Herefordshire Council

AGENDA

Health Scrutiny Committee

Date:	**Monday 2 August 2010**
Time:	**2.00 pm**
Place:	**The Council Chamber, Brockington, 35 Hafod Road, Hereford**
Notes:	Please note the **time, date** and **venue** of the meeting. For any further information please contact: **Tim Brown, Committee Manager Scrutiny** Tel: Tel 01432 260239 Email: tbrown@herefordshire.gov.uk

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Agenda for the Meeting of the Health Scrutiny Committee

Membership

Chairman	**Councillor PM Morgan**
Vice-Chairman	**Councillor AT Oliver**
	Councillor WU Attfield
	Councillor PGH Cutter
	Councillor MJ Fishley
	Councillor RC Hunt
	Councillor Brig P Jones CBE
	Councillor G Lucas
	Councillor GA Powell
	Councillor A Seldon
	Councillor AP Taylor

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AGENDA

		Pages
1.	**APOLOGIES FOR ABSENCE** To receive apologies for absence.	
2.	**NAMED SUBSTITUTES (IF ANY)** To receive details of any Member nominated to attend the meeting in place of a Member of the Committee.	
3.	**DECLARATIONS OF INTEREST** To receive any declarations of interest by Members in respect of items on the Agenda.	
4.	**MINUTES** To approve and sign the Minutes of the meeting held on 18 June 2010.	1 - 8
5.	**SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY** To consider suggestions from members of the public on issues the Committee could scrutinise in the future.	
6.	**HEREFORDSHIRE SERVICE INTEGRATION PROGRAMME** To consider the Herefordshire Service Integration Programme.	9 - 26
7.	**POPULATION HEALTH - ALCOHOL MISUSE AND SMOKING** To consider what Herefordshire Public Services are doing to address alcohol misuse and smoking.	27 - 48
8.	**INTERIM TRUST UPDATES** To receive an update from Hereford Hospitals NHS Trust, West Midlands Ambulance Service NHS Trust and NHS Herefordshire.	49 - 66
9.	**WORK PROGRAMME** To consider the Committee's work programme.	67 - 76

PUBLIC INFORMATION

HEREFORDSHIRE COUNCIL'S SCRUTINY COMMITTEES

The Council has established Scrutiny Committees for Adult Social Care and Strategic Housing, Children's Services, Community Services, Environment, and Health. An Overview and Scrutiny Committee scrutinises corporate matters and co-ordinates the work of these Committees.

The purpose of the Committees is to ensure the accountability and transparency of the Council's decision making process.

The principal roles of Scrutiny Committees are to

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- Probe, investigate, test the options and ask the difficult questions before and after decisions are taken
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- Review performance of the Council
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Provision of services relating to the well-being of children including education, health and social care, and youth services.

Community Services Scrutiny Committee

Cultural Services, Community Safety (including Crime and Disorder), Economic Development and Youth Services.

Health

Scrutiny of the planning, provision and operation of health services affecting the area.

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Environmental Issues
Highways and Transportation

Overview and Scrutiny Committee
Corporate Strategy and Finance
Resources
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HEREFORDSHIRE COUNCIL

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HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Health Scrutiny Committee held at The Council Chamber, Brockington, 35 Hafod Road, Hereford on Friday 18 June 2010 at 10.00 am

Present: **Councillor PM Morgan (Chairman)**
Councillor AT Oliver (Vice Chairman)

Councillors: WU Attfield, PL Bettington, PGH Cutter, MJ Fishley, RC Hunt and A Seldon

In attendance: **Councillors PA Andrews, LO Barnett (Cabinet Member - Adult Social Care, Health and Wellbeing), WLS Bowen and PJ Edwards. Mr J Wilkinson – Chairman of the Local Involvement Network was also present.**

1. APOLOGIES FOR ABSENCE

Apologies were received from Councillors Brigadier P Jones, G Lucas and GA Powell.

2. NAMED SUBSTITUTES

Councillor PL Bettington substituted for Councillor P Jones.

3. DECLARATIONS OF INTEREST

There were none.

4. MINUTES

RESOLVED: That the Minutes of the meeting held on 29 March 2010 be confirmed as a correct record and signed by the Chairman, subject to noting that Mr J Wilkinson, Chairman of the Local Involvement Network had been in attendance.

5. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

A member of the public suggested that the Committee should look at the provision of NHS dental Services in Bromyard. The Committee agreed to incorporate this issue into its work programme.

6. RESPONSE TO SCRUTINY REVIEW OF GENERAL PRACTITIONER (GP) SERVICES

The Committee considered the response to the recommendations made in the scrutiny review of GP Services.

The Chairman reported that the Local Medical Committee had written to congratulate the Committee on what it considered to be a fair and accurate survey of current primary health care.

The Associate Director of Integrated Commissioning introduced the report and invited questions.

The Committee discussed the response to each recommendation. The following principal points were made:

Recommendation	Discussion
Section A - Continuity of Care	
A1	The appointment of a Neighbourhood Teams Manager was questioned. The Associate Director clarified the co-ordinating role this postholder would undertake.
Section B Equitable Access	
B1	Members sought information on the effect the opening of the Equitable Access Medical Centre had had on GP practices and the out of hours service. It was agreed that this information would be incorporated into the quality assurance report to be provided to the Committee in September. The general view of GP practices was that they had not seen their workload decrease. NHS Herefordshire's analysis was that the Centre had not prompted a reduction in A&E attendances and neither had it reduced demand for GP appointments. It was asked whether the existing temporary Centre at Asda in Belmont would be retained once the permanent Centre adjoining the hospital had been constructed, noting that a petition had been submitted to Council making this request. The Associate Director said that the benefit of retaining a facility at ASDA would be considered. He commented on plans to develop a greater degree of integration between the new Centre and the Accident and Emergency (A&E) Unit to try to address the inappropriate use of A&E. National guidance was awaited on the flexibility available in developing the Centres.
B5	The scope for GPs to engage more in preventive work was discussed, recognising that prevention was both better and cheaper than providing treatment at a later date. The Director of Public Health commented that, once on offer, such preventive services were used. His annual report set out a structure which would encourage the provision of preventive care. The West Midlands Region was operating a pilot scheme whereby a certain number of patients at risk within selected GP practices received specific attention. Four practices in Herefordshire were part of this pilot.
B8	Noting the reference to the Valuing People Partnership Board (VPPB) Members requested a glossary of the various Boards in the County with responsibility for considering health and social care matters. It was also requested that the VPPB should be asked to comment on its evaluation of the outcomes for adults with learning disabilities from the Learning Disability Locally Enhanced Service incentive scheme.
B9	The Cabinet Member (Adult Social Care, Health and Wellbeing) highlighted support to those with mental health problems as a key

	area of concern.
D Rurality	The Committee was not satisfied that the responses from the Director of Regeneration (now the Sustainable Communities Director) addressed the Committee's recommendations. It was requested that officers reconsider the responses giving further thought to how services could work together to address the challenges of rurality, including scope for co-ordinating use of transport resources as a whole and co-ordinating appointments. The role of communities in helping themselves was also discussed. The Committee noted that 21 of the 24 GP Practices were now participating in the scheme to offer extended opening hours. 14 practices had been participating when the response had been prepared.
I Collaboration/co-ordination/integration/communication	Members noted that this was an area of continuing frustration where further work needed to be done.
J Relations between GPs and NHS Herefordshire and how they affect patients	The Scrutiny Review had found that "most GPs and NHS Herefordshire officers interviewed stated that this relationship gave cause for concern". Although the last set of recommendations in the review, Members considered these were some of the most important. The Director of Public Health commented on the complexities of the relationship between NHS Herefordshire as Commissioners and the GPs as independent contractors. During the period in which the review had been carried out a number of significant policy changes had been taking place including, for example, the development of the Equitable Access Medical Centre. This had inevitably led to differences of opinion. He acknowledged that there were areas where NHS Herefordshire working with local GPs could improve further but the overall direction was positive. He added that one of the aspects examined in the World Class Commissioning Panel Assessment was GP engagement with the commissioning body. The relationship compared favourably with most other areas. He considered considerable progress had been made.

The following additional points were made:

- It was proposed that the Local Medical Committee should be invited to comment on the response to the scrutiny review.

- It was noted that the Children's Services Scrutiny Committee wished to consider the health of children and young people. It was acknowledged that both that Committee and the Health Scrutiny Committee would wish to examine aspects of Children's health and that some of this work could be undertaken in partnership to avoid duplication. It was proposed that Members of the Children's Services Scrutiny Committee should be invited to attend the Health Scrutiny Committee's meeting in September at which consideration was to be given to what Herefordshire Public Services were doing to improve people's diet and take up of exercise.

RESOLVED:

That (a) the response to the findings of the scrutiny review of GP services be noted subject to the Sustainable Communities Director being invited to reconsider and strengthen his response on rurality and transport co-ordination;

(b) the Local Medical Committee be invited to comment on the response by NHS Herefordshire to the Review;

(c) a further report on progress in response to the review be made in six months time with consideration then being given to the need for any further reports to be made;

(d) the Valuing People Partnership Board should be asked to comment on its evaluation of the outcomes for adults with learning disabilities from the Learning Disability Locally Enhanced Service incentive scheme;

(e) a glossary be prepared of the various boards in the County with responsibility for considering health and social care matters; and

(f) the next quality report should include information on the numbers using the Equal Access Medical Centre and also report on any effects on use of GP surgeries and the out of hours service.

7. ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH - 2009

The Committee considered the key population health issues in Herefordshire and the recommended strategies and actions to address these as set out in the Annual Report of the Director of Public Health 2009.

The Director of Public Health (DPH) presented the annual report summarising the theme of each chapter.

A Member questioned the continued presence of machines dispensing unhealthy foods in the Council's leisure centres operated by HALO. The DPH commented that he had discussed the matter with the Chief Executive of HALO. There was now a healthy alternative choice on offer at the leisure centres. The DPH had also commissioned a study to assess what the cost would be to HALO if they were to remove the unhealthy products.

The DPH commented that the problems associated with child obesity were such that action needed to be taken now to deal with them. He acknowledged that there were children with eating disorders and this was not being overlooked. He also agreed that it was important to have a balanced diet and that exercise was an important element of a healthy lifestyle.

The Chairman emphasised the importance the Committee attached to the preventive health agenda and invited Members to gather evidence from their communities to help inform the discussions of public health issues scheduled for the Committee's future meetings.

RESOLVED:

That: the Director of Public Health's Annual Report 2009 be noted and the implementation of the report's recommendations and the proposed approach and actions highlighted in the report be supported to inform service development and commissioning during the next planning cycle and in the medium term.

8. CONSIDERATION OF POPULATION HEALTH ISSUES

The Committee considered a revised timetable for its consideration of population health issues.

RESOLVED: that reports on population health issues be presented to the Committee in the order proposed in the report.

9. MENTAL HEALTH PROCUREMENT PROJECT

The Committee considered a further update on the Mental Health Procurement project being undertaken by NHS Herefordshire and the Council.

The Project Manager presented the report. She drew particular attention to the competitive dialogue methodology adopted for the tendering process which had enabled Herefordshire to benefit from the knowledge and expertise of other Mental Health Trusts in developing a service specification. This process was nearing completion and invitations to tender were expected to be issued shortly with a view to awarding the contract in September 2010 and the new arrangements commencing in April 2011.

She also highlighted the level of consultation with the Mental Health Reference Group, noting that the Chairman of the Group was present at the Committee's meeting.

The Committee noted the detailed work that had been undertaken and the benefits the project was expected to deliver in terms of increased accessibility to services for service users and their carers, increased range and diversity of services and improved governance and value for money of those services. It requested that a further report be provided setting out how the new arrangements would deliver these benefits.

RESOLVED:

That (a) progress on the Mental Health Procurement Project be noted; and

(b) a further report be made to the Committee in November 2010 setting out how the new arrangements will improve services and benefit service users and their carers and deliver value for money.

10. WEST MIDLANDS AMBULANCE SERVICE NHS TRUST UPDATE

The Committee received an update from the Trust.

Mr N Henry, the new General Manager for the West Mercia Locality, presented the update and informed the Committee of his intention to work with the Primary Care Trust to deliver improvements.

11. HEREFORD HOSPITALS NHS TRUST UPDATE

The Committee received an update from the Trust.

Dr Budd (Medical Director) presented the report. She informed the Committee that some hospital services had recently been reviewed by the West Midlands Quality Review Service. The initial feedback had been complimentary. The formal report was expected in August.

Noting the pressures the hospital was experiencing in accident and emergency activity, a question was asked about concerns expressed in a report by the Association of Surgeons that pressure to meet targets was having a detrimental effect on standards of care. Dr Budd replied that the report had related to elective surgery. The Trust was mindful of safety and had postponed and rescheduled operations to maintain a safe system.

Dr Budd acknowledged that the increase in pressure on Accident and Emergency was a concern across the Country. The severity of the illnesses of those admitted had also increased. Consideration continued to be given to finding a solution to this difficult problem.

The Assistant Director of Integrated Commissioning commented that the Primary Care Trust acknowledged that the high attendance at A&E was an issue, leading to increased costs as a commissioner and blocking of beds for elective care. Work was underway examining unscheduled care in both health and social care services.

The Committee noted the Trust's financial position and that the level of outstanding debtors was a particular concern. Dr Budd said that the Trust Board was considering these issues.

12. NHS HEREFORDSHIRE UPDATE

The Committee received an update from the Trust.

The Director of Public Health presented the report, commenting briefly on each of the key issues set out.

The Committee noted work underway to integrate health and social care provider services. It was requested that the update to the next meeting should include further information on delayed transfers of care from hospital.

Concern was expressed about performance against targets for stroke care. Dr Budd commented that the size of the County's population meant that there was only one Doctor dedicated to the service. In addition, a number of rural areas, generally, found some of the time-sensitive targets difficult to achieve and even large city centre teaching practices found them challenging. Outcomes from treatment were however quite good although the aim was to improve. Additional investment was being made.

RESOLVED: That updates be provided on delayed transfers of care and Stroke services.

13. WORK PROGRAMME

The Committee considered its work programme.

It was noted that the programme needed to be amended to incorporate the revised programme for the consideration of population health issues, including consideration of access to dental services.

RESOLVED: That the work programme as amended be approved and reported to the Overview and Scrutiny Committee.

The meeting ended at 12.35 pm **CHAIRMAN**

MEETING:	HEALTH SCRUTINY COMMITTEE
DATE:	2 AUGUST 2010
TITLE OF REPORT:	HEREFORDSHIRE SERVICE INTEGRATION PROGRAMME
REPORT BY:	INTERIM MANAGING DIRECTOR OF PROVIDER SERVICES

CLASSIFICATION: Open

Wards Affected

County-wide.

Purpose

To consider the Herefordshire Service Integration Programme.

Recommendation

THAT the outline of the Service Integration Programme and the details of the engagement programme be noted, subject to any comments the Committee wishes to make.

Introduction and Background

1 The Committee considered a report on progress on the Provider Services integration project, now the Herefordshire Service Integration Programme, on 1 March 2010 when it was invited to comment as part of the pre-consultation process.

2. The Committee welcomed and supported the work undertaken to date on the integration of provider services. It also requested that mindful of the significance of the proposed change it was requested that the Committee be kept fully informed of progress in addition to being formally consulted; and emphasised the importance of ensuring services were tailored to localities.

3. A report on the programme and the engagement process is attached.

Background Papers

- None identified.

Further information on the subject of this report is available from
Trish Jay, Interim Managing Director of Provider Services Tel 01432 363963

Herefordshire Council

Health Scrutiny Committee – 2 August 2010

Subject:	Herefordshire Service Integration Programme
Presented By:	Trish Jay, Interim Managing Director of Provider Services

PURPOSE OF THE REPORT:

To provide information on the implementation of the Herefordshire Service Integration Programme and the intensive engagement process accompanying it.

KEY POINTS:

- Summary of the Implementation Plan
- Development of the engagement process on the new service models (care pathways)

RECOMMENDATION:

The Health Scrutiny Committee is asked to note the outline of the Service Integration Programme and the details of the intensive engagement period planned over the coming months.

HEREFORDSHIRE SERVICE INTEGRATION PROGRAMME

IMPLEMENTATION PLAN SUMMARY

1. Introduction

In August 2009, the four sponsor organisations (NHS Herefordshire, Hereford Hospitals NHS Trust, PCT Provider Services and Herefordshire Council) together with the West Midlands SHA formed an independently-chaired Transition Board with multi-disciplinary membership to develop pathways for the integrated delivery of health and social care services within the county which would contribute to maximising health and well being and reducing health and social inequalities in Herefordshire.

The work concluded with a Transition Board report with recommendations which were approved by the PCT and Herefordshire Hospital Trust in May 2010. The proposition was to:

- Create a new integrated model of health and social care provision in Herefordshire, with specific care pathways aimed at providing personalised high quality, safe and sustainable care for local people which promotes personal health, well being and independence; a model which is focused on providing care as close as possible to people's homes, rather than in an institutional setting; a model which is also aimed at identifying our most vulnerable clients and shifting the emphasis from diagnosis and treatment to prediction and prevention.
- Create an integrated care organisation under one management structure composed of an integrated NHS Trust combining community and acute health services that is also integrated with social care so far as is practicable under current legislation.

A supplementary recommendation was to create an Implementation Programme structure with a Programme Team to take forward and co-ordinate the implementation of the key recommendations above.

This paper summarises the detailed Implementation Plan that has been developed to take forward the propositions as set out in the attached summary Transition Board report to sponsors. The attached engagement plan also describes the intensive engagement process that will accompany the implementation phase.

2. Implementation Plan for the Programme

2.1 Programme of work

This is a complex programme of change management across health and social care services in Herefordshire and therefore a comprehensive Implementation Plan has been developed to ensure a co-ordinated and project management approach to this work.

The implementation is split into three main areas:

a) Implementation of the care pathways:

- Frail older people – with focussed changes relating to:
  - Locality teams
- Stroke care
- Unscheduled Care
- Diabetes
- Chronic Obstructive Pulmonary Disease
- Lower back pain

b) Development of an engagement strategy to ensure people using the services, their carers, local communities, clinical and social care professionals. independent and voluntary sector providers are all involved in the implementation of the care pathway changes.

c) Development of the proposed Integrated Care Organisation, ensuring compliance with the required approvals processes.

In order to manage specific change management tasks for each of the programme areas above, a number of workstreams have been set up and prioritised in terms of the timing and urgency of implementation. Some work streams are cross cutting and these are outlined below. Each workstream has its own Executive/Senior Lead supported by Clinical/Practitioner Leads and a team of people working in the relevant areas. The workstreams have an outline of their objectives and outputs, and the key milestones for delivery.

Service Delivery Workstreams	Priority	Cross Cutting Workstreams	Cross Cutting Workstreams
Stroke	1	Clinical Quality & Safety Risk Stratification (Case Management) Diagnostics & Clinical Imagining Localities	Workforce IT Finance & Information Estates/Resources Communications & Engagement
Frail Elderly	1		
Diabetes	2		
Lower Back Pain	2		
Chronic Obstructive Pulmonary Disease	2		
Unscheduled Care	1		
Viable futures	2		

2.2 Programme Benefits and Key Performance Indicators

The benefits against which the programme is being measured were outlined in detail in the Transition Board report to sponsors and are shown in the table below:

For service users

• Sustainable local services
• Services that maximise choice, personalisation and independence
• Improved health, well-being, quality of care and greater clinical effectiveness through:
    ○ Simplified care pathways, with single point of access, clear referral and access routes, shared assessment and management plans and a shared focus on achieving maximum well being
    ○ Reducing the focus on inpatient and institution-based care
    ○ Timely availability and seamless care from healthcare professionals
• For social care users, better integration with health services with improved outcomes for individuals and their carers

For health and social care staff
• Increased productivity and responsiveness to service users • Increased operational flexibility by better integrated working practices,

maximising the skills and knowledge available

- Development of a workforce strategy across the health and social care economy
- Creation of interesting and developmental career pathways between hospital, community and social care leading to improved recruitment and retention
- Ability to train staff across different agencies to raise awareness of well being issues

For the health and social care community

- Increased public confidence
- Led by clinical and social care practitioners, financially sustainable and safe
- More viable and cost effective services with perverse financial incentives removed
- Better outcomes for health and social care service users, via more efficient delivery of safe and high quality care through:
    - Better integration of preventative advice and services with consistent messages to service users and the wider community
    - Consistent support to carers and integrated mechanisms to seek and to receive feedback from service users and carers
    - Identifying and managing risks and measuring the effectiveness of targeted intervention and longer term outcomes
    - Achieving the optimum balance as to where services are provided
- Improved business continuity
- Increasing the input from locality groups in the review, planning, commissioning and delivery of services
- Improved business processes, as information will be more available and shared across organisations and services
- Meeting local and national requirements relating to personalised care and individual choice
- Reducing health and social care inequalities

In order to determine if the benefits of the change process are having a positive impact, a clear set of performance indicators have been developed against which progress can be measured and reported. The indicators have been grouped into the following categories:

- High level indicators on measuring the overall impact of the implementation of the care pathways e.g. admission rates, average length of stay
- Feedback from those who use the services
- Implementation of new service provision
- Service Specific indicators

- Longer Term indicators

3. Planned Engagement Process

3.1 Engagement process on the care pathway implementation
The implementation of this programme of work requires input and partnership working with people who use the services and their carers, as well as health and social care professionals, support services, other providers, statutory and voluntary agencies and a wide range of external stakeholders.

An overarching Communication & Engagement Plan has been produced. The attached, paper sets out the more detailed plans to undertake an intensive period of engagement on the implementation of the care pathways and new service models over the next few months.

4. Development of the proposed Integrated Care Organisation

Work has been completed to understand the approval processes that are required to progress the recommendation to create a new Integrated Care Organisation for Herefordshire.

The initial step in this process is to obtain approval from the NHS Cooperation and Competition Panel (CPP). This body has the right to examine all major organisational transactions in the NHS, including mergers, to ensure that they are not anti-competitive and, therefore, against the public interest. The Programme Team is in contact with the CPP and information will be provided for their consideration at the end of July 2010.

5. Recommendation

The Health Scrutiny Committee is asked to note the outline of the Service Integration Programme and the details of the intensive engagement period planned over the coming months.

Trish Jay
Interim Managing Director for Provider Services

Engagement Plan

Release/Status	DRAFT
Version	0.1
Date	19th July 2010
Prime Authors	Alan Dawson
Sponsors	Martin Woodford Trish Jay
Document Ref	Engagement Plan

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Version control number	Date last updated	By whom/contributor
V0.1	20th July 2010	Alan Dawson

1. Introduction

This document sets out how Herefordshire's Service Integration Programme Team will engage with external and internal stakeholders over the service integration proposals put forward in the Transition Board's Report to Sponsors. Beginning in August 2010, a programme of intensive engagement activities will take place during a three month period.

Communication and engagement are key components of the service integration programme and as such are managed through one of 18 workstreams, working to an overarching strategy. This document is an adjunct to the main Communication and Engagement Plan and covers a period of intensive engagement in more detail.

The engagement activities set out in this document will be delivered and monitored by the Communication & Engagement Workstream, reporting to the Service Integration Programme Board.

2. Context

In August 2009, the four sponsor organisations (NHS Herefordshire, Hereford Hospitals NHS Trust, PCT Provider Services and Herefordshire Council) together with the West Midlands SHA formed an independently-chaired Transition Board with multi-disciplinary membership to develop a model for the integrated delivery of health and social care services within the county which would contribute to maximising health and well being and reducing health and social inequalities in Herefordshire.

The work concluded with a report back with a number of recommendations which were approved at the PCT and Herefordshire Hospital NHS Trust Boards in May 2010. The proposition set out in the report was to:

- Create a new integrated model of health and social care provision in Herefordshire, with specific care pathways aimed at providing personalised high quality, safe and sustainable care for local people which promotes personal health, well being and independence; a model which is focused on providing care as close as possible to people's homes, rather than in an institutional setting; a model which is also aimed at identifying our most vulnerable clients and shifting the emphasis from diagnosis and treatment to prediction and prevention.
- Create an integrated care organisation under one management structure composed of an integrated NHS Trust combining community and acute health services that is also integrated with social care so far as is practicable under current legislation.

This document sets out how the health and social care community will engage key stakeholders in the proposals around the creation of a new model of care.

3. Aims

Over the last year, the Herefordshire health and social care community has developed a high-level statement of common purpose to reflect its ambition for health and social care in Herefordshire:

‘We will provide integrated, high quality and safe care to support personal health, well being and independence within a sustainable Herefordshire health and social care community.’

The key features of our future health and social care service are:

- A quality of care that we would want for ourselves, families and friends.
- Localised care where possible, centralised where necessary
- Led by clinical and social care practitioners
- A kind, timely and personalised approach
- The very best outcomes
- Excellent value for money
- Care models based on self care, prevention and early diagnosis
- Financially sound and efficient

The principle aim is to make all stakeholders aware of the purpose and engage them in its realisation.

4. Principles

Herefordshire’s Health & Social Care Involving People Strategy (2004) set out a framework for patient and public involvement (PPI). The objectives of the joint strategy were to:

- ensure that health and social care organisations fulfil their commitment to involving local people.
- embed a culture of involvement and recognition of its benefits in Herefordshire health & social care organisations.
- ensure the outcome of involvement work has a clear impact on service delivery.
- establish a coordinated approach to involvement, which makes best use of available resources, avoids duplication and consultation fatigue.
- build and maintain close working relationships with Herefordshire LINk, the Health Scrutiny Committee, local service users, patient, carer and community groups.
- encourage inclusion and the recognition of diversity amongst Health & Social Care services.

The table below demonstrates the involvement continuum that spans information giving to full partnership. The activities set out in this plan will be from the right of the continuum, designed to allow maximum involvement. Communication activities are already discussed within the Programme’s overarching Communication and Engagement Plan document.

Minimum Involvement			Maximum Involvement	
←				→
Giving Information	Getting Information	Forums for debate	Participation	Partnership
Exhibitions & displays Leaflets and written documents Press releases Reports Website	Questionnaires & Surveys Stakeholder Feedback PALS interactions Discovery interviews (patient stories)	Focus Groups Service User/Public Groups Visits to community groups Public Board Meetings Site Roadshows	Expert patients Membership Clinical site visits Reference Groups Advocacy for 'hard to reach groups'	PALS Involvement Group Giving feedback Stakeholder representative on Integration groups Members/ Board interactions

5. Stakeholders

The key stakeholders are listed below. A full list is available in the Communications & Engagement Plan.

Key Stakeholders
Service Users/Service User Groups
Carers/Carers Group
Employees across Hereford Hospitals NHS Trust, PCT Provider Services and Herefordshire Council
Health Scrutiny Committee
Herefordshire LINk
General public including HHT Members
Voluntary organisations and community groups
Primary Care

6. Engagement Plans

The engagement plans below are specifically designed to get the best response from each group using a mixture of the activities set out in the involvement continuum above. Each activity will be designed to obtain feedback on the key parts of the proposed new service model, specifically around the proposed care pathway changes.

Engagement materials will be produced, aimed specifically at the stakeholder group. These material will set out the proposed service model and will focus of the major pathways:

- Frail Older People
- Diabetes
- Chronic Obstructive Pulmonary Disease
- Lower Back Pain
- Stroke
- Unscheduled Care

6.1 Service Users/Service User Groups

Activity	Commentary	Key Dates/ Frequency
Engagement with Expert Patients Group	Continue existing dialogue with Expert Patients Group including pathway specific sessions, building feedback into detailed implementation plans	Aug/Sep/Oct 2010
Engagement with Service User Groups	Request for feedback from pathway specific information to appropriate service user groups such as Age Concern and Diabetes UK. Meetings with pathway specific groups will be arranged as required.	Aug/Sep/Oct 2010
HHT Member Reference Group	Engage existing HHT Reference Groups around experiences of unscheduled care including the use if Discovery Interviews (patient stories) to identify key themes	Sep 2010
HHT Older People Focus Group & HC Older People Group	Engage two existing focus groups on the Frail Older People pathway including the use if Discovery Interviews (patient stories) to identify key themes	Sep 2010
HHT Consumer Group	Engage Consumer Group in a pathway event and obtain feedback and experiences	Oct 2010

6.2 Carers/Carers Group

Activity	Commentary	Key Dates/Frequency
Herefordshire Carers Support members engagement	Care pathway proposals to be sent to all members of the HCS mailing list and feedback obtained. Further feedback will be obtained from sub-groups within HCS such as those concerned with older people	Sep 2010

6.3 Employees across Hereford Hospitals NHS Trust, PCT Provider Services and Herefordshire Council

Activity	Commentary	Key Dates/Frequency
Roadshow	County-wide Roadshow events in the main health and social care facilities. Presentation of the care pathways and a chance to comment and feed back	Aug/Sep/Oct 2010
Website with e-mail feedback option	A micro-site on each organisation's intranet with an e-mail link to feedback directly to the programme team	Aug/Sep/Oct 2010
Pathway groups	Continued engagement through existing staff pathway groups	Aug/Sep/Oct 2010
Engagement materials	Engagement materials sent to all staff across all organisations and partner organisations	Aug/Sep/Oct 2010
Staff side meetings	Engagement of staff side through existing meetings to receive member feedback	Aug/Sep/Oct 2010

6.4 Health Scrutiny Committee

Activity	Commentary	Key Dates/Frequency
Engagement event	Event for HSC members to review the proposed service model.	Sep 2010

6.5 Herefordshire LINk/Brecon & Radnorshire Community Health Council

Activity	Commentary	Key Dates/Frequency
Engagement event	Event for LINK and CHC members to review the proposed service model	Sep 2010
Distribution to LINk & CHC members	Engagement materials to be distributed to all LINk members with a request for feedback and option to undertake more detailed group work.	Aug 2010

6.6 General Public

Activity	Commentary	Key Dates/Frequency
HHT members	Engagement materials to be distributed to all 2,500 HHT members requesting feedback	Aug 2010
Distribution to Parish Councils	Engagement materials to be distributed to all parish councils with a request for feedback	Aug 2010
Website with e-mail feedback option	A micro-site on each organisation's website with an e-mail link to feedback directly to the programme team	Aug/Sep/Oct 2010
Herefordshire Matters	Short piece guiding the public to the website and offering to arrange group sessions for interested parties.	Sep 2010

6.7 Voluntary Organisations and Community Groups

Activity	Commentary	Key Dates/Frequency
Herefordshire Alliance membership	Distribution of engagement materials to Alliance members with a request for feedback	Aug 2010
Alliance Older People and Disability Group	Specific engagement event around the Frail Older People pathway	Sep 2010

6.7 Primary Care

Activity	Commentary	Key Dates/Frequency
GP engagement	Engagement through existing meetings: locality meetings, Practice Based Commissioning & Local Medical Committee GP representatives will continue to engage across the entire programme.	Aug/Sep/Oct 2010
Primary Care Engagement Meetings	Specific engagement event within localities for all primary care staff	Oct 2010

7. Evaluation

All responses provided during the engagement period will be recorded. Where a response has led to a service change, this will also be recorded along with the changes made. A final report will describe the overall process, the responses and any changes made to the service model as a result. The report will be made available in December 2010.

MEETING:	HEALTH SCRUTINY COMMITTEE
DATE:	2 AUGUST 2010
TITLE OF REPORT:	POPULATION HEALTH – ALCOHOL MISUSE AND SMOKING
REPORT BY:	DIRECTOR OF PUBLIC HEALTH

CLASSIFICATION: Open

Wards Affected

County-wide.

Purpose

To consider what Herefordshire Public Services are doing to address alcohol misuse and smoking.

Recommendation

THAT the Committee considers and comments on actions being taken to address alcohol misuse and smoking.

Introduction and Background

1. On 18 June 2010 the Committee agreed a revised timetable for its consideration of population health issues as part of its work programme for 2010/11. The attached paper considers Herefordshire Public Service's approach to alcohol misuse and smoking.

Background Papers

- None identified.

Further information on the subject of this report is available from Dr Alison Merry Consultant in Dental Public Health Tel 01432 344344 x3730

What is Herefordshire Public Services (HPS) doing to address alcohol misuse and smoking?

1 Introduction

The Health Scrutiny Committee on 18 June 2010 agreed a revised timetable for its consideration of population health issues as part of its work programme for 2010/11. This paper, which considers alcohol misuse and smoking, is the first of a series of discussion papers setting out Herefordshire Public Service's approach to population health issues.

1.1 Herefordshire's Population Health Improvement Plan

Health and health-related behaviours are influenced by a whole range of factors and in order to improve population health, action is needed at a range of levels. These can be summarised as: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services (WHO Ottawa Charter for Health Promotion). In Herefordshire, the Population Health Improvement Plan 2010/11 builds on this approach, taking into account evidence of effectiveness and recognising the key role of partnership working, to set out a range of measures and interventions for each of nine topic areas which include alcohol and smoking.[1] Each section follows a framework based on the following generic sub-headings:

Healthy start

Babies are born with a healthy lifestyle – this section is about how to support children getting to adulthood with a healthy lifestyle.

Reducing exposure to risk factors through behaviour change

As children grow up they start to adopt a range of lifestyle risk factors (eg smoking, poor diet, alcohol, low levels of physical activity etc). This section is about supporting people of all ages to change their behaviour to reduce their risk of developing disease and ill health.

Enforcement to ensure a supportive environment

This section covers the things that can be done to protect people from risk factors and to ensure that the environment that people live and work in supports a healthy lifestyle eg licensing, no smoking enforcement and legislation to protect people's health from environmental harm.

Inequalities

This section covers actions to reduce inequalities.

Advocacy

This section covers advocacy for changes in local, regional or national policy, law, pricing, etc.

Early diagnosis and treatment

This covers screening and early detection and treatment of disease.

[1] The nine sections are: smoking, alcohol, healthy diet, physical activity, oral health, infectious diseases, sexual health (inc. teenage pregnancy), accidents and injuries (inc. suicides) and mental wellbeing.

2 Alcohol

Actions to tackle population health in relation to alcohol are set out in the Population Health Improvement Plan under the headings listed below which are based on the generic headings discussed above. Some examples of the interventions in the plan are provided here. Further examples of current and planned work in relation to alcohol are given later in this paper in relation to the specific questions raised by the Committee.

2.1 Outline of Health Improvement Plan – Alcohol Section

Promote safe & responsible drinking of alcohol (Children and Young People)

Plans include, eg:

- Effective PSHE teacher delivered programmes and specialist teacher support to PHSE teachers
- Locally enhanced national social marketing campaigns.

Reduce/stop abuse of alcohol in young people and adults

Plans include, eg:

- Systematically identify people at risk and support them to reduce their level of risk by introducing structured brief interventions (also known as IBA) and lifestyle coaching on an "industrial scale" and from a wide range of providers.

Protect the public from harm to their health associated with alcohol and provide an environment that supports people to drink responsibly

Plans include, eg:

- Multiagency work, inc with Safer Herefordshire Partnership, to address excessive consumption, underage sales and alcohol-related accidents and injuries.

Reduce inequalities in relation to alcohol misuse

Plans include, eg:

- Targeted social marketing campaigns, enhanced health trainer interventions in deprived communities in addition to individual lifestyle interventions.

Advocate for action and policy to reduce alcohol-related harm to health

Plans include, eg:

- Increase public awareness of health risks and costs (eg of hospital admissions; costs to the local economy) associated with harmful drinking
- Advocacy eg re strengthened licensing requirements (eg in relation to cheap alcohol in store doorways).

Reduce premature mortality associated with the abuse of alcohol

Plans include, eg:

- Increased support for patients admitted with alcohol related problems to reduced their alcohol consumption.

2.2 Specific questions raised by the Committee in relation to alcohol misuse

- **Work with alcohol retailers/outlets to improve information about alcohol misuse? What, and with what results?**
- **Pricing and display of alcohol products?**

Environmental Health and Trading Standards (EH&TS) work with licensed trade/ Designated Premise Supervisors (DPS) as part of the Herefordshire Against Night-time Disorder Scheme (HANDS) to discourage excessive and irresponsible drinks promotions (circa 95% membership). Voluntary/compulsory use of signage regarding 'challenge 21 or 25' employed. There has to be evidence of a link between such promotions and crime/disorder etc, before statutory provisions 'kick in'.

The new Policing and Crime Act 2009 has included additional powers in relation to irresponsible drink promotions. These are yet to be tested and case law determined. Early indications imply that they will not grant the powers sought.

In addition, the Herefordshire Population Health Improvement Plan contains further plans for working with retailers (and a range of other agencies via the Safer Herefordshire Partnership) to address alcohol misuse eg in relation to product displays, special offers and promotions, pricing, information for consumers etc.

- **Licensing of premises – how many premises, what hours, etc?**

There are circa 950 licensed premises with individual licensing hours. The exact times are only available from each premises' file and are not currently computerised. There are currently no 24/7 licensed premises.

Key premises for late night alcohol in county:

Dusk	(Hereford)	3.30am
Play	(Hereford)	3.30am
Manhattons	(Hereford)	3.00am
The Jailhouse	(Hereford)	3.00am
The Loft	(Hereford)	2.00am
Jacquelines	(Ross-on-Wye)	2.30am
Euphoria	(Leominster)	3.30am

- **Many places allow under-18s to drink – what action is to be taken to clamp down on this, and to discourage binge drinking?**

The evidence to support the challenge that many places allow young people to drink is not clear. If complaints are received then EH&TS will normally liaise with the police to monitor/inspect the premises and work with DPS and premises' licence holder to resolve the situation. Any 'interested party' or 'responsible authority' can call for a premise licence to be reviewed. If reviewed, license conditions can be imposed, a licence can be suspended or ultimately, it can be removed. Regular test purchasing exercises are conducted in relation to 'off sales' especially where evidence/complaints have been received concerning underage sales or where additional licensing conditions have previously been imposed. Fixed penalty notices are also issued to those who are caught selling.

If Licensing are aware of allegations of selling alcohol to persons already intoxicated, then this is referred to the police to deal with jointly.

In addition to the above, the Health Improvement Plan covers actions to discourage binge drinking and underage drinking.

- **What is being done to address quiet over-consumption of alcohol at home by mature people?**

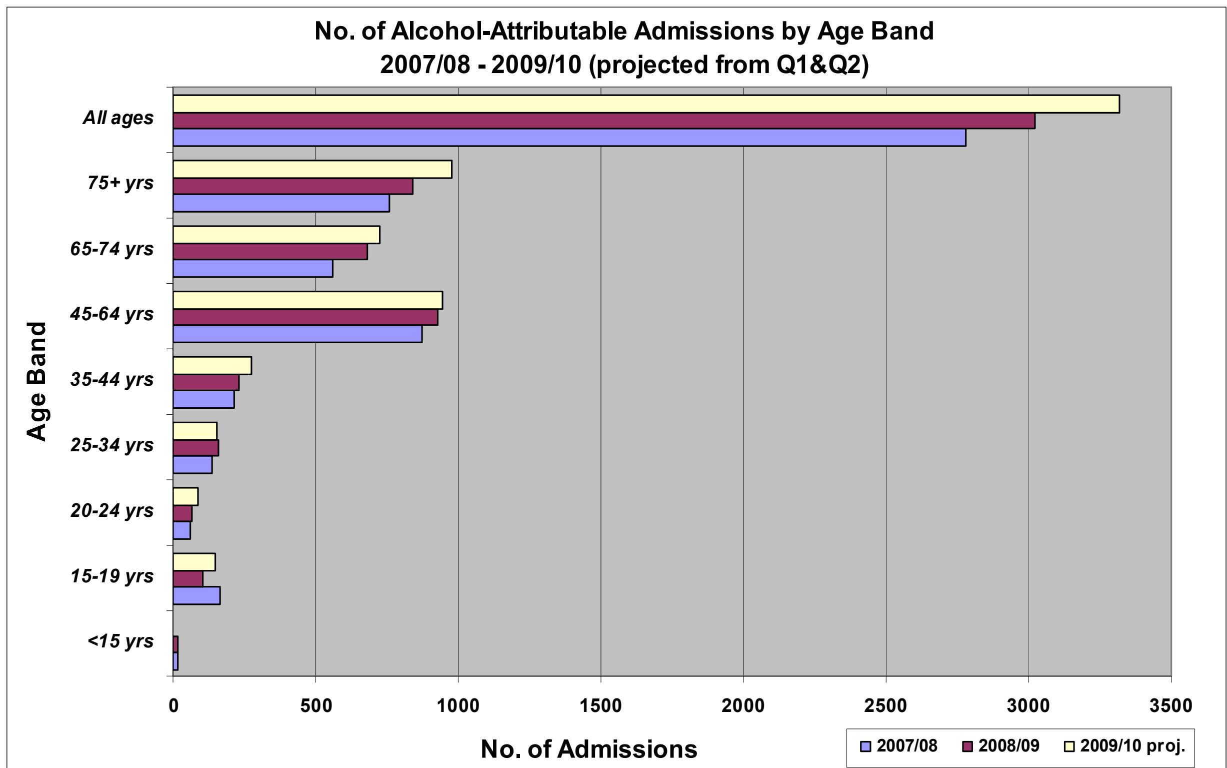
Harmful drinking in this group is potentially difficult to identify and address. The approach we are taking is to ensure that GPs (and others) routinely ask patients about their drinking habits in order to identify and support those who are at risk. For alcohol, this structured brief intervention is often referred to as IBA. A service level agreement for a Locally Enhanced Service (LES) to support GPs to offer IBA is currently in being finalised with a view to its introduction during 2010. This LES would support GPs in identifying and supporting any at risk patients (and not just those who "quietly over-consume at home"). In addition, social marketing campaigns are planned to raise awareness of safe and responsible drinking.

- **What data are available on hospital admissions due to alcohol, disease and death due to alcohol, domestic violence (reported and estimated) due to alcohol? What recent changes in these data?**

    - Alcohol use/misuse increases the risk of a range of chronic health problems (including circulatory diseases and cancers).
    - Alcohol use/misuse is also linked to accidents and injuries, the transmission of sexually transmitted infections and teenage conceptions.
    - Alcohol-attributable conditions are a significant cause of hospital admission in Herefordshire, accounting for the sixth largest number of provider spells of any diagnosis group. An average of over 3,000 alcohol-attributable admissions per annum were recorded for Herefordshire residents in the years 2007/08 – 2009/10 based on the updated (November 2008) indicator methodology. The number of qualifying admissions increased by almost 12% in 2009/10 alone.
    - A 40% increase in alcohol related hospital admission has been observed from 2003 to 2008. Without any further intervention at population level projected figures suggest another 40% rise by 2013.
    - On average slightly under a third of all such admissions are of those aged between 45 and 64 years, and a further 30% are of those aged 75+ years. However, on average almost 5% of admissions are among those aged less than 20 years and a further 15% relate to those aged between 20 and 44 years.
    - Males accounted for approximately 60% of total alcohol-attributable admissions in the years 2007/08 – 2009/10; an average of 1,850 admissions. This figure reached 2,000 admissions in 2009/10 specifically – an 11% increase. Over 80% of male alcohol-attributable admissions are of those aged 45 years and above. Just 2% of admissions are among young men aged under 20 years
    - Females accounted for an average of approximately 1,200 admissions per year in the three year period 2007/08 -2009/10. This figure reached in excess of 1300 admissions in 2009/10 specifically – an increase of nearly 13% on the previous year. Three quarters of female alcohol-attributable admissions are of those aged 45 years and above**.** However, over 8% of total female alcohol-attributable admissions are among those aged less than 20 years

- Nationally - 38% of men and 16% of women (age 16–64) are drinking above low-risk levels. Within this, 32% of men and 15% of women are hazardous or harmful alcohol users (23% overall).[2]
- The recommended limits are: up to 2 to 3 units a day for a woman; up to 3 to 4 units a day for a man and 2 days free from alcohol for everyone.[3]
- Numbers of alcohol-related hospital admissions are increasing (2,750 in 2007-08, just over 3,000 in 2008-09, 3,300 in 2009-10 (expected).
- Rates of alcohol-related hospital admissions are significantly higher in deprived areas of the county compared to more affluent areas.

Alcohol-related hospital admissions by age



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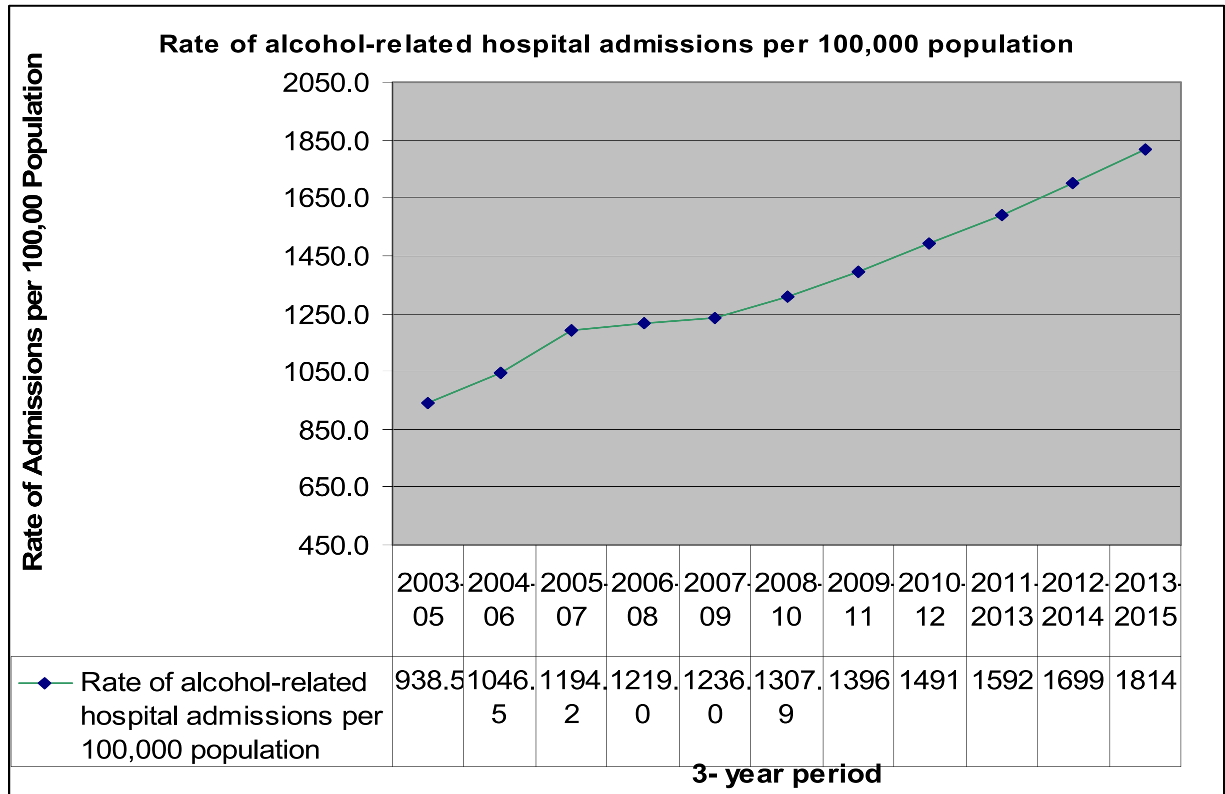
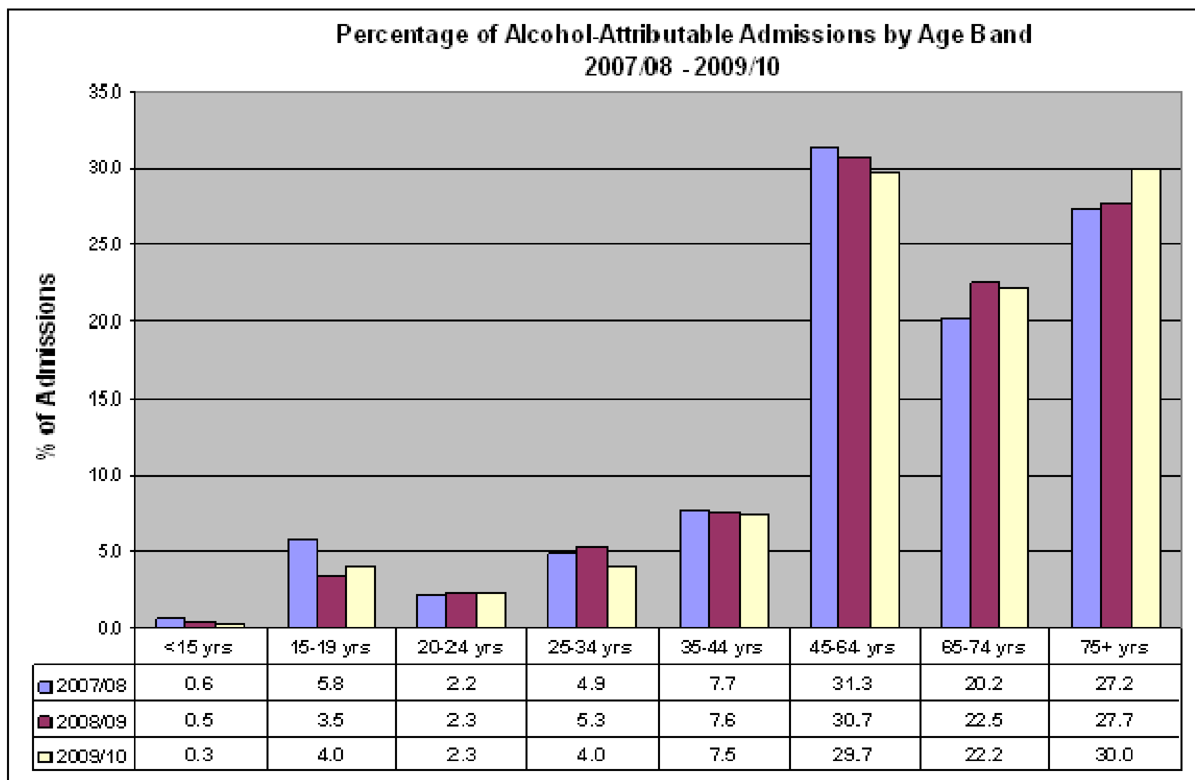
[2] The *Alcohol Needs Assessment Research Project* (Nov 2005)

[3] 1 unit = half a pint of ordinary strength beer, lager, or cider (3–4% alcohol by volume) OR a small pub measure (25 ml) of spirits (40% alcohol by volume). There are 1.5 units in: a small glass (125 ml) of ordinary strength wine (12% alcohol by volume OR a standard pub measure (35 ml) of spirits (40% alcohol by volume).

Alcohol related hospital admissions – trend analysis



Alcohol-related hospital admissions (by age band)



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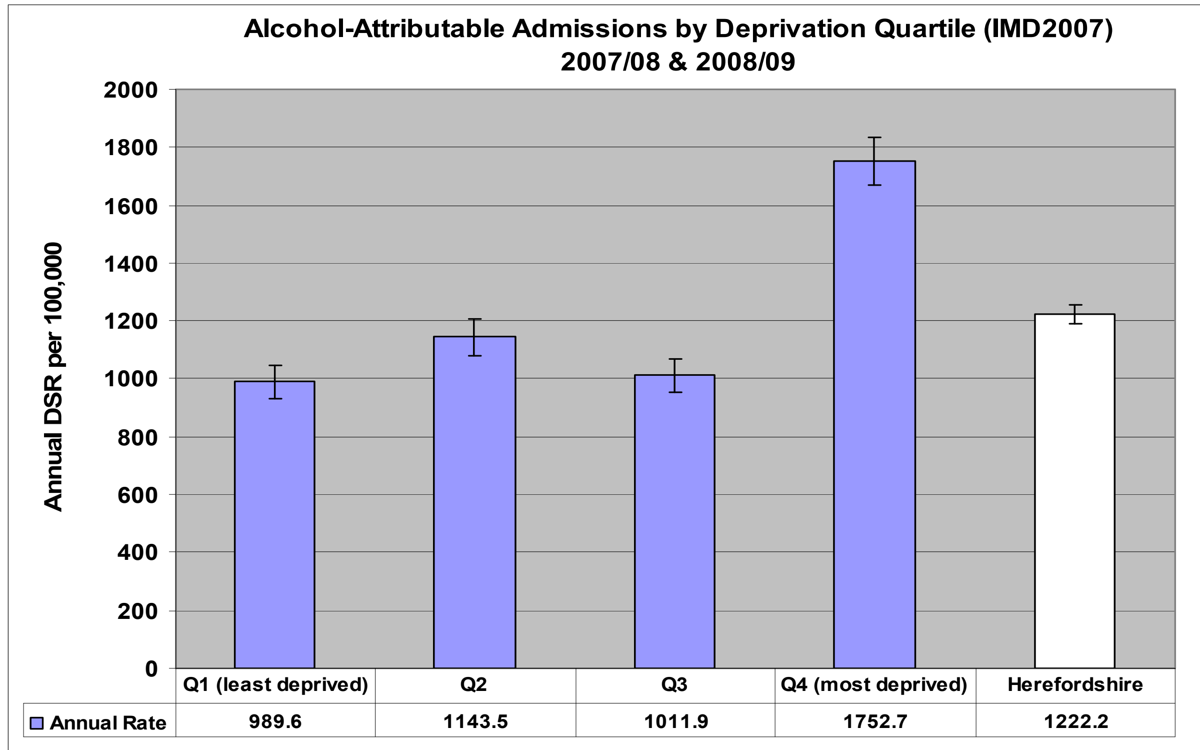
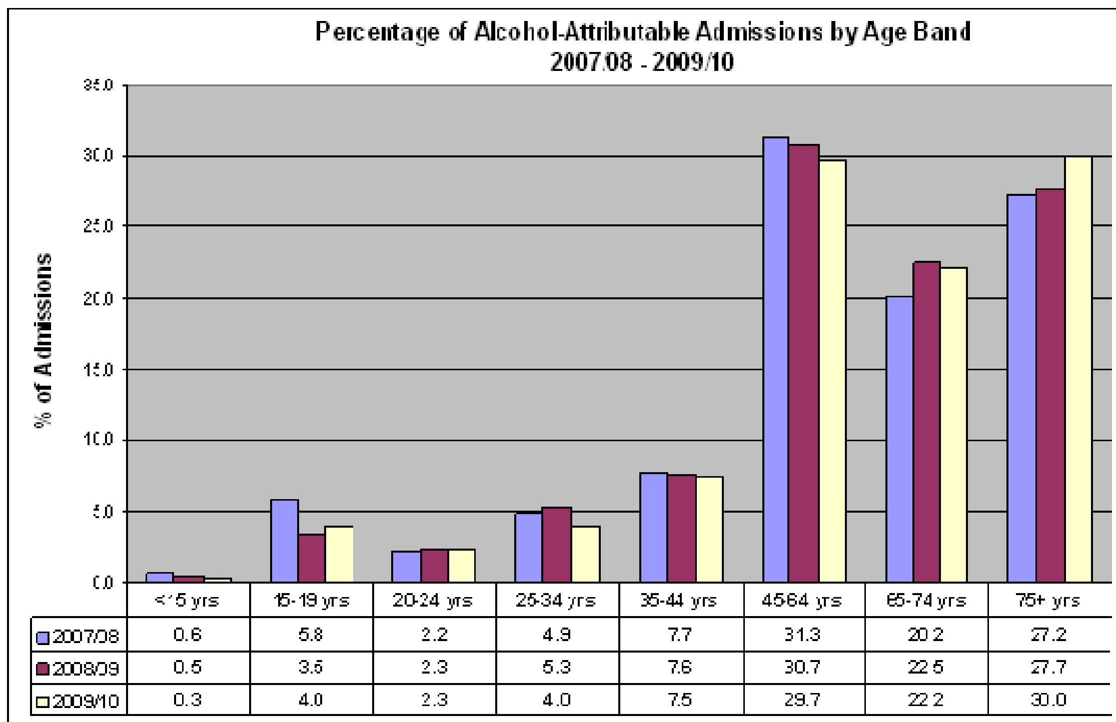
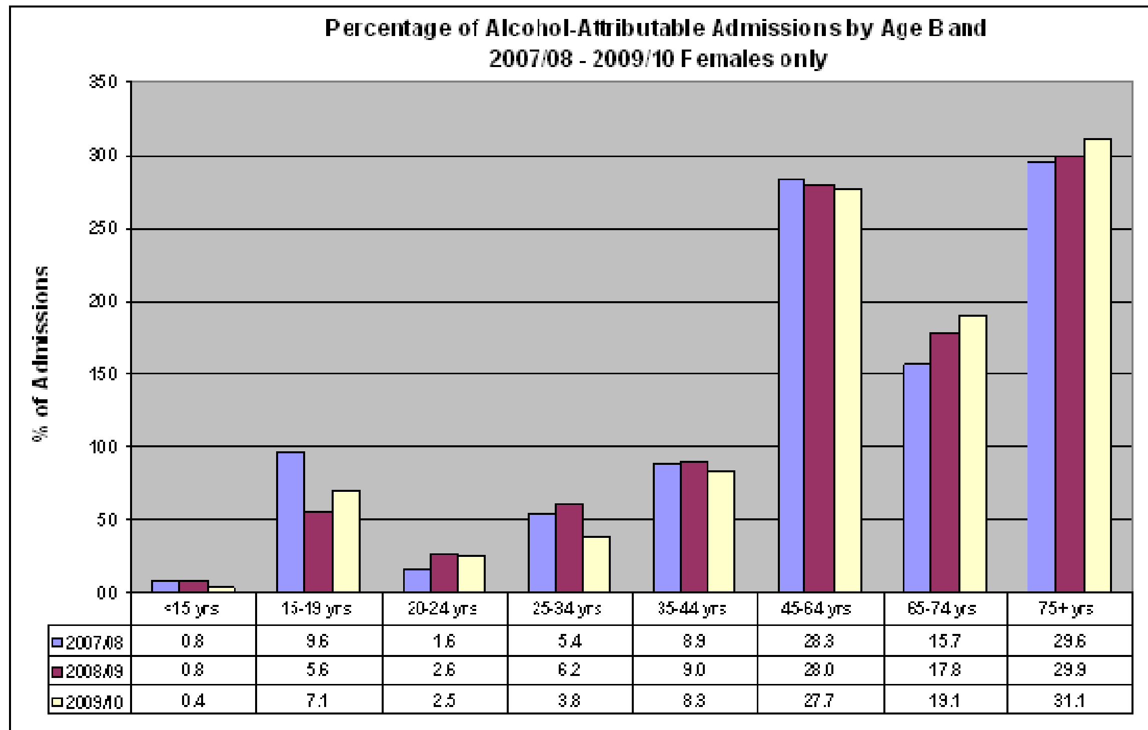
Alcohol-related hospital admissions by deprivation quartile



ALCOHOL-RELATED HOSPITAL ADMISSIONS (males)

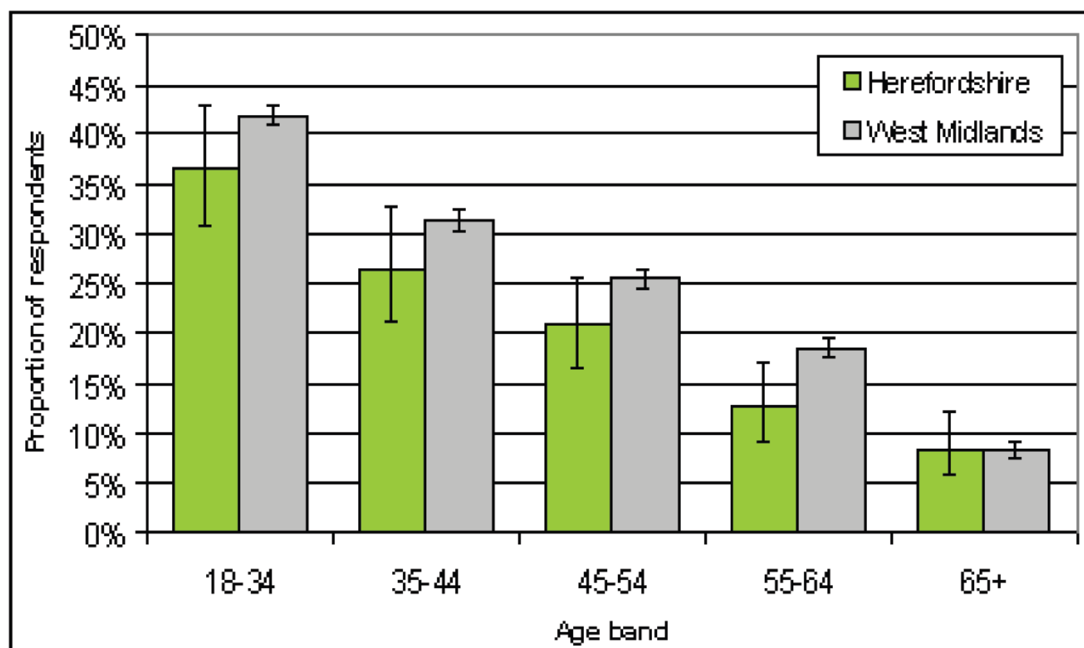


ALCOHOL-RELATED HOSPITAL ADMISSIONS (females)



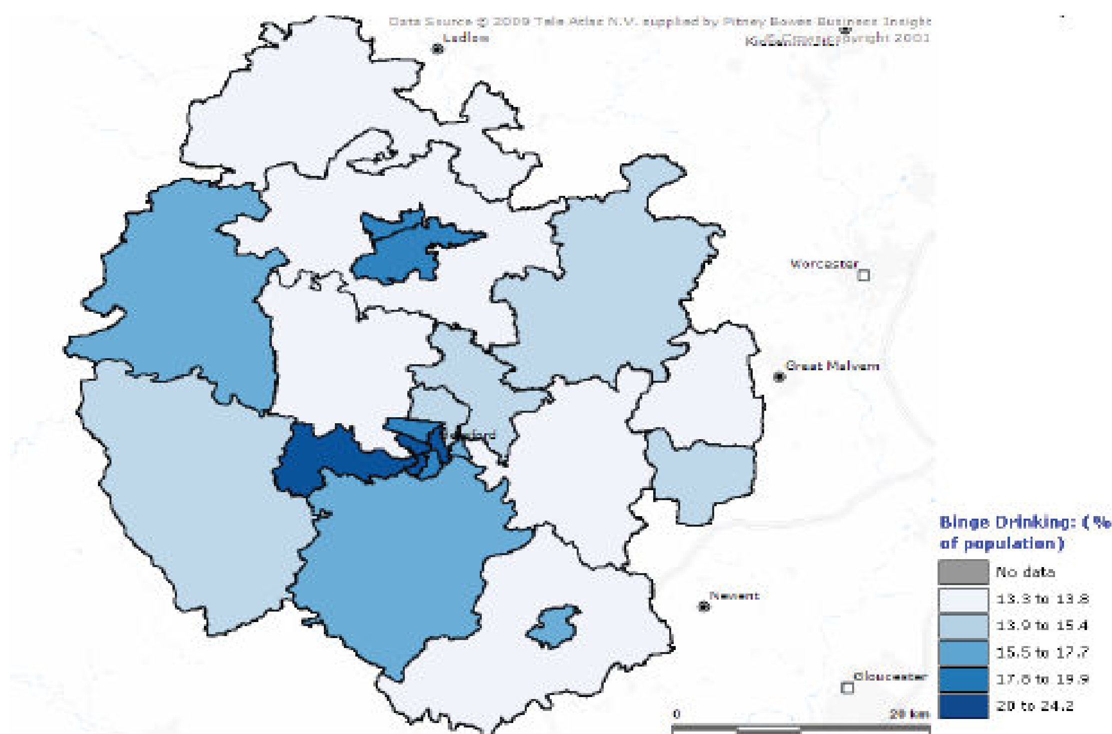
	<15 yrs	15-19 yrs	20-24 yrs	25-34 yrs	35-44 yrs	45-64 yrs	65-74 yrs	75+ yrs
2007/08	0.8	9.6	1.6	5.4	8.9	28.3	15.7	29.6
2008/09	0.8	5.6	2.6	6.2	9.0	28.0	17.8	29.9
2009/10	0.4	7.1	2.5	3.8	8.3	27.7	19.1	31.1

Prevalence of binge drinking by age



Source: Regional Lifestyle Survey 2005, WMRO & WMPHO

Binge Drinking by Middle Super Output Area 2008 – ONS Prevalence Estimates



Areas shaded darker represent Middle Super-Output Areas with higher percentages of the total population indulging in 'binge drinking'. Rates in excess of 20% are estimated for such areas.

Data on deaths from alcohol are not currently available. Data regarding numbers of cases of domestic violence related to alcohol have been requested but are not available at the time of writing.

- **What education/social pressure is HPS actioning?**

The Herefordshire Population Health Improvement Plan contains a range of specific interventions aimed at improving knowledge and awareness in relation to safe drinking including work with schools to improve PHSE in relation to alcohol and social marketing targeted at those at particular risk of harmful drinking.

Some examples of existing projects are outlined below:

Multiagency task group – Alcohol Strategy Group

Herefordshire's Alcohol Harm Reduction Strategy 2010, is currently being finalised. Its priorities relate to the nationally recommended NI39 related high impact changes and to the QIPP (Quality, Innovation, Productivity and Prevention) alcohol harm reduction work-stream imperatives which must be in place by March 2011.

Licensing and Safer Herefordshire sit on the Alcohol Group with Dr Arif Mahmood, Consultant in Public Health (Health Protection), as the lead Public Health officer. This group meets bi-monthly and is leading on the Alcohol Harm Reduction Strategy.

Licensing and Trading Standards meet monthly with the police and other relevant agencies as part of the Multi Agency Tasking And Coordination (MATAC) Group. This deals with cross-agency matters, including alcohol and crime.

Community Alcohol Service – Alcohol Liaison Nurse (ALN)/Arrest Referral Scheme

The Community Alcohol Service takes referrals via West Mercia Police and as an experienced alcohol worker, the ALN works closely with the County Hospital with both the accident and emergency department and inpatient departments to receive referrals for brief or more extended intervention with those patients who are admitted specifically regarding an alcohol related condition. Referrals are likely to be those who are frequent attenders – there is reliable evidence that such a service will help to reduce re-admission and is a nationally recommended 'high impact change' which Herefordshire is developing to suit local circumstances. Probation is working referring on those arrested for alcohol related public order offences for brief/medium intervention. This is also a recommended 'high impact change' which has been secured in Herefordshire. This scheme is known to reduce the likelihood of offenders proceeding to reoffend and possibly require hospital treatment in the future.

Herefordshire launched an Accident and Emergency based data collection system in summer 2010, which will feed this information to the Safer Herefordshire Partnership and enable local licensing, policing and also health provision to be more accurately targeted. It is expected that the system will feed back data on a fortnightly basis and will be able to highlight the availability of self referred alcohol treatment for those attenders at A&E who have been involved in an alcohol related incident, whether or not this has resulted in a violent episode. Feedback regarding how the data is being used will be shared with key hospital staff on a regular basis.

Bottletop

Bottletop is a peer led education programme which focuses on drinking safely and being safe when drinking. This was developed and launched through the Bulmer Foundation in November 2008 with support from Public Health. The programme facilitates work with existing groups of 16-19 year olds in colleges, youth clubs and other organisations and the group's website reflects the genuine voices of young people speaking to other young people in Herefordshire. The website also provides signposting for young people to help them access existing services and advice about alcohol misuse. This project has shown the potential of focussing the energy and enthusiasm of the often overlooked 16–19 year old age group in considering the issues about drinking that really affect them and using this to get health messages to their peers.

Blind Delusion

HPS is working in partnership with 2XL, a voluntary run group that uses the creative arts to raise awareness and stimulate discussion on a wide range of issues affecting young people. This work has been supported by funding from the Regional Alcohol Team. 2XL has developed a drama performance called Blind Delusion for students in college and sixth form. The group aims to challenge perceptions and myths to give their student audiences an understanding of the risks involved with alcohol. Safe and sensible drinking is the key message. Each performance is followed by an interactive workshop where students can ask questions, exchange information and, if they wish, talk to health professionals.

- **Any regulatory bodies' results, local or national target results**
- **Links with WCC pathway priorities**

The local and national targets directly relevant to alcohol are WCC44 and NI 139. The latest figures in relation to these indicators are presented in the attached dashboard. There are eight locally determined WCC outcome measures, one of which relates to alcohol.

- **What investment needs to be made to achieve goals and where is it going to come from?**

In order to make a real difference to reducing alcohol-related health problems at a population level further investment is required, notably in the following areas:

1) in the introduction across the county of structured brief intervention (SBI) for alcohol (in relation to alcohol, SBI is also know as Identification and Brief Advice or IBA) and making this available, routinely, from a wide range of providers (health and non-health) and on a so-called "industrial scale"
2) social marketing campaigns tailored to the needs of specific groups to promote safe and responsible drinking and to reduce alcohol-related harm to health.

Some specific examples of investment required to support this approach are outlined below:

Establish Alcohol Health Workers and Alcohol Liaison Nurse posts to deliver the Identification & Brief Advice (IBA) programme with Hereford Hospitals Trust, Primary Care and other public service/third sector partners. This role includes establishing and running an IBA training programme and monitoring systems re provision of IBA across the county. Resource required 1.5 wte at Scale 7 including support – admin, accommodation, laptop, mileage, mobile, etc, (includes 25% on costs) at a cost of c.£84k pa.

The posts would be based with Alcohol Service Providers team – currently the PCT provides but this to become external from 2011/12 and should become the cornerstone of a newly commissioned service via a new provider to reflect new priorities.

Develop and maintain intelligence gathering and data sharing programme re alcohol related hospital attendances and disseminate to inform practice of key partners – Safer Herefordshire, Licensing & Trading Standards Team, Police and health providers (community alcohol service) in partnership with HHT. The annual cost for running this scheme would be £4k – funding to be identified. This will be an evolving system which supports various interventions including the new IBA programme.

Continue development of social marketing related harm reduction/health improvement interventions. Seek external funding for the Bottletop (target 16-25 age range) and Blind Delusion programmes (target 16-18 age range) at a cost of c£30k pa.

Establish a core social marketing programme with support from Central Office of Information to contain and inform Bottletop and Blind Delusion development but to cover the full range of appropriate population groups to underpin the IBA and treatment developments at a cost of £30k pa.

Other areas for investment include:

- Maintenance of Arrest Referral tier 1 treatment & access
- Identified gap in service of access to tier 1 treatment by under 17's (possibly to be partially covered by developing IBA programme)

- **Public/service user evidence (to what extent is the organisation involving people who use services, and how is it communicating changes to them)**

The alcohol section of the Population Health Improvement Plan has been developed in conjunction with a range of stakeholders including the Safer Herefordshire and the Alcohol Strategy Group.

3 Smoking

As for alcohol discussed above, actions to tackle population health in relation to smoking are set out in the Herefordshire Population Health Improvement Plan. The smoking section of the Plan is set out using the following headings:

3.1 Outline of Health Improvement Plan – Smoking Section

Prevent children and young people starting to smoke

Plans include, eg:

- All schools to be smoke-free premises (whole site inc grounds); evidence-based smoking prevention in schools, social marketing aimed at preventing 11-17 year olds from starting to smoke.

Support smokers to quit

Plans include, eg:

- Routine and large scale identification of and support for smokers to quit provided by wide range of providers in healthcare settings and beyond; SBI to support pregnant smokers to quit; Stop before the Op to support smokers on elective surgery lists to quit.

Protect the public from harm to their health and provide an environment that supports people not to smoke

Plans include, eg:

- Form a Tobacco Control Alliance for Herefordshire; raise awareness of dangers of tobacco inc contraband products; detect contraband sales and enforce legislation.

Reduce inequalities in smoking rates

Plans include, eg:

- Provide community initiatives in deprived communities in Herefordshire as well as individual lifestyle interventions.

Advocate for action to reduce smoking as the biggest cause of preventable death in Herefordshire

Plans include, eg:

- Raising awareness eg that smoking remains the biggest preventable cause of premature death in Herefordshire; of the increased risk of a baby dying before 1 year if they live in a home where adults smoke; of the cost to public services of the health consequences of smoking

Early detection and treatment of smoking-related conditions (eg COPD, cancers) + supporting smokers with these conditions to quit

Plans include, eg:

- Provide high quality Structured Brief Intervention and Stop Smoking services; introduce NHS health checks and provide high-quality screening services for cancers and CHD etc.

3.2 Specific questions raised by the Committee in relation to smoking

As for alcohol above, some examples of the interventions in the Population Health Improvement Plan are provided here. Further examples of current and planned work in relation to smoking are also given in relation to the specific questions raised by the Committee.

- **Work with tobacco retailers to improve information about the dangers of smoking? What, and with what results?**

The work of the Trading Standards (TS) Team entails carrying out visits to local businesses many of which sell tobacco and other age restricted goods. TS officers offer advice to all of these businesses with regards to tobacco etc and also hand out a free CD to offer managers and owners containing guidance of how to train their staff on age restricted products. TS also have tailor-made advice leaflets for each type of business on our website. All tobacco retailers must have a prescribed notice stating that is illegal to sell tobacco to anyone under the age of 18, we check this is the case on routine inspections. TS also carry out spot checks on the retailers and statistics are very low on underage sales.

- **Pricing and display of tobacco products?**

On routine inspections or visits generated by complaints TS will ensure that the retailer advertises tobacco products within the scope of the regulations. Retailers are prohibited to advertise tobacco products in a newspaper etc, this is also monitored. The retailer is not allowed to display tobacco products or tobacco related products in such a way with can be deemed as marketing or advertising them (this would include the price or brand).

- **Many places sell tobacco to under-age consumers – what action is to be taken to clamp down on this?**

In fact statistics are quite low within trading standards to suggest that this is the case. TS will always consider the need for the provision of trader advice and education, as well as intelligence led enforcement activity by way of covert underage sales operations.

Information sharing is the key here and if the partners can identify areas for concern the information will be invaluable to TS. TS do educate tobacco retailers of the legislation and notify them of the penalties if they fall foul of this legislation.

In April 2009 the law changed and now TS can apply to the court for a ‘restricted premises order or a restricted sale order’ (in certain circumstances both) as well as a penalty of up to £2,500. A ‘restricted premises order’ means a prohibition to sell tobacco at the premises for up to 12 months and a ‘restricted sale order’ means a prohibition for a named person to sell tobacco or have a managerial role relating to tobacco for a period of up to 12 months. These sanctions will only be sought where

there have been persistent illegal sales of tobacco made to young people. In order to apply for the order the entity (premises or person) must have been convicted of making an illegal sale of tobacco to a young person and where on at least two other occasions within a two year period the entity has committed other similar offences.

- **What data are available on hospital admissions due to smoking, disease and death due to smoking? What recent changes in these data?**

Deaths from smoking have decreased slightly since 2004-06.

2004-06 – 300 deaths (DSR* of 178.4 per 100,000)
2005-07 – 284 deaths (DSR of 166.3 per 100,000)
2006-08 average 284 deaths per year (DSR of 163.1 per 100,000 aged 35+ years)
*Directly Standardised Rate

Source: Health Profiles 2008-2010

A smoking-related hospital admissions methodology is being developed but figures are not available at this stage.

- **Smoking cessation campaigns? Campaigns to prevent people from starting smoking?**

Stop Smoking Service
Ongoing co-ordination, training and service development is one of the key roles of the specialist Stop Smoking Service in order to support the introduction and further development of wide-scale routine Structured Brief Intervention and stop smoking support from a range of providers in health and other settings (eg pharmacies, dental surgeries, HALO leisure centres etc).

Smoking in pregnancy
The Stop Smoking Service continues to develop and take a strategic lead in relation to pregnant smokers. Following the recently published NICE guidance for smoking in pregnancy the following system is to be implemented: midwives will provide brief interventions and carbon monoxide (CO) monitoring at every visit (not just the booking visit). They will then operate an 'opt-out' referral system to the Stop Smoking Service – the service will contact them, assess their needs and either refer on appropriately to the range of providers developed/developing under the Health Improvement Plan, or see patients themselves (direct patient contact constitutes 20% of the service's time). The service will aim to 'skill up' a network of advisors, particularly in rural areas, who they will feel happy they can refer to for the particular issues for pregnant smokers. The stop smoking service will follow up those they refer on to determine outcomes or whether extra support is needed.

Stub Buddies
A social marketing campaign took place in spring 2010 to encourage people to quit smoking with a reward scheme to incentivise quitters. It aimed to encourage smokers to make use of free and effective NHS services by providing a "buddy" who provided practical help and support, along with tips, tricks and encouragement to ensure they quit smoking for good. A total of 36 people received £15 of rewards through the scheme, for everyone who managed a four week quit, and then all participants were entered in a prize draw at the Health and Wellbeing conference for bigger rewards.

Hereford United FC
Links are being developed with the Community Trust to get stop smoking messages into the community pages of the football match programmes and to use player appearances as opportunities to give out messages about the benefits of not smoking, particularly to children and young people.

Change Champions
The stop smoking Change Champions group from 2009 have continued to work on smoking prevention and are looking to work with schools to both develop consistent smoking policies to create smoke free schools and work with Trading Standards around enforcement at school premises.

Smoking Strategy development
A multi-sector group meets regularly to look at a county-wide strategy for prevention, cessation and enforcement in relation to smoking, drawing on the experience of the Smoke Free Herefordshire campaign in 2007.

- **Any regulatory bodies' results, local or national target results**
- **Links with WCC pathway priorities**

The local and national targets directly relevant to smoking are as follows:

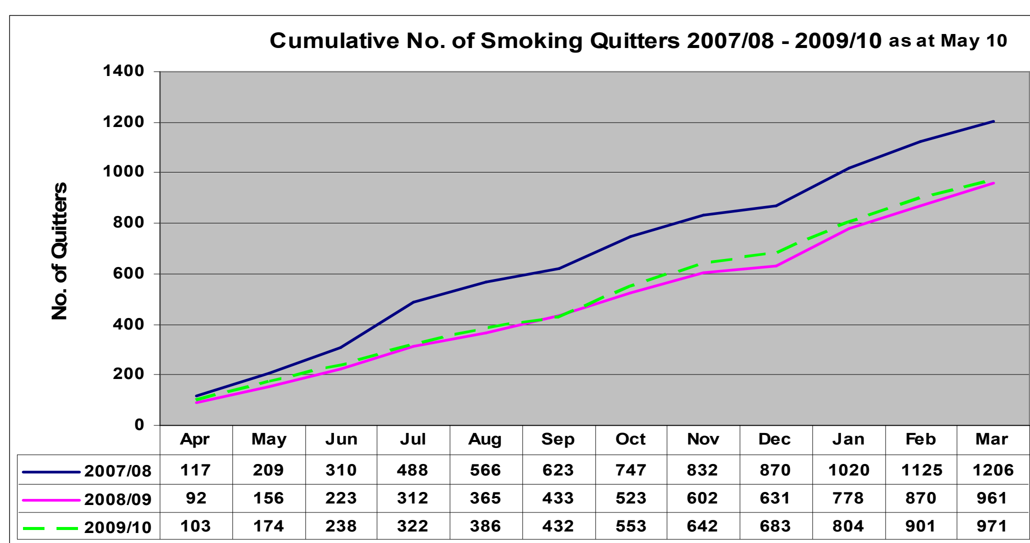
WCC23 and VSB03	Cancer mortality under 75 years
NI121 and VSB02	Circulatory disease mortality aged under 75 years
WCC66	Coronary heart disease mortality
WCC17 and VSB05	Number of smoking quitters at 4 weeks
NI123	Quit rate per 100,000 aged 16+ years

The figures for the last three years are as follows:

Indicator	07/08	08/09	09/10	Target 10/11	Indicator
No. of Smoking Quitters at 4 weeks	1201	968	971	**1200**	**WCC17**
				1245	**VSB05**
Quit Rate per 100,000 aged 16+ years	817.1	653.9	648.2	**818.5**	**NI123**

The latest figures in relation to these indicators are presented in the attached dashboard. There are eight locally determined WCC outcome measures, of which one relates to smoking.

The graph represents the quitting figures for the last three years on a monthly basis.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2007/08	117	209	310	488	566	623	747	832	870	1020	1125	1206
2008/09	92	156	223	312	365	433	523	602	631	778	870	961
2009/10	103	174	238	322	386	432	553	642	683	804	901	971

- **What investment needs to be made to achieve goals and where is it going to come from?**

The Herefordshire Partnership has a series of Policy and Delivery Groups which undertake strategic allocation of funding from the Area Based Grant. The Health and Wellbeing Partnership holds a budget for health improvement and social care.

Investment is required in order to reduce smoking rates and associated ill health. Investment required includes:

- Prevent children and young people starting to smoke by provision of external resources as part of a teacher delivered programme, 1 wte post to deliver external support to schools through PSHE, c£35k pa through the Area Based Grant (ABG) flexible pot.

- Provide evidence-based smoking prevention interventions in school settings, by completing the ASSIST peer support programme in secondary schools, 1 wte post, c£35k pa through ABG flexible pot.

- Run a social marketing campaign targeting young people aged 11-17 to prevent them starting to smoke, through a locally enhanced national Smokefree campaign delivered to all secondary schools and sixth form settings, £20k through ABG flexible pot.

- Enhance the capacity and capability to provide smoking cessation support services in Herefordshire, by ensuring sufficient capacity and flexibility of support to increase the number of smokers wanting to quit. Initiate new services in non-NHS settings with 100 quits @£150 each, at a cost of £15k through the ABG flexible pot, and set up a workplace service with 1 wte post, c£35k pa through the ABG flexible pot.

- Reduce inequalities in smoking rates by locally enhanced national Smokefree campaigns using local communication channels and local demographic knowledge, and by providing events and services in deprived communities to support the campaign, £30k pa through the ABG flexible pot.

- **Public/service user evidence (to what extent is the organisation involving people who use services, and how is it communicating changes to them)**

The smoking section of the Health Improvement Plan has been developed with input from a range of key stakeholders. The Public Health Team is undertaking the facilitation of a multi-agency smoking group to develop a smoking strategy for the county. The group may transform into a formally recognised Tobacco Alliance, but currently the group is undertaking specific activity around cessation, prevention and enforcement.

NHS HEREFORDSHIRE PUBLIC HEALTH DASHBOARD 2010/11: JULY 2010

PERFORMANCE MONITOR

MORTALITY (all ages unless specified)	BASELINE (No. of Deaths) 2005	2006	2007	2008	2009	Expected YTD No. 05-09	Actual YTD No. 2010	*Actual vs. Expected*	% DIFF.	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Target (DSR per 100,000)	Projected Outturn	Indicator No.
Cancer aged under 75 yrs	233	234	245	241	247	98	95	-3	-3.5	14	15	21	21	24								93.0 95.0	93.1	WCC23 VSB03
Circulatory diseases aged under 75 yrs	166	146	140	162	143	62	54	-8	-13.2	16	11	9	12	6								56.0 53.0	51.9	NI121 VSB02
Coronary Heart Disease	351	312	285	312	288	117	115	-2	-2.0	39	22	16	28	10								63.0	68.5	WCC56
Stroke	248	199	221	242	255	85	90	6	6.5	25	18	19	20	8										
Chronic conditions	588	511	533	561	530	250	210	-40	-15.9	63	45	33	44	25										
All Causes																								
males	965	973	933	943	910	409	387	-22	-5.4	99	63	91	76	58								625.0	586.3	VSB01
females	1044	890	1041	1040	964	444	380	-64	-14.3	90	78	76	83	53								387.0	379.4	
Accidents	57	55	54	72	54	24	19	-5	-20.8	5	2	5	5	2										
Falls	8	9	10	8	13	4	1	-3	-73.7	0	0	1	0	0										
Suicide and Undetermined Injury	19	21	14	18	16	6	5	-1	-21.9	0	1	2	2	0										
Perinatal mortality	15	14	13	8	8	5	4	-1	-17.2	1	3	0	0	0										
Land Transport accidents	14	18	17	25	18	6	3	-3	-51.6	0	1	1	1	0								10.0	3.5	WCC64
Diabetes	28	24	26	26	30	13	15	2	11.9	4	6	1	3	1										

ALCOHOL-RELATED ADMISSIONS	BASELINE (DSRs) 05/06	06/07	07/08	08/09	09/10	Expected YTD Rate 07/08-09/10	Actual YTD Rate 10-11	*Actual vs. Expected*	% DIFF.	J	F	M	A	M	J	J	A	S	O	N	D	Target (DSR per 100,000)	Projected Outturn	Indicator No.
										2010/11 Q4			*2010/11* Q1			*2010/11* Q2			*2010/11* Q3					
Alcohol-attributable DSR per 100,000 (N139)	--	--	1180.0	1254.6	1352.6	315.6																1113.0 1234.0		WCC44 NI39
Alcohol-specific under 18s crude rate per 100,000	--	--	88.4	91.6	76.0	21.3																		
Alcohol-specific males DSR per 100,000	--	--	391.6	424.5	465.9	106.8																		
Alcohol-specific females DSR per 100,000	--	--	193.0	213.1	196.1	50.2																		

OTHER INDICATORS	BASELINE 05/06	06/07	07/08	08/09	09/10	Target YTD 10-11	Actual YTD 10-11	*Actual vs. Target*	% DIFF.	J	F	M	A	M	J	J	A	S	O	N	D	Target	Projected Outturn	Indicator No.
										2010/11 Q4			*2010/11* Q1			*2010/11* Q2			*2010/11* Q3					
% MMR Uptake at 5th birthday (both doses)	74.7	75.8	73.9	78.9	81.3	270	242	-28	-10.4				117	125								90.0%	80.7%	WCC11/VSB10
Smoking Cessation																								
No. of Smoking Quitters at 4 weeks	--	--	1201	968	971	200	99	-101	-50.5				73	26								1200 1245	594	WCC17 VSB05
No. of Smoking Quitters at 12 weeks	NO BASELINE DATA AVAILABLE												n/a											
Quit Rate per 100,000 aged 16+ years	--	--	819.0	654.9	655.5	206	99	-107	-51.9				73	26								818.6	393.4	NI123
No. of Chlamydia Screenings 15-24 yrs	--	--	--	2207	4439	1785	733	-1052	-58.9				180	257	296							35.0%	14.4%	VSB13

rates updated following publication of ONS mid-year 2009 population estimates and consequent minor revisions to previous years

MEETING:	HEALTH SCRUTINY COMMITTEE
DATE:	2 AUGUST 2010
TITLE OF REPORT:	INTERIM TRUST UPDATES
REPORT BY:	HEREFORD HOSPITALS NHS TRUST, NHS HEREFORDSHIRE, WEST MIDLANDS AMBULANCE SERVICE NHS TRUST

CLASSIFICATION: Open

Wards Affected

County-wide.

Purpose

To receive an update from Hereford Hospitals NHS Trust, West Midlands Ambulance Service NHS Trust and NHS Herefordshire.

Introduction and Background

1. Full updates from the Chief Executive of each Trust to provide assurance to the Committee are made to every other meeting. At meetings when a full update report is not presented the Committee receives a report containing updates or outstanding information from the previous meeting, any urgent or very topical information and any other information that the Trusts feel should be drawn to the Committee's attention.

2. **Hereford Hospitals NHS Trust**: A report is appended.

3. **West Midlands Ambulance Service NHS Trust:** The Service is due to submit detailed reports in September 2010 and has no additional information to submit.

4. **NHS Herefordshire:** Reports are appended.

Background Papers

- None identified.

Further information on the subject of this report is available from Nick Henry, General Manager for West Mercia Locality Tel: 07971 305209, Martin Woodford, Chief Executive (Hospitals Trust) on (01432) 364000, Dr Akeem Ali, Director Public Health 01432 260668

HEALTH SCRUTINY COMMITTEE MEETING
30th JULY 2010

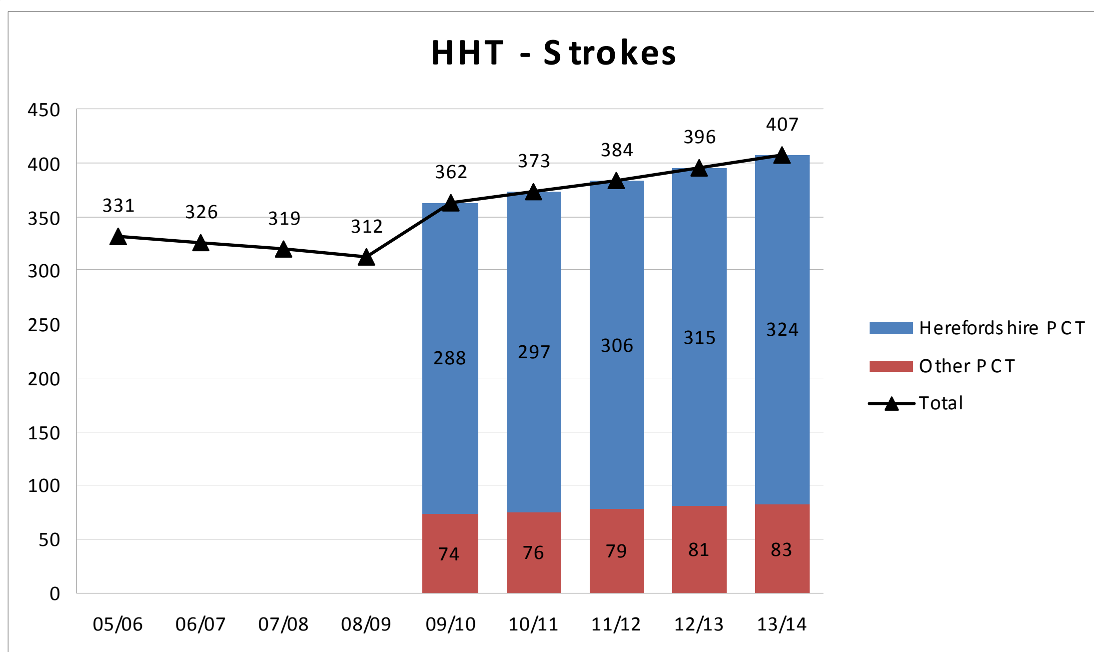
HEREFORD HOSPITALS NHS TRUST
UPDATE REPORT
JULY 2010

1) Introduction

This report provides committee members with an update on Stoke Services as agreed at the last meeting dated 18th June 2010.

2) Stroke Services

Stroke is the third main cause of death and the fourth major cause of hospital admissions in Herefordshire. Prevalence of stroke or transient ischemic attack (TIA) is more common amongst Herefordshire's GP patients (2.2% have experienced an incident) than those across England (1.7%). Despite the higher prevalence, the rate of deaths from stroke has fallen more rapidly in Herefordshire than nationally over recent years, from 76 per 100,000 people in 2000-02 to 50 in 2006-08. Taking differences in age structure into account, cerebrovascular disease mortality in Herefordshire is now lower than the West Midlands region (51), and is getting closer to England's rate of 47. Within Hereford Hospitals NHS Trust the HSMR (adjusted mortality) has fallen from 125.1 in 2008/09 to 97.3 in 2009/10. This represents a significant change from above average to better than average.
However, the incidence of stroke in Herefordshire is still expected to increase over the next few years as shown below:



This is supported by the fact that this year from January to June 2010 we have already had 198 admissions with Stroke.
Over the last year (2009/10) we made a number of improvements to Stroke Services in the hospital but there is still significant room for further work.

Staffing

There has been investment in staffing on the Stroke Unit since December 2009 which has resulted in higher levels of nursing and therapy staff. In addition the Stroke Association has provided for a full time specialist Stroke Physiotherapist, whose role also includes assessment of patients in A&E.

CT scan

The percentage of patients receiving a CT scan within 24hrs have improved to 76% in February 2010 but we aim to reach 100% this year. CT scans are available 24 hrs a day. A subgroup of patients, those who may be eligible for thrombolysis, need CT within 1 hr of admission which we have had difficulty achieving. This has been identified as an issue by the West Midlands Quality Review Service and an action plan has been put in place to ensure we meet this goal, together with the introduction of a daily monitoring system to assure us of this and allow investigation of any cases where it is not achieved.

Thrombolysis

Thrombolysis (clot busting drugs) were received by 2.5% (5) of the 198 patients so far this year.
Of the others:

- 47% (98) patients were excluded by age
- 23% (46) were excluded by time of onset of symptoms
- 9% (18) patients excluded because of haemorrhage or warfarin therapy
- 6% (11) patients were admitted out of hours
- 10% (20) patients excluded for a variety of other clinical reasons

Of the 11 patients admitted out of hours some might have been eligible for thrombolysis; the improved arrangements to ensure rapid scanning will help to identify these. As we only have one specialist Stroke Physician we are looking at how to support this decision making when he is not available; it is important that the decision is properly made as the treatment does carry risks if used inappropriately.

Rehabilitation

A Business Case has been developed together with Herefordshire Provider Services as part of the Service Integration Project to introduce a Stroke Rehabilitation service for the county; within that is provision for additional specialist Consultant Support to facilitate both acute stroke care decision making and rehabilitation. The case is going to the commissioners this month.

TIAs

The expected standard is that 60% of high risk Transient Ischaemic Attack patients receive a CT scan within 24 hrs and also seen by a clinician to advise and consider any treatment as a number of these may go on to develop preventable strokes in the future. We have clinic slots available but are not meeting this standard. The Medical Director of HHT has asked the Medical Business Unit to put into place facilities to allow daily access to this service, Mon to Fri, with additional clinical support from the neurology consultants. Neighbouring hospitals are also not yet able to met this target 7 days a week; we are looking at ways to extend the service by using protocols and using other Consultants to support the Stroke Consultant.

Stroke care pathways

One of the key objectives of the service integration project is to put in place, during the course of the year, five care pathways, one of which relates to Stroke. Once delivered, this will ensure that care is delivered on a consistent seamless basis in line with all key quality standards.

Martin Woodford
Chief Executive
Hereford Hospitals NHS Trust

DELAYED TRANSFERS OF CARE

1. INTRODUCTION

The Committee requested a briefing on delayed discharges. The key performance indicator NI131 and health check Vital Signs consistently failed to achieve the target in 2009/10. The purpose of this report is to update the committee on the action plan that is in place to improve the performance.

2. HISTORY

High quality care involves patients being cared for in the right place, by the right person, at the right time. The delay of their transfer to the next care setting has an impact on the quality of care they receive and the potential for others to receive the right care in the right place.

A vital sign target was set to monitor delays in transfers. The target is the *Number of delayed transfers of care per 100,000 population (aged 18 and over).*

This is calculated from an average weekly figure that is reported across the health and social care economy at a given point in time. The delays are defined as patients that are unable to transfer to their next care setting. There are a preset number of reasons to report the delays.

The target is the total delays reported at HTT and Provider Arm (community hospitals and inpatient mental health). This vital sign has a locally set target. The target for 2009/10 was an average of 30 delays per week. The target for 2010/11 is 27.

3. CURRENT POSITION

Delayed discharges are measured through Health Check Vital Signs and NI131. The year to date average is currently at 50 against a target of 27..

The target was consistently unmet throughout 2009/10. There have been a number of initiatives that have been implemented to improve performance. Two social workers have been employed to work directly in community hospitals to assist with complex discharges, continuing health assessment training has been provided to nurses working within the community hospitals and a policy has been developed and ratified to support the transfer of patients from an inappropriate care setting, where their refusal is causing delays.

There remain a substantial number of delays across the health and social care economy economy. The most common response for delays from HHT is the availability of community hospital beds. The community hospital and mental health delays are due in the main to *waiting for assessments* and panels to be completed. The assessments include Continuing Care, onward packages of care, nursing home etc.

4. ACTION PLAN

Historically individual providers have reported and managed the delays in transfers. It is clear that reasons being reported for transfer delays often relate to system wide issues and therefore system wide solutions. Integrated working between providers and commissioners has led to some fundamental whole system changes. Although some of the initiatives are in the early stages of development there are some positive signs of improvement.

1. **Daily monitoring of delays has to be established across providers**:
   This has been achieved and is facilitating a focused approach to reporting discharges, implementation of policies and the appropriate frequency of decision making processes such as panels.

2. **System wide bed management process has been developed between providers:**
   HHT have developed a predicative tool for bed management and it has been implemented across the health economy.

3. **Repetition of assessments between health and social care has to be avoided:**
   There are delays due to the repetitive assessment of patients. This has an obvious impact on capacity and is being reviewed.

4. **Review of panels and the benefit of joint panels:**
   There are several panels that determine a person's eligibility for care. One panel can refer to another panel which has an impact on the overall length of stay and considerably delay transfers.

5. **Review of policy:**
   There is evidence to suggest that policies are not being implemented. There are transfer delays recorded as patients refusing to go to particular community hospitals or waiting for a bed to be available in a nursing home of their choice. The policy is being reviewed to ensure it covers recent regulations and whether it is being implemented effectively.

6. **Monitoring of readmission rates to ensure appropriate transfers:**
   The reduced length of stay and emphasis on bed management can lead to an increase in readmission rates. This is being monitored.

7. **Accountability for the system wide target to be established**:
   The continued work to develop improved discharge planning and therefore a reduction in delayed discharges forms part of the work of the urgent care work stream. The vital sign target will form part of the performance management and therefore will be monitored within that group.

5. CONCLUSION

There is a commitment across the health and social care economy to improve delays in transfers of patients to an appropriate care setting. The development of a system wide bed management system will facilitate a more focused approach to monitoring the delays and the implementation of policies will support a culture of providing high quality care in the right place at the right time. There does however have to be recognition that the complexity of need together with a significant decrease in length of stay in hospital care means that a whole system approach has to be maintained and effective discharge planning has to commence on admission.

SUE DOHENY
DIRECTOR OF QUALITY & CLINICAL LEADERSHIP

***Equity & Excellence: Liberating the NHS* Government White Paper**
Briefing Paper

Key Elements from the White Paper

1. The paper, signalling the single largest re-organisation of the NHS in its history, is centred on the following key principles

    - Putting patients and the public at the heart of the NHS
    - Improves quality and healthcare outcomes
    - Gives greater empowerment to health professionals whilst improving accountability and democratic legitimacy
    - Reduces bureaucracy and improves efficiency

2. Key proposals are summarised below. ***It is important to note that the proposals are consistent with the vision and direction of travel being followed in Herefordshire***. They also place a clear emphasis on the enabling of joint working and integration between local authorities and the health system in planning commissioning and delivering services as well as holding the health and social care system to account locally.
3. The full document, and consultation documents as they are published, can be found at the following link: http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm

    Commissioning
    - GP commissioning will operate on a statutory basis, with commissioners' powers and duties enshrined in legislation.
    - All GP practices are to become part of a consortium. Consortia will need to have sufficient geographical focus to take responsibility for agreeing and monitoring contracts for locality based services such as urgent care, services for those people not currently registered with a GP and to commission services jointly with local authorities.
    - Consortia will have responsibility for managing the combined commissioning budgets of their member practices to improve healthcare and health outcomes, and will be accountable to the NHS Commissioning Board for managing public funds.
    - A comprehensive system of GP consortia in shadow form is expected to be in place by 2011/12. The consortia will then begin to assume commissioning responsibility in the following year before taking full responsibility from 2013/14.
    - A newly created NHS Commissioning Board (NHSCB) will commission GPs and family health services (dentistry, pharmacy and primary ophthalmic services); specialised services and maternity services. In addition to responsibility for ensuring the development of GP consortia the NHSCB will:
        - set commissioning guidelines, based on clinically approved quality standards, in a way that promotes joint working across health public health and social care
        - promote and extend public & patient involvement & choice
        - be responsible for allocation and accounting for NHS reserves
    - The NHSCB will be in shadow form from April 2011 as a special health authority before becoming a statutory body in April 2012.
    - Both Monitor and the NHSCB will ensure that competing to provide services is a fair and transparent process.
    - Commissioners will be free to buy services from any willing provider.

- Monitor will be able to allow transparent subsidies where these are "objectively justified and agreed by commissioners."

Risk pooling

- The white paper stipulates that current risk pooling arrangements will migrate away from SHAs.
- Monitor will be able to authorise special funding arrangements to ensure that essential services can be maintained in circumstances where they would usually have become unviable. Providers may be asked for contributions towards a risk pool by Monitor.
- GP consortia will be required to take part in risk pooling arrangements, overseen by the NHSCB.

Future of providers

- All NHS trusts will be part of or become foundation trusts (FTs) by 2013, with the abolition of the NHS trust model
- New FT models with staff-only membership (social enterprise) are intended for community FTs, but not limited to them.
- The white paper contains a clear commitment that FTs "will not be privatised."
- Consultation proposed on increasing FT freedoms including:
  - abolition of the cap on income that can be earned from other sources
  - enabling FTs to merge more easily
  - enabling FTs to tailor their governance to local needs.
- DoH will assume responsibility for provider development.
- Community services will operate under the Any Willing Provider ethos.
- Monitor takes over responsibility for regulating all NHS providers from April 2013, irrespective of status.
- Commissioning will be separate from provision by April 2011.
- Special arrangements will be made for three high secure psychiatric hospitals to benefit from FT status.

Regulation and inspection

- The white paper stipulates a stable, transparent and rules based system of regulation
- The Care Quality Commission (CQC) will have "a clearer focus on the essential levels of safety and quality of providers." It will inspect providers with a "targeted and risk-based" approach in accordance with those levels.
- CQC and Monitor will deliver a joint licensing regime, to cover essential levels of safety and quality and ensure continuity of essential services.
- Monitor as economic regulator for both health and social care will:
  - promote competition and concurrent powers with OFT to apply competition law. Powers apply to privately and publicly funded health and social care services
  - regulate pricing but only "where necessary" and with flexibility between 'efficient' and/or 'maximum' price. Monitor's powers to regulate pricing only relate to publicly funded health services
  - have responsibility for FT continuity of service – "continued access to key services in some cases"
  - authorise "special funding arrangements for essential services that would otherwise be unviable" (with agreement of NHSCB and subject to rules on state aid)
  - have powers to intervene directly in the event of failure.

- There is reference made to enforcing competition law. Monitor will be able to undertake market studies and refer structural problems to the Competition Commission.

Efficiency and bureaucracy

- The Government acknowledges that the cuts in administrative costs represent an "important but modest contribution" to the overall NHS efficiency drive.
- NHS management costs will be reduced by more than 45 per cent over the next four years.
- Strategic health authorities will be abolished by 2012/2013.
- Tight cost reduction will apply to centrally managed DH programmes.
- Other potential cost cutting solutions include: the forthcoming review of arms length bodies; NHS services increasingly empowered to be "customers of a more plural system of IT and other suppliers"; a reduction in the regulatory burden; and energy efficiency and sustainability.
- Existing providers will be freed from central and regional management and they will be supported by a system of economic regulation, overseen by Monitor.
- GP consortia will align clinical decisions in general practice with the financial consequences of those decisions.
- There is a commitment that the QIPP programme "will continue with even greater urgency" and it is hoped that SHAs and PCTs will devolve leadership of this agenda to GP consortia and local authorities as soon as practicable.
- The DH will place requirement on SHAs and PCTs to ensure rigorous financial control over the transition period, supported in this task by Monitor.
- Best practice pricing, increased use of quality incentives and a move away from average cost prices, will be an important feature of the new system.

Quality and outcomes

- The document reaffirms the Government's commitment to hold the NHS to account "against clinically credible and evidence-based outcome measures."
- The new NHS Outcomes Framework will include national outcome goals, chosen by the Secretary of State (following consultation), with the NHSCB held accountable for attainment. A further consultation document on the draft framework was published on 19th July.
- GP consortia will have a commissioning outcomes framework, which should "create powerful incentives for effective commissioning."
- The National Institute for Health and Clinical Excellence (NICE) will develop quality standards for the NHSCB, with 150 different standards ultimately expected. The library of standards should be "reflected in commissioning contracts and financial incentives."
- The NHSCB will be responsible for a payment system structure, with the economic regulator looking after pricing.
- Current Payment by Results tariffs will be refined, with the introduction of best practice tariffs to be accelerated. The DoH will evaluate the scope for a benchmarking approach.
- Commissioners will be able to pay a quality increment if providers deliver excellent patient care in line with commissioner priorities.
- CQUIN will be extended to support local quality improvement goals.
- Commissioners will be enabled to impose penalties on providers delivering substandard care.
- A "single contractual and funding model to promote quality improvement" will be developed.

- The Cancer Drug Fund will come into operation from April 2011. Value-based pricing for NHS medication will be introduced once the current scheme expires.

Choice and control

- From April 2011, patients will be able to choose their consultant-led team for elective care where clinically appropriate.
- Choice will be extended to include mental health providers from April 2011, and for diagnostic testing and choice post-diagnosis from 2011 onwards.
- Patients will be able to choose a GP practice (with an open list), not limited to where they live.
- A consultation on choice of treatment is expected later in 2010, including “potential introduction of new requirements on providers, and collecting and publishing information on whether this is happening to support patients."
- Patients will have choice of treatment and provider for most NHS-funded services no later than 2013/14.
- A single number for all types of urgent and social care will be established and technology developed to help people communicate with their clinicians.
- A further tranche of Personal Health Budget (PHB) pilots will be encouraged with general roll out informed by evaluation in 2012.This includes the potential for introducing PHBs for NHS continuing care.
- The Government has confirmed there will be no bail-outs for organisations that overspend public budgets.

Public health

- A Public Health Service will be established, encompassing the existing health improvement and protection bodies and responsibilities.
- Local authorities will assume the responsibilities for local health improvement currently held by primary care trusts. While the Public Health Service will set national objectives for improving population health, local authorities will have the freedom to determine the means by which these are achieved.
- Directors of Public Health (DPHs) will be jointly appointed by the Public Health Service and local authorities. They will be given control over ring-fenced public health budgets in their local area.
- A ‘health premium’ will be introduced, aimed at alleviating health inequalities.
- A separate Public Health White Paper is due for publication later this year.
- Health and Wellbeing Boards will be created within local government in an attempt to coordinate commissioning of NHS services, social care and health improvement. The local boards will replace existing Health Overview and Scrutiny functions and be responsible for promoting integration and partnership working across health & social care, leading joint strategic needs assessments and promoting collaboration on local commissioning plans.

Social care

- The Department of Health will establish a commission on the funding of long term care and support to report within one year. A white paper is then expected in 2011, with the aim of introducing legislation in October 2011

Workforce

- The Government advocates allowing all employers the right to determine their own pay levels. However it acknowledges that many providers will wish to utilise national remuneration contracts.
- The DoH will take more of a back seat role in relation to education and training, with employers agreeing plans and resources for workforce

development with their staff. Healthcare professions at both a local and national level will assume leadership for education commissioning.
- The review of public sector pensions chaired by Lord Hutton will examine issues including labour market mobility and the potential impact upon plurality of provision, alongside affordability and sustainability.

Mental health

- Choice of both treatment and provider will be extended into some mental health services from April 2011.
- The importance of decision aids to enable effective patient choice is particularly acknowledged for mental health and community services.
- A set of Payment by Results 'currencies' for adult mental health services will be introduced from 2012/13. There are also plans to develop currencies for child and adolescent services.
- Payment mechanisms to support the commissioning of talking therapies will be formulated.
- An assurance is made that the criteria utilised within the NHS Outcomes Framework will ensure that mental health outcomes are included.
- The NHSCB will take responsibility for commissioning some specialist mental health services.

Information revolution

- The white paper includes a focus on the publication of "comprehensive, trustworthy and easy to understand information" from a range of sources.
- Patient Reported Outcome Measures (PROMs), patient experience data and real-time feedback are all expected to be utilised more frequently in the future. Patients will have the opportunity to rate services and specific clinical departments.
- National clinical audit will be broadened out across a larger range of treatments and conditions.
- Quality Accounts will be revised in an attempt to enhance local accountability. The White Paper also states all providers of NHS care will have to publish accounts from 2011, subject to evaluation.
- Hospitals will be required to be open about mistakes and to always inform patients of errors made with their care.
- A consultation on health records will be held later in 2010 to determine the appropriate confidentiality safeguards. Records will be made available in a standardised format, with patients enabled to provide access to third parties if they wish to.
- The virtues of a voluntary accreditation system will be examined, which would allow organisations to apply for a quality standards kite mark.
- The Information Centre will have an enhanced role, with centralised data returns and the responsibility for reviewing existing data collections.
- Clear contractual obligations around accuracy and timeliness of data will be placed on providers. Compatibility of data among both providers and commissioners is paramount.
- There will be a consultation on the information strategy in autumn 2010.

Patient and public engagement

- The NHSCB is to act as a champion for patient and carer involvement.
- HealthWatch England will sit inside the Care Quality Commission. LINKs will become the local arms of HealthWatch and will be both funded by and accountable to local authorities.

- Local HealthWatch and HealthWatch England will play crucial roles in providing advocacy and support and within the complaints procedure.
- Local HealthWatch will also be empowered to recommend investigating services deemed to be inadequate.

Further consultation

4. Further, more detailed, consultation documents are expected to be issued in the coming days; the first of these *Transparency in Outcomes – a Framework for the NHS* was published on 19th July. It proposes a framework developed around five outcome domains:
    a) Preventing people from dying prematurely
    b) Enhancing quality of life for people with long term conditions
    c) Helping people to recover from episodes of ill health or injury
    d) Ensuring people have a positive experience of care
    e) Treating and caring for people in a safe environment and protecting them from avoidable harm.

5. The development of the framework will be guided by the following principles:
    - Accountability & transparency
    - Balance
    - Focus on what matters to patients and healthcare professionals
    - Promotion of excellence & quality
    - Focus on outcomes the NHS can influence, but working in partnership with other public services where required
    - Internationally comparable
    - Evolving over time

6. Two further documents were published on 22nd July: *Local Democratic Legitimacy in Health*, which provides further information on the proposals for increasing democratic legitimacy through a clear and enhanced role for local government; and *Commissioning for Patients*, which provides further information on intended arrangements for GP commissioning, and the role of the NHS Commissioning Board.

7. Consultation on all three documents runs until 11th October 2010.

8. A further consultation document will cover freeing providers and economic regulation. It should also be noted that related proposals, such as a White Paper on Public Health, and proposals on the future funding of social care will be published in the autumn.

Responding to the proposals

9. The Department of Health is carrying out a series of consultation activities with patients and the public, NHS staff, local government and the voluntary, social enterprise and third sectors. However, it will be important for Herefordshire to provide a response to both the proposals in the White Paper and the more detailed consultation documents that flow from it. Whilst not precluding responses from individual organisations or groups in the county, there is considerable value to be gained from NHS Herefordshire demonstrating its leadership of the local health economy through co-ordinating a partnership response to the consultations.

10. It is suggested that a local event be scheduled for the autumn, to draw together views from a range of partners across health and social care and to shape a distinctive Herefordshire response.

11. As importantly as responding to the consultations, the implications, both positive and negative, of the proposals for the key change programmes in Herefordshire will be assessed over the next few weeks. This will include (not exhaustive):

- Developing the Integrated Care Organisation
- The work of the Health & Social Care Commissioning Board
- The overall transformation programme
- Shared Services Project
- Workforce development matters

12. These and other matters will be discussed within the Joint Management Team and other forums over the coming weeks. A further report will be brought to Leader's Briefing and the informal NHS Herefordshire Board meeting in September. It is also proposed to report to the HPS Steering Group in September. This briefing is also being made available to the relevant scrutiny committees.

Conclusion

13. As noted above, the proposals in the White Paper are consistent with the vision for Herefordshire, and supportive of our aims to achieve improved health services and outcomes, as well as better value for money, whilst putting people at the heart of what we do.

14. We will lead a local debate to ensure that we develop a distinctive Herefordshire response to the White Paper. We will also ensure that the potential implications of the White Paper for our major change initiatives are assessed and managed appropriately.

15. The Board and Cabinet Members will be kept up to date with developments relating to the White Paper over the coming weeks, and a summary of this briefing will also be made available to all elected members.

MEETING:	HEALTH SCRUTINY COMMITTEE
DATE:	2 AUGUST 2010
TITLE OF REPORT:	WORK PROGRAMME
REPORT BY:	COMMITTEE MANAGER (SCRUTINY)

CLASSIFICATION: Open

Wards Affected

County-wide.

Purpose

To consider the Committee's work programme.

Recommendation

THAT subject to any comment or issues raised by the Committee the Committee work programme be approved and reported to the Overview and Scrutiny Committee.

Introduction and Background

1. The Overview and Scrutiny Committee is responsible for overseeing, co-ordinating and approving the work programmes of the Committee, and is required to periodically review the scrutiny committees work programmes to ensure that overview and scrutiny is effective, that there is an efficient use of scrutiny resources and that potential duplication of effort by scrutiny members is minimised.
2. The work programme may be modified by the Chairman following consultation with the Vice-Chairman and the Director in response to changing circumstances. A copy is attached at appendix 1.
3. Should any urgent, prominent or high profile issue arise, the Chairman may consider calling an additional meeting to consider that issue.
4. Should Members become aware of any issues they consider may be added to the scrutiny programme they should contact the Directorate Services Officer (Health) to log the issue so that it may be taken into consideration when planning future agendas or when revising the work programme.

Progress in response to recommendations made and issues raised by the Committee

5. A note showing progress in response to recommendations made and issues raised by the Committee at the Committee's previous meetings is attached at appendix 2.

Further information on the subject of this report is available from
Tim Brown Committee Manager (Scrutiny) on 01432 260239

Background Papers

- None identified.

Health Scrutiny Committee Work Programme 2009/11

The agenda will be based on:

- Quarterly Updates – Service Development
- Statutory Business including consultations
- Quality Assurance and Public Engagement
- Population Health and Equalities

20 September	
	• Updates from Chief Executives (including full performance Update) • Ambulance Service Review Update (including Community First Response Manager) • Patient Transport Management (if any issues raised in LINk report being prepared on this issue) • Quality assurance • World Class Commissioning • Population Health – improving people's diet and taking up exercise. • Updated Response from Director of Regeneration to Scrutiny Review of GP Services • Examination of Response to swine flu
22 November	
	• Follow up points from previous meetings and "need to know" information from Health Trusts. • Population health – Access to health services in a rural County (including dental health) • World Class Commissioning • Mental Health Procurement Update
21 January	
	• Updates by Chief Executives of Health Trusts • Population Health - health and wellbeing of older people • World Class Commissioning • Update on response to Scrutiny Review of GP Services
18 March	
	• Follow up points from previous meetings and "need to know" information from Health Trusts. • World Class Commissioning • Population Health – Issues relating to housing

Appendix 2

Progress in response to recommendations made and issues raised by the Committee

Date	Item	Resolution	Commentary
1 March 2010		**Additional Actions** **Clarification as to why 17% of respondents found it difficult to access GP Services.** **Requested consideration be given to retaining the temporary equitable access provision at South Wye when the permanent Centre at the hospital site was open.**	Briefing note to be provided The Director of Public Health acknowledged that it would be worth exploring the pattern of use of the temporary provision and other health facilities.
1 March 2010	Quality Assurance Framework	**a seminar be arranged on Quality Accounts; and** **further report be made when timely, within six months, reviewing quality performance and highlighting any areas of concern.**	Informal meeting held on 20 May Report scheduled for September 2010.
1 March 2010	Provider Services Integration	**mindful of the significance of the proposed change it was requested that the Committee be kept fully informed of progress in addition to being formally consulted.** **the importance of ensuring services were tailored to localities be emphasised.**	Report Scheduled for July 2010

Appendix 2

Date	Item	Resolution	Commentary
1 March 2010	Hereford Hospitals NHS Trust Update	**That the full updates to the Committee incorporate performance against all relevant indicators in the corporate plan**	Request made.
		Additional Actions **Requested that a more user friendly name be used for the Equitable Access Centre.** **Briefing note requested on Hospital standardised mortality ratios setting out actual numbers of cases to put the ratios in context.**	 To be considered. Briefing note circulated 14 May 2010.
29 March 2010		**That** **(a) a further report be made in six months time reviewing performance against targets including comparative information for the West Midlands Region and a more detailed breakdown showing by what margin targets were being missed, and also providing information on patient outcomes;** **(b) a report be provided to the Committee on the Community First Responder funding plan and communication links with Community First Responders and the Community Response Manager be invited to attend the meeting;**	Report scheduled for September 2010

Date	Item	Resolution	Commentary
		(c) the Committee be advised of the amount and nature of cross-border work with the Welsh Ambulance Service and the extent to which this was reciprocated. **(d) an update be requested from Hereford Hospitals NHS Trust on performance against the target for ensuring all emergency ambulance arrivals are accommodated safely in the hospital; and** **(e) the invitation from WMAS to visit the Emergency Operations Centre at Dudley be accepted.**	
29 March 2010	World Class Commissioning	**That mindful of the significant changes proposed, for example the scale of the transfer of activity from the secondary sector to the primary sector and community services, regular updates on the World Class Commissioning Strategy be provided to the Committee describing progress and providing evidence of the degree of change and its effectiveness.**	Updates Scheduled in Work Programme
18 June 2010	Suggestions from Members of the Public	**Agreed to add the provision of dental services to the work programme.**	Issue to be included in population health report on access to services in November 2010.

Appendix 2

Date	Item	Resolution	Commentary
18 June 2010	Response to Scrutiny of General Practitioner (GP Services)	**That** **the response to the findings of the scrutiny review of GP services be noted subject to the Director of Regeneration being invited to reconsider and strengthen his response on rurality and transport co-ordination;**	Meeting of Chairman and Vice-Chairman to be scheduled with Regeneration Directorate to discuss updated response.
		(b) the Local Medical Committee be invited to comment on the response by NHS Herefordshire to the Review;	Secretary to the Local Medical Committee has commented that in his view the responses of NHS Herefordshire are on the whole fair and reasonable and would have the support of GPs.
		(c) a further report on progress in response to the review be made in six months time with consideration then being given to the need for any further reports to be made;	Report Scheduled for January 2011.
		(d) The Valuing People Partnership Board should be asked to comment on its evaluation of the outcomes for adults with learning disabilities from the Learning Disability Locally Enhanced Service incentive scheme;	Information being sought.
		(e) a glossary be prepared of the various boards in the County with responsibility for considering health and social care matters; and	Information being sought.

Date	Item	Resolution	Commentary
		(f) the next quality report should include information on the numbers using the Equal Access Medical Centre and also report on the effects on use of GP surgeries and the out of hours service.	Report Scheduled for September 2010.
18 June 2010	Mental Health Procurement Project	**That (a) progress on the Mental Health Procurement Project be noted; and** **(b) a further report be made to the Committee in November 2010 setting out how the new arrangements will improve services and benefit service users and their carers and deliver value for money.**	Report scheduled for November 2010.
18 June 2010	NHS Herefordshire Update	**RESOLVED: That updates be provided on delayed transfers of care and Stroke services.**	Included in interim updates for 30 July.