Dudley Beacon & Castle
Primary Care Trust

LOCAL DELIVERY PLAN 2005/06 – 2007/08

DUDLEY BEACON AND CASTLE PRIMARY CARE TRUST

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Contents

VISIONS AND VALUES

This Local Delivery Plan has been developed using the Trust's Visions and Values.

Mission Statement

Dudley Beacon and Castle Primary Care Trust will work with partner organisations and the community to achieve a demonstrable year on year improvement in the health of the population that it services, particularly those who are most disadvantaged.

We have set out our organisational values in the form of 10 questions. They are:

- Are we improving the health and wellbeing of patients and the community that we serve?
- Are we being fair, honest, open and transparent?
- Are we striving for excellence?
- Are we encouraging innovation, creativity and new ways of working which are subject to evaluation?
- Are we using our manpower and financial resources, information, equipment and buildings effectively?
- Do we show respect for everyone?
- Are we encouraging the contribution and participation of everyone in the PCT, the community, patients and other stakeholders?
- Are we improving the safety and effectiveness of what we do, for both patients and staff?
- Do we support everyone in the Primary Care Trust with their professional development needs as aligned with the needs of the service?
- Do all staff who are not directly involved in patient care give priority to supporting clinicians?

DUDLEY BEACON AND CASTLE PRIMARY CARE TRUST

LOCAL DELIVERY PLAN 2005/06 – 2007/08

Strategic Executive Summary

Overview

The 2005/06 to 2007/08 Local Delivery Plan (LDP) has been developed in accordance with the Vision and Values of the PCT. All the strategies and plans to meet targets and improve standards have been developed by multi-disciplinary, and multi-agency where appropriate, groups of professional staff often joined by users, carers or other relevant community representatives. Bringing the plan into a coherent whole and the determination of priorities for investment has been driven by our Professional Executive Committee with its majority of clinical members. In its latter stages of completion, but none the less still at the work in progress stage, the plan has been presented to our public engagement forum "Voices for Health".

The LDP is in financial balance for each of the three years and our underlying recurring deficit is returned to surplus in 2007/08.

Excellent progress will be achieved against all the Public Sector Agreement (PSA) targets and a realistic risk assessment is given. No target is scored as red (ie high risk) and those that are scored amber (ie some risk) are often associated with data uncertainty.

The Plan also demonstrates the commitment of the PCT to addressing health inequalities and health improvement as well as providing treatment.

Finally, the first year of the Plan will see the conclusion of "Shaping the Future" – the development of community services to complement the newly configured acute hospital – an integral part of which has been the development of the new model of care which is increasingly influencing the strategic development of such services throughout Birmingham and the Black Country and beyond.

Health Inequalities and Health Improvement

The PCT remains committed to striking a new balance between long term health improvement through prevention and promotion and treatment of illness:

- support for smoking cessation programmes is increased in the context of achieving real reductions in smoking prevalence:
- new programmes to reduce obesity prevalence, to empower people in disadvantaged areas and to promote good sexual health are launched.

Race Equality
Improving health services for BME communities and employing a diverse workforce which is representative of the community across all levels in the organisation is a priority for the PCT:

- The Board and Chief Executive will take a lead role.
- Present services will be reviewed and improved and new services for BME users will be developed.
- Communications with BME communities will improve.
- We will ensure that BME service users get the full advantages of improved access and choice.
- We will ensure that the workforce is representative of the community.

Healthy Start to Life
The PCT fully supports the increasing priority being given to the development of services for families and children and will work closely with both statutory and voluntary organisations:

- A Local Safeguarding Children Board will be established by 2006.
- Children's Trust arrangements, including the appointment of a Director of Children's Services, will be in place by 2008.
- A Common Assessment Framework for use by all services will be introduced, supported by information sharing protocols.
- Every opportunity will be taken to establish new pooled budgets between agencies to ensure seamless services.

Supporting People with a Long Term Condition
The PCT is a leader in the development of models of care and their implementation for people suffering from long term conditions:

- Implementation of care arrangements across the spectrum of need will be completed by extended assertive case management and expansion of expert patient programmes.
- New community based services will be introduced in diabetes, coronary heart disease and heart failure.
- A range of public health initiatives (eg adult weight management; smoking cessation) to reduce the incidence of long term conditions will be introduced or expanded.
- The new Heart and Lung Centre at Wolverhampton and new services in the redeveloped Russells Hall Hospitals will improve access to specialist CHD services.

Choice / Book and Choose
The PCT is committed to the improvements that the introduction of Choice and the new booking arrangements will bring to patient experience:

- Choice in cataracts and cardiac surgery are currently being introduced.
- All patients will have a choice of 4/5 providers for elective care by the end of 2005.
- Electronic and other systems as necessary will be introduced to support patient booking in line with national milestones.

Capacity and Investment Planning
The PCT is expanding capacity both in community and hospital services to improve access and reduce waiting times:

- An achievable programme to ensure that the maximum wait from referral to treatment is 18 weeks by 2008, with other milestones for good progress before then.
- Development of the new Health Improvement Centres in the community.
- Support for the Black Country Review.

Orthopaedics
The PCT recognises that the specialty of Orthopaedics is a major element of the totality of waits for specialist care:

- A new Orthopaedic Triage service will be introduced during 2005.
- The maximum wait from referral to treatment of 18 weeks by 2008 will be achieved.
- Significant use will be made of the new Treatment Centre at the Royal Orthopaedic Hospital, Birmingham and independent sector initiatives.

Diagnostics
The PCT will ensure that waits for diagnostic investigations become increasingly insignificant in the context of meeting the total 18 week target:

- GP direct access to CT scanning, MRI and other appropriate investigations will be introduced in the context of integrated care pathways.
- Through commissioning processes, waiting time standards will be improved within hospitals.

Adult Mental Health
A major redesign of mental health services will be completed, including:

- The introduction of new services including Early Intervention, Crisis Resolution and Assertive Outreach.
- A review of the scale of need for inpatient services.
- An increasing emphasis and support for mental health services in primary care.

Older People
The PCT is committed to ensuring that older people have fair access to all health services they require:

- A range of developments which are part of "Shaping the Future" (eg integrated stroke services, intermediate care, falls service) will be completed.
- Partnership working arrangements with both statutory and voluntary organisations will be further built upon.

Learning Disabilities
The reprovision of services at Ridge Hill into the community will be completed.

Family Health Services (FHS)
The PCT fully recognises Dentists, Optometrists and Pharmacists as important components of the Primary Health Care Team (PHCT):

- Access to NHS Dentistry and emergency dental care will be improved, particularly in the most deprived areas.
- Full advantage will be taken of the introduction of the new pharmacy contract to develop the PHCT role of the pharmacist.

National Programme for Information Technology (NPfIT)
The PCT has a fully operational NPfIT structure in place and acknowledges the importance of IT to 21st century healthcare:

- New mental health, community and child health IT systems will be introduced.
- IT systems development will support the introduction of patient choice and booking.

Workforce Development
This Workforce Plan has been developed in conjunction with service managers, and will be continuously developed and evolved to encompass areas outside the LDP.

- It demonstrates an understanding of the connection between the service development and workforce needs.
- It reflects local and national priorities

Payment by Results
The PCT has been gearing up for a number of months for the implementation of Payment by Results for most acute hospital services in 2005/06:

- The PCT fully supports the SHA-wide initiative to press on with implementation in 2005/06 despite the national deferment.
- The Payment by Results regime has been used where relevant throughout the LDP and in costing investments required

Practice-based Commissioning
The PCT had already decided to introduce practice based commissioning as a fundamental tool to pursue our Vision and Values:

- Building upon important progress already made in clinical engagement.
- Recognising practice based commissioning as a foundation stone of other systems reforms, including Payment by Results and Patient Choice.

Standards for Better Health ("National Standards; Local Action") and Clinical Governance
The PCT welcomes the increasing national move from targets to standards and the empowerment of local health services to meet the latter:

- We have structured our organisation to ensure deliberate progress across all standard domains.
- We have achieved CNST level 1b and are working towards level 2.

Tackling Healthcare Acquired Infection
The PCT and the Dudley Group of Hospitals NHS Trust already have a good track record in minimising healthcare acquired infections:

- Action plans to make further progress have already been approved.

Service User and Community Engagement
The PCT acknowledges the real contribution to health improvement of good public and staff engagement and communications:

- The PCT's community engagement forum 'Voices for Health' will continue to be supported.
- The increasingly fruitful liaison with the Good Health Select Committee (Overview and Scrutiny) of Dudley MBC will be built upon.
- Good communications and consultation with BME communities is a particular priority.

Local Targets
The PCT has a series of local targets associated with the implementation of the discrete projects which collectively make up "Shaping the Future". Local milestones have also been set to achieve longer term national targets (eg 18 week wait from referral to treatment).

2. UPDATE ON 2003-2006 LDP

2.1 Key achievements

The 2004/05 LDP supported a range of developments to achieve the targets facing the PCT, both in its role as a PCT commissioning services and improving the health of our community and in its role as the provider of mental health services to the whole of Dudley. Looking forward to March 2005, the PCT expects to achieve the vast majority of targets it has set itself. The specific position on the Key Targets for 2004/05 determined by the Healthcare Commission is as follows:

2.1.1 Primary Care Trust

Key Target		Expected position / commentary
Access to a GP Percentage of patients able to be offered a routine appointment to see a GP within two working days.	Green	100% (already being achieved)
Access to a Primary /Care Professional (PCP) Percentage of patients able to be offered a routine appointment to see a primary care professional within one working day.	Green	100 % (already being achieved)
Drug Misusers Accessing Treatment Increase in drug misusers accessing treatment.	Green	100% increase by 2008 against 1998 baseline already being achieved.
Elective Patients Waiting Longer than Standard Measurement of the breaches of the 9 month target for an elective inpatient or day case admission.	Green	No patient will have waited longer than 9 months throughout 2004/05. No patient will wait longer than 6 months by 31 March 2005.
Financial Management Achievement of the financial position shown in the 2004/05 Plan, submitted to the Department of Health, without the need of unplanned financial support.	Green	Will be achieved.

Four-Week Smoking Quitters Number of smokers who quit at four-week follow-up with the NHS smoking cessation services (performance against plan).	Green	The target of 1200 will be achieved.
Outpatients Waiting Longer than the Standard Measurement of the breaches of the 17 week target for a first outpatient appointment following GP written referral.	Green	No patient will have waited longer than 17 weeks throughout 2004/05. No patient will wait longer than 13 weeks by 31 March 2005.
Total Time in Accident and Emergency (A&E): 4 Hours or Less Percentage of patients waiting 4 hours or less in A&E from arrival to admission, transfer or discharge.	Red	While steady improvement towards 98% was being seen through 2004, sustained performance at 98% has not been achieved so far in 2005.

With regard to waiting times in A&E, the Dudley Health Economy is committed to achieving the 98% target through the completion of the "Shaping the Future"' project described in section 3.4. The immediate urgency of improved performance is however also fully recognised and some specific, short term initiatives have been put in place, including opening additional hospital beds, the expansion of intermediate care capacity and the provision of extended primary care capacity in the Emergency Department.

2.1.2 Mental Health Trust

Key Targets		Expected position / commentary
Care Programme Approach (CPA) Systems Implementation Criterion for CPA systems implementation is that care plans are held on an electronic central database which is regularly updated and available 24 hours a day.	Green	In place.
Crisis Resolution/Home Treatment Team Implementation Target number of Crisis Resolution Teams in place.	Green	The planned 2 teams will be in place by 31 March 2005, both achieving full fidelity to the required model.

Financial Management Achievement of the financial position shown in the 2004/05 Plan, submitted to the Department of Health, without the need of unplanned financial support.	Green	Will be achieved.
Hospital Cleanliness Hospital Cleanliness: PEAT 2005 assessment.	Green	Will be achieved.
Mental Health Minimum Data Set (MHMDS) Implementation Trusts assessed against their ability to demonstrate full implementation of the MHMDS.	Green	Already being achieved.

2.1.3 Other significant progress in 2004/05 includes:

"Shaping the Future":- this is the long term project to achieve the complementary development of community and acute hospital services consequent upon the Private Finance Initiative redevelopment of the Dudley Group of Hospitals. The project is due for completion in 2005/06 and will result in the concentration of care in the community and in people's homes rather than in hospital unless hospital admission and stay is required because of the acute condition of the patient. There has been considerable progress with the project in 2004/05, as supported through the LDP, including introduction of a new stratified model of care for long term conditions, the "Pathways" scheme to improve the total patient experience of those requiring elective surgery, developments in the management of trauma services to improve quality and reduce length of stay and expansion of intermediate care services.

New Contract for General Practitioners (nGMS):- this was successfully introduced from April 2004 and has also included the development and implementation of an Enhanced Services Strategy and the smooth introduction of new Out-of-Hours arrangements from December 2004.

Mental Health Services:- a new Mental Health Strategy has been completed and the PCT has embarked upon a major redesign project which has already seen the introduction of a range of specialist services including Early Intervention, Assertive Outreach and Graduate Worker support in primary care. These will lead in due course to a reappraisal of inpatient bed requirements. In addition Social Services staff will be seconded to one management structure within the PCT from 1 April 2005.

Children's Services:- there has been significant strengthening of Health's contribution to child protection arrangements in Dudley through appointment to newly introduced medical and nursing posts.

Prescribing:- Prescribing Adviser support to all Practices of the PCT which has both improved clinical prescribing practice and significantly reduced costs.

E-Booking Programme- substantial progress has been made towards the December 2005 targets of 100% of day cases, inpatient admissions and outpatients being pre-booked.

Clinical Negligence Scheme for Trusts:- Achievement of level 1b is an important indicator of the clinical risk management systems in place to assure the quality of care. This is the highest level available to a Primary Care Trust.

2.2 Residual Targets and Risk Assessment

There are a number of targets from the "Priorities and Planning Framework 2003 – 2006" which continue into 2005/06, the first year of the new LDP period. These targets are listed below and a risk assessment given:

Key Target		Expected Position/Commentary
Improve life outcomes of adults and children with mental health problems by ensuring that all patients who need them have access to crisis services by 2005, and a comprehensive child and Adolescent and Mental Health service by 2006.	Green	
Ensure that by the end of 2005 every hospital appointment will be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs. By December 2005, patients will be able to choose from at least four to five different health care providers for planned hospital care, paid for by the NHS.	Amber	The achievement of this target is dependent upon the availability of N3 links (see section 3.5.3) and other aspects of the NPfIT (see section 5) programme, which are not fully in the control of the PCT.
Ensure a maximum waiting time of one month from diagnosis to treatment for all cancers by December 2005.	Green	
Achieve a maximum waiting time of two months from urgent referral to treatment for all cancers by December 2005.	Green	
800,000 smokers from all groups successfully quitting at the 4-week stage by 2006.	Green	
In primary care, update practice-based registers so that patients with CHD and diabetes continue to receive appropriate advice and treatment in line with NSF standards and, by March 2006, ensure practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a BMI greater than 30.	Amber	All practices currently have up to date registers of patients with CHD and Diabetes, and are using them to provide systematic care. While registers of "at risk" patients will not be in place throughout the PCT by March 2006, there is a programme in place to achieve this by 2008 (see trajectory PSA01b), which includes some progress by March 2006.

A minimum of 80% of people with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy by 2006, and 100% by 2007.	Green	
Achieve maximum wait of 3 months for an outpatient appointment by December 2005.	Green	
Achieve a maximum wait of 6 months for inpatients by December 2005.	Green	
Deliver a ten percentage point increase per year in the proportion of people suffering from a heart attack who receive thrombolysis within 60 minutes of calling for professional help.	Green	
Delayed transfers of care to reduce to a minimal level by 2006.	Green	

3. BIRMINGHAM AND BLACK COUNTRY STRATEGIC HEALTH AUTHORITY STRATEGIC FRAMEWORK AND PCT ACCORD

3.1 Health Inequalities and Health Improvement

3.1.1 Summary

The PCT remains committed to striking a new balance between long term health improvement through prevention and promotion and treatment of illness:

- support for smoking cessation programmes is increased in the context of achieving real reductions in smoking prevalence:
- new programmes to reduce obesity prevalence, to empower people in disadvantaged areas and to promote good sexual health are launched.

3.1.2 Relevant Data Tables (see section 8)

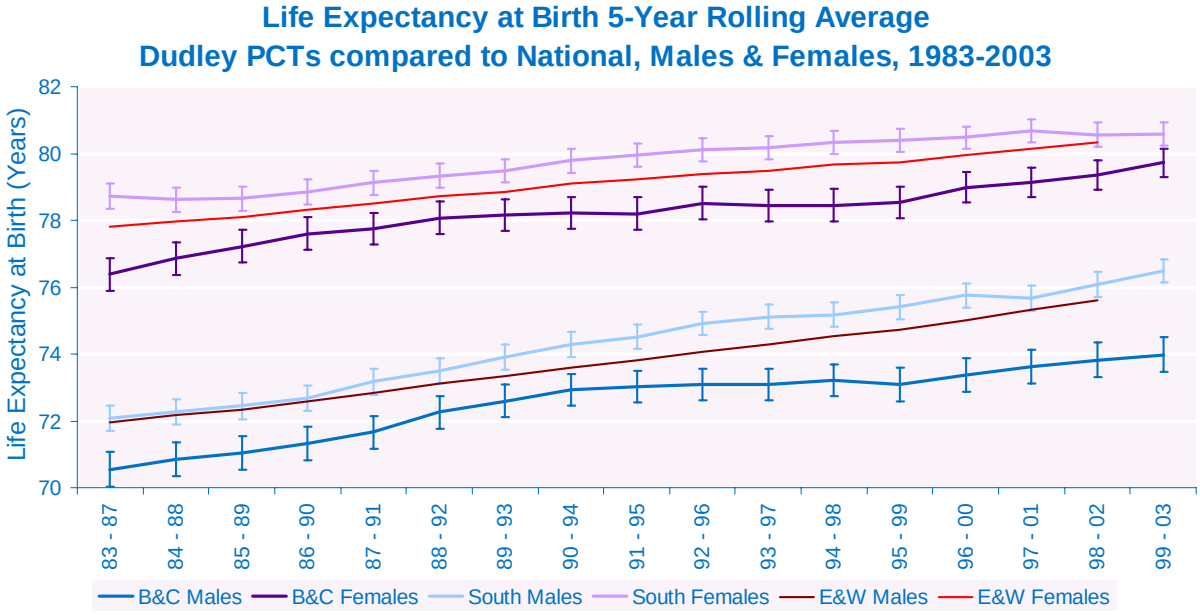
PSA01a	The mortality rate from heart disease and stroke and related diseases in people aged under 75 per 100,000 (directly age standardised) population: **no more than 95 pa by 2008.**
PSA01b	The number of GP practices with PCT-validated registers of patients without symptoms of cardiovascular disease but who have an absolute risk of CHD events greater than 30% over the next 10 years: **100% by 2008.**
PSA01c	The percentage of patient with CHD whose last blood pressure reading (measured within the last 15 months) is 150/90 or less: **75% by 2008.**

PSA01d	The percentage of patients with CHD whose last measured cholesterol (measures within the last 15 months) is 5mmol/l or less: **70% by 2008.**
PSA03a	The mortality rate from cancer in people aged under 75 per 100,000 (directly age standardised) population: **no more than 115 pa by 2008.**
PSA 03b	The progress on the implementation of the improving outcomes series of guidance for cancer as demonstrated by the number of designated specialist multi-disciplinary teams in place for different tumour groups: **1 team per tumour group (already in place).**
PSA06a	The percentage of mothers smoking during pregnancy: **no more than 17% by 2008.**
PSA06b	The percentage of new mothers known to have initiated breastfeeding: **48% by 2008.**
PSA08a	The number of 4-week smoking quitters, who attended NHS Stop Smoking Services, per 100,000 population: **at least 876 by 2008.**
PSA08b	Smoking status among people aged 15 to 75 years, as recorded in GP records: **no more than 20,650 smokers by 2008.**
PSA10b	Obesity status among people aged 15 to 75 years, as recorded in GP records: **no national or local target set yet.**
PSA11a	The number of conceptions to under 18 year olds in a calendar year per thousand females aged 15 to 17: **no more than 74 pa by 2008.**
PSA11b	The percentage of patients attending GUM clinics who are offered an appointment to be seen within 48 hours of contacting a service: **no local target set yet.**
PSA11c	The number of new diagnosis of gonorrhoea per 100,000 population: **no local target set yet.**
PSA14a	Increase the number of problem drug users in drug treatment programmes by 100% between 1998 and 2008: **already achieved.**
PSA15a	The percentage of drugs misusers discharged during the financial year who were retained in treatment for 12 weeks or more: **53% throughout Plan**

3.1.3 Background

People born in Dudley can, on average, expect to live longer now than if they were born 20 years ago. Life expectancy at birth has improved over the last 20 years. However, life expectancy for men is lower than for women and life expectancy for both men and women is much lower for Dudley Beacon & Castle PCT than for Dudley South PCT. Dudley Beacon & Castle PCT has life expectancy below the average for England and Wales, whilst Dudley South PCT has life expectancy, for both men and women, which is above the average for England and Wales. Whilst life expectancy for both men and women has increased over the last 20 years for people born in Dudley Beacon and Castle area, the rate of increase for men in Dudley Beacon and Castle has been lower than the rate of increase for England and Wales. As the chart below shows, life

expectancy for men in Beacon and Castle PCT is falling away from the average both for England and for Dudley South PCT, whereas the gap for women has closed somewhat.



The two largest causes of mortality and therefore the biggest factors in life expectancy in Dudley, as elsewhere in the UK, are coronary heart disease (CHD) and cancers. We have analysed the distribution of directly standardised mortality rates for cancers and CHD as well as looking at the geographical distribution by ward of life expectancy at birth. There remain marked inequalities in mortality experience which, in general (though by no means universally), mirror the general deprivation experience of the population. The inequalities across Dudley are stark. Life expectancy at birth for men in Netherton and Woodside ward (the ward with the lowest life expectancy in Dudley) is 8.5 years less than that in Norton Ward in Dudley South (the ward with the highest life expectancy in Dudley). There are also some marked differences between men and women. In Dudley Beacon and Castle's most deprived ward, Castle and Priory, men can expect to live 8.5 years less than women. In Norton ward, in Dudley South (where the highest overall life expectancy is experienced), the difference between men and women is less than 2 years. Our analysis of these and other data including those associated with the wider determinants of health eg literacy and numeracy, poverty have informed Dudley's recent commitment to a new strategy for tackling health inequalities. A first draft of the strategy has been produced (available on request) and is currently with all contributing agencies to ensure that there is sign up to the targets and action plan proposed.

The action plan has been developed along the lines of that proposed in the Department of Health's Health Inequalities Programme for Action and includes

specific actions, lead responsibilities, national and local targets and resourcing for a set of actions on each of:-

- Determinants of health
- Preventing illness and providing effective treatment and care
- Supporting families and children
- Engaging with communities and individuals

Action on improving health and narrowing the gap in health inequalities is firmly embedded in the work of the Dudley Community Partnership (the local Strategic Partnership for Dudley). The Dudley Community Partnership comprises a series of theme partnerships, all working on aspects of delivery of the multi-agency community plan. As its name suggests, the Dudley Health and Wellbeing theme partnership focuses on health and wellbeing issues linked across the theme partnerships of jobs, life long learning, culture and leisure, environment, children and young people and community safety.

Following the establishment of PCTs, the Health and Wellbeing Partnership was reconstituted and reviewed its priorities for action in the current period. The strategic objectives were determined as:-

- Reduce the number of people in Dudley who smoke
- Reduce the number of people in Dudley who are obese
- Contribute to reducing the number of people in Dudley who abuse drugs
- Contribute to reducing the number of teenage pregnancies in Dudley
- Reduce the number of accidents in Dudley

Work has continued and actions implemented in each of these areas:

<u>Smoking Prevalence</u>
We have no reliable estimates for smoking prevalence in Dudley. HDA 'synthetic estimates' suggest that 31% of adults in Dudley Beacon and Castle are current smokers. This implies approximately 30,000 people.

The Dudley Health and Lifestyle Survey (2004), currently being analysed, will provide local smoking prevalence data, at a small area level, which will greatly assist the further targeting of services. Survey results are expected in March 2005 and will provide the baseline for this particular 3 year LDP period.

An annual tobacco control and smoking cessation action plan has been agreed for each of the years since the inception of the PCT and the action plan for 2005/06 is designed and resourced to achieve the previously agreed LDP targets of 627 four week-quitters for the year. The capacity of the current smoking cessation services is to see approximately 1,200 people per annum with a quit rate of approximately 54% at 4 weeks. The programme has good quit rates (just above England average) and is cost efficient (one of the lowest cost per quitter in

the West Midlands region). Our Smoking Cessation Health Equity Audit demonstrated that the service is targeting resources to the more deprived areas. However the capacity is out of scale with the likely demand, if we were to attempt to achieve the prevalence reductions suggested in 'A Wider View'. Prevalence reduction will require action on tobacco control – in effect a smoke free Dudley – as well as a much increased smoking cessation service to back it up. LDP investments over the three year period allow for expansion of the smoking cessation service and will ensure that proposed SHA targets for 4 week quitters are met. The additional revenue will be used to implement the recommendations from our Health Equity audit; as well as increasing the core service in primary care (22 out of our 24 practices now run primary care based smoking cessation clinics). We shall continue to increase our highly successful community-based 'quitathon' events, targeting 'mini' events in deprived communities. Smoking cessation clinics will be built into the 'Choose and Book' system. We shall work with partners, through the Dudley Health and Wellbeing Partnership to try and achieve a comprehensive 'smoke-free Dudley'.

Obesity

Reducing the number of people in Dudley who are obese will be a challenging target, given that we are on a rising epidemic curve nationally. We have no reliable estimates of obesity prevalence within the PCT, but if national Health Survey for England estimates are applied, we could see as many as 95,000 adults in Dudley who are overweight (BMI 25-30); with a further 53,000 who are obese (BMI between 30 and 40) and just over 3,500 adults very obese (BMI 40 plus). We can estimate that just over one third of these would be in Beacon and Castle PCT. Again, the Dudley Health and Lifestyle Survey will provide local prevalence estimates.

The multi-agency Obesity Task Group has prepared a strategy and action plan for tackling this issue by reviewing the epidemiology, critically reviewing the evidence on interventions, undertaking a gap analysis of current initiatives versus possible effective interventions and developing a draft strategy/action plan (available upon request). Whilst some of the actions require substantial service redesign – not the least in the Dudley MBC services, there remain substantial numbers of actions which require additional resources.

LDP investment includes funds to introduce a new adult weight management pathway which aims to provide support for weight reduction and maintenance for approximately 1,500 people pa in a full year, incorporating some additional personal support for people in disadvantaged circumstances. It will provide a single, seamless pathway incorporating community, primary and secondary care services. Development has been based on current available evidence and best practice benchmarks and uses an innovative, cost-effective approach through use of the commercial sector. As this is a new venture, an evaluation protocol will be built in from the outset.

Our NOF funded 5-a-Day and national LEAP programmes will be mainstreamed.

Work on obesity in children will be focussed through the Dudley Health Promoting Schools programme (which now has sign up from 100% of the Borough's schools). A children's weight management pathway is to be developed during 2005/06, but there is no additional investment available to implement it until beyond this current LDP period.

Teenage Conception

The current strategy for reducing teenage conceptions is updated and rolled forward annually. Thus far, it has seen some success with overall 3 year rates for Dudley falling from 1998 to 2002. Nevertheless, the rate remains higher than the national average and within Dudley there is substantial local variation. The main focus in the next 2 – 3 years will need to be a redesign and refocusing of effort on the contraceptive services. Dudley has few services which can be described as 'young people friendly' and these need to be developed to a much greater degree – either in general practice or through the PCT provided Contraception and Sexual Health (CASH) service. Provision has been made in the LDP to secure continued funding of the teenage pregnancy programme at current activity levels when the grant comes to an end.

Accidents

The health and wellbeing multi-agency Accident Prevention Partnership has reviewed the existing strategy which is coming to an end in the current year. Overall, the news is good – Dudley's mortality from accidents is lower than that for England and continues, unusually, to follow a falling trend. The same can be observed for hospital admissions and A & E attendances. Nevertheless the strategy is currently being revised and rolled forward to drop ineffective interventions and ensure that existing successful interventions are properly funded and continue. The LDP makes available funding to assist with continuation of the Borough's successful home safety equipment loan service.

Drug and Alcohol Services

Dudley Drug and Alcohol Action Team has now merged with the Crime and Disorder Reduction Partnership, the configuration in Dudley is that of two implementation groups, Dudley Substance Misuse Implementation Group (SMIG) and Dudley Crime Reduction Implementation Group (CRIG).

SMIG has now submitted a draft Treatment Plan for 2004/05 to the National Treatment Agency (NTA).

The document outlines planned expansion and development of treatment services using the central government's pooled treatment budget and local resources. This continues the development of an integrated system, linking the various treatment services according to the principles of Models of Care service framework, commissioned through SMIG and reporting to Strategic Board.

Developments include identification of adequate accommodation, the full implementation of Drug Intervention Programme (DIP) and investment in developing Dual Diagnosis and Substance Misuse Services in the Dudley Group of Hospitals.

Sexual Health

The Health and Wellbeing Partnership priorities, though considering teenage conceptions, has not thus far focussed attention on the more recent concern with sexually transmitted infections (STIs). The evidence from such data as exists, suggests that Dudley is not exempt from the rise in STIs which have been observed nationally. The rates for the Dudley area are not as high as inner-city areas, but continue to rise. A multi-agency sexual health outline strategy has been developed and it is clear that there is a need for major service re-design, if this epidemic is to be tackled efficiently and effectively. This ties in with the proposed approach on contraceptive services for teenage conceptions and forms the plank of the sexual health action plan for Dudley. However, additional investment is required if the 2008 GUM access target is to be achieved and for the chlamydia screening programme in Dudley.

The LDP provides new investment designed to support GUM clinic expansion and redesign to ensure that, by 2008, 100% of new contacts are seen within 48 hours, but this does not come on stream until 2007/08. The recently published HPA survey of GUM clinic attenders shows 50% of Dudley Beacon and Castle patients surveyed to have waited 48 hours or less but the uncertainty around this estimate needs to be acknowledged.

The LDP also provides Beacon and Castle's share of investment to enable the introduction of a formal Chlamydia screening programme. Introduction of the programme needs to be Borough-wide and requires the matching investment from Dudley South PCT.

Empowering people in disadvantaged areas – health trainers

Investment is provided in year 2 of the LDP to start a programme of health trainers and personal health plans for people in disadvantaged communities. The detail of the programme has yet to be worked out and relies on further work at national level in relation to training accreditation. Nevertheless, Dudley is in a good position to move quickly on this programme given our positive experience with the smoking cessation community volunteer programme and our current Neighbourhood Renewal Fund supported project to expand the community volunteer concept into physical activity and food/nutrition programmes. The new investment available will make a welcome start but is sufficient to reach only a minority of people in our disadvantaged communities.

3.2 Race Equality

3.2.1 Summary

Improving health services for BME communities and employing a diverse workforce which is representative of the community across all levels in the organisation is a priority for the PCT:

- The Board and Chief Executive will take a lead role.
- Present services will be reviewed and improved and new services for BME users will be developed.
- Communications with BME communities will improve.
- We will ensure that BME service users get the full advantages of improved access and choice.
- We will ensure that the workforce is representative of the community.

3.2.2 Relevant Data Tables (see section 8)

None directly relevant.

3.2.3 Background

The PCT has 9,700 people from black and minority and mixed ethnic groups, which is 8.7% of the resident population. This population is expected to grow over the period of the 3 year Local Delivery Plan.

It is well documented that for people from black and minority ethnic (BME) communities, there are higher rates of mortality from CHD, hypertension, disease, stroke and a higher incidence of long term conditions such as diabetes.

Importantly for the PCT, as the provider of mental health services across the Borough, there is national evidence of sections of the BME community failing to access mental health services, or of receiving sub-standard services compared with other sections of the community.

Over the 3 year timescale for the LDP, the PCT will make substantial progress to improve health services for BME communities and it will improve as an employer of a diverse workforce.

3.2.4 Accountability

Race equality is a priority for the Board:

- The Board will monitor the implementation of the plans in the LDP to improve race equality by appointing a non-executive director and by receiving regular reports on progress.

- The Board already receives regular reports on progress against the Race Equality Scheme.

- The Chief Executive will take executive responsibility for progress, working through a Diversity Matters Lead Group.

- The PCT will employ a senior manager to take a co-ordinating role of improving diversity.

3.2.5 Service Access

Services will be improved through a review of current service provision (including the views of users) and the development of new services.

- Develop and implement a diversity tool with race equality standards for services/functions to self-audit for cultural competency and adverse racial impact.

- Survey patient satisfaction with hospital meals.

- Initiate a programme of service audits.

- Incorporate learning from the results of the National Patient Survey on the experience of BME service users and information collated by the Patient Advice & Liaison Service.

- Integrated mental health and social care services will have systems in place to collect data on ethnicity of service users and staff. This will be used to challenge evidence of inadequate services for the BME community.

- Monitor race equality in primary care/pharmacists/dentists and optometrists.

- Develop a costed Service Improvement Plan for services provided by the PCT, to ensure that current services are sensitive to the needs of BME patients and to fund accordingly – see LDP sections on Adult Mental Health Services and Long Term Conditions.

- Develop costed proposals for new services in partnership with voluntary and community groups, e.g. the appointment of community development workers and to fund accordingly – see LDP sections on Adult Mental Health Services and Long Term Conditions.

- Improve the support to BME carers, building on the Dudley Carers Strategy.

3.2.6 Equality of Access of Information.

The PCT will improve communication with the BME community.

- Improve patient information as part of the communications strategy. The PCT will engage communities in deciding the most appropriate form of communication, building on progress so far (e.g. leaflets, seminars and newspapers).

- To provide additional interpreting support in primary care and mental health.

3.2.7 Equality and Access to Choice.

The PCT will ensure that the Choice Initiative is available to all sections of the community, to ensure that BME patients get the full advantages of improved access and choice, and this is already reflected in the Choice Communications strategy.

3.2.8 Employment

The PCT will ensure that its workforce is representative of the community it serves.

- Monitor applications and staff in post by ethnic group to develop action plans to address deficiencies.

- Promote opportunities within local BME communities.

- Ensure that all staff undertake diversity training, this to include Board and PEC members.

- Promote equal opportunities in primary care.

- Develop initiatives to encourage BME employees to be successful in being recruited to senior manager and director posts.

3.3 Healthy Start to Life

3.3.1 Summary

The PCT fully supports the increasing priority being given to the development of services for families and children and will work closely with both statutory and voluntary organisations:

- A Local Safeguarding Children Board will be established by 2006.
- Children's Trust arrangements, including the appointment of a Director of Children's Services, will be in place by 2008.
- A Common Assessment Framework for use by all services will be introduced, supported by information sharing protocols.
- Every opportunity will be taken to establish new pooled budgets between agencies to ensure seamless services.

3.3.2 Relevant data tables (see section 8)

PSA06a	The percentage of mothers smoking during pregnancy: **no more than 17% by 2008.**
PSA06b	The percentage of new mothers known to have initiated breastfeeding: **48% by 2008.**

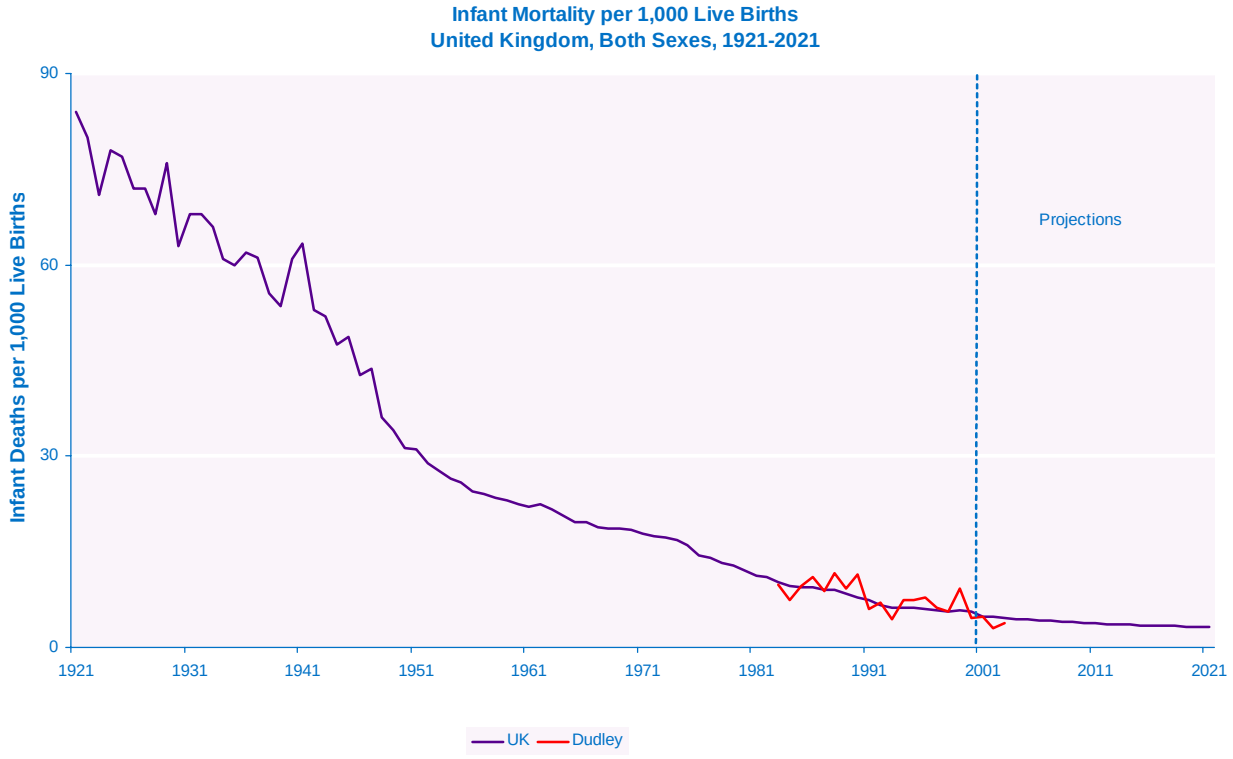
3.3.3 Background

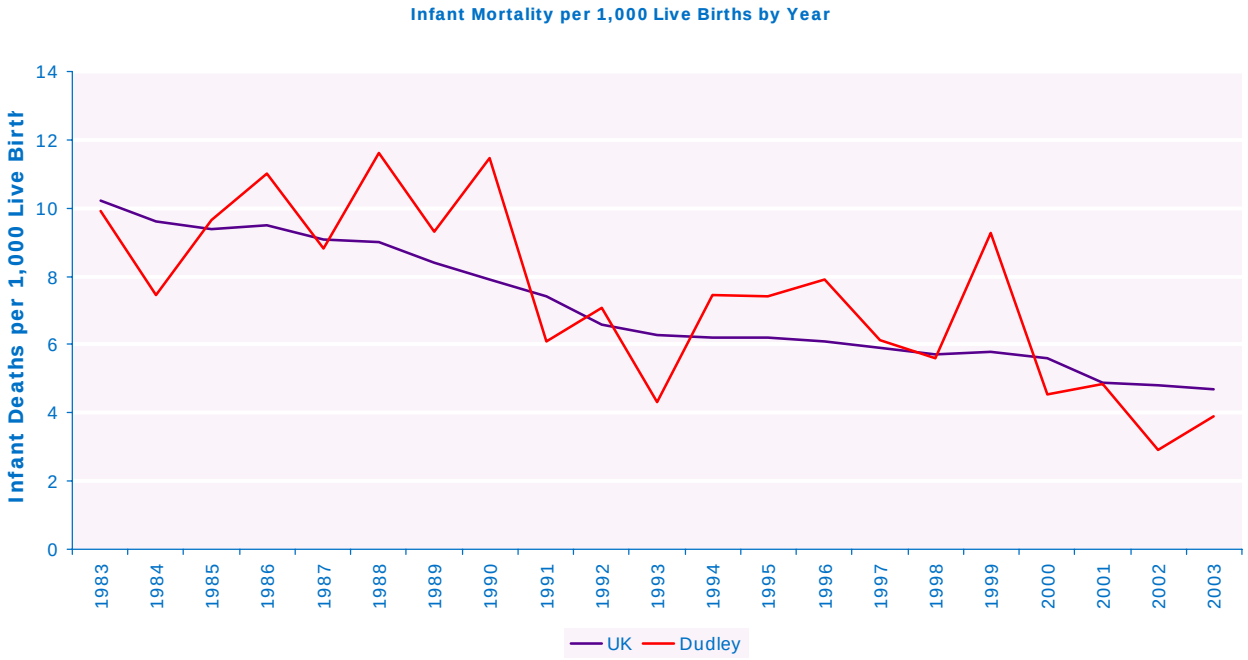
Nationally there has been a drive towards developing person centred services through a whole systems approach across all public services. This has underpinned recent national policy: Children Act; National Service Framework for Children; Young People and Maternity Services; Public Health White Paper 'Choosing Health: Making Healthier Choices Easier'; development of clinical networks.

Local policy is also driving the children's agenda, the PCT Accord priority (reducing perinatal mortality) being an example, raising improving maternity services as a priority with our Local Authority colleagues.

Infant Mortality

Infant mortality (deaths under 1 year) has decreased in Dudley over the last two decades. The rate for Dudley fluctuates around the national average, but generally follows the national trend over the period.





The annual numbers of deaths in children under 1 year is now quite small (c.16 each year since 2000) so it is not possible, at this level of analysis to comment on the gap between manual and non-manual population group, as measured for the national PSA target. For this reason, we concentrate on risk factors for mothers and babies. The PSA targets focus on smoking in pregnancy and breastfeeding. Targets have been set in both these areas, but issues remain in relation to some aspects of data collection, to monitor them; issues which will need to be resolved during 2005/06.

Service Development

National policy as the key driver for children's services, provides the momentum towards the development of child and family centred services through redesign. This will address the key determinants of health that will, in the long term, have a significant positive impact on adult services, provide effective and efficient services and improve the life chances of children.

Redesign needs to be informed by need, communities, workforce, resource and policy. There will be an emphasis on ensuring equity of service and a whole systems approach to meeting the needs of children, young people and families.

Implications for Dudley

Children, young people, parents and carers will have greater control, involvement and choice of the services they receive. Joint planning, commissioning and working will lead to services meeting shared standards to enable quality and equity of delivery. Appointments will be synchronised as much as possible, so as to reduce the number of visits a child and its family has to make. Services will be accessed through a single point of entry.

3.3.4 Children Act

Background

The Children Bill gained Royal Assent in November 2004, and is now the Children Act. The Children Act has been described by the government as "the most far-reaching reform of Children's Services for 30 years." The Act and "Every Child Matters: Next Steps" (March '04), set out a framework for children's services, which focuses on 5 outcomes for children:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being

The emphasis will be early Intervention and prevention and the development of shared targets and priorities.

Legislative Requirements

The Children Act includes the following provisions:

- A new legal **duty** to co-operate (commencing on 1st April 2005) - amongst partner agencies to improve children's well-being, to safeguard and promote their welfare relating to factors such as the physical and mental health of children; their protection from harm and neglect; their education and training; the contributions made by children and young people to society; as well as, finally, the social and economic well-being of children. **This duty will result in children's trust arrangements being established by 2008.**

- Information Sharing – arrangements between agencies for future regulations and guidance to establish databases are proposed.

- Children's Commissioner in England to be a voice for children and young people, especially those who are most vulnerable.

- Local Safeguarding Children Boards (established by April 2006) to be established on a **statutory** footing to strengthen, widen the remit and replace Area Child Protection Committees, with scope for pooling budgets.

- Director of Children's Services (Appointed by 2006) – A Children's Services Authority will be required to appoint a Director of Children's Services to have responsibility for improving children's lives at a local level and for ensuring that statutory agencies who come into contact with children, such as education, social services, health and the police work together to protect children. The precise nature of this lead responsibility, whether it should be strategic or also operational, is still a matter of debate nationally.

- Lead Elected Member for Children - to be identified for Children's Services in each Local Authority.

- Inspection (commences 1 September 2005) – An integrated inspection framework to be developed for all Children's Services, including schools.

Birmingham Black Country Strategic Health authority (BBCStHA) states…

> **"We must ensure that the planning and commissioning of services is genuinely integrated between the statutory agencies and in particular this means bringing together Education, Social Care and Health. Real gains for children and their families can be made by joining together services which have in the past been provided separately by different agencies."**

3.3.5 Support to vulnerable children and young people

Effective targeted and specialist services
Through the "Every Child Matters" programme high quality, more integrated services will work together with targeted and specialist services for children with additional needs. These children will need:

- High quality multi agency assessment
- A wide range of specialist services
- Effective case management by a lead professional working as part of a multi-disciplinary team.

There is a statutory requirement within the Children Act that **individual services ensure they discharge their functions with regard to the need to safeguard and promote the welfare of children and young people.** Services must take responsibility and will be held accountable for ensuring this happens.

Local Safeguarding Children Board
The Local Authority has a statutory responsibility to establish a Local Safeguarding Children Board to strengthen local arrangements for safeguarding and promoting the welfare of children and young people. Authorities and partners need to take account of statutory guidance, which is expected by December 2005, and to have a Board in place by April 2006. Dudley has conducted a self-assessment against the safeguarding standards and has agreed several principles and values. Dudley's Area Child Protection Committee is developing its 'intelligence', and positioning itself to be ready to establish the Local Safeguarding Children Board in a timely fashion. Working towards the establishment of a pooled budget as part of the development of the Local Safeguarding Children's Board will enable this challenging work programme to be delivered. A funding strategy will be developed to support the Board and its broader agenda.

Within Dudley this development will lead to a further strengthening of our services' ability to keep our children safe, and identify any child who needs protection. Dudley's Local Safeguarding Children Board will be key in prevention and protection across all our services and communities.

Looked After Children
For looked after children the Children Act plays a particular responsibility to promote their educational achievement. This builds on specific areas of action to improve life chances of children in care referred to in the report "A better education for children in care". From June 2005 authorities need to make

arrangements to review support for looked after children in light of this new duty as well as safeguarding and promoting their welfare.

Dudley is developing and implementing an Action Plan for the continued improvement of educational outcomes for looked after children; and is implementing LPSA targets.

Key targets are to improve educational and health outcomes together with training and employment opportunities for care leavers. Placement stability is key to achieving these outcomes and therefore key services such as CAMHS are critical.

Performance in Dudley is poor with regard to educational outcomes and performance of care leavers, absence from school and numbers of children placed for adoption. Improving the education of looked after children is a specific duty in the Children Act and is an LPSA target. Educational attainment is also a good proxy measure for the health outcomes of this vulnerable group of children.

Homestart

Home-Start, a voluntary organisation, is a home support service and has a key role in prevention and early intervention working with families with children under 5. Home-Start engages with, and supports families at times of stress and vulnerability: new/multiple births, isolation, behavioural difficulties, disability, mental or physical health, domestic violence etc. Outcomes for families include; positive parenting delivered in a safe home setting and developing parental responsibilities in respect of the child's social and health well being.

Home Check Service

The overall aim of this scheme is to reduce the risk of serious accidents in the homes of the most vulnerable families with young children in Dudley Borough.

The local scheme provides essential safety equipment (mainly fixed fire guards, safety gates, finger protectors, locks and smoke alarms) for vulnerable families to improve the safety of the living environment of children in these families. The scheme also raises awareness of child accident prevention in the home through direct one to one advice and a detailed home check if required, using the schemes Home Check List for Child Safety

3.3.6 Integrated Processes

Common processes will promote better co-operation between universal services, such as schools, GP practices etc. Financial and workforce gains will be apparent over time as duplication is identified and addressed.

These processes will improve the care pathway in Dudley by reducing the number of times the child, young person and/or parent/carer has to tell their story.

It will break down barriers and ensure organisational and professional boundaries do not hinder meeting the needs of children, young people and families.

Common Assessment Framework

A Common Assessment Framework is being developed to provide a national, common process for early assessment. Guidance should be published by March 2005 and all local authorities and their partners should be preparing for implementation by 2008.

For Dudley children and young people will not have to re-tell their 'story' unnecessarily, professionals from a range of services can add to the same assessment and identify support/treatment needed based on having the whole picture, and delivering a service that is coordinated and timely.

Information Sharing

In parallel with the Common Assessment Framework, partners are already working together to improve sharing of information between practitioners in children's services. Guidance is expected to be published by September 2005. The Children Act requires the establishment of national standards of database or index systems to enable practitioners to identify the child or young person, identify which other practitioners are involved, and to indicate concerns. The timescale for implementation will be announced in the autumn of 2005.

Needs Analysis and Planning

Partners will focus on the most urgent and important needs for children and young people in their area. Needs analysis will form the basis for the development of 'The Dudley Children and Young People's Plan', which will replace a number of existing statutory plans and will be in place by April 2006. This plan will be aligned with other local strategic plans including the PCT's Local Delivery Plan.

Dudley's Local Preventative Strategy will be further developed during 2005 through the Family Support Sub Group of the Children and Young People's Partnership and aims to support vulnerable children to achieve their potential, focusing on prevention and early intervention.

Joint Commissioning

The Joint Planning and Commissioning Group (Health, Education, Social Services and Dudley Council for Voluntary Services), which is chaired by health, meets to develop joint commissioning on behalf of the Children and Young People's Partnership. A joint commissioning framework will be developed over 2005, in order to develop our shared understanding of commissioning and enable services to deliver using a more coordinated, innovative and cost effective approach based on need in order to lead to improved equity for the population of Dudley.

Joint commissioning will lead to more relevant and effective response to children's needs. The arrangements will be developed focusing on improving outcomes and more effective use of resources.

3.3.7 National Service Framework for Children, Young People and Maternity Services

The National Service Framework for Children, Young People and Maternity Services was published in September 2004 and is presented as a ten year developmental strategy (the Children's Act is also viewed as a 10 year plan). These standards will be used as the basis of joint inspection for Health, Social Care and Education and running in parallel with the implementation of the Children Act, will form the basis for service developments and redesign in the future.

3.3.8 Maternity Services - PCT Accord: Reducing Perinatal Mortality

The project builds on national and regional research and follows maternity review recommendations and aims to redesign maternity services to enable a service which is equitable, evidence based and fulfils the needs of mothers and babies, ensuring community care is strengthened and joined up with other aspects of primary care.

There is evidence that adverse outcome is strongly linked to social deprivation and inequalities. It is therefore the intention of the proposal to target those geographical areas that are viewed as being most deprived/excluded.

<u>Core components of community based maternity service</u>

Evidence highlights the 3 core components of a community based maternity service as;

- Continuity of carer: the cornerstone of the approach is the mother establishing a constructive relationship with a lead midwife. A target of 75% of ante and post-natal contacts would be with the same lead midwife.
- Lead midwife to co-ordinate all services: the lead midwife would act as a key worker in liaising with and referring to relevant specialist support or agencies.
- The service should be readily accessible: the local facilities for the provision of services could be in GP surgeries, Sure Start or Children's centres including schools or other suitable venues

Within Dudley this work is being developed by a multi-agency team based on service redesign sustaining evidenced based practice. Children's Centres will play a key role in creating an additional resource to support women through pregnancy.

<u>Implications</u>

The implications of the above service redesign are:

- Foetal heart monitoring training, confidential case reviews and maternal experience survey and case note review.

- Reduction on midwifery caseloads in areas of high deprivation.
- A skill mix will be developed that will support women in relation to breast feeding, smoking cessation, parent craft etc.

This will include delivery within Children's Centres to establish an equitable maternity service across the Borough that takes into account need, deprivation, evidence of best practice and resources.

3.3.9 Clinical Networks

Neo-Natal Networks

The development of a managed network means that Dudley residents will have the best skills and experience available to care for their babies. This would include the designation of some hospitals that are specially equipped to care for the sickest and smallest babies with other hospitals providing high dependency care and shorter periods of intensive care as close to home as possible. It will also mean that there will be a transport service skilled and equipped to meet the needs of babies.

Children in Surgery

The West Midlands Review of Surgery for Children (September 2002) was carried out by West Midlands Strategic Commissioning Group to address concerns around occasional practice, capacity of specialised children's surgery units to cope with unplanned drift and capacity to deal with emergencies. This Group has laid down a number of principles in order to reshape surgical services for children. Essentially it says that only appropriately trained surgeons and anaesthetists who have a workload sufficient to maintain competence should carry out surgery in children. There is also guidance on children's nurses, the physical environment and organisational issues.

The Children in Surgery Network will be developed on a Black Country basis with our partners in Walsall and Wolverhampton.

3.3.10 The Development of Children's Centres in the Borough of Dudley

The concept of Children's Centres was promoted in the report of the Inter-Departmental Childcare review published in November 2002. The review found that an integrated approach which ensures the joining up of services and disciplines such as education, care, family support and health is a key factor in the delivery of good outcomes for children.

Since 2003 there have been a number of significant documents published by the Government which clarify further the important role that Children's Centres are expected to play in the future. These documents are:

- Every Child Matter (DfES)
- National Service Framework for Children (DOH)
- Five Years Strategy (DfES)

- Ten Year Childcare Strategy(Treasury)

Children's Centres will be the main vehicle for implementation of 'Every Child Matters' for the under 5's. Many previous Government initiatives aimed at the development of integrated services for children under 5 - such as the Sure Start local programmes, Neighbourhood Nurseries and Early Excellence Centres will be transformed into Children's Centres. Children's Centres - will eventually be universal services offered across the Borough. The aim is for a new 'recognisable' service delivery hub in every community, each with a set of core activities enhanced by other appropriate activities to meet local need.

In Phase 1 (2004-2006), 7 Children's Centres will be created in the Borough of Dudley:

- Brierley Hill Children's Centre (an existing Sure Start local Programme)
- Kates Hill and Sledmere (an existing Sure Start local Programme)
- Lye, Rufford and Wollescote (an existing Sure Start local Programme)
- Netherton Children's Centre
- Priory and Castle (2)
- Hobb Green
- Further Centres will be developed subsequently as part of a second phase.

The revenue funding for Children's Centres is to be announced shortly (January /February2005)

With the development of Children's Centres and the delivery of integrated and co-ordinated services to achieve good outcomes for Children 0-5, it is envisaged that there will need to be a redesigning of services such as health visiting, midwifery, speech and language and associated services in order to address the issue of mainstreaming and to develop equitable services within the borough based on need. Additional resources may be required but this has yet to be identified, with the exception of community maternity services.

Children's Fund

The overall aim of the programmes work is to reduce the level of social exclusion in relation to Children and Young People aged 5 – 13. Services are based on local and nationally gathered research into the gaps in preventative services within the Borough. Given the links between social exclusion and social deprivation, direct services are targeted at the most deprived areas of the Borough that are co-terminus with the 2 original Sure Start (Children's Centre) areas to give a degree of consistency in service delivery.

3.3.11 Extended Schools

An extended school is one that provides a range of services and activities often beyond the school day to help meet the needs of pupils, their families and the community. Dudley is taking a cluster approach to developing its programme of

extended school provision, and there will be close collaboration with the PCTs in the development of associated health and social services.

Extended schools will become one of the key access points to services for children, young people and families alongside Children's Centres and Family Centres.

3.3.12 Children with disabilities

A multi-agency strategy for children with disabilities is being developed through the Dudley Children and Young People's Partnership following an audit and analysis of needs. An Action Plan will be progressed which will align with the Children Act and the NSF requirements.

A pooled budget for children with disabilities has been established between Health, Social Services and Education.

Review of Children with Disabilities Services

Following Social Services Inspection Report, a review of children's services is planned over 2005. This will be an opportunity to take a whole systems approach to children's services within Dudley.

Healthy Living Centre (Family Centre); The Orchard Family Centre

The Orchard Family Centres service is delivered inline with the National Service Framework for Children, Young People and Maternity Services. The overall objective of the Centre is to provide services, information and support to disabled children and young people, those with complex health needs and their families/carers. Orchard Family Centre provides services, which reduce the need for statutory services to intervene by way of expensive resources such as external placements. The project aims to promote health and well being through provision of support and information activities; complimentary therapies (pamper days), smoking cessation sessions; fit kids sessions (tackling obesity); green gym for carers (tackling diet - 5 fruit or vegetables per day - and weight.

KIDS, a national charity, manage the centre, which is steered by Orchard Committee. The committee has a membership of 14 people, 12 of which are parents, who were the drivers for the development of the centre. A multi-agency professional advisory group, that also includes parents, supports the centre and is viewed as a 'helping hand'.

The project covers the whole of the Dudley Borough but takes particular account of areas where disadvantage is heightened.

Short Breaks

Short break services for children with severe learning disabilities and challenging behaviour has been identified as a multi-agency priority in terms of improved

outcomes for children with disabilities and their families which would reduce the number of children that we are seeing placed out of borough.

Families often need breaks, especially at weekends and during school holidays, that are flexible and offer choice. There is often a particular need for services for children with complex health needs, challenging behaviour or autistic spectrum disorders and children from minority ethnic families.

Disabled Children Standard of the National Service Framework states that; 'PCT's and NHS Trusts ensure that families are offered a range of appropriate family support services through multi agency packages of care'. Short breaks are viewed as an essential element of the development of these packages.

Palliative Care – The See-Saw Team

The See-Saw Team was set up with three years funding from the New Opportunity Fund. This funding will run up to July 2006. The team is based with the Children With Disabilities team.

The team work with children who have life limiting conditions who are likely to die before they are 18. This is following an holistic assessment of need which is completed with the family.

3.3.13 Child and Adolescent Mental Health Service

"The Mental Health and Psychological Well-being of Children and Young People Standard of the National Service Framework (NSF) for Children" has recently been published. This Standard will underpin the further development of Dudley CAMHS and implementation of the local CAMHS joint strategy.

The CAMHS Standard has many challenges, examples of which include access for children and young people with learning disabilities and an increase in the age range to access the service. Dudley has carried out work to begin to address some of the issues through the development of new posts and improving transition arrangements with Adult Mental Health.

A single point of access has been developed where a multi disciplinary team assesses and assigns referrals. This approach eliminates unnecessary delays for priority cases.

There is work planned to develop the information collection systems within CAMHS in order to have better data and analysis to inform the commissioning and planning of the service within the context of the broader children's agenda.

Dudley has over the past 2 years increased investment in CAMHS by more than 20%. This rate of investment will continue in 2005/06 and we are currently developing a joint investment strategy in partnership with the Local Authority.

3.4 Supporting People with a Long Term Condition

3.4.1 Summary

The PCT is a leader in the development of models of care and their implementation for people suffering from long term conditions:

- Implementation of care arrangements across the spectrum of need will be completed by extended assertive case management and expansion of expert patient programmes.
- New community based services will be introduced in diabetes, coronary heart disease and heart failure.
- A range of public health initiatives (eg adult weight management; smoking cessation) to reduce the incidence of long term conditions will be introduced or expanded.
- The new Heart and Lung Centre at Wolverhampton and new services in the redeveloped Russells Hall Hospitals will improve access to specialist CHD services.

3.4.2 Relevant data tables

PSA12a	Reduction in emergency bed days: **down to 72,264 by 2008.**
PSA12b	Number of staff in the community matron role providing case-management in primary and community settings for the people with complex long-term conditions and high intensity needs: **3 by 2005.**
PSA12c	The number of patients in primary and community settings with complex long-term conditions and are very high intensity users of secondary care services whose case is being managed by a community matron: **200 by 2006.**

3.4.3 Background

In Birmingham and the Black Country, the PCT Accord Case Management Project has been instrumental in shaping the PCT approach to case management. National evidence has been combined with a local approach to facilitate joint learning events and the development of a locally designed education package for case managers. Dudley Beacon and Castle PCT clinicians and managers have been a major influence on the outcomes of the project and have shared their innovative practice as a result of Shaping the Future to help to shape the project. Clinical engagement in the Dudley Beacon and Castle model has been one of the particular successes shared with the project.

The target to reduce inpatient emergency bed days by 5% by March 2008 is achievable using the PCT's model, and we further consider that this decrease will be sustainable even when the aging population is taken into account. Both life expectancy and health life expectancy (how many healthy life years are attainable) is increasing, but they are not increasing at the same rate. We believe that effective long-term conditions management will add to the healthy life years expectancy and therefore allow for the containment of emergency admissions.

3.4.4 The Model of Care

"Shaping the Future"', incorporating the major redevelopment of the Dudley Group of Hospitals through Private Finance Initiative (due for completion early summer 2005), includes major community redesign which has been structured to support bed day savings, resulting in a balance of community and acute services designed to care for people in the right place, at the right time, in the right way by the right staff. The following diagram describes the new model of care for patients with long term conditions.

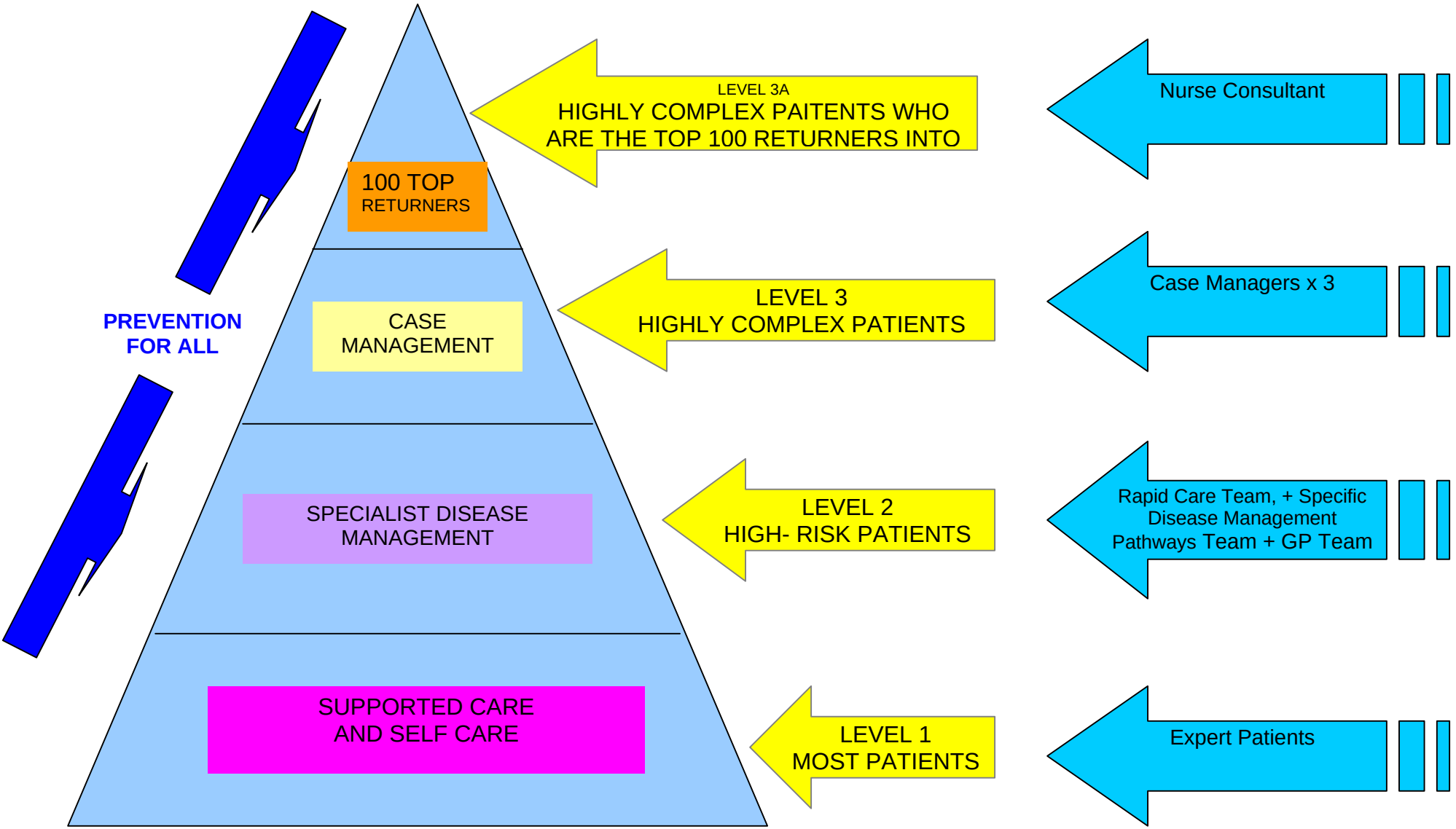


Figure 2: The 'Kaiser Pyramid' Incorporating Dudley Beacon & Castle Model of Care

Our strategic aims are:

- To embed into our local health and social care community an effective, systematic approach to the care and management of patients with a long-term condition.
- To reduce the reliance on secondary care services and increase the provision of care in a primary, community or home environment
- To meet the individual requirements of people with long term conditions through high quality personalised care.

The Public Health White Paper 'Choosing Health' underpins the entire long-term condition approach. This will build on the public's growing desire for a healthier future by ensuring that the self care support is in place for people- particularly those in disadvantaged groups and areas- to make healthier choices about diet, physical activity and lifestyle.

The general way forward is through:

- The need to identify all long term condition patients in the health community
- The need to stratify the patients to match care to the different needs of patients in accordance with our model:

<u>Level 3A - Patients with Highly Complex Needs</u>

The proactive management of the top 100 returners into hospital who have very complex needs and a requirement for intensive coordination at a complex health and social care multidisciplinary team level. A recent Kings Fund report raised concerns regarding long term condition management pathways which, it identified, would not prevent admissions to hospital if models such as 'Evercare' were used on their own. It is our belief, backed by data analysis which shows a 5% reduction in general medical admissions to hospital in the latter six months of this post when the case load had risen to 50 patients, that the inclusion of Level '3A' care at the top of the Kaiser pyramid will give a whole system of care which will both proactively manage patients avoiding admissions in the future, but will also avoid admissions immediately.

- A Nurse Consultant has been appointed to manage patients in our model at Level 3A - the top 100 returners into hospital with complex needs - which may be a result of long term conditions. These patients need coordination and clinical management at a highly complex level by the nurse consultant supported by a multidisciplinary health and social care team.
- Patients are continuingly being identified using the DGOH admission data, and local referral by local clinicians including GPs and Community Nurses. Our Nurse Consultant also does ward rounds in the hospital to triage patients and move them back into community services in a coordinated way.

<u>Level 3 - Case Management - Patients with Multiple Complex Needs</u>

The proactive management of the most vulnerable people with complex multiple long-term conditions.

- The appointment of three Community Matrons/Case Managers to use a case management approach to anticipate, co-ordinate and join up the health and social care of vulnerable patients with multiple complex long-term conditions.
- Patient numbers have been identified using local public health data and acute and community clinical data on the management of patients with long term conditions such as COPD, Diabetes, Arthritis.

Level 2 - Disease-Specific Care Management

Providing people who have a complex single need or multiple conditions with responsive, specialist services using multi-disciplinary teams and disease-specific protocols and pathways, such as the National Service Frameworks and Quality and Outcomes Framework. Working with our GP colleagues and their primary health care teams, we will build on the chronic disease management at practice level, adding resources as identified in the QOF process to assist practices to manage patients according to agreed pathways.

- Expansion of Specialist Nurses in: -
    - Coronary Heart Disease
    - Heart Failure Palliative Care
    - Diabetes

Specialist Nurses are specifically tasked to up skill existing multidisciplinary health and social care clinicians in the care of patients with specific diseases. In some instances they will take over the specific case management of patients, but our model recognises that the specialist function should be advisory and complementary in order to prevent deskilling our teams.

- Rapid Care Teams
  Our model of care takes our existing District Nursing Teams, adds staffing resources, education and training and an operational philosophy of service redesign to ensure that patients are nursed in their own homes where appropriate, resulting in a Rapid Care Team which proactively avoids hospital admission and pulls patients who have been admitted through the acute care system back out into the community. Our Rapid Care Coordinators do ward rounds in the hospital to proactively manage patients back into the community and educate the acute staff where appropriate regarding services that are available in the community.
- Staffing resources, education and training investment in the nine community teams and the out of hours team will be completed in 2005/06.

Level One- Supported Self Care

Collaboratively helping individuals and their carers to develop the knowledge, skills and confidence to care for themselves and their condition effectively, through:

- Extending the Expert Patient Programme
- ‘Meet the Medics’ Programme
  This clinical governance funded initiative involves disease specific patient education meetings where full multidisciplinary teams including consultants

make themselves available to patients alongside the voluntary sector and patient involvement groups to answer patient's questions on general care management themes. This is very positive in terms of whole systems working as the consultants and the community staff meet patients together with the voluntary services and carers.

The aims are: -

- To educate patients and their carers so that they can effectively care for themselves
- To provide a forum outside a formal outpatient attendance where patients can raise issues that may be troubling them, but also may get answers which help them to manage their own care more effectively.
- To provide an 'expert patient' identification for the Expert Patient Programme.
- To provide a patient focus group leading on from the session where patients with specific long-term conditions can offer their perspective on care and be consulted on new and proposed redesigned services.

Medicines Management

As we have seen from national guidance, medicine compliance is also a key issue in long-term conditions management. Supplementary Prescribing by professionals such as nurses and pharmacists is well underway in the PCT, but the planning of services in our enhanced services in the new Pharmacy Contract are allowing us to use the skills of pharmacists and their staff in a very much more proactive way.

3.4.5 Specific applications of the generic Model of Care

Primary Care Physicians in A&E and the Medical Assessment Unit (MAU)

In order to manage patients more effectively we have appointed a GP in the MAU and in A&E. This is an extremely important part of the model, which allows for a primary care physician to help secondary care physicians to appreciate that the community may have the necessary skills to cope with patients in the community as an alternative to admission. The GP also enables acute trust doctors to reduce the length of stay for patients by taking part in joint risk assessment processes. The GP also educates colleagues where there are inappropriate admissions as he is the clinical governance lead for the PCT.

Diabetes Services

The Dudley Diabetes Strategy supports the model of care in that the guiding principle is that every effort should be made to enhance a model of self care and reduce the dependency not only on specialist and hospital services, but also on primary care services. The philosophical and organisational changes in the provision of care for people with diabetes and, in particular, the move towards greater patient self-management will require healthcare professionals and others to work together and with patients in new ways. The consequences for the existing workforce are far reaching with changes in roles, responsibilities and working practices for all. The new strategy identifies changing the approach to some services, using available resources in different

ways within primary and secondary care by enhancing some current services and investing in new ones.

A phased approach will be taken to initially support primary health care teams to care for all type 2 people with diabetes and as many people with type 1 without complications or with stable complications. The PCT has invested in an Enhanced Service to support the primary health care teams to deliver this care and it is planned that Annual Reviews, excluding retinopathy screening, will be transferred from secondary to primary care from April 2005. Transfer of this "routine" activity will release capacity within secondary care to develop the much needed specialist services to manage the existing people with complex diabetes related problems. This service redesign is integral to the community redesign project in that, once the patients with complex needs have been assessed and a Management Plan agreed, the patient would, if clinically stable, be discharged back to primary care and supported by the community diabetes multidisciplinary team, or remain under the management of the consultant for long term specialist follow-up by using the case management approach.

The Diabetes Enhanced Service is pivotal to the service redesign of diabetes services and comprises three inter-dependent elements:-

- An incentive based scheme to support practices to care for their own diabetics and undertake annual reviews
- The development of primary care integrated nurse teams, supported by a community multidisciplinary team.
- The development of an Educational Programme for Healthcare professionals involved in the provision of Diabetes care.

<u>Coronary Heart Disease.</u>

Relevant Data Tables (see section 8)

PSA01a	The mortality rate from heart disease and stroke and related diseases in people aged under 75 per 100,000 (directly age standardised) population: **no more than 95 pa by 2008.**
PSA01b	The number of GP practices with PCT-validated registers of patients without symptoms of cardiovascular disease but who have an absolute risk of CHD events greater than 30% over the next 10 years: **100% by 2008.**
PSA01c	The percentage of patient with CHD whose last blood pressure reading (measured within the last 15 months) is 150/90 or less: **75% by 2008.**
PSA01d	The percentage of patients with CHD whose last measured cholesterol (measures within the last 15 months) is 5mmol/l or less: **70% by 2008.**

The Dudley Health Economy is committed to improving the quality of care that we provide. With higher than average levels of Coronary Heart Disease (CHD) amongst the population that we serve the two Dudley Primary Care Trusts have continued to invest in a range of new initiatives to tackle

associated problems with heart disease. Through the Dudley CHD Local Implementation Team (LIT), the economy has continued to build on the substantial achievements demonstrated in 2003/04 and has ensured that services have been developed and implemented within the available resources to meet the standards of the NSF.

A Performance Assessment Framework (PAF) has been developed, as a strategic framework, to review local service delivery and identify priorities for service developments to meet the requirements of the Local Delivery Plan and the National Service Framework (NSF). Monitoring of the national and local targets in the PAF demonstrates that continuing progress has been made across all aspects of service delivery including prevention, diagnosis and treatment

- Reducing heart disease in the population and preventing CHD in high risk patients

  The Dudley PCTs and partner agencies in Dudley have developed comprehensive local strategies and policies for physical activity, tobacco control and nutrition and obesity. The PCTs have also developed and strengthened partnerships with key partner agencies to ensure that service delivery has an impact on CHD prevention and the reduction of inequalities. Partners include, Age Concern, Action Heart Cardiac Rehabilitation, Local Authority departments to include: Directorate of the Urban Environment (leisure and sport and Environmental Health), Education, Priority Neighbourhood initiative, Groundwork Black Country and the Workers Education Association (WEA)**.**

  Integral to the model of care for patients with long-term conditions, our CHD specialist nurse has continued to work with all practices and their primary health care teams, to ensure that all known patients with CHD are offered structured care and supported to manage their condition. Primary prevention remains challenging and has been identified as a high priority for 2005/6. A Community-based Cardiovascular Primary Prevention Programme is being developed to identify “at risk” patients and ensure that they receive appropriate advice, treatment and referral to support services via a co-ordinated systematic care pathway. A phased approach will be taken initially focusing on hypertensives and known patients with a BMI of >30, then identifying additional at risk patients via a whole population based patient survey.

  Both the Community-based Cardiovascular Primary Prevention Programme and the interrelated Adult Weight Management Programme and additional Public Health Programmes, as detailed in the Health Inequalities section, are fundamental components of a comprehensive prevention programme to reduce future risks of developing CHD and diabetes and will form the basis of the “Prevention for All” facet of the model of care pyramid detailed in the Long Term Conditions section.

- Secondary and tertiary care services

  The Dudley Economy has made two major investments, which offer great opportunities for changing historical referral patterns and improving access for our patients. The first is the commissioning of a Cardiac Catheter Laboratory at Russells Hall Hospital, due to open in May 2005, and the 4th Cardiac Centre in Wolverhampton. Both will provide increased access to diagnostic and surgical capacity. Elective Percutaneous Coronary Interventions (PCIs) will be performed by Dudley Interventional Cardiologists at Wolverhampton, working in collaboration through the Black Country Network. The natural evolution will be to develop on site PCI at Russells Hall Hospital, especially for urgent and emergency cases.

  These investments should realise an increase in access to diagnostic catheterisations from a baseline of 2198pmp in 2003/04 to meet the NSF target of 3000pmp for revascularisation by 2005/06 and further phased increases over subsequent years to meet the BCIS recommended target of 3750pmp. Increased access to diagnostic catheters will result in concomitant step-wise increase in access to Coronary Artery Bypass Grafts and PCIs to meet the NST target of 750pmp and the Black Country agreed target of 1000pmp for both interventions as outlined in the West Midlands Cardiac Finance Group planning assumptions for access to revascularisation.

  The appointment of the 4th cardiologist and an additional cardiac specialist nurse has improved access through early intervention, early thrombolytic intervention of acute myocardial infarctions and the expansion of the rapid access chest pain service resulting in the local Trust meeting and in some cases exceeding national targets.

- Heart Failure

  As part of the “Shaping the Future” Community Investment Strategy the Dudley Economy is developing a Community Heart Failure Service which will be integrated into the existing community palliative care and secondary care service and provide access to a community echocardiography. The service has been designed to reflect the need to diagnose the patient early, support patients in their homes and act as a filter and referral system for complex cases into secondary care. The overall strategy is to improve the management of patients with heart failure in line with the NICE clinical guidelines, meet the local target to reduce hospital admissions by 2000 bed days and ensure that all those with heart failure are receiving a full package of appropriate investigation and treatment as outlined in the NSF. Additional local targets include reduction in frequent admissions, emergency and non-elective admission and improved end of life experience for both patients and carers.

- Cardiac rehabilitation

  The cardiac rehabilitation programme/secondary prevent programme has maintained its Department of Health "Action Heart" Beacon Site status. The new department opened at Russells Hall Hospital early in the year and continues to provide a patient centred service that meets all local and national targets as outlined in the Performance Assessment Framework.

Cancer Services

Relevant Data Tables (see section 8)

PSA03a	The mortality rate from cancer in people aged under 75 per 100,000 (directly age standardised) population: **no more than 115 pa by 2008.**
PSA 03b	The progress on the implementation of the improving outcomes series of guidance for cancer as demonstrated by the number of designated specialist multi-disciplinary teams in place for different tumour groups: **1 team per tumour group (already in place).**
PSA03c	Percentage of 50-70 year old adult population screened for Bowel Cancer: **no national target set yet.**

The Cancer Action Plan 2004-08 seeks to achieve the NHS Cancer Plan for the whole population of Dudley. The plan responds to the draft findings of the recent Cancer Services Peer Review and identifies the priorities for service development to achieve the National Headline Targets for Cancer, the Health and Social Care Standards and A Wider View (the Strategic Health Authority's Strategic Framework).

- The NHS Cancer Plan aims to reduce mortality and illness caused by cancer, by reducing the incidence of cancer, and when cancer is present, by ensuring fast and effective diagnosis and treatment, including appropriate palliative care.
- The Health and Social Care Standards and Planning Framework sets out a standard-based planning framework for health and social care and standards for NHS health care to be used in planning, commissioning and delivering services.
- The SHA Strategic Framework sets out the highest priorities for the NHS in Birmingham, Solihull and The Black Country between 2004–2010. Its seven key priorities include improving the health of the population through reducing inequalities and improving access to services.

The Local Delivery Plan aims to ensure that in addition to the national targets which will be met, other important milestones in achieving high quality cancer services are not ignored.

The breast screening service has already extended the age coverage. Increased access and waiting time targets will be achieved through the commissioning of secondary care services through payment by results and the consequent increased funding of oncology drugs. Local smoking cessation

services will be maintained and increased. Work continues with the Cancer Network to improve palliative care and over the period of the LDP will see significant movement to meet the NICE guidelines.

Finally primary care will receive support to reduce the patient pathway and tackle health inequalities in terms of early detection and rapid referral and to improve the cervical screening programme through increased uptake, increased laboratory capacity and the introduction of liquid based cytology in 2006.

3.5 Choice / Book and Choose

3.5.1 Summary

The PCT is committed to the improvements that the introduction of Choice and the new booking arrangements will bring to patient experience:

- Choice in cataracts and cardiac surgery are currently being introduced.
- All patients will have a choice of 4/5 providers for elective care by the end of 2005.
- Electronic and other systems as necessary will be introduced to support patient booking in line with national milestones.

3.5.2 Relevant Data Tables (see section 8)

None directly relevant.

3.5.3 Background

Choose and Book is a high priority programme with key performance targets to deliver. The programme aims to deliver informed choice to patients and to improve access to services.

Recent communication from the Department of Health will change the direction of the local implementation plan. A revised plan is currently being developed for submission on 18th Feb 05, which will cover the local approach to delivery of national targets resulting in incentive payments to PCTs.

The first incentive payment to the PCT will be in June 2005 consisting of approximately £6k per average practice and is subject to the delivery of the following:

- **100% of eligible patients will have a choice of 4-5 providers by end of 2005**
  The project team will work with GPs to ensure that choice of provider is given to patients at the point of referral. The programme also includes GDP referrals within this target. As yet no commissioning rules are set up with GDPs. This will be addressed.

- **Information about all providers' services is loaded onto the Directory of Services by June 2005.**
  A working group has been set up at Dudley Group of Hospitals to determine a plan to take this forward.

- **At least 30% of GPs are NPfIT registered so that they can access Choose and Book.**
  This involves the identification and registering of all users and issuing of smart cards. The first incentive payment for PCTs is dependent upon the relevant Registration Authority (RA) training being given, availability of equipment and smart cards availability.

  In addition, Choose and Book or Indirect Bookable Services (IBS) must be available for GPs. This is dependent upon N3 links being available, GPs

PC compliance and NPfIT deployment of the Choose and Book/IBS application.

The second incentive payment to the PCT will be in October 2005 of £100k subject to the delivery of the following:

- **50% of monthly GP and GDP referrals for first outpatient appointments are made using Choose and Book (including Indirect Bookable Services (IBS)) by October 2005.**
  To achieve this we will increase the rollout of registration of GPs to ensure that 50% of referrals made are captured using this method. In addition, Choose and Book or IBS must be available for GPs. This is dependent upon N3 links being available, GPs PC compliance and GP systems compliance, NPfIT deployment of the Choose and Book/IBS application.

  GDPs will also require either access to web-based Choose and Book or their patients be booked via the Booking Management Service. These options will be explored as the implementation plan is updated.

  Each provider will require a call centre with access to the PAS and Choose and Book in order to book patients agreed appointments and to update the Choose and Book system to ensure accurate information to referring clinicians.

The third incentive payment of £100k to the PCT will be made as follows:

- **As soon as 90% of monthly GP/GDP referrals for first consultant outpatients appointments are made using the fully integrated (or web-based) Choose and Book service. This must be by end of 2006 at the latest but could be earlier. This excludes the interim IBS solution.**

  To achieve this target, rollout will need to be increased from 80% in October 2005, whereby a significant number may be via IBS, to 90% by end of 2006 using the fully integrated or web-based Choose and Book.
  This is dependent again upon N3 links being available, GPs PC compliance, GP systems compliance and NPfIT deployment of the Choose and Book/IBS application. The success of a fully integrated or web-based Choose and Book is dependent upon a Booking Management Service to support those patients who do not wish to book their appointment with the referring clinician. The provision of this service is being led by the Birmingham and Black Country StHA in conjunction with NHS Direct.

In addition to targets that are incentive payment related we aim to achieve the following:

- **A minimum of 80% of GP/GDP referrals for first consultant outpatients by end of 2005. Any remaining referrals should be processed ensuring that patients are able to pre-book the date and time of their appointment at least 4-6 weeks in advance.**

To support the implementation of both IBS and Choose and Book, a process whereby patients are partially or fully booked manually will need to be sustained.

- **Choice of 4 to 5 providers including 1 from the Independent Sector**

  This is a key priority for the Trust to develop and deliver by December 2005.

3.5.4 Choice in Cataracts

Dudley PCTs have implemented the StHA wide approach to the delivery of Choice of three providers in Cataracts by end of January 2005. Commissioning rules have been agreed with Optometrists in order for Choice to be given to patients at the point of referral.

3.5.5 Choice in Cardiac Surgery

This policy is being led by the West Midlands Specialised Services Agency in order to achieve the April 2005 target of Choice in Cardiac Surgery.

3.5.6 Mental Health

Dudley PCTs will develop means to ensure that Mental Health services are available on the Directory of Services. They will also explore the potential to electronically book those services that are directly bookable where there are compatible GP systems following the implementation of the new Mental Health PAS system expected May 2005.

3.5.7 Smoking Cessation

The Choose and Book facility will incorporate smoking cessation services by the end of this current LDP programme.

3.6 Capacity and Investment Planning

3.6.1 Summary

The PCT is expanding capacity both in community and hospital services to improve access and reduce waiting times:

- An achievable programme to ensure that the maximum wait from referral to treatment is 18 weeks by 2008, with other milestones for good progress before then.
- Development of the new Health Improvement Centres in the community.
- Support for the Black Country Review.

3.6.2 Relevant Data Tables

PSA12a	Reduction in emergency bed days: **down to 72,264 by 2008.**
PSA13a	Number of outpatients waiting longer than the standard: **0 throughout plan.**
PSA13b	Number of patients waiting longer than the standard for MRI or CT scans: **0 by mid 2005.**
PSA13c	Number of patients waiting longer than the standard for other diagnostics tests and procedures, excluding MRI and CT: **no local targets set yet.**
PSA13d	Number of inpatients waiting longer than the standard: **0 throughout plan.**
SUP04	Acute hospital activity: **see Data Table.**
SUP05	Elective admissions to be delivered by the Independent Sector: **900 by 2008.**

3.6.3 Developing the 'Whole-Systems' Approach in Dudley

The overall strategic direction for services is described in "Shaping the Future", which focuses on appropriate care for patients in the appropriate place. A new PFI hospital with a reduced number of beds has given the health and social care community the opportunity to review all health and social care and, using redesign methodology, to focus on the needs of the patient in redesigning a service for the future.

The fundamental target for "Shaping the Future"' is to reduce hospital occupied bed days by 56,551 against the 2002/03 position.

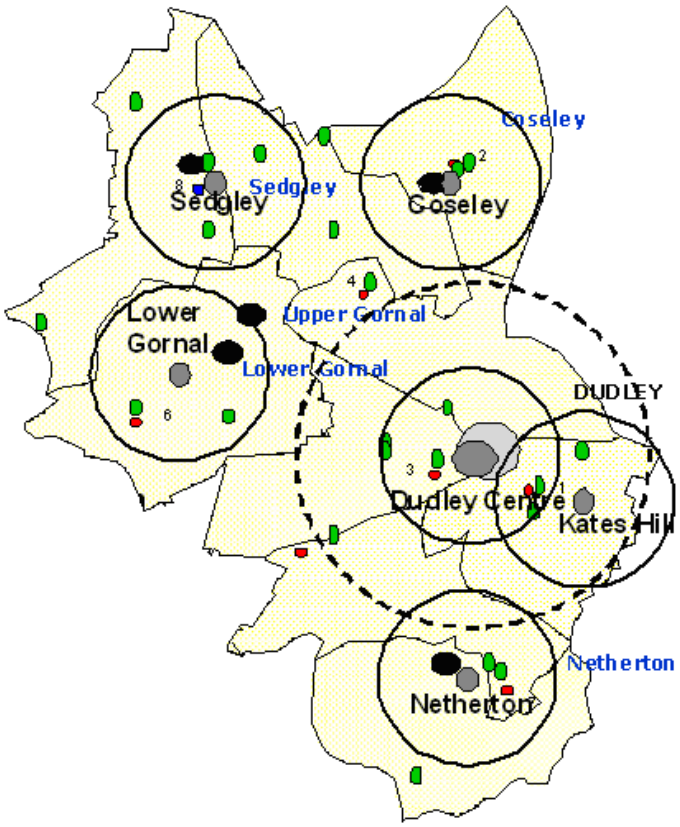
3.6.4 Primary Care

A new model of care has been developed which focuses on the whole health care system and the whole workforce. To assure equal access to services, the model is based upon tiers. Some services will be provided at GP practice level, some locally to the patient in for example health centres or neighbouring GP practices, and finally those services requiring specialist skills or particular resources at a PCT-level centre of excellence.

This model of care, together with the Black Country Review Strategy, have been major drivers in determining plans to develop the primary and community estate of the PCT. The preferred option seeks to consolidate the benefits of a range of approaches including coverage, health inequalities and deprivation

and benefits of economies of scale in a geographically compact, urban PCT. This model proposes a centralised facility incorporating full diagnostic and primary and community services, located within easy reach of the most deprived areas of the Dudley Beacon and Castle population. The central facility is then supported by health improvement centres scattered across the Dudley Beacon and Castle area. Satellite outreach locations, provided by General Practitioners or nurse consultants provide the final link into local communities. Resources have been identified in 2006/07 and 2007/08.

The proposed location for the health improvement centres is presented in the illustration below:



3.6.5 Secondary Care

<u>The Black Country Review</u>
The whole systems approach described above continues to heavily influence the Black Country Review. The PCT is committed to supporting the project to achieve a coherent disposition of safe, high quality secondary care services across the Black Country which complement local community services based upon this model of care.

<u>Emergency</u>
"Shaping the Future"' includes a range of developments both to avoid admission through the proactive care of people with long term conditions and the expansion of intermediate care together with average length of stay

reductions. The projected impact of this is described in the table below, which relates to all our Acute Trust providers and not just the Dudley Group of Hospitals NHS Trust. "Shaping the Future"' will ensure achievement of the national requirement to reduce emergency bed days by 5% as above.

Elective

Against the long term national target of nobody waiting longer than a total of 18 weeks from referral to commencement of treatment by 2008, the PCT has set the following milestones which are reflected in the data tables and our investment profile:

	Maximum Outpatient Wait (weeks)	Maximum Inpatient Wait (weeks)	Maximum Diagnostic Wait (weeks)
March 2005	13	26	-
March 2006	13	21	12
March 2007	8	13	6
March 2008	4	9	2

We have considered the feasibility of making greater progress on those milestones in 2005/06, but the cost of achieving, for example, 8 weeks (outpatient) and 18 weeks (inpatient) is estimated at £200,000 and this is unaffordable in that year.

It is presumed that under Payment by Results the achievement of diagnostic waiting times will be a requirement on hospital provider Trusts although some diagnostic waits may be eliminated by their integration into pre-referral triage (eg in orthopaedics, see section 3.7 'Orthopaedics') and the PCT will be negotiating GP and Primary Care access to a range of diagnostic investigations (eg MRI, CT Scan) where it is not currently available. This will involve some 'unbundling' of tariffs under the Payment by Results regime.

As part of "Shaping the Future"', the PCT has also developed the "Pathways" scheme which places the management of the total elective care pathway within Primary Care.

3.6.6 Activity Implications

The levels of activity required to achieve both the emergency and elective targets and plans described above is as follows:

Totals	2005/06		2006/07	2007/08
	Outturn Activity 01/10/2003 – 20/09/2004	Total Activity Required	Total Activity Required	Total Activity Required
	Spells / Attendances	Spells / Attendances	Spells / Attendances	Spells / Attendances
Elective Daycase	7131	7347	7601	7530
Elective Inpatients	3159	3415	3600	3578
Emergency	7993	7631	7631	7631
Outpatients	101525	103196	103984	105236

Detailed activity data by individual specialty projected through the three years of the LDP is available to support the above summary.

Funding is identified in the PCT's investment plans through to 2007/08 to achieve these levels of activity in the context of Payment by Results.

3.6.7 Specialised Services

The 2005/06 LDP financial investment profile includes the full amount identified to the PCT by the Black Country Local Specialised Commissioning Group.

All the financial and patient activity figures quoted below relate to the entire Black Country Consortium. Dudley Beacon and Castle PCT's share of each of these is on average 13.3%.

Cardiac Services

The new Heart & Lung Centre will be fully operational in 2005/06. It will become the principal tertiary provider for the Black Country health economy, providing all but the most specialised cardiac and thoracic procedures. After 4 years of regional subsidies the Black Country PCTs will become the principal funders of the centre. The net cost of transferring patient flows from across the region into the centre and increasing capacity by an additional 132 procedures is £4,605 million. An additional £194k will fund growth in interventional cardiology at Sandwell DGH also.

This financial burden on Black Country PCTs will be offset by the Pan-Birmingham LSCG which, subject to conclusion of other negotiations, will provide a non-recurrent £1 million subsidy.

The new capacity will allow for increased surgical and cardiological activity, ensuring delivery of 1500 revascularisations pmp and 3 months maximum waits, in line with national targets.

Local ICD programmes at the Heart Centre and Dudley Group of Hospitals will also be developed to increase local access to specialised services. The cost of this growth is £357,000. Further growth in revascularisation and ICDs will cost in the region of £1m in years 2 and 3.

Renal Services

Growth in Renal Dialysis numbers has been dramatic in 2004/05, producing an in-year cost pressure of approx. £1,175,000, of which £475,000 related to the Dudley Group of Hospitals service. Further growth will be met through expansion of capacity, including a dialysis satellite unit in Wolverhampton and increased capacity at Dudley Group of Hospitals. Annual projected growth for the next three years is at 11% per annum. This equates to 36 patients in 2005/06 at a cost of £450,000 (£900,000 recurrently), with similar growth in the next two years.

Growth in home dialysis to reflect the Renal NSF, and the growth in living related donor transplantations will cost an additional £75,000 in 2005/06, rising to £105,000 in years 2 and 3. The second part of the Renal NSF has now been published and the Consortium is establishing a Local Renal Group to take forward an initial baseline audit of services across primary, secondary and tertiary care which will be used as the basis for developing a prioritised action plan.

Clinical Oncology & Radiotherapy

In-year and recurrent growth in day case chemotherapy and drug costs, resulting from increases in second line treatments, and follow-ups, will cost £356,000 in 2005/06, with similar growth in years 2 and 3.

Development of clinical oncology to support repatriation of Walsall patients following the repatriation of urology and lung cancer surgery may need to be brought forward from years 2 and 3 of the plan, if slippage allows, whereas development of shared care paediatric oncology and other children's specialist service developments at RWHT for the Black Country have been deferred to years 2 and 3 of the LDP.

The cost (£850,000) of opening one of the two new linear accelerators at the Royal Wolverhampton Hospitals is approved, to deliver normalised working hours and improved hourly fraction rates. £107,000 is also required to support 2 new Linear Accelerators at University Hospital Birmingham. Funding may be required to open the 4th linear accelerator in year 2 or year 3 of the plan to accommodate repatriation of Walsall flows from Birmingham.

Tier 2 Acute Services & Forensic Services

Continued growth in the Forensic pool requires ongoing long-term investment of £853,000 per annum, whilst acute services require £738,000 per annum.

3.6.8 Individual Funding Requests

The PCT receives a small but regular flow of requests to fund treatment not covered by our Service Level Agreements with Provider Trusts. The 2005/06 investment profile shows a small uplift to this budget which will not cover the range of potentially legitimate requests in the context of our current policies. These will therefore be reviewed to align levels of approval to funding available.

3.7 Orthopaedics

3.7.1 Summary

The PCT recognises that the specialty of Orthopaedics is a major element of the totality of waits for specialist care:

- A new Orthopaedic Triage service will be introduced during 2005.
- The maximum wait from referral to treatment of 18 weeks by 2008 will be achieved.
- Significant use will be made of the new Treatment Centre a the Royal Orthopaedic Hospital, Birmingham and independent sector initiatives.

3.7.2 Relevant data tables (see section 8)

PSA13b	Number of patients waiting longer than the standard for MRI or CT scans: **0 by 2005.**
PSA13e	Number of outpatients waiting longer than the standard in Trauma and Orthopaedics: **0 throughout plan.**
PSA13f	Number of inpatients waiting longer than the standard in trauma and orthopaedics: **0 throughout plan.**

3.7.3 Introduction

Orthopaedics is a capacity constrained specialty that poses the biggest challenge to achieving access targets and delivering choice. The reduction of waiting times will require additional capacity and better management of the referral process in primary care. Within Birmingham and The Black Country a plan has been agreed that will deliver at least 1 year ahead of NHS Plan a maximum wait of 3 months, leading to achievement of a total waiting time target for admission of 18 weeks by March 2008. Additionally all patients will receive the benefit of a comprehensive orthopaedic assessment and management plan in a primary/community care setting prior to referral, which process will also incorporate choice of provider.

Modernisation of the service locally was started through Action on Orthopaedics initiatives and more recently through the Community Investment Strategy (CIS), which has funded schemes such as hospital at home and new emergency theatres for weekend working. These initiatives aim to improve the inpatient pathway and allow earlier discharge of patients.

Much has been done to increase the capacity within orthopaedics but this must be set against a background of an increasing elderly population with the added dimension of transport needs and rising demand for elective surgery such as hip replacements. It is estimated that there will be a year on year increase in demand for orthopaedic surgery in the region of 1%-2%.

3.7.4 Activity Model

Dudley Beacon and Castle PCT are working to the following waiting time targets as agreed within the SHA Orthopaedic Project:

Inpatient Waiting Times

- To maintain 6 month maximum wait in 2005/6;

- To reduce over 3 month cohort by 40% from December 2004 levels during 2005/6 and achieve 3 month maximum wait by March 2007;
- To achieve 18 week total waiting time target by March 2008.

Outpatient Waiting Times
- To maintain 13 week maximum wait in 2005/6;
- To reduce over 8 week cohort by 40% from December 2004 levels during 2005/6;
- To achieve 18 week total waiting time target by March 2008;
- To address the inpatient consequences of reducing outpatient waiting times.

Diagnostic Waiting Times
- To identify and begin to reduce maximum waiting times for diagnostic tests and to achieve the 18 week total waiting time target;
- Address the inpatient consequences of reducing diagnostic waiting times.

Returns to the Orthopaedic Project demonstrate the intention of Dudley Beacon and Castle PCT to meet the inpatient and outpatient waiting times, working towards the total waiting time of 18 weeks by 2008. In addressing these issues Dudley Beacon and Castle PCT is working within the framework of the Birmingham, Solihull and the Black Country Orthopaedics Project in a coordinated approach to the development of orthopaedic services.

The main focus of PCT orthopaedic services development, mirrored by the project, is directed towards the development of capacity, choice and primary care assessment.

Primary Care Assessment – Physiotherapy Triage
Within Birmingham and the Black Country, orthopaedics has been identified as the pilot specialty for delivering Choice at Referral with Primary Care Assessment (PCA) as the accepted mechanism for its provision. In Dudley this will be delivered through a physiotherapy-led triage service. The PCT is a Phase 3 implementer (June 2005 to September 2005).

Physiotherapy Triage will:
- Provide a service that meets national requirements of providing Choice at the point referral and meets maximum waiting times against a backdrop of increased activity
- Provide streamlined, integrated local services, maximising use of available resources within the economy, providing high quality patient services.
- Support the health economy's commitment to moving services into a primary care led setting where possible
- Provide a mechanism by which to implement Choice at referral in Orthopaedics for Dudley patients, delivered through a Clinical Assessment Service
- Re-route referrals to secondary care appropriately, including diagnostic services, releasing valuable resources and capacity
- Improve clinical pathways and the patient experience

- Assist in the achievement of the target of 8% of all elective surgical activity being carried out in for independent sector by March 2008.

Current Service

Within the community services in Dudley there has been a longstanding service of physiotherapy triage for patients with back pain. More recently a pilot using extended scope practitioners has been undertaken with respect to shoulder triage and provision of joint injections in the community. This existing limited triage service for shoulder and back problems will be used as the foundation on which to build the orthopaedic triage service. The service, being developed in conjunction with Dudley South PCT, will initially be for referrals to Dudley Group of Hospitals. However, links are already in place with the Royal Orthopaedic Hospital and through the Orthpaedics Project and PbR pathways, these will be developed with other providers and patients will be offered a choice of provider at the appropriate point in the pathway.

Proposed Service

The proposed service will provide a single point of entry for all orthopaedic referrals through physiotherapy triage arrangements. Patients will be triaged by extended scope physiotherapy practitioners and allocated to the appropriate pathway.

Access to active treatment will be facilitated and direct access to diagnostic services will be available early in the treatment pathway either at the Dudley Group of Hospitals or in local community based services. Choice will be offered at the point of referral for inpatient services.

It is expected that by 2007/08 the new service will deliver 40% reduction in orthopaedic new outpatient attendances and support reduced waiting time targets.

By 2008 15% of elective admissions are planned to be carried out in the Independent Sector. The Physiotherapy Triage service will assist in the achievement of this target though its mechanisms of offering choice and patient assessment.

3.7.5 Use of G-Supp Activity

In 2005/06, activity provided through the G-Supp programme will be available on a direct referral basis i.e. by the referral of patients from primary care to the Nuffield Hospital (independent sector provider) rather than the transfer of patients from existing secondary care lists.

The activity will only be available to health economies who have launched their primary care assessment services and who are able to undertake the necessary anaesthetic pre-assessment to identify suitable patients.

Dudley Beacon and Castle PCT is proposing the following G-Supp activity:

Year	2005/06	2006/07	2007/08
Allocation	21*	42	41

* 2005/2006 activity represents a half year effect in line with commencement of the primary care assessment service in Dudley Beacon and Castle PCT

3.7.6 The Royal Orthopaedic Treatment Centre (ROHTC)

Birmingham and Black Country Chief Executives have agreed to underwrite 90% of the activity at the ROHTC at tariff for 2004/5 and 2005/6. The centre however, does not yet have a date for becoming operational and discussions regarding the current limited case mix are ongoing.

Practice based commissioning will support the PCT in making referrals to ROHTC but numbers may be constrained by Choice and the current restricted case mix.

Indicative activity to be commissioned by Dudley Beacon and Castle PCT at ROHTC is as shown in the table below but may grow if the case mix is widened.

Year	2005/06	2006/07	2007/08
Activity	51	51	51

3.7.7 Diagnostic Waiting Times

Dudley Beacon and Castle PCT will begin to reduce waiting times for diagnostic tests to achieve the 18 week total waiting time target and will address the inpatient consequences of reducing diagnostic waiting times.

To assist in reducing waiting times, additional MRI activity will be available through a nationally funded programme whereby a mobile unit will be sited at the Dudley Group of Hospitals at various times during 2005/06 and following years.

The PCT has 256 patients waiting more than 12 weeks for an MRI scan as at December 2004, which will be addressed by the additional MRI capacity. This is planned to result in an additional 58 spells in 2005/06 and these will be predominantly in orthopaedics.

3.8 Diagnostics

3.8.1 Summary

The PCT will ensure that waits for diagnostic investigations become increasingly insignificant in the context of meeting the total 18 week target:

- GP direct access to CT scanning, MRI and other appropriate investigations will be introduced in the context of integrated care pathways.
- Through commissioning processes, waiting time standards will be improved within hospitals.

3.8.2 Relevant data tables (see section 8)

PSA13b	Number of patients waiting longer than the standard for MRI or CT scans: **0 by mid 2005.**
PSA13c	Number of patients waiting longer than the standard for other diagnostics tests and procedures, excluding MRI and CT: **no local targets set yet.**

3.8.3 Introduction

The wait for diagnostic tests often contributes significantly to the overall patient wait from initial outpatient consultation to inpatient procedure. Measures to address this will include new configurations of diagnostic services, improving access through better use of existing equipment, increasing the diversity of diagnostic settings and opening up direct access to diagnostic services to GPs and extended scope practitioners. The PCT is addressing diagnostic services through its involvement in the Birmingham and Black Country PCT Accord project and through direct investment in local services as part of “Shaping the Future”’.

The Birmingham and Black Country PCT Accord Diagnostic Project is now established and Dudley Beacon and Castle PCT clinicians and managers are making a significant contribution to the development of the project. Whilst it is still in its early stages certain areas have been identified for development within the independent sector. These include:

- Increased access to MRI through expansion of the mobile facility including the development of direct access for primary care
- Increased primary care access to endoscopy
- Development of a range of investigations to support cardiology, respiratory and audiology

Another area of development for the group is in the development of community based phlebotomy services though this is already in existence and working well in the PCT.

The PCT recognises that improved access to diagnostics is required to address the access target of 18 weeks by 2008 ensuring that diagnostic waits are no longer that 12 weeks by 2006 and the LDP access trajectories demonstrate the progress that the PCT expects to make.

There are issues with data provision and quality and the PCT will be ensuring strategies are in place to reduce diagnostic waits, setting standards for providers and ensuring systems are in place to monitor activity.

The Dudley Health Economy is nearing completion of the "Shaping the Future"' project which will see the redevelopment of all acute hospital services, including the centralisation of all inpatient services on the Russells Hall Hospital site and the development of two ambulatory care centres at the Corbett and Guest Hospital sites, as well as substantial and complementary development of services in the community. The immediate consequence of this in the context of diagnostic demand and capacity is that hospital based diagnostic facilities in particular have been scoped and provided in the context of a modern local health service, ie in general, physical capacity across the range of diagnostic services is or will be available shortly.

As part of the "Shaping the Future"' project, in conjunction with Dudley South PCT, Dudley Beacon and Castle PCT has reserved £100,000 in 2005/06 and £82,000 in 2006/07 to address 'hidden waits'. It is intended that a significant proportion of this sum will be allocated to the expansion of specific diagnostic services to reduce waiting times through primary care direct access. A group has been established within this overall project to review diagnostic services and the best use of this resource.

The introduction of Clinical Assessment Services via Physiotherapy Triage in orthopaedics in 2005/06 will require access to diagnostic services by Extended Scope Practitioners who work beyond the recognised physiotherapy scope of practice.

The introduction of payment by results will change the financial relationship between PCTs and NHS Trusts, with timely access to diagnostics included within tariff payments.

Details of specific diagnostic services in Dudley currently are as follows:

3.8.4 Imaging

Plain Films and Ultrasound

New X-ray facilities are available at Dudley's main hospital site (Russells Hall) as well as at one of the two ambulatory care centres (Corbett). Physical capacity is therefore not an issue, particularly if the available scope to extend working hours is taken into account and there is evidence of local improvement in the recruitment of radiographers and radiologists. In addition PACS will be available to improve reporting processes.

GPs already have direct access to plain X-rays and will be seeking similar access to ultrasound services in the context of integrated care pathway development and "Shaping the Future"'.

CT scanning

The installation of a second CT scanner was concluded during 2004 and this, together with scope for extended hours usage of both CT scanners, should provide adequate capacity for the foreseeable future.

MRI Scanning

There is a single MRI scanner currently routinely used only during normal working hours. Even with extended working, it seems unavoidable that a second scanner will be required.

There was additional investment in 2004/05 and a further £38k pa is identified from within nGMS enhanced services floor spend as part of primary care assessment/ orthopaedic triage development.

To assist in reducing waiting times, additional MRI activity will be available through a nationally funded programme whereby a mobile unit will be sited at the Dudley Group of Hospitals at various times during 2005/06 and following years.

The PCT has 256 patients waiting more than 12 weeks for an MRI scan as at December 2004, which will be addressed by the additional MRI capacity. This is planned to result in an additional 58 spells in 2005/06 and these will be predominantly in orthopaedics.

Pathology

New pathology facilities are available at the main hospital site (Russells Hall). Physical capacity is therefore not an issue, particularly if the available scope to extend working hours is taken into account and flexibility between departments in terms of capacity.

Phelbotomy services are extensively provided within primary care.

We are suffering locally from the national shortage of Biomedical Scientists, Cytoscreeners and Consultant Histopathologists, the last being pursued through international recruitment.

GPs have direct access to the range of pathology tests and usage has increased following the introduction of the new GMS contract, particularly for haematology and biochemistry.

Waiting times in this area are not an issue. The introduction of the electronic patient record and continuing development of integrated care pathways should reduce duplication of requests, facilitate control of requests for more expensive/complex investigations and ensure appropriate requesting for specific conditions.

Endoscopy

There are three dedicated Endoscopy rooms in the new hospital that provide some scope for expansion. The provision of Endoscopy facilities has specific

health and safety, disinfection and high equipment cost characteristics which together indicate such facilities need to be purpose built and used full time. This would tend to locate such facilities within a hospital setting. The use of nurse endoscopists is supported.

GPs already have direct access to endoscopy through a 'triaged' referral system.

Current waiting times for new endoscopies are contained within the 13-week wait standard for outpatient appointments. Significant numbers of patients require follow up endoscopies at regular intervals and these are liable to be deferred in the face of new referral pressures.

3.8.5 Physiological Measurement

Cardiology

New cardiology facilities are available at the main hospital site (Russells Hall) as well as at one of the two ambulatory care centres (Corbett). Physical capacity is therefore not an issue, particularly if the available scope to extend working hours is taken into account. We are, however, suffering locally from the national shortage of technical staff in the laboratories.

GPs already have access to ECGs, exercise tests and echocardiograms. The development of heart failure services in the context of "Shaping the Future"' will include the development of more local echocardiogram services in primary care.

The implementation of the CHD NSF is revealing significant unmet need across the full range of care pathways in cardiology. The use of myocardial perfusion scintigraphy has recently been recommended by NICE. This service is already available in Dudley and its se will be expanded, resourced through Payment by Results.

Respiratory Physiology

New facilities are available at the main hospital site (Russells Hall). Physical capacity is therefore not an issue, particularly if the available scope to extend working hours is taken into account. Spirometry is now extensively available in general practice, but the requirements of the new GMS contract have significantly increased demands for other lung function testing to which GPs already have direct access.

Audiology

There are significant physical constraints currently which will be addressed in the medium term through Dudley South PCT LIFT Project. There exists, however, a national shortage of audiologists, which is giving rise to local recruitment and retention problems. Waiting times are currently extensive caused by changing demography, improvements in clinical practice and the introduction of digital hearing aids, the last receiving specific further investment in 2005/06.

4. OTHER CLIENT GROUPS / PROGRAMMES

4.1 Adult Mental Health

4.1.1 Summary

A major redesign of mental health services will be completed, including:

- The introduction of new services including Early Intervention, Crisis Resolution/Home Treatment and Assertive Outreach.
- A review of the scale of need for inpatient services.
- An increasing emphasis and support for mental health services in primary care.

4.1.2 Relevant Data Tables (see section 8)

PSA05a	Mortality rate from suicide and undetermined injury per 100,000 (directly age standardised) population: **reduced to 7 pa by 2008.**
PSA05b	Percentage of people on enhanced CPA receiving follow up (by phone or face to face) within 7 days of discharge from hospital: **100% from 2005/06 onwards.**

4.1.3 Strategy

The Dudley Health Economy has made a commitment through the development of its Mental Health Strategy that Mental Health services will link with other agencies and programmes to promote the Mental Health of the general population of Dudley and the full citizenship and social inclusion of people with mental ill health. Dudley Health and Social Care Economy, as an integrated mental health service, have embarked upon a complex and challenging strategy built around primary and community services, recognising that:

- 90% of all patients with mental health problems (including 30-50% of all those with serious mental illness) only use primary care services (DoH 1999, Kendrick et al 2000).
- Mental health concerns, which affect an individual's family or functioning, are present in 30-60% of all primary care consultations.
- Mental health problem is identified as a main issue in 30% of all primary care consultations.

This has included the recruitment of five Primary Care Mental Health Workers who will help to facilitate the move towards a Primary Care led service enabling secondary care to focus on the most appropriate patients. It will also assist in the strategic objective of improved access to psychological therapies.

Dudley's Mental Health Service has been developed within the framework of the Mental Health Policy Implementation Guide (PIG). As well as increasing capacity in the community, Dudley is re-designing services to ensure that the new model supports the development of pathways across the care continuum.

Dudley is now re-designing both inpatient and community services. There is a planned bed reduction of 30% to be achieved by 2006 and the re-aligned structure will lead to a significant rebalance of existing resources to support

the development of new services. Dudley has committed to the development of an Assertive Outreach service through the modernisation of the rehabilitation service together with the continuing development of a Crisis Resolution/Home Treatment Team.

The economy has also supported the development of an Early Intervention service to reduce the stigma associated with psychosis and the length of time young people remain undiagnosed and untreated. The service is user centred, seamless and care at the end of treatment will be transferred thoughtfully and effectively.

From 2005/06 mental health services within Dudley will provide greater consideration to the social inclusion agenda and inequalities building the community capacity in respect of the following:

- BME
- Gender sensitive services
- Housing
- Access to employment
- Education and meaningful activities
- Links with local regeneration schemes.

As part of this commitment Dudley will invest in the recruitment of Community Development Workers, whose role is to enable greater understanding and ownership of the issues facing people from BME communities so that real improvement takes place in the commissioning and provision of mental health services across the full age range. The economy has also committed to the training of STaR workers, the creation of these roles having been achieved through re-design, restructuring and service development.

Mental health services in Dudley have an integrated health and social care management structure and will be signing off S31 Health Act (flexibilities) in April 2005. This enables us to deliver the Mental Health Strategy's model for the future, which is:

- To deliver patient focused services
- To develop services outside of the hospital
- Prevent avoidable admissions to hospital and reduce delays in discharge
- To support clinical decision making within primary care.

The Mental Health Strategy has also committed the health economy to work, over the next five years, towards addressing the gap between the current position and the desired situation, which ensures that the balance of developments reflects the burden of illness, and that services reflect the most effective use of every pound spent on mental health services. The investment for 2005/06 is the starting point with discussions planned for further investment during 2006/07 and 2007/08 within the following areas:

2006/07

- The development of Psychiatric Intensive Care (PICU) beds with secondary care to ensure that care is provided as close to home as possible.
- The requirements of the new Mental Health Bill.

2007/08

- Citizens Advice Bureau worker to work with clients across all ages. The worker will provide welfare screening for benefits and assist with housing benefits and issues contributing to social inclusion.
- Further investment into Early Intervention.
- Services for those representing with personality disorders.

4.1.4 Suicide Prevention

Dudley has a Suicide Prevention Action Plan – 'Taking Positive Steps in Dudley – Local Suicide Prevention and Reduction Action Plan' – which is closely linked to the Public Health agenda and has emerged from the Mental Health Strategy for Dudley. At a local level suicide prevention and reduction has been highlighted as one of the key areas for action within the Joint Mental Health Strategy for the Dudley Health and Social Care Economy for 2004-2010. The strategy document stresses the importance of focusing attention onto both a Primary Care ("population approach") and a secondary care ("high risk") point of view. Strong emphasis is also given in respect to forging robust working relationships with all key agencies and stakeholders so as to ensure a consistent approach to tackling this challenging issue across the borough.

The Suicide Prevention Action Plan builds upon the core principles enshrined within the Joint Mental Health Strategy detailing seven goals for local services within Dudley:

- Promoting mental health and well being of the people of Dudley
- Reducing the risk of suicide and attempted suicide in key high risk groups
- Promoting access to information, advice and support
- Reducing availability and lethality of methods
- Improving local processes for reporting and learning lessons from suicide and self-harm
- Promoting the use of research and evidence based practice
- Working with the media

The Action Plan also identifies how these seven goals will ensure effective local suicide prevention and reduction in line with best practice outlined within both standard seven of the National Service Framework for Mental Health (Department of Health 1999) and the National Suicide Prevention Strategy for England (Department of Health 2002).

4.1.5 Mental Health Services for Older People

The integration into a single management structure of health and social care services in 2005 will also improve support to older people with mental health problems, in accordance with NSF Standard 7.

Following the publication of the Commission for Health Improvement's (CHI) report into care on Rowan Ward, Manchester Health and Social Care Trust, in 2003, all providers of older adult mental health services with geographically isolated units were instructed to undertake a self assessment. The outcome of this for Dudley was the production of a robust action plan.

Dudley previously had an isolated ward, Holyrood, which was relocated on to the main hospital site at Bushey Fields in June 2004 as an interim measure whilst awaiting construction of the new facility also on site; this was completed in January 2005. The older adult organic in-patient mental health services now comprises of two wards, Holyrood and Sandringham. Consideration has been given to the differing needs of this particular group of people and as a result services have been reconfigured.

4.2 Older People

4.2.1 Summary

The PCT is committed to ensuring that older people have fair access to all health services they require:

- A range of developments which are part of "Shaping the Future" (eg integrated stroke services, intermediate care, falls service) will be completed.
- Partnership working arrangements with both statutory and voluntary organisations will be further built upon.

4.2.2 Relevant Data Tables (see section 8)

PSA18a	Increase the proportion of older people being supported to live in their own home and increase the proportion of those supported intensively to live at home: **Local Authority target.**

4.2.3 Background

The National Service Framework for Older People, introduced in 2001, has served as a vehicle for ensuring the needs of older people are at the hearts of the reform programme for health and social services.

The reform programme is being taken forward through: -

- assuring standards of care
- extending access to services
- ensuring fairer funding
- developing services that promote independence
- helping older people to stay healthy
- developing more effective links between health and social services and other partners

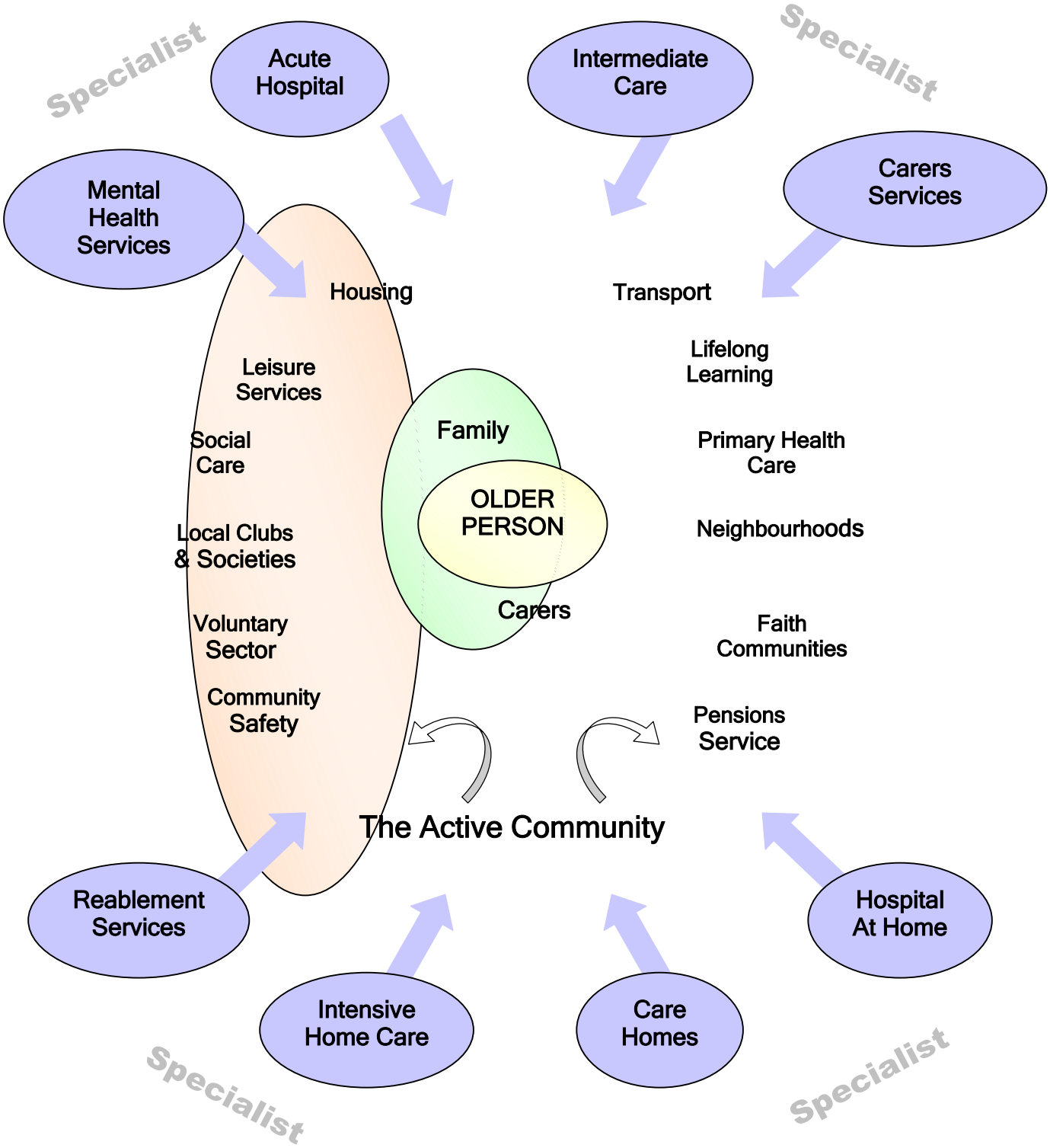
There are eight national standards, together with an additional standard on medicines and older people. The standards serve to "promote the health and well being of older people through a co-ordinated programme of action".

Many major diseases and conditions are more common in older people; the NSF has set standards for the care of older people in all settings across health and social services but importantly, where NSFs or other strategies are being developed for particular diseases (such as cancer or coronary heart disease or diabetes), the needs of older people will be addressed within these. The NSF for Older People has focused on those conditions which are particularly significant for older people, stroke, falls and mental health problems associated with older age. The NSF is clear that carers' needs should be considered as an integral part of the way in which services are provided for older people.

The standards have been addressed over the last 3 years through the direction of the Older People's Board and the Standard Leads Group. The Older People's Board has adopted the vision set out in the discussion document "All our Tomorrows: Inverting the Triangle of Care". The cross-

cutting model presented in that document has been adapted to create a Dudley model which mirrors the whole system model of patient care developed for Shaping the Future.

4.2.4 Model cross-cutting approach to older people's strategy development



4.2.5 Achievements

Progress in achieving the NSF milestones has been good. Notably a Champions Group has been established to continue to act as scrutineers of age discrimination. The Single Assessment Process has taken off and is seen as a positive vehicle to support improved in-patient care for older people. The Community Equipment service is well established. The Integrated Incontinence Service is established and developing an action plan. Major investments have been made in intermediate care and the 11 intermediate care beds for older people with mental health needs are due to be available in Spring 2005. The opening of the new hospital in 2005 will give even greater impetus to the commitment of the Acute sector to providing older people with access to specialist care within integrated provision. Improvements in stroke services have begun and are part of the Shaping the Future strategy. The Falls Service is well established, with a well-designed care pathway which has identified only a few gaps. Mental Health Services for Older People, whilst meeting many people's needs will, it is anticipated, benefit from the integration of health and social care staff into a single management structure. The promotion of a healthy and active life style for older people is supported by a number of different projects in the Borough, including flu immunisation, smoking cessation, healthy eating and physical activity. Finally, positive progress has been made implementing medicines related aspects of the NSF for Older People. Practice based pharmacists are putting in place systems to review patients on at least an annual basis and a number of other projects are in place, including self administration schemes, medication reminder charts and home visits for patients with particular needs and at risk from hospitalisation.

In addition to the NSF Older People, specific targets for older people's services were set in the Priorities and Planning Framework 2003-2006. These related to the number of older people being supported intensively to live at home and the time frame within which older people would be assessed and receive services. Achievement of these targets is well on track. Delays in hospital discharge have continued to reduce to a minimal level.

The planning framework, National Standards Local Action for 2005/6-2007/8 requires further stretching of these targets. Social Services investment should also help this.

4.2.6 Gaps in Existing Provision

The Single Assessment Process (SAP) milestones have been met through a paper based system, with electronic solutions pursued through NPfIT.

Full development of a hospital old age specialist service will be pursued with the local Hospital Trust. New staffing, as well as training of existing staff, will be required.

The top priorities for the National Director of Older People's Health - Professor Phillips - in 2005/6, are falls and stroke services. The full implementation of the integrated stroke service in Dudley is a key priority for Shaping the Future and is funded in this Local Delivery Plan.

The falls service, whilst well developed and successfully addressing the mechanical issues, still has some elements which are required in order to provide a fully integrated service model. Provision of a specialist training to existing community nurses and/or matrons with access to a consultant led Falls Clinic would close one of the gaps, and there is additional funding available for this to enable the service to deliver on targets and respond to need. Access to a DEXA scanning service is also a crucial element of the care pathway.

A range of funding is also identified to mainstream initiatives to promote physical activity (eg LEAP over 60), healthy eating (eg 5-a-day) and smoking cessation.

The Trust recognises that demand is outstripping supply for chiropody services and, subject to further review, will invest further in the service in both 2006/07 and 2007/08. In order to address an issue of sex discrimination, the PCT has also decided that its service access criterion relating to age should be harmonised at 65 years for both services.

4.3 Learning Disabilities

4.3.1 Summary

The reprovision of services at Ridge Hill into the community will be completed.

4.3.2 Relevant Data Tables (see section 8)

None directly relevant.

4.3.3 Background

Valuing People

The "Valuing People" White Paper was published in March 2001; the focus was on the rights, independence, choice and inclusion of people with a learning disability, which formed the title of the Learning Disability Task Force Report 2004. These principles underpin all the proposals in the White Paper, which address all aspects of life. However, in order for someone with a Learning Disability to have the opportunity of a fulfilled life the prerequisite is for him or her to have opportunities to be supported in achieving full citizenship, which means mainstream services are sensitive to the needs of this group and there are services to support individuals who require more specialist and intensive support or treatment.

One of the main objectives of the Valuing People White paper was to see the closure of the remaining long stay learning disability hospitals by April 2004. Dudley had an extension of this deadline to December 2005, which will see the completion of the re-provision of care from Ridge Hill Hospital.

"There are currently two main agendas to be delivered by health at present, inclusion on equal status for people with learning disabilities to access and receive health services to meet their health needs and the conclusion of the closure of learning disabilities hospitals"

A Strategic Direction for People with Learning Disabilities for Health Service, Nov 2003.
Birmingham & Black Country Strategic Health Authority

Learning disability agenda

The learning disability agenda can only be successfully achieved through partnership across organisations and with people with learning disabilities, their families and carers and communities. We must begin to focus on need and develop services accordingly and the immediate need is often access to mainstream services. This is applied to all services: housing, leisure, GPs, education etc,

4.3.4 Introduction

Standards Framework

The Birmingham and Black Country Strategic Health Authority has developed a Primary Care Standards Framework. Although this framework is health focused, it holds within it generic principles for future development of learning disability services within Dudley; rights, independence, choice and inclusion.

The strategy for learning disability services that is currently being developed will be guided by the framework and underpinned by these principles.

Equitable Services

Adults and children with learning disabilities have a right to mainstream services and the facilitation of access to those services is the responsibility of all providers. This is a fundamental aspect of equitable services. The implication for this for all Dudley services is that learning disability's priority must be raised and the vulnerability and risk for this group recognised.

Population of people with a learning disability

The difficulty in collecting precise information on the numbers of people with learning disabilities is widely acknowledged. In Dudley numbers of people with learning disabilities have been collected via the Special Needs Register. It is currently known that there are 895 (adults 18 years plus) with severe to profound learning difficulties. This figure includes some who have mild to moderate with additional health care needs, but these figures can only be viewed as an approximation. Numbers of children with learning disabilities are collected through the children with disabilities team. There are currently approximately 300 Children (up to 18 years of age) who are known to the children with disabilities team register.

The precise numbers of people with learning disabilities are estimates: around 210,000 people in England have severe and profound learning disabilities. This would suggest 8 people with severe and 50 with mild/moderate disability in a general practice list of 2000 people.

Evidence also indicates that the number of people with severe learning disabilities is rising by around 1% per annum (mild/moderate unknown) as a result of:

- Increased life expectancy
- Growing numbers of children and young people with complex and multiple disabilities surviving into adulthood
- Sharp rise in reported number of school age children with learning disabilities and autistic spectrum disorders

There is also greater prevalence amongst some minority ethnic groups of South Asian origin

The link between deprivation, poor health outcomes and learning disabilities is also widely acknowledged and therefore need to have a priority with health and social services in terms of promoting equity across all services.

Dudley Learning Disabilities Partnership Board

Social Services are the lead agency for learning disabilities within Dudley and established the Dudley Learning Disabilities Partnership Board as a requirement of the Valuing People White Paper. This has proved to be key to developing a partnership with meaningful involvement from those who are supported through learning disability services.

Partnership extends beyond Disability Services

It is the responsibility of agencies to ensure that all service and information is accessible and equitable. This needs to be understood in terms of ensuring that preventable diseases are prevented within learning disability groups, particularly in the knowledge that many people with learning disabilities have greater health and social care needs than the rest of the population. Many health problems are rooted within the lack of or inappropriate health and social support, isolation, poverty, housing, diet, exercise etc. Partnership working is key to enable person centred working which is evidenced within Dudley's Joint Community Team.

Pooled Budgets

A pooled budget arrangement is in place for Learning Disability Development Fund between the PCT and Dudley Local Authority, with an additional arrangement being agreed which will cover the Adult Community Teams, administration and Specialist Needs Register.

4.3.5 Health Inequalities.

Most people with Learning Disabilities have greater health needs than the rest of the population in respect of - mental health, poor oral health, epilepsy, diabetes, heart disease, weight problems, etc.

The health outcomes for this client group fall short in many areas: -

- Few people with learning disabilities access health screening i.e. Breast/Cervical/Testicular
- Research has highlighted inadequate diagnosis and treatment of specific medical conditions
- Studies of the management of people with challenging behaviour has shown an over dependency on the use of psychotropic drugs with poor outcomes as a consequence
- Doctors and care staff fail to recognise potential health care problems

It is important that services that support people with learning disabilities ensure that a healthy life style is meaningful within the context of choice.

4.3.6 Re-provision of care for people with learning disabilities resident within Ridge Hill Hospital

Timeline for re-provision

The re-provision of care for people with learning disabilities resident within Ridge Hill Hospital is planned for completion by December 2005, with preferred provider/s of the service being identified and commissioned by March 2005.

Person centred approach

A supported living model is to be the preferred approach for the re-provision. The involvement of people currently resident at Ridge Hill, parents, carers, staff, and other stakeholders is informing the re-provision. Person centred plans are the key to ensuring that choice and the preferences of individuals with learning disabilities are central to the development of the models and the

support packages that will be developed. Continuity of care will be key to the effectiveness and quality of the implementation and the control individuals will begin to gain over their own lives.

There are 35 people who will be supported into their own accommodation (they will hold their own tenancies), and will begin to have real choice and control over their lives.

4.3.7 Specialist Services

Current Services

Dudley South PCT provides an admission and treatment service, short break service, specialist psychiatrist, psychologists, therapy services and an intensive support team which works with people with severe challenging behaviour. The community nurses are members of the community teams which is managed by Social Services, but they receive clinical supervision through health services.

Service Developments

The Learning Disability Services is currently undergoing a period of change and service development to improve specialist health service provision for people with learning disabilities who require additional specialist support from that of mainstream health care provision. The new service is to be delivered from new purpose built buildings on Ridge Hill and to open in 2006.

Developments will include a 10-bedded provision with Admission, Rehabilitation and Short Term Break facilities. In addition, a base for Therapy and Enabling and accommodation for the clinicians and support staff of Psychiatric, Psychology, Intensive Support Service and specialist nurses. The unit will bring the specialist staff together and continue the development of multi-disciplinary working in the health care provision for clients accessing the service within Dudley

Additional work undertaken by the Specialist Services: -

- Health Screening for all people registered on the Special Needs Register
- Work to improve the take up for cancer screening
- Liaison and joint work with the Health Improvement department and Public Health to ensure that learning disability issues are included on their agenda and are being addressed in all the National Service Frameworks.
- Liaison with the Black and Ethnic Minority Social Worker to maintain inclusion in the Health Facilitation Process.
- Close work with the Special Needs Register ensures all people with a learning disability who live in the community are registered with a GP.
- Involvement with PALS and the acute hospital service by ensuring the raising by the profile of learning disabilities within mainstream hospital services.

Need for continued development

There are presently gaps in service which result in many clients not having access to support which would enable them to maintain their lives in the community without crisis.

4.3.8 Children with Learning Disabilities

Children & Families Division of Social Services will be leading on a review of disability services for children as a response to the Inspection Report 2004. This review will ensure that the National Service Framework Standards for Children, Young People and Maternity Services set the direction for service development and redesign base on taking a whole systems approach to working with children with disabilities.

Learning Disability services will be fully engaged with this process to ensure that the principles of a 'healthy start to life' are integral to the development of Dudley's Learning Disability Strategy.

4.3.9 Supporting People Programme - Five-Year Strategy 2004-2009 & Needs Mapping

The Supporting People Programme became operational in April 2003, and Dudley now funds some 98 services for supported housing and housing-related support to a range of vulnerable client groups by 46 providers from the public, private and voluntary sectors.

The key aims of the national Supporting People Programme are:

- Reducing the use of and reliance on institutional care
- Reducing homelessness
- Reducing offending
- Increasing capacity for independent living
- Combating social exclusion
- Enabling vulnerable people to access work/education/training.

4.4 Family Health Services (FHS)

4.4.1 Summary

The PCT fully recognises Dentists, Optometrists and Pharmacists as important components of the Primary Health Care Team (PHCT):

- Access to NHS Dentistry and emergency dental care will be improved, particularly in the most deprived areas.
- Full advantage will be taken of the introduction of the new pharmacy contract to develop the PHCT role of the pharmacist.

4.4.2 Relevant Data Tables (see section 8)

None directly relevant.

4.4.3 Background

Developing NHS Dentistry

There are a number of recent national policy developments, which will impact on the PCT's work with NHS dentistry. These include local commissioning, new GDS contractual arrangements and the further development of Personal Dental Service(PDS) contracts. Through the implementation of these new developments and the flexibilities they offer, the PCT will identify ways in which dentists can help them deliver on a number of the key strands of the overall healthcare agenda. In addition the Government has set specific targets for dental access and the introduction of PDS. As a consequence the PCT will focus on the following priority areas over the next three years:

- Improving overall access to NHS Dentistry and making a local contribution to the national target of recruiting the equivalent of 1000 whole time dentists by October 2005. Over the next three years the PCTs in Dudley will work together to achieve an increase in the number of people having regular access to NHS dentistry from 50% to 60%. The additional capacity in year one to be achieved through change in working practices through introduction of early PDS initiatives and years two and three through additional GDP manpower;

- Developing the existing salaried dental services in order to increase service provision to families in areas of highest deprivation and lowest registration and in nursing and residential homes;

- Developing an integrated out of hours service for NHS dentistry providing cover for all urgent and emergency cases;

- The effective implementation of the new dental contract in April 2006;

- Supporting the national target of a minimum of 25% of practices moving into early PDS.

Developing Community Pharmacy

Through the document 'A Vision for pharmacy in the new NHS' the Government described how the new community pharmacy contractual

framework is intended to improve access to pharmacy services and to raise the quality of service. This will primarily be achieved through the introduction of three levels of services to be provided by community pharmacies: essential, advanced and enhanced services.

Essential services are those that must normally be provided by all community pharmacists whilst advanced services require pharmacists and/or pharmacy premises to be accredited before they can be provided. These services will be funded nationally and will be introduced through regulation although the PCT will need to take both into account as part of its strategic planning.

The enhanced services will however, like those in the new GMS contract, be commissioned locally by the PCT. These services will also need to be funded locally by the PCT from their existing unified allocations and we will consider how the flexibility in the community pharmacy arrangements and the new GMS contract together can assist in meeting both the national public service agreement targets and the local strategic aims.

As part of the new contractual arrangements, significant revisions will be made to the 'control of entry' regulations, which should help the PCT match new pharmacies with its overall plans for the provision of pharmacy services. The new regulations will place additional management responsibilities and demands on the PCT.

As a consequence of the planned changes for community pharmacy, the PCT will need to focus on the following priority areas:

- Considering which enhanced services could be provided by community pharmacies in line with the strategy for pharmaceutical development and primary care development;

- The effective implementation of the new contract arrangements from 1 April 2005

- The effective introduction of the revised 'control of entry' regulations.

<u>Developing Optometric Services</u>
The Government's proposals for developing a new contractual framework and introducing local commissioning for optometric services are still unknown. The Department of Health are however currently negotiating changes to the optometric lists and the PCT will need to ensure that these are effectively implemented once agreement has been reached. This work has been delayed nationally and indications are that the changes will now take effect from June 2005.

Locally, the PCT has for some time acknowledged the need to explore opportunities for extending the role of the optometrist and have already identified a number of areas where this could happen.

As a consequence of the planned and perceived changes for optometry, the PCT will need to focus on the following priority areas:

- Considering which additional services could be provided by community optometrists and how they might contribute towards the overall primary care development strategy.

- The effective implementation of the new optometry list arrangements from June 2005

Access to Medicines Out of Hours

The Review published in March 2000 ‘Raising Standards for Patients. New Partnerships in Out of Hours Care’ recommended that other than in exceptional circumstances, patients should be able to receive the medication they need at the same time and in the same place as the out-of-hours consultation. Directions to be issued in April 2005 will enable the PCT to make the arrangements to meet this objective.

The PCT will be looking to develop a service, which is fully integrated with the GP out of hours arrangements provided at the Henry Lautch Centre.

4.5 Hepatitis C

4.5.1 Relevant Data Tables

None directly relevant.

4.5.2 Background

The PCT is actively contributing to the development of an appropriate action plan to implement the national Hepatitis C Strategy. It is not clear at this stage whether this will have resource implications.

5. OTHER SERVICE DEVELOPMENTS AND SYSTEMS REFORMS

5.1 National Programme for Information Technology (NPfIT)

5.1.1 Summary

The PCT has a fully operational NPfIT structure in place and acknowledges the importance of IT to 21st century healthcare:

- New mental health, community and child health IT systems will be introduced.
- IT systems development will support the introduction of patient choice and booking.

5.1.2 Relevant Data Tables (see section 8)

SUP02	Percentage of your Local Health Communities with an Implementation Plan and a Benefits Plan, signed-off and approved by the appropriate people: **already in place.**

5.1.3 Implementation

The Dudley Health and Social Care Community is in the process of implementing the first stage of the NCRS system through the Local Service Provider, CSC Alliance. This first stage known as P1R1 will implement the Lorenzo system using iSoft software for all community and mental health services. It will provide basic functionality such as:

- Registration details
- Referrals
- Booking appointments
- Outpatient clinic information
- Ability to set up clinics
- Waiting list information
- Transfer and discharge of patients

Access to the system will be on a real time 24 hour basis. The first stage of implementation will target a number of clinical staff and supporting staff with the remaining clinical staff being trained and implemented at a later stage. This deployment is designed to ensure that we are able to train sufficient users to enable us to fully populate the iSoft system at Go Live whilst ensuring that the training period is not unduly protracted. Remaining staff can then be trained after the Go Live date. It will also allow us to "switch off" our current legacy systems – PEAK and FIP as soon as the new system is implemented.

In addition to the community and mental health systems, the Dudley Health & Social Care Community will also be implementing a new Child Health system using software provided through HSW. Again this will be project managed in conjunction with CSC Alliance.

5.1.4 Benefits Realisation

As part of the production of the Project Initiation Documents for both the community and mental health services, a benefits realisation plan was

provided within each PID using the Pick List schema provided by HEDRA (part of the CSC Alliance). This was adapted to ensure that benefits realised meet the local requirements and needs of the Dudley Health & Social Care Community. For example, an improved network has been provided to all Dudley's sites as part of the implementation of the project which although not defined within the HEDRA "pick list" has proved significantly beneficial to the DHSCC. Other benefits which include:

- Provision of the right technology in the right place for all staff across both mental health and community. This includes provision of new equipment and upgrade of old equipment as well as mobile equipment where appropriate.
- Network capacity has increased substantially at each site due to improved local network. This will improve further once all N3 connections are in place.
- Improved access to training for all staff. There have been significant increases in training resources (both staff and facilities) provided.
- Ability for staff to access to the system in real time from any location through the provision of mobile technology.
- Standards of data quality will be established for each role clearly defining their responsibilities in respect of why, when and how data is entered onto the system
- System based documentation to enable easier access to assessment, appointment and discharge information.
- Real time bed occupancy and bed utilisation information will allow improved bed management decisions to be taken by clinical staff.
- Ability to manage access to the system through the provision of smartcard technology. Staff will only be able to access areas of the system relevant to their work thus improving security and confidentiality of patient data.

5.1.5 Future Programme

The above is the first stage of what will be a ten year development. Stage 2 (known as P1R2) which will provide clinical functionality will be implemented after the P1R1 deployment is completed. Additional functionality and deployments will be added as they become available from CSC Alliance.

5.2 Workforce Development

5.2.1 Summary

This Workforce Plan has been developed in conjunction with service managers.

- It demonstrates an understanding of the connection between the service development and workforce needs.

- It reflects local and national priorities

The plan will be continuously developed and will evolve to encompass areas outside the LDP.

5.2.2 Relevant Data Tables (see section 8)

SUP01	Workforce**: see Data Table**

5.2.3 Introduction

This worforce plan is based on service developments agreed for Dudley Beacon and Castle PCT and the workforce demands inherent in these developments. It includes the baseline of staff in post as at 31 December 2004, and the local plans to meet the demand.

The Trust has made significant strides in improving productivity and quality through redesign of services and review of the skill mix across services. However, we recognize that this is a continuing process especially in the light of the of the number of national programmes which are either in the process of development or implementation. These include, for example, Agenda for Change, including the Knowledge and Skills Framework, National programme for Information Technology, Practice Base Commissioning, Electronic Staff Records, Payment By Results, Choice and , Choose and Book. Therefore the full workforce implications have yet to be evaluated as are the efficiency savings to be made as outlined by Gershon.

The main local service developments influencing the plan are:

5.2.4 Shaping the Future (Community Investment Strategy)

The new PFI Scheme for the building of a new Acute hospital in Dudley with a reduction in the number of beds has provided opportunities for review and redesign of roles in the provision of health and social care services which focus on the needs of the patient and proactive management of conditions. The result has been a new model of care which takes an integrated approach, across primary and secondary care. The workforce challenges include the availability of an appropriately skilled workforce. However, community nursing teams are working closely with the primary care nurse consultant to develop and embed new ways of delivering care. This service is being expanded further with the appointment of 3 Assertive Care Managers (H Grade Nurses). In addition, each of the 9 community teams and the Evening Services are being strengthened to enable this approach to be adopted across the Trust.

5.2.5 Mental Health Service Redesign

The redesign of mental health services has necessitated considerable change in the way services are provided with specific developments to support the needs of women and young people, reduce and eliminate social exclusion and reduce inequalities in mental health service provision. The new services will introduce new ways of working across crisis resolution, home treatment and assertive outreach services, providing 24-hour, 7 days per week care outside of hospital, thereby reducing the in patient bed occupancy.

5.2.6 Mental Health/Social Care Integration

Building on pre-existing excellent working relationships with partners within Dudley, the provision of health and social care will be integrated with effect from 1 April 2005. This is being done within a Section 31 Partnership Agreement. This collaborative approach will enable delivery of an integrated mental health service in line with National Service Frameworks and will, in time, provide a seamless 'one stop shop' experience for the local community. An integrated management structure has been established and workstreams progressed.

5.2.7 Improvements in Primary Care

Primary care workload will become more diverse in terms of skill mix and interventions as more complex work is transferred from secondary care and length of hospital stay is reduced. The role of the General Practitioners with a special interest (GpwSI) has been successfully developed locally and there are plans to develop this further.

5.2.8 Improvement in Dental Care provision

National policy will impact on the provision of dental care to local residents as part of an overall package of care. This will require review of current provision and the likely workforce demands.

5.2.9 Establishing the Demand

<u>Baseline</u>

The Staff in post as at 31 December 2004 is as follows:

Staff Group	WTE
Consultants	15
General Practitioners	64.6
Dentists	40
All qualified scientific, therapeutic and technical staff	5.3
Primary Care Nurses	206.7
Nurses other than those in Primary Care	96.14
Health Care Assistants	89.6

At the time of the baseline there is one consultant vacancy in Public Health Medicine. An additional consultant psychiatrist post has been created to support the development of services within mental health. However, noting the age profile of existing consultants, this situation could change quite significantly, over the next 12 months if eligible consultants exercise their early

retirement option as Mental Health Officers. Discussions are taking place to ascertain their intentions which will enable us to develop plans to address this.

Some difficulty is being experienced in the recruitment of higher level specialist nurses in mental health, such as home treatment, child and adolescent mental health services (CAMHS) and in the experience level of applicants for nursing posts in in-patient mental health. Where it has not been possible to recruit to the required level of experience, development programmes have been put in place to enable individuals to acquire the appropriate level of skills.

This picture is replicated in primary care where there has been difficulty experienced in the recruitment of Health Visitors.

As a result of proactive recruitment, the Trust has been able to increase the number of general practitioners from its previous position.

Future Demand

The increase in demand are associated with the following :

Shaping the Future

- Primary Health Care Teams, particularly nursing roles

Mental Health (National Service Framework targets)

- Crisis Resolution and Home Treatment/Carer Support workers
- BME Community Development Workers
- Support Time and Recovery Workers
- Early intervention

Primary Care

- General Practitioners
- GPs with Special Interest
- Primary Care Nurses
- Health Care Assistants

5.2.10 Supply

It is recognized that the Trust has an ageing workforce, amongst nursing, medical and health care assistants. This is a major challenge to the Trust as it embarks on significant service redesign and delivery.

To support the Community Investment Strategy of the Shaping the Future initiative and the new model of care in particular, a Nurse Consultant together with 3 H grade nurses have been appointed. These will be supported by 9 primary health care teams, combining both experienced nurses and health care assistants who are being recruited to enable rapid responses to patients.

Some of the new roles, in Mental Health, namely the Support, Time and Recovery Workers (STR) will be achieved through re-skilling of the existing workforce to undertake enhanced roles, for example through the achievement of National Vocational Qualifications, collaborative working with the voluntary sector and as a result of the Social Services and Mental Health integration.

Medical teams will be strengthened through the appointment of middle grade doctors, namely staff grade and associate specialists to support the consultants.

There has been an improvement in the number of GPs recruited to the Primary Medical Services. Furthermore, working collaboratively with the GP Vocational Training Scheme, has increased the number of trainees assigned to practices within the PCT localities and it is anticipated that a number of these will be retained in local practices following completion of their training.

Consideration is ongoing regarding an expansion of the Advanced Nurse Practitioner role to undertake the management of patients with coronary heart disease, heart failure, palliative care, diabetes, Parkinson's disease and multiple sclerosis, thereby contributing to some of the issues surrounding the shortage of general practitioners. Similar consideration is also being given to developing the role of health care assistants to improve the skill mix in primary care.

5.2.11 Other Supply Factors

Learning and Development

The redesign of services occurring across the Trust will require diversity in the range of skills necessary to support the change agenda. To this end an extensive programme of learning and development across all sectors of the Trust is in place, incorporating training mandatory to specific services as well as those specific to managers and support staff.

There is a continuing programme of commissioning places with the local universities. Commissions for the period 2005/06 are:

4 x Health Care assistants seconded to Nurse Training
3 x Health visitors
3 x District Nurses
1 x Clinical Practice Teacher

In addition a continuing development programme in chronic disease management, leading to the Warwick Diabetes Management Diploma and certificate in the management of Asthma and Chronic Obstructive Pulmonary Disease (COPD). The Trust is participating in the Workforce Development Directorate's training for Case management, and is working with the Mary Stevens and Compton Hospices for the provision of training in palliative care and lifelong-limiting illnesses.

5.2.12 Demography

The age profile of the Trust reflects that of the national profile, namely that of an ageing workforce. Specifically, there is an under representation of 25 year olds and below; approximately 40% of staff are above 45.

Approximately 10% of the workforce are from BME communities and are represented at non-executive, senior management and senior medical and nursing levels of the Trust. We recognize, however, that staff in all our services need to be more reflective of the community. For example, in mental health and community nursing services, there is an under-representation of Asian nurses. We have a number of local initiatives aimed at encouraging applications from all sectors, including Black and Minority Ethinc (BME) communities into our workforce. In addition, the Trust is embarking on a wide-ranging learning and development programme in respect of diversity. However, we also need support from the WDD to develop programmes across Birmingham and the Black Country to train and develop people from BME communities as health care professionals. .

Links with local schools and college, and the Learning Skills Council are being established in order to encourage interest in NHS professions. The Trust is jointly involved with the local Race Equality Council's Action Project, aimed at attracting BME residents into public sector employment.

Further, work is being undertaken on a wider scale to address the diversity agenda in respect of service needs across all areas of the Trust.

5.3 Payment by Results

5.3.1 Summary

The PCT has been gearing up for a number of months for the implementation of Payment by Results for most acute hospital services in 2005/06:

- The PCT fully supports the SHA-wide initiative to press on with implementation in 2005/06 despite the national deferment.

- The Payment by Results regime has been used where relevant throughout the LDP and in costing investments required.

5.3.2 Relevant Data Tables (see section 8)

None directly relevant.

5.4 Practice Based Commissioning

5.4.1 Summary

The PCT had already decided to introduce practice based commissioning as a fundamental tool to pursue our Vision and Values:

- Building upon important progress already made in clinical engagement.
- Recognising practice based commissioning as a foundation stone of other systems reforms, including Payment by Results and Patient Choice.

5.4.2 Relevant Data Tables (see section 8)

None directly relevant.

5.4.3 Background

The PCT has always endeavoured to work and organise itself such that its strategy and policy are clearly driven by the Professional Executive Committee and the wider body of clinicians, and it welcomes Practice Based Commissioning as a new opportunity to further cement that philosophy. Indeed, the PCT had reached the view early in 2004 that the only way to meet the challenges of Payment by Results, Patient Choice and the development of community based services was through the Practice Based Commissioning approach.

The PCT has already allocated resources to expand its commissioning, finance and information functions to directly support practices, but it also recognises that the whole PCT infrastructure needs to realign itself towards practices and clusters of practices.

The PCT sees practices as fundamental building blocks for the future of its functions and the development of services for the community it serves and has recently completed the allocation of all the PCT's budgets to individual practices. This has been done following the principles of historical spend (eg for acute services) or allocations based purely on capitation (eg public health programme budgets). These have been presented to a meeting attended by over half the practices of the PCT and the next step will be for practices to decide which of these range of budgets will be managed at practice level and which will be blocked back to the PCT.

The approach so far has prompted practices to agree that the appropriate cluster at this stage will be the whole PCT and this will lead to consistency of choice by practices of budgetary responsibility, risk sharing that will support the whole PCT in balancing its own income and expenditure position year on year and co-operation and shared vision in the development of services. Most significantly, this will put clinicians in the driving seat of PCT commissioning policy with the PCT management infrastructure aligned to support and facilitate that structure rather than do commissioning itself.

A further step in the near future will see the development of a compact between the PCT and Locality Commissioning Group (the vehicle established

to bring clinicians together). This Group has already done constructive work in development of orthopaedic pathways and will be a straightforward vehicle to translate policy into action (eg the shift in the direction of referrals to increase these to the Royal Orthopaedic Hospital Treatment Centre). Even more importantly, it is clear that clinicians view Practice Based Commissioning as a big opportunity to drive up the quality of services in hospitals and develop alternatives in the community which, because they are clinically conceived and driven, will be developed appropriately and widely used.

5.5 Standards for Better Health ("National Standards; Local Action") and Clinical Governance

5.5.1 Summary

The PCT welcomes the increasing national move from targets to standards and the empowerment of local health services to meet the latter:

- We have structured our organisation to ensure deliberate progress across all standard domains.
- We have achieved CNST level 1b and are working towards level 2.

5.5.2 Relevant Data Tables

None directly relevant.

5.5.3 Standards for Better Health

In response to "National Standards; Local Action" the PCT has undertaken a number of steps to take Standards for Better Health forward as the defining infrastructure of its activities.

The business plan for the organisation will be structured around the Standards for Better Health. The Management Team will be the organisational tool, with corresponding teams to deliver the business plan for the organisation. It has been decided that the Clinical Governance Committee will report in future through the Medical Director and Director of Quality to the Management Team and subsequently to the Board. A review of all other committees is also taking place and overall responsibility for each of the 7 domains will be given to specific committees with an understanding that all the domains interrelate and consideration to them all must be given at all times.

Further to this, a baseline assessment of the standards has been undertaken as well as holding a focus group with staff to ensure a comprehensive assessment could be made. This assessment is now being transferred to the baseline assessment tool the Strategic Health Authority has requested prior to the Clinical Governance visit they will be making during April.

A further presentation has also been made to Board and PEC members regarding the Healthcare Commission's consultation on "Assessment for Improvement" and it was agreed that further focus groups with staff will continue to take place to ensure there is a complete understanding of where any potential gaps may be. Also we are undertaking a piece of work highlighting areas where staff have introduced better ways of working.

More Generally, the Clinical Governance department of the PCT will continue to facilitate initiatives to improve the quality of patient care, to proactively develop safe systems and processes as well as promote learning from incidents, complaints and near misses and to support the development of a culture of excellence within the organisation.

5.5.4 Clinical Negligence Scheme for Trusts (CNST)

The Trust has recently been rated at CNST level 1b, which has only been reached by a total of 35 PCTs throughout the country. We are currently

developing an action plan to address the key recommendations of the assessors with a view to progressing to level 2 when that has been developed by the NHS Litigation Authority.

5.6 Tackling Healthcare Acquired Infection

5.6.1 Summary

The PCT and the Dudley Group of Hospitals NHS Trust already have a good track record in minimising healthcare acquired infections:

- Action plans to make further progress have already been approved.

5.6.2 Relevant Data Tables (See section 8)

PSA20a	Number of MRSA blood stream infections: **reduced to no more than 12 in 2007/08.**

5.6.3 Background

The PCT leads an active Infection Control Committee for Dudley, reports from which are formally considered by the Board quarterly. The Committee produces an annual programme of work which typically covers development of new policies, procedures and guidelines, reviews of premises, a wide range of audits, training, surveillance and capacity for the management of outbreaks. The current action plan was recently assessed by the SHA as "good". The Dudley Group of Hospitals NHS Trust, has recently also submitted to the SHA its action plan setting out:

- The organisation and management arrangements for infection control.
- How it will:
    - achieve the requirement of Winning Ways (DOH 2003)
    - implement the Matrons Charter
    - how it will involve patients and the public in addressing infection control
- The key risks of the organisation in relation to infection control
- How it will work with the rest of the health economy to reduce infection risks.

As can be seen from the relevant Data Table PSA 20a (section 8), the Trust is working from a baseline of 31 MRSA infections in 2003/04, with a similar figure projected for 2004/05.

5.7 National Institute for Clinical Excellence (NICE)

The Health Economy NICE Implementation Group holds a budget which will continue to enable access to NICE recommended technologies within the 3-month deadline stated in the NHS Act. The group takes a stance of actively commissioning new technologies, putting measures in place to ensure appropriate uptake and auditing provision against clinical criteria.

There is currently some uncertainty about the detailed application of Payment by Results to NICE guidance and guidelines.

5.8 Supplies and Facilities Services

5.8.1 Summary

The PCT will continue to improve the quality and efficiency of its supplies and facilities management function, including offering increasing levels of services to primary care.

5.8.2 Relevant Data Tables

None directly relevant.

5.8.3 Strategy

The strategy, to be implemented during 2005/06, comprises of four inter-related activities:

- The transfer of the existing Supplies and Facilities Management facility from the Ridge Hill site into new extended warehousing accommodation.

- The development of more efficient procurement processing through the introduction of an electronic purchase order system

- A comprehensive review of all existing facilities contracts with a view to incorporating the overall day-to-day management of the PCT's Health Centres/Clinics into the PCT Facility Management Unit.

- Address the resourcing issues within the Supplies and Facilities Department so that the expected demands through qualitative research can be accommodated in order to meet customer needs.

5.8.4 What will the Strategy deliver?

- Re-housing the existing Supplies and Facilities Management Department in accordance with the timescales supporting the closure of Ridge Hill.

- Ability to generate substantial cost savings through bulk purchasing

- Reduction in wastage of products by reducing the need to hold stocks across Health Centres/Clinics/Hospitals.

- Products supplied to the Clinicians and other staff on a more timely and responsive basis.

- Opportunity to generate cost savings through consolidated purchasing for general practice.

- Improved governance arrangements in support of all procurement activity through the use of clearance validation of authorisation levels and limits.

- Substantial reduction in the time lag from placing orders and the receiving of goods.

- Modernise and improve performance of both the Supplies and Facilities service for its customers.

- Deliver a full range of high quality and cost efficient core supply chain services available to its customers including GP practices.

- Patient's satisfaction and service delivery will be monitored through a number of feedback mechanisms with contractors in particular playing an important role to ensure this happens.

- Increase flexibility of resources for example more frequent deliveries, more options available in terms of the service Supplies and Facilities provide.

- Constantly look at pricing through market testing and relay relevant information to Supplies and Facilities customers so that savings can be generated and wherever necessary tenders and contract coverage for the PCTs' increased.

- Events aimed at senior PCT staff, operational staff and patients themselves so that the department is constantly engaging in conversation that helps develop the strategy.

- Clearer lines of accountability and responsibility with a "one stop shop" through the Help Desk facility and the development of a team approach amongst Supplies, Facilities and other providers such as Estates and Contractors therefore giving a balanced approach between in house services and out sourced functions that that will be more cost effective, flexible and dependable that will also lead to increased patient choice and involvement.

5.8.5 Financial Implications

Implementing the Strategy will require set up costs of £102,000 in 2005/06, but will generate a range of recurring savings totalling £150,000 per annum.

6. FINANCIAL STRATEGY

6.1 Summary

The PCT has a financially balanced LDP in each of the three years of the Plan, including eliminating its underlying recurring deficit by 2007/08.

6.2 Relevant Data Tables (see section 8)

SUP03	Financial Plan: **see Data Table**

6.3 Overall Financial Position

The PCT at the end of the 2004/05 financial year has a recurrent deficit of £3.183 million, this is now projected to reduce to £1.75 million in 2005/06, still further to £599,000 by 2006/7 and return into surplus in the 2007/8 year.

In each of the three years the PCT plans to record a balanced position with the recurrent deficits in the years 2005/06 and 2006/07 covered through the use of non recurrent funds internally generated within the PCT.

6.4 Growth Monies

The growth monies for the three years 2005/06 to 2007/08 represent a substantial level of increased investment:

2005/6 - £10.380 million – 9.1% uplift
2006/7 - £11.423 million – 9.2 % uplift – (national average 9.2%)
2007/8 - £12.934 million – 9.5% uplift – (national average 9.4%)

Based on the Department of Health computations these allocation increases have the effect of improving the fair share position from a 6% level of under funding (as compared to a national weighted capitation figure) at the end of 2004/5 to a 2% level of under funding at the end of the 2007/08 financial year.

6.5 Premises

The use of the available funding allows for the PCT to begin the process of commissioning two new facilities as part of its Strategic Service Development Plan, with one project becoming operational in the 2006/07 year and a further development in 2007/08 year. To support these two new developments increased recurrent revenue costs for each of £500,000 has been assumed.

6.6 Non Recurrent Funds – Internally Generated

In order for the PCT to achieve financial balance in the 2005/06 year, the PCT will plan to deliver a £2.5 million underspend in the 2004/05 year and carry forward balances to be written off from its balance sheet amounting to £750,000.

The £599,000 recurrent deficit in the 2006/07 year is to be financed through the use of slippage generated across investments for the year amounting to £3.2 million – this represents an average period of slippage for each scheme of 2 months.

6.7 Inflation

In each of the three years, the level of inflation funding needing to be passed onto service providers has been set at a net 5.3% (inclusive of efficiency savings of 1.7%) – this reflects the agreed position for the 2005/06 financial year.

6.8 Prescribing Uplift

The prescribing uplift for the 2005/06 year amounts to 5%; this is some 4% greater than the levels as recommended by the Department of Health. In the years 2006/07 and 2007/08 the uplift is also 5%.

6.9 Activity Growth

A comprehensive review of the level of activity needing to be purchased for the 2005/06 year has been undertaken. This exercise is based upon the need to deliver the following targets:

- a five month maximum wait in all specialities except trauma and orthopaedics;
- 40% reduction in trauma and orthopaedic waits – 3 month waiting time

It assumes a 3% general increase in outpatient growth for all providers except Dudley Group of Hospitals where instead a 5% growth is assumed.

The financial effect of these assumptions is to create a cost pressure of £650,000 in the 2005/06 year, in the two subsequent years the level of additional funding allocated for activity growth are £425,000 and £770,000 respectively.

The review also established a sizeable impact attributable to new working practices consequent upon "Shaping the Future" leading to admission avoidance – especially within the specialty of general medicine. These are expected to generate savings in the 2005/06 year of £1.5 million; no further savings are assumed within the years 2006/07 and 2007/08.

The savings flowing through to the PCT in the 2005/06 year are based upon the full application of Payment by Results.

6.10 Specialised Services

Substantial increased investment is forecast for specialised services. In the 2005/06 year this amounts to £1.079 million, and increases by a further £781,000 in 2006/07 and £808,000 in 2007/08.

6.11 Continuing Care

Whilst the continuing care budget, which is potentially accessed by clients of all ages with physical and/or mental health problems, is increased dramatically in the 2005/06 year (to reflect the present level of overspending) in each of the years 2006/07 and 2007/08 no further funding is made available. Instead the PCT aims to contain spending through a comprehensive review of the systems underpinning the use of residential/nursing care and out of borough placements.

6.12 Mental Health Services

As a provider of mental health services, the PCT is required to actively take forward improvements to the delivery of mental health services in line with the national strategy for mental health. Additionally the PCT also has a requirement to ensure that the baseline level of funding to support the service is sustainable. To meet these two requirements in the 2005/06 year additional funding amounting to £701,000 is to be allocated to the service from Dudley Beacon and Castle PCT with a view to increasing the level of funding in 2006/07 by a further £162,000 and £209,000 in 2007/08.

All the specific service developments in Mental Health are Boroughwide and require matching financial support Dudley South PCT in accordance with the agreed commissioning strategy. Their funding requirement is £500,000.

6.13 Learning Disabilities

The PCT continues to support the changes being proposed for learning disability services within Dudley and to this end plans to increase available funding for the service by £150,000 in the 2006/07 financial year.

6.14 Public Health White Paper

In order for the PCT to take forward the Public Health White Paper, the PCT has agreed to increase its level of recurrent funding for the service by £723,000 over the two years 2006/07 to 2007/08, which exceeds the minimum commitment required of the PCT.

6.1.5 PCT Development

In accordance with the SHA request that we should set aside £50,000 non-recurring in both 2005/06 and 2006/07 for PCT development, we already have existing budgets on this scale available for this purpose.

6.16 Financial Risks

Whilst the PCT has been able to set a balanced LDP for the 2005/6 year it does so by adopting a series of potentially significant financial risks, these being:

- prescribing cost increase limited to 5% (see above);
- no contingency reserves to support the cost of PbR – the effect of which is notoriously difficult to predict;
- agenda for change – the precise cost impact of introducing agenda for change is impossible to compute – the level of reserves held amount to £600,000 for increased pay and a further £115,000 to cover the impact of increased annual leave;
- service change within mental health – the reconfiguration of the service assumes that the appointment of key medical and nursing staff is capable of taking place at the prescribed time so as to allow for the hospital reorganisation to be effected and release financial savings. Delay would

impact upon the ability to contain the service reconfiguration with the planned level of resources available.

7. SERVICE USER AND COMMUNITY ENGAGEMENT

Summary
The PCT acknowledges the real contribution to health improvement of good public and staff engagement and communications:

- The PCT's community engagement forum 'Voices for Health' will continue to be supported.
- The increasingly fruitful liaison with the Good Health Select Committee (Overview and Scrutiny) of Dudley MBC will be built upon.
- Good communications and consultation with BME communities is a particular priority.

7.1 Strategy

The PCT has a three year strategy through to 2005/06, and a new three year strategy will be developed during the coming year. The current strategy has as its main themes:

- local people in their communities
- local people as service users
- local people as individual patients
- the PCT as an enabling organisation.

Areas of specific action during the coming LDP period will include:

- engagement of young people
- systematic collation of community views to feed in to policy development
- user involvement at practice level
- expert patient programme.

7.2 Internal and External Communications

The PCT believes that informing the public about the work that we do and the services we provide not only helps to promote take-up, but also reduces the risk of confusion on the part of the patient when they interact with the service. We take a very proactive stance with media relations and have successfully engaged with local journalists to promote positive health stories. A key part of our external communications strategy is therefore to ensure that any local health achievements are highlighted in the local press.

The trust has developed a corporate image that is recognisable to the public, the literature that we develop will continue to have a corporate style that – while in line with the NHS guidelines – is distinctive to Dudley Beacon & Castle PCT.

Our website will be a gateway to discovering information about the services we provide. Every department has responsibility for maintaining their own information on the site, ensuring that the public have the opportunity to feedback on, and interact with, this information.

We will continue to support services by developing patient literature. We use existing networks of volunteers and patients to routinely bring together a representative panel to agree the content of newly commissioned literature to award it a 'Patient Passed Kite mark.' Each piece will be reviewed against the following criteria: easy to understand information, design and cultural awareness.

Black and Minority Ethnic groups represent a large section of the community served by Dudley Beacon and Castle Primary Care Trust – and a core part of the communications strategy is to engage minority groups in all areas of the work we do.

Every new piece of literature that we produce offers a translation into the six key languages that make up the majority of our BME population. We are also producing a guide to all the services in these languages for distribution in all health centres and clinics. In addition to this, we have developed a media-distribution list, which covers a number of non-English speaking print media, and have supported audio media through campaigns on Radio Ramadan.

Internally, we are committed to continue to make sure all staff are informed of developments within the PCT, the NHS in Dudley and nationally. We will ensure that the staff have opportunities to express their views and offer ideas and suggestions. We will continue to promote our Vision and Values internally.

Working jointly with Staff Side we have agreed a formal Staff Involvement Agreement, which sets out the guiding principles of what staff can expect of the organisation in terms of involvement in decision-making and what the Trust can expect of staff in terms of communication. The Trust will work with staff side to bring together a steering group to monitor the development of the Staff Involvement Agreement.

7.3 LDP Development

The primary driver in shaping this Local Delivery Plan has been the Professional Executive Committee (PEC) and the clinicians who sit on it. Building upon the ongoing role of the PEC in managing the business of the PCT, the PEC has a clear grasp of the financial and policy challenges facing the PCT and has made all significant prioritisation decisions to develop the Plan described.

There has also been wider consultation and involvement with our local community. Many of the plans put forward to improve our services have been developed by groups (eg Local Implementation Teams) that include service users and carers as part of their ongoing membership. Also, there has been a presentation at "work in progress" stage to "Voices for Health", which is the PCT's community representative forum. Arrangements are also in hand for an LDP presentation to the Dudley Overview and Scrutiny Committee.

The bottom up approach described above in the development of planning proposals also gives numbers of staff the opportunity to shape the LDP and significant opportunity to determine precisely how services should develop to achieve the desired outcomes.

Finally, the PCT intends to produce and widely publish a summary version of the Local Delivery Plan which will be accessible and meaningful to the general public.

8. DATA TABLES (NATIONAL TARGETS)

See attached

9. RISK ASSESSMENT

See attached

10. DETAILED INVESTMENT PROFILE