments and inform the SSTSTP.
	CAMHs Strategy Cabinet Member for Children and Young People – Mark Sutton	Forward Plan Item	The Strategy and direction of travel was agreed in principle subject to more work taking place on the prevention agenda. The Committee noted the challenges faced in delivering the plan with partners and asked for information on MAC budget provision; if the Strategy had gone through a similar process to the Joint Strategic Needs Assessment; and why there was an increase in figures for Tier 3 services in 2017/18.
3	Staffordshire and Stoke-on-Trent Sustainability and Transformation	January Select Committee - STP	The Committee made the following recommendations to the STP: • Young Carers to be considered in the review

December 2018	Partnership (STP) - Child Care and Maternity services Simon Whitehouse - Chief Executive Lead Manager and Lead Clinician	thematic approach	• Early help and prevention are key in most areas but particularly in self harm and mental health • Information on the trail blazer bid was requested (if successful this could generate between £3m or £4m) • Information needs to be shared between the partners. • Ward and District profiles should be sent to all Councillors for information. • Partners developing a local PSHE programme which will be informed by schools • The County wide STP consultation was due to start soon. It was felt that as the Children's workstream had been late in joining the programme, it may be beneficial to have a separate consultation just on Children's services, thus giving the service more time to develop proposals and get the service right. That a progress report detailing the priority areas come back to this Committee in April 2019.
	Adult Learning Disability Community Offer 2022 (also refered to as ALDC 22) Cabinet Member for Health Care and Wellbeing - Alan White	Forward Plan Item. Also includes the **Carers pathway review**	**RESOLVED:** The Committee made the following main points which should feed into the consultation prior to Cabinet in January 2019: • There was concern that people in some geographical areas had to travel great distance to access services. It was suggested that consideration is given to including geographical location in the assessment with extra payments for people in those areas with the need to travel longer distances to access services. • Direct Payments encouraged people to access their own provision from the private sector and should be supported. • The Independent Sector were often not monitored for quality, this was a concern and needs to be addressed. • The possibility of providing guidance to service users about providers was discussed and should be explored. • It was felt that the need to consult and deal with issues in public, to ensure transparent decision making was important. • The number of individuals who are working and also in receipt of care was requested.
4 February 2019	Burton and Derby Hospitals - update and discuss our progress going forward	Request from the Hospital and update requested at 160718 accountability meeting	That the following information/action be requested: a) It was acknowledged that integrated communication between the community and acute hospitals was a particular issue and was a valid concern which officers would take back to the Trust. b) The Committee asked if they could have sight of the Trusts financial plan, for information. c) The rationale behind the move to repatriate specialism services. d) More information on how patients with mental health issues were being managed in order to transfer them to the most appropriate service provider. e) Data relating to the AKI outcomes to be shared with the Committee.
	Discharge to Assess – South of the county and the relationship with providers.	Suggested at the 3 December 2018 Committee meeting	That the following information be requested: a) The outcomes and savings from Discharge to Assess. b) Numbers of admissions to each of the out of county hospitals from the South of the County for both planned and urgent care, and the numbers of delayed discharges for each of the out of county hospitals.

13 February 2019 10am	Joint Staffordshire and Stoke on Trent Committee to consider the CCG consultation proposals	CCG Consultation	Agreed – That the North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups provide the following information for the next Joint Health Scrutiny Committee to be held on 11 March 2019: • Evidence to show the impact on patients of stays in community beds and acute beds on dependency and mobilisation, identifying any similarities or differences; • Further detail about the finances with a clear outline of the capital costs, revenue costs an ongoing costs; • Information about the timescales that would aid understanding and improve the ability to analyse the above financial costs (in Action 2); • A 'Spotlight' document to simplify the financial information (contained in the Pre Consultation Business Case) and that the document to be made available to the public; • The additional information shared with the public at the recent consultation events to be circulated to members of the joint committee; • A detailed outline of all six options for the community beds proposals, to include : ease of access; costs; worst scenarios; and the links to NHS strategies; • Evidence to demonstrate that care home beds scored the highest, which resulted in Option 6: Haywood and care homes being the preferred option; • Evidence and analysis of the workforce requirements in terms of skills, numbers, GP numbers, recruitment and retention plans and the potential impact on GP workloads to reassure the committee that the required numbers of staff with the necessary skills will be in place prior to implementation. • Further information about any cross-border arrangements, for example, Cheshire and Shropshire and how these arrangements fit with the model of care; • Details of what will happen to the buildings that are not chosen (For example, Longton Cottage Hospital, Cheadle Community Hospital).
11 March 2019 2pm	Joint Staffordshire and Stoke on Trent Committee to consider the CCG consultation proposals	CCG Consultation	
19 March 2019	Clinical Commissioning Group (CCG) : a) Hearing Aids, b) Cancer - to include 62 day cancer target (170918) and the End of Life Services and what is happening to services now. c) Stroke services -UHDB	a) Chairs request and previous scrutiny item b) Previous scrutiny item C) CCG	
10 June 2019	Staffordshire and Stoke-on-Trent Sustainability and Transformation Partnership (STP) - Child Care and Maternity services	Suggested at the 3 December 2018 Committee meeting	
	Whole Life Strategy – Implementation of the Autism plan	Item raised at Triangulation meeting.	
8 July 2019	Staffordshire Healthwatch Contract update report	Contract renewal	

	Cabinet Member for Health Care and Wellbeing - Alan White		
12 August 2019			
16 September 2019			
28 October 2019			
2 December 2019	CAMHs Strategy – update - include a briefing on the Trailblazer bid.	Suggested at the 3 December 2018 WP item	
Items to be programmed			

Accountability Sessions - The Committee, where necessary, agreed to hold to account the Acute Trusts on a quarterly, and other NHS Trusts on performance and delivery of service

The Healthy Staffordshire Select Committee and additional Members from the relevant District/Borough committees dealing with health scrutiny meet together to hold each Trust to account for progress - with a particular emphasis on patient safety, care, dignity and engagement.

Trusts provide a self-assessment report and respond to questions on matters of interest and concern to Councillors and the public
(Further information may be requested and the sessions may give rise to recommendations or identify topics for in depth scrutiny)

		Outcomes
Monday 16 April 2018 at 5.00 pm	University Hospitals of North Midlands NHS Trust	That (a) the County Council address how they can discharge their responsibility to ensure schools are kept informed about changes in health care provision locally and particularly emergency care for children, (b) the UHNM note the following matters which require their further response: **1.** Where routine services are increasingly tendered out by CCGs having the effect of leaving the Trust with expensive specialist services which can prove not to be sustainable, all health and care partners should be encouraged to work strategically to ensure the best use of public money. 2. That accurate waiting times should be displayed in A&E waiting rooms rather than the current display which states when the waiting time would be longer than 4 hours. 3. Given the implementation of a high impact action plan to drive up cancer performance to the required 85% against the 62 day standard, the Trust agreed to look at individual pathways and offer a trajectory for all specialities.

			4. The Trust agreed to identify numbers of patients at UHNM who come from outside the county and information around their discharge and repatriation and report back to the Committee.
Thursday 10 May 2018 at 5.00 pm	South Staffordshire and Shropshire Healthcare NHS Foundation Trust (including the former Stoke on Trent and Staffordshire Partnership NHS Trust) (to be called Midlands Partnership NHS Trust from 1 June 2018.)		That (a) the Healthy Staffordshire Select Committee support: 1. the proposal for a fully integrated health and care system in Staffordshire and Shropshire 2. the approach to develop strong links with housing associations to assist in a healthy, quality life. (b) Given that changes to local NHS arrangements locally can cause some residents to be anxious, the Midlands Partnership NHS Foundation Trust should have a clear communication strategy which is comprehensive and timely.
Monday 4 June 2018 at 5.00 pm	North Staffordshire Combined Healthcare NHS Trust		That the North Staffordshire Combined NHS Foundation Trust report be received and further detail be provided to Healthy Staffordshire Select Committee on the patient journey of looked after children through the services provided by the Trust.
Monday 16 July 2018 at 5.00 pm	Burton Hospitals NHS Foundation Trust		That the Committee: a) Receive an update on the progress of the merger in six months time. – **programmed for 040219** b) The Trust provide the Committee with data on the 62 day referral target for the treatment of cancer patients for both the last quarter (pre merger) and the next (post merger)
Monday 23 July 2018 at 5.00 pm	West Midlands Ambulance Service NHS Trust		The Trust were thanked for their attendance
Working Groups/ Inquiry Days/Briefing Papers :			
25 September 2018	Informal Joint Health ScrutinyCommittee for Staffordshire and Stoke on Trent	Pre Consultation Engagement – The Future of Local Health Services in North Staffordshire	Public meetings would be held during the consultation period.
14 November 2018	NHS Financial Position - Workshop	Requested following committee questions	Information noted
29 November 2018	Modernising Adult Social Care Programme – Blueprint and Business Case - workshop	Item raised at Triangulation meeting	
	Stability of the care market . Allied Health Care contract and the fragility of the market and the role of Nexxus.		Scrutinised by Safer and Stronger Select Committee - 11th December 2018
	Mental Health – how the Police deal with people suffering from mental health issues.		Scrutinised by Safer and Stronger Select Committee - 10 July 2018

Items for consideration for the Work Programme

Suggested Items	Background	Possible Option
Role of Community Hospitals	The Committee wish to explore the role of the Community Hospitals within the wider Health Economy	North of the County – Part of the consultation with the Joint Committee with Stoke on Trent South of the County – Part of the STP consultation
Young people acting as carers for sick or disabled parents or other family	The Committee to consider what is being done to identify and support such young people in Staffordshire	
An evaluation of the Antenatal Strategy Group	Referral from the Education Scrutiny Committee Closing the Gap Review	
Consideration of the range of approaches to sharing information between PCTs (Now CCGs) and education.	Referral from the Education Scrutiny Committee Closing the Gap Scrutiny Review Scrutiny and Support Manager to undertake further work and report to the Committee	
Adult Learning Disabilities – formal consultation		
People staying at home – not being admitted to hospital	Chairs suggestion	
Midlands Partnership NHS Foundation Trust (MTFT)	How is the MPFT working with the LA following the merger. Finance and culture (and communication strategy) were the main issues raised at the last meeting (10 May 2018). Chairs suggestion	
Staffordshire Healthwatch Contract update report	October 2019 and April 2020. To be programmed into work programme	
Modernising Adult Social Care Programme An update, containing an evaluation of the introduction of the service - back to the Healthy Staffordshire Select Committee in October 2019	October 2019 – agreed at the workshop – 29 November 2018	
Virgin Care Contract	CCG to produce briefing paper	
Theatre and Surgical Ward Sir Robert Peel Community Hospital Briefing Report	The Committee consider the proposals by Burton Hospitals Foundation Trust to decommission one Day Case Theatre and Surgical Ward at Sir Robert Peel and the review by Burton Hospital of the utilisation of Endoscopy service at the Sir Robert Peel. Following meeting of 25 March 2014, Committee note receipt of the petition, proposals to decommission of Day Surgery and Theatre and a request for clarification on where services will be accessed from before implementation. When available more detailed proposals on services may be delivered from the site and the Committee take part in the dialogue at the appropriate time	
Acute Trusts outside Staffordshire	Royal Wolverhampton Walsall Manor Good Hope George Eliot	Joint informal meeting in relation to Royal Wolverhampton Hospitals NHS Trust held by Healthy Staffordshire Select Committee and Wolverhampton City Council Health Scrutiny Panel.

George Eliot Hospital Trust and Walsall Healthcare Trust	The George Eliot Hospital Trust and Walsall Healthcare Trust are amongst the identified fourteen Trusts in the country for higher than expected mortality rates. Given that they will be providing healthcare for a number of Staffordshire residents the Committee seek assurances how this issue is being addressed. Scrutiny and Support Manager to undertake further work and report to Committee	Following dialogue with the Executive Director of Quality & Safety/Chief Nurse for South East Staffordshire & Seisdon Peninsula CCG/Cannock Chase CCG/Stafford & Surrounds CCG assurance has been given that from the information available this is no longer an area of concern and in fact their most recent Board papers provide a good level of assurance. There are no regulatory reported concerns re mortality at the present time either.

Membership

County Councillors

Johnny McMahon (Chairman)
Paul Northcott (Vice-Chairman)

Charlotte Atkins
Janet Eagland
Phil Hewitt
Dave Jones
Jeremy Oates
Kath Perry
Jeremy Pert
Bernard Peters
Carolyn Trowbridge
Ross Ward
Victoria Wilson

Borough/District Councillors

Jessica Cooper (Cannock)
Ann Edgeller (Stafford)
Barbara Hughes (Staffordshire Moorlands)
Richard Ford (Tamworth)
Alan Johnson (East Staffordshire)
Janet Johnson (South Staffordshire)
Deb Baker (Lichfield)
Ian Wilkes (Newcastle-under-Lyme)

Calendar of Committee Meetings

at County Buildings, Martin Street, Stafford. ST16 2LH
(at 10.00 am unless otherwise stated)

11 June 2018
9 July 2018
13 August 2018
17 September 2018
29 October 2018
3 December 2018
4 February 2019
19 March 2019