Health Scrutiny Committee

Wednesday 16th July, 2014, at 6.00pm
In Committee Room 2 at the Council House, Priory Road, Dudley

Agenda - Public Session
(Meeting open to the public and press)

1. Apologies for absence.

2. To report the appointment of any substitute Members for this meeting of the Committee.

3. To receive any declarations of interest under the Members' Code of Conduct.

4. To confirm and sign the minutes of the meetings held on 27th March, 2014 and 8th April, 2014 as correct records.

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.

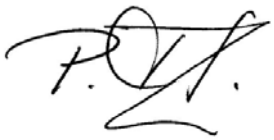
   Please note that a time limit of 30 minutes will apply to the asking of questions by members of the public. Each speaker will be limited to a maximum of 5 minutes within the 30 minutes.

6. Dudley and Walsall Mental Health Partnership NHS Trust – CQC Assessment Outcome Update

7. Update on Urgent Care Development

8. Work Programme 2014/15 (To Follow)

9. To consider any questions from Members to the Chair where two clear days notice has been given to the Director of Corporate Resources (Council Procedure Rule 11.8).



Director of Corporate Resources
Dated: 8th July, 2014

Distribution:

Members of the Health Scrutiny Committee:
Councillor Hale (Chair)
Councillor Elcock (Vice-Chair)
Councillors Barlow, Brothwood, Hanif, Hemingsley, Henley, Jordan, Roberts, E Taylor and Shakespeare

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- The Democratic Services contact officer for this meeting is Manjit Johal, Telephone 01384 815267 or E-mail manjit.johal@dudley.gov.uk

HEALTH SCRUTINY COMMITTEE

Thursday 27th March, 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, Roberts, Mrs Rogers, K Turner and Mrs Walker and Ms Pam Bradbury – Chair of Healthwatch

Officers

Democratic Services Manager (Acting 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 Haynes – Dudley Clinical Commissioning Group
Dr Narinder Sahota – NHS England
Dr William Murdoch – NHS England
Hardeep Kaur – NHS England

48 APOLOGY FOR ABSENCE

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

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49 DECLARATIONS OF INTEREST

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

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50 MINUTES

RESOLVED

That the minutes of the meetings of the Health Scrutiny Committee held on 23rd January, 2014 and 25th February, 2014 be approved as a correct record and signed subject to an amendment to Minute No 39 to record Councillor Roberts as having submitted an apology.

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51 PUBLIC FORUM

No issues were raised under this agenda item.

52 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 a Member referred to initial physiotherapy assessment appointments at Russells Hall Hospital and informed the Committee that appointments were allocated for thirty minute slots and not forty five minutes as stated and it was requested that this matter be brought to their attention.

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.

53 NHS ENGLAND

A report on behalf of NHS England was submitted together with a presentation on an overview of NHS England's plans to coproduce a primary care strategic framework and its development. Copies of the presentation slides had been included and attached to the report submitted.

Arising from the presentation given and in response to comments made and questions asked by Members, Dr Murdoch and Dr Sahota made the following points:-

- Confirmed that the data given with regard to flu vaccination for over 65s for all practices in Dudley related to the period 2011/2012 and that updated information was available on a monthly basis.

- It was stated that there were no links that receiving a flu jab resulted in the patient subsequently suffering from flu.

- Concerns relating to the continuing upward trend in people not receiving flu jabs and the lack of publicity on the importance of flu jabs were acknowledged. It was stated that the Board that considered vaccine uptake were aware of the problem and had already commenced plans to reach out and effectively deliver inoculations for the next period. Insofar as promotion was concerned there were various methods that could be used to notify and remind patients such as a personal letter from their General Practitioner (GP), via telephone or other social media such as sending a text.

  The suggestion in engaging bodies such as Age Concern with a view to administering inoculations at these Centres was a good opportunity to reach a lot of the elderly population, however, there were issues such as identifying the relevant patients' GP with a view to updating medical records.

- It was considered that it was good practice to make information publicly available for transparency purposes and data relating to the performance of GP practices was publicly available and could be accessed via the https://www.primarycare.nhs.uk website by registering on the site.

- Relating to concerns about people with diabetes not getting their blood sugar checked it was stated that targets in this regard had been increased and GP's were working hard to tackle the problem.

- Regarding comments made about the increasing pressure on existing GP's and the difficulties in recruiting new GP's it was commented that consideration was being given to addressing the issue and methods such as looking at alternative ways of working, remodelling the existing workforce and encouraging practices to network and share their work were being considered.

- In relation to monitoring of GP's it was commented that the Area Team conducted visits and the Care Quality Commission also undertook extensive in-depth visits tailored to individual practices with a view to ensuring compliance and that standards were being met. Assessments by the Area Team also involved speaking to patients that were in the building at that time. It was commented that the Area Team had limited resources and workload had to be prioritised to ensure that visits to practices with the greatest need were undertaken in the first year.

- With regard to comments made about the number of practices that achieved below average results in providing basic primary care services it was stated that the Primary Web Care Tool was a method that allowed practices to compare their performance to other practices with a view to improvements being made. Some practices were satisfied with achieving the minimum requirements and as long as practices were achieving and complying with their contract and their pertaining targets they were not in breach and there were no powers available to make them improve other than to make data publicly available.

- Referring to the query about how it was intended to improve the quality and calibre of service to residents it was stated that there was a two year plan in place together with a number of projects and it was hoped that improvements would be made by providing better access to GP's and addressing other concerns raised.

- Comments made about the need to educate patients and to inform them on the numerous changes to health were noted. It was acknowledged that confusion arose owing to the numerous points of contact available and it was considered that options for patients should be narrowed with a view to GP's being the first point of call. GP's were being encouraged to use different mechanisms with a view to engaging with their patients such as assessing patients by using video calls and the introduction of other methods to ease their workload such as sending electronic repeat prescriptions direct to local chemists.

In response to queries raised by Members, Dr Murdoch undertook to report back on the number of diabetics registered in Dudley and to seek clarification on the issuing of private prescriptions by GP's. The Chair also requested that an update report be submitted to a future meeting of the Committee.

RESOLVED

(1) That the information contained in the report and presentation given on NHS England's plans to coproduce a primary care strategic framework, be noted.

(2) That a further update report be submitted to a future meeting of the Committee.

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54 PATIENT PARTICIPATION GROUPS (PPGs) IN DUDLEY

A report of the Dudley Clinical Commissioning Group was submitted on progress made by the Group on developing a network of Patient Participation Groups.

Arising from the presentation of the report Members made the following comments:-

- There was a need to improve the quality of patient care and giving patients a stronger voice and PPG's sited at each practice was one of the many mechanisms available to consult with the community. However, it was considered that membership of PPG's should be increased to ensure that there was balanced representation to enable differing views to be captured.

- There were varying experiences of PPG's and examples were given whereby it was considered that some PPG's were not active enough and were not interested in engaging with their members.

- Concerns raised about the locality of PPG's which were sometimes not accessible for residents, PPG's were not publicised and GP's were not making the effort to get members on board.

- It was commented that there should be consistent resources allocated to all practices and it was queried what resources were available and whether practices were aware of the resources that were available to them.

- It was considered that it would be useful to spread best practice and reference was made to a report that had been published in this regard by the Patient Group.

In response to comments made above, Mr Haynes reported that resources and advice were available to GP's to assist them in setting up PPG's at their practices, however exact resources were not known. It was considered that PPG's should self-manage and it was up to individual practices to spend their resources effectively. It was further reported that there were no resources available to monitor PPG's and the Clinical Commissioning Group relied on feedback from this meeting and other Forums to bring matters to their attention. However, it was considered that improvements to PPG's had been made.

The Chair thanked Mr Haynes for the presentation of his report and requested that an update report be submitted to a future meeting of the Committee to include details of progress made, information on further publicity and details of resources available for PPG's. It was also stated that consideration be given to ensure that membership of PPG's was balanced and representative of the locality concerned.

RESOLVED

(1) That the information contained in the report, on progress made by the Group on developing a network of Patient Participation Groups, be noted.

(2) That a further progress report be submitted to a future meeting to include further information on publicity and the resources available to GP's for PPG's.

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55 COMMITTEE'S REVIEW OF TOBACCO CONTROL

A report of the Lead Officer to the Committee was submitted on key findings, observations and draft recommendations arising from the tobacco control review.

Arising from the presentation of the report reference was made to E-cigarettes and related advertisements which encouraged use by young people. Concerns were expressed about the unknown effects of using E-cigarettes given the lack of research and it was also considered that using E-cigarettes could potentially lead young people to smoke cigarettes.

RESOLVED

(1) That the information contained in the report, and Appendix to the report, submitted on the tobacco control review, be noted.

(2) That the draft recommendations as contained in the Appendix to the report submitted, be endorsed.

(3) That the Lead Officer, in consultation with the Chair, Vice-Chair and members of the Review Panel be authorised to oversee the final action plan based on the recommendations contained in the Appendix to the report submitted and to refer the Plan to the Overview and Scrutiny Management Board for consideration.

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56 SCRUTINY REVIEW 2013/14 – PATIENT EXPERIENCE IN ACUTE SETTINGS

A verbal report was given by the Scrutiny Officer on the Patient Experience in Acute Settings Scrutiny Review and a meeting would be scheduled to consider the matter.

RESOLVED

That the verbal report given on the Patient Experience in Acute Settings Scrutiny Review, be noted.

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57 QUESTIONS UNDER COUNCIL PROCEDURE RULE 11.8

Although there were no questions under Council Procedure Rule, 11.8, at this juncture, the Vice-Chair asked for a response to be given on whether there was any information available to identify national insurance contributions for the Borough.

The meeting ended at 8.00 p.m.

CHAIR

SPECIAL MEETING OF THE HEALTH SCRUTINY COMMITTEE

Tuesday 8th April, 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, Roberts, K Turner and Mrs Walker

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 P Maubach – Chief Accountable Officer (Dudley Clinical Commissioning Group)
Dr Steve Mann – Clinical Executive (Dudley Clinical Commissioning Group)
Mr Jason Evans – Urgent Care Commissioning Manager (Dudley Clinical Commissioning Group)
Mr Richard Haynes – Head of Communications (Dudley Clinical Commissioning Group)
Ms Jill Harvey – West Midlands Ambulance Service
Mr Nick Henry – West Midlands Ambulance Service
Mr Richard Beeken – Director of Operations (Dudley Group NHS Foundation Trust)
Mr David Stenson – Public Elected Governor (Dudley Group NHS Foundation Trust)
Ms Liz Abiss – Head of Communications (Dudley Group NHS Foundation Trust)
Mr Graham Hopper – Interserve

58 OPENING REMARKS OF THE CHAIR

The Chair welcomed those present to the meeting and following introductions outlined the procedure to be followed in relation to Agenda Item No 5 – Urgent Care Centre (UCC) Procurement and Draft UCC Service Specification (Version 0.9).

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59 APOLOGIES FOR ABSENCE

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

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60 DECLARATIONS OF INTEREST

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

61 PUBLIC FORUM

No issues were raised under this agenda item.

62 URGENT CARE CENTRE (UCC) PROCUREMENT AND DRAFT UCC SERVICE SPECIFICATION (VERSION 0.9)

A report of the Chief Accountable Officer, Dudley Clinical Commissioning Group was submitted providing an update on the design and procurement of the new Urgent Care Centre (UCC) that had been agreed at the Board meeting of the CCG on 9th January, 2014. The latest draft version of the UCC Service Specification had been attached as an Appendix to the report. The draft service specification had been considered by the Dudley Health and Well Being Board at its meeting held in March, 2014 and would also be submitted to the Healthcare Stakeholders meeting on 25th, April 2014 for consideration with a view to a final version being submitted to the CCG Board on 8th May, 2014.

The Lead Officer to the Committee briefly introduced the report and, in doing so, provided a background to discussions that had taken place at previous meetings and highlighted concerns that had been raised by Members. It was also reported that a series of questions had been submitted to the CCG in advance of the meeting for consideration and discussion at this meeting.

Mr Maubach then presented the report in detail, answered questions that had previously been submitted and made comments as follows:-

- The design of the UCC enabled patients to use it as a "walk-in" facility with a view to patients being triaged to determine their care and then being referred to the appropriate service from one location.

- Following approval of the UCC service specification consideration would be given to tendering for the provider of the triage service.

- A telephone system would also be operational whereby patients would be triaged at the point of call and, if needed, an appointment would be booked for attendance at the hospital.

- The final service specification would include a performance schedule and a particular key performance measure as referred to in the specification was the intention of 95% of all presenting patients at the UCC to be seen and discharged within a four hour timeframe.

- Problems in accessing General Practitioners (GP's) were acknowledged but it was stated that this was the preferred option for primary care.

- The proposal to base the facility at Russells Hall revolved around clinical reasons to integrate services and national guidelines had also stated that integrated delivery of services was best practice and the preferred model for the future.

- It was considered that people that were registered with a Dudley GP would receive a better, faster and more efficient service as all GP's had signed up to data sharing which would enable hospitals to gain immediate access to patients' medical history. Migration to the single standard system was currently underway.

Arising from the presentation of the report queries and comments were made by Members and pertaining responses given, as follows:-

- A Member expressed concern that residents he had spoken to had not wanted the facility to be based at Russells Hall Hospital and he was of the view that it was a "done deal".

  It was reported that outcomes from the consultation had been considered and covered in depth and that the Dudley Health and Well Being Board and the CCG Board had approved plans for the transfer to Russells Hall Hospital.

- Concerns expressed that people would have to pay for car parking and it was queried whether Russells Hall had capacity for the additional demand given the problems currently being experienced in finding a space. It was also queried whether consideration could be given to staggering visiting and clinic times to alleviate the parking situation.

  Arising from the consultation it had been agreed to introduce a telephone triaging system whereby an appointment could be booked for patients that needed to attend Russells Hall Hospital. This would eliminate some of the time waiting at the hospital which in turn would reduce car parking charges for patients.

  With regard to car parking spaces it was commented that visiting times already varied across wards and currently the car park was not saturated even during peak times. It was further commented that additional spaces had been made available as staff were no longer able to use the maternity car park spaces and long term plans were to spread workloads across other hospitals, including the Corbett, which would further ease the parking situation.

- The walk-in centre had been useful for people visiting from other areas, particularly children that became sick as they were unable to access their local GP's. Local residents had also indicated that the walk in centre offered a good service and had good parking facilities.

- The difficulties in recruiting GP's and associated conditions and long working hours were referred to particularly as the UCC would be operational on a twenty four hour basis.

- It was queried whether consideration had been given to best practice and whether developments at other hospitals utilising this method had been explored.

  It was reported that consideration had been given to best practice and the proposed service specification had been based on Walsall's model as they were currently operating a combined facility.

  A Member stated that it would have been useful to see the evidence for reassurance purposes.

- Reference was made to the non-clinical Navigator and it was queried why the role would only be operating from Monday to Friday 9am to 6.30 pm given the service would incorporate an out of hours provision. It was also suggested that reference to the navigator in the service specification be revisited and rephrased to clarify the exact role and what the service would achieve.

  Comments made in relation to the navigator would be taken on board.

- It was considered that there should be access to a twenty four hour pharmacy on site.

  The responsibility to license pharmacies lay with NHS England and Mr Maubach undertook to liaise with them in this regard.

- Queried whether there would be access to twenty four hour X-Rays and blood tests.

  The UCC would have access to suitably identified diagnostics commensurate with primary care and only a minority percentage would need this facility and it was not deemed to be appropriate to include as part of the specification. However, it was pointed out that there was the option to transfer patients to the Emergency Department for those that were in need of the facilities.

- Reference was made to the four hour target to see and discharge patients and it was commented that people chose to go to the walk in centre because they were able to access the facility quickly and be seen in less than an hour.

  The four hour timeframe was the national standard set for seeing patients although it was acknowledged that there should be an expectation to see as many patients as possible. However, it was pointed out that current waiting times were between one and two hours.

- Although it was acknowledged that the main assessment/treatment element of the UCC service model would be based in one area and delivered by a qualified clinician, it was requested that clarification be given on whether the clinician would be a GP, otherwise it could be viewed as a decrease in service.

  It was stated that the current walk in centre was not GP led. However, finite details to include the qualification of the principle assessors would be firmed up in the final specification.

  The Chair requested that consideration be given to wording being included in the final specification stating that a GP was available, if needed.

- There was no reference in the service specification to deal with vulnerable people that self presented and concerns were expressed that a clearer pathway needed to be identified in this regard.

  Discussions were taking place with the Mental Health Trust with a view to ascertaining the level of service required and a report would be submitted to the Safe and Sound Board with a view to a recommendation being made.

- Although the contract for the current walk-in centre had been extended to March, 2014, it was queried whether there was sufficient time to undertake the procurement process and for the proposed UCC to be erected and fully operational by that time.

  It was reported that it was expected to achieve the target, and if need be, the contract could be extended further to ensure that there was not a break in service.

- It was suggested that consideration be given to offering GP receptionists training with a view to offering a triaging service given the difficulties in getting appointments with GP's.

- It was requested that consideration be given to patient experience and that sufficient footage and space be allocated for the UCC to cope with demand and that appropriate enclosed rooms be available for consultation to allow patients their privacy and dignity. Also consideration be given to personal safety, particularly on weekends when treating patients that had been consuming alcohol.

  The capital planning of the UCC had not as yet been completed but it was envisaged that there would be a certain level of footage. With regard to privacy and dignity the NHS were obligated and had to adhere to meeting the required legal standards.

- The amount of revenue generated from car parks that was re-invested in sustaining quality health services was queried.

  The element of income received from Interserve to reinvest into health services had been £435,000 for the current financial year. It was commented that should this income not be received this amount would need to be found from elsewhere to sustain current health services.

- The Chair stated that car parking charges at Russells Hall Hospital were in line with charges across other hospitals, however it was commented that there was a need to publicise concessions.

  It was acknowledged that there was a need to undertake work to publicise concessions.

- A Member requested that financial details of the proposed model be provided to enable appropriate scrutiny to take place.

  It was stated that financial information was commercially sensitive and providing this information could prejudice the tendering process.

Arising from further questions and comments made by Members, Mr Maubach reported that a publicity campaign would be undertaken with regard to using the 111 telephony service, that the UCC would not require a huge amount of space, that there was extensive CCTV across the hospital site that would be extended to the UCC and that the facility would be placed near to the Accident and Emergency Department to allow for the sharing of skills.

Representatives form the West Midlands Ambulance Service commented that they were in agreement with the plans for co-location of the UCC and that they had been fully engaged and involved in discussions with a view to a joint approach. Reference was also made to the 111 service that would be used as the telephone triaging facility and it was stated that efforts would be made to publicise the facility and to put in place measures to cope with demand.

Mr Stenton, the Publicly Elected Governor (Dudley Group NHS Foundation Trust) reported that all Governors had been given a copy of the consultation documents and that a number of comments had been made including the need to ensure that patients understood the concept of the new model. He stated that the CCG Board had considered feedback and acted accordingly and it was pointed out that it was vital to move in this direction in the interests of the people of Dudley.

In concluding Mr Maubach stated that the proposed UCC model was safer as it was in one location and provided a better quality service, it conformed to national guidelines, the migration of all GP's to use one system was a phenomenal achievement as it would improve access to patients records and eliminate medical errors and that overall it would be a more efficient service. With regard to measuring the success it was indicated that performance indicators were in place however, these had not been included in the service specification. He undertook to consider comments made by Members with a view to including in the final version of the service specification.

RESOLVED

(1) That the information contained in the report, and Appendix to the report, submitted on the design and procurement of the new Urgent Care Centre and the draft Urgent Care Centre Service Specification (Version 0.9), be noted.

(2) That arising from consideration of the draft Service Specification the comments made, as indicated above be considered by the CCG for consideration and inclusion in the final version of the Service Specification.

(3) That the Chief Accountable Officer (Dudley Clinical Commissioning Group) be requested to submit an electronic version of the final service specification to all Members of the Committee in May, 2014.

The meeting ended at 8.10 p.m.

CHAIR

Dudley Metropolitan Borough Council

Agenda Item No. 6

Health and Adult Social Care Scrutiny Committee – 16 July 2014

Dudley and Walsall Mental Health Partnership NHS Trust – CQC Assessment Outcome Update Report

1.0 Purpose of Report

To inform the committee on the outcome of the recent Care Quality Commission (CQC) Assessment report of Dudley and Walsall Mental Health Partnership NHS Trust (DWMH) and of the actions that have been undertaken by the Trust to ensure full compliance with the CQC requirements.

2.0 Background

Following the recent Francis, Winterbourne and Keogh reviews, the CQC has made significant changes to the way they inspect and regulate Health and Social Care services. The recently published CQC strategy 2013-16 aims to transform the assessment into a more in-depth and joined-up approach for the review, registration and regulation of Health and Social Care Services.

The new CQC strategy identifies eight key priorities:

- **Appointing Chief Inspectors** – Hospitals – Professor Mike Richards (Supported by 8 Heads of Hospital Inspections), Adult Social Care – Andrea Sutcliffe, GP and Primary Care – Professor Steve Field

- **Changing the way they inspect NHS hospitals** by focusing on the following five key questions:
    - Are they safe?
    - Are they effective?
    - Are they caring?
    - Are they well led?
    - Are they responsive to people's needs?

  National teams with relevant expertise will carry out these inspections which will now occur over a number of days or weeks. One element which can trigger inspections is the Intelligent Monitoring Report which replaces the CQC Quality Risk profile which is aiming to contain much more up to date and varied sources of intelligence.

- **Responding more quickly to services that are failing** – using data, intelligence and evidence in a more sophisticated and transparent way.

Also using feedback including complaints and from local organisations e.g. Healthwatch.

- **Improving understanding of how different care systems work together** – by carrying out two themed inspections – looking at dementia care and care when people move between services. Also a 'thematic probe' into inductions for Healthcare Assistants (HCAs)

- **Work better with other partners and regulators** – sharing intelligence and co-ordinating inspections and joint activities; especially with Monitor, NHS Trust Development Authority, NHS England, the Healthwatch network and local Councils.

- **Publish ratings of hospital services** to improve transparency and help the public to make informed choices about their care

- **More rigorous tests for organisations applying to provide care –** making sure named directors and managers commit to meeting standards and are tested on their ability to do so beginning initially with organisations that provide learning disability services

- **Building a high performing organisation –** improved training and development for their staff and better tools and information for them to do their jobs

As part of this new inspection regime, Dudley and Walsall Mental Health Partnership NHS Trust was selected as a pilot site for the new CQC Assessment process. The new process was designed to be much more collaborative and involved the CQC hearing feedback from a range of stakeholders, including both Dudley and Walsall Local Authorities.

Prior to the assessment, a detailed preparation plan was implemented, which included undertaking significant communications and engagement processes to help ensure that Trust staff and other key stakeholders knew what to expect (as far as possible) and how they could contribute to the assessment process.

The Trust was informed that Monitor would use the outcome of the assessments to determine whether the Trust is able to continue with its Foundation Trust application.

3. Inspection Methodology

Early in 2014, the CQC inspection team started their assessment of the Trust, reviewing a very wide range of information from a number of sources, including:

- Reviews of documentation including policies and processes, strategies, papers from the Trust Board and other Committees.

- Healthwatch Dudley were asked to facilitate a 'listening event' to enable the CQC to gather independent, 'first hand' experiences from people who had used Trust services.
- A public meeting was held, along with media releases to encourage people with feedback about the Trust to contact the CQC.
- The team interviewed key stakeholders, including both Dudley and Walsall Local Authorities.
- The inspection team (consisting of more than 50 individuals) were on-site at the Trust during late February 2014. The team interviewed clinicians and managers, met with key staff from the Trust, spoke with service users and carers, and undertook a range of both planned and unannounced visits to Trust wards and team bases.

4.0 CQC Assessment Outcome / Findings

The final report of the inspection of the Trust was published by the CQC on 14th May 2014. Links to the report can be found on the Trust's website www.dwmh.nhs.uk.

Overall, the outcome of the assessment was very positive, with excellent findings such as 'staff treating service users as people' and 'staff are passionate about the care they provide'. The Trust's Safeguarding and Governance processes were also highly commended by the CQC, as was the quality of the Trust's non-Executive Directors. The Trust was commended for its involvement of Service Users and Carers in improving services, and for the robust 'learning lessons' processes following untoward incidents. The assessment team noted that communication between clinical teams was comprehensive.

The report also highlighted some areas for improvement. These included three compliance notices – these are mildest level of enforcement action which can be placed on a Trust. The Trust took immediate action to address these important areas, as follows:

4.1 – Compliance Notice 1

Regulation 17 – Ensuring the dignity, privacy and independence of service users – This concern was in specific relation to:

"People's privacy and dignity was not respected because the separate toilets for male and female patients were not easily identifiable. We saw male patients using female toilets and vice versa and staff did not intervene. We saw male patients using toilets and not closing the doors, these toilets were in the communal areas of the ward and could be directly viewed.

We saw that each bedroom had a commode placed in there at night. Staff told us told that the need for commodes was never assessed. This meant that the person's previous level of function was not always acknowledged and respected and their previous routines and independence were not always promoted.

We found that people's privacy and dignity was not respected because men had to walk through the female bedroom, toilet and bathroom areas to access the communal areas of the ward."

4.2 – Action Undertaken by Trust in respect to Compliance Notice 1

All actions that were required to address these concerns have been fully implemented by the Trust – actions implemented in relation to these concerns included

- Full review of signage
- Secured the agreement of commissioners for Grasmere Ward at Dorothy Pattison Hospital to become a gender specific environment
- Specialist dementia architect survey undertaken on Holyrood ward in Bushey Fields Hospital.
- Increased staff awareness and training regarding maintaining privacy and dignity of service users
- Commodes removed and only to be utilsed within bedroom areas when assessed as required as part of a person's care plan

4.3 – Compliance Notice 2

Regulation 9(1)(b)(i), 9(1)(b)(ii) and 9(1)(b)(iii)

The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of –b) the planning and delivery of care and, where appropriate, treatment in such a way as to –i) meet the service users individual needs,
ii) ensure the welfare and safety of the service user iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment. This concern was in specific relation to:

"Patients were not always cared for in an environment that assured their safety and welfare. Individual patient preferences and needs were not always met because the staff did not have the knowledge and skills to meet these needs. Seclusion was seen to be practiced without following the guidance from the Mental Health Act 1983 Code of Practice"

4.4 Action Undertaken by Trust in respect to Compliance Notice 2

All actions that were required to address these concerns have been fully implemented by the Trust – actions implemented in relation to these concerns included:

- Address the immediate environmental risks identified by the CQC including the removal of swipe card access on corridor doors and ensuring that appropriate signage is in place.

- Commissioning an independent mental health specialist architects assessment of the Holyrood Ward environment.

- Designing and implementing a staff training plan, based on a training needs analysis, in respect to “Behaviours that Challenge”

- To ensure the Trust has robust reporting and monitoring processes in place regarding use of restrictive practice, and develop a restrictive practice policy to ensure that Trust has clearly defined processes in line with the MHA Code of Practice 1983.

4.5 Compliance Notice 3

Regulation 10(1)(b)
The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to – b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity. This concern was in specific relation to:

- *An effective system was not in place to enable patients to summon assistance in the event of an emergency. This risk had not been adequately managed on Holyrood ward. There was no effective system in place to ensure that staff could summon assistance in the event of an emergency where they or others were at risk of harm. Patients could not be assured that risks were managed in accordance with the least restrictive principle.*

4.5 Action Undertaken by Trust in respect to Compliance Notice 3

All actions that were required to be undertaken by the Trust to address these concerns have been fully implemented by the Trust – actions implemented in relation to these concerns include:
:

- Undertaking a review of Holyrood service users risk assessments and risk management plans to ensure they meet standards of best practice.
- Continuing the roll out the new FACE risk assessment tool implementation plan which includes refresher training for staff will include the formulation of person centred risk management plans
- Ensuring Holyrood Ward has local process in place which enable service user to summons assistance (this replicates a process already in operation on Malvern Ward)

- All staff on Holyrood Ward have been reissued with personal alarms.(It is also reiterated to staff in each handover that they should be wearing the alarms at all times.)
- Review of all care plans on Holyrood Ward has been undertaken to ensure they met the least restrictive practice principles

5.0 CQC 'Must, Should and Could Do Actions'

In addition to the areas highlighted above, the report identified a number of 'Must, Should and Could Do' recommendations, many of which overlap with the compliance areas.

The Trust is however taking immediate action to also fully address these additional concerns and is working closely in partnership with the CQC, its commissioners and other partner organisations to develop robust actions to fully address these areas of concern. A number of these concerns are commissioner or health economy wide actions and the Trust would welcome the support of the Overview and Scrutiny Committee in relation to addressing these areas.

6.0 Monitoring and Feedback

Following the receipt of the CQC feedback and report and in order to monitor the effectiveness of the actions described above, the Trust has established a Quality Governance Assurance Team that performs regular checks across the Trust including areas such as the environment, to ensure that all actions have been fully implemented, are effective and to ensure that compliance is maintained.

The outcomes of these checks are reported to the Trust CQC Steering Group who then report any areas of concern or good practice to the Trust Board and Governance and Quality Committee.

In the longer term, the Trust will be expanding its programme of internal quality improvement reviews to ensure that the CQC model and requirements form part of this process. By undertaking these internal reviews and assessments the Board will receive ongoing assurance as to the Trust maintaining compliance with the regulated requirements and standards.

7.0 Committee Action

Committee members are specifically asked to:

- Note the new CQC Assessment processes and inspection regime

- Be aware of the outcome of the assessment including the areas of good practice highlighted by the CQC and the 3 compliance notices.

- Gain assurance from the work already undertaken by the Trust in fully addressing the Compliance notice / areas of concerns

- Continue to support the Trust in the work undertaken to address fully the "Must, Should and Could" identified actions / areas for further improvement.

8.0 Finance

There are no direct financial implications arising from this report.

9.0 Law

All NHS Trusts and healthcare providers are required by law to meet the requirement of the Health and Social Care Act 2008

Equality Impact

The CQC Standards promote Equality and Diversity in both the services provided by the Trust and also in relation to its workforce / operating principles.

Recommendation

To note contents of report and gain assurance from the actions taken by the Trust and the findings of the CQC Assessment.

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Agenda Item No. 7

Dudley Clinical Commissioning Group

Report of the Chief Accountable Officer, Paul Maubach

Update on Urgent Care Development

1.0 Purpose of Report

To update members on progress towards the opening of a new Urgent Care Centre (UCC) in Dudley. The development will deliver a significant improvement in urgent care, offering 24/7 access to urgent primary care services in a new centre which is located next to, and will deliver care seamlessly with, the Emergency Department at Russells Hall Hospital. The UCC will replace the current Holly Hall Walk In centre (WIC), which currently opens 8.00 am to 8.00 pm, as well as providing a new base for the GP Out of Hours (OOH) service.

2.0 Background

The CCG is currently going through a procurement process for the development of a new Urgent Care Centre (UCC) to be sited next to the Emergency Department (ED) at Russell's Hall Hospital.

Once open, the UCC will replace the Walk-in Centre (WIC) currently based at Holly Hall and will provide an enhanced service to the one currently offered at the WIC. (The WIC and GP Out of Hours contract have been extended to March 2015 to allow sufficient time for the UCC to be built, staffed and opened.)

The Dudley UCC is a key enabler for the new system of urgent and emergency care envisaged in Dudley CCG's Primary Care Strategy 2013/14 and Operational Plan 2014/16.

The strategic intention to remodel the urgent care pathway in Dudley is endorsed by best practice highlighted in Sir Bruce Keogh's Urgent and Emergency Care Review (November 2013), which states that for people with urgent but non-life threatening needs 'we must provide highly responsive, effective alternatives for patients to attending the Emergency Department'.

Specifically Dudley UCC will deliver a service to ensure this vision is achieved and improvements to patient care are realised. The UCC will help people with urgent care needs to get the right advice in the right place, first time.
The CCG's proposals were the subject of widespread public consultation at the end of 2013. Regular updates have been given to the OSC since the project began in September 2013. The most recent update (8 April 2014) included a copy of the draft service specification.

This report provides a summary of progress since 8 April 2014 and outlines the next steps in the development of the UCC. In recognition of the changing membership of the committee it also includes an outline of the factors behind the need to change the way urgent care is provided in Dudley and some of the benefits that the reconfigured service will bring.

3.0 Report

Primecare Ltd currently operates the Dudley Walk In Centre (WIC) and GP Out of Hours (OOH) services which are based at Holly Hall, just 700 metres from the Emergency Department (ED) at Russells Hall Hospital (RHH)

Local consultation and national best practice identifies that this configuration for patients can be confusing when they have to make choices on accessing urgent care. It also promotes inefficiencies in the use of resources to have two services which can treat similar patients operating independently but so geographically close together. Annual patient attendances within the existing urgent care configuration are **164,700** (combined ED, WIC and OHH attendances) - approximately **450** patients per day.

It is commonly estimated nationally that approximately 25-40% of patients currently presenting at ED could be treated in community primary care facilities. It is further held that 80-90% of patients presenting at WIC facilities could be treated in community primary care facilities.

A recent Nurse led streaming audit of **3000** presenting patients to RHH ED confirmed the proportion of cases that could be treated by primary care practitioners to be **32%.** This means that with the WIC, OOH and ED streamed primary care cohort activity combined the new UCC will see approximately **99,500** patients per annum and ED **65,300**.

The CCG will expect the provider of the new UCC service to focus on two main objectives:

- **To ensure the delivery of a safe, high quality, efficient urgent care service which works seamlessly with the Emergency Department at Russell's Hall Hospital**

- **To play an active part in encouraging a culture change across the urgent care system, which supports innovation by staff in delivering the service and improves the ability of patients to access services appropriately.**

The CCG expects measurable quantitative outcomes from commissioning the UCC service. Features of a successful UCC include:

- Improved patient experience of urgent care and ensure a patient's on-going healthcare needs are met in the most appropriate setting within the community or primary care
- Improved performance against NHS constitution promises to patients around waiting no more than four hours to be seen, treated and admitted or discharged.
- Reducing the number of patients attending DGFT ED. This will be achieved by treating and / or redirecting non-urgent patients presenting at the new UCC back to primary care and other community services.
- Reduce the number of RHH admissions from the ED. This will be achieved by the different approach to the clinical treatment of patients seen in the UCC by experienced GPs and Nursing Staff
- Support patients, where appropriate, by ensuring they are registered with a GP practice and aware alternative care pathways which may be better suited to their needs.
- When required provide clear information on the appropriate use of urgent and emergency care services

The UCC will not:

- Be a further access point for routine primary NHS care in the local health economy (these patients will be appropriately and actively navigated back into core primary healthcare services in the community); or
- Duplicate existing service provision by primary care services.

Developments since the last update to OSC

Since the last update to this committee, a considerable amount of time and effort has been focussed on developing and refining the service specification for the Urgent Care Centre.

The Service Specification has been developed with significant and continuing stakeholder input, steered by a UCC Reference Group meets monthly to oversee the development of the specification and associated work streams. This multiagency group consists of all key stakeholders of the UCC and includes representatives from DGFT, West Midlands Ambulance Service, NHS 111, Dudley and Walsall Mental Health Partnership Trust, Dudley MBC, Healthwatch, Primecare Ltd and patient representatives from the CCG's Patient Opportunity Panel (POPs).

The detailed service specification was still being finalised at the time of writing, prior to it being shared with a short list of potential service providers (identified following the issue by the CCG in March of a Procurement Information Notice).

At the CCG Board meeting on 8 May 2014, it was agreed to delegate executive sign-off of the final specification upon completion to Paul Maubach(Chief Accountable Officer), Dr Steve Mann (Clinical Lead for Urgent Care) and Dr David Hegarty (CCG Chair).

Next Steps

At the time of writing this report (3 July) the timetable for the rest of the process was as follows:

- The final service specification and supporting documents signed off as above and shared with shortlisted bidders by 11 July.
- Bidders to submit any questions or issues for clarification by 1 August.
- Deadline for submission of bids to the CCG – 15 August
- Bidders (successful and unsuccessful) to be informed of the CCG's decision by 19 September – after which there will be a formal 'stand still' period lasting until 30 September.
- We aim to award the contract to the successful bidder at the beginning of October, which will give them six months to prepare for the service to begin on 1 April 2015.

4.0 Recommendations

Members are asked to note the contents of the report.