NHS
Dudley
Clinical Commissioning Group

Primary Care Development Strategy

2013

Our Values:

We will be a **caring** organisation

We will be a **patient-centred** organisation.

We will **work together** as teams within the organisation and with partners

Quality and **safety** will be the foundation of everything we do.

We will be an organisation which **leads** by example.

We will be a **learning** organisation.

We will be an **inclusive** organisation.

We will have a focus on prevention and **health** promotion.

We will be an **innovative** organisation.

We will promote excellent **financial** management.

Foreword

Primary care is facing unprecedented challenges.

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

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

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

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

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

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

Dr. Jas Rathore
Clinical Executive
Finance and Performance

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

Primary Care Development Strategy Summary on a Page

Our Vision and AIms

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

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

Priorities for Developing Primary Care

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

Local Clinical Priorities for Primary Care

Local Quality Premium Areas	Quality and Productivity Indicators in QOF
Dementia	OPD Pathways: Cardiology, Pain Management, Ophthalmology
Atrial Fibrillation	Reduction in Avoidable A&E Attendances
Hypertension	Emergency Pathways: Atrial Fibrillation, Acute Asthma, Frail Elderly UTIs

To contribute to the CCG's wider strategic priorities for improving health & health services

Related CCG Strategies and Policies

Premisis Planning Framework	CCG Communications and Engagement Strategy	CCG Research and Development Strategy
CCG Innovation Strategy	Quality Monitoring Process	CCG Financial Plan
CCG OD Strategy	-	CCG IT Strategy

1. Introduction

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

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

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

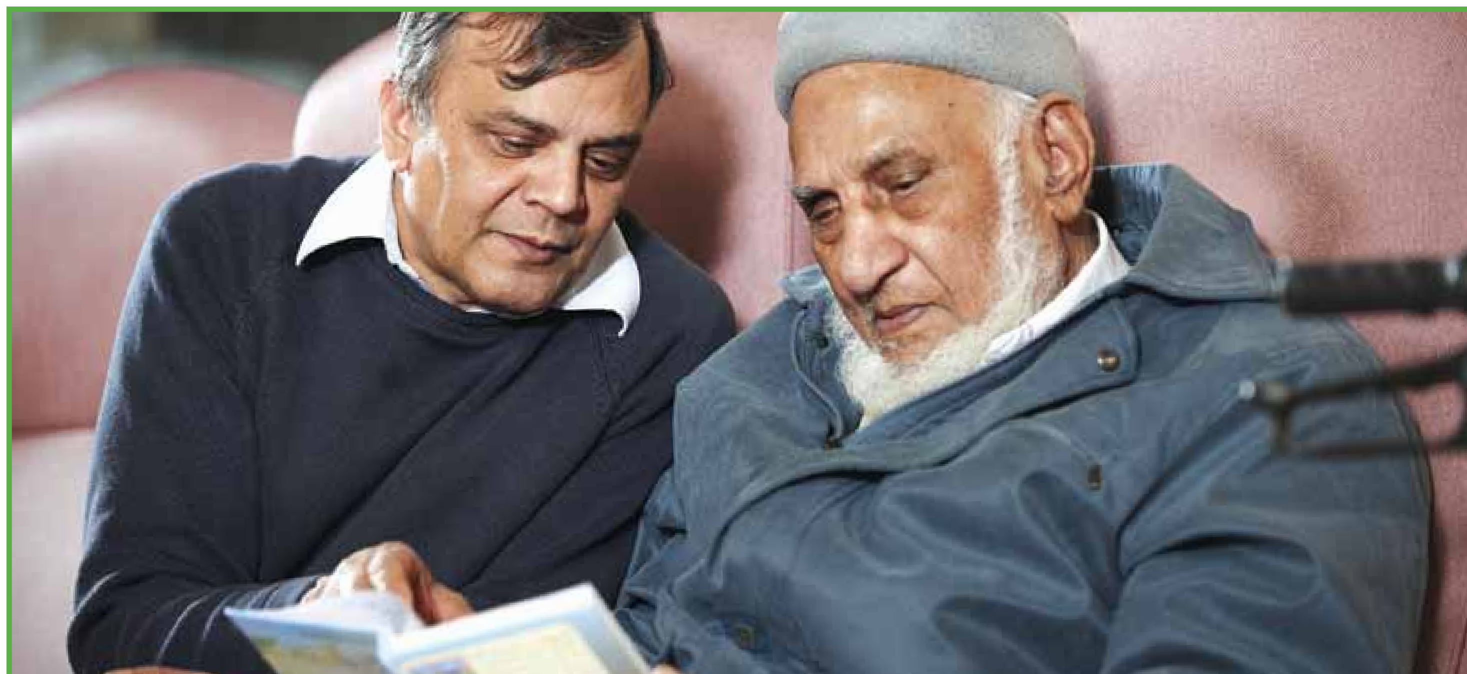
The priorities set out in this strategy are based on:

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

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

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

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



2. Vision and Aims

The vision for primary care in Dudley is:

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

The **aims** of the strategy are:

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

3. Arrangements for Commissioning Primary Care from April 2013

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

NHS England commissions national primary care services. They hold primary care contracts and are responsible for planning, securing and monitoring services commissioned by them in respect of primary care.

CCGs are responsible and accountable for commissioning local enhanced services. In addition, CCGs have a statutory duty to assist and support NHS England in securing continuous improvement in the quality of primary medical services.

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

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

4. Scope of the Strategy

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

5. Primary Care in Dudley

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

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

Facts and Figures

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

Surgeries by Locality

Sedgley, Coseley and Gornal

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

Kingswinford, Amblecote and Brierley Hill

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

Dudley and Netherton

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

Halesowen and Quarry Bank

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

Out of Area

39B Cradley Road Surgery (Wychbury Branch)

Stourbridge, Wollescote and Lye

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

Data correct as of April 2013

6. Challenges Facing Primary Care in Dudley

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

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

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

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

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

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

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

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

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

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

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

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

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

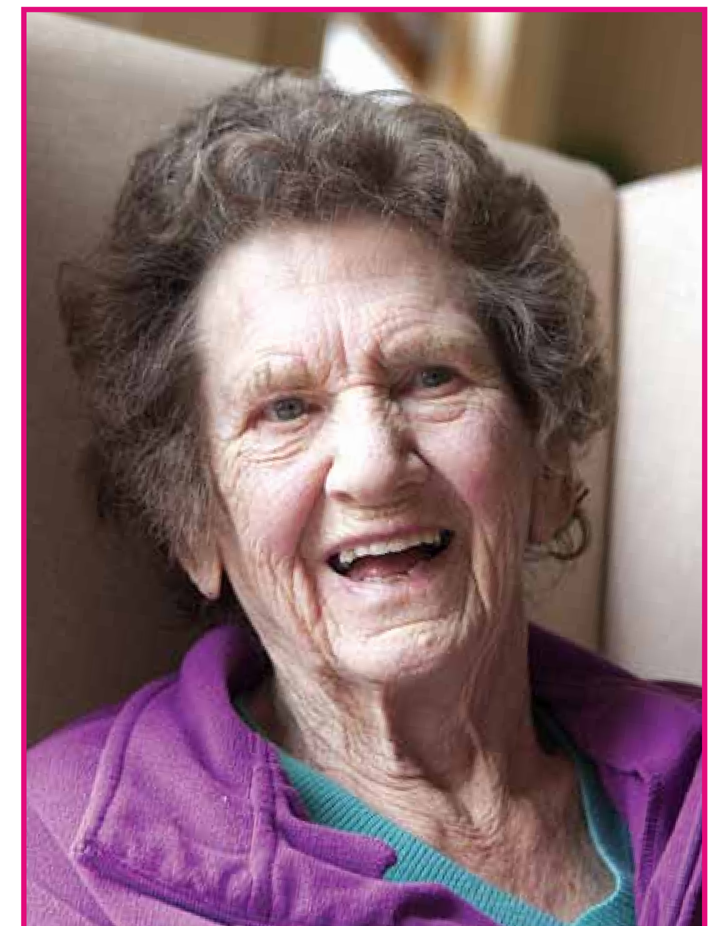
7. Being Accountable to our Patients and Communities

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

Patient Concerns

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

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



8. Priorities for Primary Care Development

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

Managing Workload and Improving Access

Why this is a priority

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

Whilst the average national list size per GP has dropped since over the last 20 years, the average consultation rate has risen. (The consultation rate is the average number of consultations per patient on the practice list, per year.) The current average consultation rate across Dudley is 5.26, which is marginally below the expected rate of 5.62. (The expected rate is the rate adjusted for local demographic characteristics.)

National trends have seen a fairly stable trend upwards since 1994 when the rate was 3.5 and rising by about 1 per decade. Most of this is driven by increasing numbers of treatments and procedures available in the community, less hospital based follow up and an aging population living longer with more disease.

None of these factors have eased during the last 5 years since the latest national consultation rate figures were published and the local Dudley rates, (calculated in March of this year, would appear to demonstrate that this trend has continued. The impact of this rising trend is huge for individual practices. For example, for a practice with a list size of 10,000 patients, an increase of 1 in the consultation rate represents an additional 10,000 consultations per year, (nearly 200 per week) which need to be accommodated. This rise in demand has not been matched by an increase in resource within primary care.

Solutions

- The CCG has funded the Primary Care Foundation to conduct a **baseline audit** of the current workload in terms of appointments, telephone traffic, opening times etc. This is helping individual practices to quantify the pressures on their current capacity, identifying where and when these are greatest. This will inform **individual practice development plans**. There is some evidence to show that some relatively simple modifications can improve patient satisfaction and help to make the workload more manageable. The PCF has therefore been working with practices to identify modifications to current working practices to help them better manage demand. The headline findings from this work when taken collectively have also helped the CCG to identify the key issues and help to produce plans to mitigate these pressures. The key messages are:
  - The need to improve **continuity of care** for patients – there is good evidence that this reduces emergency admissions, leads to reduced consultation rates and, as this is also the top of the majority of patients' wish lists, improved patient satisfaction
  - The need to ensuring **effective telephone response**
  - The need to **re-balance practice systems**, particularly appointments systems, to ensure that, as far as possible, they do not work against continuity of care. (As the expected consultation rates are adjusted to account for local demography, a higher consultation rate is not normally an indication of a greater health need or a more deprived population. Rather, it is often an indication that patients are being seen more often than is necessary for the overall health needs of the practice population. This can be caused by a number of factors, but foremost amongst these is practice systems which work against continuity of care)
  - There is evidence of a link between high patient satisfaction scores and high QOF scores and vice versa. In addition, there is evidence that **ease of access for patients can affect their use and interaction with those services and therefore any connected services e.g. A&E.**
  - Need to review current practice with regard to the **clinical assessment of home visit requests** to ensure that requests are assessed quickly and any resulting urgent home visits are completed earlier in the day.

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

- Ensuring that the CCG thinks carefully about **the way in which it procures additional services** from primary care (including any new **Local Enhanced Services (LES')**. This includes:
  - Planning new procurements carefully and avoiding hurried introduction of new schemes
  - Ensuring procurements cover a time period which is long enough for practices to make sensible choices regarding any additional staffing to cover the procured service requirements and ensure that this represents a genuine increase in capacity within primary care where this is required
  - Newly procured services should be monitored to ensure they are delivering the agreed improvements for patients and commissioners. This includes agreeing in advance the outcome measures and the action which should be taken if these outcomes are not being achieved either by individual practices or across the board.
  - Ensuring that the improvements afforded by the introduction of newly procured services in primary care will be available to all patients across the CCG area irrespective of which practice they are registered with.

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

Developing Integrated Locality Based Services

Why this is a priority

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

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

Solutions

- the CCG will support the **development of the role of localities**, to enable them to gain more control over the development of services within their area. This will **promote integration** between local health services and also **with social services and other community and voluntary groups**.
- The CCG will develop plans to **commission 'community' services** in a way which requires providers to ensure they are **locality based and are directly linked to individual practices** (or groups of practices) to enable a more integrated approach to planning and delivery of services within the locality.
- CCG members will agree a **minimum range and quality of services** which will be available, (over and above core GMS), at practice and locality level. Building up a core of services based around **multi-disciplinary teams** and extended teams including primary care based mental health services, psychology services, pharmaceutical advisers, counsellors etc.
- Developing **locality based education, research and training.**
- Further work to learn from best practice elsewhere, where moves towards community-based multi-**professional extended primary healthcare teams based around general practices** that include generalists working alongside specialists and care coordinators have delivered significant improvements in patient experience, outcomes and satisfaction.
- The CCG and localities will support **closer working between practices** in order to ensure that the full range of services are available to all patients within their locality irrespective of which practice they are registered with. In addition, closer working should help practices to build resilience and manage costs. This will need to be done in a way which does not undermine continuity of care for patients.
- Localities will build links with local community and voluntary sector groups to further support the delivery of coordinated care for patients.

Managing the Shift from Secondary to Primary Care Service Provision

Why this is a Priority

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

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

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

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

Solutions

- The CCG will commission **improved access to diagnostics and secondary care advice** e.g. extending direct access to imaging and electrophysiological diagnostics. Commissioning more accessible specialist advice without the requirement for an outpatient appointment.
- The CCG will make **further use of Local Enhanced Services** (or other procurement vehicles) which ensure that primary care is appropriately resourced to develop and participate in new care pathways which address local priorities and provide better services for patients.
- The CCG will develop a comprehensive and **innovative IT Strategy** which supports better coordination and integration across services and allows commissioners to track spend at each stage of the patient journey.
- Ensuring that the primary care aspects of the CCG's strategy for **Long Term Conditions** are appropriately implemented via specifically commissioned services and care pathway development and implementation for conditions such as diabetes, rheumatic diseases, knee replacements, hip replacements, gallstones etc.
- The CCG will consider the further development of **locality attachments for hospital consultants** based on the paediatrics model currently being implemented. This will promote closer working and learning and education.
- The CCG will ensure that local **Quality Premium** targets are introduced in a way which enables Primary Care to be supported to deliver them.
- The CCG will seek to ensure that **primary care premises** are developed to support service delivery in primary care settings where this is clinically appropriate.

Urgent Care – Primary Care's Role

Why this is a priority

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

PATIENT COMMENTS

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

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

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

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

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

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

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

"Standardised set up for all GP practices with criteria"

"Better telephone access to GP surgery"

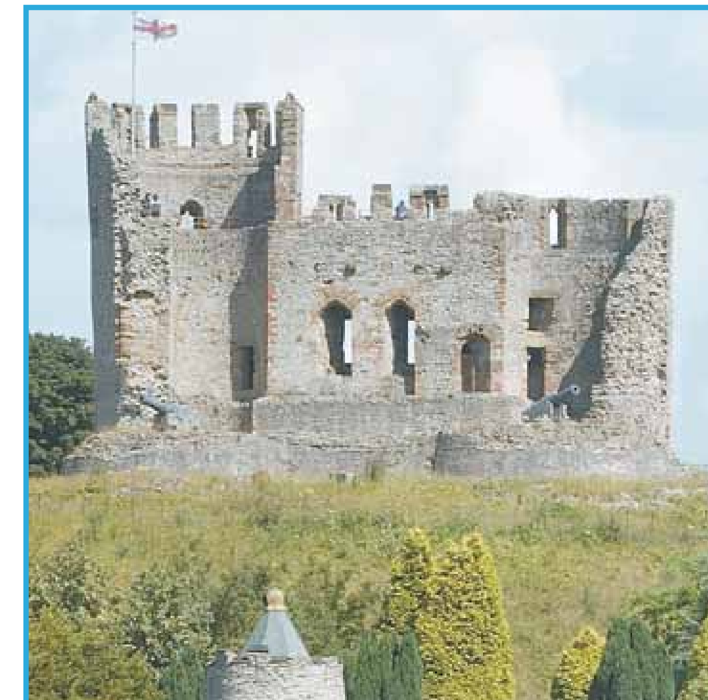
Solutions

- To ensure that the **CCG's Urgent Care Strategy takes full account of primary care's current and potential contribution** to managing urgent care across Dudley.
- to develop and evaluate a pilot scheme which sees **a step change in the quantum and nature of primary care commissioned with the express aim of reducing avoidable A&E attendances and admissions**, and improving coordination and integration across services in and out of hours.
- To take a pro-active and appropriate approach to consider the role of primary care in relation to **innovative responses** to the national move towards **7 day primary care and community services** and the availability of key health and social care services at evenings and weekends. To work with local practices to design solutions which fit local circumstances and meet the needs of patients and practices.
- To ensure that the urgent care strategy includes specific actions such as the use of risk stratification tools, clinical decision support software within GP practices, and a range of relatively simple primary care based interventions to improve the early identification and **successful management of ACS patients**
- Other **primary care based aspects of urgent care** will also be reviewed within the context of the urgent care strategy including:
  - disease management and support for self-management for those with long-term conditions (see also workload section above)
  - telephone health coaching
  - increased continuity of care within GP practices (see also workload section above)
  - ensuring effective out of hours arrangements
  - providing effective signposting to help patients choose the right service
  - the ability to flex primary care and community services in response to short-term changes in demand
  - processes within practices for the timely review and management of requests for home visits (see also PCF work above)
- The **use of real time information and IT** to support early decision-making in primary care

Building Resilient Primary Care and Supporting Practices to Thrive

Why this is a priority

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



Solutions

- **Close working with the NHS England local area team** to ensure that the CCG has some influence over the direct commissioning of primary care, for example following the retirement of a single-handed practitioner, and can shape local services in line with agreed local strategies.
- To compile clear plans based on the **detailed modelling of anticipated local changes** e.g. retirements, premises changes, income changes.
- Supporting each member practice to develop a **practice Organisational Development plan**, (which also meets AT requirements), and to ensure that wider CCG strategies and plans reflect these individual plans
- Support practices (and practice managers) to explore **cooperative approaches** within a locality model, (where this is desirable and supported by local practices) e.g. sharing 'back room' functions e.g. payroll, centralising call and recall, choose and book. NB such cooperative models could be of any size or shape (of 2 practices or more) to suit local practice requirements and would not need to encompass a whole locality
- To develop a **CCG based primary care support team** with senior clinical and managerial leadership
- To explore the establishment of **a shared locum bank** for local practices in order to improve quality and effectiveness of locums
- To support and **further develop the practice managers' group** to lead innovative solutions to issues facing primary care and to support high quality practice management consistently across the CCG area
- Develop a **practice nurses group** to provide professional support, lead innovative solutions to service provision in primary care and support high quality service provision consistently across the CCG area
- To **increase the number of training practices** in Dudley
- To **continue initiatives which support and enable member practices to participate in the work of the CCG and be kept informed**. For example, the practice engagement LES which supports practice attendance at meetings, improving practices' ability to engage with the CCG support team and produce practice development plans
- To **support workforce training and development**, (e.g. CCG wide procurement where this benefits members), developing the mentorship schemes, statutory training/revalidation/support, remediation etc The CCG will ensure appropriate links with education and training networks including Local Education and Training Boards (LETB's)
- To develop the **Primary Care Quality Monitoring Group** to ensure on-going close liaison between the CCG, the AT, LMC and Responsible Officer. (See diagram Attachment 4)
- To ensure that the **CCG Organisational Development Strategy has an emphasis on supporting the development of CCG members.** This should set out how CCG members will work together to support each other to build a strong, high quality CCG, and how CCG membership benefits members and ultimately their patients.

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

GP Engagement and Membership Development

GP Lead: Jas Rathore

5 Locality Groups

- Locality Commissioning
- Closer Working Between Practices
- Peer Review
- Developing PPGs
- Primary and Community Integration
- CCG Accountability

GP Lead: 5 GP Chairs

Practice Performance

- National Quality Dashboard ↔ NHSE Contract and Performance
- Quality Productivity Indicators
- Individual Practice Visits
- Commissioning Scorecard By Practice
- Understanding Patient Experience
- Implementation of Quality Premium

GP Lead: Richard Gee

Workforce Development

- GP Mentorship Programme
- Practice Nurse Mentorship Programme
- Practice Manager Mentorship Programme
- Monthly GP Education Events
- Developing GPSIs ↔ GP Appraisal
- Annual Quality & Productivity Peer Review

GP Lead: David Parry

Business Support

- Productive Practice
- Improving Patient Access
- IT Infrastructure and Systems
- Business Information (MiCS) ↔ Premises Investments Programme
- Supporting Premises Development
- Practice Manager Alliance

Reducing Unwarranted Variation and Rewarding Excellence

Why this is a priority

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

Solutions

- The CCG will complete further work to **share detailed benchmarking information** regarding primary care service delivery with practices and agree actions arising from this.

- CCG members will agree a **process for monitoring and managing primary care** performance against the national assurance framework (and any locally agreed indicators), and will work closely with NHS England local Area Team to ensure that local knowledge is applied to raw data.

- The CCG fully acknowledges the central role practice managers have in the delivery of high quality primary care services and will work with practices to **ensure all practices have access to consistently high quality practice management and organisational skills**. There is good evidence to demonstrate that the achievement of clinical priorities (particularly those related to prevention and management of long term conditions), are directly influenced by how well practices can organise their activities to ensure that they consistently reach all targeted patients. In addition, those areas which are of most concern to patients i.e. access to appointments etc. are those which are most directly affected by the way in which the practice is managed.

- The CCG will **build on the PMS Review work** undertaken by the PCT to agree further quality measures with practices and support sustainable moves towards equitable resource distribution. In doing this the CCG will work with the NHS England local Area Team to take account of national initiatives in this respect.

- CCG members will agree a **scheme which incentivises** good performance against agreed indicators and rewards excellence as judged against national benchmarks.

- The CCG will ensure that methods of **procuring services** from primary care will ensure equality of access for all patients.

9. Clinical Priorities for Primary Care

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

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

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

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

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

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

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

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

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

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

11. Measuring and Monitoring Quality in Primary Care

National Assurance Framework

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

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

Local Processes for Monitoring Quality

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

12. Premises

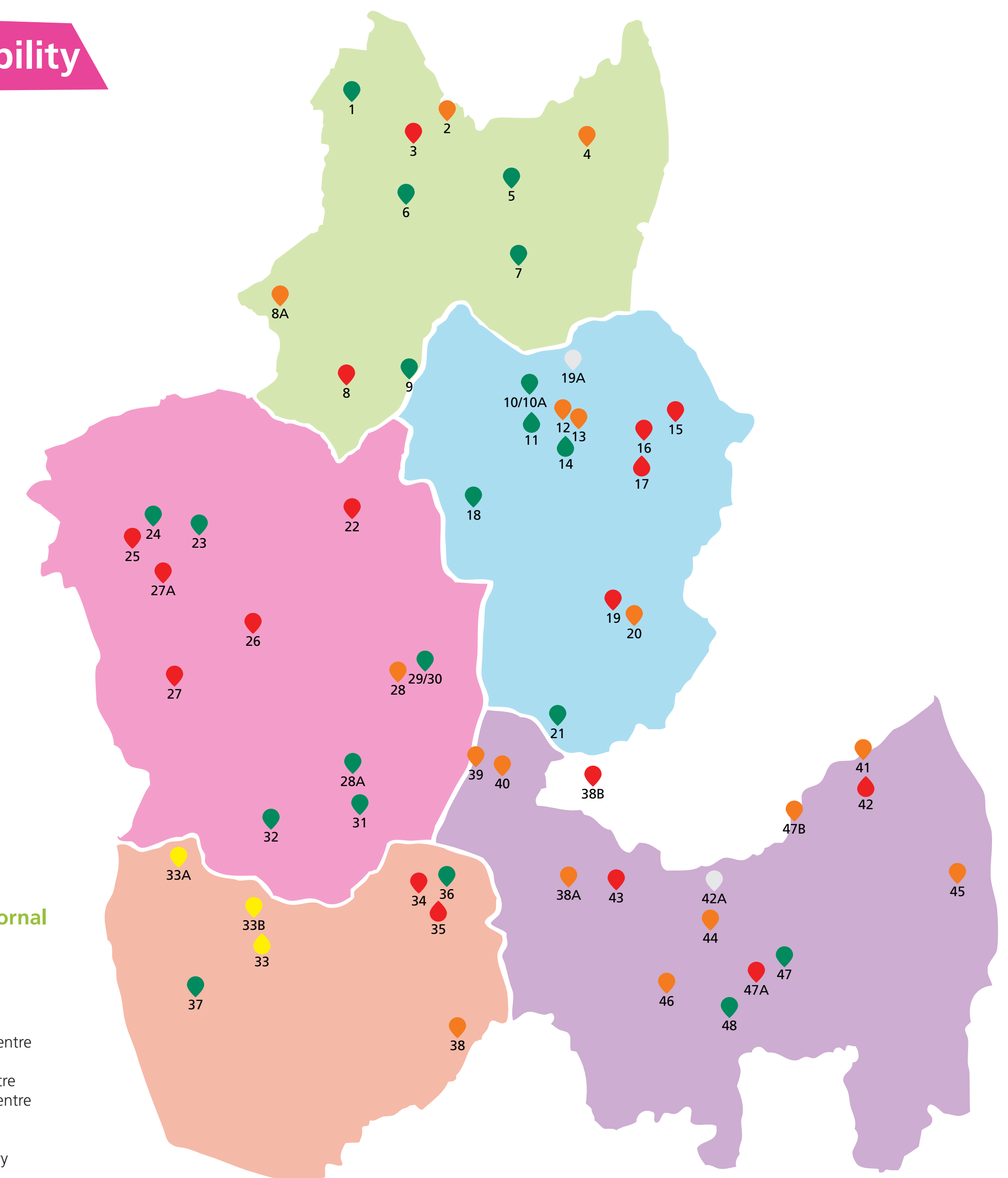
If the CCG is to respond local health needs and develop service models which provide opportunities for more integrated care, closer to patient's homes, primary care premises development will be essential. The CCG is fast moving towards a position where the lack of suitable premises will lead to sub-optimal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

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

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

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

Premises Suitability



Colour Key

Not Suitable
Limited Suitability
Suitable
Incomplete Data
New Premises Under Construction

Sedgley, Coseley and Gornal

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

Dudley and Netherton

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

Kingswinford, Amblecote and Brierley Hill

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

Stourbridge, Wollescote and Lye

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

Halesowen and Quarry Bank

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

Out of Area

- 38B Cradley Road Surgery (Wychbury Branch)

Data correct as of April 2013

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

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

Underlying Principles for Decision-making

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

14. Implementing the Strategy and Monitoring Progress

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

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

Strategic Commissioning Plan on a Page Summary

Our Vision:

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

What We Do:

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

Our Objectives:

Reducing Health Inequalities
- Reducing premature mortality
- Reducing emergency hospital admissions due to alcohol
- Reducing childhood obesity
- Reducing CVD mortality
- Improve AF review and treatment rates

Delivering Best Possible Outcomes
- Improve patient experience of healthcare (use of friend and family test)
- Increased early detection of dementia
- Reducing the levels of undetected hypertension and diabetes
- Improve access and choice of services

Improving Quality and Safety
- Reduce incidence of pressure ulcers
- Reduce unwarranted variations
- Reduce incidence of Clostridium Difficile
- Zero tolerance of MRSA bacteraemia
- Safeguarding children and adults

Our Commissioning Priorities:

Children's Services
- Reducing childhood obesity
- Safeguarding children

Improving Urgent Care
- Reducing avoidable emergency inpatient admissions

Primary Care Mental Health
- Improving the levels of diagnosis of dementia

Improving Care for Older People
- Reducing incidence of pressure ulcers
- Safeguarding adults

Improving Diabetes Services
- Reducing the levels of undetected hypertension and diabetes

Improving Access to Cardiology
- Reducing cardiovascular disease mortality

Ophthalmology Pathway
- Improving access to ophthalmology services

Improving Stroke Care
- Reducing mortality rate from stroke
- Improving AF review and treatment rates

Community Nursing Services
- Improving care to people with limiting long term illness, health problem or disability

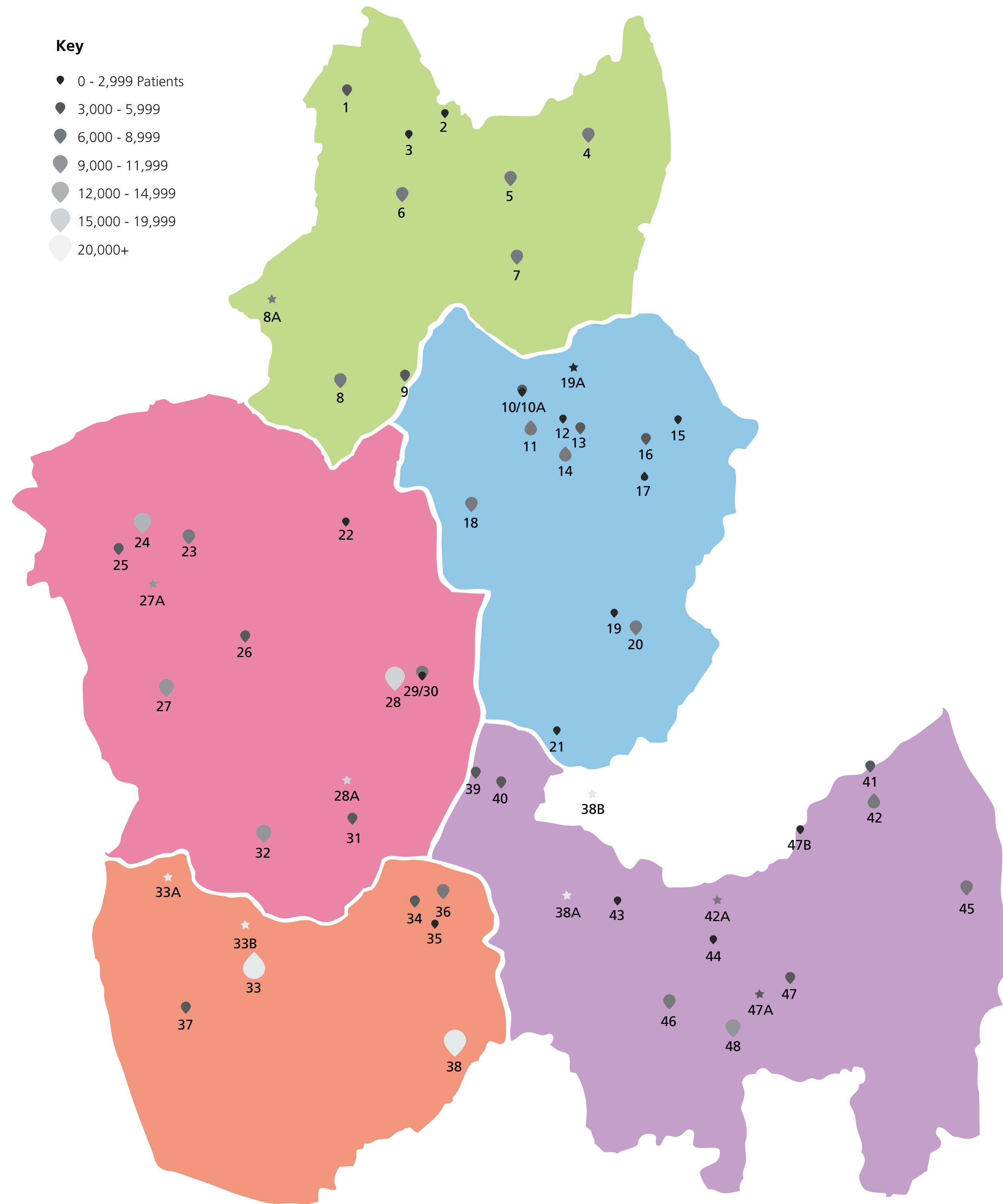
Alcohol Service
- Reducing emergency admissions linked to alcohol

Primary Care Strategy
- Supporting quality improvement in primary care sevices
- Reducing unwarranted variation in performance

Prioritisation of Resources
- Improving productivity to achieve financial sustainability
- Redesigning services to provide more efficient care to patients

Our Key Documents and Government Processes:

Surgery Patient List Sizes



Surgery Patient List Sizes Key

Sedgley, Coseley and Gornal

No.	Surgery	Patients
1	Northway Surgery	5,459
2	Bath Street Surgery	2,727
3	Bilston Street Surgery	2,999
4	Coseley Medical Centre	7,026
5	Woodsetton Medical Centre	6,328
6	The Ridgeway Surgery	8,994
7	The Greens Health Centre	7,754
8	Lower Gornal Health Centre	8,970
8A	Masefield Road Surgery (Lower Gornal Branch)	*
9	Castle Meadows Surgery	4,781

Dudley and Netherton

No.	Surgery	Patients
10	St James Medical Practice (Dr White)	2,307
10A	St James Medical Practice (Dr Porter)	5,135
11	Eve Hill Medical Practice	7,077
12	Tinchbourne Street Surgery	1,702
13	Cross Street Health Centre	4,363
14	Steppingstones Medical Practice	6,385
15	St Thomas's Medical Practice	1,205
16	Central Clinic	4,155
17	Bean Road Surgery	2,091
18	Keelinge House Surgery	6,351
19	Netherton Surgery	2,582
19A	Hazel Road Surgery (Netherton Surgery Branch)	*
20	Netherton Health Centre	7,253
21	Quarry Road Surgery	2,787

Kingswinford, Amblecote and Brierley Hill

No.	Surgery	Patients
22	High Oak Surgery	2,800
23	Kingswinford Health Centre	7,861
24	Moss Grove Surgery	14,685
25	Summerhill Surgery	5,644
26	Rangeways Road Surgery	5,049
27	Wordsley Green Health Centre	9,849
27A	Market Street Surgery (Wordsley Green Branch)	*
28	AW Surgeries	18,763
28A	Withymoor Surgery (AW Branch)	*

Kingswinford, Amblecote and Brierley Hill

No.	Surgery	Patients
29	Waterfront Surgery	6,418
30	Brierley Hill Health Health and Social Care Centre	2,151
31	Quincy Rise Surgery	3,218
32	Three Villages	9,346

Stourbridge, Wollescote and Lye

No.	Surgery	Patients
33	Worcester Street Surgery	24,995
33A	Meriden Avenue Surgery (Worcester St Branch)	*
33B	Greenfield Avenue Surgery (Worcester St Branch)	*
34	Pedmore Medical Practice	3,704
35	Chapel Street Surgery	1,877
36	The Limes Surgery	7,962
37	Norton Medical Practice	5,810
38	Wychbury Medical Group	21,395

Halesowen and Quarry Bank

No.	Surgery	Patients
38A	Chapel House Lane (Wychbury Branch)	*
39	Thorns Road Surgery	3,680
40	Quarry Bank Medical Centre	3,777
41	Clement Road Medical Centre	3,386
42	Feldon Lane Surgery	8,390
42A	Hawne Lane Surgery (Feldon Lane Branch)	*
43	Crestfield Surgery Ltd	1,555
44	Alexandra Medical Centre	2,884
45	Lapal Medical Practice	6,679
46	Meadowbrook Surgery	7,455
47	Halesowen Health Centre	4,871
47A	Tenlands Avenue Surgery (Halesowen HC Branch)	*
47B	Coombs Road Surgery (Halesowen HC Branch)	2,295
48	St Margaret's Wells Surgery	9,108

Out of Area

No.	Surgery	Patients
38B	Cradley Road Surgery (Wychbury Branch)	*

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

Data correct as of April 2013

NHS Outcomes Framework 2011/12 at a Glance

One framework
defining how the NHS will be accountable for outcomes

Five domains
articulating the responsibilities of the NHS

Ten overarching indicators
covering the broad aims of each domain

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

Fifty-one indicators in total
measuring overarching and improvement area outcomes

* Shared responsibility with Public Health England

**EQ 5D™ is a trademark of the EuroQol Group. Further details can be found at: www.euroqol.org

***Indicator also included in the Adult Social Care Outcomes Framework

Indicators in italics are placeholders, pending development or identification of a suitable indicator

1 Preventing people from dying prematurely

Overarching indicators

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

Improvement areas

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

Reducing premature death in people with serious mental illness
1.5 Under 75 mortality rate in people with serious mental illness*

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

2 Enhancing quality of life for people with long term conditions

Overarching indicator

2 Health-related quality of life for people with long-term conditions (EQ-5D)**

Improvement areas

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

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

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

Enhancing quality of life for carers
2.4 Health-related quality of life for carers (EQ-5D)**

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

3 Helping peopleto recover from episodes of ill health or following injury

Overarching indicators

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

Improvement areas

Improving outcomes from planned procedures
3.1 Patient-reported outcomes measures (PROMs) for elective procedures

Preventing lower respiratory tract infections (LRTIs) in children from becoming serious
3.2 Emergency admissions for children with LRTIs

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

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

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

Helping older people to recover their independence after illness or injury
3.6 The proportion of older people (65 and over) who werestill at home 91 days after discharge from hospital into rehabilitation services***

4 Ensuring that people have a positive experience of care

Overarching indicators

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

Improvement areas

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

Improving hospitals' responsiveness to personal needs
4.2 Responsiveness to inpatients' personal needs

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

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

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

Improving the experience of care for people at the end of their lives
4.6 An indicator needs to be developed based on the survey of bereaved carers

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

Improving children and young people's experience of healthcare
4.8 An indicator needs to be developed.

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

Overarching indicators

5a Patient safety incident reporting
5b Severity of harm
5c Number of similar incidents

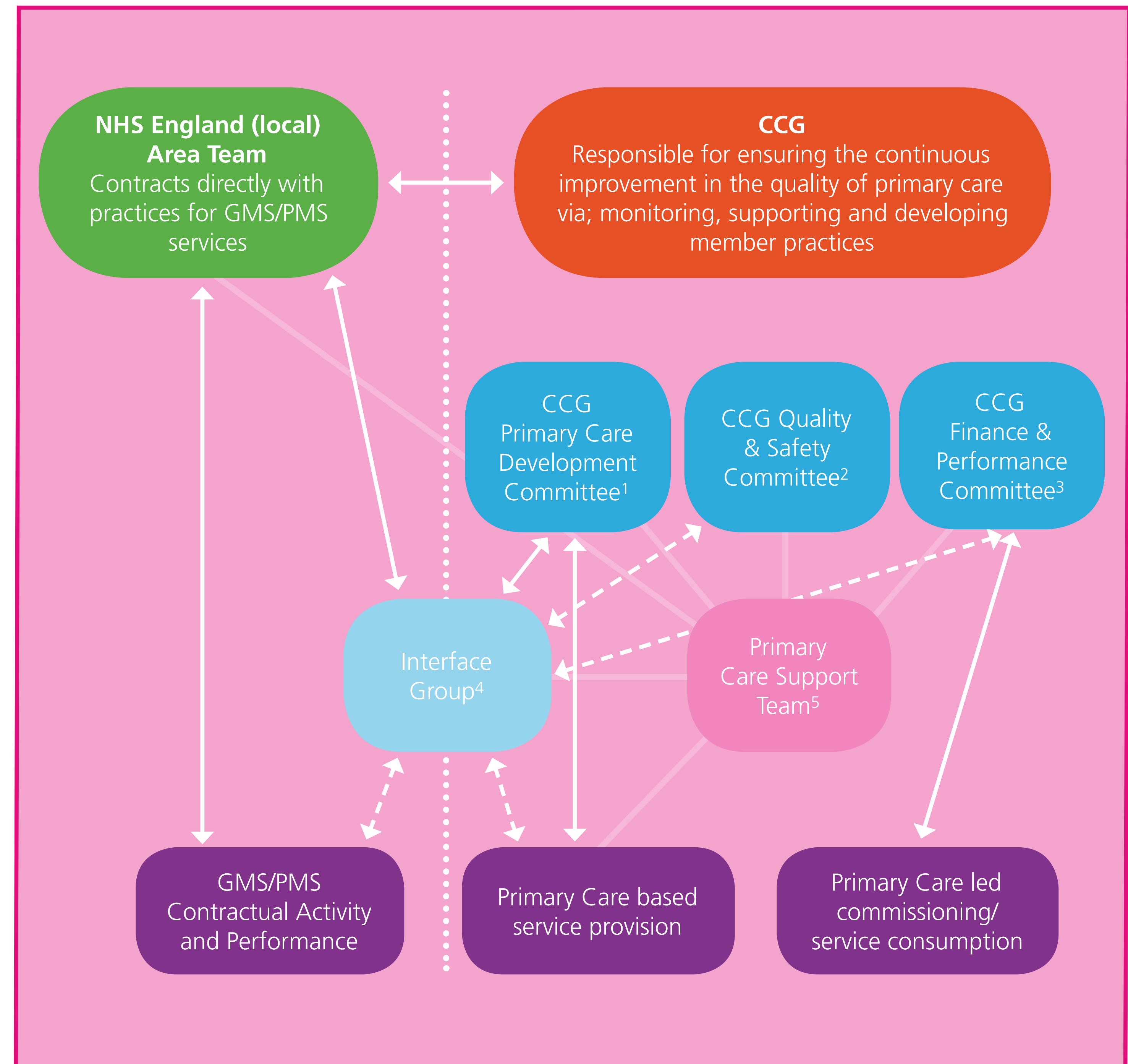
Improvement areas

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

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

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

Monitoring Quality in Primary Care - Proposed Process



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

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

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

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

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

Glossary: Abbreviations

Abbreviation	Meaning
A&E	Accident and Emergency
ACS	Ambulatory Care sensitive Conditions
AT	NHS England local Area team
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
CHD	Coronary Heart Disease
CIAMS	Commissioner Investment and Asset Management Strategy
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CVD	Cardio Vascular Disease
DES	Directed Enhanced Service
DNA	Did not attend
DoH	Department of Health
EMI	Older People with Mental Illness (Elderly Mentally Ill)
EPP	Expert Patients Programme
FOI	Freedom of Information
GMS	General Medical Services
GP	General Practitioner
GPAQ	General Practice Assessment of Quality
GPwSI	GPs with Special Interest
HR	Human Resources
HV	Health Visitor
IAPT	Improved Access to Psychological Therapies
IT	Information Technology
LETB	Local Education and Training Board
LES	Local Enhanced Service
LIFT	Local Improvement Finance Trust
LMC	Local Medical Committee
LTC	Long Term Conditions
MDT	Multi Disciplinary Team
NGMS	New General Medical Services
NHS	National Health Service
NICE	National Institute for Clinical Excellence
NRT	Nicotine Replacement Products
OD	Organisational Development
OPD	Out Patient Department
OOH	Out of Hours
PCDC	Primary Care Development Committee
PCF	Primary Care Foundation
PCT	Primary Care Trust
PMS	Primary Medical Services
POPS	Patient Opportunity Panel
PSA	Public Service Agreement
QIPP	Quality, Innovation, Productivity and Prevention
QMAS	Quality Management and Analysis System
QP	Quality Premium
QOF	Quality and Outcome Framework
SLA	Service Level Agreement
SSDP	Strategic Services Development Plan
THR	Total Hip Replacement
TKR	Total Knee Replacement
UTI	Urinary Tract Infection
WIC	Walk in Centre
WTE	Whole Time Equivalent

References

Bodenheimer T (2008).'Co-ordinating care – a perilous journey through the healthcare system'. *New England Journal of medicine, vol 358, pp 1064-70.*

Department of Health (2005). Supporting people with Long-term Conditions: An NHS and social care model to support local innovation and integration. London: Department of health

Dudley Primary Care Trust. *Primary Care Strategy 2009-14 - 'Reaching Excellence'.*

Health England (2009). Intervention Report: Report no 5.

NHS Information Centre. *Trends in Consultation Rates in General Practice 1995/1996 to 2007/2008: Analysis of the QSearch Database.* September 2008

Joint Health and Wellbeing Strategy - 'Wellbeing for life – our plan for a healthier Dudley borough 2013 -2016'.

The King's Fund (2013) Transforming our Healthcare System – Ten Priorities for Commissioners. (Revised version 1 April 2013)

Marmot Review (2010). ***Fair Society, healthy Lives: Strategic review of health inequalities in England, post 2010.*** London.

NHS Dudley. Commissioner Investment and Asset Management Strategy (CIAMS) 2010 -2015

Starfield B (1998). *Primary Care: Balancing health needs, services and technology.* Oxford: Oxford University Press.

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