Health Scrutiny Committee

Wednesday 8th July, 2015, 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 meeting held on 26th March, 2015 as a correct record.

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.

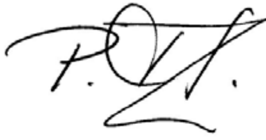
6. Terms of Reference for the Health Scrutiny Committee

7. Work Programme 2015/16

8. Developing New Models of Care in Dudley

9. Delegated responsibility for the Commissioning of General Medical Services (GP services).

10. 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).



Strategic Director (Resources and Transformation)
Dated: 26th June, 2015

Distribution:

Members of the Health Scrutiny Committee:
Councillor Hale (Chair)
Councillor A Goddard (Vice-Chair)
Councillors M Attwood, K Casey, K Finch, S Henley, S Phipps, N Richards, M Roberts, D Russell and E Taylor.

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- Please turn off your mobile phones and mobile communication devices during the meeting or set them to silent.
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- Information about the Council and our meetings can be viewed on the website **www.dudley.gov.uk**
- The Democratic Services contact officer for this meeting is Kim Buckle, Telephone 01384 815242 or E-mail kim.buckle@dudley.gov.uk

Minutes of the Health Scrutiny Committee

Thursday 26th March, 2015 at 6.00 p.m. in Committee Room 2 at the Council House, Dudley

Present:-

Councillor C Hale (Chair)
Councillor N Barlow (Vice-Chair)
Councillors M Hanif, D Hemingsley, S Henley, I Kettle, K Turner, K Shakespeare, E Taylor and D Tyler and Ms P Bradbury

Officers

S Griffiths (Democratic Services Manager (Acting Lead Officer to the Committee)), K Jackson (Deputy Director of Public Health), B Kaur (Consultant in Public Health) and M Johal (Democratic Services Officer – Directorate of Resources and Transformation).

Also in Attendance

Ms Jacky O'Sullivan – Dudley Walsall Mental Health Partnership Trust
Mr Mark Axcell – Dudley Walsall Mental Health Partnership Trust
Dr David Hegarty – Dudley Clinical Commissioning Group
Dr Mona Mahfouz – Dudley Clinical Commissioning Group
Mr P Maubach – Chief Accountable Officer (Dudley Clinical Commissioning Group)
Ms Liz Abbis – Dudley Group NHS Foundation Trust

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51 Apologies for Absence

Apologies for absence from the meeting were submitted on behalf of Councillors C Elcock, K Jordan and M Roberts.

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52 Appointment of Substitute Members

It was reported that Councillors I Kettle and D Tyler had been appointed to serve in place of Councillors C Elcock and K Jordan for the meeting of this Committee only.

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53 Declarations of Interest

In accordance with the Members' Code of Conduct, a non-pecuniary interest was declared by Councillor S Henley in respect of Agenda Item No 6 (Mental Health Quality and Performance Review) in view of the fact that his wife works for the Black Country Partnership National Health Service (NHS) Trust.

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54 **Minutes**

A Member referred to Minute No 38 relating to phlebotomy and stated that the service based at Russells Hall had been moved to near the maternity part of the hospital. Complaints were being made by residents as they were not aware that the service had moved and were being redirected. The new base for the phlebotomy service was located in the opposite direction to the outpatient clinics and was a long walk which was particularly tiring for the elderly. Mr Maubach (Chief Accountable Officer (Dudley Clinical Commissioning Group) undertook to relay comments back to the Trust.

Resolved

That the minutes of the meetings of the Health Scrutiny Committees held on 22nd January and 16th February, 2015 be approved as correct records.

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55 **Public Forum**

No issues were raised under this agenda item.

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56 **Mental Health Quality and Performance Review**

A report of the Head of Commissioning – Dudley Clinical Commissioning Group (CCG) was submitted on the arrangements in place for the commissioning of mental health services.

Arising from the presentation of the report the following queries and comments were made by Members and responses were given as indicated:-

- There were a number of mechanisms in place to monitor quality and safety such as holding the monthly contractual and clinical review meetings where minutiae was discussed and information checked with a view to ensuring compliance and continuous improvements being made. Surveys of service users were also undertaken to ascertain their views on issues.

- In referring to Tier 4 – specialist day and inpatient units it was queried whether there was a similar facility in the Dudley area, and if not, whether there were any plans in the foreseeable future.

  Dr Mahfouz stated that the number of children requiring admission was extremely low which made it economically unviable. However, the Black Country Partnerships NHS Trust were considering the development and commissioning of a joint unit but it was pointed out that beds in the unit had to be opened nationally and that they could not be reserved just for local patients.

- Reference was made to a policy paper associated with the mental health services and on achieving better access and it was queried how this related to the Child and Adolescent Mental Health Services (CAMHS) particularly on the tier process.

  The information as contained in the report detailed the current provision and the CCG were in the process of addressing the Department of Health's document with a view to updating the service to be open and more accessible for 0-25 year olds. However, it was reported that Tier 3 was commissioned by the Dudley Walsall Mental Health Partnership Trust (DWMHPT) and that this provision would not change because of its specialist nature as it specifically catered for young persons with acute conditions.

  An assurance was given that a system without tiers would still be robust and that joint triaging and assessment of an individual would be undertaken when being referred to the general hub or to CAMHS. The redesign of the mental health service would include several audits and evaluations taking place with a view to ensuring that every young person was assessed and appropriately referred.

- The redesign and delivery of the mental health service would be based on the "new hub and spoke" model which meant that a range of services would be provided from a central point over a defined geographical area to people within the surrounding community.

- The need for CAMHS to react and attend scheduled meetings relating to an individual child as complaints had been received from certain primary school Head Teachers that they experienced delays and often representatives did not attend these meetings. There was also insufficient input from General Practitioners (GP's) at case meetings.

  In responding it was stated that GP's were increasingly being approached by parents with a view to providing a sick note for their child to substantiate absences, however GP's were not informed about any meetings or discussions that were taking place. Further, GP's did not receive minutes of any case that was discussed by the school and if parents notified their GP's about any issues, they were advised to contact the school direct to request that they submit a report to the GP for consideration and action.

- It was considered that given extensive joint and partnership working the methods of communication needed to be improved and that a simple accessible structure should be in place within the various organisations to ensure that problems could easily be resolved to enable services to be appropriately delivered.

- The assessment process for delivering the service was explained. It would commence in the next few weeks and representatives of various organisations would assess the best service for individual young people. The GP would remain as the co-ordinator and the Hub would assume an overarching role and therefore proper communication was vital. It was further stated that Health Advisers, schools, parents and young people could access the hub at anytime.

- Reference was made to young people placed outside of the Borough, particularly those placed a considerable distance away from their home and it was commented that parents were not able to visit their children regularly because of affordability issues and other factors. It was queried whether a local unit could be provided for young people in the Black Country and capacity issues were also questioned.

  It was reported that should a collaborated unit be provided in the Black Country the Trust would still be under an obligation to prioritise places on a national basis and that beds could not be ring fenced to local young people. Prior to NHS England taking over the service there had been sufficient local provision, however beds were now filled to their capacity and taken up by national patients which has had an adverse impact on local services. Representations were continuing to be made to NHS England by the CCG and the Trust with a view to action being taken.

  The costs associated with out of Borough placements was explained in that the local CCG's were responsible for funding and costs were reciprocal. Young children that were placed out of the Borough were of all ages and placements were allocated according to the nature of their needs.

- In referring to paragraph 14 of the report it was stated that the national standard waiting times for treatment for Tier 3 services was eighteen weeks. National standards applied to waiting times for treatment and also to quality of care and some of the contractual and quality key performance indicators were contained in the appendix to the report.

- The reasons for not meeting some of the targets as highlighted in the Appendix to the report were explained in that this was largely due to staff vacancies and sickness. Also some targets were measured on a yearly basis as these would always show a dip in certain months each year due to holiday periods which resulted in there being fewer clinics.

Resolved

That the information contained in the report, and Appendix to the report, submitted on the position in relation to the quality and performance of mental health services, be noted.

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57 Update on Transfer of the 0-5 years Public Health Commissioning to Local Authorities

A report of the Office of Public Health was submitted on the Local Authorities' new commissioning responsibilities for 0-5 year olds. In presenting the report the Consultant in Public Health reported that the planning and commissioning of public health services for 0-5 year olds would be transferring from the NHS to Local Authorities in October 2015.

Arising from the presentation of the report the following queries and comments were made by Members and responses were given as indicated:-

- In response to a query about the contract value it was reported that the figure of £4,757,599 for 2015/16 was the total package to fund the seventy two health visitors and additional support needed, which also included an element of Family Nurse Partnership (FNP). There was additional funding available for employing an extra two FNP nurses. It was considered that the current funding package was sufficient to deliver the service, however it was unlikely that the same amount would be received in future years. The allocation to Local Authorities was based on a national formula calculated by the Department of Health and it was essential that funding and resources were distributed efficiently to maximise its effectiveness. Consideration was being given to the possibility of integrating with Children's Centres to maintain delivery.

  In relation to how health visitors were to be allocated and resourced across the Borough it was stated that from October 2015 the service would be in line with resident based boundaries. Although there was no set number of health visitors to be allocated to each Ward, all parents with new born children would have access to a health visitor and depending on their individual needs a variance of support would be available.

  There was a national shortage of health visitors and the current service provider used "bank staff" when required. However upon transferring to the Council this would be discouraged due to the costs involved and also because it was important to have a committed, dedicated and consistent workforce.

- With regard to training it was commented that there was a commitment to provide continual professional development and an assurance was given that all staff would be fully capable of performing their duties.

- Questions were asked about the composition and diversity of the workforce and it was queried whether health visitors would focus on meeting the local community needs and whether they had bilingual skills to cater for the needs of the Borough.

  The Consultant in Public Health indicated that there were varying levels of grading amongst the staff and efforts would be made to empower them to undertake their duties based on a community led role. It was not known whether staff were bilingual and the Consultant in Public Health undertook to respond to Members in writing.

- Reference was made to integrating services with Children's Centres and it was queried how those children that did not attend these centres would be reached.

  It was stated that Children's Centres had extensive contact with young children and their associated families, particularly those that had new born babies. Recently, GP clinics had moved to Children's Centres and attendance at these centres had since increased. Also the mandatory elements of the Healthy Child Programme applied and a health visitor would be required to make contact with every parent through ante natal and the six to eight week assessments.

- The number of children born in Dudley during the previous year and the time slots that were allocated for health worker visits was queried.

  Time slots varied and were based on the level of the service allocation which was dependent upon the needs of the family. The number of children that were born in Dudley during the previous year was not known and the Deputy Director of Public Health undertook to respond to Members in writing with an approximate figure.

- It was queried whether the service operated out of hours and whether training would be provided to health visitors with a view to managing and reducing minor illnesses. There was the need to ensure continuity and good communication and it was queried how this would be conducted with relevant GP's, particularly when administering inoculations and its recording.

  Clarification was given in that the health visiting service contract would transfer to the Local Authority but the workforce would remain in the control of the Black Country Partnership Trust. Therefore the full details of the operation of the service were not known. With regard to managing minor illness and in reducing illnesses it was pointed out that treatment of illnesses

was a specialist area and the role of the health visitor would be to direct people to appropriate pathways and in line with prevention rather than curing. The health visitor would be the main contact person with a view to offering support, advice and guidance to address health concerns, particularly to those patients discharged from hospital. There was an element of related training in the delivery of the core safeguarding programme which provided staff with competency and appropriate skills that were required.

Concerns regarding nurses being given autonomy to undertake a prescribing role were noted and it was stated that these issues would be considered when developing the service and model. Public Health were in the midst of finalising the contract and were currently involved in the process to procure staff.

- It was noted that the need for a robust procedure to be in place was vital to ensure that mental illness was detected early. It was also crucial that visits were undertaken at people's homes to gauge a true picture of the circumstances surrounding the case. There were various Departments, structures and policies in place surrounding health and concerns were raised about the potential of someone 'slipping through the net', particularly during transfers and handover.

  The Consultant in Public Health referred to the emotional well being agenda and stated that service specifications contained detailed information and work undertaken in conjunction with their partners was crucial to ensure a smooth transition. Work was ongoing with a view to improvements being made and they were currently in the process of recruiting an additional three posts.

  A response in writing would be submitted to Members relating to the current procedure in place surrounding home visits and on how they were conducted particularly if being refused access and entry.

- In referring to paragraph 2 of the report detailing the benefits from research conducted in the United States of America and the United Kingdom and in referring to the fifth bullet point it was stated that it should read "improved school attendance".

- Although it would be useful for various agencies to have access to a central database containing all information relating to a young person this was not possible because of data protection issues. However, there was certain information available on the child's medical history but there were limitations on sharing this data.

Arising from further discussion the Chair requested that a report to include specific information relating to queries as raised above be submitted to a future meeting. It was also suggested that a health visitor and a representative from the service provider be requested to attend that meeting to enable the Committee to gain an understanding and perspective of issues that were encountered in delivering the service.

Resolved

That the information contained in the report on the Local Authorities' new commissioning responsibilities for 0-5 year olds, be noted.

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58 **Responses to Questions Arising from Previous Meetings**

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

Resolved

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

The meeting ended at 8.25 p.m.

CHAIR

Dudley
Metropolitan Borough Council

Agenda Item No. 6

Health Scrutiny Committee – 8th July, 2015

Report of the Strategic Director (Resources and Transformation)

Terms of Reference for the Health Scrutiny Committee

Purpose of Report

1. To note the terms of reference for the Health Scrutiny Committee.

Background

2. At the meeting of the Overview and Scrutiny Management Board on 11th December, 2014, a report was considered on the implications of the corporate restructuring on the Council's future overview and scrutiny arrangements.

   Approval, in principle, was given to establish a Scrutiny Committee structure aligned to the new Strategic Directorate structure for the 2015/16 municipal year.

   The establishment of the following Committees was recommended and approved by the annual meeting of the Council, to take effect from May 2015:

   Overview and Scrutiny Management Board
   People Services Scrutiny Committee
   Resources and Transformation Scrutiny Committee
   Place Scrutiny Committee
   Health Scrutiny Committee.

3. The Council's scrutiny arrangements are set out in Part 2, Article 6 of the Constitution (Overview and Scrutiny). The associated Scrutiny Procedure Rules are contained within Part 4 of the Constitution which also contains the terms of reference for the Resources and Transformation Scrutiny Committee. These terms of reference are attached as an Appendix to the report submitted.

Finance

4. The costs of operating the revised scrutiny structure will be contained within existing budgetary allocations.

Law

5. Scrutiny Committees are established in accordance with the provisions of the Local Government Act 1972 and the requirements of the Council's Constitution, which was adopted under the Local Government Act 2000, subsequent legislation and associated Regulations and Guidance.

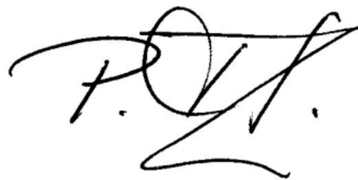
The Council's scrutiny arrangements are set out in Part 2, Article 6 of the Constitution (Overview and Scrutiny) and the associated Scrutiny Procedure Rules are contained within Part 4.

Equality Impact

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

Recommendations

7. That the terms of reference for the Scrutiny Committee, as set out in the attached Appendix, be noted.



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Philip Tart
Strategic Director (Resources and Transformation)

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List of Background Papers

The Council's Constitution

Appendix 1

HEALTH SCRUTINY COMMITTEE

Membership

11 Councillors, 1 non-voting Co-opted Member

Terms of Reference

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

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

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

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

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

To take referrals from local Patients' Forums.

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

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

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

(b) To contribute to policy development by carrying out the scrutiny of all health related functions and matters falling within the portfolio of the Cabinet Member for Health and Wellbeing (including the Office of Public Health) (with the exception of functions that fall within the terms of reference of the People Services Scrutiny Committee).

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

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

Dudley
Metropolitan Borough Council

Agenda Item No. 7

Health Scrutiny Committee 8th July, 2015

Report of the Lead Officer to the Committee

Work Programme - 2015/16

Purpose of Report

1. The purpose of this report is to approve the committee's work programme for 2015/16.

Background

2. Close consultation across the system is crucial for health scrutiny to remain a legitimate contributor to health, care and wellbeing services.

3. Key health improvement bodies including Dudley's Clinical Commissioning, Group, Dudley Group of Hospitals and Public Health have been engaged in the development this year's work intentions; helping lay the foundations for targeted, incisive and timely scrutiny on issues of local importance. This is attached at Appendix 1 for approval.

4. The proposed programme accounts for issues and commitments experienced in 2014/15, along with new system developments envisaged through 2015/16.

5. With transformational agendas remaining elevated, a commensurate degree of flexibility ought to be recognised in order to respond to new matters. Similarly, some issues that have been included in the proposed plan may be overtaken by events.

In-depth Review

6. On 10th June, 2015 the Overview and Scrutiny Management Board approved proposals to roll-forward work on the committee's Sports Participation and Physical Activity review into 2015/16.

7. The scope of work was originally agreed September 2014 overseen by a small working group comprising elected members and field specialists. However, more immediate work pressures affected momentum directly resulting in delays against project milestones; necessitating work to extend into 2015/16.

8. It is envisaged that members will be consulted on a fresh review topic later in the year; allowing opportunity for Cabinet to consider conclusions and recommendations arising from the current investigation in the shorter term.

9. As such, it is proposed to reappoint to the 2014/15 working group with the specific aim of ensuring work is treated with added impetus in 2015/16.

Guide for Members

10. A members guide has been circulated exploring different parts of the health system, national, regional and local their interrelationships with each other; including the role of local government and scrutiny. It specifically provides:

    - a quick introduction to the health and social care system since the reforms of 2012 for all councillors
    - a brief outline of the purpose of the reforms and how they are intended to improve health
    - a discussion of the role and potential contribution of elected Members to health
    - ‘must knows’ for councillors with different roles and where they can get further information

Finance

11. There are no direct financial implications arising from this report. Any costs associated with specific work items would need to be scrutinised further.

Law

12. Section 111 of the Local Government Act, 1972, enables the Council to do anything, which is calculated to facilitate or is conducive or incidental to the discharge of its functions.

13. The Health and Social Care Act 2012 places oversight and scrutiny of the planning, development and provision of health, care and well-being services by Local Authority members onto a statutory footing.

Equality Impact

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

Recommendation

15. It is recommended that members:

- note the contents of the report;
- approve the outline work plan described at paragraphs 2-5 and;
- endorse the proposal to reappoint the Sports Participation and Physical Activity Review working group in order to finalise recommendations to Cabinet.

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Mohammed Farooq

Assistant Director – Resources and Transformation

Aaron Sangian - Senior Policy Analyst People Directorate

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Email: aaron.sangian@dudley.gov.uk

Appendix 1

The following work programme for 2015/16 is proposed:-

July

- Member Workshop: Setting the Scene - health, care and well-being priorities and interrelationships
- Scrutiny Terms of Reference
- Clinical Commissioning Group (CCG) : Vanguard Scheme and Better Care Fund
- CCG: Co-Commissioning and Primary Care Development
- Local Healthwatch: Priorities going into 2015/16

September

- Sandwell and Birmingham CCG: Stroke Review: Follow-up
- Dudley Walsall Mental Health Trust: Older Adult Mental Health Services
- Dudley Group of Hospitals (DGH) : Regulatory Follow-up

November

- All key NHS Bodies: Winter Pressures: Mortality Follow-up and Resilience
- CCG: Urgent Care Centre: Specification Follow-up
- West Midlands Ambulance Service (WMAS): Hospital turnarounds
- Council: Physical Activity Framework and Community Sport

January

- DGH: Maternity: Delivery against National Standards
- Carers Review and Care Act Follow-up
- Committee Review: Sport Participation and Physical Activity: Final Report
- Public Health: Embedding 0-5 years Framework
- Committee Review: Approve Scope of 2015/16 Investigation

February

- Quality Accounts

March

- WMAS: Strategic direction / operational plan
- 2015/16 Committee Review: Interim Report
- CCG/Council: Vanguard Scheme and Quality Transfers of Care Follow-up
- Public Health: Delivery against Tobacco Strategy and Committee Recommendations

Developing New Models of Care in Dudley

Dr Steve Mann, Clinical Executive
Dudley CCG

OUR PRINCIPLES OF MUTUALITY

1. Shared ownership – the NHS is owned by the public. Each patient registered with a Dudley practice is therefore a member of Dudley CCG. All public services are similarly owned by UK citizens.

2. Shared responsibility – all service users and all staff have a shared responsibility to work together to co-create the best healthcare and well-being provision.

We also we want to shift responsibility from 'the system' providing care to dependant individuals, to instead achieve mutual responsibility whereby health, social care and wellbeing are co-produced with people.

3. Shared benefits- the benefits of the Council, NHS and other public services are mutually shared between stakeholders.

We aim to achieve defined outcomes – both for the whole community in improving overall health and wellbeing; and for individuals in their personalised care and wellbeing.

Maximising the potential of:

- The individual (in their community)
- Our staff in supporting the individual
- Our staff working effectively with each other

Our Model

MCP : Commissioning Shared Outcomes

Value added treatments : Commissioning best practice pathways

Consultant-led care

Person

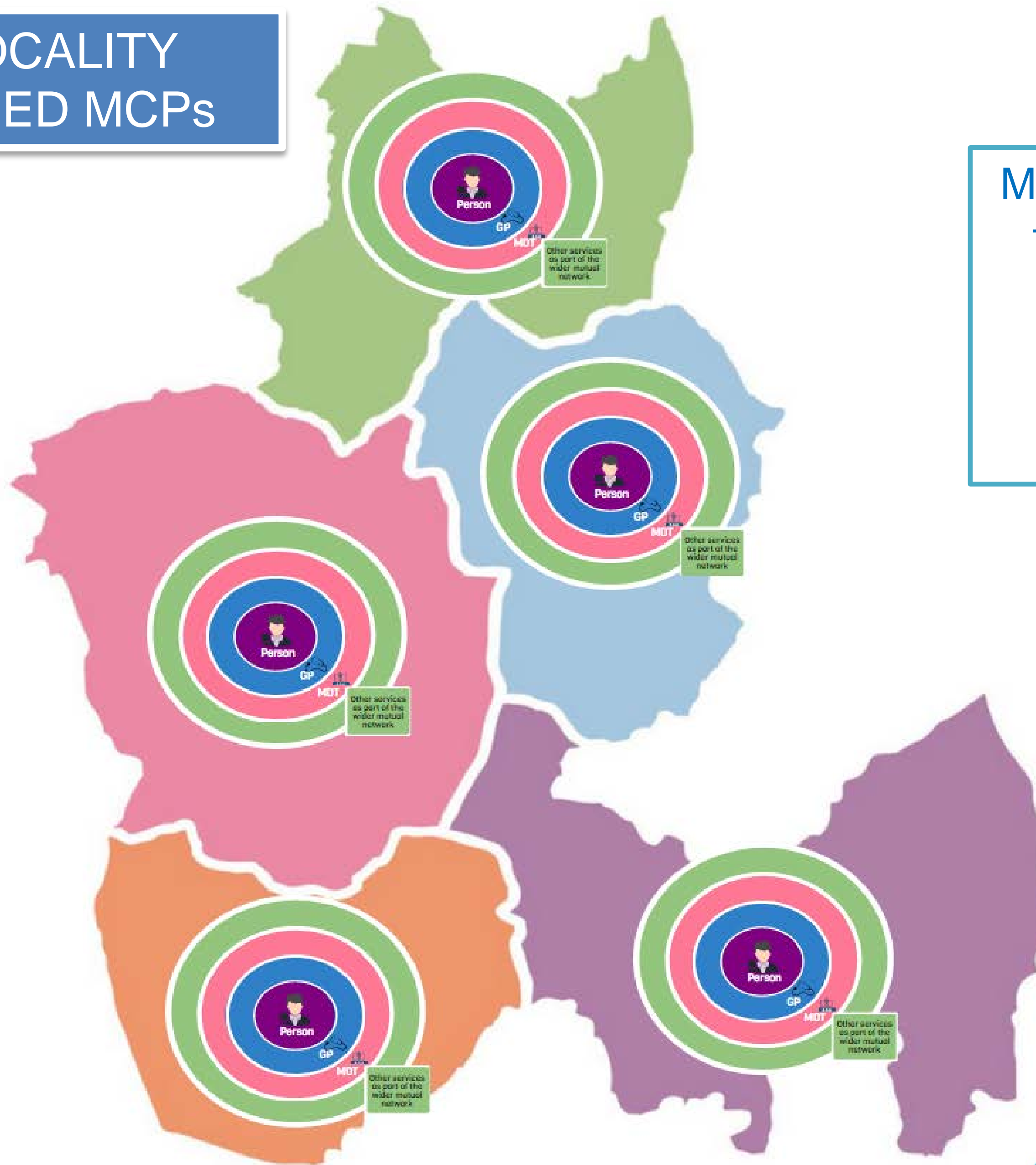
GP

MDT

Other services as part of the wider mutual network

GP - Led care

LOCALITY BASED MCPs



MCPs connected to their community.

Supported by a wider mutual network of care.

DUDLEY
Multispecialty Community Provider
Working differently

PUBLIC VIEWS

Healthcare Forum
5th March 2015

DUDLEY
Multispecialty Community Provider
Working differently

PUBLIC VIEWS

Access

- More flexibility in booking GP appointments
- Easier access 7 days a week

Continuity

- Continuity of person for engaging in my condition- recent access survey showed a significantly higher proportion of Dudley registrants having a preferred GP than national averages
- Recognising that carers are patients and have needs to – we need more support

Coordination

- A more integrated and person centred approach to health and social would be a great positive move forward
- We like the fact the CCG are trying to improve quality and the way it works by more integration with the people in the borough

Communication

- Communication between agencies is vital
- We want joined up services with no delays in care or treatment
- Poor communication between GP and hospital or delays between the both leading to unnecessary waiting and anxiety

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Working differently

DEVELOPMENT OF THE MODEL

	General	Long-term Conditions	Frailty and EOL
System	New Urgent Care Centre; specialist triage services; real-time access to consultant opinion	Consultants providing advice / support working in the community to the same outcome basis	Geriatricians supporting MDT-led frailty pathway, removing all transfers of care
Locality	Developing community-hubs to improve accessibility 7 days a week	Telehealth; direct access to services; Connecting to other public services and the voluntary sector	Lead GP co-ordinating locality approach; Falls prevention; telecare; dementia gateways, integration plus, care homes
Practice	Near patient testing; Avatar system for enabling access	Named primary point of contact	MDT as the locus of coordination
GP	GMS +	LTC framework, outcome based, prioritising hypertension and depression	GP as Lead co-ordinator of care
Person	**Accessibility**	**Continuity**	**Coordination**
Outcomes	Improved patient experience, More efficient and effective utilisation, healthier lifestyles	Stable management of conditions, reducing risk, reducing variation and the health inequalities gap	Reduced social isolation, Enabling individuals to remain in their home and connected to their community

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Working differently

DRIVERS FOR CHANGE

Dudley Population Health Status & Health Inequalities

Long-term Conditions

- 20% of our population have a limiting long term illness
- Widening life expectancy gap due to CHD,COPD and Lung Cancer in men
- Gap in life expectancy across Dudley of 8.2 years
- A quarter of deaths in 40 – 59 age band are due to CVD, smoking, obesity, cardiovascular disease and lack of physical activity
- Recorded disease prevalence rates are lower than modelled prevalence rates

Frailty and social isolation

- In two decades time there will be, 25,100 more people 65+ & 9,900 85+
- 20% of single person households are in 60+ age group
- An increasing number of older people are carers of older people

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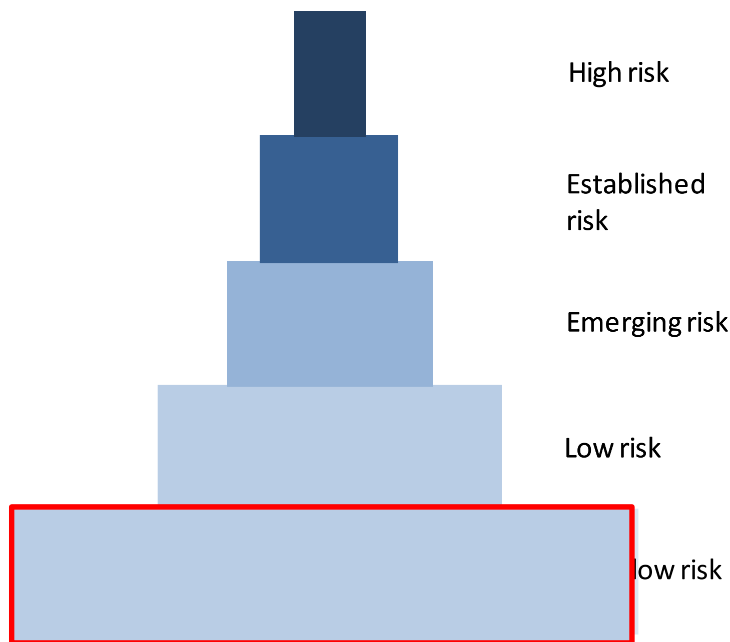
Very low risk (n = 251,835)



Key population characteristics:

- Majority young people or early middle-age
- Virtually no sign of frailty
- Few or no chronic conditions detected
- Of those with morbidities majority are MSK, ENT and Skin diagnoses
- 88% of the total population, but only 50% of total resource utilised
- Low costs per head (£402), not predicted to rise or fall over next 12 months
- Low current levels of IP, OP and A&E usage
- Very small probabilities of acute activity and pharma costs in next 12 months.

Intervention approaches:

- Key health messages – 'Do it Right Dudley'
- Primary prevention CVD
- Lifestyle interventions – Health Champions in schools, Health Improvement for our staff, physical activity & sports action plan
- Accessibility to diagnosis – improving access, virtual access and near patient testing

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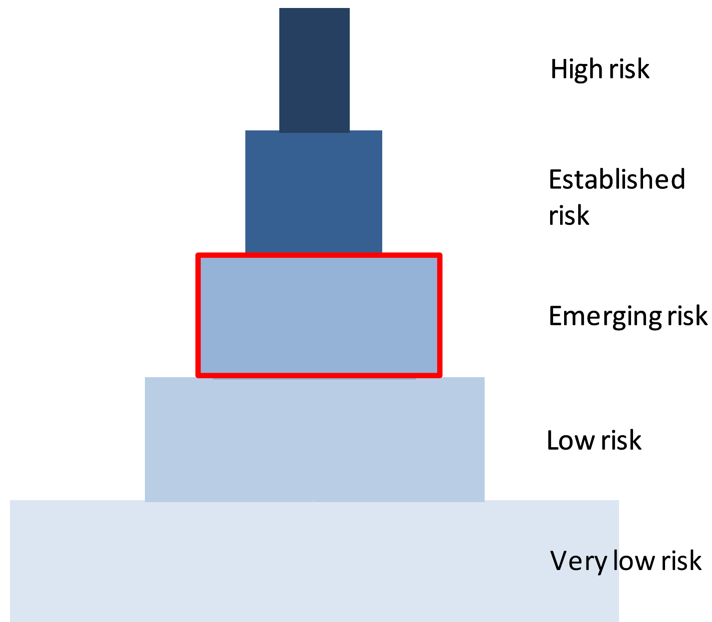
Working differently

Emerging risk (n = 6,273)



Key population characteristics:

- Vast majority 65+ years, more females
- 1 in 3 now have 1 or more frailties at this stage
- 50% now have 5+ morbidities
- Of those with morbidities majority are CVD, MSK and endocrine diagnoses
- 2.2% of the population but 11% of healthcare costs
- Costs per head £2,854, although predicted to rise by £195 in next 12 months
- Average 7 OP encounters per patient and 1+ IP spells. 1 in 2 will have A&E 'episode'
- Still relatively small probabilities of acute activity in next 12 months.

Intervention approaches:

- Regular Health checks across whole risk band
- Telehealth to support the person in the management of their long-term conditions
- An established main point of contact for each individual
- Consultant input into community delivery for key conditions

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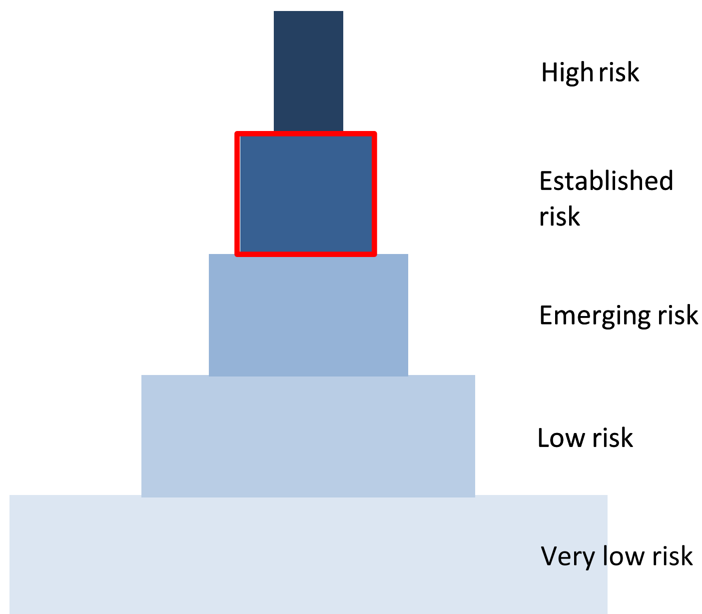
Established risk (n = 4,278)



Key population characteristics:

- More even age distribution but most with several established chronic conditions
- 4 in 10 have at least one frailty marker
- Of those with morbidities majority are CV, MSK & endocrine although renal now prev.
- 1.5% of the total population, but 9% of healthcare costs utilised
- High avg. costs per head (£3,656), predicted to rise by 20% in next 12 months
- OP and IP spells now fairly regular, A&E usage approx 1 per patient during year.
- 1 in 3 likely to have IP spell < 6 mths and over half likely to have high pharma costs in next 12 months

Intervention approaches:

- Care Coordination provided by the MDT
- Telecare underpinning support provided by MDT
- Falls prevention
- Frail elderly pathway which brings physician support to MDT

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WE ARE NOT A CLOSED SYSTEM - ACTIVITY OUTFLOWS

Wolverhampton

South East Staffs & Seisdon Peninsular CCG

Walsall CCG

Sandwell & West Birmingham CCG

B'ham Cross City CCG

Wyre Forest CCG

Redditch & Bromsgrove CCG

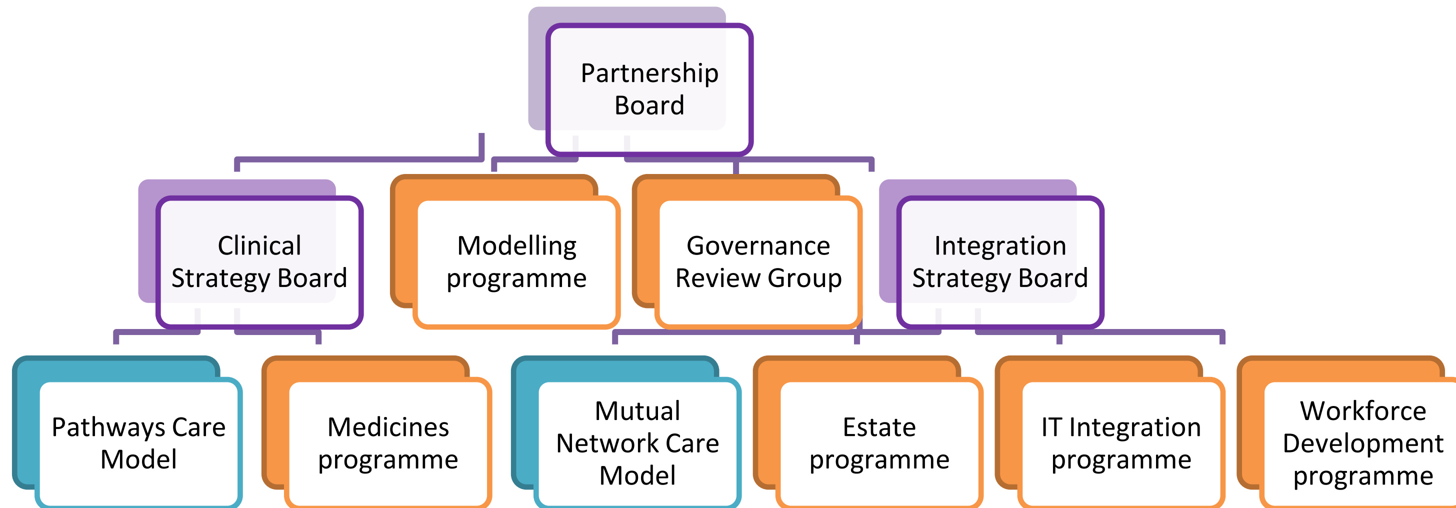
MCP-£283m
Pathways- £127m

£9m

£18m

£1M

Our Governance Structure



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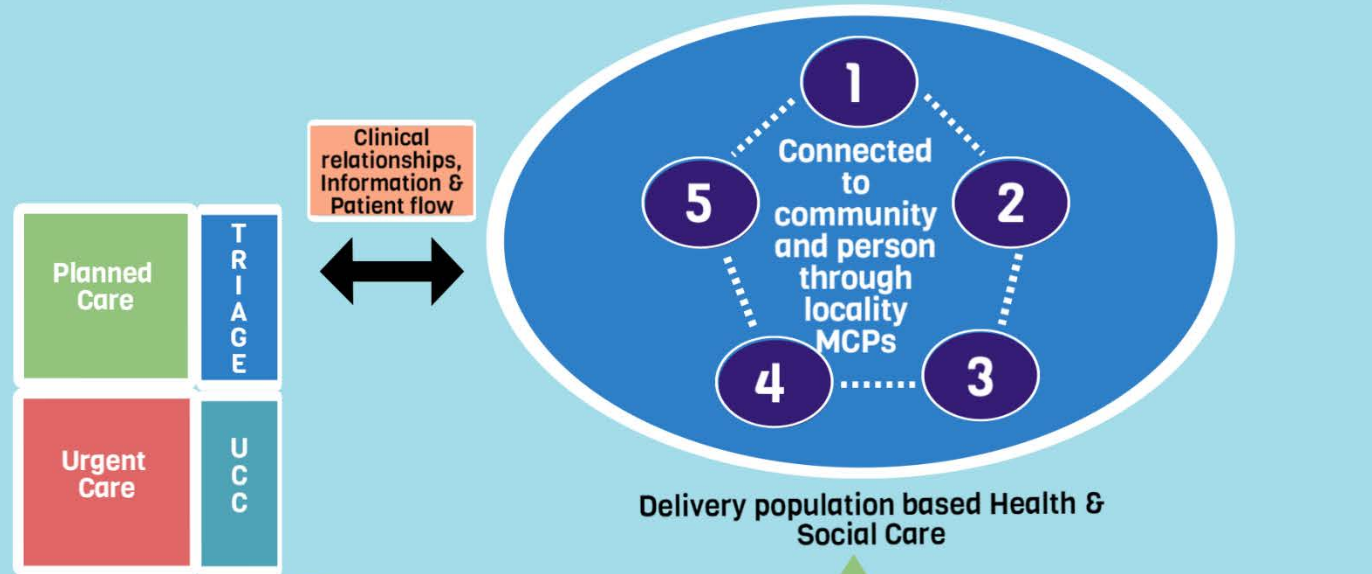
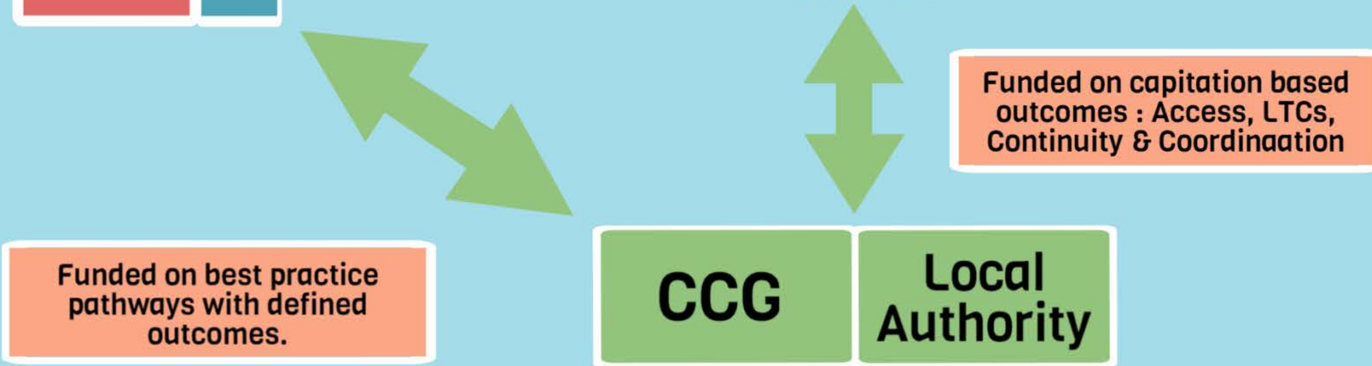
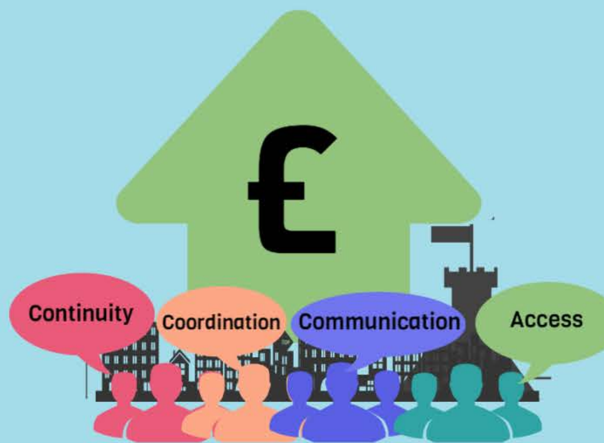
Multi specialty Community Provider Group



Delivery population based Health & Social Care





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Describing Success – What People are saying

"Due to this disability I have had to give up work and I am now virtually housebound. The link officer has opened up a lot of possibilities for me by encouraging me to become involved with a number of activities which has been a massive help to me, she has done really well and it has made a huge difference to my life."

"I could have just stayed at home and given up. I wished I would have known about this five years ago. I've got what I really want, it's lifted me and I have a laugh. I can feel a change in myself – I feel more alive to be honest. If I hadn't have gone to the doctors and been referred to Integrated Plus none of this would have happened, its Jason's help that's got me here and I thank him very much".

"I feel safer now, really secure. The (Integrated Plus) service is fantastic – although my GP had tried to help I was getting nowhere. They are someone to turn to when you feel you have no one and I can't thank Terry enough. Since he came on the scene it's all gone one way, and that's up. He made me aware of places I didn't even know existed and I dread to think what my situation would be if he hadn't helped me. If I can give a mark to represent his support it would be 10 out of 10, he has given me a lot of backing. I'm really chuffed".

"(Link Officer) has helped me a lot, he has given me my confidence back. He is a very kind person. I am getting on well with people and beating everyone at pool. My life is getting better and I feel I will get back into work."

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Dudley
Metropolitan Borough Council

Agenda Item No. 9

Delegated responsibility for the Commissioning of General Medical Services (GP services)

Purpose of Report

1. To update the Committee regarding the CCGs delegated responsibility for the commissioning of GP services.

Background

2. In January 2015 the Committee received an update on the process and the progress of the CCG taking on the delegated responsibility for the commissioning of GP services.

3. The CCG has since received approval from NHS England to take on this responsibility. The CCG Board has approved a delegation agreement that sets out the legal basis and arrangements that apply in relation to CCG exercising its delegated functions.

4. The CCG negotiated local terms into the delegation agreement with NHS England to reflect that the CCG would not assume full delegation until 1st July 2015.

5. The local terms negotiated into the agreement were approved by the CCG Board in order to ensure that there was a safe and managed transition of functions to the CCG. The CCG Board will be receiving an assurance of the transition of functions at its Board meeting in July 2015.

6. The CCG has established a Primary Care Commissioning Committee. The Committee has the responsibility to exercise the functions specified in the delegation agreement in accordance its statutory powers under section 13Z of the National Health Service Act. The Committee will be meeting in public from July 2015.

7. The CCG does not have a responsibility with the delegation agreement for the management of individual GP performers that remain the responsibility of NHS England.

8. The Primary Care Commissioning Committee has to date been meeting in shadow form to manage the safe transition of commissioning functions into the CCG and put in place robust governance arrangements and sound systems and processes as part of a managed handover with NHS England.

9. The addition of delegated commissioning to the CCGs portfolio has required additional investment in support staff. The CCG structure has been reviewed and additional posts have been established and recruited for all of the functions supporting delegated commissioning.

10. The CCG has a delegated Annual Budget as at April 2015 of £38,030,807 for the commissioning of GP services. NHS England will continue to provide the full range of transactional finance functions until April 2016.

Challenges

11. The CCG has previously shared its Primary Care Development Strategy with the Committee that describes the way in which the CCG was discharging its statutory duties to improve the quality of primary care.

12. The strategy describes the challenges facing primary care in Dudley. Those pressures and demands remain with rising workload and pressure, set against a reducing and less resilient GP workforce.

13. The CCG has been approved as a National Vanguard to develop a new model of care in Dudley. Our core objective is to support population-based health and well-being: for the person, registered with their GP, with the GP as the main co-ordinator of care, organised around the concept of mutual-networked care.

Plans

14. The CCG plans for the delegated commissioning of GP services are integral to the development of the new models of care in Dudley.

15. The GP has overall responsibility for the care for the person and the services in the practice organise around this. The CCG model is divided into three component parts: general health care and access to specialities, continuity of care for people with long term conditions, and frailty and end of life care.

16. The CCG plans for the commissioning of GP services supports the development of new models of care, and are focussed on the same component parts. Specifically:

    - Access: to enhance the ways in which patients access services from General Practice and commission those services over seven days. The CCG recognise that access is one of the biggest single issues for patients and the attached summary of the GP survey results demonstrates the challenges that the CCG is inheriting based on patients experience recorded through the GP survey.
    - Continuity of care for people with Long Term Conditions: to create and commission an alternative contract for the management of patients with long term conditions that enables GPs to spend more consultation time managing patients with long term conditions, and the frail elderly.
    - To create and commission shared outcome measures so that the hospital and the community services and GP contracts are aligned so that clinicians are all working to the same outcome for the same group of patients.
    - Workforce planning: to work with the practices and the new models of care team to undertake detailed workforce planning and resilience mapping.

17. A timetable has been produced and submitted to the new models of care National team that incorporates the work programme and timetable for managing the changes to the community services, hospital and GP contracts.

18. The contractual changes in relation to the commissioning of GP services will reduce (unwarranted) variation, improve efficiency, reduce waste, and improve patient experience.

Recommendation

19. It is recommended that that the Committee receive this update for assurance

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List of Background Papers
GP Survey Summary: Access Measures

What is our Patients Experience of access?

NHS
Dudley
Clinical Commissioning Group

	Dec 2012	June 2013	Dec 2013	July 2014	
	81%	78%	78%	76%	**5%** decline in patients getting through with ease to someone at GP surgery by phone
	79%	78%	75%	75%	**4%** decline in patients having a good overall experience of making an appointment
	24%	24%	27%	25%	**1%** increase in patients who had a waiting time at surgery greater than 15 minutes
	80%	78%	79%	77%	**3%** decline in patients that state their GP surgery is open at times that are convenient
	87%	84%	86%	84%	**3%** decline in patients who had a good overall experience at their GP Surgery