HEALTH SCRUTINY COMMITTEE

THURSDAY 27TH MARCH 2014

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

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Dudley
Metropolitan Borough Council

IMPORTANT NOTICE

MEETINGS IN DUDLEY COUNCIL HOUSE

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Directorate of Corporate Resources

Law and Governance, Council House, Priory Road, Dudley, West Midlands DY1 1HF
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Your Ref:	Our Ref:	Please Ask For:	Telephone No:
	270314/MJ	Mrs M Johal	01384 815267

19th March 2014

Dear Member

Meeting of the Health Scrutiny Committee

You are requested to attend a Meeting of the Health Scrutiny Committee to be held on Thursday 27th March, 2014 at 6.00pm, in Committee Room 2 at the Council House, Dudley to consider the business set out in the agenda below.

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

Yours sincerely,

Director of Corporate Resources

A G E N D A

1. APOLOGIES FOR ABSENCE

   To receive apologies for absence from the meeting

2. APPOINTMENT OF SUBSTITUTE MEMBERS

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

3. DECLARATIONS OF INTEREST

4. MINUTES

To approve as a correct record and sign the minutes of the Meetings of the Health Scrutiny Committees held on 23rd January, 2014 and 25th February, 2014.

5. PUBLIC FORUM

To receive questions from members of the public:-

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

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

6. RESPONSES TO QUESTIONS ARISING FROM PREVIOUS COMMITTEE MEETING (PAGES 1 – 4)

To consider a report of the Lead Officer to the Committee.

7. NHS ENGLAND (PAGES 5 – 28)

To receive a presentation from NHS England on the Primary Care Strategic Framework

8. PATIENT PARTICIPATION GROUPS (PPGs) IN DUDLEY (PAGES 29 – 32)

To consider a report of the Dudley Clinical Commissioning Group

9. COMMITTEE'S REVIEW OF TOBACCO CONTROL (PAGES 33 – 43)

To consider a report of the Lead Officer to the Committee

10. SCRUTINY REVIEW 2013/14 – PATIENT EXPERIENCE IN ACUTE SETTINGS

To consider a verbal report of the Lead Officer to the Committee

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

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

Councillors:-

Billingham	**Cotterill**	**Harris**	**Hemingsley**
Jordan	**Kettle (Vice-Chair)**	**Ridney (Chair)**	**Roberts**
Mrs Rogers	**K Turner**	**Mrs Walker**	**Ms Bradbury (Co-opted Member)**

HEALTH SCRUTINY COMMITTEE

Thursday 23rd January, 2014 at 6.00 p.m.
in Committee Room 2 at the Council House, Dudley

PRESENT:-

Councillor Ridney (Chair)
Councillor Kettle (Vice-Chair)
Councillors Cotterill, Elcock, Harris, Hemingsley, Jordan, Ms Nicholls, Roberts and Mrs Walker and Ms Pam Bradbury – Chair of Healthwatch

Officers

Assistant Director of Law and Governance (Lead Officer to the Committee), Director of Public Health, Assistant Director, Adult Social Care (Directorate of Adult, Community and Housing Services), Ms K Jackson – Consultant (Office of Public Health Chief Executive's), Scrutiny Officer (Directorate of Adult, Community and Housing Services) and Mrs M Johal (Directorate of Corporate Resources)

Also in Attendance

Councillor S Turner – Cabinet Member for Health and Well Being
Mr P Maubach – Accountable Officer (Dudley Clinical Commissioning Group)
Mr J Evans – Urgent Care Commissioning Manager (Dudley Clinical Commissioning Group)
Mr C Harris – West Midlands Ambulance Service
Ms C Clayton – West Midlands Ambulance Service

27 CHAIR'S REMARKS

The Chair welcomed Ms Pam Bradbury, the Chair of Healthwatch, to the meeting and indicated that she would fill the vacant position on the Committee as a Co-opted Member to the end of the Municipal Year.

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28 CHANGE IN ORDER OF BUISNESS

Pursuant to Council Procedure Rule 13(c) it was:-

RESOLVED

That Agenda Item No 8 (Update on Urgent Care Public Consultation) be considered after Agenda Item No 6 (Responses to Questions Arising from Previous Committee)

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29 APOLOGIES FOR ABSENCE

Apologies for absence from the meeting were received on behalf of Councillors Billingham and Mrs Rogers.

30 APPOINTMENT OF SUBSTITUTE MEMBER

It was reported that Councillor Elcock had been appointed as a substitute member for Councillor Mrs Rogers for this meeting only.

31 DECLARATIONS OF INTEREST

No Member made a declaration of interest in accordance with the Members' Code of Conduct.

32 MINUTES

RESOLVED

That the minutes of the meeting of the Health Scrutiny Committee held on 7th November 2013 be approved as a correct record and signed subject to an amendment to Minute No 25 to include the following paragraph at the end of the preamble "In conclusion a Member stated to the Dudley Clinical Commissioning Group that whatever conclusion came out of the consultation on urgent care that the Committee would view it as a substantial variation to services and would wish to scrutinise that decision."

33 PUBLIC FORUM

No issues were raised under this agenda item.

34 RESPONSES TO QUESTIONS ARISING FROM PREVIOUS COMMITTEE MEETING

A report of the Lead Officer to the Committee was submitted on updates and responses arising from the previous Committee meeting.

RESOLVED

That the information contained in the report, and Appendix to the report, submitted on updates and responses arising from the previous meeting, be noted.

35 UPDATE ON URGENT CARE PUBLIC CONSULTATION

A report of the Chief Accountable Officer, Dudley Clinical Commissioning Group (CCG) was submitted on the public consultation on urgent care in Dudley which the CCG carried out from 1st October to 24th December, 2013. Attached as appendices to the report submitted were copies of reports that had been submitted to the CCG Board on the consultation exercise and a report outlining proposals for urgent care reconfiguration developed in response to feedback received during the consultation.

In presenting the report, Mr Maubach stated that the CCG had undertaken a robust consultation process and had listened to the views of the Committee which had resulted in additional surgeries being held. Healthwatch Dudley had been commissioned to carry out a targeted research exercise that involved talking to service users at Russell's Hall Accident and Emergency Department and the Walk-In Centre over a period of seven days from 29th November – 5th December.

The consultation process had highlighted some positive views and also some concerns and three main areas of concern were whether transferring urgent care to Russells Hall would create additional pressure on the Accident and Emergency Department (A&E), accessibility and issues around parking. The CCG Board had discussed the issues at length and it was considered that the proposed model would reduce the pressure on A&E as all patients would be triaged at the single point of entry and that Russells Hall was easier to get to by public transport. With regard to parking it was considered that although it was an issue it was not a sufficient reason to outweigh the health benefits to the public. However, for mitigation purposes, it was proposed that a telephone system would be introduced whereby a patient would initially call and be triaged over the phone. Following assessment if attendance at Russells Hall was required an appointment would be made which would reduce the waiting time for the patient resulting in reduced parking charges.

Another key issue emanating from the consultation process was that the public were keen on the Walk in Centre so the Board took the view that a walk in service should also be provided as part of the new urgent care facility. The current Walk in Centre operated from 8 am – 8 pm and it was proposed that the combined walk in service would operate as a 24 hour facility.

A Member commented that he had attended several meetings with the CCG and he was of the opinion that proposals for the urgent care facility to be based at Russells Hall were being pushed. He stated that he had spoken to several people and the view was that the public wanted more walk in centres spread across the Borough. Another member referred to public transport and indicated that the argument of accessibility to Russells Hall being easier by public transport only applied whilst buses were operating. It was also commented that if a person was not well they did not want to travel on the bus.

Arising from further comments and queries from Members Mr Maubach stated that the contract for the Walk in Centre had been extended until September, 2014 to allow the consultation that had just been completed to take place and to then give time to develop the new service specification before tendering for the new service. The detailed report produced by Healthwatch would be taken into account to aid design specifications for the urgent care facility. The proposal to base the facility at Russells Hall revolved around clinical reasons to integrate services as it was deemed to be safer and a national report had also stated that integrated delivery of services had better outcomes and was safer for the public. Insofar as more walk in centres spread across the Borough were concerned, Mr Maubach stated that this would inevitably incur additional costs and cuts would need to be made elsewhere.

In responding to further questions Mr Maubach refuted the comment made that the CCG were putting money before patients and he stated that the overriding factor was to improve services and the only objective was to produce a high quality service. National guidelines and best practice all pointed towards the integration of services and by creating a single 24 hour service would assist patients as they would not be going to different centres at different times and the telephone service would also enhance the facility and save time for patients.

Further comments made included:-

- How much had the consultation cost
- Walk in centres were clinically risky as staff could not access patient records and it was queried whether the new urgent care facility would have access to patient records
- Parking at Russells Hall was an issue and the relevant Scrutiny Committee should investigate the matter
- Dudley Group Foundation Trust should give consideration to staggering hospital clinic opening and visiting times to alleviate the parking situation.
- Would it not be better for individual GP's to set up their own triaging services at their surgeries that could be run by suitably qualified nurses
- It was suggested that the current contract for the Walk in Centre be extended beyond September 2014 to enable new systems and the facility to be fully operational and in place.
- The public wanted easier access to GP's and it was considered that efforts should be targeted on that aspect instead of concentrating efforts to moving a facility to Russells Hall

Mr Maubach responded to comments made and stated that although the urgent care facility was still to be based at Russells Hall the proposed design was substantially different as public views had been taken into account. Full patient records at the current Walk in Centre and at A&E were not available for medical staff and one of the benefits in seeing your own GP was that they had full patient history and records. However, discussions were being undertaken with a view to the creation of a single computer system to enable all medical staff to gain access to patient records but this was a long process and required significant collaboration. With regard to triaging Mr Maubach stated that currently at A&E it was carried out by a nurse and by a trained administrator for the 111 service. A decision had not been made on what triaging method would be used but best practice would be followed

and Mr Maubach undertook to report back to a future meeting on the preferred option. With regard to GP access it was stated that the biggest issue was to ensure that access to GP's did not get worse as any deterioration would have a significant adverse impact.

A Member referred to the proposal for reconfiguration of urgent care and commented that this was a substantial change in service which affected a large number of people using the service and queried why there was no financial information provided. A recommendation or review could not be undertaken until full financial details and a precise specification of the proposed model to include staffing structures and an implementation plan for continuous improvements was available to enable comparisons to be made.

The Chair on behalf of the Committee thanked Healthwatch for the work undertaken in producing the report and time spent in interviewing people.

In conclusion it was agreed that a Special Meeting of the Committee be held in March, 2014 to consider the matter further including cost implications, staffing and parking and that various partners be invited to give evidence and answer specific queries.

RESOLVED

(1) That the consultation activities set out in the report submitted by way of assurance that the CCG has fulfilled its statutory obligations to properly consult on proposed changes to the urgent care system, be noted.

(2) That the feedback received which would be taken into account when agreeing steps in developing an improved urgent care system for the people of Dudley, be noted.

(3) That the Dudley Clinical Commissioning Group be requested to provide a further report to include details of capital resource, costs involved, staffing structure and parking issues to a Special Meeting of the Committee to be held on a date to be determined in March, 2014.

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36 HEALTH AND WELLBEING BOARD PROGRESS REPORT 2013/14

A report of the Chair of the Dudley Health and Well Being Board was submitted updating the Committee on the developments of the Health and Wellbeing Board and progress of work from 1st, April 2013.

Arising from the presentation of the report the Cabinet Member for Health and Well Being, Director of Public Health and Ms Jackson responded to Members' queries and commented that revenue generated from consequences of breach remained within the CCG's budget to use to make health improvements; hospital ambulance turnarounds were an issue but improvement work was ongoing and that work that had previously been undertaken by the Shadow Health and Well Being Board had continued and follow up work undertaken.

In responding to a query from a Member on whether it was considered that three Members of the Council were sufficient to sit on the Health and Well Being Board, the Director of Public Health confirmed that there were four Members and stated that the minutes of the Health and Well Being Board were available for public perusal and were included in the White Book for Members' attention. It was further commented that constitutional arrangements stipulated membership for Council Members to be at a minimum number but that there was no maximum limit set. However, it was pointed out that there was a need to strike a balance given the number of various partners on the Board and to ensure that there was sufficient community as well as Members' views. In response to a request the Director of Public Health undertook to circulate to Members the membership of the Health and Well Being Board.

In responding to further questions Ms Jackson indicated that timescales for commissioning a Mental Health Service for the 16 – 18 age group and key actions could not be given as yet as the matter had been referred to the Children's Commissioning Board for consideration. In referring to Healthy Services: Urgent Care Dashboard as referred to in the Appendix to the report, in particular to ambulance handover and ambulance crew readiness the Vice Chair requested that figures, based on the worst scenario, be given on how many ambulances were available to undertake normal emergency work taking into account the number of queuing ambulances in hospitals. Mr Harris (WMAS) undertook to provide the requested information to Members and commented that queuing ambulances at hospitals was an issue but efforts were being made to monitor the situation with a view to escalating through the system at various trigger points.

In responding to a query from a Member relating to what work the Health and Well Being Board had undertaken since April last year to improve the health and well being for residents in the borough and any relating evidence and how the spotlight sessions had been chosen, the Cabinet Member for Health and Well Being and the Director of Public Health explained the work undertaken and also referred to the Health and Well Being Strategy. The strategy had identified five priority areas and spotlight sessions with key stakeholders were arranged, one for each priority area and attempts were made to ascertain and determine positive and negative aspects with a view to improvements being made. The Cabinet Member for Health and Well Being stated that achievements were based on integrating services and joint commissioning which was a challenge.

In conclusion the Chair requested that a further report be submitted to the Committee in the Autumn to include overall indicators, an implementation Plan and performance framework.

RESOLVED

(1) That the information contained in the report, and Appendices to the report, submitted on the developments of the Health and Wellbeing Board and progress of work for 2013/14, be noted.

(2) That a further report to include overall indicators, an implementation Plan and performance framework be submitted to a future meeting of the Committee.

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37 111 SERVICE

A verbal report and presentation was made on the 111 Service by the West Midlands Ambulance Service (WMAS). Copies of the slides of the presentation were circulated for information to Members.

In presenting the information on the 111 Service, Ms Clayton, West Midlands Ambulance Service, provided some background information in that the WMAS had been approached by the National Health Service (NHS) England as the preferred "step in" partner for the West Midlands region following withdrawal of the contract from NHS Direct. The transfer took place in November 2013 and since that date, NHS 111 had continued to improve on performance and now regularly achieved over and above the set target.

There had been a number of changes to the delivery model including increased access to clinical support for non clinicians; a Clinical Manager running each shift and additional training for new staff that incorporated the accredited First Person on Scene course. During the Christmas period (23rd December – 5th January, 2014), 37,913 calls were answered and on average, 97.2% of those calls were answered within sixty seconds, which exceeded the target of 95%. Since providing the service, WMAS had received various compliments and there was a feeling of positivity for NHS 111 staff.

Ms Clayton then went on to explain points about the 111 structure, how calls were dealt with, clinical governance, winter contingency, partnership and integrated working.

Arising from questions from Members, Ms Clayton stated that there was a peak in calls during early mornings and evenings which coincided with the closing times of General Practitioners (GP's) surgeries, the contract was due to end in August 2015, there were 41 Health Advisors and 19 Clinical Advisors on duty and that they were constantly striving to win back public confidence which was being achieved given the number of increased calls.

The Chair thanked the West Midlands Ambulance Service for their presentation and commented that some faith had been restored and she urged that they attend the special meeting to consider urgent care.

RESOLVED

That the verbal report and information contained in the presentation on the 111 Service, be noted.

The meeting ended at 8.40 p.m.

CHAIR

HEALTH SCRUTINY COMMITTEE

Tuesday 25th February, 2014 at 6.00 p.m.
in Committee Room 2 at the Council House, Dudley

PRESENT:-

Councillor Ridney (Chair)
Councillor Kettle (Vice-Chair)
Councillors Cotterill, Harris, Hemingsley, Jordan, K Turner and Mrs Walker and Ms Pam Bradbury – Chair of Healthwatch

Officers

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

Also in Attendance

Mr Richard Catell – Dudley Group NHS Foundation Trust
Ms Carrie Spafford – Dudley Group NHS Foundation Trust
Ms Liz Abbiss – Dudley Group NHS Foundation Trust
Mr Derek Eaves –Dudley Group NHS Foundation Trust
Mr Nick Henry – West Midlands Ambulance Service
Ms Joanne Kavanagh – West Midlands Ambulance Service
Ms Marsha Ingram – Dudley and Walsall Mental Health Partnership NHS Trust
Ms Rosie Musson – Dudley and Walsall Mental Health Partnership NHS Trust

38 CHAIR'S REMARKS

The Chair welcomed Councillor K Turner as a Member to the Committee for the remainder of this Municipal Year.

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39 APOLOGY FOR ABSENCE

An apology for absence from the meeting was received on behalf of Councillor Mrs Rogers.

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40 DECLARATIONS OF INTEREST

No Member made a declaration of interest in accordance with the Members' Code of Conduct.

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41 MINUTES

As the Minutes of the meeting of the Committee held on 23rd January, 2014 had been omitted from the agenda it was agreed that they be approved as a correct record and signed at the next meeting of the Committee.

42 PUBLIC FORUM

No issues were raised under this agenda item.

43 RESPONSES TO QUESTIONS ARISING FROM PREVIOUS COMMITTEE MEETING

A report of the Lead Officer to the Committee was submitted on updates and responses arising from the previous Committee meeting.

Arising from the presentation of the report concerns were expressed about the total number of hours (equating to over 74 days) that were lost in ambulances not being available for other emergency work due to delays in turnover at hospitals.

Reference was made to an incident regarding a particular transport provider whereby a terminally ill patient had been left for forty minutes in the ambulance as the crew member could not lift the patient up a flight of stairs and it was queried which provider the West Midlands Ambulance Service (WMAS) used. In responding Mr Henry informed the Committee that the WMAS used Ambuline and further stated that they had appropriate trained staff to handle varying situations. In responding to further queries Mr Henry reported that the number of hoax calls was very low and a support plan was in place for frequent callers. He undertook to provide a definitive answer on the number of hoax callers.

The Chair of Healthwatch undertook to ascertain through her group on whether there were any major concerns regarding hoax calls and private ambulance services.

RESOLVED

That the information contained in the report, and Appendix to the report, submitted on updates and responses arising from the previous meeting, be noted.

44 NATIONAL HEALTH SERVICE QUALITY ACCOUNTS

A report of the Lead Officer to the Committee was submitted on the delivery of NHS providers against current Quality Account improvement priorities and leading issues moving into 2014/15. Quality Account information had been attached as Appendices to the report submitted from the West Midlands Ambulance Service, Dudley and Walsall Mental Health Partnership NHS Trust and the Dudley Group NHS Foundation Trust. The Scrutiny Officer reported that the Black Country Partnership Trust had not submitted their information for consideration.

Dudley and Walsall Mental Health Partnership NHS Trust

Arising from the presentation of the report Members made comments and raised questions as follows:-

- It was queried when the new evidence based risk assessment tool (FACE) and the development of the new standard discharge letter were introduced. It was also queried how the discharge letter was submitted to GP's.

- Reference was made to progress made in relation to Priority 8 and the adoption of the 'Triangle of Care' model and it was stated that effective engagement with families and carers was of a major concern and it was queried how the goal would be achieved and assessed.

- There were various complexities involved in personalisation and re-enablement for the Local Authority and the person concerned and an assurance was sought that the full needs of the person, in conjunction with their families, were being addressed.

- The type of training offered to staff was queried.

- It was queried why the figures were so low, the national average being 42%, in providing service users with a copy of their care plan and it was considered that efforts should be made to strive higher.

- There were numerous complaints about the attitude of staff towards patients.

- It was requested that statistical information relating to the number of service users experiencing falls to evidence the downward trend and for analysis purposes be provided. The final report should also include detailed statistical information relating to the number of staff that had been trained to include time trends and information relating to the number and nature of complaints and a breakdown on actions that had been taken in addressing the complaints.

In responding to comments made and queries raised by Members, Ms Ingram and Ms Musson made the following points:-

- FACE that was being used as part of service users care management processes had not been introduced until Quarter 3 (Q3) and its implementation had been delayed due to problems with electronic systems.

- The development of the new standard discharge letter had also been introduced in Q3 resulting in a lack of feedback but a satisfaction survey of GP's would be undertaken in April of this year. Currently the discharge letter was sent to GP's by post although consideration was being given to electronic means.

- Clinical and care audits were currently carried out internally with the exception of 'Triangle of Care' which was audited by an external provider.

- With regard to personalisation although it was acknowledged that it posed challenges, it was commented that this was not an add-on but an embedded service linked to mental health; personalisation was used as a vehicle to deliver services and outcomes for service users was assessed via clinical assessment tools.

- The number of priorities had originally been 15 but these had been reduced to 9 and the national recommendation was to have between 5 and 6 priorities.

- All staff had to undertake customer care training and where the implementation of medicine was concerned training was restricted to professional staff such as Doctors and nurses.

- In relation to targets for patients to receive copies of their care plan there was a key performance indicator target set at 95%. However, the lower percentage figure of 42% given related to all service users including referrals which were not subject to the care programme approach. Regardless of the figures there was a need to simplify and make care plans clearer as very often patients did not understand the content and were reluctant to seek clarification.

- It was acknowledged that the highest complaints made were about staff attitude but at the same time the highest compliments received were also about good staff attitude. Customer care training that was provided included an element whereby staff were asked to consider and reflect on how others perceived their style.

In responding to further queries and comments made it was reported that advice was given to patients in taking medication in line with medication that was currently prescribed to them, including over the counter medicine; information was provided to patients in various formats which was available online and support was also given to those that could not access the information; as part of the Care Programme Approach, regular reviews and monitoring exercises were undertaken, with a view to involving the individual and their families and carers.

In conclusion Ms Ingram undertook to circulate to Members a copy of a report that had been produced based on feedback received on patient and carers experiences and a copy of the Annual Complaints Report as the reports contained some of the information as requested above.

West Midlands Ambulance Service

Mr Henry and Ms Kavanagh, West Midlands Ambulance Service circulated additional information and explained specifics relating to the information contained in the report and information circulated.

Arising from the information presented Members made comments and raised questions and appropriate responses were given as follows:-

- Concern expressed that record keeping and documentation was not completed to a satisfactory standard – It was acknowledged that completion of documentation was not as good as it should be but it was pointed out that some of the paperwork was retrospective and there were occasions where there were plausible reasons why documents could not be completed and a judgement call was made relating to the situation concerned. It was commented that a Project Board had been assigned to consider electronic methods which would ease the capturing and recording of relevant data.

- Reference made to the number of complaints from renal patients and the nature of the complaint and whether any had been upheld was queried – Information relating to the types of complaint was not available but of the twenty complaints made, five had been justified.

- Concerns expressed that the longest handover time at Russell's Hall Hospital had been recorded at being 2 hours and 38 minutes which was startling given the target was 30 minutes to include the completion of documentation and tidying of the vehicle by the ambulance crew.

- It was acknowledged that it took longer for ambulance crews to attend an emergency in rural areas and it was queried how often the Computer Aided Despatch Address, "Gazetter" was updated – The system was updated regularly but a definitive answer would be provided to Members.

- Queried whether consideration had been given to addressing the situation given the number of hours lost in staff waiting to handover at hospitals which equated to 39 staff out of the 157 whole time equivalents – It was reported that the Hospital Ambulance Liaison Officer was responsible for the monitoring the situation.

- Given the receipt of 53 completed surveys out of 200, it was queried why the patient survey had only been distributed in the month of May and not staggered across the following months and whether surveys were continuous – It was commented that staff were reluctant to engage in surveys, however, a response to ascertain the reason for not distributing evenly over several months and whether surveys were continuous would be provided to Members.

- It was considered that some of the questions in the survey were not appropriate and a view was also expressed that staff should not be spending their time giving out surveys to patients to complete and should be concentrating on undertaking their duties.

In responding to further questions Mr Henry and Ms Kavanagh reported that should the service experience an upsurge in incidents and calls they were able to utilise support from regional areas and beyond and internal operational managers could also assist as they were trained paramedics; staff mainly worked 48 hours on a rota system based on twelve hour shifts over four days; and that ambulance crews had four hours to respond where a GP had visited the patient as it was classed as a referral and was not subject to the thirty minute response time.

Mr Catell, Dudley Group NHS Foundation Trust referred to the longest handover time and acknowledged that it was not acceptable but stated that the matter was being taken seriously with a view to improvements being made. He reported that additional staff had been taken on, an external agency had been appointed to provide guidance on how improvements could be made and consideration was also being given to expand the space to the entrance at Russells Hall to alleviate some of the problems. The Hospital were working extremely hard to combat problems and it was in their interests as they were financially penalised by Dudley Clinical Commissioning Group each time the target of a 30 minute handover was not met.

In concluding it was reported that there were various methods available, such as an online facility via the Trust's website, Facebook and Twitter to enable patients and staff to voice their opinions on which priorities should be included in the following financial year.

As Members had struggled with understanding some of the information presented, a Member asked that consideration be given to arranging an informal meeting with the West Midlands Ambulance Service with a view to discussing ways to present information in a more legible manner.

<u>The Dudley Group NHS Foundation Trust</u>

Arising from the presentation of the report and in response to Members' comments and queries the following responses and points were made by Mr Eaves, Dudley Group NHS Foundation Trust:-

- Attempts were made to recruit nurses locally but this was not easy given the national nursing shortage; there was a requirement for nurses recruited from abroad to complete certain assessments and the interview process was used to ascertain their standard of English.

- A survey of nurses had been undertaken and no reference had been made to indicate that the working pattern and long hours was an issue and it was confirmed that staff did work part time.

- There were a number of reasons other than not being turned or using certain mattresses why patients could get pressure ulcers such as the patient having certain medical conditions which made them more prone to getting pressure ulcers. Aims to reduce pressure ulcers included a variety of initiatives such as staff training, better documentation and better nutrition.

- It was acknowledged that there was a need to ensure that visitors and staff regularly used sanitation dispensers to control infection and increasing the number of dispensers, particularly near main entrances, was potentially an option.

- In relation to nutritional status and why the target was not at 100% it was commented that it was difficult to achieve and unrealistic.

- With regard to “bed blocking” it was stated that there were currently eighty five patients that were awaiting relocation and options such as using other homes was being considered but there was a need to assess the particular situation as some patient’s required home support and funding also had to be taken into account.

Mr Eaves, Dudley Group NHS Foundation Trust undertook to provide a response as to why they were unable to recruit people from Ireland given they were part of the European Union.

RESOLVED

That the information contained in the report and Appendices to the report, submitted on the Quality Accounts relating to the West Midlands Ambulance Service, Dudley and Walsall Mental Health Partnership NHS Trust and the Dudley Group NHS Foundation Trust, be noted.

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45 REALIGNMENT OF COMMUNITY PHSIOTHERAPY CLINICS

A report of the Dudley Group NHS Foundation Trust was submitted on the changes to the provision of community musculo-skeletal physiotherapy.

Arising from the presentation of the report and in responding to Members' queries, Ms Spafford, Dudley Group NHS Foundation Trust stated that the initial physiotherapy session at Russells Hall Hospital was allocated a forty five minute slot and subsequent follow-up appointments were for thirty minutes. In response to a query regarding the waiting times being reduced from eight weeks to four weeks, Ms Spafford undertook to circulate further information and a breakdown to clarify whether figures related to patients waiting for their initial assessment or whether they were GP referrals.

RESOLVED

That the information contained in the report on the changes to the provision of community musculo-skeletal physiotherapy, be noted.

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46 PATIENT EXPERIENCE

A report of the Dudley Group NHS Foundation Trust was submitted on The Dudley Group Friends and Family Test results and the new Patient Experience Strategy.

Arising from the presentation of the report, Ms Abbiss, Dudley Group NHS Foundation Trust responded to questions from Members and reported that two complaints had been referred to the Ombudsman, patient surveys were issued at point of leaving the Accident and Emergency Department and in patients were asked to complete surveys within forty eight hours of their discharge via posting in a box at the hospital, online or by freepost. With regard to menus and food Ms Abbiss confirmed that they did not cook food on site and used an external provider.

During the ensuing debate and in responding to complaints made about multiple appointment letters being sent out and the confusion caused to patients, Ms Abbiss reported that attempts were made to alleviate problems and that consideration was being given to improving Information Technology.

RESOLVED

That the information contained in the report and Appendices to the report, submitted on The Dudley Group Friends and Family Test results and the new Patients Experience Strategy, be noted.

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47 TOBACCO REVIEW - FINDINGS

A verbal report was given by the Scrutiny Officer on the Tobacco Review and he informed the meeting that a draft copy of the report was available for perusal. However, he stated that the report was likely to change as the document was currently being considered by the Director of Public Health with a view to submitting to Review Panels later this week. A final report would be submitted to the next meeting of this Committee with a view to submitting to Cabinet in due course.

RESOLVED

That the verbal report given on the Tobacco Review be noted.

The meeting ended at 8.55 p.m.

CHAIR

Agenda Item No. 6

Health Scrutiny Committee – 27th March 2014

Report of the Lead Officer to the Committee

Responses arising from previous Committee meetings

Purpose of Report

1. To consider progress updates and responses arising from previous Committee meetings.

Background

2. Information requests from members are regularly experienced as part of the scrutiny of Dudley's health, care and wellbeing services; with the aim of securing improved outcomes and experiences across the sector. Clearly some queries cannot be answered immediately with some prompting further investigation, or consultation, prior to being reported back to Committee.

3. To keep members briefed, updates and responses arising from previous meetings including resulting proposals are presented at appendix 1.

Finance

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

Law

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

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

Equality Impact

7. The work of the Committee can be seen as contributing to the equality agenda in the pursuit of improving care for all. This implies a challenge to

ensure that services meet the needs of all sectors of the community to make this an even greater reality in Dudley.

Recommendation

8. Members approve proposals at Appendix 1.

.....
Mohammed Farooq – Assistant Director Corporate Resources

LEAD OFFICER FOR HEALTH SCRUTINY

Contact Officer: Aaron Sangian
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Documents used in the preparation of this report:-

1. Minutes of Committee held 25 February 2014

Appendix 1

West Midlands Ambulance (WMAS)

Arising from a presentation from WMAS focusing on progress against 2013/14 performance priorities set as part of the NHS Quality Accounts process members queried:

- the prevalence of hoax calls experienced by the Trust?
- how often is the Computer Aided Despatch address gazetteer updated?

Response

The Trust experiences a very small amount of hoax calls and as a result this data is no longer routinely monitored. However it should be emphasised frequent service users referred to in the Trust's report is more of an issue.

The second question was how often is the Computer Aided Despatch address gazetteer is updated? This is completed every 6 months

Dudley Group of Hospitals Foundation Trust

Arising from Dudley Group of Hospitals report on Quality Account improvement priorities members sought clarification regarding barriers to recruiting Irish nurses experienced as part of the latest Hospital recruitment drive.

Members also noted that the initial physiotherapy assessment appointment session at Russells Hall Hospital in the community was allocated a forty five minute slot and subsequent follow-up appointments were 20-25 minutes.

In response to a query regarding the waiting times being reduced from eight weeks to four weeks, members requested a further breakdown of waiting times by clinic from point of referral from any referrer. Overall staffing numbers was also queried.

Response :

Following a freeze on all public sector jobs instituted by Irish Government UK hospitals found that it was useful to recruit from Ireland particularly as nurses were unable to attain employment in Ireland under the restriction.

The freeze is now lifted meaning Irish nurses can get jobs in Ireland and UK hospitals now find there is no pool of interested nurses.

Regarding physiotherapy assessments please see breakdown by clinic of longest wait from the point of referral from any referrer – GP/health professional or self referral for all clinic locations to first available appointment.

Next Available Appointment for Each Clinic Location. As at 18 February 2014

LOCATION	NEXT AVAILABLE APPT	WAIT (weeks)
Albion House	24.03.2014	5
BHHSCC	21.03.2014	4
Castle Meadows	02.04.2014	6
Guest Hospital	24.03.2014	5
Halesowen HC	27.03.2014	5
Kingswinford HC	01.04.2014	6
Meadowbrook	28.03.2014	5
Northway	02.04.2014	6
SHSCC	20.03.2014	4
St James's	01.04.2014	6
St Margarets Well	26.03.2014	5
The Limes	28.03.2014	5
Three Villages	19.03.2014	4

Data indicates the shortest waiting time for patients able to attend anywhere in the Borough would have been 4 weeks at the time of the Committee meeting.

On staffing, the service comprises 12.5 whole time equivalent roles across a total headcount of 20 clinical staff.

Agenda Item No 7

Dudley Health and Overview Scrutiny Committee – 27th March 2014

Purpose

Provide Dudley Health and Overview Scrutiny Committee with an overview of NHS England's plans to coproduce a primary care strategic framework and discuss/inform its development.

Background

Developing primary care is essential to ensure that the NHS England vision of 'high quality care for all, and for future generations' is delivered upon. The changing nature of health and social care means that all aspects of the current system, especially primary care have to respond to the new opportunities and challenges to be able to deliver the vision.

The existing CGG and Health and Wellbeing strategies define a number of key outcomes which are important to Dudley. For many of these, good, consistent, primary care is a vital ingredient in order that they may be delivered. Good primary care is also an essential ingredient of a well-functioning community.

Birmingham, Solihull and the Black Country Area Team are committed to work together with Dudley CCG, Dudley Health & Well Being Board and Dudley Health and Overview Scrutiny Committee to improve the performance and quality of primary care. Our initial work has focused on establishing the systems and processes to underpin this work alongside engaging with all key partners to establish the key priorities going forward.

General practice services face increasingly unsustainable pressures. In responding to these pressures, we have the opportunity to transform the way in which general practice services are delivered, placing them at the heart of more integrated systems of community-based health services. Key issues to be addressed in this transformation are:

- Changing demographics
- Access & Satisfaction
- Pressure on financial resources
- Workforce pressure

Taken together, these challenges culminate in an unsustainable system for general practice provision. Through a local strategic framework we want to enable a transformation by providing resources and tools for local commissioners. Two key principles shape our approach:

- We want to create a **shared purpose** (amongst commissioners and general practice providers) to improve outcomes in collaboration.
- We want to **build possibility** to empower communities, patients and all those working in general practice and to liberate and equip NHS general practice to be the best it can.

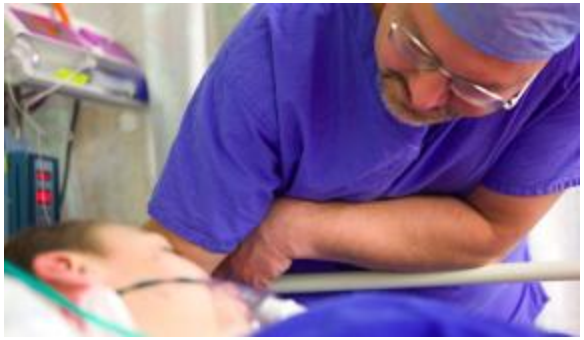
NHS England is working through various steps to develop a primary care strategic framework. One of the key steps is to undertake engagement with key stakeholders to support the coproduction of a framework that achieves high quality primary care. This will support the coming together of various stakeholders to serve the local population in the best way possible.

Proposal to Dudley Health and Overview Scrutiny Committee

It is proposed to explore and discuss key aspects relating to primary care with Dudley Health and Overview Scrutiny Committee and partners so that they can help support and inform NHS England in both its strategic and operational aims regarding Primary Care.

Primary Care Quality

Dr Narinder Sahota - Assistant Director
Dr William Murdoch – Assistant Director



Birmingham, Black Country and Solihull Area Team

March 2014

THE NHS CONSTITUTION
the NHS belongs to us all

The New Commissioning Landscape

- Clinical Commissioning Groups
- NHS England
- Local Authorities

High quality care for all, now and future generations


Wolverhampton CCG
Walsall CCG
Birmingham CrossCity CCG
Sandwell & West Birmingham CCG
Dudley CCG
Solihull CCG
Birmingham South and Central CCG

Quality in Primary Care

- Joint responsibility between Area Teams and CCGs
  - Management responsibility - Area Teams
  - CCGs - have a statutory duty to assist and support the NHSE in securing continuous improvement in the quality of primary medical services
- Underpinned by the NHS constitution and the NHS outcomes framework

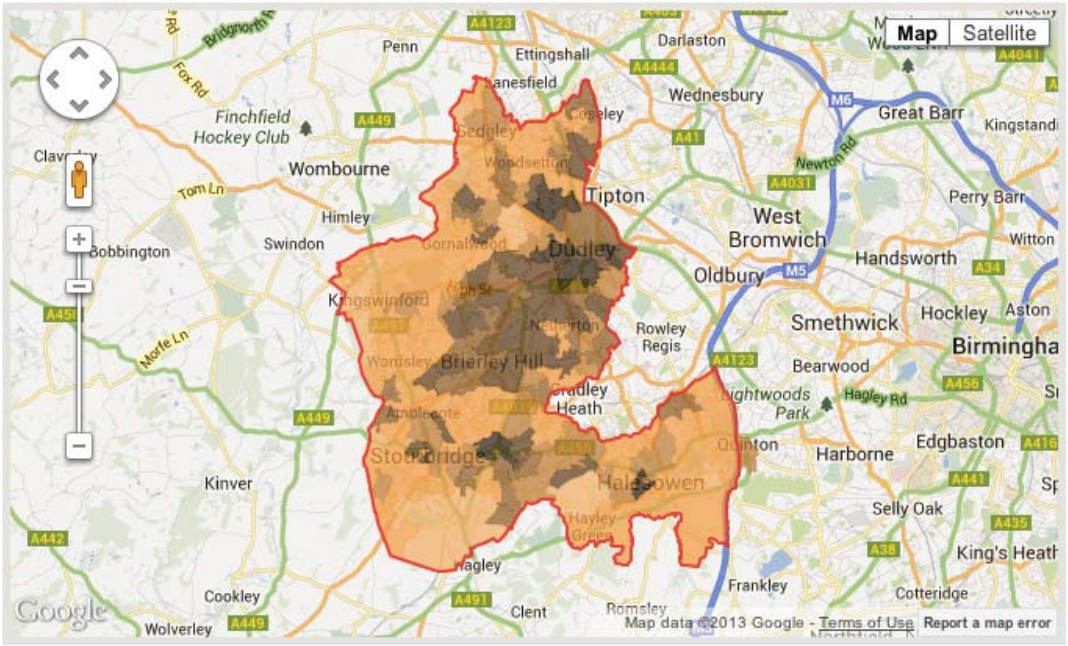
Aim of the Primary Care Strategic Framework

- Support and develop all four contractor groups* in providing quality healthcare by;
  - Raising quality
  - Reducing unwarranted variation
  - Improving access to services
  - Reducing inequalities

- *Medical, Pharmacy, Optometry and Dentistry

Local context

- Dudley serves a population of 312,900
- It has an index of multiple deprivation (IMD) mean score of 26.33 (national average = 22.69)



Local context (continued)

- Across the Area Team there are:
  - Number of GP practices 476
  - Number of pharmacy contracts 658
  - Number of dental contracts 389
  - Number of eye health contracts 569

What we have done so far

- Agreed a project initiation document to take us on the journey of coproducing a primary care strategic framework.
- Undertaken a ‘call for action – general practice’
- Appointed LPN chairs for dental, eye health and pharmacy
- Engagement journey with key stakeholders:
  - Clinical commissioning groups
  - Healthwatch
  - Health and Wellbeing Boards
  - Health and Overview and Scrutiny Committees

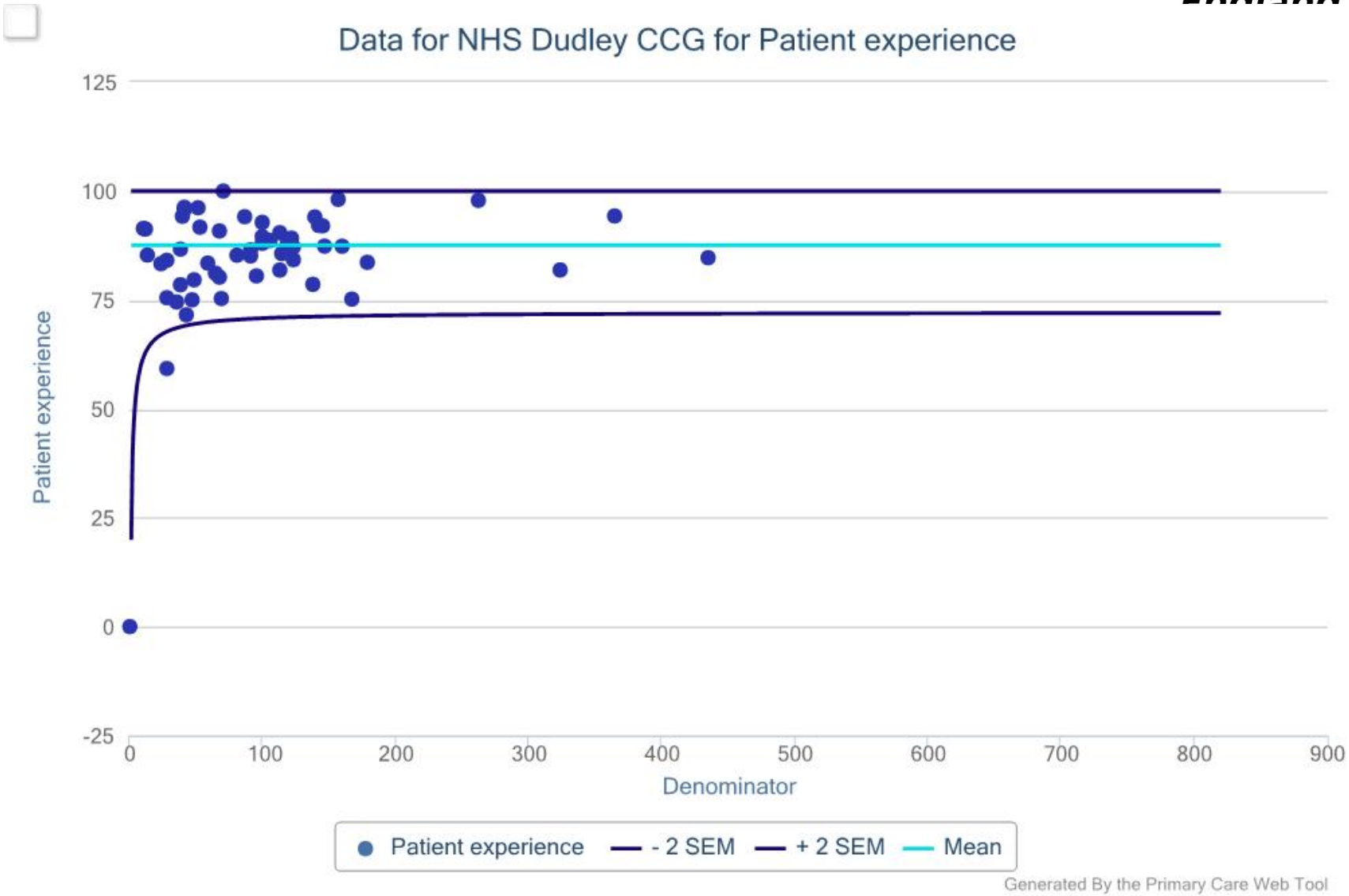
What we have found so far

- From the engagement work so far the key themes that have emerged are:
  - Access and patient experience
  - Unwarranted variation
  - Workforce
  - Workload
  - Premises

Access and patient experience

- Within the Midlands and East region we have the lowest patient experience, with access being one of the areas of concern.

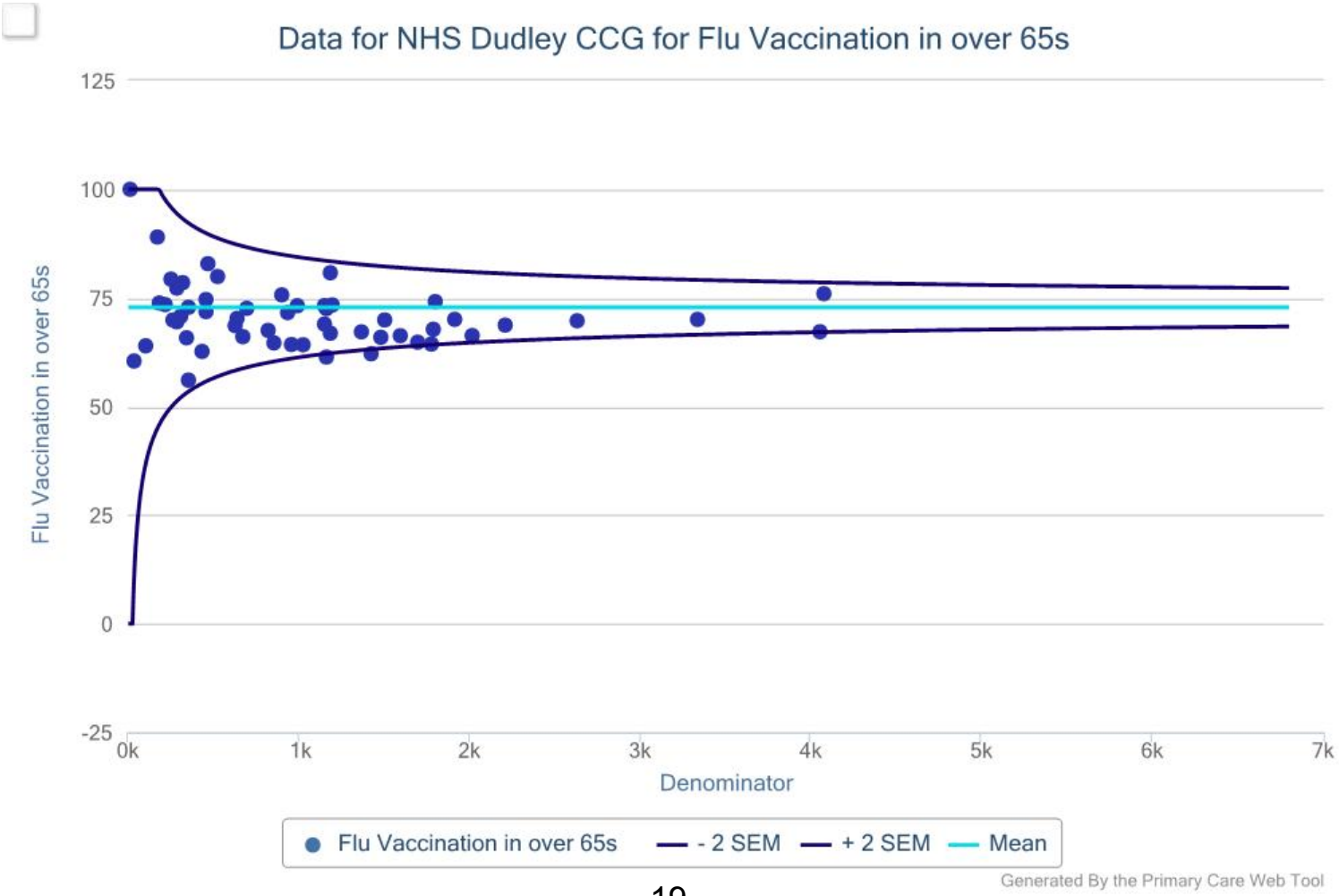
CCG	Getting through by phone		Making an appointment	
	CCG Mean	National Average	CCG Mean	National Average
Dudley CCG	0.82	0.82	0.79	0.8


Data for NHS Dudley CCG for Patient experience
125
100
75
50
25
0
-25
Patient experience
0
100
200
300
400
500
600
700
800
900
Denominator
Patient experience
- 2 SEM
+ 2 SEM
Mean
Generated By the Primary Care Web Tool

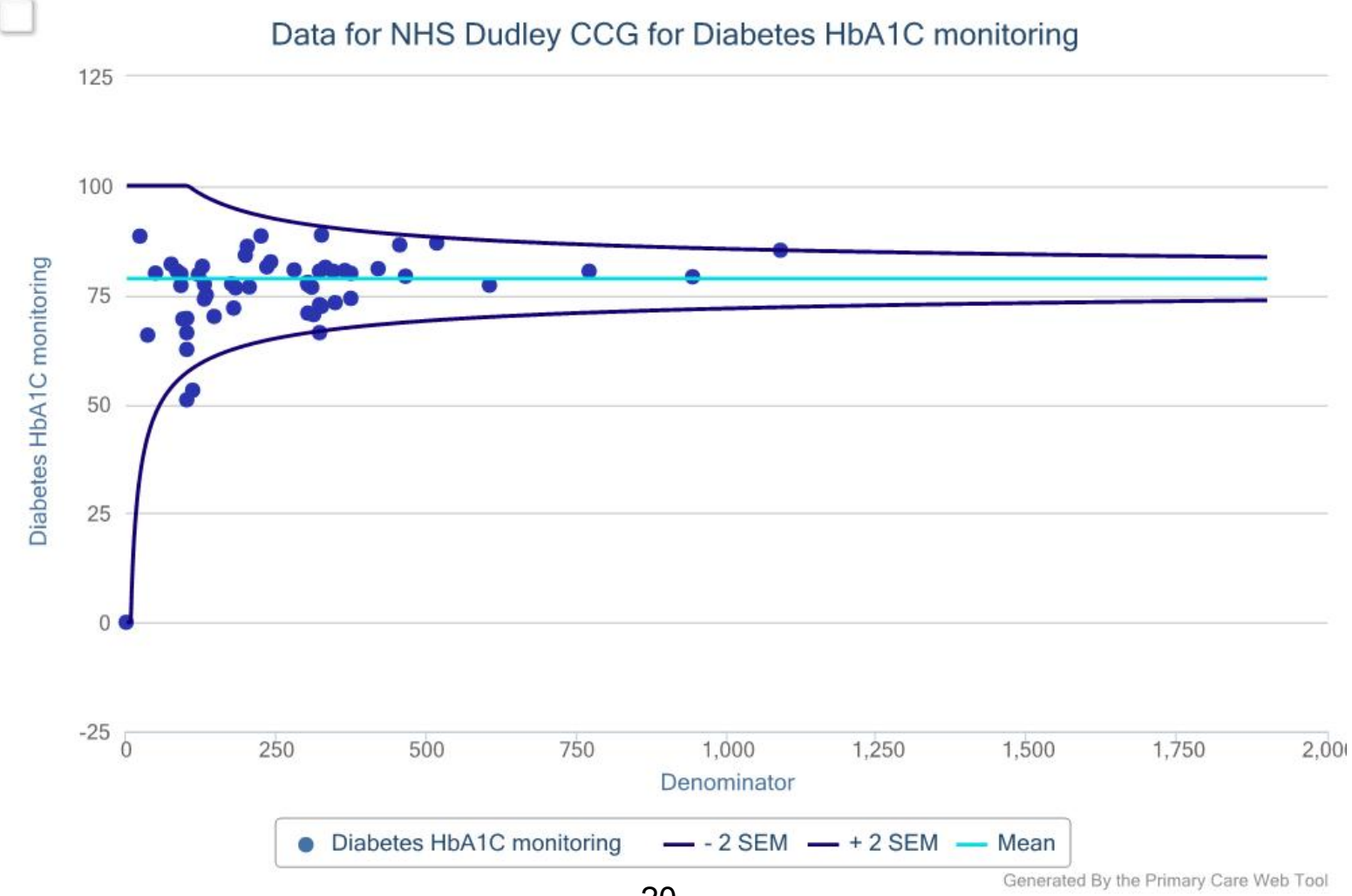
Unwarranted variation

- Reducing unwarranted variation will support raising quality and reducing inequalities in healthcare
- Data sources show unwarranted variation in a number of areas, some examples are:
  - Flu uptake for at risk patients varies from 20% to 90%
  - Diabetes management (HBA1c) varies from 37% to 95%

Flu vaccination for over 65s for all practices in Dudley



Diabetes Management (HbA1c) across Dudley



Workforce

Based on the most recent HSCIC census data PCTs in the Birmingham, Solihull and the Black Country Local Area Team had:

- 1871 GP FTE (excluding GP Registrars and Retainers)
- 683 Practice Nurse FTE
- 1.6% of the GP workforce aged under 30, 28.5% aged over 55 and 18% aged over 60 years (range 10-30%)
- an GP FTE per head of weighted population that ranged from 0.47 (in Sandwell PCT) and 0.65 (Solihull PCT)
- a Practice Nurse per head of weighted population that ranged from 0.13 (in South Birmingham PCT) and 0.50 (Solihull PCT)
- 19.9% single handed practices, 43% practices 2 or less GPs

GP and Practice Nurses per head of population (2011)

PCT Name	GPs FTE (excluding Registrars and Retainers)	Practice Nurse FTE	Weighted PCT population	Weighted population divided by 1000	GPs per 1000 weighted population	Practice Nurse FTE per 1000 weighted population
Dudley PCT	174	63	312,083	312.08	0.56	0.20

Age breakdown of GP FTE

PCT Name	All Practitioners (excluding Retainers & Registrars)	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +	Unknown	% Under 30	% 55 and over
Dudley PCT	174	6	27	26	16	25	26	19	8	17	4	-	3.4	27.2

Workload

- Every year GPs provide over 300 million consultations in England
- Consultation rates have almost doubled in the last decade from nearly three to six times per year with the elderly consulting between 12 and 14 times per year
- In the 12 months leading to September 2011 the number of consultations rose from 3.5%: GP numbers rose by 0.2% full time equivalent in the same period
- Patients over 65 years of age consult their GP on overage more than twice as frequently as those aged 15-44 years of age
- One in 20 consultations result in a referral to secondary care

Premises

- Large number of premises of poor quality
- Area Team director of finance currently leading a work stream on premises to assess current needs

Managing performance

- Safety systems and measures
- Outcome measures, assurance and patient feedback
- Professional regulation and compliance through:
  - CQC
  - GMC
  - LMC
  - NMC
  - and other professional bodies

Current performance issues

- Total number of current investigations = 131
  - 10 of these are being dealt with locally
  - 121 are being dealt with by professional bodies
  - Of the 121:
    - 93 relate to GPs
    - 21 relate to Dentists
    - 3 relate to Optometrists
    - 4 relate to Pharmacists
    - Since April 2013 422 complaints and concerns have been resolved and 156 are currently being dealt with.
    - Primary care assurance dashboard – 57 outliers, 39 below average practices

Next steps

- Coproduction of Primary Care Strategic Framework by June 2014 – 6 areas of focus:
  - Objective 1 - To continuously improve quality of primary care services through contracting and regulating processes
  - Objective 2 - To improve patient experience, access and satisfaction
  - Objective 3 - To develop a sustainable workforce to enable the delivery of quality primary care
  - Objective 4 - To improve primary care outcomes and reduce health inequalities
  - Objective 5 - To improve the estate in which we provide primary care
  - Objective 6 - Work with key stakeholders to deliver system change and new models of primary care

Next steps (continued)

- Start contractual compliance visits for **all** practices from April 2014
- Revalidation and appraisal of GPs to continue
- To complete engagement sessions with HWBBs and HOSCs
- To work together with CCGs and support them with primary care strategies and local plans

Thank you

Any questions?

Dudley Clinical Commissioning Group

Report from Paul Maubach, Chief Officer

Patient Participation Groups (PPGs) in Dudley

1.0 Purpose of Report

To update members on progress made by the CCG on developing a network of Patient Participation Groups.

2.0 Background

PPGs are made up of patients from a particular GP Practice, along with the practice manager and one or more of the practice GPs.

The National Association of Patient Participation (NAPP) traces the origins of PPGs back to the early 1970's. There is no set way for a PPG to work, but their general aim is to help the practice to make sure that it can put the patient, and improving health, at the heart of everything it does.

In Dudley, as in other parts of the country, PPGs are playing an active role in delivering real improvements to primary care services.

At Dudley CCG, PPGs are a vital part of our plans to get more people more actively involved in how their health care services are planned, developed and delivered.

We are investing a significant amount of resource in developing PPGs at an individual practice level and we are also supporting them to work together across a wider area so that they can help to strengthen the patient voice in all aspects of the CCGs role as local leaders of the NHS.

PPG members also have a forum which enables them to meet with each other and the CCG management team on a regular basis – our Patient Opportunities Panel or POPs.

3.0 Report

Of the 49 GP practices in Dudley, 39 currently have an active PPG, eight of which have been established in the last six months. 5 practices are just in the process of setting up PPGs and discussions continue with the remaining 5 practices about what support they might need to establish a PPG.

To reflect the importance the CCG attaches to PPGs, and further encourage those practices that do not have a group yet, practices have to demonstrate that they have an active PPG before they can benefit from an incentive scheme which provides financial rewards for improving access to primary care.

We also provide ongoing support for PPGs, although this is very much with the aim of encouraging them to be as self-sufficient as possible.

PPG members have worked with GPs and practice staff to shape real improvements in primary care at practices across Dudley, on projects including the introduction of online booking for

appointments or repeat prescriptions, revised opening hours and text reminder services to reduce the number of patients who do not attend for their appointments.

PPGs have also planned and managed events at their practices including health days and screening events and we are working with them to co-ordinate involvement in national initiatives such as Self-Care Week (which takes place in November).

At a wider level, PPGs have been closely involved in wider pieces of consultation and engagement activity – including input to the CCG's recent high-profile consultation on Urgent Care.

As well as feeding back on the consultation itself, three PPG members are now part of the Urgent Care Centre Reference Group which has been set up to allow stakeholder input into the design of the proposed new centre.

Next Steps

Building networks: As well as working with practices which do not yet have an active PPG, we are also responding to feedback from existing PPGs that members would welcome opportunities to work together, network and share best practice.

To that end we are discussing with them the development of a network support structure which reflects the locality structure groups of our GP membership (see attached diagram)
The first tier of this model would be an active PPG for each GP Practice.

The second tier would see each of those PPGs represented at their respective locality forum. Each locality would then be represented at a borough-wide PPG forum (which would in all probability be developed from our current POPs).

This model of patient engagement will only work effectively if it has the support and active participation of PPG members. We also need to ensure that the CCG and the PPGs have the capacity and capability to make the model deliver the best results.

Training and development - Building capacity and capability
The CCG is fortunate to have a number of enthusiastic PPG representatives but their needs and abilities vary from practice to practice.

To make sure that PPGs have the capacity and capability to continue driving improvements to healthcare, and to support the development of the networks described above, we plan to invest in two critical areas over the next year:

Development of improved communications systems: Early discussions suggest that areas of potential greatest benefit include: Website developments; online communications system using social media; electronic or hard copy newsletters; publicity and recruitment materials; advanced video editing and production software plus training for key members of staff.

Training and development: Again we have had early discussions to identify areas of greatest potential benefit and these include: Training in how to plan and manage/chair effective meetings; good governance for committees, personal resilience and impact, influencing and planning skills.

We are working in partnership with Dudley Council of Voluntary Services (DCVS) to progress this work over the coming months. Two workshop development sessions have been planned. The first session was held on 25 February with 26 participants and a further one is planned (at the time of writing this report) for 19 March.

Participants at the first session agreed with a locality representative model and were keen to discuss further in terms of how representation could be achieved. There were further discussions around support needs to enable PPGs to function effectively. These included

funding from the CCG, support for social media training, effective chairing, how to influence and how to write newsletters.

Feedback will be collected from the March development session and will be discussed at our POPs meeting on the 27 March.

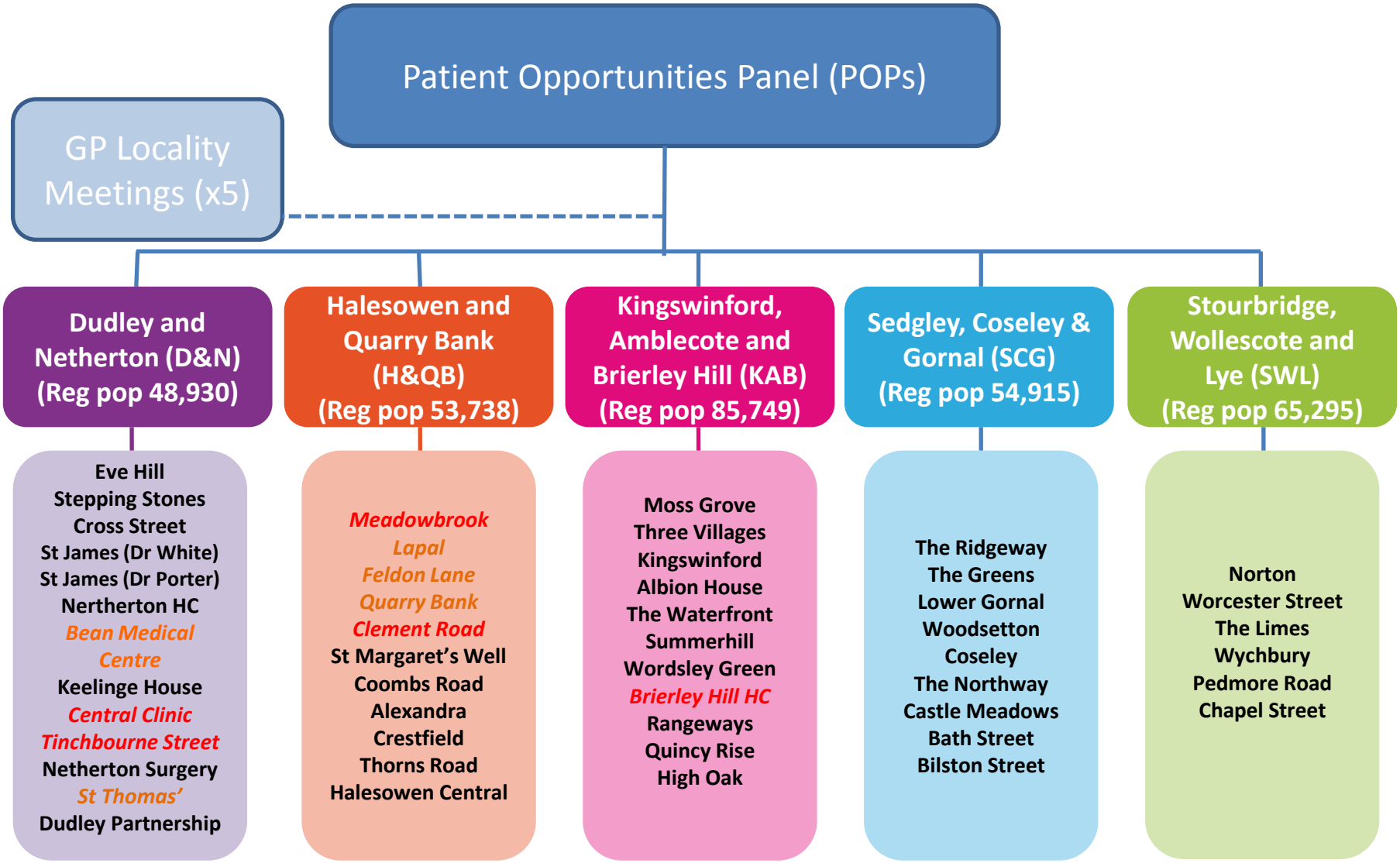
C**onclusion**

PPGs are an important part of the CCGs plans to give patients and the public a strong voice in the way their health services are delivered. Although they are by no means our only channel for communicating with the public, they do have a key role to play in helping us to have open and productive conversations with the communities we serve.

Our aim is to develop a framework for a systematic and sustainable focus on

- Maintaining a thriving network of PPGs and supporting locality and borough wide forums.
- Sharing best practice on setting up and maintaining effective, self-sufficient PPGs.
- Identifying and meeting the training and development needs of PPG chairs and other committee members
- Encouraging all public members of the CCG (ie all registered patients with member practices) to embrace the concept of good ‘health citizenship’ – making positive health choices and making appropriate choices on use of health care services and contributing towards wellbeing.

PPG Locality Model. ***NB Practices in red are those that do not yet have an active PPG. Amber is for practices just setting up a PPG. All population figures are approximate***



Agenda Item No. 9

Health Scrutiny Committee – 27th March 2014

Report of the Lead Officer to the Committee

Committee's Review of Tobacco Control

Purpose of Report

1. To consider a summary of key findings, observations and draft recommendations arising from the Committee's scrutiny of tobacco control.

Background

2. Smoking is a major problem for public services both nationally and locally. Within Dudley it is estimated to be the cause of over 480 deaths per year; and is the single biggest determinant of inequality in life expectancy across communities.

3. Members wanted to investigate how the prevalence of smoking in the borough might be tackled and shape practical recommendations for developing and strengthening the work of the Council and health improvement partners in the area of tobacco control.

4. The review panel was established in October 2013 comprising Councillors: Ridney; Harris; and Rogers specifically to:

    - evaluate effectiveness of partnership working in reducing overall prevalence and assess outcomes of local strategy
    - spotlight challenging areas and discuss possible solutions involving partner organisations
    - assess measures geared to minimise uptake of smoking amongst young people and tackle consumption of illicit products across areas of high smoking prevalence
    - evaluate the current level of involvement and contribution of key public employers to the promotion of smoking cessation and prevention services for staff.

5. Two evidence sessions were subsequently held with key witnesses and experts in the field enabling members to gain a richer insight into tobacco control measures and priorities; to identify ways of securing even more successful outcomes.

6. Contributors included representatives from; Trading Standards; Housing Management; Public Health and the Family Nursing Partnership. Moreover Members were particularly grateful to the young people from 'Kick-Ash' whose views on services needed were very useful.

7. The attached document presents a summary of key findings, observations and draft recommendations emerging from the panel's scrutiny.

8. It is proposed that members endorse the recommendations based on the evidence received with a view of advancing the corresponding review action plan, in consultation with the membership of review panel, stakeholders and the Lead Officer.

9. It is envisaged the final action plan will be steered through the Overview and Scrutiny Management Board for approval for appropriate executive action.

Finance

10. This report outlines findings to date on tobacco reduction and control in accord with panel's terms of reference and outlines further options for accelerating this reduction.

11. Implementation of at least some of the recommendations may have financial implications (e.g. training costs) for the Council and health improvement partners however it is not possible to quantify costs at this stage.

12. Changes to services provided by the authority arising from the review would require further explanation and financial implications scrutinised further in the light of the Council's on-going budget development and financial planning process.

Law

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

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

Equality Impact

15. The work of the Committee can be seen as contributing to the equality agenda in the pursuit of improving health and wellbeing for all. This implies a challenge to ensure that services meet the needs of all sectors of the community to make this an even greater reality in Dudley.

Recommendation

16. It is recommended that the committee:-
    - note this report
    - endorse the draft recommendations at appendix 1
    - authorise the Lead Officer, in consultation with the Chair, Vice Chair and members of the review panel to oversee the final action plan based on the recommendations at appendix 1 then make the appropriate arrangements for Overview and Scrutiny Management Board consideration.

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Mohammed Farooq – Assistant Director Corporate Resources

LEAD OFFICER FOR HEALTH SCRUTINY

Contact Officer: Aaron Sangian
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Email: aaron.sangian@dudley.gov.uk

Documents used in the preparation of this report:-

1. Terms of Reference and Annual Scrutiny Programme 2013-14. Health Scrutiny Committee July 16th 2013.

Dudley Health Scrutiny Committee

Tobacco Control Review

Chair's Forward

Smoking is a major problem for public services both nationally and locally. Within Dudley it is estimated to be the cause of over 480 deaths per year; and is the single biggest determinant of inequality in life expectancy in our communities.. Continued investment in reducing smoking prevalence and increasing cessation is crucial to realising ambitions to close the gap in health inequalities; envisaged in Dudley's Joint Health and Well Being Strategy.

As health scrutiny members we wanted to investigate how the prevalence of smoking in the borough might be tackled and shape practical recommendations for developing and strengthening the work of the Council and health improvement partners in the area of tobacco control.

A lot of strong views were expressed and resonating at the heart of this review was the call for more preventative work amongst younger people; and more community based tobacco control measures in areas of highest smoking prevalence. Whilst improving local knowledge about key community groups and smoking patterns, agencies should consider what incentives could be given to shift deep rooted behaviours in de-normalising tobacco use.

This report is particularly timely as it coincides with consultation on the latest version of Dudley's Tobacco Control strategy outlining new national and local priorities. We hope the task group will find our recommendations helpful and seek to implement them as the main change agent.

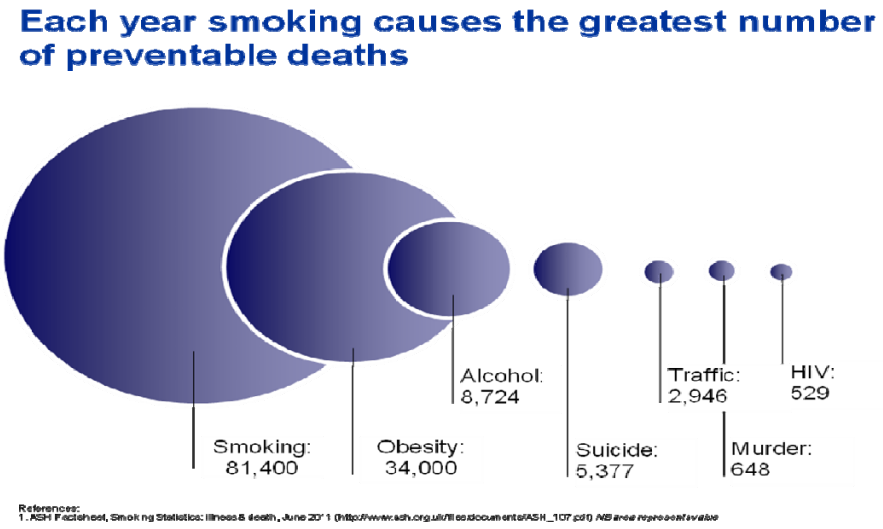
However, whilst strategy looks to empower local communities to change their smoking behaviour, the onus is on all of us to make policy a real success in achieving a society free from the harms of smoking for future generations.

We are extremely grateful to Council and NHS professionals and experts in the field who gave us their time and insights into the work they do as witnesses at our evidence hearings; and to the potential service users such as young people whose views on the services needed were extremely useful.

Cllr Mrs Susan Ridney
Chair Dudley Health Scrutiny Committee

1. Introduction

Smoking remains the single greatest cause of preventable death in the UK. It kills more people each year than obesity, alcohol, road accidents and illegal drug use put together.



Over 80,000 people die from smoking related diseases every year in England (approximately **480+** in Dudley). Tobacco is unique. It is the only product that kills when it is used entirely as intended. There are no safe levels of consumption and this is where tobacco differs from alcohol and fast food.

Legislation and national action by the current and previous UK Government has gone some way to address the problem of tobacco use. Progress has been made over the last decade in reducing the prevalence of smoking in England from 28% to 22%, with a decline in smoking among 11–15 year olds from 11% to 6% between 1998-2007.

This fall is estimated to have delivered net annual revenue benefits of £1.7 billion, in addition to health improvements. The total cost of tobacco control measures in the UK is currently around £300 million per year. A one percentage point drop in the prevalence of smoking is estimated to produce a net revenue gain of around £240 million per year through NHS cost savings, increased tax revenue (due to extra years of working life), less workplace absenteeism and fewer payments of disability benefits.

Overall smoking rates in Dudley have come down from 22.5% in 2004 to 18.5% (based on the 2009 Dudley Health Survey). However, there remains higher smoking prevalence in our most deprived areas, Castle & Priory (24.5%) and Brierley Hill (26.4%).

Smoking is the single biggest cause of health inequalities and life expectancy differences we see in our communities. The more deprived you are, the more likely you are to smoke. Almost every social indicator of social deprivation,

(e.g. income, socio-economic status, education and housing tenure) independently predicts smoking behaviour.

People living in deprived areas in Dudley are more likely to take up smoking, and at a younger age. They are more likely to smoke heavily and are less likely to quit smoking, increasing the burden of smoking-related disease on the local economy .

It is estimated that there are 50,500 people that still smoke in Dudley, which costs our economy around £76.8 million per year based on output lost from early death (£23.5 million), loss of productivity from smoking breaks (£16.6 million), smoking related sick days (£14.3 million), NHS costs (£15.5 million), passive smoking (£4 million), smoking related fires (£2.9 million) and cost of cleaning smoking litter (£1 million).

Tobacco Control refers to a co-ordinated and comprehensive approach to reducing the prevalence of tobacco use. The comprehensive tobacco control agenda requires a structure that supports clear accountability and strategic decision-making as well as allowing for a wide range of partners with different fields of expertise and interests to engage at different levels across a wider geographical area. Dudley is a key member of the Black Country Tobacco Control Alliance and have benefitted from shared cross boundary working to address key challenges specifically around illicit and counterfeit tobacco.

The current Tobacco Control Strategy for Dudley – 'Creating A Smokefree Generation' was based on meeting Government 2010 targets and is undergoing a review and update to bring this programme of work into line with new national data and local priorities. Health Scrutiny can help shape local approaches to inform this process.

Terms of reference

The review panel was established October 2013, following approval of the Committee's 2013/14 work plan specifically to:

- evaluate effectiveness of partnership working in reducing overall prevalence and assess outcomes of local strategy
- spotlight challenging areas and discuss possible solutions involving partner organisations
- assess measures geared to minimise uptake of smoking amongst young people and tackle consumption of illicit products across areas of high smoking prevalence
- evaluate the current level of involvement and contribution of key public employers to the promotion of smoking cessation and prevention services for staff.

Recommendations will be framed into a multi-agency action plan for consideration by the Overview and Scrutiny Management Board in the spirit of

embedding closer links with executive policy development; envisaged in new scrutiny procedures.

2. Summary and Recommendations

After receiving evidence from key witnesses and experts in the field (across two member led workshops) outlined in this report the Committee makes the following recommendations.

Smoking is a major problem for public health and public services both nationally and locally. Within Dudley it is estimated to be the cause of over 480 deaths; and has a strong bearing on inequalities of life expectancy.

Collaborative working has enabled a holistic approach to Tobacco Control; outcomes of partnership strategy clearly demonstrate the benefits and commitment to closer working between the Council, Public Health and NHS in addressing public health priorities. Smoke-free legislation has helped to protect people in public places from the health risks of second hand tobacco smoke and challenged the perception that smoking is a normal behaviour. However, there is a long way to go to denormalise tobacco use and achieve a society that is free from the harms of tobacco for future generations.

Recommendation One – Stop Smoking Services

Identifying community groups with high smoking prevalence is important, particularly if tobacco control activity is to be targeted for best effect. The National Institute for Clinical Excellence concludes reducing smoking prevalence among people in routine and manual groups, some BME groups and disadvantaged communities will help reduce health inequalities more than any other public health measure. As such the panel recommends this measure is taken on board as part of the strategy development through challenging local targets, supporting targeted groups and monitoring progress over time.

The NHS stop-smoking service is successful but only reaches a small part of the smoking population. Access has reduced over the last 2 years particularly within GP services. Alternative community based access needs to be explored in the light of Dudley's increasingly diverse communities. As such the panel recommends that tobacco control activity takes place within community settings to increase accessibility and use. Scope, feasibility and cost benefits should also be explored in commissioning voluntary and community sector to deliver cessation services in maximising participation across all community groups.

The panel recognise different groups require different methods of engagement. Consulting BME communities can help shape improved and relevant interventions and services. Reaching these smokers often means delivering services in different ways, and so methods to best access more of these target groups should be explored.

Evidence indicates health care professionals can play a pivotal role in delivering cessation support and facilitate appropriate referrals across patient journeys. Barriers exist to health & social care workers being empowered to consistently deliver this support. More health professionals and front-line staff should receive suitable training to have the confidence to administer this important public health role.

The Family Nursing Partnership (FNP) work intensively with young mothers-to-be aged 16-19 years old. Stop smoking support is available through motivational interviewing techniques and provision of smoking medications. Support continues into the postnatal period based on national evidence based cessation training. FNP assessment represents a systematic challenge on perception and attitudes towards smoking among young parents and new families; contributing to a shift in thinking of tobacco use being normal. However, the FNP lead stated in the workshop that they are currently not able to provide more intensive stop smoking support because the service is not staffed at full capacity levels. As such, the panel is keen that the FNP is commissioned to recommended capacity; with the particular aim of accelerating reduction of tobacco use across new families.

During the review, members were made aware of particularly high smoking prevalence among mental health service users. Clearly this adds to their health inequalities. However members did not have occasion to assess access to support services across in-patient and primary care settings. Particular focus on support for mental health service users should be explored as a potentially significant health improvement issue.

The Committee recommends that:

- tobacco control interventions should be closely integrated with community health services, community based and shaped around Dudley's range of community groups through specific engagement on: what would best help them to quit; what support areas are important to them; effective communication to educate smokers on the harmful effects of smoking.
- Council and Public Health explore the scope and feasibility of a distinct intervention programme for mental health service users helping them to quit smoking to reduce contribution of on-going health inequalities.
- Public Health promote tobacco control and cessation support across community champion's from particular groups that have been identified as high risk e.g. people in routine and manual groups, some BME groups and disadvantaged communities.
- Dudley CCG commissions Family Nursing Partnership to recommended capacity with the particular aim of accelerating reduction of tobacco use across new families. The service should encourage a focus on communities identified as high-risk.

Recommendation 2 -Young People-Tobacco Education

Delivering a consistently strong message across younger people is imperative in creating a society free from the harms of smoking for future generations. Different and more creative engagement methods should be used to better identify with young people such as special events co-ordinated through the Kick–Ash programme. Updating the local strategy is an opportunity to strengthen how tobacco control is delivered across younger people both inside and outside school settings. Members are particularly keen to see the Kick-Ash programme being extended across the school network targeting a younger age group as a first step in creating a significant shift in social attitudes towards smoking among young people. Research shows that the best way to stop children from smoking is to get those around them, particularly their parents to stop.

The National Tobacco Control Strategy states "the merits of establishing smoke free areas for all children's play areas" will be considered. More work is required to further denormalise tobacco use, for example by having smoke-free children's play areas to promote smoke free awareness. As such a voluntary smoke-free code for children's play areas is encouraged to empower local communities themselves to change their smoking behaviour.

The Committee recommends that:

- Council and Public Health review how tobacco control education is delivered in schools and consult with the Youth Parliament on the development of an improved programme. The Kick-Ash scheme should be central to future plans in embedding the best, evidence-based methods of providing tobacco control education to young people with a focus.
- Council should explore implementation of a voluntary smokefree code/policy across outdoor play areas in the spirit of other Council trailblazers empowering communities themselves to change their smoking behaviour.

Recommendation 3 – Leadership, Partnership and Communication

Local authorities now have a leading public health role. Raising the profile of tobacco control should be encouraged within the local authority by appointing a lead member to champion the issue; secure council-wide support; raise awareness among partners and in the community; and to keep tobacco control at the forefront of the health and wellbeing agenda.

Given the integration of public health, it is easier for Council services to navigate tobacco control and make appropriate referrals. It follows that there is potential for other Council services to contribute to the tobacco control agenda through contact with wider communities and socially isolated groups. These services might include Dudley Council Plus, front line staff within libraries, leisure services, Community Care and Housing Management

Services etc. The Panel is keen to incorporate interventions and referrals to stop smoking support across these services to maximise impact of tobacco control measures.

Tobacco is expensive and concerns remain about increased demand elasticity for illicit and counterfeit products, particularly among younger people in the light of tax levies and broader economic challenges. Housing Managers and Trading Standards should remain vigilant across high prevalence areas and target so called 'fag houses' to accelerate smoking reduction. Members suggested using Housing Home Checks to feed intelligence led enforcement.

There is a worrying grey area when it comes to e-cigarettes that needs to be addressed. Members are concerned that the growing popularity of e-cigarettes could undermine years of anti-smoking efforts, with particular concerns about promotion to children and non-smokers. There are no age restrictions in statute affecting the sale of e-cigarettes. Dudley's Pharmaceutical Needs Assessment should be sensitive to these concerns and to restrict sales across affiliated outlets to over 16s. This could be extended across the commercial sector by canvassing organisations to pledge an action under the 'Smoke Free Generation' programme.

The Committee recommends that:

- Public Health, Trading Standards and Housing Services review areas where enforcement and educational activity can be combined. (e.g, when carrying out compliance duties, officers identify an opportunity to refer, educate or advise about accessing support services for smoking).
- Training to be provided for frontline staff undertaking statutory / enforcement duty (ideally smoking advisor level 1) enabling a consistent tobacco control message and systematic cessation support across all community groups.
- A local champion for Dudley is identified to raise the profile of tobacco control across partnerships with a seat on the Tobacco Steering Group.
- Council explores how Adult Social Care, Libraries, Customer services, Leisure services and Housing Services, particularly through routine Home Checks, can assist with the promotion of smoking cessation. We recommend at least level 1 advisor training empowering staff to make referrals.
- Council explores how routine Housing Services Home Checks can be developed to accelerate the reduction of counterfeit and illicit sales.
- The PNA should be developed to exclude sales of e-cigarettes to under 16s across affiliated retail outlets. This should be followed-up by a campaign for organisations to pledge an action under the 'Smoke Free Generation' programme.
- Public Health and Trading Standards develop clear communication channels for Council members and the public to whistle blow underage sales tobacco and counterfeit/illicit trade; in the spirit of local intelligence-led enforcement**.**

Conclusion

Smoking is a significant determinant of inequality in life expectancy. Continued investment in reducing smoking prevalence and increasing cessation will be key to realising ambitions to close the gap in health inequalities; envisaged in local Joint Health and Well Being Strategy.

A lot of frank views were expressed and resonating at the heart of this review was the call for more preventative work targeting younger people; along with greater controls and support across communities experiencing highest smoking prevalence. Whilst improving local knowledge about key community groups and smoking prevalence, agencies should consider what incentives could be given to shift behaviours and challenge current perceptions and thinking of tobacco use in communities being normal.

Overall, anti-smoking policies are seen as cost-effective health interventions which deliver revenue benefits to public finances as well as wider social benefits. Scaling back investment in tobacco control would more than likely result in net revenue losses rather than gains to increasingly constrained budgets.