HEALTH SCRUTINY COMMITTEE

TUESDAY 16TH JULY, 2013

AT 6.00 PM
IN COMMITTEE ROOM 2
AT THE COUNCIL HOUSE
DUDLEY

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

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Dudley
Metropolitan Borough Council

IMPORTANT NOTICE

MEETINGS IN DUDLEY COUNCIL HOUSE

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Directorate of Corporate Resources

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

Your Ref:	Our Ref:	Please Ask For:	Telephone No:
	160713/MJ	Mrs M Johal	01384 815267

8th July 2013

Dear Member

Meeting of the Health Scrutiny Committee

You are requested to attend a Meeting of the Health Scrutiny Committee to be held on Tuesday 16th July, 2013 at 6.00pm, in Committee Room 2 at the Council House, Dudley to consider the business set out in the agenda below.

Please note that it is proposed that an informal development session be held at the conclusion of the formal business.

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

Yours sincerely,

Director of Corporate Resources

A G E N D A

1. APOLOGIES FOR ABSENCE

   To receive apologies for absence from the meeting

2. APPOINTMENT OF SUBSTITUTE MEMBERS

   To report the appointment of any substitutes for this meeting of the Committee.

3. DECLARATIONS OF INTEREST

4. MINUTES

To approve as a correct record and sign the minutes of the Meeting of the Health and Adult Social Care Scrutiny Committee held on 27th March, 2013.

5. TERMS OF REFERENCE, ANNUAL SCRUTINY PROGRAMME AND WORK PROGRAMME 2013/14 (PAGES 1 - 9)

To consider a report of the Lead Officer and the Director of Corporate Resources

6. FORWARD PLAN OF KEY DECISIONS (PAGES 10 – 14)

To consider a report of the Director of Corporate Resources.

7. PRIMARY CARE DEVELOPMENT STRATEGY (PAGES 15 - 49)

To consider a report of the Dudley Clinical Commissioning Group

8. MATERNITY UPDATE (PAGES 50 – 51)

To consider a report of the Dudley Group of Hospitals.

9. MORTALITY RATES – UPDATE

To consider a verbal report of the Dudley Group of Hospitals.

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

To:- All Members of the Health Scrutiny Committee, namely

Councillors:-

Billingham	**Cotterill**	**Harris**	**Hemingsley**
Jordan	**Kettle (Vice-Chair)**	**Nicholls**	**Ridney (Chair)**
Roberts	**Mrs Rogers**	**Mrs Walker**	

HEALTH AND ADULT SOCIAL CARE SCRUTINY COMMITTEE

Wednesday 27th March, 2013 at 6.00 p.m.
in Committee Room 2 at the Council House, Dudley

PRESENT:-

Councillor Ridney (Chair)
Councillor K Finch (Vice-Chair)
Councillors Cowell, Elcock, Harris, Hemingsley, Kettle, Mrs Rogers, Vickers and C Wilson

Officers

Assistant Director of Law and Governance (Lead Officer to the Committee), Head of Service (Private Sector Housing), Head of Service and the Scrutiny Officer (Directorate of Adult, Community and Housing Services) and Mrs M Johal (Directorate of Corporate Resources)

Also in Attendance

Councillor Waltho – Cabinet Member for Adult and Community Services
Ms Laura Broster – Head of Communication, Dudley Clinical Commissioning Group
Mr Derek Eaves – Dudley Group of Hospitals NHS Foundation Trust
Ms Mandy Green – Communications Manager (Dudley and Walsall Mental Health Partnership NHS Trust)
Mr Howard Finegan – Primary Care Project Manager
Dr Paul Harrison – Medical Director
Mr Paul Maubach – Dudley Clinical Commissioning Group

37 APOLOGY FOR ABSENCE

An apology for absence was received on behalf of Councillor Roberts.

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38 MINUTES

RESOLVED

That the minutes of the meeting of the Committee held on 26th February 2013 be approved as a correct record and signed.

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39 PUBLIC FORUM

(a) Kate's Hill Surgery

The Chair referred to a question that had been submitted to the Castle and Priory/ St James's/St Thomas's Community Forum at its last meeting, which had subsequently been referred to this Committee for consideration. The questioner was not in attendance and the Chair reported that the questioner had referred to the decision made on the closure of Kate's Hill Surgery and had commented that it would consequently lead to the dispersal of 1500 residents and had posed the following two questions:-

(1) Has the Health Scrutiny Committee done enough to look after the rights of residents to continuity of care and quality care?

(2) What is the Council doing to specifically defend the health of residents in this very needy ward?

Mr Howard Finegan, Primary Care Project Manager was in attendance and explained that the Practice would close the following day. The list size at the Practice had only reached approximately half the contracted levels and this had resulted in financial difficulties for the Provider following the ending of minimum income guarantees after year two of the contract. The Commissioner and Provider had been in discussions for several months to explore alternatives to an early end to the contract. Any significant change to the original Financial Model Template fell outside what the Commissioner was able to achieve, therefore an alternative to the termination of the contract was not available.

Mr Finegan stated that it was with great regret that the Provider gave notice that they would not be able to continue with the service beyond March 2013 due to financial difficulties. The Commissioner accepted the notice and the parties agreed to work together through a suitable Exit Plan. Talks between the Provider and Commissioner were conducted confidentially until early January 2012 when patients and staff were notified of the closure. Confidentiality was requested by the Provider on the basis that to do otherwise would destabilise the Practice. The Commissioner consulted internally during this period regarding the impact of termination of contract at the end of year three and sought legal advice throughout and due consideration had been made to procurement law and full consideration had been given to the issues around displaced patients.

The small list size at the Practice (1431 at the start of January 2013) meant that it had not been viable to go to the market, a formal tender was therefore not appropriate. This had been based on a number of factors such as the fact that a tender exercise would have been based on a far less favorable Financial Model Template. A proposal to disperse patients had been accepted by the FHS Functions Committee in January 2013 following submission of a report that detailed the options and the capacity of other local Practices. Listed patients had been written to on three separate occasions, explaining the closure and offering further advice and support to patients seeking an alternative listing. There were three other Practices within a very short distance of the Kate's Hill Site, each with capacity and desire for an increase in their own list sizes and these Practices had been consulted over the closure.

Mr Finegan then presented statistical information in that the list size comprised 1431 patients as at 29th January, 2013 and of the 1431 patients, 454 came to the Practice from the three other local Practices over the three years. Less than two thirds (886 or 62%) of the total number of patients came to the Practice from other Dudley Practices (including those from local Practices). The remaining patients (545) on the list came to the Practice from out of the area.

The Commissioner had not conducted any recent analysis of the local / out of area distribution of the patients currently remaining on the list however, previous experience had led to the belief that patient dispersal accelerated in the remaining weeks and days of a contract. As at 21st March, 2013 approximately 500 patients had moved from the Practice. The Commissioner and Provider had liaised closely throughout this process to minimise any identified risks and the Commissioner would continue to provide information and support to those patients who had yet to approach an alternative General Practitioner Practice.

Members expressed concern at the late submission of this item to the Committee and suggested that in future proposals or decisions such as this be submitted to the Committee in sufficient time to allow proper scrutiny to take place. It was also suggested that an update report on this issue be submitted to the next meeting of the Committee. It was requested that the report should detail information on the strategic care of people in that area and statistics to show that their health had not suffered and also show any improvements in their health.

The Chair indicated that a written response would be submitted to the questioner.

RESOLVED

(1) That the Scrutiny Officer be requested to provide a written response to the questioner.

(2) That an update report on the strategic care, to include information on whether the health of people in the St Thomas's area had suffered or improved since the closure of the Practice, be submitted to the next meeting of the Committee.

(b) <u>The Future of New Bradley Hall</u>

Mr Mac Scott was in attendance at the meeting and spoke on the future of New Bradley Hall.

He stated that he had previously raised the issue at a meeting of the Council in November, 2011. At the meeting of the Cabinet held in June 2012, the decision was made that New Bradley Hall should remain open as a residential care home for long term residents for the duration of their stay for current residents and for the foreseeable future and that a Stakeholder Working Group comprising Members of

both political groups and other stakeholders be set up to consider the full range of the wider implications for all older people in the Borough. Mr Scott indicated that only one official meeting of that Working Group had been held last year and he asked the Committee what proposals they had considered for the future of New Bradley Hall for the foreseeable future.

In responding the Cabinet Member for Adult and Community Services reported that he had supported the decision for New Bradley Hall to remain open. He referred to the Stakeholder Working Group and indicated that this had been an information gathering exercise and he commented that he had hoped that elderly vulnerable residents would have attended that group to ascertain their views. Following the Stakeholder Working Group meeting the information was considered and discussions had been held with Mr Scott and it had been agreed that a conclusion on the matter be deferred pending consideration of the Council's budget. Since then a Cabinet Advisory Meeting had been held and consideration was being given to a possible range of options. Reference was made to "foreseeable" and the Cabinet Member stated that this would be a couple of years and a guarantee was given that consideration was being given to various options.

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40 PRESENTATION ON MORTALITY INDICATORS

A presentation regarding the recent announcement by the National Health Service Medical Director to review fourteen Trusts with historically high mortality indicators and mortality indicators appertaining to the Dudley Group was received.

Arising from the presentation of the report Dr Harrison undertook to provide figures on the percentage of patients at Russells Hall from across the Borough with terminal conditions that had died at home.

A Member suggested that the outcomes and recommendations, as contained in Chapter Six of the Francis Report on Mortality Indicators, be included as an agenda item to the next meeting of the Committee.

RESOLVED

That the presentation given on the recent announcement by the National Health Service Medical Director to review fourteen Trusts with historically high mortality indicators and mortality indicators appertaining to the Dudley Group, be noted.

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41 DIGNITY IN CARE REVIEW – FOLLOW UP

A report of the Lead Officer to the Committee together with information from the Dudley Group National Health Service Foundation Trust was submitted arising from the Committee's 2010/11 review on the theme of Dignity in Care in hospital settings.

RESOLVED

That the information contained in the report, Appendices to the report submitted and presentation given, arising from the Committee's 2010/11 review on the theme Dignity in Care in hospital settings, be noted.

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42 UPDATE ON SERVICE IMPROVEMENT PLANS FOR PATIENTS WITH DIABETES

A report of the Head of Service Improvement, Dudley Clinical Commissioning was submitted on the role of Clinical Commissioning Groups (CCGs) in ensuring people with diabetes and those at risk of diabetes received the best care and support available.

Arising from the presentation of the report and in responding to Members' questions, it was reported that prevention work was utmost and information was communicated via posters, websites and various booklets. Work was also ongoing with schools to target young people via healthy school projects, School Advisers and exercise groups whereby young people at risk were identified and referred to their General Practitioners for proper testing. With regard to the waiting times from diagnosis it was indicated that there had been no cases in February that had waited for more than six weeks, however, there was an issue with variations across the patch for dieticians and chiropodists and consideration was being given to a service model.

RESOLVED

That the information contained in the report submitted, on the role of Clinical Commissioning Groups in ensuring people with diabetes and those at risk of diabetes received the best care and support available, be noted.

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43 HOUSING ADAPTATIONS

A report of the Director of Adult, Community and Housing Services was submitted on the current position relating to the provision of adaptations to private and public sector housing in the borough.

Arising from the presentation of the report the Head of Service Private Sector Housing undertook to provide Members with information on how long the Occupational Therapist posts had been vacant.

RESOLVED

That the information contained in the report submitted, on the current position relating to the provision of adaptations to private and public sector housing in the borough, be noted.

The meeting ended at 8.30 p.m.

CHAIR

Dudley Metropolitan Borough Council

Agenda Item No. 5

Health Scrutiny Committee – 16th July, 2013

Report of the Lead Officer and the Director of Corporate Resources

Terms of Reference, Annual Scrutiny Programme and Work Programme 2013/14

Purpose of Report

1. To note the terms of reference of the Committee and the items included in the Annual Scrutiny Programme and the Work Programme for consideration by this Scrutiny Committee during 2013/14.

Background

2. On 25th April, 2013, the Cabinet considered a report on a review of the Council's overview and scrutiny arrangements. The recommendations from Scrutiny Chairs were endorsed by the Cabinet and formally approved at the annual meeting of the Council on 16th May, 2013.

3. The principles of the new structure are to strengthen the Council's overview and scrutiny arrangements; to ensure proper democratic accountability and to promote confidence in the conduct of the Council's business. The new scrutiny arrangements are also set in the context of significant financial pressures faced by the Council and the need to focus limited resources in the most effective way.

4. The review was also based on the following principles, as agreed by Scrutiny Chairs:-

- That the former informal "Chairs of Scrutiny Committees" meeting be formalised into an "Overview and Scrutiny Management Board".

- That a revised structure of Overview and Scrutiny Committees be adopted, including Scrutiny Committees to carry out detailed scrutiny reviews and a separate Scrutiny Committee with a remit for Corporate Performance Management, Efficiency and Effectiveness.

- That the role of Scrutiny Committees be developed further to comprise:-

  - The adoption of the "Parliamentary Select Committee" model by undertaking single item in-depth scrutiny investigations/inquiries with reports from the Scrutiny Chair being presented to the Cabinet/Council.

- Being more strategic and selective in selecting topics for scrutiny with Scrutiny Committees focussing on in-depth investigations. The Overview and Scrutiny Management Board will have a role in overseeing and co-ordinating the annual scrutiny programme.

- Enhancement of the role of Scrutiny Committees in policy development by carrying out the in-depth scrutiny reviews as referred to above.

- All scrutiny "Call-ins" to be determined by the Management Board (with provision for inviting statutory co-opted members in the case of Education matters).

- Cabinet Members/Chief Officers and others to attend scrutiny meetings to give evidence/reports if required by the Scrutiny Committee (given advance notice).

- The retention of statutory co-opted members on the Scrutiny Committee that considers "Education" matters (ie: Children's Services).

- The Chair of the Overview and Scrutiny Management Board to submit an annual report to the Council on corporate scrutiny activity.

- The Minutes of the Overview and Scrutiny Management Board and individual Scrutiny Committees to be submitted to Council.

5. The approved terms of reference of the Scrutiny Committee are set out in Appendix 1. The terms of reference of the Committee also gives a clear indication of the Cabinet portfolios and Directorate functions within the remit of the Scrutiny Committee.

6. Scrutiny Committees have discretion to set their own programme of meetings to carry out the reviews that are allocated to them. Meetings of this Scrutiny Committee have also been scheduled on the dates set out below to enable the Committee to carry out its functions during the year:-

Wednesday, 25th September, 2013 – 6PM
Thursday, 7th November, 2013 – 6PM (to include detailed scrutiny of the Council's revenue budget proposals)
Thursday, 23rd January, 2014 – 6PM
Tuesday, 25th February, 2014 – 6PM
Thursday, 27th March, 2014 – 6PM

Themes for In-depth Review

7. In April, 2013, Scrutiny Chairs considered the development of a draft Annual Scrutiny Programme for the 2013/14 municipal year taking account of the views of Cabinet Members and Directors as part of their business planning cycle. The Overview and Scrutiny Management Board formally endorsed the Annual Scrutiny Plan at its meeting on 29th May, 2013. The items for detailed consideration by the Health Scrutiny Committee during 2013/14 are:

- Tobacco Control Strategy -Update/Development
- Elements of Patient Experience in Acute Care

8. Appendix 2 gives more detailed information on the topics set out in the Annual Scrutiny Programme for 2013/14 as referred to in paragraph 7 above.

9. Immediately following this first formal meeting of the Scrutiny Committee, an informal development session will be held for members and officers to discuss the scope of the topics to be scrutinised; the process of gathering information (including the 'witnesses' to be invited to attend) and the timescales for carrying out the reviews (with timescales for both informal and formal meetings).

Broader Work Programme 2013/14

10. NHS agencies have a duty to consult the health scrutiny committee on service development with the aim of strengthening democratic accountability across the health sector.

11 Key stakeholders across the health, care and well-being sector including Dudley's new Clinical Commissioning Group, Dudley Group of Hospitals and Public Health have been engaged in the development of the 2013/14 work plan to ensure its effective development; helping lay the foundations for targeted, incisive and timely work on issues of local importance, where scrutiny can add value.

12. The work plan (attached at appendix 3) also reflects issues arising from previous meetings identified for closer scrutiny and regular review.

Public Forum and Co-opted Members

13. Under the Scrutiny Committee Procedure Rules, as contained in the Constitution, all Scrutiny Committees previously had the discretion to include a standard item entitled 'Public Forum' on the agenda to facilitate members of the public asking questions on any matter falling within the terms of reference of the Committee. This discretion remains under the revised Scrutiny arrangements and the Committee is invited to express views on whether such an item should be included on future agendas.

14. At the annual meeting of the Council on 16th May, 2013, reference was made to the potential appointment of a co-opted member to this Committee during the municipal year. The Committee is now recommended to make provision for the Chairperson of Dudley's local Healthwatch organisation - as the locally appointed consumer champion for health and social care - to be appointed as a non-voting co-opted member for the remainder of the municipal year; with the particular aim of attaining a deeper understanding of health, care and well-being issues impacting Dudley's communities.

Review and Improvement

15. The revised scrutiny arrangements will be subject to ongoing review and further consideration by the Overview and Scrutiny Management Board during the municipal year.

Finance

16. The costs of operating the revised scrutiny arrangements will be contained within existing budgetary allocations.

Law

17. Scrutiny Committees are established in accordance with the provisions of the Local Government Act 1972 and the requirements of the Council's Constitution, which was adopted under the Local Government Act 2000, subsequent legislation and associated Regulations and Guidance. Scrutiny powers relating to health are included in the Health and Social Care Acts 2001 and 2012 and associated Regulations and statutory guidance.

Equality Impact

18. Provision exists within the recommended scrutiny arrangements for overview and scrutiny to be undertaken of the Council's policies on equality and diversity.

Recommendations

19. That the terms of reference of the Committee, as set out in Appendix 1, be noted.

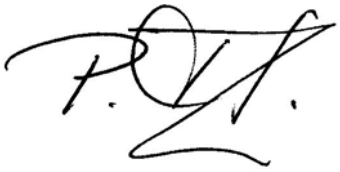
20. That the issues contained in the Annual Scrutiny Programme for 2013/14, as referred to in paragraph 7 and Appendix 2, be noted.

21. The outline work plan at appendix 3 reflecting key developments across partners and stakeholders for 2013/14; and issues arising from previous scrutiny meetings, be approved.

22. That an informal development session be held for members and officers, at the conclusion of the formal business of this meeting, to discuss how they wish to progress the items for detailed consideration by the Committee during 2013/14.

23. That the Committee include a "Public Forum" session as a standing item of business on the agenda for future meetings.

24. That the Chairperson of Dudley Healthwatch be appointed as a co-opted member of this Committee for the remainder of the municipal year.



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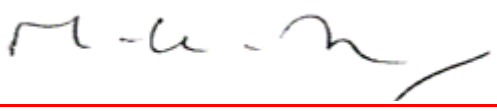
Philip Tart
Director of Corporate Resources



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Mohammed Farooq
Lead Officer

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List of Background Papers

Reports and minutes of the Cabinet dated 25th April, 2013
Reports and minutes of the Council dated 16th May, 2013
Reports and minutes of the Overview and Scrutiny Management Board dated 29th May, 2013

Appendix 1

Terms of Reference

Health Scrutiny Committee

To fulfil all of the overview and scrutiny functions of a Scrutiny Committee as they relate to the improvement of local health and associated services, as a contribution to the Council's community leadership role, in accordance with relevant legislation, regulations and associated guidance.

To make reports and recommendations to local National Health Service (NHS) bodies and to the Council on any matter reviewed or scrutinised which will explain the matter reviewed, summarise the evidence considered, provide a list of participants in the scrutiny exercise, and make any recommendations on the matter reviewed as appropriate.

To proactively receive information within given timescales, with some exceptions as per Government Guidance, requested from local NHS bodies.

To be consulted by and respond to (as appropriate) NHS bodies in connection with the rationale behind any proposal and options for change to local health services made by the NHS.

To ensure the involvement of local stakeholders in the work of the Committee.

To take referrals from local Patients' Forums.

To act in accordance with Government Guidance relating to Health and Scrutiny functions.

In accordance with any relevant statutory requirements and the Annual Scrutiny Programme approved by the Overview and Scrutiny Management Board:-

(a) To undertake in-depth scrutiny investigations, inquiries and reviews in accordance with the Annual Scrutiny Programme;

(b) To contribute to policy development by carrying out the scrutiny of all health related functions and matters falling within the portfolio of the Cabinet Member for Health and Wellbeing (including the Office of Public Health).

To submit reports and recommendations to the Cabinet and/or the Council on the outcomes of scrutiny investigations, inquiries and reviews.

To make recommendations to the Overview and Scrutiny Management Board on any proposed amendments to the Annual Scrutiny Programme.

Appendix 2

Health Scrutiny Committee		
Portfolio		Cabinet Member for Health & Wellbeing
Area for Scrutiny		Tobacco Control Strategy Update/Development
Council Priorities		
	Council Plan:	Health & Wellbeing- to strengthen the role and impact of ill health prevention
Context		• Tobacco use remains one of our most significant public health challenges. Although overall smoking rates in Dudley have continued to decline over the past decade to 18.5% (based on the 2009 Dudley Health Survey) there remains higher smoking prevalence in our most deprived areas, Castle & Priory (24.5%) and Brierley Hill (26.4%). The national rate is 21%. Further action is needed to reduce rates further. • Tackling tobacco is seen by the Local Government Association as priority to improve the health and wellbeing of their communities and reduce inequalities in health. • Key to this is adopting a comprehensive approach to tobacco control locally that includes strategies and action in 6 key areas (known as the 6 strand approach) which are: -enforce the minimum price of tobacco -ensure non-price measures such as advertising restrictions,smokefree laws and health warnings are in place locally - provide information and advocacy - provide effective stop smoking programmes - restrict access to minors - control the illicit trade • Dudley's Tobacco Control Programme is co-ordinated by the Office of Public Health and has an annual plan with key actions across the 6 strand approach. This requires longer term commitment and input from several partners to be effective.
Rationale		• The Tobacco Control Strategy for Dudley – 'Creating A Smokefree Generation ' was based on meeting Government 2010 targets and needs updating to bring this into line with new national data and local priorities. • Dudley has been identified by HMRC as 'hot spot' area for illicit tobacco being sold and a more structured approach needs to be developed and reflected in the strategy and action plan. • The continued importance of Tobacco Control is reflected in the Coalition government's proposals to monitor tobacco control indicators as part of the Public Health Outcomes Framework. • This is an opportunity to review key stakeholders and partners to agree action and ensure delivery as some elements of Tobacco Control should be everyone's business.
What are we asking from the Scrutiny Committee?		To support and input into the development of a refreshed Dudley Borough Tobacco Control Strategy & Action Plan

Health Scrutiny Committee		
Portfolio		Cabinet Member for Health & Wellbeing
Area for Scrutiny		Elements of Patient Experience in Acute Care
Council Priorities		
	Council Plan:	Ensure local people receive the highest quality healthcare from their local health services.
Context		The independent inquiry into care provided by Mid-Staffordshire NHS Foundation Trust – January 2005 – March 2009, chaired by Robert Francis QC, highlighted serious failings in care at that Trust which were set out in the report published in 2013 and recommended changes at the Mid-Staffordshire acute hospital. The report also comments that in respect of Mid-Staffordshire, it received evidence of *'perceived ineffectiveness'* of the local authority Overview and Scrutiny Committee (OSC). Comments concerned *'lack of understanding and grip'* on the real local healthcare issues. Sir Robert Francis found *'little evidence that the OSC took a particularly aggressive proactive approach to their scrutiny of the NHS';* though this view was countered by the Chair of the District Council OSC.
Rationale		The Dudley MBC OSC has taken a proactive approach to the quality of care in the local acute trust. The Committee may now wish to take a more in-depth look at the area of patient experience – ensuring that it provides opportunity to hear from patients and their relatives on the standard of care received and seek assurance that the responsible commissioner is adequately monitoring standards of care. It is suggested that the Committee consider 1 of 2 potential areas: - personal and oral hygiene - nutrition and hydration.
What are we asking from the Scrutiny Committee?		That the Committee examines, in depth, the quality of the patient experience in 1 of 2 proposed areas of patient experience; and make recommendations for healthcare bodies based upon such a review.

Appendix 3

Topic	Meeting
Maternity Services– Managing Future Demand in Dudley	July
In-depth Reviews: Initial Scoping: Tabacco Control and Patient Experience	July
CCG: Development of Primary Care Strategy	July
Keogh Review: Mortality Rates: District Hospital Follow-Up	July
DGH: Development of the Vascular Services Hub	September
Black Country Partnership Trust – Transforming Community Services Quality Improvement Priorities and CQC follow-up (Children's Services and LD's)	September
CCG Commissioning Priorities 2014/15	September
CCG/DGH Stroke Services Review – local implications of national review	November
HWWB: Delivery against Joint Health and Well-Being Strategy	November
In-depth Reviews: Initial Scoping: Tabacco Control and Patient Experience	January
Development of Local HealthWatch – Dudley's consumer champion for health and social care	January
NHS Quality Accounts - Progress on Improvement Priorities – Local Provider Trusts	February
Joint Scrutiny of Mental Health Services across Dudley and Walsall	March
Development of Dudley's Health Watch – local health consumer champion	March
CCG: Development of Dudley's Urgent Care Framework	March

A degree of flexibility needs to be built into the above programme so as to be responsive to new developments across the sector; particularly as reformed NHS structures bed-down and pressure to meet efficiency savings targets continues to build. Similarly, some issues that have been included in the proposed plan may be overtaken by events.

Dudley Metropolitan Borough Council

Agenda Item No. 6

Health Scrutiny Committee – 16th July, 2013

Report of the Director of Corporate Resources

Forward Plan of Key Decisions

Purpose of Report

1. To consider the Forward Plan of Key Decisions for the four-month period commencing 1st June, 2013, and make any recommendations as to items to be scrutinized to the Overview and Scrutiny Management Board.

Background

2. The Access to Information Procedure Rules set out in Part 4 of the Constitution include a requirement for a Forward Plan to be prepared by the Leader covering a period of four months.

3. Attached as an Appendix is the Forward Plan covering the four-month period from 1st June, 2013. The Forward Plan sets out information on key decisions that are likely to be taken by the Council, Cabinet, a Cabinet Member or Chief Officers in the period covered by the Plan.

4. The Forward Plan is available on the Internet via the Committee Management Information System (CMIS).

5. The Forward Plan is reported to all ordinary meetings of the Cabinet and will also be reported to the Overview and Scrutiny Management Board in future. Increasing accessibility to the Forward Plan will assist the process of overview and scrutiny of key decisions.

6. The Overview and Scrutiny Management Board at its meeting held on 29th May,2013 considered the Forward Plan and agreed that it be referred to the Council's five Scrutiny Committees with a request that they inform the Board of any items that they would wish to scrutinise so that further consideration can be given to this matter by the Board at a future meeting.

Finance

7. The financial implications associated with individual key decisions will be included in reports submitted on each individual item.

8. A key decision is defined as an executive decision which is likely:-

(a) to result in the Council incurring expenditure, or the making of savings, which are £250,000 or more (revenue or capital); or

(b) to be significant in terms of its effects on communities living or working in one or more wards in the Borough.

Law

9 The requirement to produce a forward plan is set out under the Access to Information Procedure Rules in Part 4 of the Constitution.

10. The Constitution is adopted by the Council pursuant to the requirements of the Local Government Act 2000.

Equality Impact

11. The equality impact of specific key decisions will be referred to in individual reports on the items concerned.

Recommendation

12. That consideration be given to the Forward Plan of Key Decisions with a view to making any recommendations to the Overview and Scrutiny Management Board as to items to be scrutinised.

……..
Director of Corporate Resources

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List of Background Papers
The Constitution

Forward Plan of Key Decisions

Decisions due to be made during the four month period from 01 Jun 2013

Decision No Directorate	Project Name	Key Decision	Decision Period Meeting Date	Reports, Appendices & Background Papers	Consultation Details	Decision Taker	Contact Name
0506 Corporate Resources	Localism Act 2011	To consider the ongoing implications of the Localism Act 2011 on the governance arrangements adopted by Dudley MBC.	March 2013 - October 2013	Localism Act 2011 and any guidance issued by the Secretary of State	Cabinet Members, The Audit and Standards Committee, other Committees depending on the implications of the Act; any other consultation as may be required by the legislation.	Cabinet; Full Council	Philip Tart Director of Corporate Resources (Phone: 01384 815300)
0546 Urban Environment	Publication of the Community Infrastructure Charging Schedule	To approve the Publication of the Community Infrastructure Charging Schedule for statutory public consultation and subsequent submission to the Secretary of State for Independent Examination.	Cabinet September 2013	Community Infrastructure Charging Schedule	Key internal officers and Cabinet Member for Regeneration. Draft document will be available to view prior to the Cabinet meeting.	Cabinet	Annette Roberts Directorate of the Urban Environment (Phone: 01384 - 814172)
0551 Corporate Resources	Localised Council Tax Rebate Scheme	Adoption of our local scheme to replace the current national council tax benefit scheme alongside a 10% reduction in expenditure.	June 2013	Local Government Finance Bill and any associated secondary legislation; and guidance issued	Key internal stakeholders (elected members, directorates, business units, etc), major preceptors, the public, the voluntary sector, other interested parties.	Cabinet; Full Council	Mike Williams Assistant Director, Corporate Resources (Phone: 4970)
0574 Corporate Resources	Acceptance of Tenders or Quotations	Agreement, in consultation with the Cabinet Member for Finance, to accept Tenders or Quotations for the Supply of Goods, Provision of Services or Works (or the Disposal of Goods) with a value in excess of £250,000 per annum - following a procurement exercise by the Directorate of Corporate Resources (Procurement, Contract Management and Credit Services Division). Decisions will be taken throughout the year in accordance with tendering programme. Items will be considered in private session to avoid the disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A to the Local Government Act 1972 relating to the financial or business affairs of any particular person (including the authority).	April 2013 - March 2014	Summary of Tender Evaluation Report by Head of Procurement; Associated documents and reports prepared by Head of Procurement;	Key stakeholders (directorates, business units, schools etc) participating within the resulting contract are included in the tendering/evaluation processes. Appropriate Legal and Financial advice is also taken. The Director of Corporate Resources is required to consult the Cabinet Member for Finance on proposed contract awards - this occurs through correspondance and discussion as required. Contracts of this value are tendered and awarded in accordance with EU Procurement Directives which	Philip Tart	Philip Tart Director of Corporate Resources (Phone: 01384 815300)

Forward Plan of Key Decisions

Decisions due to be made during the four month period from 01 Jun 2013

Decision No Directorate	Project Name	Key Decision	Decision Period Meeting Date	Reports, Appendices & Background Papers	Consultation Details	Decision Taker	Contact Name
					require advance publication of proposed contracts and the outcome of the tender exercise following a contract award.		
0575 Corporate Resources	Monitoring and Review of Capital and Revenue Expenditure or Income	To consider issues which have a significant impact upon the Capital or Revenue Expenditure and/or Income of the Council including those issues arising from the monitoring, review and implementation of the approved Revenue Budget and Capital Programme. [This is a standing item at each Cabinet meeting and the Decision Taker will be the Cabinet and then the Council, or individual members/officers in accordance with relevant delegations].	April 2013 - March 2014	Periodic and ad-hoc reports	Consultation appropriate to individual proposals.	Cabinet; Full Council	John Everson Technical Accountant, Corporate Resources (Phone: 01384-814806)
0576 Corporate Resources	Spending Projections 2013/14	To report details of the projected outturn for 2013/14 and to recommend amendments to the revenue budget, funded from General Balances if necessary.	April 2013 - March 2014	Report of the Treasurer	Council Directors	Cabinet; Full Council	Iain Newman Treasurer (Phone: 01384-814802)
0577 Corporate Resources	Waiver of Contract Standing Orders	Waiver of Contract Standing Orders by the Cabinet Member for Finance in appropriate circumstances. Items will be considered in private session to avoid the disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A to the Local Government Act 1972 relating to the financial or business affairs of any particular person (including the authority).	April 2013 - March 2014	Returned tender documents/Council's Standing Orders; Records; maintained by the Chief Executive; Reports/correspondence by the; Director of Corporate Resources	The Scheme of Delegation requires the Cabinet Member for Finance to consult the Treasurer. Where approporiate Stakeholders with an interest in the contract(s) will also be consulted as part of the contract evaluation exercise.	Cllr Peter Lowe	Iain Newman Treasurer (Phone: 01384-814802)
0578 Urban Environment	Dudley Local Enterprise Zone (LEZ)	To approve the management plan for the Dudley LEZ scheme.	Cabinet September 2013	Cabinet Report - Proposed Dudley Local Enterprise Zone - 14th March; 2012; Black Country Local Enterprise Partnership - Submission to DCLG; for a Black Country Enterprise Zone - August 2011	Consultation with property owners will be undertaken in December 2012. Consultation has taken place with the Dudley Business Group on the 19th December, 2012.	Cabinet	Phil Coyne Assistant Director, Economic Regeneration & Transportation (Phone: 4004)

Forward Plan of Key Decisions

Decisions due to be made during the four month period from 01 Jun 2013

Decision No Directorate	Project Name	Key Decision	Decision Period Meeting Date	Reports, Appendices & Background Papers	Consultation Details	Decision Taker	Contact Name
0582 Adult, Comm & Hous.Services	Exceptions to the Council's Housing Allocations Scheme (Special Cases)	Individual decisions may be made in regard to the housing applications of people with exceptional circumstances not catered for within the Council's Housing Allocations Scheme. Items will be considered in private session to avoid the disclosure of exempt information as defined in paragraph 2 of part 1 of schedule 12a to the Local Government Act 1972 relating to information likely to reveal the identity of an individual.	February 2013 - March 2014	Individual reports; Lettings Policy	Individual cases are not consulted upon. The Council Housing Allocations scheme is subject to statutory consultation with registered providers and informal and formal consultation with other stakeholders.	Andrea Pope-Smith	Diane Channings Assistant Director of Housing (Housing Management) (Phone: (01384) 815063)
0586 Corporate Resources	Revenue Budget Strategy 2014/15	To consider the Revenue Budget Strategy for 2014/15 and future years.	June 2013 - February 2014	Report(s) of the Chief Executive,; Treasurer and Director of Corporate Resources	Public consultation - possible use of Citizen's Panel and Internet. Consultation with representatives of the Non-Domestic Ratepayers.	Cabinet	Iain Newman Treasurer (Phone: 01384-814802)
0587 Corporate Resources	Review of Housing Finance	To approve the revised Housing Revenue Account budgets for 2013/14 and updates to the 30 year Housing Revenue Account Business Plan. To approve the amendments to the Public Sector Housing Capital Programme for 2013/14 to 2017/18.	Cabinet June 2013		Corporate Board, Directorate of Adult, Community and Housing Services Senior Management Team. Corporate Resources (Finance).	Cabinet	Catherine Ludwig Housing Finance Manager, Directorate of Finance, ICT etc (Phone: 01384 815075)
0591 Urban Environment	20mph zone priorities	To consider the outcome of consultation into the process and to agree priorities for further investigation.	Cabinet June 2013	Revised draft protocol for the selection of sites for 20mph zones	Detailed schemes would be subject to full public consultation in line with Council protocol for consultation as part of the ongoing programme development.	Cabinet	Martyn Holloway DUE

Agenda Item No. 7

Health Scrutiny – 16th July 2013

Dudley Clinical Commissioning Group Primary Care Development Strategy

Purpose of Report

1. To present the final draft of Dudley CCG's Primary Care Development Strategy (attached) to the Overview and Scrutiny Committee. The CCG Bard is considering this draft at its meeting on 4th July. (It is expected that by the time of the Overview and Scrutiny Committee meeting that this will have been approved by the CCG Board. Any amendments will be reported verbally at the OSC meeting.)

Background

2. The attached Primary Care Development Strategy, has been developed over a series of months and the priorities it sets out are based on input from CCG members (GPs) and local patient and community groups. It also takes account of the NHS England and local Area Team priorities for primary care as we understand them at the present time.

Process to Date

Whilst developing the strategy, early discussion papers and later drafts of the strategy have been shared with a number of groups and individuals including:

- CCG members (including membership development events)
- Practice managers
- CCG Locality forums
- CCG Communications and Engagement Committee
- Healthcare Forum
- CCG Patient Opportunities Panel
- CCG Executive Team
- A core group established specifically for the purpose of developing the strategy which included GP members, a practice manager, LMC and managerial support.

A short 'patient facing' summary of the strategy has also been produced and a draft of this will be available for members at the meeting.

Focus

The focus of the strategy is on developing local primary care and supporting practices to provide high quality services for patients. This means that, rather than focussing in the first instance on specific clinical or service priorities, instead, the intention has been to describe approaches which will build strong, high quality primary care providers who are as well placed as possible to meet new service

challenges and deliver clinical priorities now and into the future. Primary care is the cornerstone of local healthcare, so if we don't tackle the challenges facing local practices, then it is unlikely that the CCG will be able to deliver the improvements in health outcomes and health services it aims to achieve.

Next Steps

Subject to the approval of the Board, this strategy will be designed to meet CCG corporate style. The final version will then be distributed to CCG members and partner organisations and will be presented to the Health and Wellbeing Board.

The next challenge will be to develop a detailed, timed implementation plan for the strategy. This process will be led by the CCG Head of Membership Development and overseen by the CCG Primary Care Development Committee. The strategy and its implementation will be discussed at a forthcoming membership development event and CCG Locality forums. Local patient groups will be a central part of the development and monitoring of the implementation plan. There is good evidence to show that direct patient involvement helps to maintain momentum, drive agreed change and therefore will increase the likelihood of achieving the aims of the strategy.

The CCG will also need to ensure that it continues to participate in the process with the NHS England local Area Team to develop its primary care strategy and adjust the CCG's plans to meet any must do's arising from this.

Equality Impact

7. The aim of the CCG Primary Care Strategy is to ensure high quality, primary care services which are accessible to all.

Recommendation

8. It is recommended that:-

   - ***the Health Overview and Scrutiny Committee note the CCG Primary Care Development Strategy and the outline plans for its implementation.***

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List of Background Papers

See references section on attached strategy

Dudley Clinical Commissioning Group

Primary Care Development Strategy

Final Draft

Foreword

Primary care is facing unprecedented challenges. We have the biggest change in the NHS since its inception, severe national economic constraints, an ageing population and increase in demand. Over the last decade, general practice has become more robust in its governance and clinical practice and is in a much better place to face the rigours of modern health care.

There are, however, further demands on primary care which are currently underway or which we will face in the coming years. Care Quality Commission registration, revalidation, GP workforce issues and changes to the general practitioner contract will mean that we will have to contend with a more difficult working environment in the future.

In developing this strategy we have taken into consideration the objectives set by NHS England to improve quality and reduce variation in general practice. We have listened to what patients want, which is improved access to services and continuity of care with their family doctor. The CCG membership have been clear that the main issue that they have to deal with is of increasing workload.

The problems have arisen because of a lack of service capacity due to increasing demand and underinvestment in primary care over the last few years.

The strategy looks at increasing capacity in general practice and investment in primary and community care along with the development of integrated extended primary care teams using innovative solutions which the Health and Social Care Act offers us.

Primary care is at the heart of the delivery of the new NHS agenda and it is only by recognising that it has this pivotal role and by supporting practices to deliver good quality general practice that we can meet these challenges.

Dr Jas Rathore

Contents

Attachments

Author
Mrs Gillian Goodlad

Contributors
Dr Jas Rathore
Dr Tim Horsburgh
Dr Kevin Dawes
Dr Richard Gee
Mr Daniel King
Mr Paul Maubach
Mrs Carol Jones
Ms Helen Ashford

Related CCG Documents
CCG Primary Care Premises Planning Framework
CCG IT Strategy
CCG Research and Development Strategy
CCG Innovation Strategy

Primary Care Development Strategy – Summary on a Page

Vision & Aims

" To ensure high quality, accessible primary care for the people of Dudley."

- *To support local practices to maintain and improve the quality of primary care provision for patients*
- *To support the CCG's strategic aims by continuing to reduce health inequalities, improving health outcomes, improving services and improving health & safety*

Priorities for Developing Primary Care		
Improving Access & Managing Workload	**Developing Locality-based Services**	**Managing the shift from Secondary to Primary Care**
Primary Care's role in delivering the Urgent Care Strategy	**Building Resilient Primary Care & Supporting Practices to Thrive**	**Reducing Unwarranted Variation & Rewarding Excellence**

Local Clinical Priorities for Primary Care	
Local Quality Premium Areas	**Quality & Productivity Indicators in QOF**
Dementia	OPD Pathways: Cardiology, Pain Management, Ophthalmology
Atrial Fibrillation	Reduction In Avoidable A&E Attendances
Hypertension	Emergency Pathways: Atrial Fibrillation, Acute Asthma, Frail Elderly UTIs
To contribute to the CCG's wider strategic priorities for improving health & health services *(See Att 1)*	

Related CCG Strategies & Policies		
Premises Planning Framework	CCG Communications and Engagement Strategy	CCG Research and Development Strategy
CCG Innovation Strategy	Quality Monitoring Process	CCG Financial Plan
CCG OD Strategy		CCG IT Strategy

Reducing Health Inequalities & Preventing Ill Health

1. Introduction

Dudley Clinical Commissioning Group (CCG) has identified a need for a primary care development strategy which supports local practices to further improve the quality of primary care and helps the CCG to meet its overall strategic aims.

Primary care services are the bedrock of local healthcare. Over 90% of all patient contact with the health service happens in primary care. In addition, general practitioners are the key gatekeepers to hospital and other specialist healthcare services. Achieving the aims and priorities of the CCG's wider strategic commissioning plans will in large part be dependent upon local practices being able to deliver improvements and participate fully in the prevention agenda. Ensuring stable, high quality, accessible primary care services is therefore essential to meeting the healthcare needs of our population.

As a clinically-led membership organisation, Dudley CCG is uniquely placed to deliver change and improvement in primary care. This strategy aims to build on this opportunity, whilst acknowledging the freedoms and restrictions of the new NHS arrangements for the direct commissioning of primary care.

The priorities set out in this strategy are based on:

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

The priorities which have been identified locally also mirror many of the key elements of the top ten priorities for commissioners published by the Kings Fund in 2012 and updated this year. A key feature of the priorities set out by the King's Fund is the extent to which they involve a change in primary care itself and the way in which primary care works with the rest of the system.

If CCGs are to maximise the opportunities afforded by the direct engagement of GPs in commissioning, then it will be necessary to invest in developing it members, growing as a strong commissioning organisation and building good working relationships across the health system. These aspects are addressed in the CCG's Organisational Development Plan.

This strategy also builds upon some of the aims and ambitions set out in Dudley PCT's primary care strategy 2009-14 **'Reaching Excellence'.**

2. Vision and Aims

The **vision** for primary care in Dudley is:

"To ensure high quality, accessible primary care services for the people of Dudley."

The **aims** of the strategy are:

- *To support local practices to maintain and improve the quality of primary care provision for patients*
- *To support the CCG commissioning strategy by contributing to reduce health inequalities, improving health outcomes, improving services and improving health and safety.*

3. Arrangements for Commissioning Primary Care from April 2013

As part of the new NHS organisational arrangements from April 2013, there have been significant changes in the way in which primary care services are commissioned. In summary:

> ***NHS England commissions national primary care services. They hold primary care contracts and are responsible for planning, securing and monitoring services commissioned by them in respect of primary care.***
>
> ***CCGs are responsible and accountable for commissioning local enhanced services. In addition, CCGs have a statutory duty to assist and support NHS England in securing continuous improvement in the quality of primary medical services.***

These new arrangements have implications for the remit, development and implementation of this strategy, as they determine what the CCG has direct control over and what is outside its direct control in relation to the commissioning of primary care.

It is clear that CCGs will now be required to play an active role in supporting NHS England to exercise its responsibilities. This means that close working between the CCG and The NHS England local Area Team (AT) will be essential. Neither organisation will be able to bring about the required changes alone or by focussing solely on those services over which they have direct budgetary control. This reinforces the need for Dudley to have a clear local strategy for primary care, with agreed aims, processes and policies. This will offer clarity and assurance to the AT that Dudley CCG is equipped to meet any national performance requirements for primary care and is likely to give the CCG more freedom to address its local priorities in the way it thinks best for its local communities.

4. Scope of the Strategy

This strategy focuses on general medical services and does *not* directly cover pharmacy, dentistry and eye care services. This reflects the fact that the CCG's membership is comprised of general practitioners and the CCG's responsibility to ensure the continuous improvement of primary medical services.

5. Primary Care in Dudley

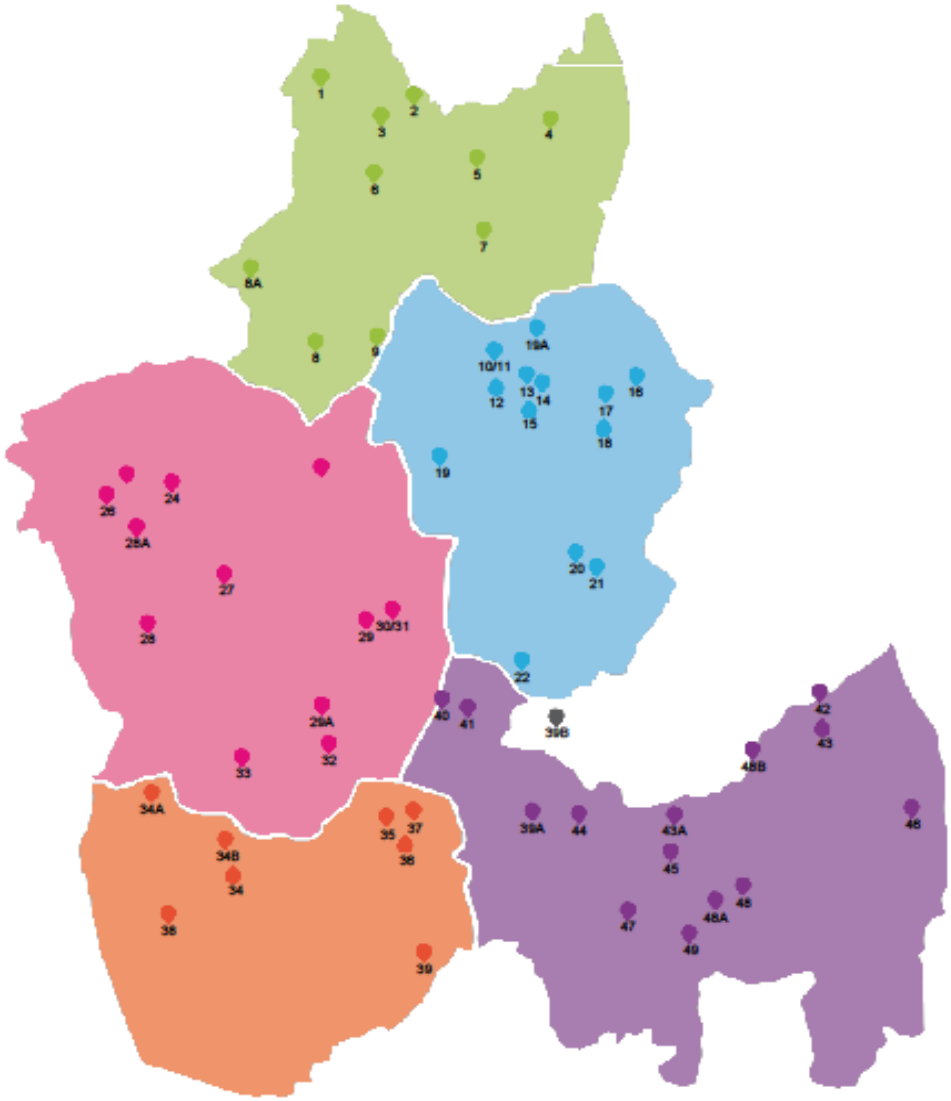
Many of the features of the local population and the current primary care delivery models remain unchanged from those described in the PCT strategy *'Reaching Excellence'*. General issues affecting primary care in Dudley, and as reflected in the local Health and Wellbeing Strategy, include:

- Rising demand for healthcare services
- A slower than average rate for improving local people's health
- Persistent long-term inequalities, (despite targeted action having been taken in the past)
- Worsening trends in lifestyle risks, particularly from obesity and alcohol
- Significant levels of undetected and untreated disease.

Facts and Figures

- Dudley CCG has a population of approximately **314,500**.
- There are **49 General Practices** plus a Walk in Centre in Dudley. These practices occupy 47 main practice premises and 9 branch surgery sites, making a total of 58 facilities. The CCG has organised its practices into 5 geographical **localities**. *(see map below)*
- There are **199 General Practitioners**, **(174 WTEs).**
- Almost **27% of Dudley GPs are aged 55 or over** (compared to a national average of 22%). More worryingly, **over 10% (21) GPs are aged 65 or over** compared to a national average of only 4%. In some practices half or more of the GP workforce is over 60. (This is important because over a quarter of GPs may retire during the next ten years.)
- Practices vary in size. Total **list sizes** range from just over **1,000 patients to 25,000 patients**. Nearly **one fifth of practices in Dudley are single handed** which is almost double the national average. Over **40% of practices in Dudley have 2 partners or less**, compared to a national average of 28.5%. *(see Attachment 1)*
- Practice list sizes per WTE GP vary, with the average being **1,808 per WTE GP** (national average 1,765). Further work is required to understand the impact of the availability of other community and primary care services alongside GPs has on the WTE requirement.
- Current accessibility for existing primary care facilities in terms of geography appears good and **most of the population are within 30 minutes walking distance of a GP surgery**. The majority of residents have good access to public transport, with **most residents living within 10-20 minutes of their nearest GP practice.**

Surgeries by Locality



Sedgley, Coseley and Gornal

1 Northway Surgery
2 Bath Street Surgery
3 Bilston Street Surgery
4 Coseley Medical Centre
5 Woodsetton Medical Centre
6 The Ridgeway Surgery
7 The Greens Health Centre
8 Lower Gornal Health Centre
8A Masefield Road Surgery (Lower Gornal Branch)
9 Castle Meadows Surgery

10 St James Medical Practice (Dr White)
11 St James Medical Practice (Dr Porter)
12 Eve Hill Medical Practice
13 Tinchbourne Street Surgery
14 Cross Street Health Centre
15 Steppingstones Medical Practice
16 St Thomas's Medical Practice
17 Central Clinic
18 Bean Road Surgery
19 Keelinge House Surgery
20 Netherton Surgery
20A Hazel Road Surgery (Netherton Surgery Branch)
21 Netherton Health Centre
22 Quarry Road Surgery

Kingswinford, Amblecote and Brierley Hill

23 High Oak Surgery
24 Kingswinford Health Centre
25 Moss Grove Surgery
26 Summerhill Surgery
27 Rangeways Road Surgery
28 Wordsley Green Health Centre
28A Market Street Surgery (Wordsley Green Branch)
29 AW Surgeries
29A Withymoor Surgery (AW Branch)
30 Waterfront Surgery
31 Brierley Hill Health and Social Care Centre
32 Quincy Rise Surgery
33 Three Villages

Stourbridge, Wollescote and Lye

34 Worcester Street Surgery
34A Meriden Avenue Surgery (Worcester St Branch)
34B Greenfield Avenue Surgery (Worcester St Branch)
35 Pedmore Medical Practice
36 Chapel Street Surgery
37 The Limes Surgery
38 Norton Medical Practice
39 Wychbury Medical Group

Halesowen and Quarry Bank

39A Chapel House Lane (Wychbury Branch)

41 Quarry Bank Medical Centre
42 Clement Road Medical Centre
43 Feldon Lane Surgery
43A Hawne Lane Surgery (Feldon Lane Branch)
44 Crestfield Surgery Ltd
45 Alexandra Medical Centre
46 Lapal Medical Practice
47 Meadowbrook Surgery
48 Halesowen Health Centre
48A Tenlands Avenue Surgery (Halesowen HC Branch)
48B Coombs Road Surgery (Halesowen HC Branch)
49 St Margaret's Wells Surgery

Out of Area

39B Cradley Road Surgery (Wychbury Branch)

Data correct as of April 2013

6. Challenges Facing Primary Care in Dudley

There are a range of significant challenges facing primary care generally and GP practices in particular. These include:

- **Rising workload and pressure on access**. Rising demand from patients within the context of limited and stretched capacity in primary care has been placing increasing pressure on practices. This is a major barrier to practices being able to maintain or improve quality standards and impedes their ability to support new care pathways.

- Proposed changes to the **national contract** and other national initiatives will have a significant impact on general practice in a range of ways. The detail of the impact of the various changes on individual practices is difficult to calculate, but we know that most practices will need to make significant adaptations to their organisational arrangements to implement these changes successfully, meet required performance standards and maintain income. Changes include:
    - Changes to the Quality and Outcomes Framework indicators with increased thresholds
    - Introduction of new Directed Enhanced Services
    - Equitable funding proposals from 2014 onwards will impact differentially on practices.

  In addition to the concerns regarding the impact of these changes on workload and income, there are also concerns that this will be a negative impact on patient access, and recruitment and retention to general practice in the medium term.

- A changing **workforce and labour market** point to the need for detailed and proactive succession planning and recruitment and training plans. For example, up to one quarter of Dudley GPs may retire within the next 10 years. In addition, other issues such as **CQC registration, revalidation** and the national contract changes outlined above will have a direct effect on the primary care workforce.

- **Pressure on practice income** due to cost inflation, static 'pay settlements' and increasing activity. The proposed national contract changes and the introduction of capitation based budgets will affect practices differentially and the full implications of this for future primary care provision in Dudley need to be gauged.

- **Historic funding differences** between practices and between GMS/PMS overall is a specific challenge within Dudley and there is a need to understand the impact of the proposed contract changes and develop strategies to manage the change smoothly, fairly and safely.

- Increased **transfer of work from secondary to primary care.**

- Pressure on **premises** which are too cramped and/or not of a sufficiently high standard for modern day primary care service provision.

- Too much **unwarranted variation** in GP practice performance and the quality of service offered to patients.

- **Reduced organisational and management capacity at Area Team level** due to the recent NHS reorganisation. In addition to the expected teething problems, this seems also to be resulting in significant delays to decision-making processes for crucial issues eg practice merger requests.

The priorities and actions set out in this strategy must enable the CCG and its members to meet these challenges. This will require a willingness from members to:

- ***work together***
- ***adopt best practice***
- ***think and act innovatively***.

7. Being Accountable to our Patients and Communities

The CCG already has a great deal of information regarding local patients' views of primary care services and their priorities for improvement. The CCG has established a range of processes for involving local patients and community groups in the work of the CCG which are overseen by the CCG's Communications and Engagement Committee. Many of the issues most regularly raised by patients, mirror those of local practices. Especially those focussed on access issues which directly relate to practices' concerns regarding the increasing pressures on their available capacity. The key messages and issues have been consistent over the last few years and are set out below.

Patient Concerns

- **Telephone access and access to appointments** – especially same day access. *NB this is by far the greatest concern raised by local people.*
- Ensuring **continuity of care** between primary and secondary care and vice versa.
- **Communication** needs of those with sensory impairment.
- **More time** during consultations for explanation and checking patients have understood.
- Taking proper account of **carers' needs** and their views regarding the needs of those they care for.
- Improved **links** with social services and sign-posting.
- Being treated as an equal and with **dignity and respect**.
- **Understanding patients' needs** and helping them to get the right help at the right time.
- **Informed choice** – more advice. (*GPs, patients and specialists do not always share a common understanding of why a referral is being made, for example, whether it is primarily for diagnosis, investigation, treatment or reassurance.).*
- More **telephone consultations**.
- **Lack of understanding re role of nurses and nurse practitioners** – feeling of being offered a lesser service if not seeing a doctor.

The way in which the priorities identified in this strategy are addressed will take account of these views and address the concerns of local people.

8. Priorities for Primary Care Development

This section forms the most important part of the strategy as it sets out the key priority areas for developing primary care locally and the ways in which the CCG will seek to address these.

Managing Workload and Improving Access

Why this is a priority

During work on this strategy, the consistent message we received from member practices was that the workload in primary care has become unmanageable within the existing capacity and is in danger of compromising the quality of the service offered. This is mirrored by the views we have consistently received from patients - that difficulty in getting appointments continues to be their number one concern. There is a need therefore to develop plans which create capacity in primary care, help to reduce pressure on practices and improve access for patients.

Whilst the average national list size per GP has dropped over the last 10 years, the average consultation rate has risen. (The consultation rate is the average number of consultations per patient on the practice list, per year.) The average consultation rate across Dudley is 5.26, which is marginally below the expected rate of 5.62. The expected rate, is the rate adjusted for local demographic characteristics. In line with national trends, the overall consultation rate has increased by approximately 1.5 over the last 15 years. For a practice of 10,000 patients this represents an additional 15,000 consultations per year which need to be accommodated. This rise in demand has not been matched by an increase in resource within primary care.

Solutions

- The CCG has funded the Primary Care Foundation to conduct **a baseline audit** of the current workload in terms of appointments, telephone traffic, opening times etc. This is helping individual practices to quantify the pressures on their current capacity, identifying where and when these are greatest. This will inform **individual practice development plans**. There is some evidence to show that some relatively simple modifications can improve patient satisfaction and help to make the workload more manageable. The PCF has therefore been working with practices to identify modifications to current working practices to help them better manage demand. The headline findings from this work when taken collectively have also helped the CCG to identify the key issues and help to produce plans to mitigate these pressures. The key messages arising from this work are:

    - *The need to improve continuity of care for patients – there is good evidence that this reduces emergency admissions, leads to reduced consultation rates and, as this is also the top of the majority of patients' wish lists, improved patient satisfaction*

    - *The need to ensuring effective telephone response*

    - *The need to re-balance practice systems, particularly appointments systems, to ensure that, as far as possible, they do not work against continuity of care. (As the expected consultation rates are adjusted to account for local demography, a higher consultation rate is not normally an indication of a greater health need or a more deprived population. Rather, it is often an indication that patients are being seen more often than is necessary*

for the overall health needs of the practice population. This can be caused by a number of factors, but foremost amongst these is practice systems which work against continuity of care)

- *There is evidence of a link between high patient satisfaction scores and high QOF scores and vice versa. In addition, there is evidence that ease of access for patients can affect their use and interaction with those services and therefore any connected services eg A&E.*

- *Need to review current practice with regard to the clinical assessment of home visit requests to ensure that requests are assessed quickly and any resulting urgent home visits are completed earlier in the day.*

- The CCG is putting in place plans to build on the GPs with a special interest **(GPWsI's) development programme** to improve capacity in primary care, help with the retention of GPs, aid service development and help succession planning.

- Ensuring that the CCG thinks carefully about **the way in which it procures additional services** from primary care (including any new **Local Enhanced Services (LES').** This includes:

  - *Planning new procurements carefully and avoiding hurried introduction of new schemes*

  - *Ensuring procurements cover a time period which is long enough for practices to make sensible choices regarding any additional staffing to cover the procured service requirements and ensure that this represents a genuine increase in capacity within primary care where this is required*

  - *Newly procured services should be monitored to ensure they are delivering the agreed improvements for patients and commissioners. This includes agreeing in advance the outcome measures and the action which should be taken if these outcomes are not being achieved either by individual practices or across the board.*

  - *Ensuring that the improvements afforded by the introduction of newly procured services in primary care will be available to all patients across the CCG area irrespective of which practice they are registered with.*

- Further development to encourage **increased self management by patients**. Around 70% –80% of people with long-term conditions can be supported to manage their own condition (Department of Health 2005).There are a number of well-established self-management programmes that aim to empower patients to improve their health. Evidence has highlighted the importance of ensuring the intervention is tailored to the condition (de Sliva 2011). For example, structured patient education can be beneficial for people with diabetes, while people with depression may benefit more from cognitive and behavioural interventions. Recent work conducted by the Richmond Group of Charities and The King's Fund (2012) called for patients to be offered the opportunity to co-create a personalised self-management plan which could include the following:

  - *patient and carer education programmes*
  - *medicines management advice and support including advice about diet and exercise*
  - *use of tele-care and tele-health to aid self-monitoring*
  - *psychological interventions (eg, coaching, including telephone based coaching)*
  - *pain management*
  - *patient access to their own records.*

Developing Integrated Locality Based Services

Why this is a priority

Both practices and patients have identified the need for much better coordination and integration between services. Highly integrated primary care systems that emphasise continuity and co-ordination of care are associated with better patient experience (Starfield 1998; Bodenheimer 2008).

Few practices now have the close links they would wish with colleagues in the wider primary healthcare and community services team – particularly District Nursing. The coordination and integration of care seems to be quite variable for patients with on-going health needs. Nursing services across GP practices and the community are not always well coordinated and carers and voluntary sector services are not seen as being an essential part of the primary care system. This leads to more fragmented care for patients and their carers and more pressure on GPs and other professionals struggling to provide this care in isolation. In addition, there are some services which should be provided as close to patients' homes as possible, but which smaller practices do not have the capacity to provide.

Solutions

- the CCG will support the **development of the role of localities**, to enable them to gain more control over the development of services within their area. This will **promote integration** between local health services and also **with social services and other community and voluntary groups.**

- The CCG will develop plans to **commission 'community' services** in a way which requires providers to ensure they are **locality based** and are **directly linked to individual practices** (or groups of practices) to enable a more integrated approach to planning and delivery of services within the locality.

    - CCG members will agree a **minimum range and quality of services** which will be available, (over and above core GMS), at practice and locality level. Building up a core of services based around **multi-disciplinary teams and extended teams** including primary care based mental health services, psychology services, pharmaceutical advisers, counsellors etc.

- Developing **locality based education, research and training**.

- Further work to learn from best practice elsewhere, where moves towards community-based **multi-professional extended primary healthcare teams based around general practices** that include generalists working alongside specialists and care coordinators have delivered significant improvements in patient experience, outcomes and satisfaction.

- The CCG and localities will support **closer working between practices** in order to ensure that the full range of services are available to all patients within their locality irrespective of which practice they are registered with. In addition, closer working should help practices to build resilience and manage costs. This will need to be done in a way which does not undermine continuity of care for patients.

- Localities will build links with local community and voluntary sector groups to further support the delivery of coordinated care for patients.

Managing the Shift from Secondary to Primary Care Service Provision

Why this is a Priority

Recent years have seen a steady increase in the transfer of work and services to primary care which were previously carried out in secondary care settings. This includes care pathway changes such as;

- reduced number of hospital follow-up appointments
- earlier discharge from hospital
- more post-operative care done in primary care
- more primary care led management of long term conditions.

These changes, together with an ageing population and increased prevalence of chronic diseases, call for a strong shift away from the current emphasis on acute and episodic care, towards prevention, self-care, more consistent standards of primary care, and care that is well co-ordinated and integrated. To date, however, movements towards more care being provided in primary care and community settings have not generally been matched by a shift in resources.

The scale of the change management task to achieve this fundamental shift has generally been underestimated and moves to change the balance in the way in which care is provided have often been under planned and left to drift. There has been an assumption that doing more in primary care and community settings will result in savings. This does not happen however unless the increased investment in community services has been accompanied by a clear and planned strategic disinvestment from hospitals. The CCG needs to be able to make a robust case for such disinvestment where it is clinically justified, and will need strong communication and political skills in order to overcome resistance to such change – whether from local communities or from local practices.

Solutions

- The CCG will commission **improved access to diagnostics and secondary care advice** eg extending direct access to imaging and electrophysiological diagnostics. Commissioning more accessible specialist advice without the requirement for an outpatient appointment.

- The CCG will make **further use of Local Enhanced Services** (or other procurement vehicles) which ensure that primary care is appropriately resourced to develop and participate in new care pathways which address local priorities and provide better services for patients.

- The CCG will develop a comprehensive and **innovative IT Strategy** which supports better coordination and integration across services and allows commissioners to track spend at each stage of the patient journey.

- Ensuring that the primary care aspects of the CCG's strategy for **Long Term Conditions** are appropriately implemented via specifically commissioned services and care pathway development and implementation for conditions such as diabetes, rheumatic diseases, knee replacements, hip replacements, gallstones etc.

- The CCG will consider the further development of **locality attachments for hospital consultants** based on the paediatrics model currently being implemented. This will promote closer working and learning and education.

- The CCG will ensure that local **Quality Premium** targets are introduced in a way which enables Primary Care to be supported to deliver them.

- The CCG will seek to ensure that **primary care premises** are developed to support service delivery in primary care settings where this is clinically appropriate.

Urgent Care – Primary Care's Role

Why this is a priority

Both nationally and locally, urgent care services continue to be a high priority. Urgent care services consume a large part of the available healthcare resource. These are costly services which should only be used when necessary. Dudley has a higher than average admission rate for conditions which would not normally require hospital admission. National benchmarked data suggests that there are higher than expected numbers of patients going to hospital A&E with conditions that can readily be treated in primary care. In addition, once patients reach the hospital they are often admitted with conditions for which admission is largely preventable. This is especially true of ambulatory care-sensitive conditions (ACS) such as congestive heart failure, diabetes, asthma angina and hypertension. According to the Kings Fund, ACS conditions account for 15.9% of all emergency admissions and national evidence demonstrates that there is a significant variation in how effectively ACS conditions are managed in primary care which impacts upon admission rates. This issue is therefore directly linked to primary care. It is interesting to note that at the CCG's Urgent Care event with the local Healthcare Forum most of the issues raised by patients related to the difficulties in accessing primary care which they felt contributed to pressure on A&E services. See comment box below.

Patient Comments from Healthcare Forum Urgent Care Event June 2013

"Need improved access to primary care outside of routine work" hours"

"More availability of appointments in primary care including extended hours"

"Greater co-operation between practices to cover longer hours e.g. rota"

"Better telephone access to GP surgery"

"Need to see GPs as required – difficulty to speak to GP or get an appointments and the problems start when you need emergency access"

"More receptionists to receive calls to avoid the engaged tone"

"CCGs to be stricter with GP practices – set standards of what GPs have to do"

"Standardised set up for all GP practices with criteria"

"Spend money on GP surgeries instead so they provide out of hours"

Solutions

- To ensure that the **CCG's Urgent Care Strategy takes full account of primary care's current and potential contribution** to managing urgent care across Dudley.

- to develop and evaluate a pilot scheme which sees **a step change in the quantum and nature of primary care commissioned with the express aim of reducing avoidable A&E attendances and admissions**, and improving coordination and integration across services in and out of hours.

- To take a pro-active and appropriate approach to consider the role of primary care in relation to **innovative responses** to the national move towards **7 day primary care and community services** and the availability of key health and social care services at evenings and weekends. To work with local practices to design solutions which fit local circumstances and meet the needs of patients and practices.

- To ensure that the urgent care strategy includes specific actions such as the use of risk stratification tools, clinical decision support software within GP practices, and a range of relatively simple primary care based interventions to improve the early identification and **successful management of ACS patients**

- Other **primary care based aspects of urgent care** will also be reviewed within the context of the urgent care strategy including:

    - disease management and support for self-management for those with long-term conditions *(see also workload section above)*
    - telephone health coaching
    - increased continuity of care within GP practices (*see also workload section above)*
    - ensuring effective out of hours arrangements
    - providing effective signposting to help patients choose the right service
    - the ability to flex primary care and community services in response to short-term changes in demand
    - processes within practices for the timely review and management of requests for home visits *(see also PCF work above)*

- the use of real time information and IT to support early decision-making in primary care

Building Resilient Primary Care and Supporting Practices to Thrive

Why this is a priority

As has been outlined in the earlier section, general practice is facing a series of major challenges over the coming months and years. Whilst all practices will be affected, it is likely that some practices may be more adversely affected than others, or that some practices are less well placed than others to weather the changes and challenges. If Dudley CCG is to be successful and ensure high quality healthcare services for local people, it is essential that it has stable and strong primary care primary providers. By anticipating the likely local impact of planned changes at a national level and by mapping local trends in terms of retirements, recruitment and retention etc, CCG members will be much better placed to develop agreed strategies for successfully coping with these changes.

Solutions

- **Close working with the NHS England local area team** to ensure that the CCG has some influence over the direct commissioning of primary care, for example following the retirement of a single-handed practitioner, and can shape local services in line with agreed local strategies.

- To compile clear plans based on the detailed **modelling of anticipated local changes** eg retirements, premises changes, income changes.

- Supporting each member practice to develop a **practice Organisational Development plan,** (which also meets AT requirements), and to ensure that wider CCG strategies and plans reflect these individual plans

- Support practices (and practice managers) to explore **cooperative approaches** within a locality model, (where this is desirable and supported by local practices) eg sharing 'back room' functions eg payroll, centralising call and recall, choose and book. NB such cooperative models could be of any size or shape (of 2 practices or more) to suit local practice requirements and would not need to encompass a whole locality

- To develop a **CCG based primary care support team** with senior clinical and managerial leadership

- To explore the establishment of **a shared locum bank** for local practices in order to improve quality and effectiveness of locums

- To support and **further develop the practice managers' group** to lead innovative solutions to issues facing primary care and to support high quality practice management consistently across the CCG area

- Develop a **practice nurses group** to provide professional support, lead innovative solutions to service provision in primary care and support high quality service provision consistently across the CCG area

- To **increase the number of training practices** in Dudley

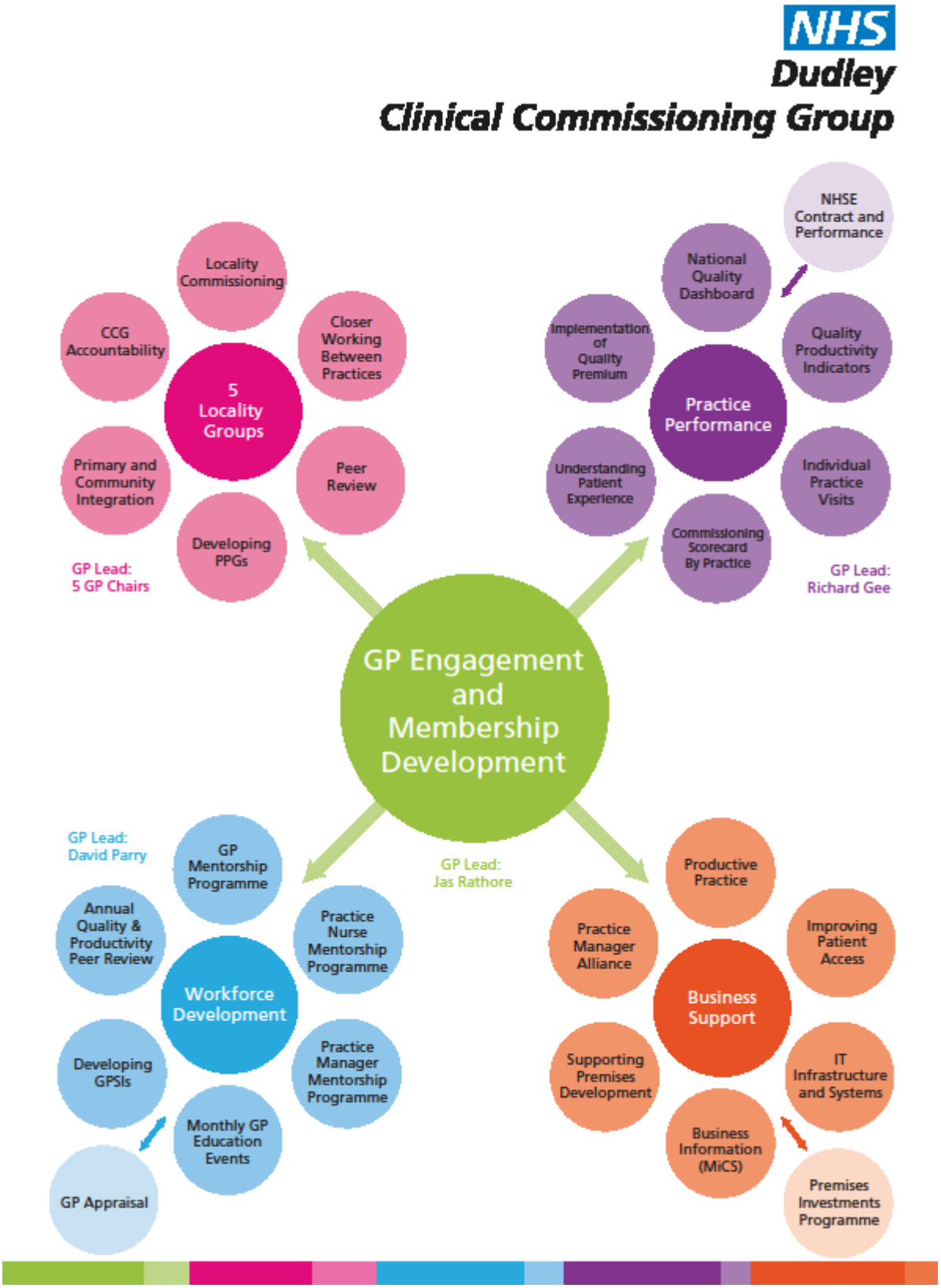
- To **continue initiatives which support and enable member practices to participate in the work of the CCG and be kept informed.** For example, the practice engagement LES which supports practice attendance at meetings, improving practices' ability to engage with the CCG support team and produce practice development plans

- To **support workforce training and development**, *(eg CCG wide procurement where this benefits members)*, developing the mentorship schemes, statutory training/revalidation/support, remediation etc. The CCG will ensure appropriate links with education and training networks including Local Education and Training Boards (LETB's)

- To develop the **Primary Care Quality Monitoring Group** to ensure ongoing close liaison between the CCG, the AT, LMC and Responsible Officer. *(See diagram Attachment 4)*

- To ensure that the **CCG Organisational Development Strategy has an emphasis on supporting the development of CCG members.** This should set out how CCG members will work together to support each other to build a strong, high quality CCG, and how CCG membership benefits members and ultimately their patients.

Processes for supporting the CCG member practices are summarised in the diagram below.



Reducing Unwarranted Variation and Rewarding Excellence

Why this is a priority

At a national level, we know that there is substantial variation between practices in the range, quality and experience of services such as the systematic implementation of approaches towards secondary prevention. For example, disease registers where only a minority of patients receive all recommended interventions. Current information and benchmarking data for Dudley demonstrates that locally there is some significant variation in the quality and outcome of services offered by individual practitioners, practices and localities. Some of these differences can be readily explained and may even be desirable given the different needs of individual localities and patient preferences. Other differences, however, are not readily explained and demonstrate differences in access and quality between practices which are not acceptable for patients and which need to be addressed to ensure improved equitable health outcomes in Dudley. Dudley CCG as a membership organisation is committed to driving up quality, rewarding excellence and driving out poor quality primary care services.

Solutions

- The CCG will complete further work **to share detailed benchmarking information** regarding primary care service delivery with practices and agree actions arising from this.
- CCG members will agree a **process for monitoring and managing primary care performance** against the national assurance framework (and any locally agreed indicators), and will work closely with NHS England local Area Team to ensure that local knowledge is applied to raw data.
- The CCG fully acknowledges the central role practice managers have in the delivery of high quality primary care services and will work with practices to **ensure all practices have access to consistently high quality practice management and organisational skills.** There is good evidence to demonstrate that the achievement of clinical priorities (particularly those related to prevention and management of long term conditions), are directly influenced by how well practices can organise their activities to ensure that they consistently reach *all* targeted patients. In addition, those areas which are of most concern to patients ie access to appointments etc are those which are most directly affected by the way in which the practice is managed.
- The CCG will **build on the PMS Review work** undertaken by the PCT to agree further quality measures with practices and support sustainable moves towards equitable resource distribution. In doing this the CCG will work with the NHS England local Area Team to take account of national initiatives in this respect.
- CCG members will agree a **scheme which incentivises** good performance against agreed indicators and rewards excellence as judged against national benchmarks.
- The CCG will ensure that methods of **procuring services** from primary care will ensure equality of access for all patients.

9. Clinical Priorities for Primary Care

The priorities identified in this primary care development strategy are designed to support primary care to deliver high quality services generally and any specifically identified clinical priorities. Primary care has a crucial role in delivering all of the national priorities across each of the 5 domains as set out in attachment 3. In addition to the national priorities, there are specific local clinical priority areas for primary care linked to the quality premium and the quality and productivity indicators for QOF.

Local Quality Premium Areas	Quality & Productivity Indicators in QOF
Dementia	OPD Pathways: Cardiology, Pain Management, Ophthalmology
Atrial Fibrillation	Reduction in Avoidable A&E Attendances
Hypertension	Emergency Pathways: Atrial Fibrillation, Acute Asthma, Frail Elderly UTIs
To contribute to the CCG's wider strategic priorities for improving health & health services	

10. Health and Wellbeing - Delivering Public Health Priorities and Reducing Health Inequalities

By supporting the development of high quality primary care, this strategy is also designed to ensure that local primary care providers are best placed to play their part in the delivery of Dudley's *'Joint Health and Wellbeing Strategy Wellbeing for life – our plan for a healthier Dudley borough 2013 -2016'*. The aim of this plan is to improve the health and wellbeing of local people and reduce health inequalities.

Dudley is changing and although in national comparisons it scores average for deprivation, the health of people in Dudley lags behind the rest of the country. Some people are living longer and fewer are dying from the big killers – cancer, respiratory disease and heart disease - but not all. There are stark differences across the Borough, with certain wards experiencing disproportionately high levels of ill health and deprivation. Improvements over the last decade have been partly due to improved living conditions and treatments but are also due to people reducing risks to their own health by stopping smoking and reducing cholesterol levels. Rising obesity levels and alcohol consumption are increasing risks into the future. Primary care in Dudley has a crucial role to play in responding to these changes.

More systematic primary prevention in general practice has the potential to improve health outcomes and save costs (Health England 2009). For example, five minutes of advice in a general practice setting to middle-aged smokers to quit smoking can increase quit rates and save £30 per person for a cost of £11 per person.

Evidence suggests that the 'inverse care law' applies and those in greatest need are least likely to receive beneficial services. Identifying those at risk and intervening appropriately is one of the most effective ways in which GPs can reduce the widening gaps in life expectancy and health outcomes (Marmot Review 2010). More systematic and proactive management of long term conditions and preventative healthcare initiatives will improve health outcomes, reduce inappropriate use of hospitals, and have a significant impact on health inequalities. In order to ensure this systematic approach it is crucial that practices are organised and managed to excellent standards (see sections above), and the CCG is committed to supporting all practise to ensure that they have access to this.

More specifically, primary care has a key role in delivering a range of public health initiatives including:

- Immunisation programmes
- Child health
- Cytology/breast screening
- NHS Healthchecks
- Early detection programmes
- Diabetes, hypertension

The CCG will continue to ensure that practices are supported and monitored to ensure that these initiatives are successfully delivered.

11. Measuring and Monitoring Quality in Primary Care

National Assurance Framework

Phrases such as '*improving the quality of primary care'* are used frequently, but in order for this to be meaningful for practitioners and patients there is a need to define what is meant by *'good'* or *'high quality'* and identify how this would be measured or demonstrated. Inevitably different practitioners have different perspectives on this and service users often have yet another view. There are now, however, some performance indicators which have been nationally determined. NHS England has provided a suite of measures which are intended to be transparent and consistent. This indicator set applies to all practices and Area Teams nationally and allows for comparisons to be made across CCGs, nationally or in customised clusters for practices or CCGs with similar characteristics. This tool is called the Primary Medical Assurance Framework: web interface and has recently been launched.

The web interface provides pre-analysed data to facilitate relationships between area teams and practices. Unique practice profiles are also available. It will be important for member practices to understand how to use the tool to compare their practice with peers. Events to introduce practices to the tool are being held nationally and the CCG will be arranging workshops locally. Local workshops will be focussed not just on how practice can use the tool but also on understanding how the tool will be used by NHS England and CCGs.

Local Processes for Monitoring Quality

CCG members will need to agree which other sets of data and benchmarking information should be used locally in addition to the national assurance tool. This will be based on processes currently in use, but these will need to be updated and streamlined in order to reduce duplication and focus on areas of most interest locally eg local priority areas. The organisational arrangements for how this data is reviewed and acted upon will also need to be agreed. An outline process built around a joint primary care quality monitoring group has been drafted. Attachment 4 summarises this and shows how this will link directly to the CCG's wider Committee structure and therefore governance arrangements. The CCG is currently in the process of discussing this with the Area Team in order to ensure that the CCG and Area Team processes are dovetailed as far as possible.

12. Premises

If the CCG is to respond local health needs and develop service models which provide opportunities for more integrated care, closer to patient's homes, primary care premises development will be essential. The CCG is fast moving towards a position where the lack of suitable premises will lead to sub-optimal arrangements for service delivery and the loss of opportunities for closer working between practices to deliver a wider range of services. This is of even more concern when one considers that the areas with the most pressing need for re-developed premises are those with the highest deprivation scores and where there are the greatest health inequalities.

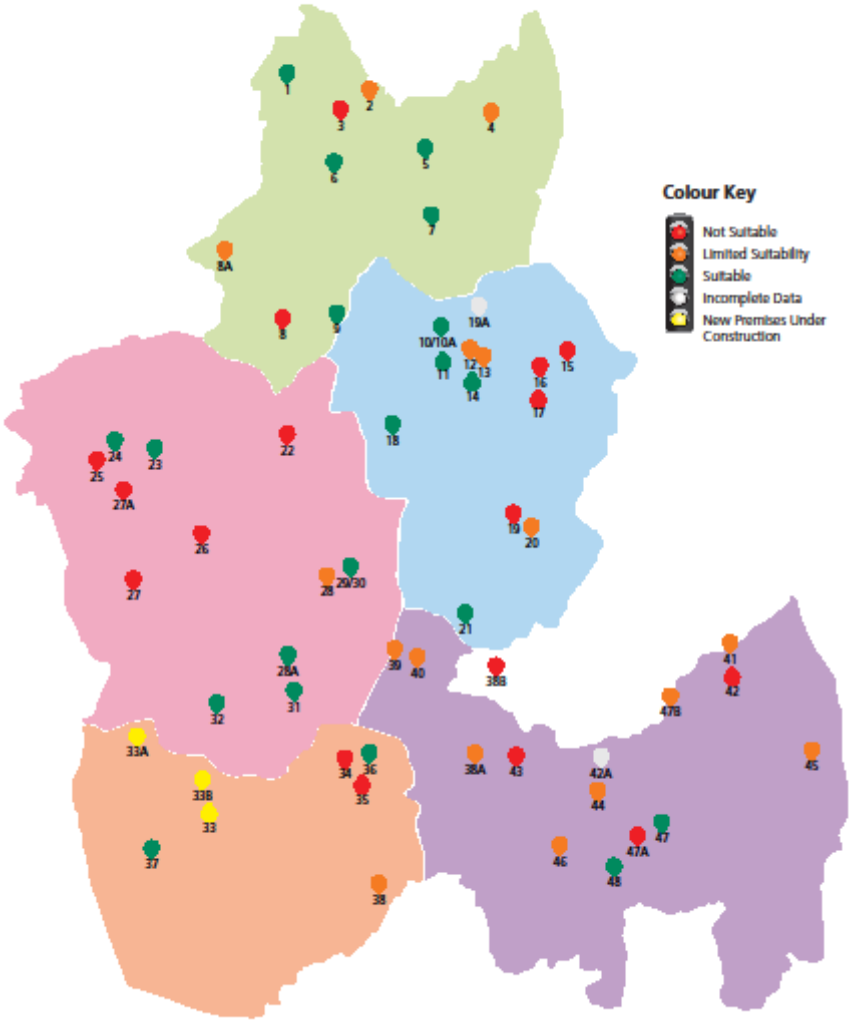
As a result of the recent NHS reorganisation, the process for approving and funding new primary care premises developments is currently unclear, although we do know that this will be under the control of NHS England and its local Area Teams. Whatever the process, however, it is almost certain that this will involve prioritisation between different CCG areas and that decisions to fund new developments will only be made where it can be demonstrated that they address pressing needs and are congruent with local strategic plans. It is essential, therefore, that the CCG has a clear idea of its preferred direction of travel and its premises development priorities in order to be able to act promptly once the process is known and influence funding decisions in ways which support its strategic service development plans.

As part of this process, the CCG has undertaken an initial review of local primary care premises to begin informing this process. This is summarised in the map below. This review, together with existing data and the previous PCT Commissioner Investment & Asset Management Strategy (CIAMS), helps the CCG to begin to focus on potential priority areas for premises development. In order to move forward with this crucial area the CCG will need to ensure that the following actions are incorporated into the implementation plans for this strategy:

- The CCG will ensure that it keeps abreast of **local Area Team plans for managing the premises development process** and participate fully in this.
- The CCG will ensure that the local Area Team is fully aware of the **urgency** of the need for premises developments to ensure that patients are receiving care in facilities which are fit for purpose and to enable the delivery of service developments in areas of greatest health need. (ie putting all new developments 'on hold' indefinitely is not an option.)
- The CCG will agree a view regarding its **preferred procurement route** and whether it wishes to have a choice -at the very least some clarity regarding the application of the LIFT exclusivity agreement to the CCG is required. *(Some schemes, especially small individual schemes, are unlikely to be considered viable via a LIFT route and the CCG needs to have the flexibility to devise innovative solutions to these.)*
- CCG members will agree **prioritisation criteria for new premises developments** which take account of both known and opportunistic aspects of premises development. These then need to be applied to the current information and priorities agreed.
- CCG members will agree the **minimum criteria** which will be applied to new premises developments in order to ensure that these meet the strategic service needs.
- The CCG will consider pulling together **broad outline costs for a replacement/development programme to address the most urgent needs** in order to provide a basis for planning and discussion with the local Area Team.

Premises Suitability

NHS
Dudley
Clinical Commissioning Group



Colour Key

- Not Suitable
- Limited Suitability
- Suitable
- Incomplete Data
- New Premises Under Construction

Sedgley, Coseley and Gornal

- 1 Northway Surgery
- 2 Bath Street Surgery
- 3 Bilston Street Surgery
- 4 Coseley Medical Centre
- 5 Woodsetton Medical Centre
- 6 The Ridgeway Surgery
- 7 The Greens Health Centre
- 8 Lower Gornal Health Centre
- 8A Masefield Road Surgery (Lower Gornal Branch)
- 9 Castle Meadows Surgery

Dudley and Netherton

- 10 St James Medical Practice (Dr White)
- 10A St James Medical Practice (Dr Porter)
- 11 Eve Hill Medical Practice
- 12 Tinchbourne Street Surgery
- 13 Cross Street Health Centre
- 14 Stoppingstones Medical Practice
- 15 St Thomas's Medical Practice
- 16 Central Clinic
- 17 Bean Road Surgery
- 18 Kooltinge House Surgery
- 19 Netherton Surgery
- 19A Hazel Road Surgery (Netherton Surgery Branch)
- 20 Netherton Health Centre
- 21 Quarry Road Surgery

Kingswinford, Amblecote and Brierley Hill

- 22 High Oak Surgery
- 23 Kingswinford Health Centre
- 24 Moss Grove Surgery
- 25 Summerhill Surgery
- 26 Rangeways Road Surgery
- 27 Wordsley Green Health Centre
- 27A Market Street Surgery (Wordsley Green Branch)
- 28 AW Surgeries
- 28A Withymoor Surgery (AW Branch)
- 29 Waterfront Surgery
- 30 Brierley Hill Health Health and Social Care Centre
- 31 Quincy Rise Surgery
- 32 Three Villages

Stourbridge, Wollaston and Lye

- 33 Worcester Street Surgery
- 33A Meriden Avenue Surgery (Worcester St Branch)
- 33B Greenfield Avenue Surgery (Worcester St Branch)
- 34 Pedmore Medical Practice
- 35 Chapel Street Surgery
- 36 The Limes Surgery
- 37 Norton Medical Practice
- 38 Wychbury Medical Group

Halesowen and Quarry Bank

- 38A Chapel House Lane (Wychbury Branch)
- 39 Thorns Road Surgery
- 40 Quarry Bank Medical Centre
- 41 Clement Road Medical Centre
- 42 Foldon Lane Surgery
- 42A Hawne Lane Surgery (Foldon Lane Branch)
- 43 Crestfield Surgery Ltd
- 44 Alexandra Medical Centre
- 45 Lapal Medical Practice
- 46 Meadowbrook Surgery
- 47 Halesowen Health Centre
- 47A Tenlands Avenue Surgery (Halesowen HC Branch)
- 47B Coombs Road Surgery (Halesowen HC Branch)
- 48 St Margaret's Wells Surgery

Out of Area

- 38B Cradley Road Surgery (Wychbury Branch)

Data correct as of April 2013

13. Principles to Inform Decision-making Processes for Primary Care Development and Investment

Reaching agreement regarding future models of service delivery and making investment decisions is not a straightforward process. For any issue, it is likely that there will be a range of varying, strongly held views across the patch and it is important, therefore that members have an agreed set of underlying principles which guide future strategic and investment decisions and ensure that these are made fairly and in an open and transparent way.

Underlying Principles for Decision-making

- *Decisions should improve services and outcomes for patients*
- *Investment decisions must be made in line with locally agreed policies for managing conflicts of interest and procurement (which are compliant with national and statutory requirements)*
- *Priorities for investment should be in line with CCG strategic aims eg reducing health inequalities, and support the achievement of local priorities for quality and service improvement*
- *Decisions must be transparent and made via agreed processes as set out in the CCG's Constitution*
- *Decisions should, wherever possible, seek to reduce unwarranted variation*
- *Investment decision-making should allow for the encouragement of innovation and rewarding excellence*
- *That all member practices will be consulted and have the opportunity to give appropriate consideration on future models of service delivery*

14. Implementing the Strategy and Monitoring Progress

Once the final strategy is agreed and signed off by CCG members there will need to be a clear process for implementing and monitoring progress for each of the priority areas and action plans. This process will be overseen by the Primary Care Development Committee which will approve the implementation plan and will receive regular reports on progress against this plan. The implementation of the Strategy will be led and coordinated by the Head of Membership Development. Reports on progress will also be made to individual locality groups and to the CCG membership engagement events. In addition, regular reports on progress will be made to key patient groups including the CCG Patient Opportunities Panel (POPs) and the local Healthcare Forum.

Patient groups will be central to the process for developing and monitoring the detailed implementation plans. Research has shown that direct involvement of patients can be a great driver for change and for ensuring actions are delivered. As a minimum, each action/priority will have an outcome measure or measures, together with milestone measures. These outcome measures will be agreed with CCG membership.

Attachment 1

Dudley CCG Strategic Commissioning Plan on a Page

Thinking Differently

NHS
Dudley Clinical Commissioning Group

Our Vision:

To promote good health and ensure high quality health services for the people of Dudley

What we do:

- Set the vision and objectives for healthcare in Dudley
- Hold the local health economy to account for delivery
- Facilitate improvements and transformational changes
- Engage with our public and patients
- Support quality improvement with our members
- Ensure good governance and work with key partners

Our Objectives:

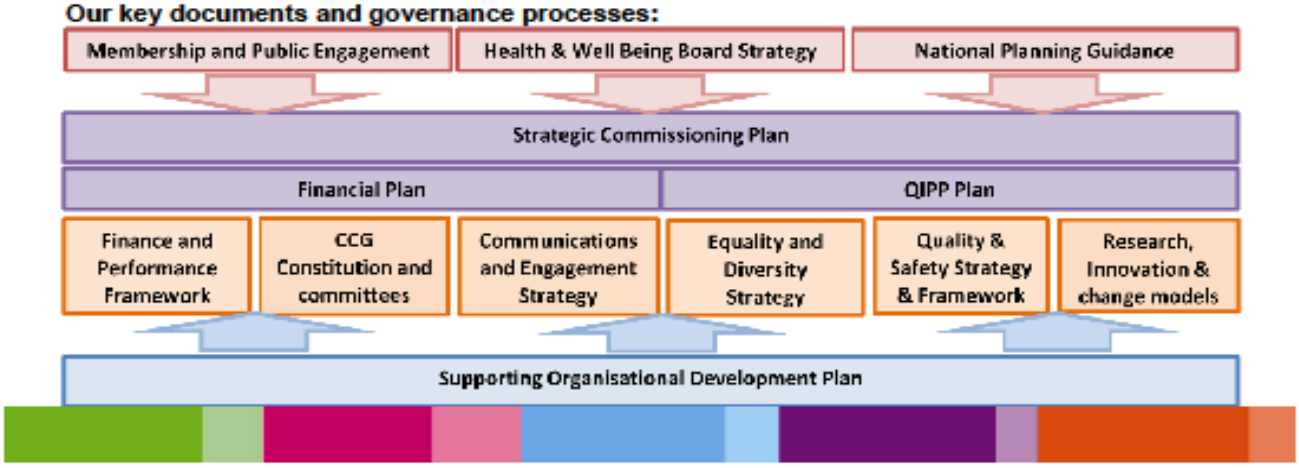
Reducing Health Inequalities	Delivering Best Possible Outcomes	Improving Quality and Safety
•Reducing premature mortality •Reducing emergency hospital admissions due to alcohol •Reducing Childhood Obesity •Reducing CVD mortality* •Improve AF review & treatment rates*	•Improve patient experience of healthcare (use of the friends & family test) •Increased early detection of dementia* •Reducing the levels of undetected hypertension and diabetes* •Improve access and choice of services	•Reduce incidence of pressure ulcers •Reduce unwarranted variations •Reduce incidence of Clostridium difficile •Zero tolerance of MRSA bacteraemia •Safeguarding children and adults

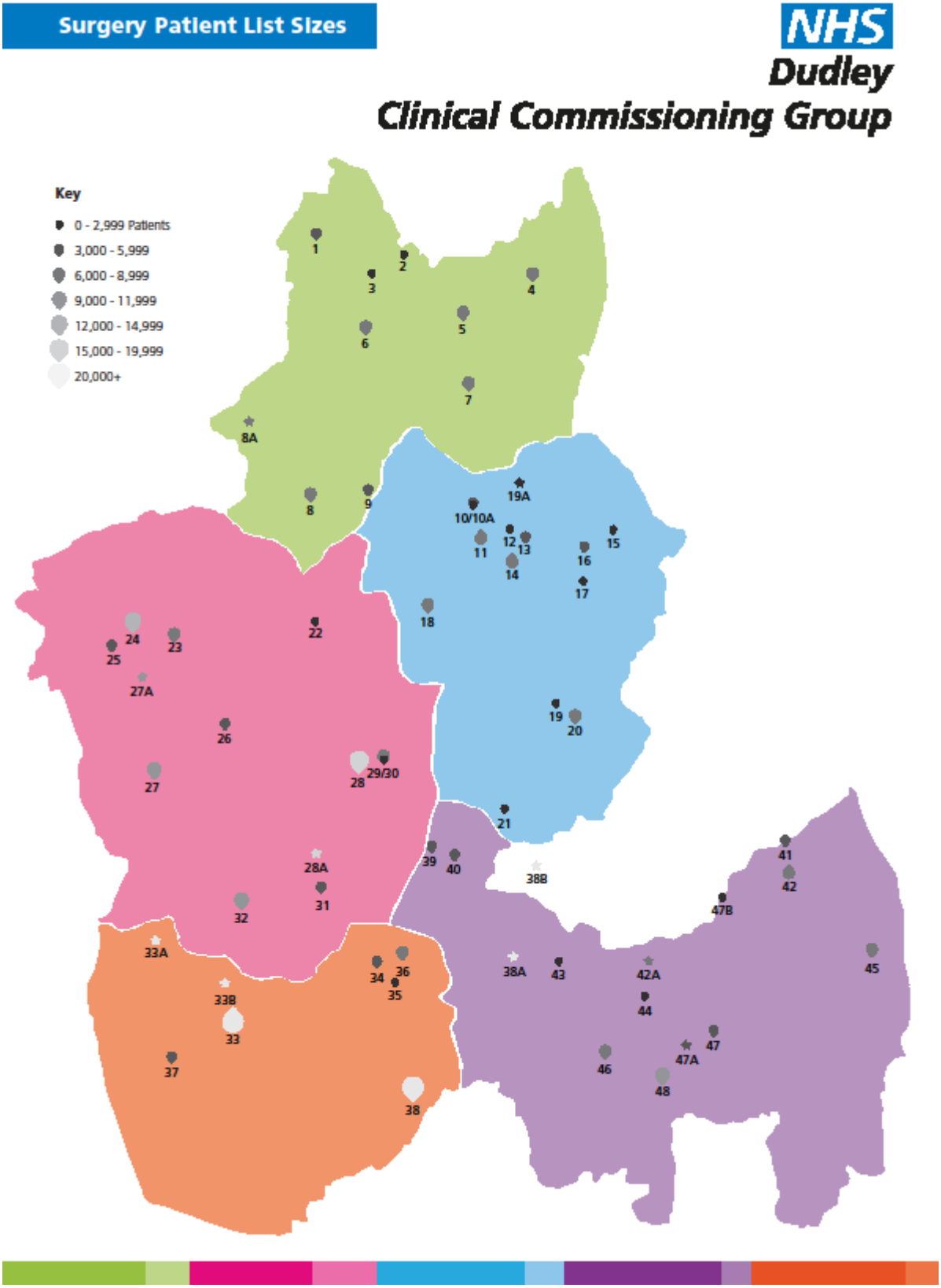
*Our Local Quality Premium Targets

Our Commissioning Priorities:

Children's Services -Reducing childhood obesity -Safeguarding children	**Improving Urgent Care** -Reducing avoidable emergency inpatient admissions	**Primary Care Mental health** -Improving the levels of diagnosis of dementia*	**Improving Care for Older People** -Reducing incidence of pressure ulcers -Safeguarding adults	**Improving Diabetes Services** - Reducing the levels of undetected hypertension and diabetes
Improving Access to Cardiology - Reducing cardiovascular disease mortality*	**Ophthalmology Pathway** -Improving access to ophthalmology services	**Improving Stroke Care** -Reducing Mortality rate from stroke -Improving AF review & treatment rates*	**Community Nursing Services** - Improving care to people with limiting long term illness, health problem or disability	**Alcohol Service** -Reducing emergency admissions linked to alcohol
Primary Care Strategy - Supporting Quality Improvement in primary care services - Reducing unwarranted variation in performance		**Prioritisation of Resources** - Improving productivity to achieve financial sustainability - Redesigning services to provide more efficient care to patients		

Our key documents and governance processes:




Surgery Patient List Sizes
NHS
Dudley
Clinical Commissioning Group
Key
0 - 2,999 Patients
3,000 - 5,999
6,000 - 8,999
9,000 - 11,999
12,000 - 14,999
15,000 - 19,999
20,000+
1
2
3
4
5
6
7
8A
8
9
10/10A
19A
11
12
13
14
15
16
17
18
22
24
23
25
27A
26
27
28
29/30
19
20
21
39
40
38B
28A
31
32
41
42
47B
33A
34
36
35
38A
43
42A
45
44
33B
33
37
47
47A
46
48
38

NHS
Dudley
Clinical Commissioning Group

Surgery Patient List Sizes Key

- 0 - 2,999 Patients
- 3,000 - 5,999
- 6,000 - 8,999
- 9,000 - 11,999
- 12,000 - 14,999
- 15,000 - 19,999
- 20,000+

* Branch data is included with the Main Practice data with the exception of 47B Coombs Road Surgery (Halesowen HC Branch)

Data correct as of April 2013

Sedgley, Coseley and Gornal

1	Northway Surgery	5,459
2	Bath Street Surgery	2,727
3	Bilston Street Surgery	2,999
4	Coseley Medical Centre	7,026
5	Woodsetton Medical Centre	6,328
6	The Ridgeway Surgery	8,994
7	The Greens Health Centre	7,754
8	Lower Gornal Health Centre	8,970
8A	Masefield Road Surgery (Lower Gornal Branch)	*
9	Castle Meadows Surgery	4,781

Dudley and Netherton

10	St James Medical Practice (Dr White)	2,307
10A	St James Medical Practice (Dr Porter)	5,135
11	Eve Hill Medical Practice	7,077
12	Tinchbourne Street Surgery	1,702
13	Cross Street Health Centre	4,363
14	Steppingstones Medical Practice	6,385
15	St Thomas's Medical Practice	1,205
16	Central Clinic	4,155
17	Bean Road Surgery	2,091
18	Koellnge House Surgery	6,351
19	Netherton Surgery	2,582
19A	Hazel Road Surgery (Netherton Surgery Branch)	*
20	Netherton Health Centre	7,253
21	Quarry Road Surgery	2,787

Kingswinford, Amblecote and Brierley Hill

22	High Oak Surgery	2,800
23	Kingswinford Health Centre	7,861
24	Moss Grove Surgery	14,685
25	Summerhill Surgery	5,644
26	Rangeways Road Surgery	5,049
27	Wordsley Green Health Centre	9,849
27A	Market Street Surgery (Wordsley Green Branch)	*
28	AW Surgeries	18,763
28A	Withymoor Surgery (AW Branch)	*

Kingswinford, Amblecote and Brierley Hill

29	Waterfront Surgery	6,418
30	Brierley Hill Health Health and Social Care Centre	2,151
31	Quincy Rise Surgery	3,218
32	Three Villages	9,346

Stourbridge, Wollaston and Lye

33	Worcester Street Surgery	24,995
33A	Meriden Avenue Surgery (Worcester St Branch)	*
33B	Greenfield Avenue Surgery (Worcester St Branch)	*
34	Pedmore Medical Practice	3,704
35	Chapel Street Surgery	1,877
36	The Limes Surgery	7,962
37	Norton Medical Practice	5,810
38	Wychbury Medical Group	21,395

Halesowen and Quarry Bank

38A	Chapel House Lane (Wychbury Branch)	*
39	Thorns Road Surgery	3,680
40	Quarry Bank Medical Centre	3,777
41	Clement Road Medical Centre	3,386
42	Foldon Lane Surgery	8,390
42A	Hawne Lane Surgery (Foldon Lane Branch)	*
43	Crestfield Surgery Ltd	1,555
44	Alexandra Medical Centre	2,884
45	Lapal Medical Practice	6,679
46	Meadowbrook Surgery	7,455
47	Halesowen Health Centre	4,871
47A	Tenlands Avenue Surgery (Halesowen HC Branch)	*
47B	Coombs Road Surgery (Halesowen HC Branch)	2,295
48	St Margaret's Wells Surgery	9,108

Out of Area

38B	Cradley Road Surgery (Wychbury Branch)	*

The 2011/12 NHS Outcomes Framework

One framework
defining how the NHS will be accountable for outcomes

Five domains
articulating the responsibilities of the NHS

Ten overarching indicators
covering the broad aims of each domain

Thirty one improvement areas
looking in more detail at key areas within each domain

Fifty one indicators in total
measuring overarching and improvement area outcomes

1 Preventing people from dying prematurely

Overarching indicators

1a Mortality from causes considered amenable to healthcare *(The Commissioning Board would be expected to focus on improving mortality in all the components of amenable mortality as well as the overall rate)*
1b Life expectancy at 75

Improvement areas

Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease*
1.2 Under 75 mortality rate from respiratory disease*
1.3 Under 75 mortality rate from liver disease*
1.4 Cancer survival
i One- and ii five- year survival from colorectal cancer
iii One- and iv five- year survival from breast cancer
v One- and vi five- year survival from lung cancer

Reducing premature death in people with serious mental illness
1.5 *An indicator needs to be developed**

Reducing deaths in young children
1.6i Infant mortality*
1.6ii Perinatal mortality (including stillbirths)

** Shared responsibility with Public Health England*

2 Enhancing quality of life for people with long-term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions

Improvement areas

Ensuring people feel supported to manage their condition
2.1 Proportion of people feeling supported to manage their condition

Improving functional ability in people with long-term conditions
2.2 Employment of people with long-term conditions

Reducing time spent in hospital by people with long-term conditions
2.3i Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
2.3ii Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Enhancing quality of life for carers
2.4 Health-related quality of life for carers

Enhancing quality of life for people with mental illness
2.5 Employment of people with mental illness

3 Helping people to recover from episodes of ill health or following injury

Overarching indicators

3a Emergency admissions for acute conditions that should not usually require hospital admission
3b Emergency readmissions within 28 days of discharge from hospital

Improvement areas

Improving outcomes from planned procedures
3.1 PROMs for elective procedures

Preventing lower respiratory tract infections in children from becoming serious
3.2 Emergency admissions for children with LRTI

Improving recovery from injuries and trauma
3.3 *An indicator needs to be developed*

Improving recovery from stroke
3.4 *An indicator needs to be developed*

Improving recovery from fragility fractures
3.5 The proportion of patients recovering to their previous levels of mobility/walking ability at i 30 and ii 120 days

Helping older people to recover their independence after illness or injury
3.6 Proportion of older people (65 and over) who were still at home after 91 days following discharge from hospital into rehabilitation services

4 Ensuring that people have a positive experience of care

Overarching indicators

4a Patient experience of primary care
4b Patient experience of hospital care

Improvement areas

Improving people's experience of outpatient care
4.1 Patient experience of outpatient services

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to in-patients' personal needs

Improving people's experience of accident and emergency services
4.3 Patient experience of A&E services

Improving access to primary care services
4.4 Access to i GP services and ii dental services

Improving women and their families' experience of maternity services
4.5 Women's experience of maternity services

Improving the experience of care for people at the end of their lives
4.6 Survey of carers

Improving experience of healthcare for people with mental illness
4.7 Patient experience of community mental health services

Improving children's experience of healthcare
4.8 *An indicator needs to be developed, although this may be difficult to measure*

5 Treating and caring for people in a safe environment and protect them from avoidable harm

Overarching indicators

Three part measure patient safety measure consisting of:
5a patient safety incident reporting
5b severity of harm; and
5c number of similar incidents

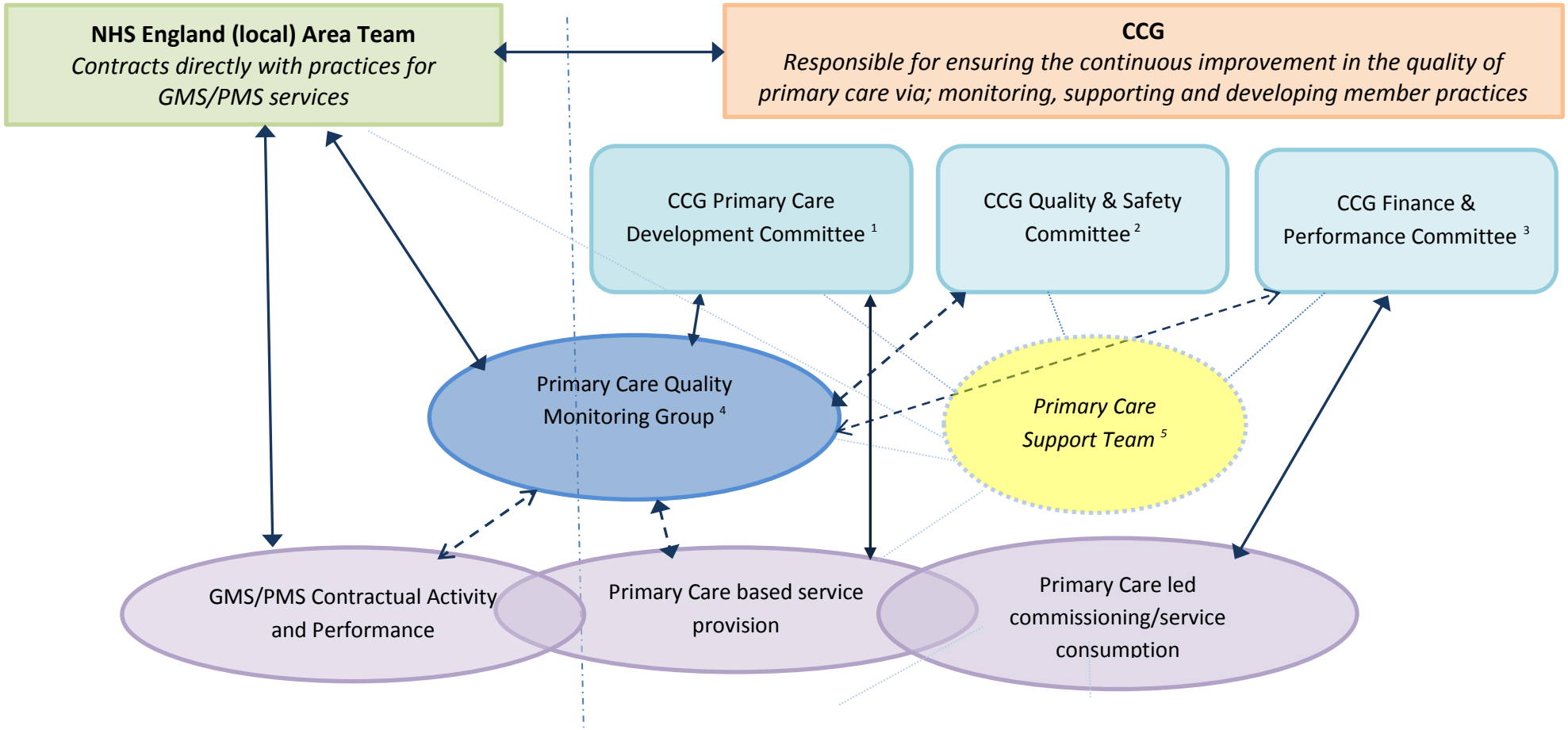
Improvement areas

Reducing the incidence of avoidable harm
5.1 Incidence of hospital-related venous thromboembolism (VTE)
5.2 Incidence of healthcare associated infection
i MRSA
ii D Difficile
5.3 Incidence of newly-acquired category 3 and 4 pressure ulcers
5.4 Incidence of medication errors causing harm

Improving the safety of maternity services
5.5 Admission of full-term babies to neonatal care

Delivering safe care to children in acute settings
5.6 Incidence of harm to children due to 'failure to monitor'

Monitoring Quality in Primary Care – Proposed Process



Note 1: CCG Primary Care Development Committee is responsible for overseeing all CCG activity in relation to the development of primary care. This includes mentoring, training, education, research initiatives.

Note 2: CCG Quality and Safety Committee is responsible for monitoring CCG wide quality indicators and ensuring action is taken to improve quality where this is falling below agreed standards.

Note 3: CCG Finance and Performance Committee monitors performance in relation to commissioned services

Note 4: 'Primary Care Quality Monitoring Group' has joint membership from Area Team, CCG and LMC. Reviews and monitors primary care quality using data and soft intelligence. Agrees appropriate actions and keeps progress under review. Actions could range from mentoring, training and support, to the instigation of a more formal process in relation to contract compliance which would be led by the AT.

Note 5: CCG Primary Care Support team is led by Head of membership Development and GP Engagement Lead. It supports each element of the process. Reviews data and other relevant intelligence and provides reports to appropriate committees. Has day to day liaison with AT.

Primary Care Development Strategy
GLOSSARY

ABBREVIATIONS

Abbreviation	Meaning
A&E	Accident and Emergency
ACS	Ambulatory Care sensitive Conditions
AT	NHS England local Area team
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CHD	Coronary Heart Disease
CIAMS	Commissioner Investment and Asset Management Strategy
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CVD	Cardio Vascular Disease
DES	Directed Enhanced Service
DNA	Did not attend
DoH	Department of Health
EMI	Older People with Mental Illness (Elderly Mentally Ill)
EPP	Expert Patients Programme
FOI	Freedom of Information
GMS	General Medical Services
GP	General Practitioner
GPAQ	General Practice Assessment of Quality
GPwSI	GPs with Special Interest
HR	Human Resources
HV	Health Visitor
IAPT	Improved Access to Psychological Therapies
IT	Information Technology
LETB	Local Education and Training Board
LES	Local Enhanced Service
LIFT	Local Improvement Finance Trust

LMC	Local Medical Committee
LTC	Long Term Conditions
MDT	Multi Disciplinary Team
NGMS	New General Medical Services
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NRT	Nicotine Replacement Products
OD	Organisational Development
OPD	Out Patient Department
OOH	Out of Hours
PCDC	Primary Care Development Committee
PCF	Primary Care Foundation
PCT	Primary Care Trust
PMS	Primary Medical Services
POPS	Patient Opportunity Panel
PSA	Public Service Agreement
QIPP	Quality, Innovation, Productivity and Prevention
QMAS	Quality Management and Analysis System
QP	Quality Premium
QOF	Quality and Outcome Framework
SLA	Service Level Agreement
SSDP	Strategic Services Development Plan
THR	Total Hip Replacement
TKR	Total Knee Replacement
UTI	Urinary Tract Infection
WIC	Walk in Centre
WTE	Whole Time Equivalent

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The Dudley Group NHS
NHS Foundation Trust

Agenda Item No 8

Dudley Health Scrutiny Committee – 16th July 2013

The Dudley Group NHS Foundation Trust
Maternity Update

1.0 Purpose of Report

To update the Committee on the Trust's progress to manage maternity demand.

2.0 Background

As per previous papers which laid out the requirement to restrict our maternity bookings to ensure we continue to provide safe, effective care for women and their babies.

3.0 Update

3.1 Following discussions with the Black Country Commissioning Cluster, restrictions were placed upon bookings from a specified number of GP practices in Sandwell which are closer to City Hospital than Russells Hall Hospital (RHH).

The restrictions, implemented in December 2011, have resulted in the desired reduction in births of approximately 100 per month, mostly for Sandwell women. Dudley GP practices were not restricted and no complaints were received from Dudley women. Agreement was reached with local commissioners and stakeholders to continue the cap throughout the financial year of 2013/14 with a midyear review during July/August, date yet to be determined.

A maternity strategy business case was submitted to our Trust Board in October 2012 outlining options ranging from maintaining restrictions on bookings to the expansion of services to accommodate predicted maximum potential activity. As would be expected all proposals in the business case indicate significant financial implications to address maternity activity long term.

In order to meet the choices of women who wish to deliver here, the preferred option outlined in the business case was for the maternity unit to expand into part of a neighbouring ward space, increasing the bed capacity by 12 beds. The business case was fully supported by The Dudley Group Board and immediate investment was made into increased midwife levels.

However, since receiving authorisation to work towards expansion of the maternity unit, the introduction of a Maternity Tariff during April 2013 has resulted in a significant drop of income to maternity services which necessitate us to review the financial viability of expanding maternity services at Russells Hall Hospital.

Data is being collated in an attempt to predict the likely impact of releasing part or all of the booking restriction both clinically and financially. Results of this analysis and recommended options will be shared with The Dudley Group Board by autumn 2013 and will inform further discussions with commissioners on the management of maternity demand in Dudley.

4.0 Guidelines

4.1 Safer Childbirth guidelines

5.0 Equality Impact

5.1 Once set the Maternity Strategy will be clear and will apply equally. An Equality Impact Assessment is being carried out.

6.0 Recommendation

6.1 For information
6.2 Reassurance that we are working with stakeholders to provide the safest possible care for Dudley women.
6.3 Reassurance that current pressures have not impacted on service quality

Richard Cattell
Director of Operations
The Dudley Group NHS Foundation Trust

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