DUDLEY CLINICAL COMMISSIONING GROUP BOARD
AGENDA

Thursday 12 March 2015
1.00pm – 4.00pm
Boardroom, Brierley Hill Health & Social Care Centre, Venture Way, DY5 1RU

QUORACY
Meetings will be quorate when four elected GP clinical members and one other Board member are present, (one of whom shall be the CCG Chair, Chief Officer or Chief Finance Officer)

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<th>Time</th>
<th>Agenda Item</th>
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<tr>
<td>1pm</td>
<td>1. Apologies</td>
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<td>2. Declarations of Interest</td>
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<td>To request members to disclose any interest they have, direct or indirect, in any items to be considered during the course of the meeting and to note that those members declaring an interest would not be allowed to take part in the consideration for discussion or vote on any questions relating to that item.</td>
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<td>1pm</td>
<td>3. Minutes from 8 January 2015</td>
<td>Enclosed</td>
<td>Dr D Hegarty</td>
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<td>1pm</td>
<td>4. Matters Outstanding</td>
<td>None</td>
<td>Dr D Hegarty</td>
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<td>1.05pm</td>
<td>5. Public Voice</td>
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<td>1.15pm</td>
<td>5.1 Questions from the Public; To respond to questions from members of the public present at the meeting on the provision of health care to the population served by the CCG.</td>
<td>Verbal</td>
<td>Dr D Hegarty</td>
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<td>1.15pm</td>
<td>5.2 Feet on the Street: Do It Right Dudley</td>
<td>Presentation</td>
<td>Dr D Hegarty</td>
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<td>5.3 Public Update</td>
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<td>Mrs L Broster</td>
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<td>6. Chairman &amp; Chief Executive Officer Report</td>
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<td>Mr P Maubach</td>
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<td>7. Strategy</td>
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<td>2.05pm</td>
<td>7.1 Section 75 Agreement – Better Care Fund</td>
<td>Enclosed</td>
<td>Nr N Bucktin</td>
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<td>2.15pm</td>
<td>7.2 CCG Operational Plan 2015/16</td>
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<td>Mr N Bucktin</td>
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<td>7.3 Draft Financial Plan 2015-2016</td>
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<td>7.4 Primary Care Education Strategy</td>
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<td>Dr J Rathore</td>
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<td>8. Quality &amp; Safety</td>
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<td>8.1 Report from Quality and Safety Committee</td>
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<td>Mrs T Curran</td>
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<td>9. Commissioning</td>
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<td>9.1 Report from Clinical Development Committee</td>
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<td>Dr S Mann</td>
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<td>** BREAK **</td>
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<td>3pm</td>
<td>10. Communications &amp; Engagement</td>
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<td>3.10pm</td>
<td>10.1 Report from Communications and Engagement Committee</td>
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<td>Mrs L Broster</td>
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<td>3.20pm</td>
<td>11. Governance</td>
<td>Enclosed</td>
<td>Mrs J Jasper</td>
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<td>3.30pm</td>
<td>11.1 Report from Audit Committee</td>
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<td>Mrs J Jasper</td>
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<td>11.2 Combined Board Assurance Framework and Risk Register</td>
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<td>Mrs J Jasper</td>
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<td>12. Finance and Performance</td>
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<td>Dr J Rathore</td>
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<td>12.1 Report from Finance &amp; Performance Committee</td>
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<td>13. Primary Care</td>
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<td>Dr J Rathore</td>
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<td>13.1 Report from Primary Care Development Committee</td>
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<td>14.1 Glossary</td>
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<td>Time and Date of Next Meetings</td>
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<td>EXTRA-ORDINARY BOARD</td>
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<td>BOARD DEVELOPMENT SESSION – GGI FEEDBACK</td>
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<td>This replaces the Board Development Session scheduled for Thursday 9 April which is now cancelled</td>
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<td>DATE AND TIME OF NEXT BOARD MEETING</td>
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DUDLEY CLINICAL COMMISSIONING GROUP BOARD
PUBLIC MINUTES

MINUTES OF THE MEETING HELD IN PUBLIC ON THURSDAY 8 JANUARY 2015
AT 1.00 PM, BOARDROOM BRIERLEY HILL HEALTH AND SOCIAL CARE CENTRE

ATTENDEES:

Dr D Hegarty Chair – Dudley CCG
Miss R Bartholomew Chief Quality & Nursing Officer – Dudley CCG
Dr J Darby GP Board Member (Halesowen and Quarry Bank) – Dudley CCG
Dr P D Gupta GP Board Member (Dudley and Netherton) – Dudley CCG
Mr M Hartland Chief Operating and Finance Officer – Dudley CCG
Dr T Horsburgh LMC Representative – Dudley LMC
Mrs K Jackson Interim Director of Public Health – Office of Public Health
Mrs J Jasper Lay Member for Patient and Public Engagement – Dudley CCG
Mr P Maubach Chief Executive Officer – Dudley CCG
Mr J Polychronakis Chief Executive – Dudley MBC
Dr J Rathore Clinical Executive – Finance and Performance – Dudley CCG
Dr S Mann Clinical Executive – Acute and Community Commissioning – Dudley CCG
Dr R Tapparo GP Board Member (Kingswinford, Amblecote and Brierley Hill) – Dudley CCG
Mr S Wellings Lay Member for Governance – Dudley CCG

IN ATTENDANCE:

Mrs L Broster Head of Communications and Public Insight – Dudley CCG
Mr N Bucktin Head of Commissioning – Dudley CCG
Mrs S Cartwright Head of Organisational Development and Human Resources – Dudley CCG
Mrs T Curran Interim Chief Nurse – Dudley CCG
Mrs H Codd Patient Engagement Manager – Dudley CCG
Ms J Emery Chief Executive – Healthwatch
Dr R Gee GP Engagement Lead – Dudley CCG
Mr D King Head of Membership – Dudley CCG
Ms T Downton Minute Taker – Dudley CCG

CCG001/2015 APOLOGIES

Apologies were received from Dr S Cartwright, Dr K Dawes, Dr R Edwards, Dr C Handy, Dr M Heber and Ms S Johnson.

CCG002/2015 DECLARATIONS OF INTEREST

Members were asked to disclose any interest they may have, direct or indirect, in any of the items to be considered during the course of the meeting and to note that those Members declaring an interest would not be allowed to take part in the consideration or discussion or vote on any questions relating to that item.

Mr Wellings declared that all Clinical Members of the Board should declare an interest in the item relating to the proposal for devolved commissioning of General Medical Services (item 11.4).

Dr Gee informed the Board of his change in interests in that he has recently been appointed to the Council of Governors for Dudley Group Foundation Trust and has relinquished his position on the Shadow Board for Dudley and Walsall Mental Health Partnership Trust.
Dr Hegarty declared an interest in the item relating to the devolved commissioning of general medical services as his practice was involved in some detail (item 11.4).

Dr Hegarty informed Board members that Mr Polychronakis is retiring and this would be his last meeting. On behalf of the Board, Dr Hegarty thanked Mr Polychronakis for his contribution and support in the formation of the CCG and for the cooperation in partnership working that has taken place.

Mr Polychronakis responded by saying he was proud to be a member of the CCG Board and has always had the upmost cooperation from colleagues. He felt that the partnerships within the borough are a real strength and to be associated with one of the best performing CCGs in the country is a proud way to end his career and wished the Board and the CCG the best for the future.

The minutes of the meeting held on 13 November 2014 were accepted as a true and accurate record subject to the following amendments:

Dr Horsburgh highlighted that the designation for himself and Mrs K Jackson in the list of attendees is incorrect and should be changed.

Resolved:
1) The Board accepted the minutes from the 13 November 2014 as an accurate record subject to the amendment stated above

Dr Hegarty confirmed he had spoken to Mr James Morris MP regarding the issues raised around IAPT and reported that there are some changes being made which will facilitate IAPT. Numbers being counted into the performance measures by which the CCG are judged has not yet been finalised but Mr Morris has requested that he is kept informed if the follow up is unsuccessful.

Dr Hegarty welcomed members of the public to the Board meeting. He also welcomed two students from Pedmore Technology College, Miss Nawaz and Miss Khayal who have been instrumental in making the ME festival a success.

Dr Hegarty informed the meeting that the CCG will not take statements from the public at the Board meeting, it will only take questions and if people do have statements that these will be assessed by another route.

**Task and Finish Group**

**Question:** In the minutes of the last meeting, Paul Maubach said there would be a report on co-commissioning to this meeting but it doesn’t appear to be on the agenda.

Dr Hegarty confirmed that the report is under a different heading and is item 11.4 on the agenda ‘Proposal for Devolved Commissioning of General Medical Services’.

**Mr Alan Ward**

Mr Ward is a full time carer for his wife and has been in recent contact with the CCG about her care needs. Mr Ward requested the Board answered the following three questions:
**Question 1:** If and when will the CCG acknowledge the serious gap in provision which the private sector are unable or unwilling to meet and do something about?

**Question 2:** Is there an effective performance monitoring scheme which systematically identifies individuals’ accountability and training needs as a basis for improving the organisations overall effectiveness?

**Question 3:** If and when will the CCG recognise the crucial role of carers and support them by providing the appropriate service and facilities to help them to deliver sustained quality of care and so safeguarding their wellbeing and treating them with the dignity that they deserve?

Dr Hegarty informed Mr Ward that the CCG have been in a prolonged dialogue with himself and that the Board would not enter into the personal details of the case but would answer the questions raised.

Mr Maubach responded to the questions and reported that in terms of the issue around the complex needs for individuals with challenging behaviour, the CCG have written to Mr Ward to advise that the CCG are increasing the capacity of a facility in Halesowen as it was evidenced there was a need to do this.

With regards to the accountability of individuals, Mr Maubach informed Mr Ward that the CCG has a review process in place which includes all members of staff and is reviewed by the Remuneration Committee against performance objectives and values of the organisation and addresses the issues and performance of individuals.

In relation to the last question around support for carers, Mr Maubach reported that this is an area of work that the CCG is working closely with Dudley MBC on as the Care Act has made quite substantial changes in the expectation and requirements in terms of support to carers. Dudley MBC is working productively to provide a more comprehensive response to carers and as part of the funding arrangements, resources have been allocated so there is an infrastructure in place which is being developed as part of the Care Act.

Dr Rathore highlighted that the Board recognise the CCG is looking at unprecedented financial constraints in the budget for health and social care and the services in which can be commissioned however, GPs are working with multi-disciplinary teams to allow them to recognise the need of individual patients which the CCG has established to make it easier for patients. The Better Care Fund will also be a more sufficient process to allow patients to be cared and nursed for in their own homes but this does take time.

Ms Emery informed Board members that Healthwatch have been in contact with Mr Ward and a video is being produced which highlights Mr Ward’s experience. This has been shared with the Adult Social Care Team at the Local Authority who have recognised that there are some improvements to made.

Dr Hegarty requested that if Mr Ward had any further issues, that he should speak with Mrs Broster and she would make Dr Hegarty aware. Mr Ward welcomed this opportunity.

**Resolved:**

1) The Board thanked the members of the public for their questions

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Mrs Codd was in attendance for this item and presented a video to the Board following the #ME Festival which was held on 20 November 2014.

The event was funded and co-ordinated by Dudley CCG and working collaboratively with the Office of Public Health, Dudley Council for Voluntary Services, Healthwatch Dudley and Children’s Services in Dudley MBC. The aim of the event was to empower young people to develop the skills and confidence to manage their health and happiness but making the day fun. 16 out of 21 schools were represented on the day which was made up of over 180 students and 23 teaching staff. A number of activities were organised which young people actively took part in which included a headmasters workshop for teachers facilitated by Miss Nawaz and Miss Khayal.
A meeting is being held in March to present to Headteachers the links between health and education and how these are strengthened. In addition to this, it is proposed to look at a network of health champions.

Mrs Codd explained that a survey has taken place by the Dudley Youth Council and Healthwatch Dudley to look at children and their needs and how they would access primary care services and it was noted that 3 in 10 young people would not talk to their GP.

Mrs Emery announced that the Youth Council were nominated for a British Youth Council Award on the work they have undertaken and have been successful.

Mrs Codd introduced Miss Nawaz and Miss Khayal to talk to the Board about the Teachers workshop that they were involved in and to gain their perspective as a young person.

Miss Nawaz and Miss Khayal informed the Board that as part of the Teachers workshop, they created scenarios which they have seen in their school and asked teachers if they saw it happening, what would their reaction be and what action would they take? The scenarios created were around young people drinking, using PE lessons for other subjects such as theatre groups, young people smoking and the impact these areas can have on the lifestyles of young people. This gave a mixed reaction from teachers in that some were quite understanding and would tackle the situation should they see it happen but others were surprised by the scenarios that were presented.

Mr Polychronakis asked whether in their experience at school, did they think enough is done to encourage young people to have healthier lifestyles. The students’ response was that they felt it was associated with peer pressure and also the communication between teachers and parents and letting students smoke or drink for example, and nothing being said to parents.

Dr Gee highlighted that when he was a practising GP, he was aware that young people were reluctant to go to their GP because they didn’t understand patient confidentiality. He stressed that the message needs to be sent out to young people telling them that when they attend their GP surgery the GP is not allowed to breach patient confidentiality and therefore their discussion is taken no further. The students’ felt that if they saw the same doctor as their parents that their issues may also be brought up hence why they are reluctant to see their GP.

Dr Horsburgh discussed health champions and highlighted how important it is to get young people more involved in the commissioning of health care and education in order to develop healthier lives and to take this forward the CCG, in partnership with education, sign up to a constructive programme in a similar way that Shropshire CCG have. In addition to this, he felt the Board should support a mentoring programme which has a link between young people in the classroom and school health advisers. The students’ response to this was that they felt the sign up to the health champions would work well as it would enable schools to have a health committee which allows pupils to be listened to and given a voice.

Mrs Jasper asked the students whether they felt discussions relating to health education should start in primary schools and the response was that they felt it should start as early as possible to encourage a healthier lifestyle at a younger age.

Mr Wellings commended the amount of design, preparation and delivery of a successful day and highlighted that the #ME Festival is the start of a process which should have been happening for a long time. This is a challenge for all those organisations involved to continue to make it better and consistent but unless all the necessary partnerships and agencies are involved, this will not happen.

Dr Gupta asked whether the students felt that young people from an ethnic minority background may have any influence of a healthy or unhealthy behaviour and if teachers of an ethnic minority background made any difference in picking up issues and bringing it to the attention of young people? The response was that there are groups of pupils from different ethnic backgrounds and it is evident that some will talk about their lifestyles within their groups but some may not. It was noted that some teachers are sceptical to bring cultures and religion into it and feel it can be controversial to discuss.

Dr Horsburgh asked whether schools would be interested in feeding back how best to buy services for the Dudley borough and it was highlighted that some students would have the attitude that nothing is going to be done and feel there’s no point.
Mrs Codd and Dr Horsburgh emphasised that in order to implement the same scheme as Shropshire CCG, it would need support from Board members to take this forward. The key thing would be to get a range of young people to give their views and input around the commissioning process within Dudley.

Dr Hegarty informed members that this issue was raised at a Healthcare Forum where it was highlighted by a member of public that young people should be more involved in the healthcare system and for the Board not to support these approaches would be contradictory to what has already been agreed.

Mr Polychronakis felt the best place to present in order to start making change would be a similar presentation to the Headteachers Forum and the Governing Bodies which the Local Authority convene.

Mr Maubach asked for it to be noted that taking this approach forward, it would be on the priority list of investment resources for next year.

Dr Hegarty thanked both Miss Nawaz and Miss Khayal on behalf of all Board members for attending today’s meeting and informed them that he would write to their Headteacher for allowing them to attend the Board and what great ambassadors they both are to the school and for all their hard work at the #ME Festival.

Resolved:
1) The Board agreed to support the recommendations in the paper
2) Mrs Codd to liaise with Mr Polychronakis’s PA and Mrs Jasper to ascertain the Forum in which they should attend to promote the approach

Mrs Codd, Miss Nawaz and Miss Khayal left the meeting

CHAIRMAN AND CHIEF EXECUTIVE OFFICER REPORT

CCG007/2015 REPORT

Mr Maubach updated the Board on the following:

Notices and Acknowledgements

New Appointments to Dudley CCG

GPs have been appointed to all five locality lead roles overseeing integrated working:

- Dr Richard Bramble (Dudley and Netherton) and overall lead
- Dr Girish Narasimham (Sedgley, Coseley and Gornal)
- Dr Becci Lewis (Halesowen)
- Dr Becky Willetts (Stourbridge, Wollescote and Lye)
- Dr Devna Prashara (Kingswinford, Amblecote and Brierley Hill)

Dr Tim Horsburgh has agreed to take on an extended role with the CCG for six months to support the CCG on the co-commissioning process, as well as his lead on the clinical leadership for children’s services.

Miss Bartholomew will be leaving the CCG to take up a similar role at Warwickshire North CCG and the Board thanked Miss Bartholomew for her contribution to the CCG and wish her all the best in her new role.

Mrs Curran will take over the role of Chief Nurse on an interim basis until a permanent appointment is made.

New Appointments to Dudley MBC

The Senior Team at Dudley MBC is near completion and the appointments made to date are as follows:

- Sarah Norman – Chief Executive
- Phil Tart – Strategic Director, Resources and Transformation
• John Miller – Strategic Director, Environment, Economy and Housing
• Matt Bowsher – Chief Officer, Adult Social Care
• Debra Harkin – Chief Officer, Health and Wellbeing
• Mike Williams – Chief Officer, Corporate and Customer Services
• Iain Newman – Chief Officer, Finance and Legal Services
• Phil Coyne – Chief Officer, Planning and Economic Development
• Matt Williams – Chief Officer, Environmental Services

Appointments which are still to be announced or appointed to are as follows:

• Strategic Director, People’s Services
• Chief Officer, Housing
• Chief Officer, Children’s Services

New Appointments to NHSE

The West Midlands Sub-Region of NHS England has made new appointments. The two Area Teams which have merged to create the sub-region are Birmingham and Black Country and Hereford, Worcester and Warwickshire. The appointments are:

• Andrew Reed – Director of Commissioning Operations
• Dr Kiran Patel – Medical Director
• Brian Hanford – Finance Director
• Sue Doheny – Nursing Director

New Appointments to Provider Organisations

All three NHS Providers have appointed new Chairs to their organisations as follows:

• Danielle Oum – Dudley and Walsall Mental Health Partnership Trust
• Jo Newton – Black Country Partnership Foundation Trust
• David Badger – Dudley Group Foundation Trust

HSJ Article
Dudley CCG’s model of care was featured in a two page article in the HSJ in December as an example of good practice.

Workshop on Care for the Frail Elderly
A workshop has been held which was attended by parties across the whole system, including public representation, to develop plans for the care of the frail elderly across the borough. The key themes from the workshop reinforced the need to expand and develop integrated working and removing organisational boundaries across the system, particularly around reducing the number of transfers of care.

NHS England PMS Reviews
All PMS practices have been met with during December to support them in deciding how they should respond to the national review deadline of the 5 January. Even though the timeframe was short, all practices were met with to discuss and understand that they thought the implications would be for them and how the CCG can support them in the coming months as they make the transition.

System Resilience
There has been significant demand pressure within the system over the Christmas period, particularly in relation to transfers of care. Despite this, Dudley Group Foundation Trust are the only hospital Trust locally to achieve the 95% A&E target for quarter three which they should be congratulated on. The Trust are also the fifth best performing nationally which is quite an achievement.

NHS England’s Five Year Forward View
NHS England have published their planning guidance for 2015/16 based upon issues outlined in the Five Year Forward Plan which informs the contractual process which will impact quite significantly and form a large part of the CCG’s work in preparation for next year’s contracts.
**Today’s Board Papers**

**Co-Commissioning of GP Services**

One of the key papers is the proposed submission to NHS England to take on devolved commissioning of GP services. The West Midlands Sub Region have had sight of the paper as presented to the Board and the feedback given was that they would support the paper. If approval is given from Board members then the next step would be to discuss, debate and develop the next reiteration of the CCG’s strategy. Mr Maubach highlighted that the key consideration is the Five Year Forward View developed by NHS England which offers opportunities to local areas. Consideration needs to be given as to whether Dudley CCG put themselves forward to demonstrate the model of care that is being operated.

Dr Horsburgh made comment with regards to the PMS Review changes in that the sum of money will be retained in the borough and felt it was important to note that Dudley will maintain the stability and sustainability of the GP community and that members of the public and the Board are reassured of the ongoing development of primary care as part of the PMS review process.

Dr Gupta asked if Dudley Group Foundation Trust performance of 95% was for one quarter of for the whole year. Mr Maubach responded by reporting that the Trust had achieved the target for quarters two and three but not for quarter one.

Dr Hegarty informed the Board that Paula Clark, Chief Executive – Dudley Group Foundation Trust, had been on the local news and Radio 4 and had given a very succinct and appropriate description of what the challenges are at the Trust and how they have responded.

Resolved:

1) That the Board noted the report for assurance

**STRATEGY**

**CCG008/2015 DEVELOPMENT OF THE CCG LONG-TERM STRATEGY**

Mr Maubach spoke to this item and reported that the paper outlines the CCGs thinking around how the model of care is further developed and expanded. The Board were asked to endorse the proposed next steps in developing the model of care and to approve the initial submission to NHS England to develop Dudley’s model of care as a national pilot.

Dr Hegarty reported that he had discussed with Mr Wellings prior to the Board meeting, the whole approach for Co-commissioning and that the approach the CCG is taking is being driven forward nationally. He further reported that it is very clear that new models of care will be needed and has been reinforced recently over the pressures within the system and how organisations have responded to it. Dr Hegarty recommended that the Board supports the paper.

Mr Polychronakis stated that having discussed the proposal with colleagues at Dudley MBC, they felt it was an excellent proposal and fully endorsed the recommendation.

Mrs Jasper requested assurance with regards to the interaction between GPs and Consultants and that the relationship is robust as this is integral to how things move forward.

Dr Hegarty responded by informing the Board that there is a Clinical Strategic Board jointly chaired by Dr Hegarty and the Medical Directors at Dudley Group Foundation Trust. Dr Mann and Dr Darby also attend the meeting together with associate Medical Directors at the Trust. It has been agreed at that meeting that there is a joint OD programme with Consultants at the Trust but recognising there are gaps in current working relationships, partly due to new structures at Dudley Group Foundation Trust.

Mrs Jasper asked for reassurance on GP workforce as it is mentioned within the paper to shift the care (including that provided by Consultants) from hospital to community and the impact this would have.

Mr Maubach reported that Dr Carol Griffiths was commissioned to carry out a piece of work to develop a proposal around a training and development programme which the Primary Care Development Committee has reviewed and the implementation of this will support the development of primary care. In addition, the GPs themselves in establishing their new organisation Future Proof Health Ltd will also...
help. Mr Maubach also reported that the shift from secondary to primary care does not mean transfer of work from the hospital to GPs thereby increasing GP workload, its around moving resources out of the hospital into primary care.

Dr Horsburgh emphasised the importance to have physicians out in the community and to engage in the process, not only around paediatric specialities, but all specialities and to work collaboratively with the GP and multi-disciplinary teams.

Mr Wellings commented on recent headlines with regards to the NHS being unable to cope and that the present system isn’t working because too many people are trying to access A&E. In contrast to that, where the Trust is performing well this is because they have worked together in an integrated way and Mr Wellings stressed the importance of engaging consistently with providers to ensure they understand what the CCG is doing.

Ms Emery questioned the language within the document and was uncertain whether members of the public would understand the terminology being used.

Mr Maubach agreed that the terminology should be changed and her concern was noted. In relation to public engagement, the paper has been informed by public forums that have been held and once some of the issues have been tested with Providers and Dudley MBC the next stage is to gain a public view.

Resolved:
1) Recognising the points raised, the Board supported the proposals

QUALITY AND SAFETY

Unannounced visit – Dudley Group Foundation Trust
Miss Bartholomew reported that a summary report has been prepared and will be discussed under a separate agenda item.

Discharge Information
Miss Bartholomew informed Board members that at the time of writing the report, Dr Edwards was awaiting a response from Dr Jane Dale with regards to progressing on resolving the issue. This letter has now been received at CQRM and discussed. The interim solution with regards paper discharge letters reaching practices will be confirmed as it has become apparent that there may be problems in relation to some of the information contained within them. CQRM and the Quality and Safety Committee will be tracking progress to ensure the problems are resolved by the 1 April 2015 in order to start electronic discharges.

Never Events
It was noted that two never events have been reported for Dudley Group Foundation Trust. Following the receipt of the manufacturer’s report which stated there was no equipment failure identified, the serious incident has been upgraded to a never event as a surgical error.

Pressure Ulcers
Dudley Group Foundation Trust has achieved an 80% reduction in avoidable pressure ulcers over three years.

Family and Friends Test
The inpatient friends and family response rate is 24.8% which is below the 2014/15 target of 30% and the national response rate of 37.6%. This will be addressed by CQRM to understand how improvements can be achieved.
Speech and Language Therapy Waiting Times
Concerns have been raised regarding the waiting times for access to Speech and Language Therapy. An action plan has been put in place and will be monitored by CQRM and Quality and Safety Committee to ensure it is adhered to and resolution achieved by March 2015.

MRSA
One case of MRSA has been reported to Dudley CCG during 2014/15 to date.

Serious Adult Reviews
It was noted that there are currently two cases which reach the threshold for Serious Adult Review. There is one case which does not meet the threshold but the Dudley Safeguarding Adult Board has requested a review which is being carried out by the CCG’s Lead Nurse.

Continuing Health Care and Intermediate Care Assessments
Work is ongoing around the backlog of CHC reviews and annual assessments and a further update will be available at the next meeting.

Complaints to Dudley CCG
Complaints continue to be responded to, reported and assessed but it was noted that there are no emergent themes.

Risk Register
The Board was asked to note that a new risk has been added to the risk register regarding the backlog of Continuing Health Care and Intermediate Care assessments.

Resolved:
1) The Board noted the report for assurance

CCG010/2015 UNANNOUNCED VISIT REPORT

Miss Bartholomew spoke to this item and informed the Board that the report is a summary of the unannounced visit that took place on 15 August 2014 which was prompted by whistleblowing incidents which were sent to the CQC. The action plan outlined in the report will be monitored by CQRM and the Quality and Safety Committee. It was also noted that Dudley Group Foundation Trust have also carried out their own internal visit and the CCG will be seeking the results following the visit.

Mrs Jasper asked for assurance that the actions will be taken forward as some of the Directors identified will be leaving. Miss Bartholomew responded by informing the Board that a request has been made to the Trust to identify the names of the person responsible for undertaking the action that will affect the change, as well as the Director responsible for the monitoring.

Dr Hegarty reported that he will be meeting with David Badger, new Chair of the Trust, and will express the Board’s concerns around the length of time it has taken to agree the report that has been presented.

Dr Mann expressed his concern that the report presented does not resemble the report that was presented to the private board in November and does not give adequate assurance to the Board.

Miss Bartholomew reported that the report is a summary component of the original report and there are actions that have taken place by the Trust which may not reflect the position they are in currently. The intention is for the Quality team to do a follow up visit and when that report comes to the Board, should offer a different view of where the Trust were when the Team visited in August.

Mr Wellings requested that the next visit includes clinicians from the CCG and to ensure that the report which is presented to the Board following the next visit is accurate.

Board members were in agreement that the report does not provide assurance on the current position and however accurate the action plan is, it reflects the Trust’s position five months ago. Members agreed that this should be treated as a learning process and that a process needs to be put in place on how unannounced visits are carried out in future.
Resolved:
1) With the conditions raised within the discussion, the Board agreed to receive the report.

**COMMISSIONING**

**CCG011/2015  CLINICAL DEVELOPMENT COMMITTEE REPORT**

Dr Mann spoke to this item and confirmed that the report summarised the key issues discussed at the Clinical Development Committees on 19 November 2014 and 17 December 2014.

**Integrated Diabetes Model of Care**
Dr Mann reported that a proposal has been approved by the Committee to commission an integrated model of care for diabetes and commended Dr Tapparo for the work that has been involved in getting to this stage. This signifies that people with the most common form of diabetes will be able to be seen in their GP surgeries.

**Integration of District Nursing and Virtual Ward Teams**
Dr Mann informed the Board that the Committee has approved in principle a proposal to integrate the virtual ward and district nursing teams into one community nursing service.

**Dudley Health and Wellbeing Peer Review**
Dr Mann reported that the Committee has noted the outcome of a peer review of the Health and Wellbeing Board. An agreed set of performance metrics is now reflected in a draft action plan that will be reviewed by the Committee.

**111 Service Specification**
Dr Mann notified the Board that the CCG are contributing to the development of the 111 Service Specification and note that there are conflicts of interest between WMAS and 111.

In order to comply with the procurement timetable for the service, the Committee recommend that the Board delegate authority to Dr Mann to approve the Service Specification for 111.

It was noted that delegated authority can only be given to one person in conjunction with other persons named.

**Physical Activity and Sport Action Plan**
Mrs Jasper asked for more detail in relation to the physical activity and sport action plan. The Board were informed that there had been an issue with funding for playing spaces within Dudley which was discussed at the Committee. Mr Dean Hill has been asked to produce a formal proposal, together with an action plan, for the Committee to consider further.

Mrs Jasper also asked if the Board could have feedback regarding the healthy town outdoor activity centres and how successful they have been. Mrs Jackson informed members that a full evaluation has been carried out and would ensure this is presented to the Board at a future meeting.

Mr Maubach notified the Board of the major conflict of interest in relation to the 111 Service Specification in that the main referrer of patients to the Ambulance Service is also being run by the Ambulance Service and it is important to note when delegating authority to be conscious of the potential outcome of the tendering process.

Resolved:
1) The Board supported delegated authority to approve the service specification with Dr Mann in conjunction with Mr Maubach, Mr Hartland, Mr Bucktin and Dr Darby

**CCG012/2015  HEALTH AND WELLBEING REPORT**

Mr Bucktin presented the report and informed the Board that the report was being presented for assurance. There was no further discussion on the paper.
Resolved:
1) The Board noted the report for assurance

**CCG013/2015 BETTER CARE FUND – SECTION 75**

Mr Bucktin spoke to this item and informed the Board that there were two issues relating to the Better Care Fund, the first one being the current process for agreeing the Better Care Fund plan and the resources associated with it. The second issue was regarding the governance of the Better Care Fund and the associated Section 75 agreement that provides the legal basis for providing a pooled budget.

Mr Bucktin reported that the CCGs Better Care Fund proposal was submitted to NHS England and approved with conditions which related to the level of ambition to reduce emergency admissions. This has been reviewed and reprofiled to reduce emergency admissions by 3.5% per year over four years which would have an impact on the resources that underpin the Better Care Fund. This has been renegotiated with the Local Authority and brought to a conclusion as per the report. A revised plan has been submitted to NHS England in December and a response is anticipated week commencing 19 January.

Mr Bucktin further reported that having agreed the activity reductions and the finances associated with it, and assuming the plan is approved by NHS England, that a Section 75 agreement needed to be developed to underpin the governance arrangements around the pooled budget. Discussions were taking place with the Local Authority relating to the issue.

Resolved:
1) The Board approved the revised financial plan for the Better Care Fund
2) The Board approved the proposed arrangements for the Section 75 agreement and pooled budget

**COMMUNICATIONS & ENGAGEMENT**

**CCG014/2015 COMMUNICATIONS AND ENGAGEMENT COMMITTEE REPORT**

As the Communications and Engagement Committee have not met since the last Board, there was no report available for this month.

**GOVERNANCE**

**CCG015/2015 AUDIT COMMITTEE REPORT**

Mrs Jasper spoke to this item and confirmed that the report summarised the key issues discussed at the Audit Committee held on 2 December 2014.

Mrs Jasper highlighted that the Committee, with its delegated powers approved were, The Freedom of Information and Engagement with Pharmaceutical Industry Policies and the Local Security Management workplan for 2014/15.

It was noted that the Committee were being asked for approval for the Co-Commissioning Task and Finish Group to report to the Audit Committee, however this was superseded by the revised Constitution and Terms of Reference which state that the Committee will now report directly to Board.

Mrs Jasper also asked the Board for approval on the closure of risk 21 within the BAF and Risk Register which relates to the challenge to resources within the CSU and their ability to deliver the service the CCG requires. It was noted that this service has now been brought in house.

Resolved:
1) The Board noted the report for assurance
2) The Board approved the closure of Risk 21
Mrs Jasper spoke to this item and asked the Board for their approval of the revised Terms of Reference for the Audit Committee.

Resolved:
1) The Board approved the revised Terms of Reference

Mr Hartland spoke to this item and reported to the Board that those risks scored 16 and above are presented. Members were notified of one change relating to the DGFT discharge system which was to note that the score has been increased. In addition, the Board were asked to approve the closure of risk 21 which relates to the challenge to resources within the CSU and their ability to deliver the service the CCG requires.

Mr Maubach referred to risk 26 which relates to inadequate staffing levels for women and neonates as a result of increased volume of patients. It was felt there is a need to understand what the mortality rates are in Dudley as there has been a change in the way perinatal mortality is reported. The associated risk is that patient choice is being restricted for maternity services and that a review on restrictions should take place. Members agreed the Clinical Development Committee should carry out this review.

With regards to the way in which perinatal mortality is reported, it was agreed that this should be discussed with Public Health to include input from the Quality and Safety Committee.

Resolved:
1) The Board approved the closure of risk 21
2) The Board agreed that the Clinical Development Committee should carry out a review of patient choice restrictions for maternity services
3) The Board agreed that the way in which perinatal mortality is reported should be discussed with Public Health which includes input from the Quality and Safety Committee

Mr Wellings took the Chair for this item as Dr Hegarty had declared an interest

Mr Wellings informed members that Dudley CCG have been developing a proposal to take over the commissioning of General Medical Services from NHS England for a number of months with clear support from the Board, Health and Wellbeing Board and the appropriate Committees within the CCG. A Task and Finish Group was established to develop a submission to NHS England by 9 January 2015, but the local West Midlands Sub Region of NHS England requested a draft submission prior to the date, hence the submission being made in advance of approval by the Board.

Mr Wellings made acknowledgements to both the staff that developed the submission and to the Task and Finish Group who met regularly to ensure the submission was completed in a timely manner.

It was noted that within the submission, the CCG recommend the proposed Committee meet in private and subsequently to the CCG Board in public, as per the other Committees. NHS England is requesting the meeting is held in public but due to a number of contractual issues which need to be resolved, it was felt the meeting be private. It was stressed that the public be reassured that the processes followed on how GPs practices are remunerated.

Mr Wellings reported that the CCG has changed its Conflict of Interest policy, Constitution, proposed Terms of Reference and new requirements for devolution in order for the process to be managed in the correct manner however, a number of concerns have been raised on whether there is enough clinical input in the process. Board members were assured that there has been clinical input throughout the process in that there are two clinicians on the Task and Finish Group and Dr Richard Bramble, who is not a voting member of the Board, has also provided input. Members were asked to note that a decision has been made that at this stage, that voting membership will be non-clinical although this does not
mean that clinical membership can't be co-opted onto the Committee to have clinical input on a regular basis.

Members were asked to note therefore that from a governance perspective, clinical members would not be able to take part in a decision that directly/indirectly affects the remuneration of practices and it was strongly recommended that the process is approved, particularly the proposed membership. There is still work to be completed with regards how the Committee would be supported in the work it produces and a review of the Primary Care Development Committee is taking place by Mr P Capener, Governance Support to decide how that may change.

In conclusion, members were asked to approve the proposed submission to NHS England to accept delegated commissioning of GP services, approve the changes to the constitution that the Task and Finish Group have included within the submission, approve the Terms of Reference for Primary Care Commissioning Committee, noting the new guidance from NHS England and devolve responsibility to the Chief Executive Officer and Chief Finance Officer, in conjunction with the Chair of the Task and Finish Group; to negotiate with NHS England on mitigating the risks that are shown in the report, particularly the financial uncertainties. As it was unclear on what resources would be delegated, members were asked to approve conditionally on the risks being mitigated.

Dr Rathore, having declared an interest as a GP, felt the guidance on conflicts of interest is timely and gives more detail around what a Committee may look like which takes on Primary Care Commissioning. Dr Rathore made reference to Paragraph 74 within the guidance which states “the arrangements for primary medical care decision making do not preclude GP participation in strategic discussions on primary care issues, subject to appropriate management of conflicts of interest…”

Dr Rathore also made reference to the committee membership examples on page 22 of the guidance which gives provision, under strict guidelines, to have GP members on the Committee, in a non-voting role. Dr Rathore suggested to the Board that Dr Hegarty, as Chair of the CCG and himself, as Primary Care Lead for the CCG, attend the Committee in a non-voting capacity to allow access to the Committee to clinical leadership and accountability back to the CCG's Clinical Executive Team.

Mr Maubach supported Dr Rathore’s suggestion with the exception of Dr Hegarty being a member. Members were in agreement with this and Mr Wellings explained that discussions around the membership of the committee had taken place with the Task and Finish Group and it was raised by the Good Governance Institute that if the Committee was in the position whereby a decision had been made and it was challenged, an independent person would need to hear the challenge who hadn’t taken place in the voting process.

Dr Horsburgh raised his concerns about members being invited to attend as required and felt there needed to be some consistency by having established non-voting members on the Committee, particularly if decisions are being taken relating to how general practice works and there is no representation to provide the input.

Dr Horsburgh raised a point under paragraph 25 of the Terms of Reference which state “Governing Body elected GPs, Clinical Executives or other GP members will only be in attendance for those agenda items that the Committee membership has deemed appropriate for their input”. It was felt that this could be seen as exclusion and it was agreed that this should be amended to read “there will be non-voting members in attendance but where national guidance defines in terms of conflicts of interest, those individuals will not be present.”

Dr Gee questioned whether there is a risk that the funds which are available to the CCG, and having gained authorisation to commission primary care, will be less than at the present time.

Mr Hartland responded by saying that although this is how the position currently stands, the CCG has gained assurance that the value of the budget being transferred is sufficient to cover the value of the GP practice contracts. The challenge being faced is the additional reserves which the CCG will have to hold which NHS England currently holds.

Another consideration is that the CCG's internal capacity would need to increase which could pose a financial risk to the CCG. Mr Hartland notified members that the running costs budget for 2015/16 include the 10% reduction required by NHSE and this has resulted in the budget being at capacity. Any
additional posts required under co-commissioning will be a cost pressure to the CCG and will need to be mitigated as no additional Running Cost resource will be forthcoming.

Resolved:
1) With the exception of paragraph 25 being amended, the non-clinical Board members approved the recommendations within the report

Mr Wellings handed the Chair back to Dr Hegarty
Dr Darby left the meeting

FINANCE AND PERFORMANCE

CCG019/2015 FINANCE AND PERFORMANCE COMMITTEE REPORT

Dr Rathore spoke to this item and confirmed that the report summarised the issues discussed by the Finance and Performance Committee at its meetings held on 27 November 2014 and 18 December 2015.

QIPP 2015/16
Dr Rathore reported that the QIPP target for next year has been increased from £9.2m to £11.2m and that the Finance and Performance Committee have discussed ways of mitigating the risks for next year. The suggestion made is to limit the number of initiatives within QIPP to those that deliver the most benefit. In addition, the value of reserves will be reduced to mitigate against an increasing savings target which is currently at £3.8m.

Members were informed that a prioritisation tool will be developed to re-commission and decommission services and stressed that this is an important concept moving forward and that an 'invest to save' principle will be adopted for service developments and business cases.

Over Performance at Dudley Group Foundation Trust
Dr Rathore advised the Board that the Finance and Performance Committee had considered over performance at Dudley Group Foundation Trust and the areas to address are in relation to emergencies, drugs excluded in tariff and A&E.

Diagnostics and Performance
Dr Rathore reported that diagnostics was not achieved in October and a rectification plan has been received from DGFT. With regards to 18 weeks RTT, assurance has been provided from the Head of Intelligence & Analytics that the target will be met but the two biggest challenges are in relation to ophthalmology and urology.

Resolved:
1) The Board noted the report for assurance

PRIMARY CARE

CCG020/2015 PRIMARY CARE DEVELOPMENT COMMITTEE REPORT

Dr Rathore spoke to this item and confirmed that the report summarised the key issues discussed by the Primary Care Development Committee at its meetings held on 14 November 2014 and 11 December 2014.

Productive General Practice (PGP) – Wychbury
Dr Rathore reported that the Committee received a feedback presentation from members of Wychbury Medical Group on their experiences with Productive General Practice. The aim is to implement PGP in another six general practices. It was noted that Wychbury received support and backfill to allow clinicians and management time to complete the pilot which is key to its success and that if it is rolled out it has to be done in a meaningful way.
Extended Hours Plus Service Specification
An Extended Hours Plus Service Specification has been put forward to try and improve the number of appointments available over the Winter period developed ending March 2015. It was reported that seven practices are signed up and open on Saturday mornings.

Evaluation of Primary Care Education
An evaluation of the Primary Care Education support was received by the Primary Care Development Committee and the recommendations will be taken forward by the Committee.

Risk Register
Dr Rathore advised members that a recommendation had been made to the Audit Committee to add a risk to the register for the ability of member practices to fulfil their contractual obligations to NHS England as a result of difficulties recruiting substantive GPs resulting in contractual breach, or termination of contract.

Dr Rathore informed the Board that there will be a GP Job Fayre in May which runs in co-ordination with the GP Education Programme to encourage GP colleagues to advertise their vacancies.

Dr Horsburgh requested further information around A&E attendances on a Saturday morning for those practices who are signed up to the Extended Hours Plus Service Specification scheme to ascertain whether numbers had reduced. Mr King reported that this information should be available and will report back to the Board.

Resolved:
1) The Board noted that Mr King would report back on the Extended Hours Plus Service Specification
2) The Board approved the recommendation to add a risk to the register regarding fulfilling contractual obligations.

DATE OF NEXT MEETING
Thursday 12 March 2015
1pm – 5pm
Boardroom, Brierley Hill Health & Social Care Centre

MINUTES ACCEPTED AS A TRUE AND CORRECT RECORD

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Introduction

This report is presented with the aim of keeping Board members up to date with important communications and engagement issues and ‘hot topics’ that may be outside or beyond the assurance required from the Communications and Engagement Committee Report.

It is also produced with the specific aim of further strengthening the patient voice at our board meetings by including sections dedicated to feedback from our Patient Participation Groups, Patient Opportunities Panel and Healthwatch – a response to a series of requests from some of our more active patient representatives.

Feet on The Street

The Feet on the Street video screened at today’s Board meeting features our ‘Do it right, Dudley’ campaign. We hear from Dr Steve Mann, Clinical Lead for Urgent Care on the vision for this campaign and hear from the public on the street, with whom we tested some of the campaigns ideas.

This is a snapshot of opinion and the Board should be assured that more work will be taking place to test campaign ideas with Dudley residents before investment for campaign materials later in the year.

Patient Voice

This section includes specific updates from, and issues raised by, Public and Patients at our public meetings and Patient groups, plus snapshots of what our patients are saying on social media and other relevant arenas.

This report also includes updates on issues identified from our analysis of a comprehensive suite of patient experience data and feedback. This new analysis is possible as we now have a Patient Insight specialist in post, Rob Franklin and we have made great progress with our local hospital Dudley Group FT to have an open & transparent approach to Patient Experience data.

- Patient Participation Groups (PPGs)
  We have 44 PPGs across the borough and we are working with the GP Engagement Lead to support the remaining 3 practices to develop this resource for their patients.

The CCG set aside funding for our PPGs, ‘the PPG Purse’. Two PPGs have applied for this funding so far, Wychbury and Eve Hill and both have been approved. Eve Hill have received funding for newsletters, leaflet stands and to hold a practice open evening with PPG members and practice staff – other organisations will be invited to share their information too.
Wychbury PPG have applied for funding for electronic communications equipment to enable them to produce information and presentations in a variety of formats for internal and external use.

- **Patient Opportunities Panel (POPs)**
  At the most recent meeting Paul Maubach attended and gave members an opportunity to ask him questions about Integration. A new film has been produced to summarise the vision for this new model of working ([www.dudleyccg.nhs.uk/integration](http://www.dudleyccg.nhs.uk/integration)) and this film was played at the meeting. There were some interesting questions about the communication with the patients and their consent for information to be discussed at the Multi Disciplinary Team Meetings. A follow up discussion will take place on this.

  There were also queries raised on the new Urgent Care Centre which were answered.

  In relation to Engagement on the new Urgent Care Centre Procurement, two members of POPs were representing the group. Their input was extremely valuable but they expressed concern at the meeting that they had not been fully communicated with on the final decisions to appoint Malling Health. These concerns were noted and the individuals concerned have been contacted by the Urgent Care commissioner. They will be attending a walk through of the new centre in the near future.

  Some members of the POPs group have invited the CCG to attend a meeting to understand their views on how the group is currently working. We will feedback to the Communications & Engagement Committee on this.

- **Healthcare Forum (HCF)**
  Our last Healthcare Forum was on December 11th 12-2.30pm at Brierley Hill Civic Hall.

  The event gave participants the opportunity to live a ‘day in the life’ of CCG decision makers. The attendees looked at commissioning decisions in a key area to understand and role play different perspectives and contribute views on how decisions should be made. We used the example of IVF to facilitate insight in this area and the comments made by participants have been used to inform the new IVF policy. Namely that the participants felt that 3 years was a long time to wait for IVF treatment to start if your age is toward the upper end of eligibility criteria. The split in opinion in the room with regard to funding IVF treatments was mirrored by comments posted after recent media coverage locally on this topic but all views have been considered in revising the policy.

  Chaired by our Dr Steve Mann the meeting received some really positive feedback, some of which are quoted below,

  “I really enjoyed today! I feel I have learnt a lot about IVF treatment and enjoyed doing the scenario. Thank you.”

  “I really enjoyed the session & really got me thinking about how finances are spent in NHS”

  “Loved the discussion and activity about IVF very educational. Has given me a better understanding from all sides”
The next HCF is on the 5th March 2015. The topic is the 5YFV (5 Year Forward View) and how Dudley CCG is responding. We will be looking to discuss integration and the next steps to achieving the vision set out in our submission to NHS England.

Other areas of Public opinion / insight include:

- **Doing it right in Dudley – Easing the burden on healthcare services in Dudley.**

  Here in Dudley, the NHS has a fixed amount of money to spend on delivering care to its patients. With an aging population and an increase in long-term conditions adding strain to services, the way these funds are used is more important now than ever before.

  Whilst the NHS in Dudley has a responsibility to ensure its funds are used appropriately, all patients in the area have an equally important part to play.

  Currently, 4 in 10 people who go to A&E could have been seen by their GP, and many people who visit their GP could have seen a pharmacist or even self-cared at home. Even worse, there are incidences where 999 ambulance calls are made for non-life threatening conditions.

  The incorrect use of services puts an additional and unnecessary strain on our local NHS, waste vital funds, and can put people’s lives at risk. The time has come to address these issues, and we’re working to make a positive change for our local NHS and all patients in Dudley.

  Our Choose Well campaign – *Do it right, Dudley!* – is being developed to promote the correct use of NHS services in Dudley. It’s a strong and memorable way of communicating directly with patients, and will create an engaging platform of conversation between all service users and healthcare professionals.

  Alongside educational and awareness activities, this conversation will bring about a sustainable and long-term change in how the residents of Dudley use their healthcare services.

  With shared expertise in selecting the right healthcare service, and a greater connection between services and patients, the NHS should see a number of measurable benefits.

  The campaign will be designed to be flexible, and will be able to communicate key messages from all service providers in the Choose Well spectrum. It can work as equally effectively for an individual service such as Urgent Care, or the whole of the NHS in Dudley.

  The launch of the conversation, started with a letter from Dudley CCG GP Board members along with the Medical Director at Dudley Group FT.

- **Urgent Care Centre Opening**

  The new Dudley Urgent Care Centre will open on the 1st April 2015. The Existing Walk in Centre (WiC) located at Holly Hall will close on the 31st March 2015.

  There are many messages to communicate including the relocation of phlebotomy clinics to make room for the new UCC within Russell Hall Hospital. A communications plan has been developed across partners and is being implemented.
Key messages include:

- 24/7 urgent care centre opens at Russell’s Hall Hospital (RHH) on 1st April 2015
- The service will be tested in the preparatory month, March 2015-03-04
- The Walk-in centre at Holly Hall will close its doors at 10pm on the 31st March 2015
- Out of Hours GP Service will be available from RHH from the 1st April 2015
- If it’s not a 999 emergency, but you need medical help fast call 111

The main focus is on safe transfer of services from WiC at Holy Hall to the new Urgent Care Centre.

We do not want to push up demand for this new service simply to ensure that people who need healthcare know where to go or who to call.

Materials include new signs for outside Holly Hall once it closes, posters and business cards for GP surgeries and WiC to advertise the changes, new signage on the floor with RHH to guide people to the UCC from ED, a leaflet for patients planning why they are being sent from ED to the new UCC, press releases, articles for newsletters and a full suite of FAQs covering popular topics of parking and staff transfers.

We have already received some media coverage on this which was largely focussed around the number of jobs and was a positive story for us.

- **Big Balloon Debate**

We are holding an event on the 23rd March 2015 at Oldswinford School to encourage students to get involved and start thinking about health topics. The debating event will see year 12 student teams from each school debate on the topic of spending NHS money. There will be a prize for the top 3 teams. This is part of our commitment to finding new ways to engage young people in the health agenda and bring education & health closer together in Dudley.

Significant developments have been made with Dudley Group Foundation Trust over the last 3 months in developing the infrastructure required for a much more complex patient experience reporting system. Quarter 3 (Appendix 2) style of reporting received feedback from a number of sources ranging from the DGFT hospital directors, DGFT patient experience group and the CCG Quality & Safety committee, recommendations were made and a new style of reporting was jointly developed. This style of reporting will use a system of generic categorisation which will allow for the unification of common categories to show the most pertinent issues across a range of data sets. This style of data recording and analysis will also allow for information to be presented in a much more visually inclusive format as the picture demonstrates.

This style of reporting will be further enhanced with the addition of complex analytical software comfortably sitting behind this visual representation to allow for a much deeper level of analysis. To
support this new model we have requested as part of the contracts with providers that patient experience information is received monthly in a source format which will allow for the complex level of analysis by areas such as area, ward, category & date.

To enhance patient feedback we have begun work on the development of a patient feedback app, initial conversations have taken place with the developer and a baseline specification has been agreed. The project is being overseen by the CCG IT Strategy group, with involvement from the Head of communications from both the CCG & DGFT but also clinical and system leadership through the support of Dr Darby. We plan that the first iteration of the product will be available for download at the end of May 2015; following release this will then follow a process of development where the product will be updated to meet user needs.

Tea & Chat

Carers Rights Day in November was marked with a new hospital tea and chat service which has got off to a flying start. Since it’s launch more than 700 people have been given information about the support available for carers in Dudley borough.

‘Tea and Chat’ was set up by the hospital Carer Coordinator with the support of Healthwatch Dudley to identify hidden carers.

The service is available one afternoon each week on the wards of Russells Hall Hospital during visiting times between 2pm & 4pm. Trained Healthwatch Dudley and hospital volunteers offer patients and their visitors a warm drink, a friendly chat and the chance to find out more about the help, support or benefits that carers can tap into.

The free service is part of the Dudley Group NHS Trust charity and is funded entirely through donations. Sainsbury’s supermarket in Merry Hill initially backed the service by providing a tea trolley and refreshments.

Case study…

Margaret was sitting at her husband’s bedside and was offered a cup of tea by a tea and chat volunteer together with information about being a carer.

The following day, Margaret called the carer coordinator to say thank you for the information and then broke down in tears on the phone.

Margaret said that she had never thought of herself as a carer before and had been feeling quite desperate about her situation and how she was going to continue to cope. She said that the volunteer listened to her experience of being a carer and she felt very emotional, as in the five years that her husband had been ill she had not thought about her own needs and had not been asked.
Patient Journeys

Healthwatch Dudley staff and volunteers are currently visiting Dudley Group every week to capture patients’ views and experiences of their journeys through surgical and medical wards. There is a focus on gaining an understanding of procedures and experiences by examining relationships and conversations between patients, families, carers, hospital staff and any other relevant people on their journey through a ward. Patient experiences and journeys may highlight gaps in communication and service, identify opportunities for improvement and raise awareness of what is being done well. Volunteers are involved to ensure that real voices are heard in an independent and unbiased way.

A final report will be produced including case study experiences, key findings and our recommendations by the end of April.

Urgent Care Centre

Patient feedback is of the utmost importance to us and with the imminent opening of the new Urgent Care Centre we are keen to independently ask visitors to the service to share their views and experiences with us. With the support of Healthwatch Dudley volunteers, we are planning to collect feedback during June and July. Findings will be shared at a future CCG Board meeting.

Stroke Review

In addition to the work being led by Sandwell & West Birmingham CCG on the Birmingham, Solihull and Black Country Stroke Reconfiguration Programme we have been commissioned by Dudley CCG to collect a range of different patient views and relevant organisational perspectives on stroke services provided within Dudley. The research will aim to examine and better understand the patient journey component of stroke services. We are working with Dudley Stroke Association to obtain access to stroke patients and carers and stories about their healthcare experience. This piece of work is currently underway.

New People’s Network for adult social care

Healthwatch Dudley has teamed up with Dudley Council & Making It Real to host regular events for networking with positive people with similar interests in adult social care.

The new People’s network will:

- Be a space for discussions and knowledge sharing about local services
- Inform policies and influence what local services look like
- Give real opportunities to feedback to decision makers
- Involve people in testing the accuracy and readability of public documents before they go live
Invite people to bring and share powerful stories, journeys and experiences

A launch event will take place on **11th of March between 11am & 1.30pm** where people who attend will be invited to plan the focus of the next two network events. The network is for people who access or provide services or those who care for people who do.

**Hot Topics**

This section of the report includes updates on proactive and reactive media activity and any other current issues.

**Proactive and Reactive Media Activity**

**Communications and Engagement – Media Monitoring – January 2015**

The table in appendix 1 gives a breakdown and hyperlinks to recent media activity for the CCG.

The total coverage value in AVE (Advertising Value Equivalent) equates to £79,300 with £40,000 of this relating to positive coverage.

Topics covered include, CCG co-commissioning, walk in centres must remain open and new care centre jobs boost.

**Membership Matters**

In order to produce our Annual Report we must seek the views from our GP Membership. At a recent Members Meeting the Communications & Engagement Team attended to capture views on what have been this years, highs, lows and areas for work. This was done through the use of a roadmap image and a survey will be sent out in early March to add to this insight.

The team also tested the new texting service at the event. This is a new telephone number which has been purchased enabling live texts from people attending an event to be shown live on the screen at the front of the room. This proved successful, giving those who didn't want to raise a point verbally the chance to contribute to the meeting as it went along.
<table>
<thead>
<tr>
<th>Title/weblink</th>
<th>Summary</th>
<th>Release Date</th>
<th>Coverage (with links where available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Bed Blocking at High Cost to the NHS</td>
<td>Media Story&lt;br&gt;Bed blocking is costing the NHS in Dudley around £145,000 with patients who are well enough to leave hospital taking up beds on wards</td>
<td>01.01.2015</td>
<td>All Local Chronicles&lt;br&gt;<a href="http://www.dudleyccg.nhs.uk/wp-content/uploads/2015/01/Hospital-Bed-Blocking-at-High-Cost-to-the-NHS.pdf">http://www.dudleyccg.nhs.uk/wp-content/uploads/2015/01/Hospital-Bed-Blocking-at-High-Cost-to-the-NHS.pdf</a></td>
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<tr>
<td>Members of Public Invited to Dudley Health Meeting</td>
<td>Coverage of Press Release&lt;br&gt;HEALTH chiefs are inviting members of the public to find out the latest on borough healthcare issues at a meeting this week.</td>
<td>06.01.2015</td>
<td>Cotswold Journal&lt;br&gt;<a href="http://www.dudleyccg.nhs.uk/wp-content/uploads/2015/01/Members-of-the-public-invited-to-Dudley-health-meeting.pdf">http://www.dudleyccg.nhs.uk/wp-content/uploads/2015/01/Members-of-the-public-invited-to-Dudley-health-meeting.pdf</a></td>
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<tr>
<td><strong>Urgent Care Centre Update – Media Enquiry</strong></td>
<td><strong>Media Enquiry</strong></td>
<td><strong>07.01.2015</strong></td>
<td><strong>Sunday Mercury – Bob Haywood</strong></td>
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<tr>
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<tr>
<td>People in Dudley are being asked not to go to Accident and Emergency (A&amp;E) departments unless they have a serious or life threatening condition.</td>
<td></td>
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<thead>
<tr>
<th><strong>IV Policy Media Enquiry</strong></th>
<th><strong>Media Enquiry</strong></th>
<th><strong>12.01.2015</strong></th>
<th><strong>BBC – Gareth Ford-Lloyd</strong></th>
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<tr>
<th><strong>N in the NHS has lost its meaning</strong></th>
<th><strong>Coverage of Media Enquiry on IVF</strong></th>
<th><strong>12.01.2014</strong></th>
<th><strong>Express &amp; Star West Midlands</strong></th>
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</thead>
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<tr>
<th><strong>All We Want in the World is to Start a Family</strong></th>
<th><strong>Coverage of Media Enquiry on IVF</strong></th>
<th><strong>12.01.2014</strong></th>
<th><strong>Express &amp; Star West Midlands</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Neg</strong></td>
<td></td>
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<td><a href="http://www.dudleyccg.nhs.uk/wp-content/uploads/2015/01/All-We-Want-in-the-World-is-to-Start-a-Family.pdf">http://www.dudleyccg.nhs.uk/wp-content/uploads/2015/01/All-We-Want-in-the-World-is-to-Start-a-Family.pdf</a></td>
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<tr>
<th><strong>Taking the Forward View from the Bottom Up</strong></th>
<th><strong>Media Story</strong></th>
<th><strong>14.01.2015</strong></th>
<th><strong>HSJ (Health Service Journal)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Innovation” and “change” are words that are increasingly bandied about, not just in the health sector but across all sectors under strain from the after-effects of recession.</td>
<td></td>
<td><a href="http://www.dudleyccg.nhs.uk/wp-content/uploads/2015/01/Taking-the-Forward-View-from-the-Bottom-Up.pdf">http://www.dudleyccg.nhs.uk/wp-content/uploads/2015/01/Taking-the-Forward-View-from-the-Bottom-Up.pdf</a></td>
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<tr>
<th><strong>Students Lead the Way at CCG Board</strong></th>
<th><strong>Press Release</strong></th>
<th><strong>15.01.2015</strong></th>
<th><strong><a href="http://www.dudleyccg.nhs.uk/students-lead-the-way-at-ccg-board/">http://www.dudleyccg.nhs.uk/students-lead-the-way-at-ccg-board/</a></strong></th>
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<tr>
<th><strong>Prime Ministers Challenge Fund Bid – have we applied? – Media Enquiry</strong></th>
<th><strong>Media Enquiry</strong></th>
<th><strong>16.01.2015</strong></th>
<th><strong>Pulse Magazine – Sofia Lind</strong></th>
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<tbody>
<tr>
<td>Frequent Caller to WMAS – Media Enquiry</td>
<td><strong>Media Enquiry</strong></td>
<td>16.01.2015</td>
<td>Stourbridge News – Kelly Harris</td>
</tr>
<tr>
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<tr>
<td>Co-Commissioning – Media Enquiry (Spoke to Paul Maubach – Chief Accountable Officer)</td>
<td><strong>Media Enquiry</strong></td>
<td>16.01.2015</td>
<td>Health Service Journal - HSJ</td>
</tr>
<tr>
<td>Students Praised for Health Festival</td>
<td><strong>Coverage of Press Release</strong></td>
<td>19.01.2015</td>
<td>Express &amp; Star (Main)</td>
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<tr>
<td>Paramedics called to Stourbridge address 242 times in 12 months</td>
<td><strong>Coverage of Media Enquiry</strong></td>
<td>19.01.2015</td>
<td>Stourbridge News</td>
</tr>
<tr>
<td></td>
<td>STOURBRIDGE MP Margot James has said people &quot;shouldn't rush to judgement&quot; after it was revealed paramedics were called to one property in Stourbridge more than 200 times within a 12 month period.</td>
<td></td>
<td><a href="http://www.dudleyccg.nhs.uk/wp-content/uploads/2015/01/Paramedics-called-to-Stourbridge-address-242-times-in-12-months.pdf">http://www.dudleyccg.nhs.uk/wp-content/uploads/2015/01/Paramedics-called-to-Stourbridge-address-242-times-in-12-months.pdf</a></td>
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<tr>
<td>How much funding has CCG allowed for extended opening hours</td>
<td><strong>Media Enquiry</strong></td>
<td>21.01.2015</td>
<td>Express &amp; Star – Andrew Turton</td>
</tr>
<tr>
<td>Winter workload sees practices open their doors on Saturdays</td>
<td><strong>Coverage of Press Release</strong></td>
<td>21.01.2015</td>
<td>Practice Business</td>
</tr>
<tr>
<td></td>
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<td><a href="http://www.practicebusiness.co.uk/Practice-Business/articles/winter-workload">http://www.practicebusiness.co.uk/Practice-Business/articles/winter-workload</a></td>
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<tr>
<td>Practices open on Saturdays to ease NHS winter pressures</td>
<td>Coverage of Press Release</td>
<td>21.01.2015</td>
<td>GP Online</td>
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<td>Call-Out Calm Pleas is Made</td>
<td>Coverage of Media Enquiry</td>
<td>22.01.2015</td>
<td>Stourbridge News</td>
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<tr>
<td>Exclusive: Third of CCGs apply for full co-commissioning powers over GP members</td>
<td>Coverage of Media Enquiry</td>
<td>22.01.2015</td>
<td>Health Service Journal</td>
</tr>
<tr>
<td>GP Access &amp; Retention in Dudley</td>
<td>Parly Hub Request</td>
<td>23.01.2015</td>
<td>NME Comms</td>
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<tr>
<td>Everyone is a Change Agent</td>
<td>Media Story</td>
<td>23.01.2015</td>
<td>Nursing Times</td>
</tr>
<tr>
<td>Date</td>
<td>Title</td>
<td>Source</td>
<td>Link</td>
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<td>Release Date</td>
<td>Coverage (with links where available)</td>
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<tr>
<td>UPDATED: Third of CCGs apply for full co-commissioning powers over GP members</td>
<td>Media Story</td>
<td>01.02.2015</td>
<td>Health Service Journal (HSJ)</td>
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<tr>
<td>Should the national GP contract be scrapped?</td>
<td>Media Story</td>
<td>03.02.2015</td>
<td>Pulse Magazine</td>
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<tr>
<td>Top Tory Minister visits Clinical Group</td>
<td>Media Story</td>
<td>05.02.2015</td>
<td>Stourbridge News</td>
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<td>UCC Media Enquiry</td>
<td>Media Enquiry</td>
<td>09.02.2015</td>
<td></td>
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<td>MCP/PAC Applications – Media Enquiry</td>
<td>Media Enquiry</td>
<td>09.02.2015</td>
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<tr>
<td>GPs bid for 'vanguard' pilot funding with plans to run care homes and</td>
<td>Coverage of Media Enquiry on MCP</td>
<td>10.02.2015</td>
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14
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<tr>
<th>Dudley MP calls for help before hospitals financial crisis threatens lives</th>
<th>Media Story</th>
<th>24.02.2015</th>
<th>Stourbridge News</th>
</tr>
</thead>
</table>
Appendix 2: Patient Experience Infographic Q3

**Top 5 PALS Concerns**

This quarter DGFT received 270 concerns through patient advice and liaison service. This is up from 241 the previous quarter.

**Patient Experience**

**DGFT Q3**

Friends and Family Test Q3

- A&E: 83.4% Score, 21.6% Response Rate
- Inpatient: 97% Score, 30.9% Response Rate
- Antenatal: 98% Score
- Birth: 99.2% Score
- Postnatal Ward: 98.8% Score
- Postnatal Community: 100% Score

**FFT Inpatient**

856 Positive Comments

- 73 (13.3%) felt food could be improved
- 37 (15.4%) felt more staff are required
- 15 (6.2%) felt pharmacy could be improved
- 15 (6.2%) felt discharge & TTOs could be improved

**FFT A&E/EAU**

76 Positive Comments

- 9 (17.5%) felt waiting times could be improved
- 25 (52.6%) felt food could be improved
- 12 (25.0%) felt parking & fees could be improved
- 25 (52.6%) felt appointment times could be improved

**FFT Maternity**

105 Positive Comments

- 25 (33.3%) felt waiting times could be improved
- 5 (8.1%) felt appointment times could be improved

**Patient Opinion & NHS Choices**

- 86 Positive, 29 Positive, general nursing care
- 3 Negative, communication with patient family verbal

2305 compliments received this quarter
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Board:** 12 March 2015  
**Report:** Clinical Development Committee Report  
**Agenda item No:** 7.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Better Care Fund – Section 75 Agreement and Section 256 Transfer of Resources From NHS England to Dudley MBC</th>
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<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
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</tbody>
</table>
1. To approve the heads of terms for the Better Care Fund (BCF) Section 75 Agreement, made under Section 75 of the NHS Act 2006.  
2. To approve the transfer of resources from NHS England to Dudley MBC under Section 256 of the NHS Act 2006. |
| AUTHOR OF REPORT: | Mr N Bucktin, Head of Commissioning |
| MANAGEMENT LEAD: | Mr N Bucktin, Head of Commissioning |
| CLINICAL LEAD: | Dr S Cartwright, Clinical Executive – Partnerships and Integration |

**KEY POINTS:**

1. Dudley’s BCF Plan has now been fully approved by NHS England.  
2. This will involve the establishment of a pooled budget between the CCG and the Council, the total value of which is £69.0m.  
3. An element of the pool will be resources transferred from the CCG to the Council totalling £4.625m, part of which £1.625m is performance related.  
4. In order to create and manage the pooled budget, both parties must enter into an agreement made under Section 75 of the NHS Act 2006.  
5. This Section 75 Agreement covers the arrangements for managing performance of the pooled budget, including risk sharing arrangements for under/overspends. The agreement is overseen by the “Integrated Commissioning Executive” – a joint group responsible to the Health and Wellbeing Board. The Board are required to approve the Agreement.  
6. For 2014/15, there is a separate transfer of resources to the Council from NHS England and the Board is required to formally approve this.

**RECOMMENDATION:**

1. That the heads of terms for the BCF Section 75 Agreement be approved.  
2. That the transfer of resources from NHS England to the Council be formally approved.

**FINANCIAL IMPLICATIONS:**

1. The schedule at Appendix 1 shows the total resources that will be included in the pool, totalling £69.0m.  
2. This includes £4.625m from the CCG’s baseline budget, an element of which £1.625m is performance related.  
3. There are risks associated with this. If emergency admissions do not reduce the CCG will not have the resources to put into the pool and the performance related element will not be available to the Council.  
4. The schedule at Appendix 2 shows the resources to be transferred from NHS England to the Council in 2014/15 and its use, totalling £7,155,000.

**WHAT ENGAGEMENT HAS TAKEN PLACE:**  
N/A

**ACTION REQUIRED**

- Decision  
- Approval  
- Assurance
1.0 PURPOSE OF REPORT

1.1 To approve the heads of terms for the Better Care Fund (BCF) Section 75 Agreement, made under Section 75 of the NHS Act 2006.

1.2 To approve the transfer of resources from NHS England to Dudley MBC under Section 256 of the NHS Act 2006.

2.0 BACKGROUND

2.1 The Board will recall that at its meeting in December 2014, it received a report on progress with the BCF Plan and the associated Section 75 Agreement for the BCF pooled fund.

2.2 This report updates the Board on progress with the BCF Plan, sets out the heads of terms to be approved for the Section 75 Agreement and seeks approval to the use of monies transferred from NHS England to the Council in 2014/15.

3.0 BETTER CARE FUND PLAN

3.1 The Board will recall that the original BCF Plan was approved by NHS England “with conditions”. The main condition related to the rate at which emergency hospital admissions were expected to reduce.

3.2 The resubmitted plan amended the profile of the reduction in activity over a longer time period. This plan has now been fully approved.

4.0 SECTION 75 AGREEMENT

4.1 The Council and the CCG are required to enter into such an agreement in order to create a pooled budget.

4.2 It is proposed that the pooled budget, as set out in Appendix 1, will be “hosted” by the CCG. This is currently the matter of negotiations with the Council. The Agreement sets out the technical accounting arrangements for managing the pool. In addition, it sets out how under and overspends and other financial arrangements will be managed between the partners. In particular:-

- where any overspends are identified, these will need to be offset, in the first instance, by underspends that can be achieved elsewhere in the pool;

- at the year end, any over/underspends will be apportioned between the partners in proportion to their relative contributions to the pool;

- any excess bed day charges placed upon the CCG as a result of delayed transfers of care from hospital where the delay is the responsibility of the Council, will be reimbursed to the CCG by the Council.

4.3 The Agreement will be overseen by a joint group – the Integrated Commissioning Executive, made up of 4 senior representatives of the partners, chaired by a representative of the CCG and reporting to this Board.

4.4 This body will:-

- provide strategic direction on the individual BCF schemes;
- receive financial and performance reports;
• review the operation of the Agreement and the operation of individual schemes;
• agree any variations to the Agreement;
• ensure that no changes to the budget for, or operation of, any schemes are made without
  the Executive’s consent;
• ensure appropriate reports are made to this Board.

4.5 A performance framework is being developed jointly and this will ultimately be managed by the
CCG. A separate Finance and Performance Sub-Group will review performance and report to the
Integrated Commissioning Executive.

5.0 TRANSFER OF RESOURCES FROM NHS ENGLAND TO COUNCIL UNDER SECTION 256 OF
THE NHS ACT 2006 - 2014/15

5.1 The Board has, on previous occasions, noted the transfer of £7,155,000 from NHS England to the
Council for the purposes of providing social care to contribute to the prevention of admission to
hospital and promote timely discharge from hospital. The use of these monies is as set out in
Appendix 2.

5.2 In 2015/16, these monies will form part of the pooled budget. The Board is required to formally
accept this transfer and recognise its responsibilities for discharging the duties associated with the
use of this funding.

6.0 RESOURCE IMPLICATIONS

6.1 The schedule at Appendix 1 shows the total resources that will be included in the pool, totalling
£69.0m. This includes £4.625m from the CCG’s baseline budget, and element of which (£1.625m) is
performance related.

6.2 There are risks associated with this. If emergency admissions do not reduce the CCG will not have
the resources to put into the pool and the performance related element will not be available to the
Council.

6.3 The schedule at Appendix 2 shows the resources to be transferred from NHS England to the
Council in 2014/15 and its use, totalling £7,155,000.

7.0 RECOMMENDATION

7.1 That the heads of terms for the BCF Section 75 Agreement be approved.

7.2 That the transfer of resources from NHS England to the Council be formally approved.

Mr N Bucktin, Head of Commissioning
February 2015
## Appendix 1 –

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Cost</th>
<th>Owner</th>
<th>team</th>
<th>PI</th>
<th>Area of Spend</th>
<th>Intervention</th>
<th>Stream2</th>
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<tbody>
<tr>
<td>Community rapid response team (CRRT) - Health</td>
<td>£ 1,321,848.00</td>
<td>CCG</td>
<td>CRRT</td>
<td>Avoidable Admissions</td>
<td>Community Health</td>
<td>CRRT</td>
<td>Crisis/Emergency</td>
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<td>Community rapid response team (CRRT) - Social</td>
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<td>CRRT</td>
<td>Avoidable Admissions</td>
<td>Social Care</td>
<td>CRRT</td>
<td>Crisis/Emergency</td>
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<tr>
<td>VW – 8 wards</td>
<td>£ 1,582,099.00</td>
<td>DGoH</td>
<td>Virtual Ward</td>
<td>Avoidable Admissions</td>
<td>Community Health</td>
<td>MDTs</td>
<td>Crisis/Emergency</td>
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<td>Care Home Nurse Practitioners</td>
<td>£ 159,005.00</td>
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<td>Care Home Nurse Practitioners</td>
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<td>CRRT</td>
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<td>£ 458,027.00</td>
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<td>Diabetes and Hypo rapid response service</td>
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<td>Heart failure</td>
<td>£ 589,533.88</td>
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<td>Emergency Response Team</td>
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<td>Out of Hours</td>
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<td>Crisis Resolution/Home Treatment Team (CR/HT)</td>
<td>£ 3,049,647.00</td>
<td>DWMHT</td>
<td>Crisis Resolution/Home Treatment Team (CR/HT)</td>
<td>Avoidable Admissions</td>
<td>Mental Health</td>
<td>MDTs</td>
<td>Crisis/Emergency</td>
</tr>
<tr>
<td>Early Access Service – adults</td>
<td>£ 656,159.00</td>
<td>DWMHT</td>
<td>Early Access Service – adults</td>
<td>Avoidable Admissions</td>
<td>Mental Health</td>
<td>MDTs</td>
<td>Crisis/Emergency</td>
</tr>
<tr>
<td>Early Intervention in Psychosis</td>
<td>£ 567,178.00</td>
<td>DWMHT</td>
<td>Early Intervention in Psychosis</td>
<td>Avoidable Admissions</td>
<td>Mental Health</td>
<td>MDTs</td>
<td>Crisis/Emergency</td>
</tr>
<tr>
<td>Tiled House</td>
<td>£ 1,846,000.00</td>
<td>DMBC</td>
<td>Residential Intermediate Care</td>
<td>Delayed Days</td>
<td>Social Care</td>
<td>IC</td>
<td>Promoting Independence</td>
</tr>
<tr>
<td>Palliative Care - transition care</td>
<td>£ 69,790.00</td>
<td>DMBC</td>
<td>Palliative Care - transition care</td>
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<td>Transition Team</td>
<td>£ 912,860.00</td>
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<td>Transition Team</td>
<td>Delayed Days</td>
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<tr>
<td>Intermediate Care Support - Dr Plant</td>
<td>£ 61,934.00</td>
<td>Other</td>
<td>Intermediate Care Support - Dr Plant</td>
<td>Delayed Days</td>
<td>Other</td>
<td>IC</td>
<td>Promoting Independence</td>
</tr>
<tr>
<td>Intermediate Care Team - Nursing</td>
<td>£ 114,086.00</td>
<td>Other</td>
<td>Intermediate Care Team - Nursing</td>
<td>Delayed Days</td>
<td>Other</td>
<td>IC</td>
<td>Promoting Independence</td>
</tr>
<tr>
<td>Intermediate/Stepdown Care - Physiotherapists</td>
<td>£ 122,400.00</td>
<td>Other</td>
<td>Intermediate/Stepdown Care - Physiotherapists</td>
<td>Delayed Days</td>
<td>Other</td>
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<tr>
<td>Intermediate/Stepdown Care - Private Care Home (Bed days)</td>
<td>£ 2,703,000.00</td>
<td>Other</td>
<td>Residential Intermediate Care</td>
<td>Delayed Days</td>
<td>Other</td>
<td>IC</td>
<td>Promoting Independence</td>
</tr>
<tr>
<td>Stepdown Cover - DGFT</td>
<td>£ 58,091.00</td>
<td>Other</td>
<td>Other</td>
<td>Delayed Days</td>
<td>Other</td>
<td>IC</td>
<td>Promoting Independence</td>
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<tr>
<td>Access - single point of contact</td>
<td>£ 1,174,310.00</td>
<td>DMBC</td>
<td>Adult Social Care Assessment</td>
<td>Reablement</td>
<td>Social Care</td>
<td>Access</td>
<td>Promoting Independence</td>
</tr>
<tr>
<td>Locality Based prevention hubs (including grants to vol orgs )</td>
<td>£ 1,245,020.00</td>
<td>DMBC</td>
<td>Community Voluntary Sector</td>
<td>Reablement</td>
<td>Social Care</td>
<td>Access</td>
<td>Promoting Independence</td>
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<td>Locality social work teams</td>
<td>£ 746,010.00</td>
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<tr>
<td>Acute Rehabilitation - Other</td>
<td>£ 1,262,890.00</td>
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<td>Reablement</td>
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<td>Reablement</td>
<td>Promoting Independence</td>
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<td>Acute Rehabilitation - Stroke</td>
<td>£ 822,368.00</td>
<td>DGoH</td>
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<td>Acute</td>
<td>Reablement</td>
<td>Promoting Independence</td>
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<tr>
<td>Acute Rehabilitation - T&amp;O</td>
<td>£ 1,205,702.00</td>
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<td>Promoting Independence</td>
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<td>Physiotherapy - MSK</td>
<td>£ 873,345.55</td>
<td>DGoH</td>
<td>Physiotherapy - MSK</td>
<td>Reablement</td>
<td>Community Health</td>
<td>Reablement</td>
<td>Promoting Independence</td>
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<tr>
<td>Rehab Single Point of Access - Community Stroke Rehabilitation</td>
<td>£ 537,906.72</td>
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<td>Rehab Single Point of Access</td>
<td>Reablement</td>
<td>Community Health</td>
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<tr>
<td>Rehab Single Point of Access - OT Primary Care</td>
<td>£ 397,962.79</td>
<td>DGoH</td>
<td>Rehab Single Point of Access</td>
<td>Reablement</td>
<td>Community Health</td>
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<td>Rehab Single Point of Access - Primary Care Neurology Team</td>
<td>£ 364,718.39</td>
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<td>Community Health</td>
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<td>Rehab Single Point of Access - Speech Therapy Adults</td>
<td>£ 202,817.29</td>
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<td>Rehab Single Point of Access</td>
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<td>Community Health</td>
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<td>Step down - Occupational Therapy</td>
<td>£ 429,780.37</td>
<td>DGoH</td>
<td>Residential Intermediate Care</td>
<td>Reablement</td>
<td>Community Health</td>
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<td>Promoting Independence</td>
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<tr>
<td>Step down - Physiotherapy</td>
<td>£ 200,273.66</td>
<td>DGoH</td>
<td>Residential Intermediate Care</td>
<td>Reablement</td>
<td>Community Health</td>
<td>Reablement</td>
<td>Promoting Independence</td>
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<tr>
<td>Community Equipment Stores</td>
<td>£ 863,000.00</td>
<td>DMBC</td>
<td>CES/OT</td>
<td>Reablement</td>
<td>Other</td>
<td>Reablement</td>
<td>Promoting Independence</td>
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<td>UT - Community Reablement</td>
<td>£ 438,800.00</td>
<td>DMBC</td>
<td>START</td>
<td>Reablement</td>
<td>Social Care</td>
<td>Reablement</td>
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<td>Category</td>
<td>Amount</td>
<td>Description</td>
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<td>OT's</td>
<td>£1,164,630.00</td>
<td>DMBC CES/OT Reablement Social Care Social Care Reablement Promoting Independence</td>
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<td>Russel Court - Residential Reablement</td>
<td>£1,467,370.00</td>
<td>DMBC START Reablement Social Care Social Care Reablement Promoting Independence</td>
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<td>START - Community Reablement</td>
<td>£1,525,000.00</td>
<td>DMBC START Reablement Social Care Social Care Reablement Promoting Independence</td>
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<td>Substance misuse</td>
<td>£192,000.00</td>
<td>DMBC Substance misuse Reablement Social Care Social Care Reablement Promoting Independence</td>
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<td>Adults team – Community Recovery Service</td>
<td>£3,217,677.00</td>
<td>DWWMHT Adults team – Community Recovery Service Reablement Mental Health Reablement Promoting Independence</td>
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<td>Community Equipment Stores</td>
<td>£523,090.00</td>
<td>Other CES/OT Reablement Social Care Social Care Reablement Promoting Independence</td>
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<td>GP over 75's</td>
<td>£1,571,000.00</td>
<td>CCG GP over 75's Avoidable Admissions Primary Care MDTs Crisis/Emergency</td>
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<td>Joint Palliative care support team</td>
<td>£440,811.00</td>
<td>DGoH Joint Palliative care support team Avoidable Admissions Community Health MDTs Crisis/Emergency</td>
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<tr>
<td>Community OPAT and oncology</td>
<td>£548,080.00</td>
<td>DGoH Community OPAT and oncology Avoidable Admissions Community Health MDTs Crisis/Emergency</td>
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<td>Continence</td>
<td>£1,169,343.00</td>
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<tr>
<td>District nursing 16 teams – 15 teams and out of hours</td>
<td>£7,924,321.00</td>
<td>DGoH District nursing 16 teams – 15 teams and out of hours Reablement Community Health MDTs Promoting Independence</td>
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<td>Macmillan nurses</td>
<td>£476,228.00</td>
<td>DGoH Macmillan nurses Avoidable Admissions Community Health MDTs Crisis/Emergency</td>
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<tr>
<td>Respiratory specialist nurses - Outpatient Follow ups</td>
<td>£245,472.05</td>
<td>DGoH Respiratory specialist nurses Avoidable Admissions Community Health MDTs Crisis/Emergency</td>
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<tr>
<td>Tissue Viability - Leg Ulcer Clinic</td>
<td>£344,839.00</td>
<td>DGoH Tissue Viability - Leg Ulcer Clinic Reablement Community Health MDTs Promoting Independence</td>
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<tr>
<td>Direct payments</td>
<td>£1,586,000.00</td>
<td>DMBC Community Maintenance &amp; Stabilisation Res Care Social Care Personalised C&amp;S Maintenance and Stabilisation</td>
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<td>Direct payments</td>
<td>£162,000.00</td>
<td>DMBC Community Maintenance &amp; Stabilisation Res Care Social Care Personalised C&amp;S Maintenance and Stabilisation</td>
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<tr>
<td>Direct payments</td>
<td>£1,164,840.00</td>
<td>DMBC Community Maintenance &amp; Stabilisation Res Care Social Care Personalised C&amp;S Maintenance and Stabilisation</td>
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<td>Disabled Facilities Grants</td>
<td>£2,867,000.00</td>
<td>DMBC DFG Res Care Social Care DFG Maintenance and Stabilisation</td>
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<td>Domiciliary Care</td>
<td>£6,955,740.00</td>
<td>DMBC Community Maintenance &amp; Stabilisation Res Care Social Care Personalised C&amp;S Maintenance and Stabilisation</td>
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<tr>
<td>Domiciliary Care</td>
<td>£1,018,000.00</td>
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<tr>
<td>Extra care housing</td>
<td>£865,000.00</td>
<td>DMBC EXCH Res Care Social Care Personalised C&amp;S Maintenance and Stabilisation</td>
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<tr>
<td>Intermediate Care - DMBC (Packages of Care)</td>
<td>£560,000.00</td>
<td>DMBC Community Maintenance &amp; Stabilisation Res Care Social Care Personalised C&amp;S Maintenance and Stabilisation</td>
<td></td>
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<tr>
<td>Palliative Care - front end</td>
<td>£208,000.00</td>
<td>DMBC Community Maintenance &amp; Stabilisation Res Care Social Care MDTs Maintenance and Stabilisation</td>
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<td></td>
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<tr>
<td>Supported living</td>
<td>£765,000.00</td>
<td>DMBC Community Maintenance &amp; Stabilisation Res Care Social Care Personalised C&amp;S Maintenance and Stabilisation</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Community mental health team for older people</td>
<td>£1,110,129.00</td>
<td>DWWMHT Community mental health team for older people Reablement Mental Health MDTs Promoting Independence</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Internal day care and Dementia Gateways</td>
<td>£1,825,000.00</td>
<td>DMBC Dementia care 2 - Dementia Diagnosis Social Care Dementia care Dementia Care</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Specialist Dementia Nurses</td>
<td>£189,886.00</td>
<td>Other Dementia care 2 - Dementia Diagnosis Mental Health Dementia care Dementia Care</td>
<td></td>
<td></td>
<td></td>
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<td>Total</td>
<td>£66,653,525</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Minus efficiencies</td>
<td>-£2,892,848</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>BCF Total</td>
<td>£63,760,677</td>
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</tr>
</tbody>
</table>
## Appendix 2

### Schedule of transfer of funds between NHS England and Dudley Metropolitan Borough Council (MBC) 2014/15

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Objective</th>
<th>Amount £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiled House Intermediate Care facility</td>
<td>365 admissions from secondary care</td>
<td>1,846,000</td>
</tr>
<tr>
<td>Dementia Gateways</td>
<td>Provide dementia support and identification from 3 hubs across the borough</td>
<td>1,623,000</td>
</tr>
<tr>
<td>Commissioned home care</td>
<td>62590 of care hours added to the existing care at home provision to support people in their own homes.</td>
<td>865,000</td>
</tr>
<tr>
<td>Social Care Emergency response service</td>
<td>39208 hours of contact time with service users</td>
<td>1,005,000</td>
</tr>
<tr>
<td>Internally provided reablement services</td>
<td>57,000 Hours of reablement services to support people to return home after a period of care.</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Out of hours services</td>
<td>Peripatetic service</td>
<td>213,000</td>
</tr>
<tr>
<td>Living independently team</td>
<td>Increased assessment capacity to support reablement services and hospital discharge</td>
<td>603,000</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>7,155,000</td>
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</tbody>
</table>
TITLE OF REPORT: CCG Operational Plan 2015/16

PURPOSE OF REPORT: To approve the Operational Plan for 2015/16

AUTHOR OF REPORT: Mr N Bucktin, Head of Commissioning

MANAGEMENT LEAD: Mr N Bucktin, Head of Commissioning

CLINICAL LEAD: Dr S Mann, Clinical Executive – Acute and Community Services
Dr S Cartwright, Clinical Executive – Partnerships and Integration

KEY POINTS:

1. NHS England has now published guidance which builds on the NHS Five Year Forward View.

2. This requires CCGs to produce an operational plan for 2015/16.

3. A particular emphasis is placed on prevention, empowerment and engagement; as well as the development of new care models; investment in mental health services; and the enhancement of quality and safety.

4. The CCG’s Operational Plan has been developed against this guidance with key priorities in relation to urgent care, planned care, integrated care and primary care development.

5. Subject to the Board’s approval, the Plan will be submitted to the Health and Wellbeing Board. The Health and Wellbeing Board are required to confirm that it properly reflects the priorities in the Joint Health and Wellbeing Strategy.

RECOMMENDATION: That the Operational Plan for 2015/16 be approved.

FINANCIAL IMPLICATIONS: The financial implications of the plan are addressed in the CCG’s Financial Plan

WHAT ENGAGEMENT HAS TAKEN PLACE: Engagement has taken place in relation to individual proposals where appropriate. This is described in the plan.

ACTION REQUIRED: Decision
☑️ Approval
☑️ Assurance
1.0 PURPOSE OF REPORT
1.1 To approve the Operational Plan 2015/16.

2.0 BACKGROUND
2.1 The Board will be aware that the national planning guidance "Forward View Into Action: Planning for 2015/16" sets out a process whereby CCGs are expected to refresh their 2 year operational plans. This plan is expected to set out how CCGs will meet a series of national planning requirements and targets.

2.2 This report sets out how the CCG's Operational Plan has been refreshed for 2015/16 in the context of both our existing strategies and plans and the national planning requirements.

3.0 EXISTING STRATEGY AND PLANS
3.1 The Board will recall that the CCG's existing strategic vision "to promote good health and wellbeing and ensure high quality services for the people of Dudley" is based upon 3 objectives:-

- reduce health inequalities;
- deliver the best possible outcomes;
- improve quality and safety.

3.2 In addition, our agreed strategic intent describes four particular types of care which patients may require, all of which are designed to deliver the objectives above:-

- planned care;
- urgent care;
- reablement care;
- preventative care.

3.3 In addition we commission care for vulnerable groups - children, the elderly, people with mental health problems and people with learning disabilities.

3.4 Our existing plans are also informed by and consistent with the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy (JHWS). They reflect the JHWS's priorities of:-

- making our services healthy;
- making our lifestyles healthy;
- making our minds healthy;
- making our children healthy;
- making our neighbourhoods healthy.

4.0 NATIONAL PLANNING GUIDANCE

Resources

4.1 The Board will recall that in 2014/15, £2.015m was made available by NHS England to support schemes to maintain system resilience, primarily during the winter period. This has now been made recurrent for 2015/16. The System Resilience Group will be reviewing schemes put in place this winter in order to determine what should be commissioned on a recurrent basis.
4.2 CCG’s are also expected to invest additional resources in mental health, equivalent to the growth of their overall allocation. In Dudley’s case this is £1,118,000.

4.3 Additional resources are being made available for primary care and the CCG will be making proposals for the development of primary care premises.

4.4 The guidance refers to the development of “new models of care” (see below). Additional resources are being made available nationally to support agreed proposals.

4.5 Issues in relation to the CCG’s Better Care Fund (BCF) Plan are dealt with elsewhere on this agenda. The guidance requires CCG’s to review these plans if there is any potential risk to delivery and vary as necessary, subject to the approval of the Health and Wellbeing Board.

**Prevention, Empowerment and Engagement**

4.6 CCGs are again required to set targets for reducing health inequalities. For smoking cessation, alcohol and obesity, these are to be set in conjunction with the Council. Particular emphasis is placed on the prevention of diabetes, smoking in pregnant women and alcohol. NHS bodies are expected to promote healthy workplaces.

4.7 Personal health budgets, currently available for people with NHS Continuing Healthcare, are to be expanded, in particular for people with long term conditions. Choice is also to be extended for people with mental health problems and for maternity services.

4.8 Volunteering is to be promoted. CCGs, in partnership with Councils are expected to draw up plans to support carers. Commissioning of services form the voluntary sector is to be facilitated through a simplified contract arrangement. CCG Boards must assess themselves against a new NHS workforce race equality standard.

**New Care Models**

4.9 The NHS Forward View set out proposals for the development of new care models. The guidance proposes working with a small number of sites on four potential models:-

- multispecialty community providers
- integrated primary and acute care systems
- approaches to create viable smaller hospitals
- models of enhanced health in care homes

4.10 The CCG has submitted a proposal which is a variant of the multispecialty community provider and an update will be given at the meeting.

**Mental Health and Learning Disability Services**

4.11 There is a particular focus on mental health services. Dementia diagnosis and IAPT access rates are to be maintained. Access and waiting time standards are to be introduced, including those for people experiencing their first episode of psychosis. Commissioners are expected to commission appropriate levels of psychiatric liaison in acute care settings.

4.12 Crisis mental health care is expected to be commissioned, as are services that avoid the need for people to receive mental health assessments in police cells. Investment in CAMHS services is expected and further guidance will be made available on establishing community based teams for children with eating disorders.

4.13 Further guidance is to be published on requirements in response to the events at Winterbourne View, to reduce the reliance on inpatient beds for people with learning disabilities.
Quality and Safety

4.14 Formal guidance on Commissioning for Quality and Innovation (CQUIN) and the Quality Premium is awaited. The initial planning guidance identifies that there will be national CQUINS on sepsis, acute kidney injury, urgent and emergency care.

4.15 CCGs are expected to ensure that secondary care providers validate antibiotic prescribing data in line with the Public Health England validation protocol.

4.16 CCGs should work with providers to ensure there is a named doctor responsible for a patient’s care across and within different care settings.

Better Information

4.17 60% of practices will be transmitting prescriptions electronically by March 2016. Coded discharge summaries will be available to professionals electronically. Electronic referrals are expected to become the norm.

5.0 CCG OPERATIONAL PLAN

5.1 The proposed Operational Plan for 2015/16 is attached at Appendix 1.

5.2 This has been developed to both reflect the CCG’s existing priorities and build on these against the background of the new planning requirements.

5.3 The plan:-

- reaffirms and develops the CCG’s objectives;
- identifies the health and financial challenges faced;
- demonstrates how the commissioning priorities will create a health system which reflects the 6 key system characteristics;
- demonstrates how we will meet the highest standards of quality and patient safety.

5.4 In particular, the plan identifies 4 specific priorities:-

**urgent care** – ensuring that the newly commissioned urgent care centre functions effectively to eliminate inappropriate demand;

**planned care** – delivering service efficiencies through the elimination of unwarranted variation in our planned care pathways;

**integrated care** – completing the implementation of our model of practice based multi-disciplinary teams; transforming the nature of joint working across health and social care; and providing a real alternative to hospital admission;

**primary care development** – taking delegated responsibility for the commissioning of primary medical services to develop a modern system of primary care; capable of managing patients systematically; in modern premises using modern IT systems.

6.0 NEXT STEPS AND TIMETABLE

6.1 The next planning submission must be made to NHS England by 10th April 2015.

6.2 The Health and Wellbeing Board will be asked to approve the Operational Plan and confirm that it is consistent with the Joint Health and Wellbeing Strategy at their meeting on 25th March 2015.
7.0 RECOMMENDATION

7.1 That the Operational Plan for 2015-16 be approved.

Mr N Bucktin, Head of Commissioning
February 2015
From: Dependency, Hierarchy and Modernism

To: Autonomy, Networks and Mutualism

Operational Plan 2015/2016

Version 2 – For submission to CCG Board/ Health and Wellbeing Board
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Dudley Clinical Commissioning Group

From: Dependency, Hierarchy and Modernism To: Autonomy, Networks and Mutualism

Background

Operational Plan 2015/2016

In February 2014, the CCG approved its Operational Plan for 2014/15 – 2015/16. This Operational Plan represents the next year of our overall strategic plan for the period until 2019.

This plan is designed to:-

• build on our achievements in implementing our plan for 2014/15;
• develop our strategic intention of implementing a model of population-based health and wellbeing, establishing integrated health and social care services with primary care at its heart;
• reflect the work we are doing as the local leader of the NHS, in conjunction with our NHS providers, our local government partners and the voluntary/community sector;
• fulfill the expectations placed upon us through the national planning system;
• take us to the next step in our development as a clinically led commissioning organisation, responding to the significant clinical, service and financial challenges of the coming years.

We have already engaged our stakeholders in the planning process through:-

• discussing proposals with our GP membership on a regular basis;
• engaging with patients and the public through our Health Care Forum and Patient Participation Groups;
• sharing the key requirements of the planning guidance with the Health and Wellbeing Board;
• seeking the Health and Wellbeing Board’s support for key system changes including our plans for population health and wellbeing, the Better Care Fund; delegated commissioning of primary medical services and urgent care;
• sharing our plan with our three NHS service providers, our local government partners and the voluntary sector, through our System Resilience Group.

This engagement lies at the heart of our value system and will continue as our plans are developed and implemented.

In the sections below we have:-

• reaffirmed and developed our objectives;
• identified the financial and health challenges we face;
• explained how our commissioning priorities will position us to have a local health and care system which reflects the "6 key system characteristics" and enables us to fulfill our vision for population health and wellbeing;
• demonstrated how we will ensure we meet the highest standards of quality and patient safety.
THREE KEY AREAS OF FOCUS FOR THE 15/16 OPERATIONAL PLAN
1. Integrating services, empowering our multi-disciplinary teams to deliver population health and wellbeing, avoid admissions and retrieve patients from hospital
2. Enhancing efficiency of elective care pathways by eliminating unwarranted variation
3. Developing a new service model based upon our vision of population health and wellbeing

ACCESS
All NHS Constitution standards and Mandate commitments to be met
A&E
Urgent care centre commissioned

Winter resilience
Street triage vehicle for mental health patients
Discharge to assess pathways Mental health urgent care centre Enhanced Programme for care homes
RTT/Diagnostics/Cancer
Enhancing pathway efficiency for diabetes, ENT, MSK, cardiology, urology, ophthalmology
IAPT
Pathway audit to eliminate unwarranted variation and increase efficiency

Dementia
Community based dementia service

Early intervention in psychosis
Audit to eliminate unwarranted variation and increase efficiency
Primary Care
Saturday opening for primary care

OUTCOMES
Delivery across the five domains and seven outcome measures
Improving health
Joint targets with Dudley Council for smoking, alcohol and diabetes
Reducing health inequalities
Young people’s health champions
Community health champions “Healthy Living” GP practices
“QOF Plus” approach to identifying and managing hypertension in primary care
Workplace health and wellbeing – CCG and its partners

Parity of esteem
“All age” primary care emotional health and wellbeing service
Healthy lifestyles programme for mental health patients

QUALITY
Patient safety
Embedded organisational learning
Patient experience
PSIAMs, patient app and “feet on the street” Extending personal health budgets

Compassion in practice
Provider strategies assured against 6 Cs

Safeguarding
Revised arrangements for safeguarding children’s services Assuring safety of all CCG commissioned nursing home placements

Staff satisfaction
Analysis of national staff surveys and follow up action with providers as part of quality intelligence scanning

Seven day services
Development and implementation of service standards for community based services

DELIVERING VALUE
Financial resilience; delivering VFM for taxpayers and patients and procurement
Planned surplus £6.295m
Contingency 0.5%
1% non-recurrent

Elective and non-elective activity plans based on outturn plus demographic growth, adjusted for impact of QIPP schemes
System wide efficiencies being sought across partners on estate/IT/medicines and consumables

TRANSFORMATION PROGRAMMES, RECONFIGURATION PLAND AND REPROCUREMENT
Commissioning a new urgent care centre
Exploiting a system wide common IT platform
Procuring an “all age” primary care emotional health and wellbeing service
Empowering staff to deliver population health and wellbeing through an extensive od programme
Partnership Board to oversee new service model
1. Vision and Objectives

a) Our Vision

Our vision is “to promote good health and wellbeing and ensure high quality health services for the people of Dudley”

Our objectives which underpin this are to:-

• reduce health inequalities;
• deliver the best quality outcomes;
• improve quality and safety;
• secure system effectiveness.

b) Strategic Intent

Our strategic intent is based around four particular types of care which patients may require, each of which displays separate characteristics but for which the ultimate objective is to contribute to the objectives above. These are:-

• planned care – to deliver quick, reliable, value added interventions at a time and place of the patient’s choice;
• urgent care – to deliver value added interventions in a crisis, where the capacity available is appropriate to the presenting need and each part of the system has a clear, distinct and exclusive role;
• reablement care – to deliver an integrated system, where people regain independence in the least restrictive setting possible;
• preventative care – to empower people to take as much care of themselves as possible, in partnership with appropriate professionals, so that their level of clinical risk is reduced and their overall wellbeing enhanced.

The following table shows the relationship between our strategic intent and the 6 key system characteristics for transformation.
In addition, we commission care for certain vulnerable groups – children, the elderly, people with mental health problems and people with learning difficulties. Their needs tend to be complex, variable over time, involve the input of social care, the third sector and other bodies. Such services have a focus on health and wellbeing. We will create specific programmes tailored to their needs.

This represents our strategic intent and is reflected in our plan.
c) Our 6 key Principles

Since inception, the following 6 key principles have informed the work of the CCG:-

i) Patient and public involvement

The meaningful involvement of patients and public is of paramount importance. Throughout the NHS the patient is usually the coordinator of their care. It is key that contact with healthcare professionals adds clinical value. We believe this contact must be re-aligned, from a hierarchical dialogue ‘expert to receptive patient’, to a horizontal dialogue ‘expert to expert’. Patients/families are most knowledgeable about their symptoms, bodies and psychological and social state. This self-expertise remains an under-tapped resource that if accessed will transform healthcare and well-being. Supporting autonomous living is of paramount importance. However when people do use healthcare we want them to have clearer information about the quality of services in order to inform their choices; and we want them to be better able to share whether services are working for them.

ii) Clinically Led

The public register with their GP and it is through the coordination that their GP provides, that they are able to best access the healthcare that they need. So our future health system will be organised around this key relationship between patient and their GP; providing a personalised service. Similarly, all population-based healthcare will be commissioned on a registered-population basis and will be organised in accordance with our GP and CCG structures (so around practices, localities and borough-wide) in order to enable a clear clinically-led approach to healthcare delivery.

iii) Primary Care at our heart

The vast majority of care is either delivered by General Practice or is accessed through it. The success of primary care is therefore central to the future success of our health services locally. We have already developed a primary care strategy, in conjunction with the Health and Wellbeing Board and NHS England. There are significant recruitment and retention challenges for our primary care services so development of primary care infrastructure and workforce will be central components to our on-going work – we want Dudley to have a national reputation as the best place to work for GPs along with their extended primary care and community staff. We will further enhance our shared commissioning of primary care with NHS England in order to ensure that this can be achieved.
iv) **Working with partners in our communities**

Our locality-based approach to the Better Care Fund initiative recognises the need to network our GPs, patients and associated primary care/community services, social care and the voluntary sector in order to respond to the variable needs of different communities across our population. Health inequalities can only be addressed through a jointly targeted community-based approach. We will build our partnership relationships through the organisation of all of our services for all of our populations based on clinical need.

v) **Focus on quality and continuous improvement**

We will take a predominantly developmental approach to quality improvement that encourages transparency by all our service providers to reduce variations in care and outcomes; and to aim for best practice performance. We will expect every service to be able to demonstrate the value and quality that it provides to patients. We will utilise a continuous evaluation process that will ultimately ensure that we do not commission any service that cannot demonstrate value; and will actively promote those that can demonstrate best outcomes for patients.

vi) **Live within available resources**

Dudley CCG will meet its financial responsibilities to address the reasonable needs of our population within available resources. This necessitates a drive for continuous efficiency and improvement given the economic constraints we face. Our emphasis will always be to maximise the effectiveness and availability of front-line services.

d) **5 Year Vision**

In our 5 year strategic plan we have applied these principles to establish a new vision for healthcare which is characterised by:-

- **A Mutualist Culture** – which recognises the mutual relationship between GP and patient and the associated rights and responsibilities in an organisation of member practices and registered patients.
- **The Structure of The System** – where we move away from traditional organisational boundaries and service categorisations to recognise the needs of individual patients in a modern world.
- **Population Health and Wellbeing Services** – commissioning proactive population based healthcare.
- **Health and Wellbeing Centres for the 21st Century** – providing the capacity to needed to deliver our vision of population health and wellbeing services.
- **Innovation and Learning** – investing in research, technology and information systems as a basis for improving our organisational performance and the effectiveness of the system.
2. The Challenges

a) System Challenges

The key challenges facing the Dudley health and social care economy are:-

- growing demand for healthcare from a population where, over the next two decades, the number of people over 65 will grow by 25,100 and the number over 85 by 9,900;
- the financial sustainability of our NHS partners;
- budgetary challenges facing Dudley MBC, in particular adult social care and children’s services;
- the specific issue of budgetary pressures in adult social care and the potential impact on system equilibrium, affecting the ability to secure safe and timely discharges from hospital;
- inflexible organisational forms, incapable of providing a responsive and integrated response to local need;
- poor access to community services;
- need to reshape the market and create choice through alternative procurement routes such as Any Qualified Provider (AQP);
- need to secure effective transformation in leadership and cultural terms at a local level to ensure our planned model of service integration is capable of delivery;
- need to secure full clinical engagement from clinicians across primary, community and secondary care;
- need for a system wide approach to IT implementation, shared records and data sharing.

b) Financial Challenges

The CCG’s financial plan for 2015/16 has been constructed to deliver a sustainable NHS in Dudley. The delivery of a financially sound health economy is, however, not without its challenges.

The CCG will meet its statutory and local financial duties, delivering a planned surplus of £6.3m per annum. To achieve this, a QIPP programme has been developed that provides real, cash releasing savings as well as delivering improvements in outcomes and quality. The value of the internal QIPP programme (excluding provider tariff deflator) for 2015/16 is £7.2m. The main focus of initiatives in 2015/16 is a reduction in emergency activity. This will be twofold: -

- expanding the community rapid response service to reduce admissions to hospital through the Better Care Fund; and
- the redesign of urgent care with the opening of an urgent care centre on the 1st April 2015 that will reduce emergency department attendances.

There are also a number of separate qualitative schemes within the programme with a particular focus on better prescribing and more efficient elective pathways.
Within the financial plan, running costs for 2015/16 have reduced by 10%. A review of all corporate services was carried out in 2014/15 in preparation for the reduction in allocation and savings were identified from internal structures, commissioning support contracts and other non-pay areas.

A key task for the CCG and its providers over the coming year is securing value for its patients. The CCG’s commissioning intentions for 2015/16 stated that we will only procure services from providers that actively demonstrate the value they provide for the patients they treat. The CCG will support providers in doing so and expect to fulfil this obligation over the next year. This is to ensure a continuous assessment of the efficiency of services used by GPs when making referral decisions.

In summary, the CCG is expected to meet its challenging financial objectives over the planning period but will need to manage a number of key risks, the main ones being:

- not realising the full transfer of care (through the BCF) from hospital through to social care;
- the over performance of Acute contracts;
- the potential under delivery of identified QIPP schemes; and
- prescribing spend risk given the volatility of prescribing costs in 2014/15.

Mitigations have been identified, but given the challenging financial year ahead, the CCG may be in a position where it would need to decommission services to meet its statutory financial duties. If faced with these circumstances any process would be clinically led and involve all appropriate stakeholders, including dialogue with the CCG’s population on how it will get best value from the resources available to it as a public body. For example, in the case of end of life care, the start point for any discussion would be the public views around the fact the CCG spends a significant proportion of an individual’s lifetime care costs in the last year of life. If the CCG were faced with financial issues during the life of this plan, these discussions will be accelerated.

c) Performance Challenges

In 2014/15, we are on track to meet our key performance targets for referral to treatment time (RTT) and the Emergency Department (ED) waiting time. Nevertheless, performance challenges will remain in relation to:-

- referral to treatment times for urology, trauma and orthopaedics, opthalmology and oral surgery;
- The impact of delayed transfers of care on the ED 4 hour target;
- waiting times for some community services including physiotherapy, phlebotomy and counseling.

Our contracts for 2015/16 are designed to ensure that all NHS Constitution targets are met in terms of contracted activity levels. It should be noted that historically referral to treatment targets have been met.
The ED 4 hour wait remains the biggest performance challenge to the health and social care system. In response to this the CCG has taken action that deals with the current performance issues and ensure that the system is capable of sustaining performance in the future.

The System Resilience Group (SRG) will review the impact of those schemes put in place to sustain the system over the winter period and following the Group’s agreement, the CCG will look to re-commission validates services on a recurrent basis.

This review will be concluded in early March. Schemes that are likely to be sustained include:-

- discharge to assess pathways;
- mental health street triage service;
- mental health urgent care centre;
- enhanced support for care homes;
- additional intermediate care assessment and therapy capacity;
- 7 day working for intermediate care and NHS Continuing Healthcare assessors.

The System Resilience Group has overseen the implementation of an action plan produced on the advice of the Emergency Care Intensive Support Team (ECIST), this will be embedded in 2015/16.

An agreed reporting mechanism to the SRG on overall performance will ensure that the system is properly held to account at both SRG and Health and Wellbeing Board levels.

As part of the Section 75 Agreement underpinning the Better Care Fund, the Council will be required to reimburse the CCG for excess bed day costs arising from delayed transfers attributable to social care.

Following work carried out with Professor David Oliver, a new care pathway will be developed for the frail elderly with a clear focus on retrieving patients from secondary care by our community teams.

Sustained performance will also be achieved through our redesign of urgent care and the implementation of our rapid response service. Both these issues are dealt with below.

d) Health Status and Health Inequalities

Dudley is characterised by significant health outcome differences between the most and least deprived parts of the Borough and bears the legacy of post industrialisation.

Our JSNA sets out a number of key messages which have informed our plans and outcome ambitions as follows:-

- nearly 20% of our population have a limiting long term illness or disability, this has increased since the 2001 census and is worse than the national average;
- the gap in life expectancy for the least and most deprived areas of Dudley has widened, mostly due to CHD, COPD and lung cancer in men;
• the mortality rate in the 60-74 age band is significantly higher for males;
• female life expectancy is 82.7 years – similar to the national average, whilst male life expectancy is 78.5 years – lower than the England average of 78.9;
• male life expectancy varies across Dudley. Halesowen South has the highest at 82.1 years, Netherton, Woodside and St. Andrews have the lowest at 73.9 years – a gap of 8.2 years;
• nearly a quarter of deaths in the 40–59 age band are due to cardiovascular disease, smoking, obesity and lack of physical activity;
• mortality from respiratory disease is significantly higher than the national average. Lower respiratory tract infection is the major condition;
• mortality rates for alcohol related diseases are significantly higher than the national rate and the rate is rising for females aged 25-39;
• emergency admissions for alcohol specific conditions increases from the 40-59 age group;
• 12.1% of adults aged 16+ participate in sport for 30 minutes 3 or more times per week, showing a downward trend and below the national average of 17.4%;
• nearly two thirds of ED attendances are for people living in the 40% most deprived group in Dudley;
• the next two decades are forecast to see an additional 25,100 people over the age of 65 and an extra 9,900 over 85;
• uptake rates for both cervical and breast cancer screening are below the national target of 80%;
• disease prevalence rates as determined by primary care disease registers are low compared to modelled prevalence, however, these have improved – most markedly for COPD;
• the rate of delayed hospital discharge attributable to social care is higher than the national rate;
• emergency admissions for gastroenteritis and lower respiratory disease are increasing for the 60–74 age band;
• emergency admissions for gastroenteritis in the 75+ age band are increasing;
• 20% of single person households are in the 60+ age group;
• with the ageing population there is an increasing number of older people who are carers of older people, or who are carers of adult children with learning or physical disabilities;
• the rate of deaths at home or in care homes remains static and there is a higher percentage of terminal admissions that are emergencies than England.

For our children and young people:-

• the infant mortality rate is 4.5 per 1,000 live births, compared to 4.3 for England and Wales;
• male babies born in the most deprived areas of Dudley are up to 4 times more likely to die than those from the more affluent areas;
• children aged 10-11 have a higher rate of obesity than the national average;
• emergency hospital admissions for 0–4 year olds have risen. This is particularly prominent for lower respiratory tract infections in the most deprived areas;
• the proportion of 9 and 11 year olds with a high self-esteem score has
risen, though 25% of pupils reported bullying. The proportion of 13-15 year olds reporting being bullied has risen to nearly 20%;

- the looked after children prevalence rate is significantly higher in Dudley and double the national rate;
- smoking at delivery was 14.3% in Dudley, higher than both England and the West Midlands;
- breast feeding initiation rates at birth and at 6-8 weeks are lower than in England. These are also lower in the more deprived parts of Dudley and in younger mothers.

“Commissioning for Prevention” suggests that in Dudley premature death is worse than average for:-

- cancer
- heart disease
- stroke
- liver disease

In addition, our review of the “Commissioning for Value Pack”, the “CSU QIPP Opportunities Pack”, “Commissioning for Prevention” and the CCG Outcome Indicators Framework, suggests that:-

- gastroenteritis
- cancer and tumours
- CVD
- mental health problems
- musculoskeletal problems
- endocrine, nutritional and metabolic
- vaccine preventable conditions
- falls
- ambulatory care sensitive conditions
- frail elderly
- admissions via A and E with a primary mental health diagnosis present opportunities for health status, service and cost improvement.

e) Our Assets

The JSNA identifies the way in which an asset based approach can help improve the resilience and lives of people at neighbourhood level, focusing on people, places, causes and influence.

Building on community assets as a means of creating sustainable communities is an issue the CCG will pursue in its contribution to partnership working and addressing the wider determinants of health. This is recognised in our approach to the development of integrated service provision (see below).

f) JSNA – Key Messages and Actions

The key messages and actions arising from our assessment of the health status of our population are:-
• We have specific health inequalities for the male population both in terms of mortality rates in the 60 – 74 year age band and alcohol specific problems for the 40-59 year age band.

• This is contributing to a widening of life expectancy gap between the most and least deprived parts of our population.

• We need to ensure our locality based service delivery model provides an appropriate, differential intervention at neighbourhood level to respond to local health inequalities.

• Interventions in relation to cancer, heart disease, liver disease and stroke are required.

• We must ensure that our practices perform well in delivering smoking cessation services.

• Improved case finding, uptake of screening services and uptake of vaccination programmes are critical. Exploiting the potential of EMIS will assist this.

• The systematic management of patients with long term conditions in primary care and community health services will be a major contributor to our success, including the management of diabetes.

• The care pathway for COPD requires attention to reduce unnecessary admissions.

• The local alcohol harm strategy needs to be fully implemented by all partners.

• The integration of maternity services with pre-conceptual, health visiting and school nursing services, together with primary care and the voluntary sector will improve outcomes across the life course.

• Child health inequalities can be reduced by promoting the uptake of breast feeding and the prevention of smoking.

• We have a growing frail elderly population, we need to improve the care pathway to prevent unnecessary admissions and create the conditions to enable people to be re-abled and retain their independence in their communities.

• The end of life pathway needs review to increase the number of people who die at home and to reduce admission to hospital at the end of life.

• We require a continued focus on mental health and the relationship between mental health, physical health and the management of long term conditions.

• We need to ensure that our approach to prescribing and the input of our practice based pharmacists continues to improve our performance in relation to the use of drugs to reduce cholesterol, reduce blood pressure and manage atrial fibrillation.

• We need to ensure that our work on the systematic management of long term conditions, redesigning urgent and planned care pathways and integrating services in our localities is sensitive to the needs of our child population.

• As part of our approach to the Equality Delivery Scheme, we need to facilitate work with those groups protected by legislation where the difference in health outcome and need is greatest, as well as analyse the barriers to improved patient access and experience for these groups. This will be reflected in our Equality Objectives.

• We will use an asset based approach to our work with partners in addressing the wider determinants of health.

This is reflected in our plans.
3) Prevention

Our approach to prevention will be based on enhancing our existing long term conditions framework to address existing prevalence gaps, reduce health inequalities and embed evidence based practice on a systematic basis. This will be developed jointly with the Office of Public Health, acting also as a critical friend for our proposals.

Our programmes will involve delivery by primary care teams, practice based pharmacists, community pharmacy and primary mental health care. This will be linked to a robust monitoring framework.

The National Audit Office report on health inequalities identified specific high impact interventions which have a direct impact on the life expectancy gap demonstrated in the JSNA. These were:-

- increasing the prescribing of drugs to control blood pressure and cholesterol – there has been a 33% increase since 2008. We have set a local quality premium target to address the diagnosis of hypertension, we will develop a systematic approach to the management of long term conditions in primary care and work with the Office of Public Health and GPs to improve the uptake of vascular checks;

- increasing anticoagulation treatment for atrial fibrillation – our standardised mortality rates for all circulatory diseases have decreased by 12.8 compared to the England and Wales average and the local quality premium target for 2013/14 has been met. We will ensure we have a sustained approach to the prescribing of new oral anti-coagulants;

- improving blood sugar control for diabetes – in 2012/13, 62.5% of patients had an HbA1C equal to 7.5%, 71.1% = 8.0% and 81.7% = 9.0%. Our revised LES and the commissioning of a community diabetes service will continue to address this issue;

- increasing smoking cessation services. We will work with the Office of Public Health to encourage improved performance from general practice in delivering these services.

We have agreed specific targets with the Office of Public Health, broken down by locality and practice for obesity, tobacco control and alcohol. These are shown as below:
a) Obesity

i) Shared breastfeeding targets (baseline 2013-14)

Breastfeeding Prevalence at Initiation, Dudley CCG Registered Population, 2013-14, with Targets to 2018-19

Breastfeeding Prevalence at 6-8 Weeks, Dudley CCG Registered Population, 2013-14, with Targets to 2018-19

data source: NHS England

produced by: Office of Public Health, Dudley MBC
ii) Shared adult excess weight targets (baseline 2013-14)

![Graph showing adult overweight and obese prevalence targets (70.2%) from 2013/14 to 2018/19.]

iii) Shared child excess weight targets (baseline 2013-14)

![Graph showing overweight and obese prevalence of reception year children in Dudley MBC from 2006/07 to 2013/14, with targets up to 2018/19.]

Source: Public Health Outcomes Framework, Dudley MBC

Produced by Public Health Intelligence, Office of Public Health, Dudley MBC

Source: NCMP data, Dudley MBC
iv) Physical Activity

Percentage of Adults (16+) Taking 150+ Minutes of Physical Activity Per Week (Baseline Active Peoples Survey 7 2014)
b) Tobacco control

i) Smoking prevalence

Dudley Smoking Prevalence Aged 18+ Projections (Based on Dudley Health Survey Prevalence 1992, 2004 and 2009*)

\[ y = -0.3265x + 675.23 \]
\[ R^2 = 0.9663 \]

* Prevalence was assumed to have remained constant between 2009 and 2013. Based on ONS Integrated Household Survey data

c) Alcohol

i) Alcohol mortality targets

PHOF 4.06i - Under 75 mortality rate from liver disease (DSR per 100,000), Dudley, 3 year rates, 2001-03 to 2011-13, with targets to 2018-20

Data source: Public Health Outcomes Framework
Produced by: Office of Public Health, Dudley MBC
ii) Alcohol related hospital admissions

We will implement our recently approved physical activity and sport action plan which includes:

- providing grants to local community groups to increase levels of physical activity;
- Including referral rates to physical activity schemes on our practice scorecard;
• looking to incorporate the inclusion of gyms in future premises development;
• building on our workplace health scheme for CCG employees and holding our providers to account for ensuring their staff have similar access.

We will extend the model of healthy living pharmacies and opticians to general practice. In partnership with the Office of Public Health a delivery framework will be developed and piloted, working with public health and practice staff.

For these practices their local community’s health and wellbeing will be at the heart of everything the team does, consistent with our approach to population health and wellbeing. They will promote a healthy living ethos and deliver high quality public health services, such as smoking cessation, sexual health, NHS health checks and advice on alcohol and weight management.

The aim is to improve health and wellbeing and reduce health inequalities by using surgery staff to promote healthy living, provide well-being advice, signposting and services, and support people to self-care and manage long-term conditions. The teams will make every contact count to provide relevant health information.

Surgeries would be awarded the Healthy Living Surgery quality mark following a robust accreditation process.

The model will include:-

• each surgery having a Healthy Living Champion (with a Royal Society of Public Health qualification), who keeps up to date with community health services and spreads this knowledge throughout the team and a practice manager who has undertaken bespoke leadership training;

• a healthy living environment – a healthy living self-assessment and information area, promotion of lifestyle services and behaviour change campaigns.

The systematic management of patients with long term conditions will be part of this model. We have a significant group of patients identified by our risk stratification tool as being in the emergent risk cohort. At present, the approach to managing these patients is disparate and disjointed and the main commissioning vehicles for managing these patients in primary care are the Quality and Outcomes Framework (QOF) and enhanced services for diabetes and COPD. A more systematic approach is required to deliver better patient care, prevent risk escalation and find the 10% of patients that QOF alone fails to reach.

We will develop a new long term conditions framework making best use of the EMIS web system to support a systematised approach; case find; manage call and recall and extract data. The system will be developed in 2015/16, with a view to replacing elements of the QOF and existing enhanced services from April 2016. This will make a significant contribution to the early diagnosis of cancer and our one year survival rate.

Access to services is a major determinant of health status. We will enhance access to services in a number of ways:-
• more systematic case finding and call/recall systems using the EMIS system;
• identifying and responding to patients through risk stratification;
• encouraging GP registration for non-registered patients attending the Urgent Care Centre; commissioning GP services at weekends and making better use of telephone appointments;
• making primary mental health care available in non-stigmatising community venues;
• commissioning a minor ailments scheme from community pharmacy.

We have self-assessed against the “Better health outcomes” and “improved patient access and experience elements of the Equality Delivery System (EDS2). As well as the areas of action identified in this plan to deliver better outcomes and improved access and experience, we will, following a period of stakeholder engagement, review an agreed range of services in relation to these EDS 2 goals.

In addition we will:-

• implement the service specification for the redesigned the Dudley Respiratory Assessment Service (DRAS), aligned to our 5 localities and providing a step down service to the Rapid Response Service;
• reviewing the COPD pathway with a view to reducing emergency admissions;
• implement our diabetes model of care with a single point of access and triage for all referrals; the majority of care being provided in a primary care setting and the decommissioning of routine type 2 diabetic reviews in secondary care;
• take part in the national Diabetes Prevention Programme;
• carry out further work on hypertension building on the outcome of the 2014/15 local quality premium scheme which has increased recording on primary care disease registers by 1%;
• implement a new pathway for anticoagulation services;
• commission IV antibiotics and IV diuretics in the community;
• implement the agreed familial hyperlipidaemia screening process;
• support a systematic approach to self-care programmes using appropriate technology, particularly in relation to COPD and heart failure;
• implement an integrated heart failure pathway across acute and community services, 7 days a week.

4. **Community and Clinician Engagement**

a) **Community Engagement**

Our key plans have all been shaped by the views of patients and the public, through specific consultation exercises and through our Patient Participation Groups, our Patient Opportunities Panel and our Healthcare Forum.

We have also been informed by the priorities contained in the Joint Health and Wellbeing Strategy and specific spotlight events run by the Health and Wellbeing Board in relation to their priorities.

The Joint Health and Wellbeing Strategy's priorities of:-
• healthy services
• healthy lifestyles
• healthy minds
• healthy children
• healthy neighbourhoods

are all reflected in our key service and outcome priorities.

The key messages received from our programme of engagement activities cover a number of themes – the most significant being:-

• improved access to primary care – most patients would rather see their own GP than go to a walk-in centre or ED;
• a simplified approach to emergency and urgent care without multiple points of access or confusion;
• education for people which starts at an early stage which includes what to do in an emergency, how to access healthcare and how to look after yourself at home;
• more support and information to manage health problems, including long term conditions;
• more integrated community health care services which are patient centred and delivered in partnerships with other agencies, including social care;
• improved access in particular for mental health patients and younger patients so they get the right care at the right place at the right time;
• improved engagement and communication so that patients can make informed choices, get involved if they want to and have influence over what the CCG commissions.

b) Clinician Engagement

As a clinically-led organisation, our member GPs play a key role in shaping our plans. GPs have a majority of the voting members on our Board. Key decision making committees which report to the Board are the Clinical Development Committee, the Primary Care Development Committee and the Quality and Safety Committee.

More widely, issues are discussed at monthly locality meetings of GPs with major strategic plans and other issues taken from these locality meetings to bi-monthly borough-wide members’ meetings.

Our key interventions in relation to the development of primary care, service integration at locality level and a new system of urgent care have all been developed in partnership with our membership.

5. Our Outcome Ambitions

Our outcome ambitions reflect our assessment of local health need and key system effectiveness priorities. They have been drawn up with regard to the JSNA and in consultation with the Dudley Office of Public Health. Appendix 1 sets out our
outcome ambitions, their relationship to the JSNA and our initiatives to respond to them:-

a) **Securing additional years of life for people with treatable conditions:**

- 3.5% reduction in potential years of life lost (PYLL) per annum from 2087 per 100,000 in 2012/13 to 1943.5 per 100,000 in 2014/15 and 1685 per 100,000 in 2018/19;
- work with the Office of Public Health to improve the uptake of smoking cessation services in primary care.
- Work with the Black Country Be Active Partnership and Dudley MBC to ensure that general practice contributes to initiatives designed to promote physical activity, as part of our physical activity and sport action plan.

![PYLL from causes considered amenable to health care (directly standardised per 100,000)](image)

b) **Improving quality of life for 15m plus people nationally with one or more long term conditions:**

- 70/100 people in 2012/13 reporting improved health status increasing to 71.6/100 in 2015/16 and 74/100 people in 2018/19;
- IAPT access level to increase from 15.3% at 31\textsuperscript{st} March 2014 to 18.3% at 31\textsuperscript{st} March 2015 (QP indicator);
- IAPT recovery rate to be 50% by 31\textsuperscript{st} March 2015;
- dementia diagnosis rate to increase from 46% at 31\textsuperscript{st} March 2014 to 67% by 31\textsuperscript{st} March 2015 (QP/Local BCF indicator);
- hypertension diagnosis rate to increase by 1% - current register 55,164 to 55,716 – an increase of 552 (local QP indicator);
- improve recording of disease in primary care registers, in particular for hypertension, heart failure and chronic kidney disease (recorded prevalence 18,838, modelled prevalence 31,398);
- work with the Office of Public Health and primary care to improve the uptake of vascular checks;
- work with the Office of Public Health on initiatives to reduce childhood obesity towards the England average.
c) Reducing time spent avoidably in hospital through more integrated community care:

- avoidable emergency admissions to be reduced from 2448 per 100,000 in 2012/13 to 2332 per 100,000 in 2015/16 and 2018/19.
d) Increasing proportion of older people living independently at home after discharge:-

- people still at home 91 days after discharge to reablement will increase by 12 people in 2014/15, from 87.4% as at March 2013 to 88% by March 2015 and a further 11 in 2015/2016 to 89%. (BCF indicator).

![Effectiveness of Reablement](chart.png)

87.4% 88.0% 89.0%

2013/14 2014/15 2015/16

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e) Increasing people's positive experience of hospital care:-

- reducing the average number of negative responses per 100 patients from 159.2 in 2012/13 to 153.5 in 2015/16 and 145 in 2018/19;
- agree a plan with local providers to address issues identified in the 2013/14 Friends and Family Test results (QP indicator);
- reducing the number of pressure ulcers: zero tolerance of grade 4s, no increase in grade 3s and a reduction in grade 2s.

![Patient experience of hospital care - average number of negative responses per 100 patients](chart2.png)
f) Increasing number of people with positive experience of care in general practice and in community:-

- reducing the average number of negative responses per 100 patients from 6.1 in 2012/13 to 5.66 in 2015/16 and 5 in 2018/19.

g) Progress towards eliminating avoidable deaths in hospital:-

- Medication incidents reported through the National Reporting and Learning System – quality of the reported learning to be shared;

- development of a reporting system to support the investigation and remedy of medication related serious incidents for which the medicines management team have received root cause analysis training.

- zero tolerance of MRSA. There have been no MRSA bacteremias in providers to date in 2014/15 , however, there has been one case attributable to the CCG.

- Clostridium difficile reduction from 117 cases to 108 cases by March 2015. This is on target to be delivered - the objective will be reduced further in 2015/16 and will be more challenging to achieve.

6. Commissioning for Quality and Safety

a) Holding providers to account

We will develop quality initiatives and use the Commissioning for Quality and Innovation (CQUIN) process to reduce patient harm and improve patient outcomes. This continues and CQUINS have been refreshed for 2015/16 and national CQUINS are awaited.
We will work with our providers to encourage the development of smart dashboards to illustrate the performance of their services and inform patient choice. We will look to work with providers who actively promote their own information to support this. Progress has been made in giving feedback to the public on quality metrics – e.g. safer staffing levels. This will continue in 2015/16.

We expect all providers to develop clear clinical quality standards for their services and measure their performance against these. In 2015/16 we will focus on outcomes based quality standards for inclusion in contracts and will monitor providers against these mapped to the NHS Outcomes Framework.

The CCG Board will use patient stories as a key mechanism for obtaining feedback from patients and build the lessons learned into the service design process. We have used the CQUIN process to incentivize this for some providers until firmly established.

Mortality data and other variate intelligence continues to be used to triangulate an overall view of deaths. Where there are emergent patterns or themes, these are explored through a quality improvement approach.

We require providers to have in place mortality tracking processes including case note review to provide assurance of safe care and reduce avoidable mortality. Mortality is tracked through the Clinical Quality Review Meeting (CQRM) process, mortality and morbidity meetings, the use of national metrics such as SHMI and other qualitative intelligence such as complaints and incidents. A collaborative approach will continue to identify where acts of omission might have contributed to an avoidable death. We will participate in specialty specific mortality reviews.

From April 2015 the CCG will assume delegated responsibility for the commissioning of primary care. The CCG will put in place a comprehensive quality monitoring programme to ensure safe care.

Our educational programmes for primary care practitioners and community services will be used to share best practice and lessons learnt.

b) Francis, Berwick and Winterbourne View

The recommendations from the Francis report continue to steer service improvements and outcomes focused commissioning specifications.

In 2014/15 CQUINs were used to focus organisations on the Berwick report around organisational learning. The culture of learning climate will continue to be a feature of CQRMs supported by evidential matrices such as professional development, access to learning, learning and sharing from adverse incidents and feedback on what worked well. Organisational learning quality indicators will be further developed in the next twelve months to be included in contract specifications for 2016/17. Francis principles are now built into our business and contract management processes.
We have developed, in conjunction with our social care partners, a Winterbourne View action plan and achieved all actions on time as planned. Patients with a learning disability continue to be a high priority to ensure appropriate and timely placements based on individual assessed need.

We are reviewing the commissioning of assessment and treatment services with a view to commissioning:-

- a community based assessment and treatment service for those patients who would have traditionally been admitted to an inpatient facility;
- a community based “short breaks” service to prevent placement breakdown and admission.

c) Staff satisfaction

In 2014/15 we used a CQUIN based on the American Association for Healthcare Research and Quality (AHRQ) report to inform and assist in the understanding of the patient safety culture as a means of influencing staff satisfaction. In 2015/16 we will build on this work and use nationally reported staff surveys to focus efforts and engagement.

d) Patient safety

There are robust processes in place to oversee the quality agenda across provider services supported by the Clinical Quality Review meetings between the CCG and each provider, and the CCG Quality & Safety Committee.

The main thrust of the patient safety agenda is to:-

- develop locally sensitive quality indicators and metrics to continually improve the quality outcomes of services;
- provide the governing body with a clear, comprehensive summary on the user view, effectiveness, safety and outcomes of services commissioned;
- monitor the performance of service providers against outcomes of agreed CQUINs and to support the development of future CQUINs;
- support the implementation of improvement plans put in place by service providers in relation to breaches in quality and safety standards, using outcome measures and appropriate time lines;
- review and act upon any notification, advice or instruction issued by the National Regulators or NHS England;
- review and act upon any notification, advice or whistleblowing issued by other agencies or individuals;
- review reports from service providers on progress and outcomes against existing Quality Account work plans, and to review the outcomes of any new work plans;
- monitor and receive reports on incident data (Serious Incidents, Never Events, unexpected deaths);
- quality exceptions reported since the last meeting previous week (such as whistleblowing, serious case review, adverse media reports);
- review safeguarding issues;
• review a suite of key indicators including HCA1 data, complaints, patient experience and a quality dashboard.

e) Seven day services

Our Service Development Improvement Plans set out our plans for implementing seven day standards. As well as assuring ourselves that our providers are putting in place appropriate arrangements for safe 7 day services, our integrated locality service model and our urgent care model will operate on the basis of a 7 day service. This will be built into the relevant service specifications.

In addition, as a national 7 day working NHS IQ transformational pilot site, we have developed 7 day service standards for community services which have been shared with NHS England. These standards will be reflected in our service specifications for 2015/16.

f) Compassion in Practice (CIP) and the 6 Cs

The nursing and allied health professional strategies of our main providers have been developed and assured against the expectations of “Compassion in Practice” and the 6Cs.

i) Care
Care is our core business and that of our organisations and the care we deliver helps the individual person and improves the health of the whole community. Caring defines us and our work. People receiving care expect it to be right for them consistently throughout every stage of their life.

ii) Compassion
Compassion is how care is given through relationships based on empathy, respect and dignity. It can also be described as intelligent kindness and is central to how people perceive their care.

iii) Competence
Competence means all those in caring roles must have the ability to understand an individual’s health and social needs. It is also about having the expertise, clinical and technical knowledge to deliver effective care and treatments based on research and evidence.

iv) Communication
Communication is central to successful caring relationships and to effective team working. Listening is as important as what we say and do. It is essential for “no decision about me without me”. Communication is the key to a good workplace with benefits for those in our care and staff alike.

v) Courage
Courage enables us to do the right thing for the people we care for, to speak up when we have concerns. It means we have the personal strength and vision to innovate and to embrace new ways of working.
vi) Commitment
A commitment to our patients and populations is a cornerstone of what we do. We need to build on our commitment to improve the care and experience of our patients. We need to take action to make this vision and strategy a reality for all and meet the health and social care challenges ahead.

The Next Steps

We will use our practice and community nurse fora to identify how the 6C principles are embedded and ensure our education programmes support this.

g) Provider cost improvement programmes

We continue to require providers to demonstrate a robust impact assessment process related to cost improvement programmes both in terms of qualitative impacts and operational impacts (such as reduced analytical or reporting capacity), and evidence of full reporting to their Boards. These will be considered by the CCG Quality and Safety Committee and appropriate assurance given to the Board.

CIP meetings are held with providers regarding the clinical quality impact of cost improvement programmes and how this translates into workforce plans. Our CIP approach extends to our commissioning plans in relation to creating a modern system of integrated community services, capable of preventing unnecessary admission.

I) Safeguarding children

i) Section 11 audit

Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard for the need to safeguard and promote the welfare of children and young people. As members of Local Safeguarding Children Board, key partner agencies have agreed to ensure that their duty to safeguard and promote the welfare of children is carried out in such a way as to improve outcomes for children and young people in the borough. Wherever possible, evidence of impact on improving outcomes for children should be identified.

For the Local Safeguarding Children Board to maintain oversight of the effectiveness of safeguarding children practice across the borough, and of the extent to which it is continuously improving, the key Section 11 agencies are expected to provide information on the arrangements they have in place to protect and promote the welfare of children and young people. This includes Dudley CCG as a statutory member of the Safeguarding Children Board.

The Designated Senior Nurse has completed the audit on behalf of Dudley CCG and its member practices for the period 2014/15. Overall the CCG is compliant with all of its statutory responsibilities. The CCG has worked hard to raise the profile of safeguarding children within the organisation and is working towards ensuring that
safeguarding is fully embedded in all aspects of CCG business including all contracts and service specifications. The correct governance structures are in place and staff have undertaken appropriate safeguarding children training.

Whilst the CCG has made excellent strides in listening to the voice of the child and determining wishes and feelings of local children and young people, they are not currently involved in service development and redesign. The CCG has plans to develop a cache of young health champions in an attempt to improve local children’s and young people’s health by: -

- working with other young people to help to set up and support new health projects;
- becoming active and key partners working with health organisations to help develop health services for young people;
- Influencing young people to live healthier and active lives and providing peer support and a voice for young people around health issues.

With regards to safer recruitment processes, whilst all of the managers and HR staff within the CCG have undertaken recruitment training, this does not specifically include the safer element. The Designated Senior Nurse has undertaken safer recruitment training and the issue is currently being addressed in conjunction with the Head of Organisational Development & Human Resources. All appropriate staff will undertake training in 2015 and this will be arranged via a Department for Education e-learning package or delivered face to face from a member of the Dudley Safeguarding Children Board.

The final report of the Midlands Safeguarding Review commissioned by the CCG in 2014 will be presented to the Quality & Safety Committee in April 2015 together with recommendations for action. The Board will be updated at its next meeting.

**Safeguarding adults**

i) Prevent agenda

The Prevent strategy is a cross-Government policy that forms one of the four strands of the Government’s counter terrorism strategy. Prevent strategy was introduced as a specific requirement within the NHS Standard Contract for 2013/14 for provider organisations.

The CCG Safeguarding Team introduced new multi-disciplinary training workshops and has delivered 24 training sessions since April 2014. Training will continue to be offered at regular intervals in the future.

Prevent training is offered to all CCG front-line practitioners, and is promoted via Member News, practice meetings, and other training events.

ii) Care Act and NHS Accountability framework

NHS Accountability Safeguarding Framework has taken into consideration the Care Act which Adult safeguarding is, for the first time, spelt out in the law in the Care Act. Local authorities must make enquiries or ask others if they believe an adult is, or is at risk of being abused or neglected. The legal framework is to enable key organisations
and individuals with responsibilities for adult safeguarding to agree on how they must work together and what roles they must play to keep adults at risk safe. Safeguarding adults board will be a key requirement which includes key stakeholders such as Health and the Police. This board will carry out safeguarding adult reviews when people die as a result of neglect or abuse and there is a concern that the local authority, or its partners, could have done more.

iii) Transforming Care – Next Steps

NHS England has published a system-wide report on transforming services for people with learning disabilities. *Transforming Care – Next Steps* sets out a cross-system programme to transform services for people with learning disabilities and/or autism. The report represents the latest stage in responding to the recommendations of the *Winterbourne View – Time for Change* report. The report was produced jointly by the following organisations:

In particular, the report focuses on the need to provide mental health hospital placements in some circumstances where there is a genuine need and in some cases as an alternative to custody, however a commitment to seeing a substantial shift away from reliance on inpatient care remains. Inter-agency efforts will be focused on:

- a substantial reduction in the number of people placed in inpatient settings;
- reducing the length of stay for all people in inpatient settings;
- better quality of care for people who are in inpatient and community settings;
- better quality of life for people who are in inpatient and community settings.

To achieve those ambitions, a number of work streams will be pursued:

- empowering people and families;
- getting the right care in the right place – both by ensuring that the current care system works for patients and families, and by designing and implementing changes for the future;
- regulation and inspection: tightening regulation and inspection of providers, strengthen providers’ corporate accountability and responsibility, and their management, to drive up the quality of care;
- workforce: improving care quality and safety through raising workforce capability;
- data and information: underlying all the work streams above will be a focus on making sure the right information is available at the right time to the people who need it.

The Quality & Safety Committee will consider this report in more detail in April 2015, and make recommendations for further action. This report will also be discussed with providers via the Clinical Quality Review Meeting process and actions taken accordingly in conjunction with commissioning teams.

7. Parity of Esteem for People with Mental Health Problems

“Healthy minds” is one of our Health and Wellbeing Board’s 5 priorities (see above). The Board has an ambition to create a “mental health friendly Dudley, where the
social determinants of health and wellbeing are understood and action is taken to tackle inequalities with all partners and stakeholders”.

To deliver parity of esteem we will increase our investment in mental health services by £1,118,000 for 2015/16.

**a) Mental health at the heart of our integration model**

Our integrated locality service model (see below) is focused on both physical and mental health. Mental health practitioners are key members of our locality teams, recognizing that physical and mental health problems are interrelated.

The links with local voluntary and community services and our focus on prevention and independence within asset rich communities is designed to reduce the harmful effects of social isolation. Access to locality link workers and a social prescribing scheme enhances this provision and the case study in our film on MDT working illustrates this.

https://www.youtube.com/watch?v=4vKTOIMwoxw

We will work with our practices to improve the recording of patients with mental health problems in primary care disease registers and in turn ensure that these patients enjoy appropriate access to physical health services in primary care.

Evidence has demonstrated that historically medications prescribed for mental illness and lifestyle have had extensive side effects on physical health and life expectancy. The lifestyle of an average person with a severe and enduring mental illness is one of poor self-care, poor diet, heavy smoking, sedentary behaviour all exacerbated by poor motivation, lack of insight and lack of capability to bring about the necessary changes. This creates a gap in life expectancy when compared to others without mental illness. There is also evidence that many people with mental illness develop diabetes, heart disease, respiratory disease and high blood pressure.

For people with a mental illness, their physical illness is just as important and must not be ignored. GPs and our service providers are required to undertake regular physical health checks on all patients and make every contact count.

We will continue to work with our partners to develop the “healthy neighbourhoods” envisaged in our Joint Health and Wellbeing Strategy, providing opportunities for guided walks, cookery and weight management classes. Our physical activity and sport action plan (see above) will contribute to this.

**b) Access**

We will work with the Office of Public Health to tackle the issue of poor access by people with mental illness to public health interventions which can increase life expectancy e.g. smoking cessation, screening programmes and immunisation.

We will ensure that there is speedy access to primary mental health services and our CCG locality groups will be empowered to monitor, review and hold local services to account for performance. We will review the provision of primary mental health services and look to use the AQP procurement mechanism to extend choice where
we consider this appropriate.

c) A new mental health service model

We will commission services which are “age appropriate”. The current age criteria do not reflect the differing ability of the brain to process cognitive information which is evidenced to be effective from 14 years of age, or to develop psychosocial maturity which enables processing of emotion and thinking evidenced to be effective from 21 to 25 years. These factors are vitally important in how people accessing services can effectively utilise and achieve optimal outcomes from the interventions provided.

We intend to commission services for people aged 0 to 25 years and 25 years upwards, together with a specialist dementia service. We will eradicate the gap in provision for young people aged between 16 and 18 years created by the current criteria. This will also include appropriate out of hours provision for young people.

As part of this model, we will commission a multi-agency hub as a single point of contact for children; young people; and their families experiencing social; emotional; developmental and/or safeguarding problems. This will include access to community based eating disorder services.

We will ensure that there is a primary care mental health service for people aged 0 to 25 years and 25 years upwards. Research demonstrates that 50% of first time experience of mental health problems will occur by age 14 years and 75% by age 25 years.

We will continue with the development of our award winning dementia gateways as a one stop shop for patients and carers (see below). Dementia diagnosis rates will be a key performance metric for the local Better Care Fund.

d) Pathway efficiency

We will look specifically at the pathway for early intervention in psychosis with a view to eliminating any unnecessary variation, enhancing pathway efficiency and meeting the new waiting time standards. We will apply the same approach to the IAPT pathway as we seek to meet the new waiting time standards for this service.

e) Crisis care

As part of our commitment to the Crisis Care Concordat, we will review the operation of our mental health urgent care centre that has been in place over winter, incorporating our existing psychiatric liaison service with a view to making this a permanent, “all age” service.

The street triage service, providing a combined ambulance service, mental health and police response to people experiencing mental health crises, has been a successful scheme this winter. It has:-
• prevented the unnecessary use of ED;
• prevented unnecessary use of our local place of safety;
• made better use of police and ambulance service resources;
• avoided the criminalisation of people with mental health problems.

We will now look to commission this service on a permanent basis. We will ensure that our new model of urgent care provides an appropriate and timely response to those presenting in crisis.

f) Substance misuse

We recognise the significance for the local system of alcohol related admissions and the associated dual diagnosis. We will work with the Office of Public Health on prevention initiatives associated with alcohol. Again, our integrated service delivery model and our approach to risk stratification will address the issues associated with substance misuse.

8. Children’s Services

We will apply the principles of parity of esteem to children as well as adults. This will apply to all children who are or might become vulnerable. Although there is no one way of measuring vulnerability, in general it can be said that a vulnerable child is one who is unable to keep themselves safe from harm, or who is at risk of not reaching their potential and achieving appropriate outcomes.

We will work with partners to commission services which ensure that this group of children have the necessary additional support to allow them to achieve and engage to the same level as other children and young people. Initiatives to support this include: -

• ensuring that the looked after children health assessment pathway meets demand and delivers outcomes;
• promoting breast feeding;
• preventing smoking by pregnant women;
• work in partnership with the Office of Public Health on initiatives to reduce childhood obesity;
• providing support to carers;
• fulfilling our statutory duty to contribute to education, health and social care plans for children with special educational needs;
• reviewing existing services designed to meet our statutory duties for safeguarding;
• reviewing the end of life pathway and improving Advanced Care Planning;
• implementing an integrated children’s community health service;
• expanding our paediatric triage service;
• introducing “Health Champions” for young people.
9. Our Key Priorities – 2015/16

In responding to the challenges we face there are 4 key priorities which need to be delivered in 2015/16:-

- **urgent care** – our new Urgent Care Centre becomes operational from 1st April 2015. We will ensure that this functions effectively to eliminate inappropriate demand;
- **planned care** – the delivery of service efficiencies through the elimination of unwarranted variation in our pathways for ENT, diabetes, cardiology, ophthalmology, urology and orthopaedics;
- **integrated care** – completing the implementation of our model of practice based multi-disciplinary teams, transforming the nature of joint working across health and social care and providing a real alternative to hospital admission;
- **primary care development** – co-commissioning a modern system of primary care capable of managing patients systematically supported by skilled staff, appropriate IT and modern premises.

These are dealt with in detail below.

**a) Impact on Providers**

The achievement of these priorities will be dependent on the appetite, ability and speed of providers to react to the change in our commissioned service model.

If providers react in the way we have indicated, then we foresee a reduction in the acute and mental health bed base within Dudley and an increase in the provision of community/primary care services. This will be done in a planned and managed way with our providers to ensure that the cost base within providers reduces in line with potential income reductions.

If providers do not work with us in delivering our service model, then there is a significant risk of financial sustainability for providers, as the CCG will have no choice but to test the market for services. The financial environment for our local NHS providers is already very challenging, so we wish to work collaboratively to ensure that the health economy is financially viable for the foreseeable future. We will not, however, work with providers that do not share our values or vision.

**b) System Characteristics for Transformation**

In December 2013, NHS England identified six key characteristics which sustainable health and care systems will need to demonstrate by 2017/18. Our key initiatives in relation to these are set out below.

In terms of delivering system transformation, the CCG has put forward a proposal to develop a new model of care as envisaged in the NHS Forward View. This is a variant of the multi-specialty provider (MCP) model and is described below.
c) A new model of care

We are implementing a sustainable and replicable whole-system change, designed around the person, communities and clinically-led delivery, which enables both mutual-networked care and best practice pathways of care.

We have already made significant progress to implement the main components and key enablers of this care model in 2014/15.

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. This, in effect, creates a Multispecialty Community Provider (MCP).

This means providing a network of care that is organised around, and adaptive to, patients’ changing needs. Care will be delivered with a focus on mutuality between patients and professionals, to change the medical dependency model of expert-patient and maximise the potential for people’s wellbeing. Care will be commissioned to encourage services to take a shared responsibility for shared outcomes for the same population of patients; and to establish co-produced outcome objectives with each individual person.

Our second objective is to implement best practice pathways of care for value-added treatments provided to individuals – either planned or in an emergency. This means re-orientating the way we both commission and organise care on the basis of patient centred pathways, removing unwarranted variation to achieve best possible clinical outcomes, as well as efficient delivery of care.

i) Clinical development

The core concepts of the clinical model are that care should first be person-centred, integrating population-based health and wellbeing services around the person:-

- to maximise people’s independence from care;
- based upon the registered patient with the practice.
- delivering best practice pathways of care:
  - to achieve best possible outcomes from treatment;
  - to provide efficient care offering the best possible experience.

Secondly, that care should be designed around our clinical delivery, with GPs as the lead coordinators of population health and wellbeing:-

- providing care-coordination of mutual-networked care;
- taking shared responsibility for achieving shared outcomes for patients.

With consultants as the lead co-ordinators of pathways of care-providing value-added treatments in line with best practice.

ii) Stage one – teams without walls

The first stage, already substantially in place, of delivering this mutual-networked
care is to establish across our borough (population c318,000) a joined up network of GP-led, community-based multi-disciplinary teams which enable health, social care and the voluntary sector to work together in “teams without walls” for shared benefits and outcomes, coordinating the care planning for individual patients.

These teams transcend organisational boundaries and interests, and focus collectively on delivering integrated patient centred care aimed particularly at that cohort of patients identified as being most at risk of emergency hospital admission. This concept begins at practice level with Multi-Disciplinary Teams (MDTs) including the GP, District Nurse, Assertive Case Manager, Mental Health Worker, Social Worker and Voluntary Sector Link Worker.

A detailed explanation of this model is set out in our film on integration https://www.youtube.com/watch?v=4vKTOIMwoxw which we have used this to inform our existing system change.

iii) Stage two – aligning specialist services

This involves expanding the mutual network of care to fully incorporate all specialist community services and some aspects of urgent care, better aligning health and social care services into a single approach – such as single access to CAMHs services and the integration of telecare and telehealth.

This includes the establishment of a community rapid response service, designed to intervene in a crisis in the patient's home – both avoiding the need to go to A&E and connecting the person back into their local network of care.

This also includes redesigning the model of urgent care to establish a primary-care led urgent care centre as a point of triage for all patients attending hospital. This will open in April 2015, will reduce the need for ED services, and will connect people back to their local primary care service.

iv) Stage three – community care led retrieval

This extends the model to include current consultant-led services which operate to support population health and wellbeing.

This next stage has already been agreed by our clinical strategy board, which includes consultants and GP leadership from across the CCG and our main provider. This will include specialties which support the management of long-term conditions such as diabetes medicine and respiratory medicine. Consultants will work in partnership with GPs to the same outcome objectives for improving population health and wellbeing. This will include collaborating to deliver improved services to the frail elderly.

Our ambition is to remove all delayed transfers of care from the system. We will achieve this by shifting the locus of control from hospital to community. The integrated MDT, with support from consultant physicians, will become responsible for the whole pathway of care for the frail elderly: from community, into hospital and back into the community – so that there are no longer any transfers of care. Patients will be retrieved back into the community rather than transferred from one team, or
one organisation, to another.

v) In parallel – whole pathway care

We will be piloting a new approach to planned care to develop best practice pathways of care – based upon the whole pathway of care followed by the patient.

Our aim will be to streamline and standardise the actual pathways that patients follow, so that they are fully patient-centred, efficient and deliver best practice outcomes. We are looking at the whole pathway, not just the stages from referral to treatment.

d) Citizen Participation and Empowerment

- Each of our practices will have an active Patient Participation Group (PPG), moving from 44/47 in 2014/15 to 47/47 in 2015/16.
- We will capture the experiences of patients in practices and develop improvement measures with our PPGs.
- We have delivered a structured programme of training and development for PPG members, we will now develop a guide to support their future development.
- We will build on the success of our #mefestival for young people, with a further event for young people in 2015/16.
- We will work with the Primary Care Foundation, our PPGs, our practices and NHS England to develop innovative approaches to enhancing access to primary care. This will include feedback given by the Youth Council to our Board on how young people prefer to access health services. Areas to be examined include arrangements for access to repeat prescriptions; telephone access and consultation; online access and arrangements for follow up appointments.
- We will ensure that we respond to the health needs of new migrants by developing a better understanding of our local communities.
- We have commissioned 5 voluntary sector community link workers in our localities to support our service integration model. We will ensure the benefits of this are embedded as our service delivery model is extended across all practices.
- We will continue to ensure our contracted levels of activity meet NHS Constitution requirements.
- Our Building Healthy Partnerships Initiative has supported the development of a refreshed community information directory for Dudley citizens. We will make sure this is promoted through all our communication channels.
- We will develop the PSIAMs tool to empower individuals to assess the impact of commissioning interventions on them. This will be used in particular for our social prescribing and primary mental health care services.
- We will work with Dudley Healthwatch and Dudley MBC to develop a local indicator of patient experience as part of our Better Care Fund performance measures.
- We will double the size of our citizen contact database to 1000 people who are interested in being actively involved in decisions about their health and
We will work with our partners to use all available communication channels to extend our reach to local citizens.

We will work with more families to exercise their right to have personal health budgets for NHS Continuing Healthcare and examine how this can be extended to patients with long term conditions.

i) Engagement channels

We have a number of engagement channels which encourage patients and the public to be actively involved in the decision making process on how their health care services are planned, developed and delivered. These include:-

- a thriving network of Patient Participation Groups. These groups provide a patient voice on the provision of primary care but also a resource which we use to shape wider discussions on commissioning intentions and other health and social care related issues. Our aim for 2015/16 is to further develop a locality and borough wide structure, mirroring our GP practices, which enables our PPGs to network and share best practice, communicate with each other more effectively and have a stronger voice at Board level;

- our Patient Opportunities Panel (POPs) – membership is drawn from PPGs across the borough. The purpose of the POPs is to give patient representatives a direct influence on the commissioning process;

- our Health Care Forum (HCF) – a less formal public meeting held quarterly with an emphasis on information sharing about health care developments and appropriate access to healthcare services.

ii) Feedback

We gather and act on patient feedback from a wide variety of sources. That includes data collected from online feedback channels, social media and provider complaints, as well as our own channels including:-

- service specific consultations;
- specific pieces of work such as our vox. pop. ‘Feet on the Street’ videos which are screened to Board meetings in public and other committees;
- our PPGs, POP and Health Care Forum;
- announced and unannounced visits to providers by the quality team;
- feedback from GP forums including locality and borough wide members’ meetings.

iii) Developing our Engagement Network

- Each of our practices will have an active Patient Participation Group (PPG), moving from 44/47 in 2014/15 to 47/47 in 2015/16.
- We will continue to deliver a structured programme of training and development for our PPG members along with supporting innovations through our ‘PPG Purse’ bid programme.
• We will support our PPGs to have a stronger voice at locality and CCG Board level and continue to develop our POP, as a representative group for our PPGs.

iv) Supporting Young People

• We will build on the success of this year’s #mefestival, to make this an annual youth summit.
• We will act on the feedback from our young people to develop a network of young health champions and strive to make our information more accessible to young people through the internet and social media.

v) Supporting Carers

• We have in place existing joint strategies with Dudley MBC to support carers and these will be refreshed for 2015/16.

vi) Improving Access to Primary Care

• We will build on the work from the Primary Care Foundation to engage our PPGs and our practices in developing innovative approaches to enhancing access to primary care.

vii) Supporting New Migrant Communities

We will ensure that we respond to the health needs of new migrants by:-

• developing a better understanding of our local communities, working with our partners and building on the JSNA; improving data recording in primary care so that we can more effectively target health interventions;
• working with Healthwatch to identify and respond to issues associated with access, quality and patient experience;
• identifying how we can ensure our engagement approaches are sensitive to the needs of new migrants.

viii) EDS 2 and the NHS Workforce Equality Standard

We will review the membership of the CCG Board in the light of the composition of the Dudley community and using the NHS workforce race equality standard. This will inform our succession planning process.

ix) Improving Information

• We will promote the new Dudley Community Information Directory for Dudley citizens.
• We will support practice staff to become Accredited Dudley Information Champions.

x) Measuring, Learning from and Improving the Patient Experience
We are working with our main provider, Dudley Group NHS Foundation Trust, to achieve openness and transparency of all patient experience data.

Through strong relationships and sustainable infrastructure we will initially work with Dudley Group Foundation Trust to establish a strong mechanism for recording and presenting patient experience from a variety of feedback sources into one central system. This system and methodology will be extended to all providers in Dudley.

- We will work with Dudley Group NHS FT to establish a system where an individual’s journey can be measured and individual feedback can be used to establish the overarching issues but also provide the actions by having the ability to go right back to the individual story. We will develop the infrastructure in general practice so that friends and family test and other information provides real insight to our members, of the experiences of patients in their practice. With this information we will support our members along with our network of PPGs to reflect on these experiences and look at how both on a practice level but also locality and borough wide improvements can be made to patient experience.
- We will encourage partnership working across multiple organisations to make patient experience learning transferable between organisations and encourage other providers to be more open through the sharing of infrastructure and experience reporting templates.
- We will support this development through mutually aligned targets and measures for the services we commission.
- We will develop a smart phone app to capture more real time patient experiences, initially in the hospital but then in all healthcare settings in Dudley.
- We will work with our PPGs to develop effective indicators of patient experience in primary care, measure these and develop action plans to enhance performance.
- We will work with Dudley Healthwatch and Dudley MBC to develop a local indicator of patient experience as part of our Better Care Fund performance framework.
- We will measure the success of this through patient experience insight of the Friends & Family test in primary care, comments posted on NHS choices and Patient Opinion and patient surveys.

xi) Invest in Social Value

- We will use the PSIAMS system of personal and social impact action measurement to understand the impact of our commissioning interventions as part of our approach to commission for value.
- We will develop the PSIAMs tool to empower individuals to assess the impact of commissioning interventions on them.
- By the end of 2015/16, 1000 assessments will be carried out by our Age UK partners leading to the issue of social prescriptions as necessary.
- We have a solid relationship with our local voluntary and community sector. The 5 locality link workers that support our practice based MDTs are an example of this. We will ensure that these workers act as a catalyst for mobilising volunteering in response to identified need.

xii) Let’s get Personal
• We have scoped those existing NHS continuing healthcare patients who may wish to exercise their right to have a personal health budget and are working with 2 families to pilot our approach. We have agreed our process and governance arrangements and will look to use a direct payment mechanism.

• In terms of children’s services, the CCG will explore how personal budgets can be used as part of the strategy for early intervention, recovery, family crisis and long term health conditions, including other circumstances identified through joint assessment.

• We will work with up to 15 families in exercising their right to have personal health budgets for NHS Continuing Healthcare and explore how this can be extended to patients with long term conditions.

• We will improve parental and young people’s choice, access and control over services by working with Dudley MBC to explore how personal budgets can be used as part of the strategy around early intervention, recovery, family crisis, exclusion from school, and long term health conditions or other circumstances identified through joint assessment.

**e) Wider Primary Care, Provided at Scale**

**i) In 2014/15**

• All practices have worked in partnership with their PPGs to implement plans to improve access within their practices; opening hours within member practices have increased and seven practices have been commissioned to provide extended access on a Saturday morning, providing approximately 2000 more GP and nurse appointments over the winter.

• We have developed and implemented a support package to practices piloting the ‘productive general practice’ quality improvement programme that has improved practice efficiency; improved knowledge and skills for clinical and non-clinical staff; improved the leadership and change management skills; improved communication, relationships and staff morale; created and embedded the skills within primary care to lead and manage change.

• We have supported all practices moving to EMIS web in 2014/15 and have put in place a support team whose sole function is to maximise the efficiency within our member practices: this has included developing standard protocols and searches across member practices and enhancing our use of risk stratification tools to identify and manage the frail elderly; reducing unplanned admissions, and co-ordinating physical, mental and social care in the community.

• We have increased the use of technologies within out member practices, such as telecare, online prescriptions and appointment booking.

• We have developed and commissioned a number of schemes and enhanced services that have resulted in service improvement and improved outcomes for patients, examples include healthy living programmes, customer service training for reception staff, telemedicine for COPD management and pilots that have prevented alcohol admissions using risk stratification tools.

• We have invested in the staff development and training for member practice staff, delivering care planning training to support the delivery of the unplanned admissions enhanced service; commissioning eLearning/online training packages to ensure CQC compliance.
We have worked with our practice managers group to develop and implement an annual training programme that has provided annual updates for practice managers, nurses and HCAs. Topics have included CPR, safeguarding, infection control, information governance and employment law.

We will be commissioning and rolling out the support package to a further cohort of member practices: expanding upon our existing and effective support structure for primary care by bringing together teams of specialist staff whose sole function is to maximise the efficiency within our member practices.

**ii) Delegated Commissioning**

Our primary care development strategy sets out six priorities which devolved commissioning will help us deliver:

- managing workload and improving access - we have already conducted a comprehensive audit for improvement with the Primary Care Foundation.

- developing integrated locally-based services - primary care is at the heart of our integrated model which we have developed in partnership with Dudley MBC.

- managing the shift from secondary to primary care service provision - we have achieved our local quality premium targets and are developing a new long term conditions framework to develop provision in primary care.

- developing primary care’s role in urgent care – we are implementing a new primary care led Urgent Care Centre.

- building resilient primary care and supporting practices to thrive - we have invested in a single IT system for all practices and established a premises development strategy to underpin delivering primary care at scale.

- reducing unwarranted variation and rewarding excellence - we have established a comprehensive practice support programme and a new quality performance tool.

Our proposal for full delegated authority is predicated on three areas:

- to effectively review and pilot new ways of commissioning outside of the core requirements of GMS – setting one set of outcome measures that will apply to all those services commissioned and working as part of an integrated population based health and wellbeing service with primary care at the heart of the model;

- to commission for shared outcomes across the whole system of integrated care to ensure that all the organisations working in Dudley are working to the same outcome objectives for our population;

- to lead and manage the process for review and revising all GP contracted activity outside of GMS (so including QOF, enhanced services and PMS resource allocations), and retain any surplus within Dudley to reinvest within
Dudley to improve the quality of primary care services and support the delivery of our service integration model.

We have well developed plans to redefine and improve the quality standards for primary care, including an option for re-investing the “PMS premium” into a local quality improvement scheme.

We have the infrastructure to engage with our GP membership to support performance improvement - capacity that is not available to NHS England.

We have well established patient and public involvement in the commissioning of our services as described above.

We have developed robust governance arrangements that have been independently assessed by the Good Governance Institute. These include a revised conflict of interest policy; standards of business conduct policy; and amended constitution that have been agreed by the CCG Board.

The ability of the CCG to lead this process of change will be supported through our education; training; mentorship; and engagement activities. We have an Organisational Development Plan that describes the support we will provide to ensure that our ambitions for devolved commissioning can be achieved.

f) A Modern Model of Integrated Care

- Emergency admissions will be reduced by from 37,813 to 37,680.
- Avoidable admissions will reduce from 2448 per 100,000 in 2012/13 to 2384 per 100,000 in 2014/15.
- Delayed days in hospital will reduce by 134 days in 2014/15 and by a further 160 days in 2015/16.
- People still at home 91 days after discharge to reablement will increase by 12 people in 2014/15 and a further 11 in 2015/16.
- The number of new admissions to nursing homes will reduce by 32 in 2014/15 and by a further 36 in 2015/16.
- We expect the specialties of general medicine, geriatric medicine, respiratory medicine and endocrinology to be most affected by the reduction in emergency admissions.
The graph above shows the planned reductions in Emergency Admissions against the backdrop of predicted activity growth due to changes in demography.

The graph above demonstrates the interventions and the respective impact required to achieve the planned reductions in Emergency Admissions.

We have described above our vision for a new model of care.
i) Our model of integrated care

This is designed to ensure that:

- every Dudley person has a high quality experience of health and care throughout their life journey;
- the health and care system promotes independence;
- prevention and wellbeing are integrated and privileged;
- every unplanned hospital admission is treated as a system failure;
- risk stratification and other tools enable an intelligent approach to service intervention.

Our approach is based upon integrating primary, community, mental health, social care and public health activities to support older people. In addition, our model supports integration with voluntary and community sector services at a neighbourhood level.

Integration will take place at three levels – practice level, locality level within our 5 CCG localities and at borough wide level. Teams will integrate services from practice to borough wide level and connect local services more effectively with their local communities.

These services will provide:

- proactive, preventative support to a common population using risk stratification and other data tools;
- an enhanced community based urgent care service as a real alternative to ED/hospital admission;
- step down for supported discharges from secondary care;
- a consistent response 7 days per week to agreed clinical standards.

Specific initiatives which underpin this model are set out below.

ii) Practice based multi-disciplinary teams (MDTs) - building on the work of our early implementer sites, we are now rolling out our MDT model across all practices, will MDTs in place fully by June 2015. This has been supported by a comprehensive organizational development programme. Our film to support the development process can be viewed here https://www.youtube.com/watch?v=4vKTOImwoxw

General practitioners will act as the lead clinicians for these community teams. A significant development programme is being rolled out to support their creation and to foster a new way of working across health and social care. The allocation of £5 per head to support this is reflected in our Better Care Fund Plan. A set of agreed performance metrics will be monitored by our GP locality groups where teams will account for their performance. Service delivery will be enabled by a single IT solution.

This will be the prime area of development within the Better Care Fund and will make the main contribution to reducing emergency admissions by 15%.
Success will be measured by:-

- an enhanced service experience for patients and users;
- reduced clinical risk measured by the risk stratification tool;
- reduced levels of dependency;
- reduced social isolation;
- reduced ED attendances and unnecessary admissions;
- better quality of life for patients with long term conditions through efficient management distributed leadership as the norm.

iii) Community nursing service – this is intrinsic to the functioning of the MDTs and will incorporate both district nursing and the virtual ward case managers. This will provide a generic community nursing skill base, support timely and safe discharge from acute care settings; through a co-ordinated ‘pull function’ as part of the MDT.

iv) Intelligent service response – MDTs are using our risk stratification tool to support their work and reviewing all admissions for over 65s in their practices. We will review the use of the existing tool in the light of others available.

v) GP locality leadership – 5 GPs have been appointed. They will lead the implementation of our integrated model in each locality in 2015/16.

vi) Locality link workers – 5 workers have been commissioned from the Council for Voluntary Service, working with the MDTs and ensuring patients are connected to voluntary services in their communities. This will be extended across all MDTs.

vii) Social prescribing scheme – commissioned from Age UK as an alternative means of supporting people in their communities. This and the locality link workers will use the PSIAMSs tool (see above).

viii) Community Rapid Response Team (CRRT) – phase 1 of this service with Advanced Nurse Practitioners co-responding to calls with the ambulance service, commenced in January 2015. Phase 2 – independent response to calls – will be fully operational in 2015/16.

ix) Dementia support - the diagnosis rate has increased to 53.7% as at December 2014. A comprehensive programme is in place to achieve the national target. The majority of practices are participating in the National Enhanced Dementia Identification service and are undertaking dementia harmonisation coding.

In addition:–

- the Dudley Dementia Strategy will be refreshed;
- a specialist dementia community team will be commissioned;
- a home treatment service as an alternative to hospital admission will be commissioned;
- patients with dementia will be offered the opportunity to have an advanced care plan.
• the ‘Namaste Care’ model for people with advanced dementia in a nursing or a residential home will be commissioned;
• MDTs to be trained on caring and managing people affected by dementia;
• minimum time from referral to psychiatric assessment to be in place for people on acute hospital wards;
• contribute to the creation of a Dementia Friendly Dudley.

x) Elderly care

A new elderly care pathway will be commissioned based upon the notion of “retrieval” of patients from hospital into the community. This will include the development of the role of the geriatrician in the community and contribute to MDT meetings on management issues in relation to complex frail elderly patients.

A new falls strategy will be developed with adult social care and public health. A particular focus will be given to primary prevention to reduce the numbers of older people falling and particularly those requiring assessment in ED or admission to hospital.

xi) Dudley Care Home Programme

The Care Home Nurse Practitioners and CPN will provide 7 day support to care homes.

Services that support care homes will be co-ordinated in an integrated approach including the care home nurse practitioners; older people’s pharmacist; specialist diabetes nurse for care homes; and Macmillan nurses for care homes. Objectives will include reducing admissions to hospital and attendances at ED; increasing utilisation of advance palliative care plans; improved discharges from hospital; consultant out-reach form hospitals; improved knowledge and management of non-life threatening conditions such as urinary tract infections.

xii) Seven day services - the provision of services on a 7 day basis has commenced for the virtual ward and community rapid response team. The community heart failure team palliative care team and care home nurse practitioners will form part of the next phase. Seven day service standards have been developed for community services as part of our work with NHS IQ and shared with NHS England. These will now feature in our service specifications.

xiii) Palliative and end of life care

Recent initiatives include:-

• Completion of Midhurst Project - the Dudley Macmillan Specialist Care at Home Team. The service has now amalgamated the hospital team, the community Macmillan team and Mary Stevens Hospice and is accessed via one single point of access with a central specialist triage team.
• Enhanced service launched on the Gold Standards Framework. The objectives/outcomes are to enhance the quality of care provided to people requiring palliative care and end of life care with a particular focus on increasing support to the non-cancer conditions; reducing admissions to hospital by
increased support in the community; and ensuring advance care plans are in place that include the patients preferred place of care at end of life, with the desired outcome of reducing deaths in hospital.

- Launched a new standardised advanced care plan across secondary, community and primary care.

Further initiatives to include:

- To launch a DNACPR (Do not attempt co-pulmonary resuscitation) form that is compatible, agreed and signed off across WMAS, primary, community and secondary care.
- To commission electronic patient care records system for end of life/palliative care that includes the utilisation by WMAS.
- To extend the palliative care service to a 7 day service
- A specialist community palliative care team will provide further community capacity to intervene early, prevent unnecessary admissions and facilitate preferred place of care for patients.

xiv) Extra care housing – we have commenced a pilot project with a community nurse to support practices with patients in extra care housing schemes. This was in response to residents requiring health services and increased admissions from extra care housing to hospital.

taxv) Community respiratory service – a community based service will be commissioned in 2015/16. Each locality will be provided with a named community respiratory nurse or nurses linked to the MDTs and palliative care nurses. Palliative care MDTs for patients with advanced respiratory disease and on the Gold Standards Framework register will form part of this model.

taxvi) Community back pain service - a community back pain clinic will be commissioned. This will comprise of triage and access to a multi-disciplinary team (GP, consultant, physiotherapist and psychologist)

taxvii) Neurology e-mail triage – initial evidence suggests that this has reduced outpatient attendances and further work will take place with practices to increase use. Further work will take place in relation to Acquired Brain Injury; muscular dystrophy, palliative care needs and advanced dementia.

taxviii) Community IV antibiotics – this service has commenced for primary care initiation. GPs can diagnose and refer patients to avoid a hospital admission.

xix) Our Better Care Fund Plan

Our BCF Plan was fully approved in January 2015:-

This centres upon the development of our integrated health and social care service model, designed to reduce emergency admissions through:

- developing integrated practice and locality based teams led by GPs;
- investing in a locality based rapid response team as the referral point of
choice for patients in crisis;
• reducing admissions to hospital and residential/nursing home care as a result of this;
• creating strong links to local community and voluntary services, reducing social isolation and supporting people to be as independent as possible in their local communities.

The Better Care Fund will invest in the development of our rapid response service and the leadership role of local GPs. The plan is based upon 4 schemes:-

• crisis and emergency intervention;
• promoting independence;
• stabilization and maintenance;
• support for people with dementia.

In terms of the key performance metrics:-

• service efficiencies will provide the recurrent investment for the rapid response service and the GP leadership role for the over 75s;
• emergency admissions to reduce by 15% in financial terms by 2018/19;
• Avoidable admissions will reduce by 129 from 8,142 (2,596/100,000 population) in 2012/13 to 8,278 (2,530/100,000 population) in 2014/15;
• delayed days in hospital will reduce by 600 days in 2014/15 and by a further 636 days in 2015/16;
• people still at home 91 days after discharge to reablement will increase by 12 people in 2014/15 and a further 11 in 2015/16;
• the number of new admissions to nursing homes will reduce by 32 in 2014/15 and by a further 36 in 2014/15 and 2015/16.

Our agreed contract with Dudley Group NHS Foundation Trust for 2014/15 and 2015/16 is constructed on the basis of the required reduction in emergency activity from the BCF.

g) Access to Highest Quality Urgent and Emergency Care

• A 22,016 reduction in ED attendances by 2015/16 resulting from a redesigned urgent care system and the rapid response team.
• A reduction in emergency admissions of 100 cases from a review of the GP respite pathway.
The graph above shows the planned reduction of A&E attendances against the backdrop of predicted activity growth due to changes in demography.

The graph above demonstrates the interventions and the respective impact required to achieve the planned reductions in ED Activity.
i) A new urgent care model

Our new urgent care system for Dudley, has been developed, following extensive patient and public engagement, in line with national recommendations on urgent and emergency care.

The service model was informed by the outcome of a “spotlight event” led by the Health and Wellbeing Board and specifically focussed on urgent care as part of the development of the Joint Health and Wellbeing Strategy’s priority of “making our services healthy”; as well as discussions that took place through our own Health Care Forum and our “feet on the street initiative” (see above).

Two key features of this engagement were a preference expressed for:-

- improved access to primary care – patients preferred to see their own GP
- rather than go to a walk in centre or to ED;
- a simplified approach to access without confusing multiple entry points. Therefore, the system we have commissioned is based on:-

  - general practice being the first place that patients go for urgent care during normal surgery hours;
  - patients ringing 111 for out of hours advice, potentially resulting in an urgent GP appointment the next day, a visit to a new urgent care centre (see below) or potentially a home visit;
  - patients being able to visit an urgent care centre at the Russells Hall hospital when their usual surgery is closed, being treated or triaged for ED.

A more effective urgent care system, complementing our approach to integrated services described above, will be a major contributor to our planned reduction in ED attendances.

We will work with local partners and NHS England to implement any proposals agreed for urgent and emergency care system reconfiguration across the Black Country.

We will work with our partner CCGs across the West Midlands to reconfigure hyper acute stroke services. Until such time as this work is concluded, our planning assumption is that there will be no change to local service provision.

ii) System resilience

Our Urgent Care Working Group, reporting to the System Resilience Group and in turn the Health and Wellbeing Board, has oversight of the urgent care system.
The Urgent Care Working Group will co-ordinate the system at times of pressure. For the winter period in 2015/16 we will have changed the existing system by:-

- implementing our community rapid response service as part of our integrated services model to reduce the number of patients going to ED;
- redesigning our existing virtual ward service so more patients are cared for at home;
- redesigning the local urgent care system to establish better pathways of care for the elderly;
- enhancing the level of support available to patients with mental health problems at times of crisis;
- using an agreed model to manage the number of supported and unsupported discharges destined for health or social care, together with an integrated community bed management system.

Alongside these major system changes, schemes that have been developed to manage demand and facilitate discharge during the 2014/15 winter period are being reviewed in February 2015 and we will invest recurrently in those initiatives which are demonstrably effective.

Schemes subject to this review are:-
## Winter Schemes 2014/15

<table>
<thead>
<tr>
<th>Better Management of current Pathways/services</th>
<th>Value £</th>
<th>Provider</th>
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<tbody>
<tr>
<td>1 Frail Elderly Assessment Unit</td>
<td>259,600</td>
<td>DGH</td>
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<tr>
<td>2 Extension of HALO cover</td>
<td>21,000</td>
<td>WMAS</td>
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<td><strong>Divert Pathway</strong></td>
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<td>3 Social Care Urgent Response Service</td>
<td>140,000</td>
<td>DMBC</td>
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<tr>
<td>4 Falls First Response Service</td>
<td>131,000</td>
<td>DMBC</td>
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<tr>
<td>5 Urgent Care Streaming</td>
<td>51,000</td>
<td>DGH</td>
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<td>6 Dudley Paramedic pathfinder</td>
<td>20,000</td>
<td>WMAS</td>
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<tr>
<td>7 Black country mental health care response service</td>
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<td>8 NHS 111 GP on calls pilot</td>
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<td>9 Walk in centre Extended hours</td>
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<td>Primecare</td>
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<tr>
<td><strong>Better Discharges</strong></td>
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<td>10 Care Home Select</td>
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<td>11 Discharge to Assess</td>
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<td>DGH</td>
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<td>12 Bed Management System</td>
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<td>13 Red Cross Patient Transport and Home Ready Initiative</td>
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<td>14 Trusted Assessor pilot</td>
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<td>15 Increase in intermediate care capacity</td>
<td>319,000</td>
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<td><strong>Consistency of services across 7 days</strong></td>
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<tr>
<td>16 Extension of DISCO OOH</td>
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<td>DGH</td>
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<tr>
<td>17 Weekend Discharge (3 day team)</td>
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<td>DGH</td>
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<td>18 Increase in therapy support to intermediate care beds</td>
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<tr>
<td>19 7 Day streaming for surgical assessment unit</td>
<td>15,600</td>
<td>DGH</td>
</tr>
<tr>
<td>20 Increase in intermediate care team capacity</td>
<td>100,000</td>
<td>CCG</td>
</tr>
<tr>
<td><strong>Local Plans for Innovation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Rapid Response Team</td>
<td>1,000,000</td>
<td>CCG</td>
</tr>
<tr>
<td>22 GP Locality Leads</td>
<td>135,000</td>
<td>CCG</td>
</tr>
<tr>
<td>23 Voluntary Sector Locality Link Workers</td>
<td>388,000</td>
<td>CCG</td>
</tr>
<tr>
<td>24 Social Prescribing Scheme</td>
<td>126,000</td>
<td>CCG</td>
</tr>
<tr>
<td>25 Mental Health Crisis Service</td>
<td>654,000</td>
<td>CCG/DWMH</td>
</tr>
<tr>
<td><strong>Preventative</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 Flu vaccination Campaign</td>
<td>N/A</td>
<td>CCG</td>
</tr>
<tr>
<td><strong>Additional A&amp;E Monies schemes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 Reconfiguration of acute medical unit</td>
<td>£821,594</td>
<td>DGH</td>
</tr>
<tr>
<td>28 Wrap around services to support patient discharge from hospital</td>
<td>£151,000</td>
<td>DGH</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Amount</td>
</tr>
<tr>
<td>----</td>
<td>------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>29</td>
<td>Spot Purchase</td>
<td>£200,000</td>
</tr>
<tr>
<td>30</td>
<td>Increased Impact therapy support</td>
<td>£20,000</td>
</tr>
<tr>
<td>31</td>
<td>Patient Trackers in ED</td>
<td>£151,575</td>
</tr>
<tr>
<td>32</td>
<td>Increased therapy into minors flow</td>
<td>£25,000</td>
</tr>
<tr>
<td>33</td>
<td>Additional Dr Support to 7 day working</td>
<td>£58,293</td>
</tr>
<tr>
<td>34</td>
<td>HIP attack</td>
<td>£35,000</td>
</tr>
<tr>
<td>35</td>
<td>PAU extension to hours</td>
<td>£23,000</td>
</tr>
<tr>
<td>36</td>
<td>Increased Portering Staff</td>
<td>£50,000</td>
</tr>
<tr>
<td>37</td>
<td>Tri Agency Funding</td>
<td>£60,000</td>
</tr>
</tbody>
</table>

It is anticipated that the following will be made recurrent:

- mental health strategic triage
- discharge to assess
- weekend discharge team
- mental health urgent care centre
- increased capacity and 7 day working for intermediate care team

Our expectation is that by implementing these initiatives and by making recurrent those winter plan initiatives deemed to be effective, the ED performance target will exceed 95% in line with the recent performance. Sustained performance will then be achieved through the implementation of a redesigned urgent care centre and the community rapid response service.

In addition in 2015/16 we will:

- redesign and re-specify admission and assessment units linked to the new urgent care centre;
- re-commission the NHS 111 service by October 2015;
- implement new ED / assessment unit payment mechanism.

**h) A Step Change in Productivity of Elective Care**

- To be met by a 20% reduction over 5 years, whilst countering a potential £100,000 cost increase, due to demographic change, per year.
- Outpatient follow up attendances to reduce by 8929 by 2015/16.
- Individual consultant performance to be assessed for every pathway.
The graph above shows the planned reduction of Elective Activity against the backdrop of predicted activity growth due to changes in demography.

The graph above demonstrates the interventions and the respective impact required to achieve the planned reductions. Reductions in Musculo-Skeletal activity are predicated on the ‘Commissioning for Value insight pack’ which demonstrates that Dudley CCG could realise significant activity and cost reductions by moving from 2nd highest CCG in England for activity and expenditure on Musculo-skeletal Elective and day cases to the average of Dudley’s ONS Cluster Group (most similar CCGs).
The graph below shows the planned reduction of Out Patient Procedures against the backdrop of predicted activity growth due to changes in demography.
i) Pathway efficiency

Planned care represents our largest area of spend. However, there is a significant variation both between services and between providers in the number of steps that a person may go through in the course of treatment. We will expect each provider to determine how they will improve the efficiency of the services they provide.

During 2014/15, referral to treatment (RTT) times have improved at Dudley Group NHS FT. In December 2014, 93.5% of patients received treatment within 18 weeks.

The number of patients waiting over 18 weeks has significantly reduced. Challenges remain for the specialties of trauma and orthopaedics; ophthalmology; urology and oral surgery.

We will invite all providers to demonstrate the effectiveness of the services they provide. Services which demonstrate effective outcomes will be positively promoted. Services where the outcome value cannot be demonstrated will be decommissioned.

We will build on the pathway model developed for cardiology services to improve the efficiency of pathways for a range of acute specialties.

In particular, we will:-

- extend access to “advice and guidance” services for GPs in gastroenterology, gynaecology, haematology, neurology, paediatrics and rheumatology based on the Taunton model, to reduce outpatient attendances;
• ensure that 100% of referrals take place using the choose and book mechanism;
• redesign those pathways where inefficiencies have been identified. This will begin with musculoskeletal services, including the contribution of physiotherapy;
• reduce the number of inappropriate referrals to secondary care through use of the Orthopaedic Assessment Service and permit direct referral by the service to other specialties;
• transfer dermatology and pain services to the community;
• neurology – embed the email triage service to reduce inappropriate referrals;
• heart failure pathway – integrate acute and community teams and move to 7 day working;
• Improving cardiac rehabilitation pathways and reducing readmission rates;
• enuresis and encopresis services – move to nurse led community clinics;
• expand paediatric triage through a pilot service at Dudley Group NHS FT to reduce out-patient Attendances;
• realign pathways to facilitate early discharge from hospital into the community or primary care including the pathways for children with neurodevelopment delays and faltering growth;
• implement alternative pathways and develop a revised service model for Community Paediatric Officers;
• develop a single point of access for all children with complex and additional needs.

i) Specialised Services Concentrated in Centres of Excellence

Specialised services are those services that are provided in relatively few hospitals to a catchment population of more than one million people. The number of patients accessing these rarer services is small and a critical mass of patients is needed in each centre in order to deliver the best outcomes. In addition a concentration of skills and expertise by the clinical team undertaking the treatment also benefits the standard of care delivered. These services are commissioned directly by NHS England.

It is important for the CCG to align its local strategy to the direction of travel nationally for specialised services over the next five years as:-

• the focus on planning across the entire patient pathway is vital i.e. any changes to a patient’s pathway considered by the CCG/Local Authority for a service such as Child and Adolescent Mental Health Services (CAMHS) will impact on the specialised element of the inpatient care given to children as part of the directly commissioned tier 4 service (or vice versa);

• historically specialised services account for £12.2 billion per annum of the NHS allocation. Historically, the growth in cost exceeds other parts of healthcare by as much as 4% per annum. Planning to look at how we work together with NHS England to review and achieve better value for money and improved quality is a key priority. Specialised services will be
developing a robust QIPP challenge of its own and the CCG will need to work with NHS England to understand the QIPP agenda on the local health economy;

- the national strategy for specialised services is in the early stages of its development but it is clear the direction of travel is towards fewer centres concentrated in centres of excellence (around 15 to 30 centres). The CCG will need to work closely with NHS England to understand the implications of the strategy and work together on how to implement the transformational change required;

- there will be joint opportunities for maximising research and teaching opportunities to encourage innovation and change;

The CCG will therefore be ensuring that local operational plans involve:-

- strong engagement in the development of the national strategy for specialised services through the call to action programme completing in July 2014;

- active participation in the proposed West Midlands governance arrangements for the strategy development;

- identification of opportunities for joint planning and development of care across the whole patient pathway within local plans. Supporting the need for change within an agreed case for change.

- close contract management arrangements with specialised commissioners for providers;

- supporting the development of the local service priorities and/or reconfigurations currently being considered by the Area Team which include camhs tier 4, cancer services, cardiology, paediatric intensive care and high dependency services and neuro-rehabilitation services.

10. Innovation

The CCG is strongly committed to supporting and championing innovation at all levels within the organisation. The Chair and Chief Accountable Officer take personal responsibility for ensuring that this process is reflected in our commissioning plans. A GP Board Member has specific responsibility for innovation and research and in addition the CCG has a designated management lead for research and innovation along with an appointed Clinical Lead for Research. Therefore a strong disseminated leadership promotes innovation throughout the membership of the CCG. These governance and facilitation arrangements are backed up with £200,000 of direct CCG investment available to the 5 localities on a non-recurrent basis to fund innovative practice specifically.

This disseminated innovation has supported:-
• the development of our community rapid response service;
• measuring individual consultant performance and pathway variance;
• having one IT system for all 49 GP practices;
• using the PSIAMS system to understand the holistic commissioning impact from the patient perspective;
• the development of a new integrated performance and analytics platform
• the development of new and user friendly methods for patient feedback on services and interventions.

However, the CCG also recognises the importance of innovation horizon scanning and connectivity with the broader network of research and innovation. Dudley CCG is linked to areas of best practice and research based interventions through membership of the NHS Benchmarking network, health literature research via academic portals and working in conjunction with Birmingham University’s Health Service Management Centre on continuing development and evaluation. The CCG embraces the acceleration of innovation described in ‘The Forward view into action: Planning for 2015/16’ and mirrors the principles of this acceleration in the development of robust and integrated outcomes measures for all services commissioned, facilitating more responsive and impactful decision-making within the commissioning cycle.

11. Effective Information Management

We will continue to make the best use of information Technology to support the delivery of better care and to influence clinician and patient behavior. This will include:-

• moving all referrals and discharges to an electronic basis;
• mobile technology, particularly for our integrated MDTs and GPs to enable remote access to clinical records;
• document management systems to improve efficiency in primary care;
• remote monitoring systems – for heart failure and COPD;
• risk stratification – evaluating the use of the EMIS tool;
• text messaging – to reduce missed appointments.

12. Governance and Performance

Our outline planning issues were shared with the CCG Board and the Health and Wellbeing Board in January 2015.

Key issues already identified in our commissioning intentions are contained in our contracts with our main providers.

Our final plans, including our outcome ambitions, key metrics and quality premium targets will be submitted to the CCG Board and the Health and Wellbeing Board on 12 and 25 March 2015. Our final plan will be considered by the CCG Board on 30 March 2015.
Our system of governance involves the oversight of our main initiatives by 4 key committees:-

- quality and safety – CQUIN performance, assurance from our clinical quality review meetings, safeguarding matters, implementation of Francis and Winterbourne View recommendations and our quality strategy;
- primary care development – implementation of our primary care development strategy;
- clinical development – our key system initiatives, including service integration, urgent care, planned care productivity, as well as health outcome metrics, quality premium indicators and our QIPP initiatives;
- communications and engagement – our plans for citizen engagement and empowerment;
- finance and performance – our financial and QIPP plan and key performance metrics.

Alongside the nationally mandated metrics for the Better Care Fund, we will develop in conjunction with our social care partners, a comprehensive system of performance metrics to manage the development and implementation of our integrated service delivery model. These will be overseen by Integrated Commissioning Executive, as the governing body of the Section 75 Agreement for the Better Care Fund, reporting to the Health and Wellbeing Board (see above).

We have described the key functions of the CCG as:-

- setting the vision for our local health system;
- holding our system to account;
- facilitating service improvements;
- engaging with patients and the public;
- supporting quality improvements;
- ensuring good governance and working with our partners.

Our internal governance processes are geared to discharging these functions and ensuring appropriate reporting and accountability arrangements to our Board through our quality and safety, clinical development, primary care development, communications and engagement and finance and performance committees.

We recognise our statutory duty to reduce health inequalities and the Director of Public Health is a member of the CCG Board. Our relationship with the Office of Public Health is reflected in an annually agreed memorandum of understanding.

As described above we also have a number of mechanisms in place to engage with and hold ourselves accountable to our local community outside our traditional governance processes. Our plans will continue to be developed with and our performance reported to our stakeholders through:-

- our Health Care Forum, Patient Participation Groups and Patient Opportunity Panel;
• our GP Membership meetings and the development of our mutuality model;
• our GP locality meetings – particularly in relation to the delivery of our integrated care model;
• Health watch – who we will encourage to act as a “critical friend” in the development of future plans;
• our partners in the voluntary and community sectors, through our Building Healthy Partnerships initiative.
• the Health and Wellbeing Board, which approved this plan at its meeting on 26th March 2014, not least as the oversight body for the BCF.

At the heart of our system vision is the development of a new model of integrated working. As described above this will be characterised by locality teams led by GPs, acting as the main mechanism for providing responsive services, capable of enabling people to live independently in strong communities, providing a real alternative to hospital admission. These teams will operate on the basis of distributed leadership, where accountability will be at its strongest within the team itself and performance reported regularly to our GP locality meetings.

13. Deliverability

The proposed changes to service models included in this strategy cannot be delivered by the current infrastructure.

A system wide organisational development programme, delivered at pace and scale, will be a key enabler for the implementation of the new service model which lies at the heart of our plan. This will encompass community nurses, CPNs, GPs and social workers and will be aimed at creating a distributed leadership model which places an onus on responsive, integrated service delivery.

The development of our primary care system, through the delegation of commissioning from NHS England, will create the capacity and capability to support and complement our urgent and planned care systems. This will include the systematic management of patients with long term conditions to meet our outcome ambitions and respond to our assessment of local health need.

We will develop our single IT platform for primary care, capable of developing the capacity to intervene systematically to manage a practice population and link with other systems as part of the integrated response process.

We will develop a Project Management function to deliver this plan, and our 5 year Strategy, to plan and on-budget.

In addition, we will ensure we get the highest quality and best value from our corporate support structures. We will review the range of services we commission from our CSU and ensure we have a management infrastructure that is fit for purpose. This may bring new corporate support providers into Dudley in addition to the external support we currently commission, including
support on organisational development, governance, patient experience and primary care. We believe this is the most appropriate model to deliver our aim to continue to innovate and support the delivery of the best services possible to the population of Dudley.

We will continue to invest in and develop our workforce. We undertake regular staff surveys and have reviewed all our employment policies. This has resulted in:

- more flexible working opportunities;
- more support for staff with carer responsibilities;
- implementation of a staff health and wellbeing programme

We have an extensive organizational development programme from Board level downwards, together with a focus on individual development opportunities for all staff.

We are committed to being a “healthy board” and will shortly conclude a comprehensive review of our governance processes and behaviours by the Good Governance Institute.

We are in the process of reassessing the organisation against the goals and outcomes of EDS2. We believe we are on track to being compliant in terms of having a “representative and supported workforce” and “inclusive leadership”. The review of our employment policies described above has contributed to this.

We will review the composition of the CCG Board in the context of the community we serve and the NHS workforce race equality standard when published. This will inform the succession planning process.
<table>
<thead>
<tr>
<th>JSNA</th>
<th>Outcome Ambition</th>
<th>Initiative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gap in life expectancy for the least and most deprived areas of Dudley has widened mostly due to chd, copd and lung cancer in men.</td>
<td>Securing additional years of life</td>
<td>• Systematic management of long term conditions</td>
</tr>
<tr>
<td></td>
<td>3.5% reduction in potential years of life lost per annum from 2087/100,000 in 2012/13 to 1875.4/100,000 in 2015/16</td>
<td>• Prescribing for heart disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Prescribing for cholesterol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Smoking cessation</td>
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<tr>
<td></td>
<td></td>
<td>• Weight management</td>
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<tr>
<td></td>
<td></td>
<td>• Sport and physical activity action plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diabetes LES and diabetes control</td>
</tr>
<tr>
<td>Nearly one fifth of 40-59 year olds are living with a long term limiting illness</td>
<td>Improving the quality of life for people with long term conditions.</td>
<td>• Responsive IAPT services</td>
</tr>
<tr>
<td></td>
<td>Average EQ-5D score for people with one or more long term condition to increase by 1.6% from 70/100 people in 2012/13 to 71.6/100 in 2015/16.</td>
<td>• Diagnosing and responding to dementia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Diagnosing hypertension</td>
</tr>
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<td></td>
<td></td>
<td>• Vascular checks</td>
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<td></td>
<td></td>
<td>• Improved recording in disease registers for heart failure, hypertension and kidney disease</td>
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<tr>
<td></td>
<td></td>
<td>• Community based respiratory service</td>
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<tr>
<td></td>
<td></td>
<td>• Community based pain service</td>
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<tr>
<td></td>
<td></td>
<td>• COPD LES review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Revised diabetes LES</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community diabetes team</td>
</tr>
<tr>
<td>The rate of delayed discharges attributable to social care is higher than the national rate</td>
<td>Reducing time spent in hospital through more integrated care</td>
<td>• Rapid Response Team</td>
</tr>
<tr>
<td></td>
<td>Avoidable emergency admissions to reduce from 8,142 (2,596/100,000 population) in 2012/13 to 8,013 (2,530/100,000) in 2015/16</td>
<td>• Redesigned virtual ward</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Care home CPN</td>
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<td></td>
<td></td>
<td>• 7 day services</td>
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<tr>
<td></td>
<td></td>
<td>• Community respiratory, diabetes and anti-coagulation services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Enhanced telehealth and telecare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community pain, dermatology and ophthalmology services</td>
</tr>
<tr>
<td>20% of single person</td>
<td>Increasing the proportion</td>
<td>• Integrated locality</td>
</tr>
<tr>
<td>Households are in the 60+ age range</td>
<td>Of people living independently at home</td>
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<td>------------------------------------</td>
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<tr>
<td>People still at home 91 days after discharge to increase by 4% from 86% at March 2013 to 90% at March 2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Rapid Response Team</td>
<td></td>
<td></td>
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<tr>
<td>- Social prescribing scheme</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Locality link workers</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Musculoskeletal services present an opportunity to improve the patient pathway, secure value for money and deliver better outcomes</th>
<th>Increasing people’s positive experience of hospital care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing the average number of negative responses from 159.2 per 100 patients in 2012/13 to 153.5 per 100 patients in 2015/16. A reduction of 3.58%</td>
<td>- Clear clinical standards</td>
</tr>
<tr>
<td>- Efficient planned care pathways</td>
<td></td>
</tr>
<tr>
<td>- Patient safety CQUIN</td>
<td></td>
</tr>
<tr>
<td>- Organisational learning CQUIN</td>
<td></td>
</tr>
<tr>
<td>- Medication error reporting</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Systematic management of long term conditions is required in primary care</th>
<th>Increasing the proportion of people with a positive experience of GP care and in the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing the average number of negative response from 6.1 per 100 patients in 2012/13 to 5.66 in 2015/16. A reduction of 7.2%.</td>
<td>- Better access</td>
</tr>
<tr>
<td>- 7 day services</td>
<td></td>
</tr>
<tr>
<td>- Active patient participation groups</td>
<td></td>
</tr>
<tr>
<td>- Reducing variation</td>
<td></td>
</tr>
<tr>
<td>- Transfer of services to primary care</td>
<td></td>
</tr>
<tr>
<td>- Managing long term conditions</td>
<td></td>
</tr>
<tr>
<td>- Single IT system for all practices</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency admissions for gastroenteritis and lower respiratory disease are increasing for the 60 – 74 age group</th>
<th>Eliminating avoidable deaths in hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>- MRSA zero tolerance</td>
<td></td>
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<tr>
<td>- Grade four pressure ulcer zero tolerance</td>
<td></td>
</tr>
<tr>
<td>- Reducing infection rates including Cdiff</td>
<td></td>
</tr>
<tr>
<td>- Reducing medication errors</td>
<td></td>
</tr>
</tbody>
</table>
## Glossary

<table>
<thead>
<tr>
<th><strong>Advanced Care Planning</strong></th>
<th>A process of discussion between an individual and a care practitioner to make clear a person’s wishes in the event of their health deteriorating.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANP</strong></td>
<td>Advanced Nurse Practitioner – a nurse working at an advanced level of practice, encompassing aspects of education, research and management but grounded in direct care provision.</td>
</tr>
<tr>
<td><strong>AHRQ</strong></td>
<td>Agency for Healthcare Research and Quality – an agency of the US Government responsible for improving quality, safety, efficiency and effectiveness.</td>
</tr>
<tr>
<td><strong>AQP</strong></td>
<td>Any Qualified Provider – a mechanism for procuring services where there are multiple providers working to a common quality standard and price.</td>
</tr>
<tr>
<td><strong>ANP</strong></td>
<td>Advanced Nurse Practitioner.</td>
</tr>
<tr>
<td><strong>BERWICK REPORT</strong></td>
<td>A report into patient safety.</td>
</tr>
<tr>
<td><strong>BCF</strong></td>
<td>Better Care Fund – a pooled budget with the Local Authority designed to support service integration and reduce admissions to hospital, nursing and residential care.</td>
</tr>
<tr>
<td><strong>6 CS</strong></td>
<td>Care, Compassion, Competence, Communication, Courage and Commitment – the Chief Nursing Officer’s ‘culture of compassionate care’</td>
</tr>
<tr>
<td><strong>CAB</strong></td>
<td>Citizen’s Advice Bureau – a charity providing advice on legal, financial and other matters.</td>
</tr>
<tr>
<td><strong>CDIFF</strong></td>
<td>Clostridium Difficile – a bacteria best known for causing diarrhoea.</td>
</tr>
<tr>
<td><strong>CEN</strong></td>
<td>Community Engagement Network – Dudley Council’s network for public consultation.</td>
</tr>
<tr>
<td><strong>CHD</strong></td>
<td>Coronary Heart Disease.</td>
</tr>
<tr>
<td><strong>CPN</strong></td>
<td>Community Psychiatric Nurse.</td>
</tr>
<tr>
<td><strong>COPD</strong></td>
<td>Chronic, Obstructive, Pulmonary Disease – a type of lung disease characterised by poor airflow.</td>
</tr>
<tr>
<td><strong>CIP</strong></td>
<td>Compassion in Practice – see 6Cs.</td>
</tr>
<tr>
<td><strong>CQUIN</strong></td>
<td>Commissioning for Quality and Innovation – a system of payment designed for commissioners to reward excellence.</td>
</tr>
<tr>
<td><strong>CSU</strong></td>
<td>Commissioning Support Unit – an organisation providing services to support the CCG’s functions.</td>
</tr>
<tr>
<td><strong>CALL TO ACTION</strong></td>
<td>A programme of engagement with the public about the future of the NHS.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CONTINUING HEALTHCARE</td>
<td>A situation where responsibility for meeting the costs of a patient’s health need continues to rest with the NHS.</td>
</tr>
<tr>
<td>ECIST</td>
<td>Emergency Care intensive Support Team – A Department of Health sponsored team which assists health and social care systems to improve emergency care.</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department.</td>
</tr>
<tr>
<td>EDS</td>
<td>Equality and Diversity Scheme – a mechanism used to deliver the CCG’s duties under the Equality Act.</td>
</tr>
<tr>
<td>EMIS</td>
<td>A computer system for general practice.</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
</tr>
<tr>
<td>FRANCIS REPORT</td>
<td>A report of an enquiry conducted by Robert Francis, QC into events at Stafford Hospital.</td>
</tr>
<tr>
<td>FRIENDS AND FAMILY TEST</td>
<td>A test of patient satisfaction based on asking 'how likely are you to recommend our services to your friends or family if they needed treatment.'</td>
</tr>
<tr>
<td>GSF</td>
<td>Gold Standards Framework – A means of managing end of life patients to agreed standards in primary care.</td>
</tr>
<tr>
<td>HED</td>
<td>Health Education Data – a system drawing upon multiple data sources to benchmark performance.</td>
</tr>
<tr>
<td>HSMR</td>
<td>Hospital Standardised Mortality Ratio – a method of comparing mortality levels in different years.</td>
</tr>
<tr>
<td>HSW</td>
<td>Health and Wellbeing Board – a statutory committee of the council responsible for producing the JSNA (see below) and the JHWS (see below). The Board consists of representatives from a number of bodies with a responsibility for health and wellbeing.</td>
</tr>
<tr>
<td>HEALTHCARE FORUM</td>
<td>Dudley CCG’s forum for consultation with patients and the public.</td>
</tr>
<tr>
<td>HEALTHWATCH</td>
<td>The voice of the consumer in healthcare.</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving Access to Psychological Therapies – an initiative to enable patients to access psychological ‘talking’ therapies.</td>
</tr>
<tr>
<td>JSNA</td>
<td>Joint Strategic Needs Assessment – a joint assessment carried out by the CCG and the Council on the main needs affecting the residents of Dudley.</td>
</tr>
<tr>
<td>JHWS</td>
<td>Joint Health and Wellbeing Strategy – a Strategy developed by the Health and Wellbeing Board in response to the JSNA.</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authority – an elected local government body, eg Dudley Metropolitan Borough Council.</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td>LES</td>
<td>Local Enhanced Service – a service commissioned from primary care beyond the scope of their usual contract.</td>
</tr>
<tr>
<td>MIND</td>
<td>A national charity supporting people with mental health needs.</td>
</tr>
<tr>
<td>MRSA</td>
<td>Methicillin Resistant Staphylococcus Aureus – a bacterial infection resistant to a number of antibiotics.</td>
</tr>
<tr>
<td>POP</td>
<td>Patient Opportunities Panel – a group consisting of representatives from PPGs (see below) with whom the CCG consults.</td>
</tr>
<tr>
<td>PPG</td>
<td>Patient Participation Group – a group established to enable engagement with practices at GP practice level.</td>
</tr>
<tr>
<td>PRIMARY CARE FOUNDATION</td>
<td>An organisation set up to support the development of best practice within primary care and urgent care.</td>
</tr>
<tr>
<td>PSIAMS</td>
<td>Personal and Social Action Measurement System – a mechanism for measuring the impact of an intervention on an individual.</td>
</tr>
<tr>
<td>QIPP</td>
<td>Quality Innovation, Productivity and Prevention – a programme designed to deliver improvements in quality and productivity.</td>
</tr>
<tr>
<td>QOF</td>
<td>Quality and Outcomes Framework – Part of the GP contract which links remuneration to the improvement of quality and outcomes.</td>
</tr>
<tr>
<td>QP</td>
<td>Quality Premium – a series of nationally and locally agreed indicators against which the CCG’s performance is assessed and for which a performance payment is received.</td>
</tr>
<tr>
<td>RMN</td>
<td>Registered Mental Nurse.</td>
</tr>
<tr>
<td>RTT</td>
<td>Referral to Treatment – The target waiting time for elective care.</td>
</tr>
<tr>
<td>SAU</td>
<td>Surgical Assessment Unit</td>
</tr>
<tr>
<td>SHIMI</td>
<td>Summary Hospital Level Mortality Indicator – an indicator of mortality at Trust level.</td>
</tr>
<tr>
<td>SHO</td>
<td>Senior House Officer.</td>
</tr>
<tr>
<td>SRG</td>
<td>System Resilience Group – Multi-agency body, reporting to the Health and Wellbeing Board, responsible for system wide management and resilience.</td>
</tr>
<tr>
<td>WINTERBOURNE VIEW</td>
<td>A former facility for patients with learning disabilities where patients were mistreated.</td>
</tr>
<tr>
<td>TITLE OF REPORT:</td>
<td>Draft Financial Plan 2015/16</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr J Rathore, Clinical Executive for Finance and Performance</td>
</tr>
</tbody>
</table>
| KEY POINTS:           | • Draft Financial Plan prepared and submitted in line with national timetable  
                        • Financial Plan prepared in accordance with NHS England Key Planning Assumptions and Business Rules  
                        • Final submission 10 April 2015. |
| RECOMMENDATION:       | The Committee is asked to receive the report for assurance. |
| FINANCIAL IMPLICATIONS:| As described in the report. |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | None |
| ACTION REQUIRED:      | Decision  
                        ✓ Approval  
                        ✓ Assurance |
1.0 INTRODUCTION
In line with the national timetable, the CCG submitted its draft Financial Plan for the next financial year on 27 February 2015.

The enclosed appendices provide a summary of the submission as follows:-

Appendix 1  Financial Plan Summary
Appendix 2  Revenue Resource Limit

2.0 KEY PLANNING ASSUMPTIONS AND BUSINESS RULES
The financial plan submitted has been prepared taking into account NHS England specific assumptions around growth and inflation and these are summarised in the table below:

<table>
<thead>
<tr>
<th>NHS ENGLAND PLANNING ASSUMPTIONS &amp; BUSINESS RULES</th>
<th>CCG PLAN AS SUBMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business Rules</td>
<td></td>
</tr>
<tr>
<td>Minimum 0.5% Contingency Fund Held</td>
<td>0.5%</td>
</tr>
<tr>
<td>1% Surplus Carry Forward</td>
<td>1.6%</td>
</tr>
<tr>
<td>2% Underlying Surplus</td>
<td>2%</td>
</tr>
<tr>
<td>1% Non-Recurrent Spend 2015/16</td>
<td>1%</td>
</tr>
<tr>
<td>Growth &amp; Inflation Assumptions</td>
<td></td>
</tr>
<tr>
<td>Demographic Growth-local determination</td>
<td>1.5% range</td>
</tr>
<tr>
<td>based on ONS age profiled weighted population</td>
<td></td>
</tr>
<tr>
<td>projections</td>
<td></td>
</tr>
<tr>
<td>Prescribing Inflation expected range 4%-7%</td>
<td>6.50%</td>
</tr>
<tr>
<td>Continuing Care Inflation – 2.5%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Net QIPP Savings – no greater than 2%</td>
<td>1.78%</td>
</tr>
<tr>
<td>Running Costs</td>
<td>Achieved £21.72 per head of population.</td>
</tr>
</tbody>
</table>

The Plan therefore meets all requirements of NHS England.

3.0 COMMENTARY
Described below are key features of the plan.

1. Overall Surplus - the CCG is planning for an overall surplus of £6.3m in 2015/16. This consists of £5.4m as the CCG’s initial planned surplus for 2015/16, plus £0.9m for the additional surplus achieved in 2014/15 as a result of the return of continuing healthcare funds. The additional £0.9m will be available for use in 2016/17.

2. Resource Limit – the CCG’s resource limit increases from £386.5m to £403.2m. The increase is due to demographic growth, the increase in 2014/15 surplus, the direct allocation for the Better Care Fund and the inclusion of winter funding, received non-recurrently in 2014/15. As can be seen in Appendix 2, the CCG remains 1.2% below target allocation.

The Board should note that the submission excludes the additional funding the CCG will receive as a consequence of taking full delegated responsibility for primary care commissioning from 1 April 2015. The value agreed with NHS England is £38.05m, which is
based on 2014/15 forecast outturn and includes 1% contingency and 0.5% non-recurrent conditions stated by the CCG in its application. The total CCG Resource Limit is therefore expected to be £441.7m at 1 April 2015.

3. Running Costs – such budgets are reduced by 10% next year in line with NHSE guidance. This results in a budget of £21.72 per head of population.

4. Underlying Surplus – this has reduced from 3.0% in 2014/15 to 2.0% in 2015/16. This is mainly due to the transfer of Better Care Funds to the Local Authority in addition to an increased QIPP target. This demonstrates the requirement for a more robust financial framework, including increased responsibility and accountability at commissioner/budget holder level in 2015/16.

5. QIPP – the target is £7.2m, equating to 1.8% of resource. The main initiatives are Rapid Response Team, Urgent Care Centre, Prescribing and Elective Pathways. It is imperative that these schemes deliver the operational and financial impact expected to maintain the positive financial position of the CCG.

6. Risks and Mitigations – risks identified in the plan are
   (i) PbR tariff – the initial PbR tariff was withdrawn and republished on 19 February. The submitted plan included a risk of £800,000 as the outcome is expected to be an increased cost to protect providers. NHS England and Monitor have since published a revised risk framework for 2015/16 that includes two revised tariffs – Default Roll-over Tariff and Enhanced Tariff. The financial consequences of the Enhanced Tariff, which Dudley Group Foundation Trust are expected to adopt, is in line with the risk as outlined in the plan.
   (ii) QIPP delivery.
   (iii) Prescribing.
   (iv) Better Care Fund.
   (v) Acute over-performance.

   If such risks occur, they will be mitigated by the use of contingency and non-recurrent reserves initially, although there will be the need to implement additional actions, such as extra QIPP schemes, disinvestment and decommissioning if required.

4.0 NEXT STEPS
Initial feedback from NHS England on the plan is positive. This is on the basis that the plan is well developed, robust and meets all NHS England requirements.

It is expected that there will be minor adjustments to the plan to reflect final contract agreements with providers. This will be supported by the Budget Book to be presented to the Board on 31 March 2015.

The CCG is required to submit a refreshed plan on 10 April 2015.

5.0 RECOMMENDATION
The Committee is asked to receive the report for assurance.

M Hartland
Chief Operating and Finance Officer
March 2015
Financial Plan Summary

### Financial Position

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£ 000</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent</td>
<td>378,451</td>
<td>396,958</td>
</tr>
<tr>
<td>Non-Recurrent</td>
<td>7,798</td>
<td>6,295</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>386,249</td>
<td>403,253</td>
</tr>
</tbody>
</table>

### Income and Expenditure

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recurrent</strong></td>
<td>378,451</td>
<td>396,958</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>37,215</td>
<td>38,333</td>
</tr>
<tr>
<td><strong>Community</strong></td>
<td>33,077</td>
<td>35,100</td>
</tr>
<tr>
<td><strong>Continuing Care</strong></td>
<td>11,539</td>
<td>13,351</td>
</tr>
<tr>
<td><strong>Primary Care</strong></td>
<td>56,247</td>
<td>57,554</td>
</tr>
<tr>
<td><strong>Other Programme</strong></td>
<td>10,078</td>
<td>21,982</td>
</tr>
<tr>
<td><strong>Total Programme Costs</strong></td>
<td>370,382</td>
<td>388,091</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Running Costs</strong></td>
<td>7,647</td>
<td>6,851</td>
</tr>
<tr>
<td><strong>Contingency</strong></td>
<td>1,925</td>
<td>2,016</td>
</tr>
<tr>
<td><strong>Total Costs</strong></td>
<td>379,954</td>
<td>396,958</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surplus/(Deficit) In-Year Movement</strong></td>
<td>897</td>
<td>0</td>
</tr>
<tr>
<td><strong>Surplus/(Deficit) Cumulative</strong></td>
<td>6,295</td>
<td>6,295</td>
</tr>
<tr>
<td><strong>Surplus/(Deficit) %</strong></td>
<td>1.6%</td>
<td>1.6%</td>
</tr>
<tr>
<td><strong>Surplus (RAG)</strong></td>
<td>GREEN</td>
<td>GREEN</td>
</tr>
</tbody>
</table>

- **Net Risk/Headroom**: 307
- **Risk Adjusted Surplus/(Deficit) Cumulative**: 6,602
- **Risk Adjusted Surplus/(Deficit) %**: 1.6%
- **Risk Adjusted Surplus/(Deficit) (RAG)**: GREEN

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contingency</td>
<td>1,925</td>
<td>2,016</td>
</tr>
<tr>
<td>Contingency %</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Contingency (RAG)**</td>
<td>GREEN</td>
<td>GREEN</td>
</tr>
</tbody>
</table>

- **Notified Running Cost Allocation + Quality Premium**: 8,370
- **Running Cost**: 7,647
- **Under / (Overspend)**: 723
- **Running Costs (RAG)**: GREEN

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Size (000)</td>
<td>314</td>
<td>315</td>
</tr>
<tr>
<td>Spend per head (£)</td>
<td>24.34</td>
<td>21.72</td>
</tr>
</tbody>
</table>

### Key Planning Assumptions

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notified Allocation Change (£’000)</td>
<td>11,350</td>
</tr>
<tr>
<td>Notified Allocation Change (%)</td>
<td>3.0%</td>
</tr>
<tr>
<td>Tariff Change - Acute (%)</td>
<td>-0.8%</td>
</tr>
<tr>
<td>Tariff Change - Non Acute (%)</td>
<td>1.2%</td>
</tr>
<tr>
<td>Demographic Growth (%)</td>
<td>1.5%</td>
</tr>
<tr>
<td>Non Demographic Growth - Acute (%)</td>
<td>1.4%</td>
</tr>
<tr>
<td>Non Demographic Growth - Cont Care (%)</td>
<td>0.0%</td>
</tr>
<tr>
<td>Non Demographic Growth - Prescribing (%)</td>
<td>0.0%</td>
</tr>
<tr>
<td>Non Demographic Growth - Other Non Acute (%)</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

### Net QIPP Savings

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent (inclusive of full year effect)</td>
<td>5,166</td>
<td>7,190</td>
</tr>
<tr>
<td>Non-Recurrent</td>
<td>2,000</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7,166</td>
<td>7,190</td>
</tr>
<tr>
<td>% of Notified Resource</td>
<td>1.9%</td>
<td>1.8%</td>
</tr>
<tr>
<td>% Unidentified</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

### Non Recurrent Requirement

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value</td>
<td>9,270</td>
<td>3,830</td>
</tr>
<tr>
<td>Agreed plans in place</td>
<td>9,270</td>
<td>3,830</td>
</tr>
<tr>
<td>Difference</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
## Appendix 2 – Revenue Resource Limit

<table>
<thead>
<tr>
<th>£’000</th>
<th>sign</th>
<th>Opening 2014/15 Allocation</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Baseline Allocation - Published Dec 14</td>
<td>+ve</td>
<td>370,804</td>
<td>382,950</td>
</tr>
<tr>
<td>Post Mth07 Recurrent Transfers in 14/15</td>
<td>+ve/(-ve)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Running Cost Allocation - Published Dec 14</td>
<td>+ve</td>
<td>7,647</td>
<td>6,851</td>
</tr>
<tr>
<td>Total Notified Allocation</td>
<td></td>
<td>378,451</td>
<td>389,801</td>
</tr>
</tbody>
</table>

**Additional Better Care Fund Allocation**

| Non Recurrent Allocations                  |      | 7,157                      |

| Other Non Recurrent allocations            | +ve/(-ve) | 2,400                      |
| Return of Surplus/(Deficit)                | +ve/(-ve) | 5,398                      |
| Non Recurrent Requirement                  | (-ve)   | (9,270)                    |
| Non Recurrent Return                       | +ve     | 9,270                      |
| 50% Non Elective Collection                | +ve     | -                          |
| 50% Non Elective Return                    | (-ve)   | -                          |
| Total Non Recurrent Allocation             |         | 7,798                      |
|                                          |         | 6,295                      |

| Total Allocation                          |         | 386,249                    |
|                                          |         | 403,253                    |

| Closing target allocation per head         | +ve    | 1,195                      |
| Allocation per head                        | +ve    | 1,180                      |
| Distance from Target                       | (15)   | (15)                       |
| Distance from Target % (Dec14 Board Paper) |       | -1.2%                      |
|                                          |       | -1.2%                      |
# DUDLEY CLINICAL COMMISSIONING GROUP BOARD

**Date of Report:** 12 March 2015
**Report:** Primary Care Education Strategy  
**Agenda Item No:** 7.4

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Primary Care Education Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To present the outcome and recommendations to the Board following a review of primary care education requirements for the CCG.</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr D King, Head of Membership</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr D King, Head of Membership</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr J Rathore, Clinical Executive for Finance and Performance</td>
</tr>
</tbody>
</table>

## KEY POINTS:

- The CCG has commissioned an external review of primary care education requirements.
- The Primary Care Development Committee has supported the recommendation to develop and integrated education strategy for primary care and broader organisational development.
- The Primary Care Development Committee supported Option 6 to commission a bespoke training and development organisation.
- Option 6 requires more detailed work to scope the specification and cost of implementation.

## RECOMMENDATION

- That the Board note the contents of the review and supports the recommendations of the review specifically that
  - The CCG develops an integrated education strategy for all elements of the primary care workforce
  - The CCG delegates responsibility to the Primary Care Commissioning Committee to develop and scope the implementation of this process within its delegated limits.

## FINANCIAL IMPLICATIONS:

- To be determined by the Primary Care Commissioning Committee within delegated limits

## WHAT ENGAGEMENT HAS TAKEN PLACE:

- CCG GP membership
- CCG Practice Managers
- Health Education West Midlands
- Local Education and Training Board
- West Midlands Health Academic Network
- West Midlands Clinical Senate
- CCG Primary Care Development Committee

## ACTION REQUIRED:

- Decision
- Approval
- Assurance
1.0 INTRODUCTION

The CCG commissioned a review of primary care education requirements from an external provider in August 2014. The review concluded in December 2014 and has been presented to the Primary Care Development Committee who has supported the recommendations within the paper. The review is attached in the Appendix.

2.0 RECOMMENDATIONS FROM THE REVIEW

2.1 The CCG develops an integrated education strategy that encompasses all elements of the primary care workforce. The strategy should extend beyond the provision of training and other development interventions to provide a broader organisational development context in which the identification and provision of development needs form a core dimension.

2.2 The CCG seeks to establish a central role in managing the provision of this strategy within their operating area through the provision of funds and management of the process. This is seen as critical in breaking the culture of short term thinking.

2.3 The CCG seeks to exert greater influence on the development and funding of primary care education through forging more focussed links with the LETC and other external stakeholders including crucially secondary care.

2.4 The CCG create a working party and co-opt representatives from both the LETC and LETB thus establishing the agenda and being more directive in the nature of LETB support for primary care.

2.5 The CCG actively promotes the benefits of engagement with the strategy to GPs through the enhancement of existing practice based development discussions. The creation of practice development plans will be of increasing importance for GPs and support should be provided for this with particular emphasis on 'younger principles'.

2.6 The CCG consider six Options for implementation ranging from Option 1 – do nothing to Option 6 - The establishment of a bespoke training and development organisation.

2.7 The Primary Care Development Committee has previously considered the report and supported the recommendations noting that, it would not be for the CCG to establish a bespoke training and development organisation – but that it would be the CCGs responsibility to specify that service and commission within the resources available to the CCG.

3.0 RECOMMENDATION

That the Board note the contents of the review and supports the recommendations of the review specifically that

- The CCG develops an integrated education strategy for all elements of the primary care workforce
- The CCG delegates responsibility to the Primary Care Commissioning Committee to develop and scope the implementation of this process within its delegated limits.

Daniel King
Head of Membership
March 2015
Dudley Clinical Commissioning Group  
Brierley Hill Health and Social Care Centre,  
Venture Way,  
Brierley Hill,  
West Midlands  
DY5 1RU

Investigation and Report  
Dudley Clinical Commissioning Group (CCG) Integrated Education Strategy

Client: Mr D King - Head of Membership, Dudley Clinical Commissioning Group

1. Background

Primary Care in England is facing many challenges over the coming years. This has been put into sharp focus recently by the publication from Simon Stevens, NHS England, of a five year plan which, although promising investment, will require vast change by primary care providers.

This is at a time of severe pressures in primary care which appear to be multifactorial and reflect increased patient load, increased expectations, increased administrative workload and increased auditing and data collection. This on a foundation of primary care funding being at an all time low, at 8.3% of the NHS budget.

There is supporting evidence from the Centre for Workforce intelligence (CWFi), stating the GP workforce is under considerable strain and current levels of activity may not be sustainable. The Seventh National GP Work life Survey (Hann, et al. 2013), found falling job satisfaction among General Practitioners (GPs), with the highest levels of stress since the start of the survey series in 2006 and a substantial increase in the proportion of GPs intending to cease direct patient care within the next five years.

This evidence can be replicated in other areas of the primary care workforce. A 2014 Medeconomics survey of 210 practice managers found that many felt the complexity and intensity of the work has increased. They reported increased workload (96%) increased work intensity (95%) increased stress (90%). Recent workload changes had prompted 67% to contemplate leaving their job, 64% had thought about moving away from working in general practice, 42% about leaving the NHS and 35.3% had contemplated either retiring or reducing their hours.

Furthermore the Practice nurse workforce is not immune. Deloitte (2012) estimates that 1 in 5 General Practice Nurses were over 55 years old in 2012 and that between 20-33% of them were likely to retire in the next few years.
There is numerical evidence to support the feelings of the workforce with patient demand for general practice services showing strong growth in recent decades. The latest available GP workload survey activity and consultation rate data points to longer average consultation times, more consultations per patient (particularly for older people), and more case complexity than a decade ago. The population has an increased life expectancy and 53% of population self report a long term condition- this is increasing and often underreported. In addition, the government is emphasising the importance of transferring facets of patient care from hospitals into the community. This has significant implications for future GP workload, added onto the recent 7 day access drive, requiring increasing hours at evenings and weekends and the raft of new requirements of service provision.

At the same time however, growth in the GP workforce has not kept pace with the change in requirements. The number of GPs rose by 23% on a full-time equivalent basis (excluding registrars, retainers and locums) between 1995 and 2013. By contrast, the number of consultants in other medical specialties more than doubled over the same period. Failure to implement the Doctors and Dentists Review Board recommendations and recent pension changes are contributing, together with the factors above, to highly experienced and skilled GPs looking to leave the profession at age 55 onwards. The workforce pressures have also been exacerbated by the feminisation of the GP workforce, together with clinicians fulfilling CCG commitments and other external non clinical work all contributing to less clinical face to face time. A further relevant feature is the increase in the number of GPs requesting a certificate of good standing from the GMC to emigrate, which has increased by over 50% over the last 4 years to 529 in 2013.

The CfWI has also concluded that the current level of GPs being trained is inadequate and likely to lead to a major workforce demand-supply imbalance by 2020 unless action is taken. The CfWI recommends that Health Education England (HEE) consider a substantial increase in GP training numbers and also proposes a number of measures to help boost workforce supply, particularly in the short term, given the significant lead-in time in training new GPs.

So part of the political agenda is to train more GPs but the number of young doctors looking to train as GPs is under pressure, with 12% of the training posts for GPs in England this year unfilled, despite an unprecedented 3\textsuperscript{rd} round of recruitment. Wilkie in the BMJ suggests that a lack of fulfilled happy GP role models is partly to blame with students and trainees witnessing stressed and burnt out GPs who feel isolated and unsupported hence are unlikely to choose general practice as a career. She felt that preventing attrition in the workforce to be as important as recruiting new trainees.

This description is of great tension in a workforce with an evidence base supporting this assertion and yet a requirement for a massive change programme with primary care required to make new partnerships, support a radical upgrade in public health and prevention and to support patients to gaining more control of their own care. The barriers between secondary and primary care and social care need to be revisited and all this is to be delivered by the existing workforce without a current cohesive training and education programme to support them. It seems little wonder the workforce is expressing strain.

Simon Stevens has stated ‘HEE will work with employers, employees and commissioners to identify training needs and education of our current workforce. This strategy it acknowledges requires greater investment in training for existing staff and the active engagement of clinicians and
managers who are best placed to know what support they need to deliver new models of care.’ The agenda for HEE is massive and there is currently a lack of clarity how this strategy translates into practice for Dudley Primary Care providers and their workforce.

There is no statutory requirement for Dudley CCG to involve itself in the education provision of the provider workforce, but the Health and Social Care Act does create a statutory duty for clinical commissioning groups to ‘promote research, innovation and the use of research evidence’ Furthermore, recent important reviews, such as the Francis report, questioned the quality of care provision in the NHS with the conclusions all highlighting the need for more consistent and higher standards of patient care. These reports conclude that ensuring a skilled and effective workforce to be of paramount importance.

It would appear that a training and education agenda should form a crucial part of the development strategy for Dudley CCG. The possibility of a co-commissioning agenda would bring an education and training strategy for Dudley into even sharper focus and should look to achieve;

- A skilled workforce for Organisational Development
- Improved recruitment and retention
- Support for succession planning
- Support for the increasing quality agenda
- Reduction in variation of care

The Dudley CCG vision states ‘We want Dudley to be a place where people want to come and work, because they will get the best possible training support and satisfaction for a job well done by extension our population will get the best possible care. So investing in the workforce is mission critical’.

The crucial area for consideration is how this will be achieved.

This provides the background for this report.

2. Terms of Reference

Purpose/ Aim

The purpose of undertaking this project was to clarify and define the feasibility of establishing a collaborative and co-ordinated approach to the provision of education services to support the Dudley CCG strategy.

The aim is to establish a sustainable framework to encompass the multifaceted requirements of an education strategy that can be practically implemented and managed in support of the broader Dudley CCG aims and objectives.
Objectives:

1. Determine the key stakeholders associated with this strategy.
2. Evaluate the ‘appetite’ of stakeholders for an integrated strategy.
3. Define the broad scope and terms of reference for ‘Education Services’.
4. Identify wants and needs of stakeholders and key success factors for the strategy.
5. Define the scope of activities to be included within DCCG Education Strategy.
6. Research and evaluate ‘best practice’ from other areas.
7. Present alternative operating frameworks for the service.

Deliverable:

a) Report with clear recommendations for consideration by Dudley CCG board.

3. Research Methodology

The research underpinning this report was conducted using three interrelated methodologies to provide;

a) A wider perspective of the range of approaches to education across the primary care sector.

b) General perspectives from within the Dudley CCG operating area.

c) Focused consideration of the priorities and challenges faced by GP Practices.

The three methods used were desk research of the internet and printed published material, surveying via email based questionnaires and telephone and face to face interviews of key stakeholders.

Desk research sought to identify the key stakeholders within the project and to investigate the national drivers and priorities for education in Primary Care. This was also a valuable source of alternative strategies adopted or proposed in other CCG areas. Questionnaires were issued via email to all GP partners (Appendix 1) and Practice Managers (Appendix 2) working within the Dudley CCG area to enable all key stakeholders within GP practices to provide feedback and comment on priorities and challenges.

Focussed interviews were also undertaken with the following stakeholders:

- Seven GP Partners
- Seven GP Practice Managers
- One Primary Care Education representative
- One Health Education West Midlands representative
- Two West Midlands Academic Health Science Network representatives
- One Secondary care Education lead
- One Health Education Primary care leadership
- Two CCG representatives

These interviews provided the opportunity for further exploration of the critical elements governing the development of the strategy and allowed gathering of ideas from each of the parties.
4. Findings

a) Key Stakeholders

For the purposes of this report a stakeholder has been defined as any party whom may be interested in or impacted by the development of the strategy or could exert influence on the future direction.

The primary stakeholders were identified as

**Dudley CCG**
Responsible for the development and funding of an integrated strategy. It was considered that the funding and promotion of the strategy would be critical in securing sufficient engagement of GP practices.

**Dudley CCG GP members**
Responsible for the development and prioritisation of clinical education at both individual and practice level. These were considered to be the key decision makers and therefore their commitment was seen as being central to the effective implementation of any strategy.

**GP Practice Managers (DPMA)**
Currently taking responsibility for the development of local education policies and procedures for managerial and non-clinical staff. They would also be important in the functional scheduling and accessing of education and training for all practice staff.

**Black Country Local Education and Training Committee (LETC)**
Responsible for delivery of plans for training and development locally after agreement with LETB

Secondary stakeholders were identified as

**Health Education West Midlands (HEWM)**
Establish regional priorities for education within a national framework and represent significant opportunities for access to development funding.

**West Midlands Academic Health Science Network**
A young organisation that are enthusiastic about working with primary care in the development of learning. The role of this organisation is evolving and their remit will develop to meet the needs of its stakeholders.

**University Medical Schools**
Current relationships with practices undertaking education and also development of new programmes like Physicians Assistant
Training providers eg Blue Stream Academy, Palm Training, Skills for Health

Providers will be important in developing course content and models of delivery and assessment of learning within the workforce.

Secondary care

Primary care education needs to be aligned to development in secondary care and they offer an opportunity for collaborative working within the development arena. Crucial to current NHS agendas and to affect change in workload.

Clinical senates

Mainly currently supportive agenda regionally will direct specialist clinical care

b) Review of current education structure

Health Education England

The role of Health Education England (HEE) is to provide leadership for the new education and training system and its business plan states it will ‘ensure that the shape and skills of the future health and public health workforce evolve to sustain high quality outcomes for patients in the face of demographic and technological change’. They aim to ensure that the workforce has the right skills, behaviours and training and ensure sufficient workforce capacity to support the delivery of excellent healthcare and drive improvements.

HEE will support healthcare providers and clinicians to take greater responsibility for planning and commissioning education and training through the development of Local Education and Training Boards (LETBs), which are statutory committees of HEE, the local one being Health Education West Midlands (HEWM)

HEE is required to deliver against the Education Outcomes Framework outlined in the guidance from ‘Design to Delivery’ published January 2012 which has 5 high level domains

- Excellent education
- Competent and capable staff
- Adaptable and flexible workforce
- NHS values and behaviours
- Widening participation

HEE states the Priorities for Primary care in their 2014-15 business plan to be

- Build capacity and capability in primary care workforce
- Increase placements in primary and community care
- Strengthen leadership in primary care settings

These plans are on the background, however, of HEE recently launching a consultation on planned changes to its structure which are designed to reduce running costs and reduce numbers of senior
The aim is to cut running costs by 20% and it is suggested this may impact for the short term on the effectiveness of the LETB (HEWM).

Health Education West Midlands (HEWM)/ Local Education Training Board (LETB)

Regionally work is being done with the role of HEWM to ensure the security of supply and ongoing development of the multi-professional workforce. They will commission education and training to support employer led systems.

Black Country Local Education and Training Council (BC LETC)

The LETC (in our case The Black Country LETC) is chaired by Chief Executives of local provider organisations for Dudley this is Paula Clarke (CEO Dudley Group NHS Foundation Trust) to support HEWM in meeting its responsibilities, by providing local leadership and acting as the delivery arm of the system.

The LETCs are accountable to the HEWM Board for:

- identifying local priorities
- to support the development of clear and deliverable plans
- supporting and ensuring delivery of agreed programmes of work
- actively reviewing the quality of education provision
- proactively championing excellent workforce planning
- supporting the governance of the HEWM

The difficulty for this organisation from a Dudley and primary care perspective is the requirement to cover all health care providers and not solely focus on primary care (see appendix 4 for its current priorities).

Clinical Commissioning Groups (CCG)

CCGs have a duty when exercising their functions to have regard for the promotion of education and training for their employees but not as previously noted to their providers. The difficulties appear to arise at the interface between a group of disparate providers working as Primary Care and an understanding of the educational and training needs of the spectrum of workers within these organisations both now and in terms of workforce development in the future. There is not a cohesive understanding of the requirements and responsibilities for education and training provision for these workers.

General Practices

Primary care General Practice provider organisations are businesses in their own right and as such have a duty to consider the educational needs of their staff, but obviously the requirements of the
CCG to deliver the ambitious agendas ahead of them must ensure providers are skilled, competent and flexible enough to deliver change.

c) Summary of Best Practice Research

We found little if any evidence of a competency/ learning /training needs analysis supported by a planned education and training strategy across the primary care workforce being arranged cohesively within any CCG. All CCGs request practice development plans, but they are often not completed and when they are being done it is suggested this is at a very superficial level with consideration being given to numbers of staff required at the current time and not a view of skills competencies and workforce structure required to deliver future health care.

Although we found some patchy evidence of competency assessments this was informal and lacked any degree of standardisation. There is some research evidence to suggest a variation in skills within specific cohorts of primary care workers. For example, in a study of 511 practices in the East of England in 2012 showed the confidence levels in primary care nurses treating respiratory conditions to be very variable, only 24% were confident in interpreting spirometry, only 35% had a diploma in COPD management and finally only 32% were confident in emergency treatment. The authors concluded that on-going professional education was haphazard and that it was an area needing addressing. (Davison and Jongepier 2012.) If this data is transferable it will impact on all agendas being considered by the CCG. Formal research on the effects of an education programme on primary care performance is very skimpy; however there is some evidence showing structured education can improve delivery of care.

We carried out an extensive review of current and best practice across the country to identify any areas which may affect the development of an education strategy for Dudley CCG by reviewing the education aspect of the 5 year strategic plans (2014-19) of the two hundred plus CCGs across England

We found a widespread understanding of the relevance of an education and training agenda and strategies/policies are being developed and supported across most CCGs.

The main themes emerging from the review of the 5 year strategic plans can be considered as follows

What are other CCGs Supporting?

- Protected learning time, although mainly clinical and we found very little evidence of managerial or administrative protected learning time with various degrees of control exhibited by the CCGs
- Silos of education provision for particular areas which were target areas for CCGs e.g. diabetes learning provision
- Statutory requirements being delivered.

Further areas being developed

Some CCGs are beginning to report closer educational links with their LETBs, for example
Cambridge are working with HEE to review workforce and commission educational packages
Central Manchester report working to establish relationships across the educational arena
Barnet CCG using resource from LETB to develop educational partnerships with community trusts for learning through peer review of referrals.

There is also some evidence of CCGs seeking to expand their agenda;

Ealing have developed a model known locally as ESTAR Ealing a structured model of multi-disciplinary learning involving colleagues from other organisations.
A joint project between Health Education Wessex and South Eastern Hampshire CCG. An Education and Training Project (AvOCET) is to develop the non-medical workforce – clinical and non-clinical roles – for primary and community care. ‘The purpose of this project is to ensure sustainable development of a knowledgeable and skilled non-medical workforce that is able to meet the needs of patients across the health and social care continuum’.
Health Education Kent Sussex and Surrey are developing a federated system of community providers (Community Education Provider Networks) which offer students, trainees, staff and the public innovative multi-professional educational models formed within primary care and community settings.

We found evidence that some CCGs are already being more ambitious, developing organisations which are providers as well as facilitators. The Cumbria Learning and Improvement Collaborative (CLIC) aims to ‘Drive a positive transformation in health and social care across Cumbria by leading and embedding a culture of collaboration for continuous learning, continuous improvement and living within our means’. www.theclic.org.uk

Developing this approach further the Primary Care Development centre in Derbyshire appears to be the most advanced ‘The Primary Care Development Centre will be a resource hub supplying advice and support on organisational, workforce, leadership and service development through free access to training, mentoring, facilitation and the pooling and sharing of educational and business intelligence and skills. It is a not for profit, community focused organisation, supported by NHS commissioners but given free rein to work with GP practices and their staff to meet their personal and organisational development needs in innovative ways’. www.pcdcnotttingham.co.uk

Further considerations

The drive to break down boundaries between secondary and primary care has also to be considered when looking at the requirements of the provider organisations. The Kings fund recently (October 2014) reported on six case studies of specialists working outside hospital settings. The key role of the consultants working in the community involved spending more time supporting and training other health care workers rather than working directly with patients. The Kings fund concluded ‘Specialists must become educators who dedicate time to advising and supporting primary care and community staff to better diagnose and treat patients in their local communities’ They noted the tension between service provision and education element provision to be difficult and felt it required innovative thinking.
Education provision

There is a bewildering amount of education provision from a multiplicity of providers available although there are issues around fragmentation of approach and a lack of a central repository where provision can be easily accessed, merely each individual provider showcasing their wares. A second important issue is the lack of quality markers attached to these providers, with anecdotal evidence of important time devoted to courses not producing required outcomes.

Assessing needs

Hicks (Birmingham University) as far back as 1996 noted ‘The growing demand for professional updating and training within the health service has created a proliferation of post-registration courses, many of which fail to reach the appropriate personnel or the real training objectives of the participants and their managers. One reason behind this problem relates to the fact that many such courses are constructed and delivered in a haphazard way, without systematic reference to the direct and indirect consumers of the educational programmes. A more rational approach to post-experience provision of this sort might involve the methodical collection of information regarding the training needs of target health professional populations. Such a data base would afford a global overview of competencies and deficiencies, both within and between individuals. From this the content, level and focus of training could be customized to meet the reported needs, thereby streamlining the commissioning process to enhance efficiency and effectiveness’.

We could find little evidence that even after this time passage this approach was being delivered, but there are agencies developing the tools to inform this process. In 2004 the NHS Knowledge and Skills framework was developed. This was about the application of knowledge and skills – not about the specific knowledge and skills that individuals need to possess to do their jobs. There have now been competencies frameworks available to assess needs with Skills for Health having a National Occupational Standards (NOS) database for specific competences. The Royal College of General Practitioners (RCGP) Foundation has produced competency frameworks for both practice nurses and health care assistants. The Chartered Management Institute (CMI) has competencies which could be developed for primary care managers.

Education and recruitment

Finally we found evidence that CCGs are starting to use the provision of an education component as a aid to individual recruitment such as this recent post in Hull ‘Six year contract rotational placement across 3 GP practices, CCG, Secondary care and public health opportunities to develop skills in commissioning, teaching and research, public health strategy and care of the elderly with an education bursary availed to support study towards a Masters or PhD programme’
5. Conclusions

Having considered the range of evidence collected we would draw the following conclusions

a) Current situation

a) Primary care is facing a period of significant change that will necessitate a move to more flexible and innovative working practices and collaborative working. The increasing demand for primary care is not being matched by a growth in the workforce.
b) GPs are currently reporting very low levels of job satisfaction and high levels of work-related stress that is leading to many developing the protection of early exit strategies.
c) Education is considered to be an essential component of delivering change in primary care and therefore enjoys widespread support from all stakeholders. The low response rate to surveys, although appearing to suggest a lack of interest within practices, was explored in interviews and was attributable to the lack of time available to complete and return the surveys and a perception that surveys of this type do not generally lead to any tangible benefit to practices, consequently being treated as a very low priority.
d) Engagement in workforce development within practices would appear to be the remit of more senior partners with relatively less involvement of young principles.
• Currently there is relatively little assessment of the training needs of the primary care workforce or any accessible and accepted developmental training and education routes available.
• The GP partners and practice managers through the identification of clear organisational benefits are essential to the effective implementation of an education strategy with Dudley CCG.
• Although there is some evidence of practices establishing development budgets these are generally perceived to be limited and small in relation to the size of the organisation. In a time of reducing earnings training and development budgets are perceived by many as a ‘necessary evil’ and a cost to the business rather than an investment. This was more evident in GP partners than practice managers where development was seen to be higher on the agenda.
e) There would appear to be a weakness in the workforce in respect of the level of knowledge and understanding of the benefits of development (financially and operationally) and the range of available development solutions and support services available. This lack of understanding of the benefits of engagement is instrumental in creating the current situation.
f) The current arrangements are generally considered to be appropriate but have significant perceived limitations in terms of scope, access and suitability to meet the needs of the range of primary care workforce. The provision for mandatory training through The Dudley Practice Managers Service Association (DPMA) is generally considered to be acceptable and is accessed by most practices. Overall the current training offer is perceived as limited.
g) Practice managers value the networking opportunities provided by DPMA and see this as an important arena for the development of best practice.
h) There is evidence that practices would ideally like to access group face to face training in most cases, but are receptive to media based learning with, for example, Blue Stream Academy considered to be a valuable tool.

i) Practices perceive significant challenges facing them in relation to training and development as a result of time and budgetary issues and the increasing workload on clinical and non-clinical staff. A number of respondents comment that the pressure on staff time is becoming increasingly onerous and is preventing access to development opportunities as frontline staff have difficulties being released from clinical work.

j) There is only very limited evidence that GP practices systematically evaluate the development needs of staff, with no specific budget being allocated although some comments were noted that funds are made available if the development was considered relevant. There would appear to be a weakness in most practices in relation to appraisal and development reviews.

b) Support

k) There is significant evidence that CCGs across the country are developing approaches to education, although this is fragmented and tends to primarily focus on the clinical development of GPs and practice nurses. There is not a currently an accepted ‘norm’ of model of best practice.

l) There is broad support for an integrated approach to education in Dudley with the CCG playing a central role. The key elements being to support access to information, advice relating to development and provision of funding to facilitate operational coverage of practices. The key determinant in this space is ‘convenience’ with clear evidence that there would be an increase in the uptake of training if the process of identifying and sourcing a supply of validated training could be simplified.

m) CCG support for development is currently perceived as being heavily concentrated on preparation of practices to meet the requirements of Care Quality Commission inspection through addressing mandatory training needs (Blue Stream Academy). This has obvious value but its impact is limited in the overall context of organisational development.

n) There is an opportunity to enhance the current practice engagement work undertaken by the CCG clinical engagement lead to encompass a wider organisational development remit.

o) There would appear to be multiple funding streams that are currently accessed (or planned) by CCGs to support education and training including pharmaceutical companies (subject to CCG business rules and ABPI), LETBs, LMCs, Skills Funding Agency (SFA), innovation funding (Dept of Health etc), NHS development funds, European Skills Fund (ESF) and Royal College of General Practice (RCGP).

p) The current broad remit of HEWM and BCLETC negates the required level of focus and discussion of primary care needs within regional meetings and there is an opportunity to forge specific primary care collaboration within this framework. There is an acknowledgement within LETB and LETC that they do not sufficiently understand the current and development needs of primary care and are seeking clear identification of needs from CCGs as a function of any funding and provision arrangements.
c) **Key development areas**

The relatively limited response rate from GP partners and Practice Managers means that any specific indication of priorities will be biased by the limited scope of the respondent group. Presented below are the key areas identified from the respondent groups.

**GP Partners**

<table>
<thead>
<tr>
<th>Clinical</th>
<th>Non-clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>The range of development needs is extensive  with these areas specifically identified within the research; Mental Health, Dementia, LD Diabetes Public health issues updates Safeguarding training Practical skills e.g. minor surgery</td>
<td></td>
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<tr>
<td>The research shows that there is a clear appetite within this group for maintaining and enhancing clinical skills. In addition the link to revalidation and appraisal is seen a powerful driver for ‘update’ training. Although there is some evidence that GPs feel that they need more ‘business skills’ there is a lack of clarity of what this could be. The indications through discussion would suggest that strategy development and performance management could be areas for consideration.</td>
<td></td>
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</tbody>
</table>

| Other clinical staff                      |
|-------------------------------------------|-------------------------------------------|
| Clinical                                  | Non-Clinical                              |
| Induction training                        | Clinical coding                           |
| Vaccination                               | LES/DES requirements                      |
| Cytology                                  | IT Skills, EMIS                            |
| Palliative care                           | Enhanced HCA training                     |
| Specific skills training                  |                                           |

There was evidence that space exists for developmental work relating to Practice Nurses and Health Care Assistants which should be focussed currently on expanding the clinical capability of these roles. There is a requirement for an education agenda for clinicians moving from other NHS arenas to primary care.
## Practice Managers

<table>
<thead>
<tr>
<th>Induction training</th>
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</thead>
<tbody>
<tr>
<td>HR, Payroll, Pension, Financial management</td>
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<tr>
<td>Statutory issues</td>
</tr>
<tr>
<td>Contract changes</td>
</tr>
<tr>
<td>LES/DES requirements</td>
</tr>
<tr>
<td>IT Skills</td>
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<tr>
<td>EMIS</td>
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<tr>
<td>Business awareness</td>
</tr>
<tr>
<td>Strategic and business planning</td>
</tr>
<tr>
<td>Legal issues</td>
</tr>
<tr>
<td>Aspiring Practice Manager</td>
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<tr>
<td>Commissioning understanding</td>
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<tr>
<td>Mentoring peer support coaching</td>
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</tbody>
</table>

There appeared to be quite widespread perception that the role of the Practice Manager is evolving rapidly and that there is very limited opportunity for established practice managers to developed ‘advanced’ management skills and knowledge to meet these changing demands. There is also a need for whole CCG economy training in delivery requirements for practice managers around multiple arenas.

## Non-Clinical staff

<table>
<thead>
<tr>
<th>Clinical coding</th>
</tr>
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<tbody>
<tr>
<td>EMIS/IT</td>
</tr>
<tr>
<td>Team working</td>
</tr>
<tr>
<td>Understanding organisational goals</td>
</tr>
<tr>
<td>Coping with patient demands</td>
</tr>
<tr>
<td>Receptionist refreshers /Advanced Receptionist</td>
</tr>
<tr>
<td>Handling conflict</td>
</tr>
<tr>
<td>Induction to NHS</td>
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<tr>
<td>Communication skills</td>
</tr>
</tbody>
</table>

There is a recurrent theme within the research that suggests that key areas for development within this group are related to people interaction either internally or externally.

d) **Summary of conclusions**

In summary there would appear to be a pressing requirement for primary care providers to actively engage with the concept of workforce and organisational development in order to meet the demands of a rapidly evolving environment. It would seem that CCGs as member organisations have to be at the heart of this development and should seek to establish a central role in facilitating this to happen. The primary care workforce (clinical and non-clinical) feels that their roles are more stressful and demanding than at any point in the past and have hence adopted a coping mechanism of ‘short termism’. This is preventing the development of future plans and without the provision of tangible support through financial and advisory input this situation is unlikely to change.
6. Recommendations

Based on the conclusions shown above we would offer the following recommendations for your consideration

1. Dudley CCG develops an integrated education strategy that encompasses all elements of the primary care workforce. The strategy should extend beyond the provision of training and other development interventions to provide a broader organisational development context in which the identification and provision of development needs form a core dimension.

2. Dudley CCG seeks to establish a central role in managing the provision of this strategy within their operating area through the provision of funds and management of the process. This is seen as critical in breaking the culture of short term thinking.

3. Dudley CCG seeks to exert greater influence on the development and funding of primary care education through forging more focussed links with the LETC and other external stakeholders including crucially secondary care. We suggest that Dudley CCG create a working party and co-opt representatives from both the LETC and LETB thus establishing the agenda and being more directive in the nature of LETB support for primary care.

4. Dudley CCG actively promotes the benefits of engagement with the strategy to GPs through the enhancement of existing practice based development discussions. The creation of practice development plans will be of increasing importance for GPs and support should be provided for this with particular emphasis on ‘younger principles’. There is a significant danger that without this engagement any strategy could fail to be implemented and this will require close attention.

5. We recommend that the strategy should cover the following areas

   a) Development of primary care provider strategy for workforce development planning.
   b) Creation and monitoring of Learning Needs Assessments (LNA) and performance management frameworks.
   c) Provision of information, advice and guidance relating to all aspects of workforce development.
   d) Networking and collaborative learning facilitation both within the CCG and other agencies (secondary care, social services etc.).
   e) Funding and management processes
   f) Collaborative links with LETC/LETB and other stakeholders
   g) Commissioning and quality management of development and training providers.
   h) Innovation and development of learning strategies.
6. Key success factors

The relevant factors that could be used to assess the success of the strategy are:

a) Supports general practice to deliver high quality of care
b) Enable a responsive approach to the changing environment
c) Develop practices as commissioners and providers
d) Reduces avoidable referrals to secondary care
e) Optimises business practice and development of collaborative processes
f) Facilitates the sharing of good practice
g) Ensures effective use of resources
h) Reduces variance in quality across Dudley
i) Attracts and retains staff

Engagement options

In implementing a strategy there are available a number of options relating to the role adopted by Dudley CCG which you may wish to consider. The selection would be primarily dependant on the level of financial commitment and degree of operational control that would be seen as desirable. These, with the exception of option 1, are not necessarily seen as mutually exclusive, but as a graduated process by which the strategy could be implemented in a phased programme to the required level.

In this report we have not considered the financial implications or funding of the options but this would need to be explored further to enable Dudley CCG to reach a final decision.

Option 1- Do nothing.

The current limited system does have broad support from the workforce and generally meets the needs of statutory training in relation to regulatory compliance. We would not consider this to be a viable option given the changing nature of primary care and the political expectation placed upon CCGs.

Option 2- Information Clearing House

This would involve the creation and maintenance of a central repository of information /directory of training providers and potential funding streams. This would address one of the primary barriers cited by practices and enable a convenient access point for service providers thus eliminating the need for ‘hunting’. This could incorporate basic feedback on quality from users (a Trip Advisor type model) to inform practices decisions.

Option 3- Filtration and Assessment Service

This option would involve the assessment of providers against agreed suitability criteria to establish a ‘preferred supplier listing’ thereby limiting number of suppliers and validating the quality and suitability of provision. This could also establish preferential buying terms for member organisations.
thus enabling practices to manage costs more efficiently. This option would allow the CCG to exert a degree of control over the nature and quality of the training provision.

**Option 4-Advisory and Assessment Role**

This option has a requirement for the CCG to develop, with practices a comprehensive assessment of the whole workforce training needs and skills competencies areas for development, hence supporting an understanding of the needs of the providers. This would allow for a cohesive plan for education and training across the whole provider element of the CCG and enable practices to plan areas requiring development within their own organisations. The CCG could provide organisational development consultancy to practices and provide advice on undertaking workforce planning and learning needs analysis (LNA). The remit of this service could be extended to encompass advice on access to funding streams and collaborative working. This could be developed in parallel with the current work being done with during a rolling programme of practice visits by CCG officers. GP practices would then contract independently with training providers.

**Option 5-Training and Development Commissioning**

Following on from option 4 the CCG could formally commission training and development services on behalf of its members. This would require the CCG to have involvement in the design and engagement of training interventions, provision of intervention, monitoring of engagement, quality and outcomes. This may also provide a vehicle for accessing funding through a central agency.

**Option 6-Forming a Training Provider**

This would require the establishment of a bespoke training and development organisation to meet the needs of the member organisations and would involve the management of all aspects of the end to end process. This would enable complete control of the process and may provide opportunities for provision of services to other CCG areas.
7. Acknowledgements

All who took the time to complete our surveys and were willing to discuss their views with us face to face and via telephone.

8. Appendices

1. GP Partner Survey results
2. Practice Manager surely results
3. Interview notes
4. LETC agenda for primary care
5. Reference List articles documents and websites accessed during the research for this report
### Appendix 1

#### General Practitioner Survey Results

**Survey 1**

The survey was issued to all General Practices for completion by doctors on 10th October 2014 and re-issued 23rd October.

The number of responses received was 11 which represent a response rate of 3.6%.

| Q1 | What do you see your personal education objectives/priorities for 2015-16? | Complete PDP  
General updates  
Respiratory disease/ NICE guidelines  
Keeping up to date (2)  
Gynaecology (2)/ diabetes/ cardiovascular  
IHD/Hypertension  
Post-operative guidance  
NHS changes and reforms  
Mental health |
|----|-------------------------------------------------------------------|-------------------------------------------------|
| Q2 | What barriers do you currently experience that may impact on your ability to achieve these objectives? | Time management  
No barriers at present  
Time restrictions (2)  
Work load (2)  
Work load/ time (2)  
5.00-7.00 education sessions  
Work load due to unfilled vacancies  
Lack of streamlined information  
Lack of relevant sessions |
| Q3 | Would you support a CCG wide approach to GP education? | All respondents indicated support for an integrated approach |
|    | If so how do you feel you could benefit from a Dudley CCG integrated education strategy? | Provide sessions ‘as topics identified’  
Continue education session  
Half day (afternoon) session on hot topics  
GP’s to suggest topics  
Continue current system (2)  
Less lecture, more conversation based sessions  
Networking events (2)  
Consultant teaching  
Broader focus in education session |
<table>
<thead>
<tr>
<th>Q4</th>
<th>What support would you require from CCG to enable the achievement of your education priorities?</th>
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<tbody>
<tr>
<td></td>
<td>Protected time (2)</td>
</tr>
<tr>
<td></td>
<td>Continue current practice</td>
</tr>
<tr>
<td></td>
<td>Half day closure (funded)</td>
</tr>
<tr>
<td></td>
<td>Current surgery cover system</td>
</tr>
<tr>
<td></td>
<td>Provide tailored education sessions</td>
</tr>
<tr>
<td></td>
<td>Funded education days</td>
</tr>
<tr>
<td></td>
<td>Support practices to close discuss/ resolve practice issues</td>
</tr>
<tr>
<td></td>
<td>Sessions 4.00-6.00pm</td>
</tr>
</tbody>
</table>

### Appendix 2
**Practice Manager Survey Results**

**Survey 2**  
This survey was issued to all Dudley CCG practice managers on 10th October and reissued on 23rd October.  
The number of responses received was 5 which represent a response rate of 1.06%.

<table>
<thead>
<tr>
<th>Q1</th>
<th>What do you see as the educational objectives/priorities for your practice in 2015-16 in respect of each of the groups below?</th>
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<tbody>
<tr>
<td></td>
<td>Doctors</td>
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<tr>
<td></td>
<td>Mental Health, dementia, LD LES/DES requirements, IT Skills, EMIS More specialisation Better knowledge of business Diabetes Sufficient to meet appraisal needs</td>
</tr>
<tr>
<td></td>
<td>Other Clinical staff</td>
</tr>
<tr>
<td></td>
<td>Vaccination, cytology Clinical coding LES/DES requirements, IT Skills, EMIS More enhanced clinical training Enhanced HCA training Palliative care</td>
</tr>
<tr>
<td></td>
<td>Managers</td>
</tr>
<tr>
<td></td>
<td>HR, Payroll, Pension, Contract changes LES/DES requirements, IT Skills, EMIS Business awareness Strategic and business planning HR/Legal issues</td>
</tr>
<tr>
<td></td>
<td>Other non-clinical staff</td>
</tr>
<tr>
<td></td>
<td>Clinical coding EMIS/IT Team working Understanding organisational goals Coping with patient demands Receptionist refreshers Handling conflict</td>
</tr>
</tbody>
</table>
| Q2 | What barriers do you currently experience that may impact on your ability to achieving your objectives? | Time (3)  
Budget (3)  
Lack of cover (2)  
Lack of training  
Shortage of GPs  
General apathy due to time and resource pressures |
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<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Q3</td>
<td>Would you support a CCG wide approach to education?</td>
<td>Yes (all practices)</td>
</tr>
</tbody>
</table>
| | If so how do you feel your practice could benefit from a Dudley CCG integrated education strategy? | Sharing of best practice  
Regular staff meetings to cover hot topics  
Learning from peers  
Continuity of education  
Integrated learning across roles and disciplines |
| Q4 | What support would you require from CCG to enable the achievement of your education priorities? | Funds for E-learning solutions (2)  
Practice opening hours to allow for all staff training.  
Half day surgery closures for training  
High quality speakers  
Protected time and backfill clinical cover for nurses, admin. (3)  
Access to sessions for nurses (equivalent to GP sessions)  
Extra staff |
| Q5 | Do you have a practice budget for education in 2014-15?  
If so, at what level? | Most funded through DPMA or ESF, small additional budget.  
Not sure  
Only mandatory DPMA/CCG  
No current budget but funds could be available for relevant training.  
No fixed budget but training is funded on ad hoc basis  
Yes, currently being agreed |
Appendix 3

Interview results

Interviews

The areas emerging from discussions are as follows

GP Partners

Current situation
Most considered protected time and current system of practice cover is invaluable and a significant enabler for GP education.
Generally supportive of current system especially secondary care input.
Networking opportunities considered valuable
Current programme of late afternoon events generally good but of variable quality
GPs utilise a range of providers (MDU, RCGP, On-line, conferences etc) on ad hoc basis to access training and education
Occasional training in practices
Some evidence of development reviews but mainly centred around revalidation and Personal Development Plans [PDP]

Key Issues
Time to attend sessions
Releasing staff to attend sessions
Cost of education programmes for GPs and staff.
Perceived cost effectiveness of releasing staff
Time sourcing training
Lack of contacts in CCG to advise on training issues

Would like
DES/LES updates and guidance
Revalidation and appraisal targeted development
CCG guidance and updates
Public health issues updates
Safeguarding training
Practical skills e.g. minor surgery
Business skills
Practice Managers

Current practice
Training and development considered essential for the future
Access to mandatory training considered good
Accessed staff training from DPMA (mandatory)/ Halesowen College (receptionist)
Blue Stream Academy programmes well received.
Some evidence of informal support and mentoring between practice managers
Information gathered via word of mouth or internet searches (considered time consuming)

Key issues
Difficulties around releasing staff for training
Available budget to fund development
Availability of information relating to training and development
Variable quality of current training provision with issues around level, assessment etc
Lack of availability of skills training (communication, conflict resolution, finance etc) relevant to practices
Releasing staff due to cover

Would like
More networking events and shared learning across practices
Central repository for training and development information
More advanced courses for receptionists beyond Association of Medical Secretaries, Practice Managers, Administrators and Receptionists [AMSPAR)
Targeted development for newly appointed practice nurses
Development programme for Practice Managers/ Aspiring Practice Managers
IT/HR training particularly pensions
DES/LES updates and expectations updates
Standardised induction information for all staff new to NHS

Notes from discussion with Health Education West Midlands [HEWM]

HEWM request all trusts to do a 5 year workforce plan, which they renew yearly and based on this they commission education.
They also have a large role in checking delivery/ placement quality to determine if they are fit for purpose. CCGs will approve these plans after reviewing trust plans and will ensure that in their view the trusts can deliver to support their commissioning intentions. CCGs also then provide a document for primary care and specialised services which also to some degree consider social care implications. HEWM would commission ‘registered staff’ e.g. if needed specialist diabetes nurses would commission further places for this course with providers
One of their challenges is that primary care is not clear on their workforce and development plans Blocks of money go into trusts for specific sectors such as training for band 1-4 staff
HEWM driven also by political agendas so for example Accident and Emergency [A/E] targets are struggling they will look to pump prime primary care education to provide staff with skills to try to stop so many people going to A/E
Notes from discussion with West Midlands Academic Health Science Network

This network was very keen to be involved with CCGs and want to consider ways to add value to primary care, but they perceive a difficulty in deciding the main issues as so many facets to education. They are especially interested in best use of digital tools. Education for patients must be more proactive integration with social care important. Can offer high level advice about digital spaces and tools to deliver education training remotely e.g. virtual classrooms and simulation training, CCG involvement in developing digital solutions

Opportunities to learn from training departments of pharmaceutical companies
They could signpost to people who have already got answers across regional contact with academic colleagues and we could help to inform regional opinions their engagement with primary care so far is not good. What does really good engagement look like?
They run advisory groups of consultants, GP, education, training, HEWM, academic institutions business schools, industry etc.

Notes from Secondary Care Education lead

Our local provider was very keen to work together to establish a shared education portfolio and strategy.
Appendix 4

Priorities identified by Black Country Local Education and Training Board [BCLETB]

1. Medical staffing workforce and physician’s assistants
2. Midwifery
3. Sonographers
4. Volunteers to provide greater support in the community and enable widening participation
5. Widening participation
6. Leadership
7. Community at home/out of hospital workforce
8. Falls prevention
Appendix 5

Documents and websites accessed

Design to Delivery Education Outcomes Framework January 2012
Francis report February 2013
Health and Social care act 2012
HEWM business case documents
Pay and pensions continue to raise doctors hackles Tom Moberley BMJ 12.7.2014
HEE consults on cost cutting plans BMJ 12.7.2014
Faculty of medical leadership and management website
Kings Fund Report Specialists in out of hospital settings Findings from six case studies October 2014
BMJ vacant training posts HEE figures 1/11/2014
In depth review of the general practice workforce: executive summary July 2014 Centre for Workforce Intelligence
NHS England a call to action evidence pack August 2013-4
Management in practice 8/4/2014 referencing MEDeconomics survey
Liberating the NHS: Developing the Healthcare Workforce From Design to Delivery Jan 2012 DOH
Nursing in Primary Care – ‘a roadmap to excellence’ RCGP
The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process 2004
Development of a psychometrically valid training needs analysis instrument for use with primary care teams Hicks C, Hennessey D, Barwell F Health Service Management Research November 1996
Skills for Health website
RCGP General Practice Foundation general practice nurse competencies and health care assistant competencies
Nursing in Primary Care – ‘a roadmap to excellence’ RCGP27
Seventh National GP worklife survey Hann et al 2013
Five year forward view NHS England October 2014
British General Practice: another Collings moment Wilkie BMJ October 2014
Black Country Local Education and Training Council workforce development plan

West Midland Academic Health Science Network Board papers July 2013

Regional Primary Care workforce development group papers July 2014

Training deficiencies and a lack of confidence around knowledge in primary care nurses treating asthma and COPD patients Davidson and Jongpier Thorax 2012

Primary Care Development Centre Prospectus Nottingham 2014-5

Strategic 5 year plans of CCGs in England 2014-19
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Board:** 12 March 2015  
**Report:** Quality & Safety Committee Report  
**Agenda item No:** 8.1

<table>
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<th>TITLE OF REPORT:</th>
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<tr>
<td>PURPOSE OF REPORT:</td>
<td>To provide on-going assurance to the Governing Body regarding quality and safety in accordance with the CCG’s statutory duties.</td>
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</table>
| AUTHOR(s) OF REPORT: | Ruth Edwards, Clinical Executive Lead for Quality  
Trisha Curran, Interim Chief Nurse |
| MANAGEMENT LEAD: | Trisha Curran, Interim Chief Nurse |
| CLINICAL LEAD: | Ruth Edwards, Clinical Executive Lead for Quality |

**KEY POINTS:**

Report of the Quality & Safety Committee Meetings held on 20 January 2015 and 17 February 2015

- National Issues update on
  - a) the Friends and Family Test
  - b) the Transforming Care report.
- Downgrading of previously reported Never Event at DGFT to a serious incident.
- Completion and submission of a Section 11 audit of the Children Act 2004

**RECOMMENDATION:**

The Board is asked to:

1. **Accept** this report as a source of on-going assurance that the CCG Quality & Safety Committee continues to maintain forensic oversight of all clinical quality standards in line with the CCG’s statutory duties.

2. **Note and endorse** the excellent work covered by the *Clostridium difficile Significant Event Analysis Programme* and the achievement of its member practices and other agencies involved in delivering the programme.

**FINANCIAL IMPLICATIONS:**

None to report

**WHAT ENGAGEMENT HAS TAKEN PLACE:**

User experience is an essential component of quality assurance and surveillance and as such public views and feedback form part of the triangulation of hard and soft intelligence.

**ACTION REQUIRED:**

✓ Assurance  
Approval  
Decision
1. INTRODUCTION

1.1 The CCG Quality & Safety Committee meets monthly and is chaired by Dr Ruth Edwards, Clinical Executive Lead for Quality. This report is a material summation of the Committee’s meetings in January and February 2015.

1.2 The Governing Body will be briefed on any contemporaneous matters of consequence arising after submission of this report at its meeting.

2. NATIONAL ISSUES

2.1 Friends & Family Test

2.2 In February 2015, NHSE made an announcement about the current friends and family test, and next steps. The statement contained the following key messages:

- Launched in April 2013, the FFT question has been asked in all NHS inpatient and A&E departments across England and, since October 2013, all providers of NHS funded maternity services. Since it began, the FFT has produced more than 4 million pieces of feedback.

- The FFT is now being rolled out to additional areas of NHS care making the opportunity to leave feedback possible in almost all NHS services. See section on Implementing FFT Guidance for details.

- The FFT has just become available to many additional patients, going live in 8000 GP practices across England from 1 December and in all NHS-funded mental health and community health services from 1 January. From 1 April 2015, it will be expanded to NHS dental practices, ambulance services, patient transport services, acute hospital outpatients and day cases.

- The feedback gathered through the FFT is being used in NHS organisations across the country to stimulate local improvement and empower staff to carry out the sorts of changes that make a real difference to patients and their care.

- While the results will not be statistically comparable against other organisations because of the various data collection methods, FFT will continue to provide a broad measure of patient experience that can be used alongside other data to inform service improvement and patient choice.

- The results of the FFT are published at monthly intervals on both NHS England and NHS Choices websites.

2.3 Transforming Care – Next Steps

2.4 NHS England has published a system-wide report on transforming services for people with learning disabilities. Transforming Care – Next Steps sets out a cross-system programme to transform services for people with learning disabilities and/or autism. The report represents the latest stage in responding to the recommendations of the Winterbourne View – Time for Change report. The report was produced jointly by the following organisations:

- Association of Directors of Adult Social Services (ADASS);
2.5 In particular, the report focuses on the need to provide mental health hospital placements in some circumstances where there is a genuine need and in some cases as an alternative to custody, however a commitment to seeing a substantial shift away from reliance on inpatient care remains. Inter-agency efforts will be focused on:

- a substantial reduction in the number of people placed in inpatient settings;
- reducing the length of stay for all people in inpatient settings;
- better quality of care for people who are in inpatient and community settings;
- better quality of life for people who are in inpatient and community settings.

2.6 To achieve those ambitions, a number of workstreams will be pursued:

- Empowering people and families;
- Getting the right care in the right place – both by ensuring that the current care system works for patients and families, and by designing and implementing changes for the future;
- Regulation and inspection: tightening regulation and inspection of providers, strengthen providers’ corporate accountability and responsibility, and their management, to drive up the quality of care;
- Workforce: improving care quality and safety through raising workforce capability;
- Data and information: underlying all the workstreams above will be a focus on making sure the right information is available at the right time to the people who need it.

2.7 The Committee will receive a full briefing paper on this report in April 2015, together with recommendations for further action. This report will also be discussed with providers via the Clinical Quality Review Meeting process.

3. ITEMS DISCUSSED

3.1 The following sections provide a brief update on issues discussed by the Committee, or matters arising of which the Governing Body need to be aware.

4. DUDLEY GROUP FOUNDATION TRUST (DGFT)

4.1 Themes of meetings

4.2 Infection Prevention & Control, Cancer, Learning in Action, Stroke Pathway and Mortality have featured as topics at CQRMs in January and February 2015.

4.3 Discharge information

4.4 Work is on-going between Dudley CCG and DGFT to resolve the issues with electronic discharge letters. Progress is being made to improve the JAC system. Outstanding work still to be completed includes closing of 8500 open episodes and double sign-off by clinician and pharmacist for TTOs on discharge letters.
4.5 DGFT is awaiting an electronic script from JAC\(^1\) to deal with the open episodes. Testing will then take place in a non-live environment before sending of electronic letters can be resumed. This work is anticipated to be completed this Spring.

4.6 The work on double sign-off cannot be completed until 2016 due to delays caused by JAC (beyond the control of DGFT). It is anticipated that this will only involve 5-10 clinical letters per week, when additional changes are made to TTOs by the pharmacist. In these situations a second letter will be sent out overriding the first discharge letter. It has been assessed that this is a manageable risk.

4.7 Accuracy of paper discharge letters remains in question as 300 out of 1800 computers within DGFT require updating with the correct letter template. This should be updated in the next few weeks.

4.8 **Serious Incident reporting and management**

4.9 Provider organisations reporting Serious Incidents (SIs) are required to submit a completed Root Cause Analysis (RCA) investigation tool to complete the investigation process and provide appropriate assurance to the CCG. There is a timeline of 45 working days for submission of RCAs related to SIs. The RCA should demonstrate learning which has taken place and improvements which have been introduced as a result of the SI.

4.10 An update of SIs reported by DGFT on the national Strategic Executive Information System (STEIS) for 2014/15 to date, 2013/14 (by quarter) and 2012/13 is shown below (Figure 1).

**Figure 1: Serious Incidents reported by DGFT**

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<tbody>
<tr>
<td>Total SIs Reported*</td>
<td>207</td>
<td>28</td>
<td>28</td>
<td>42</td>
<td>45</td>
<td>143</td>
<td>39</td>
<td>95</td>
<td>31</td>
<td>18</td>
<td>28</td>
<td>77</td>
<td>39</td>
<td>250</td>
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*Source: STEIS (by date of reporting)*

4.11 January 2015 saw the highest number of SIs reported by DGFT in a month during 2014/15. 28 of the 39 SIs involved pressure ulcers.

4.12 **Never Events**

4.13 Never Events are defined by NHS England as “serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented”. They include incidents such as wrong site surgery, retained instrument post operation, or wrong route administration of chemotherapy.

4.14 The number of Never Events reported by DGFT on the national Strategic Executive Information System (STEIS) for 2014/15 to date, 2013/14 (by quarter) and 2012/13 is shown below (Figure 2).

---

\(^1\) JAC Computer Services Ltd (JAC) is a leading, international provider of specialised healthcare solutions. In May 1996, JAC was acquired by Mediware Information Systems, a global provider of clinical software systems for healthcare. Mediware is publicly traded on the NASDAQ exchange in the United States (NASDAQ: MEDW).
4.15 Further discussions with DGFT and review of the medical equipment failure / surgical error SI (reported in April 2014) has resulted in a decision to downgrade the incident from a never event to a serious incident. This was not a case of something which should have been taken out being left in such as swab or guide wire. It was a case in which an incident took place, was checked by the consultant concerned and cleared but subsequently found that a fragment had broken off. It is a reportable serious incident, but is not one which meets the classification of a ‘Never Event’. NHSE West Midlands Sub-regional Unit (previously known as the Area Team) and CQC have been advised of this decision.

4.16 DGFT reported a never event in September 2014 with regard to a retained piece of medical equipment (nasogastric guide wire). At the time of this report, a response has been received from DGFT and a Trust-wide review has been carried out. The CCG Quality team is satisfied that all action that should be taken by the Trust has been done.

4.17 There have been no never events reported since September 2014.

4.18 Falls resulting in Harm

4.19 A month-by-month breakdown of Slips / Trips / Falls (resulting in harm) reported onto STEIS by DGFT to date during 2014/15, along with a quarterly breakdown of Slips / Trips / Falls (resulting in harm) reported onto STEIS by DGFT during 2013/14 is shown below (Figure 3).

4.20 “Severe injury” is consistently classified as a debilitating fracture, i.e. fractured neck of femur, fractured pelvis. This is a local indicator agreed by the Quality & Safety Committee.

Figure 3: Falls resulting in harm recorded by date of entry onto STEIS

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<tbody>
<tr>
<td>Falls resulting in harm</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>7</td>
<td>12</td>
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<td>7</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Falls resulting in severe injury</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>16</td>
<td>3</td>
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<td>1</td>
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<td>1</td>
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<tr>
<td>Total Falls</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>12</td>
<td>28</td>
<td>3</td>
<td>12</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>24</td>
<td></td>
</tr>
</tbody>
</table>

Source: STEIS (by date of reporting)

4.21 In December 2014, the fall resulting in severe injury involved a patient who fell from a bed in A&E, resulting in a fractured hip.

4.22 In January 2015, the fall resulting in severe injury involved an unwitnessed fall, resulting in a fractured femur.

4.23 Slips / trips / falls which do not result in harm are recorded by DGFT on their own internal incident reporting database. There is no requirement for Provider organisations to record details of all falls on STEIS.
4.24 The Quality team will continue to monitor and maintain oversight of falls data.

4.25 Grade 3 and Grade 4 pressure ulcers

4.26 DGFT have done considerable work to eliminate avoidable pressure ulcers, there is no relaxation of this effort and the nursing care metrics in place across the Trust flag any variance within 24 hours to the senior nurse responsible for the area.

4.27 Figures 4a and 4b below show:
- a month-by-month breakdown of pressure ulcers reported onto STEIS by DGFT during 2014/15;
- a quarterly breakdown of pressure ulcers reported onto STEIS by DGFT during 2013/14;
- the number of pressure ulcers reported onto STEIS by DGFT during 2012/13;
- the split between hospital-acquired and community-acquired pressure ulcers from July 2014 for reference purposes.

Figure 4a: Incidence of Grade 3 pressure ulcers

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<td>13</td>
<td>58</td>
<td>20</td>
<td>14</td>
<td>53</td>
<td>28</td>
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Source: STEIS (by date of reporting)

Figure 4b: Incidence of Grade 4 pressure ulcers

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<td>Total</td>
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<td>0</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>0</td>
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</table>

Source: STEIS (Grade 4 figures reflect validated data as of 9/2/15)

4.28 The number of pressure ulcers may be subject to change depending on the findings and outcomes of DGFT’s RCA investigations and whether the CCG Quality team agree with any request for reclassification or downgrading.

4.29 The numbers of pressure ulcers for 2014/15 shown in Figures 4a and 4b (above) reflect categorisation at the time of this report.

4.30 Safety Thermometer

4.31 The NHS Safety Thermometer provides a quick and simple method for surveying patient harm free care and analysing results so that this can be measured and monitored over time. For acute providers this focuses on reducing the incidence of four harms; pressure ulcers, venous thromboembolism, catheter acquired urinary tract infections, and falls. This provides organisational context for the services we commission.

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2 From July 2014, acute and community services at DGFT have been consistently reporting pressure ulcers. This has resulted in the increase in SIs attributable to pressure ulcers, primarily reported from community settings.
The methodology is to audit a sample of patients from across the Trust on a designated day each month. The percentage of sampled patients reported by DGFT as having no harm identified is shown below (Figure 5), and reflects the consistently high levels of harm free care reported by DGFT. The results reported by DGFT are in line with peer Trusts.

Figure 5: Harm Free Care reported by DGFT January 2014 – January 2015

4.33 Friends & Family Test (FFT)

4.34 There are three indicators in 2014/15 – Inpatients, A&E and Maternity.

4.35 From 2 October 2014, presentation of data changed from Net Promoter Score (NPS) to the percentage of respondents who would / would not recommend the service. NPS was the only measurement used up to and including data for July 2014. In August 2014, both sets of data were published. From September 2014, only new ‘percentage recommended / not recommended’ measurement has been published. It is therefore difficult to present meaningful comparison of the different scoring measurements, and new graphics have been developed.

4.36 The 2014/15 CQUIN guidance covering FFT for inpatients confirms funding will be based on increasing and/or maintaining response rates in inpatient services (30% by Q4 2014/15), and for reducing (or maintaining at zero) negative responses from inpatient services.

4.37 Figure 6 (below) shows DGFT’s percentage recommended score remains above the national result, with the percentage not recommended score remaining below the national result.

4.38 After exceeding the national response rate in November 2014, DGFT’s December response rate (30.8%) has returned to lower than the national response rate (33.6%), but remains slightly above the 2014/15 target of 30% of eligible patients.
4.39 The 2014/15 CQUIN guidance covering FFT for A&E confirms funding will be based on increasing and/or maintaining response rates in A&E (to 20% by Q4 2014/15), and for reducing (or maintaining at zero) negative responses from A&E.

4.40 Figure 7 (below) shows a significant change in DGFT’s A&E results for percentage recommended and percentage not recommended in December 2014. A similar change in results does not seem evident amongst other local providers. This will continue to be monitored and raised via CQRM.

4.41 DGFT’s response rate has decreased from 19.3% (November 2014) to 17.5% (December 2014), which is slightly below the national response rate in December (18.1%) and below the 2014/15 target (20%).
4.42 FFT is operational in maternity services across four touch-points (antenatal, birth, postnatal ward and postnatal community).

4.43 In summary, for December 2014, DGFT continues to perform better than the national score in all categories for percentage recommended and in all categories for percentage not recommended.

4.44 The ‘percentage recommended’ and ‘percentage not recommended’ data for the four maternity categories is shown below (Figure 8).
Figure 8: FFT scores for maternity services at DGFT

Source: NHS England
**4.45 Clinical Quality Review Meeting (CQRM)**

CQRMs are held monthly with DGFT together with other associate commissioners and colleagues from the Office of Public Health as appropriate. All stakeholder commissioners receive copies of reports and minutes. Meetings are focused on reviewing the quality of care given supported by surveillance data and reports and data / analysis. Meetings are attended by senior management from DGFT and CCG(s) and operate on the basis of scrutiny and challenge. All providers are now subject to monthly meetings and have a schedule of dates going forward.

**4.47** Any issues of concern are referred to Quality & Safety Committee and have been included in this report.

**5. DUDLEY & WALSALL MENTAL HEALTH TRUST (D&WMHT)**

**5.1 Serious Incident reporting and management**

**5.2** Serious Incident (SI) notification and Root Cause Analysis (RCA) reports relating to Dudley patients are received directly from D&WMHT. Investigation reports are reviewed by the Quality Team. Issues are addressed via monthly CQRMs.

**5.3** January and February 2015 have seen three instances of patients who are under 18-years of age being admitted to adult wards at D&WMHT as a result of insufficient T4 beds being available (a known national problem). Safeguarding colleagues at D&WMHT and at the CCG have been in contact about each of these occurrences, and the CCG has received appropriate assurance that there have been no immediate causes for concern. D&WMHT ensured that two of the patients in question were kept separate from adult patients. This highlights the need for suitable placements for young people suffering with mental health problems to be identified.

**5.4 Never Events**

**5.5** There have been no Never Events reported by D&WMHT during 2014/15.

**5.6 Safety Thermometer**

**5.7** The safety thermometer is a national initiative focused on reducing harm at the point of care – in mental health providers this focuses predominantly on reducing harm related pressure ulcers and falls, other work looks at reducing the risk of harm from violence and aggression and at the point of handover. This provides organisational context for the services we commission.
5.8 There are no concerns relating to safety thermometer data.

5.9 **Friends & Family Test**

5.10 During Q2 2014/15, D&WMHT reported that 78% of 390 people responded that they would be extremely likely or likely to recommend the D&WMHT service to friends and family. This compares with 78% in Q1 2014/15.

5.11 **Clinical Quality Review Meetings**

5.12 Items discussed at CQRM are reported to the Quality & Safety Committee. These included staffing levels as a contributory factor in incidents and complaints, enhancing quality through safer staffing levels, and service experience.

6. **BLACK COUNTRY PARTNERSHIP FOUNDATION TRUST (BCPFT)**

6.1 **Serious incident reporting and management**

6.2 Receipt of Serious Incident (SI) notification and Root Cause Analysis (RCA) reports continues via Wolverhampton CCG.

6.3 There were no SIs involving Dudley patients reported by BCPFT.

6.4 **Never Events**

6.5 There have been no Never Events reported by BCPFT during 2014/15.

6.6 **Patient Experience / Friends & Family Test**

6.7 The Friends & Family Test has been implemented within the Children, Young People and Families division and is currently being offered to service users and parents / carers at initial appointments, review and discharge. Meetings involving BCPFT’s Divisional Lead Nurse, Patient Experience Team and Performance Manager are taking place to review and confirm...
how results will be fed back and followed up.

6.8 Clinical Quality Review Meetings

6.9 Monthly CQRMs continue to be held.

7. INDEPENDENT PROVIDERS UPDATE

7.1 Dudley CCG commissions services from Ramsay Healthcare at its West Midlands Hospital. There are no quality concerns to report.

8. HEALTHCARE ASSOCIATED INFECTION

8.1 The Office of Public Health (OPH) provide support and advice to the CCG on Infection, Prevention and Control matters, and provide epidemiology reports to the CCG which are discussed by the Quality & Safety Committee.

8.2 C difficile

8.3 For 2014/15, C difficile thresholds have been set at 48 cases for DGFT and 108 cases for the CCG.

8.4 At the time of reporting, OPH had published their latest weekly report (dated 20 February 2015) and there have been:
   - 31 confirmed cases at DGFT;
   - 71 confirmed cases within the community (CCG attributed);
   - DGFT and DCCG are both below trajectory.

8.5 In addition, DGFT reported a Period of Increased Incidence (PII) of C difficile over a 28-day period on Ward C6 at Russells Hall Hospital (STEIS 2937).

8.6 The Interim Nurse Consultant for Communicable Disease at the Office of Public Health (OPH) has acknowledged that January 2015 has been the worst month for some considerable time for C difficile. He has also advised that it is not uncommon to have spikes at this time of year with increased antibiotic usage and increased pressure on primary/secondary care. OPH will continue to monitor this closely.

8.7 OPH has recently confirmed that 2015/16 C difficile thresholds have been set at 29 cases for DGFT (a reduction of 40%) and 76 cases for Dudley CCG (a reduction of 30%). These thresholds will be extremely challenging to meet.

8.8 MRSA

8.9 In 2014/15 the MRSA threshold set is zero for DGFT and the CCG.

8.10 There has been one case of MRSA reported (in September 2014) to date during 2014/15. This has been assigned to Dudley CCG.

8.11 Significant Event Analysis (SEA) programme

8.12 C difficile remains a key priority of the Government, forms part of the NHS Outcome Framework and is a Dudley CCG performance indicator.

8.13 To ensure the health economy achieved nationally set objectives to reduce the number of Clostridium difficile Infections (CDI), and as part of the learning process to continually reduce the risk to patients, in December 2013 Dudley CCG and the Office of Public Health launched
the *Clostridium difficile Significant Event Analysis Programme*. The programme aims to understand what, how, and why an infection may have occurred and what all parties involved might do to prevent it happening again.

8.14 The process primarily involves the general practice of the patient, but includes information and investigation across secondary and primary care sources. At the time of writing around 60 cases have been investigated and learning has been shared at practice, CCG and health economy level.

8.15 The process, although based loosely on Root Cause Analysis, was established as a new initiative in primary care and the overriding response at practice level in Dudley has been extremely positive. Infection Control Teams based in other Local Authority/CCG areas have requested information on our process, as attempts to launch similar initiatives in their areas have not met with such a positive response.

8.16 The Board should endorse the excellent work covered by the *Clostridium difficile Significant Event Analysis Programme* and the achievement of its member practices and other agencies involved in delivering the programme.

9. **SAFEGUARDING CHILDREN**

9.1 Section 11 audit

9.2 Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard for the need to safeguard and promote the welfare of children and young people. As members of Local Safeguarding Children Board, key partner agencies have agreed to ensure that their duty to safeguard and promote the welfare of children is carried out in such a way as to improve outcomes for children and young people in the borough. Wherever possible, evidence of impact on improving outcomes for children should be identified.

9.3 For the Local Safeguarding Children Board to maintain oversight of the effectiveness of safeguarding children practice across the borough, and of the extent to which it is continuously improving, the key Section 11 agencies are expected to provide information on the arrangements they have in place to protect and promote the welfare of children and young people. This includes Dudley CCG as a statutory member of the Safeguarding Children Board.

9.4 The Designated Senior Nurse has completed the audit on behalf of Dudley CCG and its member practices for the period 2014/15. Overall the CCG is compliant with all of its statutory responsibilities. The CCG has worked hard to raise the profile of safeguarding children within the organisation and is working towards ensuring that safeguarding is fully embedded in all aspects of CCG business including all contracts and service specifications. The correct governance structures are in place and staff have undertaken appropriate safeguarding children training.

9.5 Whilst the CCG has made excellent strides in listening to the voice of the child and determining wishes and feelings of local children and young people, they are not currently involved in service development and redesign. The CCG has plans to develop a cache of young health champions in an attempt to improve local children’s and young people’s health by:

- working with other young people to help to set up and support new health projects;
- becoming active and key partners working with health organisations to help develop health services for young people;
- influencing young people to live healthier and active lives and providing peer support
and a voice for young people around health issues.

9.6 With regards to safer recruitment processes, whilst all of the managers and HR staff within the CCG have undertaken recruitment training, this does not specifically include the safer element. The Designated Senior Nurse has undertaken safer recruitment training and the issue is currently being addressed in conjunction with the Head of Organisational Development & Human Resources. All appropriate staff will undertake training in 2015 and this will be arranged via a Department for Education e-learning package or delivered face to face from a member of the Dudley Safeguarding Children Board.

9.7 The final report of the Midlands Safeguarding Review commissioned by the CCG in 2014 will be presented to the Quality & Safety Committee in April 2015 together with recommendations for action. The Board will be updated at its next meeting.

10. SAFEGUARDING ADULTS

10.1 Prevent agenda

10.2 The Prevent strategy is a cross-Government policy that forms one of the four strands of the Government’s counter terrorism strategy. Prevent strategy was introduced as a specific requirement within the NHS Standard Contract for 2013/14 for provider organisations.

10.3 The CCG Safeguarding Team introduced new multi-disciplinary training workshops and has delivered 24 training sessions since April 2014.

10.4 Prevent training is offered to all CCG front-line practitioners, and is promoted via Member News, practice meetings, and other training events.

10.5 Care Act and NHS Accountability framework

10.6 NHS Accountability Safeguarding Framework has taken into consideration the Care Act which Adult safeguarding is, for the first time, spelt out in the law in the Care Act. Local authorities must make enquiries or ask others if they believe an adult is, or is at risk of being abused or neglected. The legal framework is to enable key organisations and individuals with responsibilities for adult safeguarding to agree on how they must work together and what roles they must play to keep adults at risk safe. Safeguarding adults board will be a key requirement which includes key stakeholders such as Health and the Police. This board will carry out safeguarding adults reviews when people die as a result of neglect or abuse and there is a concern that the local authority, or its partners, could have done more.

11. CONTINUING HEALTH CARE ANNUAL ASSESSMENTS

11.1 The Board has previously been briefed on the backlog of annual health checks for people in receipt of Funded Nursing Care / Continuing Health Care – plans are now in place to ensure these are all completed before the end of March 2015.

12. NATIONAL REGULATORS

12.1 Care Quality Commission (CQC)

12.2 As previously reported the CQC undertook a visit to The Dudley Group NHS Foundation Trust in March 2014 and published its report on 3 December 2014, identifying that DGFT “requires improvement”. DGFT’s response to the CQC report was expected at the February 2015 CQRM but had not completed Board ratification at that time. It is expected to be made available before the March 2015 CQRM.
12. Monitor

12.4 Monitor is presently undertaking its final assessment of Dudley & Walsall Mental Health Partnership Trust before making a final decision about licensing the organisation as a Foundation Trust.

13. COMPLAINTS TO CCG

13.1 There are currently twelve active complaints at the time of this report which are reviewed each week at the CCG’s Clinical Executive meeting. There are no common emergent themes.

14. RISK REGISTER

14.1 The Committee reviewed the Quality components of the CCG risk register, and is adding a new risk from the February 2015 meeting. Changes will be submitted to the Audit Committee.

14.2 New Risk – Speech & Language Therapy (SALT)

14.3 This risk relates to current waiting times for access to speech and language therapy services across the borough. The quality team is investigating these through the CQRM process, particularly to better understand the impact on children and stroke patients. Providers will also be asked about alternative means of undertaking swallowing assessments to help remedy the situation.

14.4 The two risks noted below have residual ratings of above 15.

- Risk 22 “Delivery of efficiency savings could impact the drive for quality in healthcare” – this risk is being mitigated by undertaking quality impact assessments of QIPP projects.
- Risk 58 “JAC electronic system not operating efficiently” - work is on-going and systems are being put in place to mitigate this risk.

15. PROVIDER QUALITY ACCOUNTS

15.1 All providers must publish their annual quality accounts at the end of Quarter 4. The Committee will receive a report in April regarding these following which the Board will be updated accordingly.

16. Q&S TERMS OF REFERENCE

16.1 The terms of reference for the Committee will be updated to include the Head of Communications in its membership to ensure strong ties to patient experience surveillance, feedback and engagement.

17. CONCLUSION

17.1 The Quality & Safety Committee continues to provide forensic oversight of the quality agenda supported by the CCG Quality Team. Any matters of relevance are contained in this report to the Board. If there are material issues that arise after submission of this report, the Chair of the Quality & Safety Committee will provide an oral briefing to the Board.
18. DECISIONS TAKEN BY COMMITTEE UNDER DELEGATED POWERS FROM BOARD

18.1 None.

19. DECISIONS REFERRED TO THE BOARD

19.1 None.

20. RECOMMENDATION

20.1 The Board is asked to:

20.2 **Accept** this report as a source of on-going assurance that the CCG Quality & Safety Committee continues to maintain forensic oversight of all clinical quality standards in line with the CCG’s statutory duties.

20.3 **Note and endorse** the excellent work covered by the *Clostridium difficile Significant Event Analysis Programme* and the achievement of its member practices and other agencies involved in delivering the programme.

Ruth Edwards, Clinical Executive Lead for Quality
Trisha Curran, Interim Chief Nurse

26 February 2015
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Board:** 12 March 2015  
**Report:** Report from the Clinical Development Committee  
**Agenda item No:** 9.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Report from the Clinical Development Committee</th>
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| PURPOSE OF REPORT: | 1. To advise the Board of matters considered by the Committee at its meetings on 21st January and 18th February 2015.  
2. To approve changes to the CCG’s Treatment of Infertility Policy |
| AUTHOR OF REPORT: | Mr N Bucktin, Head of Commissioning |
| MANAGEMENT LEAD: | Mr N Bucktin, Head of Commissioning |
| CLINICAL LEAD: | Dr S Mann, Clinical Executive |

**KEY POINTS:**

1. Update received on progress with the Community Rapid Response Team, Urgent Care Centre and IT Programme.
2. Direct referral for diagnostic testing by The Orthopaedic Assessment Service approved.
3. Paediatric Triage service 12 month pilot at Dudley Group NHS FT, to run in conjunction with the existing Taunton service, approved.
4. Revised specification for community nursing service approved.
5. Proposed new service model for mental health services approved in principle.
6. Physical activity and sport action plan approved.
7. Guidelines for nil by mouth/swallowing for Parkinson’s Disease patients and antibiotic prescribing for community acquired infections in general practice approved.
8. Revised terms of reference for the Prescribing Sub-Committee and the Nutrition Sub-Group of the Area Clinical Effectiveness Sub-Committee approved.
10. QIPP progress for 2014/15 and 2015/16 noted.
11. Proposed package of care for an individual patient meeting the NHS Continuing Healthcare criteria considered. This is the subject of a separate report to the Board. Due to the confidential nature of the item, it is recommended that this be considered in private.
12. Revisions to the Treatment of Infertility Commissioning Policy recommended to the Board for approval.
| **RECOMMENDATION:** | 1. That the matters considered by the Clinical Development Committee be noted.  
2. That revisions to the Treatment of Infertility Commissioning Policy be approved. |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| **FINANCIAL IMPLICATIONS:** | All proposals have been approved on the basis that they are either cost neutral or deliver a saving.  
The Prescribing budget is currently overspending and this matter is referred to in the Finance and Performance Committee report. |
| **WHAT ENGAGEMENT HAS TAKEN PLACE:** | Engagement has taken place in relation to individual proposals considered by the Committee as necessary |
| **ACTION REQUIRED:** | Decision  
✓ Approval  
✓ Assurance |
1.0 BACKGROUND

1.1 The Clinical Development Committee met on 21 January and 18 February 2015.

1.2 One item requiring the approval of the Board is set out below.

2.0 MATTERS CONSIDERED UNDER DELEGATED POWERS

Urgent Care Centre Update

2.1 The Committee received an update on the implementation of the new Urgent Care Centre (UCC) service.

2.2 The Committee noted that the scheme is on track to begin on 1st April 2015 utilising an interim premises solution. From 1st March 2015, the service will be piloted from 9am to 9pm.

2.3 In order to facilitate the changes within the hospital, some phlebotomy services will relocate to the Corbett and Guest hospitals. In addition, some out-patient clinics will relocate to the Guest Hospital.

2.4 All patients will go to the Emergency Department (ED) reception desk in the first instance. Patients will then be streamed to either ED or the primary care element of the service. In the interim, ambulance conveyed patients will not be streamed.

Community Rapid Response Service Update

2.5 The Committee has noted that the Community Rapid Response Service (CRRS) has commenced operating on a limited basis from 7th January, 2015.

2.6 The CRRS Advanced Nurse Practitioners (ANPs) have been co-responding to ambulance calls during this period with the ambulance service. Initial data shows that the service has had some success in preventing patients being conveyed to hospital.

2.7 After the first month of operation, the service will be reviewed with the intention of moving towards full operation with the ANPs responding to calls independently. A further update will be given at the meeting.

Information Technology Programme

2.8 The Committee have noted the progress being made with a significant number of IT schemes. The Committee were particularly interested to understand the extent to which schemes were designed to impact upon the behaviour of clinicians and patients. Use of choose and book, standardised material on EMIS, Docman (a document management system for general practice), remote monitoring and risk stratification are all designed to do this.

Orthopaedic Assessment Service – Access to Diagnostic Tests

2.9 Subject to appropriate protocols being in place and operating in accordance with NICE Guidance, the Committee has approved the Orthopaedic Assessment Service having direct referral rights for a number of tests, as a means of saving time for the patient, GP and the service.

Paediatric Triage

2.10 The Committee has approved a pilot paediatric triage service at Dudley Group NHS Foundation Trust, with the intention of avoiding unnecessary referrals.
2.11 This service will run in conjunction with the existing service provided from Taunton for 12 months. At the end of this period both services will be evaluated.

**Community Nursing Service – Revised Service Specification**

2.12 The Committee has approved a revised service specification that will combine the existing virtual ward and district nursing services into an integrated community nursing service. This is intended to:

- provide closer working with general practice as part of the practice based multi-disciplinary teams;
- enhance the skill base and resilience of nursing teams;
- provide a case management model;
- support an efficient discharge process from secondary to primary care.

**New Service Model for Mental Health**

2.13 The Committee have supported, in principle, a proposed new service model for mental health services.

2.14 This is based upon commissioning:

- an all age emotional health and wellbeing service;
- a 0 – 25 years secondary care mental health service;
- a 25 plus years secondary care mental health service;
- a specialist dementia service.

2.15 Evidence suggests that transition to adult services at the age of 25 results in better outcomes due to the increased capacity and resilience of individuals to cope with transition at that age. There is also no evidence to sustain the existing separation of adult services into those for under and over the age of 65.

2.16 The service model would also be designed to complement the move to greater integration at practice level, with a focus on prevention, early intervention, recovery and continuity of care.

**Physical Activity and Sport Action Plan**

2.17 The Committee has approved a proposed physical activity and sport action plan which is attached as Appendix 1 subject to a suitable contribution from Dudley MBC/Office of Public Health.

2.18 The 2012/13 Active People Survey showed that 12.1% of adults in Dudley participate in sport for 30 minutes three or more times per week, this is on a downward trend and is below the national average of 17.4%. Children in Dudley aged 10 – 11 years have a higher rate of obesity than the national average. This action plan is intended to contribute to the CCG’s overall approach to prevention in relation to coronary heart disease, hypertension, diabetes, cancer and stroke.

**Medicines Management**

2.19 The Committee, on the advice of the Prescribing Sub-Committee, have approved guidelines for nil by mouth/swallowing for Parkinson’s Disease patients and antibiotic prescribing guidelines for community acquired infections in general practice.

2.20 The Committee have also approved revised terms of reference for the Prescribing Sub-Committee and the Nutrition Sub-Group of the Area Clinical Effectiveness Sub-Committee. As far as the former are concerned, the Committee have made clear the Prescribing Sub-Committee’s responsibilities in terms of managing the prescribing budget and the medicines management QIPP schemes.

2.21 The Committee have considered the draft Pharmaceutical Needs Assessment. As a result of this, discussions are taking place with the new provider of the Urgent Care Centre to develop appropriate
Patient Group Directions to provide access to pharmaceutical services between Midnight and 7a.m. This would represent an enhancement to existing provision.

**QIPP Progress 2014/15**

2.22 The Committee have noted that this will be achieved for 2014/15 through the use of £1,984,000 non-recurrent funding against a total target of £7,164,000.

2.23 The target for QIPP in 2015/16 is £ 7,190,000 and the commissioning team are in the process of developing schemes to be agreed by 27th March 2015.

**Patient with NHS Continuing Healthcare Needs – Proposed Package of Care**

2.24 The Committee have considered this individual case. This matter and the Committee’s recommendation are dealt with elsewhere on this agenda.

3.0 **MATTERS FOR CONSIDERATION BY THE BOARD**

**Treatment of Infertility Commissioning Policy**

3.1 The Board will recall that, in July 2014, they considered a proposal to amend the existing policy for infertility treatment. The Board were concerned about the level of clinical, patient and public engagement that had been carried out in relation to this proposal.

3.2 This matter has now been considered again by the Committee, in the light of consultation carried out with the public through a specific meeting of the Healthcare Forum and with GPs through the CCG locality meetings.

3.3 Following consultation, some further changes are proposed as follows:-

- range of treatments to be included in the policy – to include one cycle of Intravenous Uterine Insemination (IUI);
- duration of sub-fertility – to be reduced from 3 years to 2 years;
- previous assisted conception treatment – removal of previous clause preventing treatment for anyone receiving previous treatment either via the NHS or privately;
- same sex couples – sub-fertility – to be the same as heterosexual sex couples.

3.4 The Committee considered whether it might be appropriate to adopt a sliding scale in relation to the duration of sub-fertility of 3 years, to 2 years, to 1 year, depending upon the age of the female applicant. The Committee accepted, with some reluctance, that this could not be implemented due to the risk of challenge on the grounds of inequality.

3.5 The Committee were satisfied that sufficient consultation had taken place and approved the further changes as set out in 3.3 above.

3.6 The Board should note that the adoption of the revised policy as outlined above, results in potential savings of approximately £100,000 not being achieved.

4.0 **RECOMMENDATION:-**

4.1 That the matters considered by the Clinical Development Committee be noted.

4.2 That the proposed changes to the Treatment of Infertility Commissioning Policy be approved.

**Dr. S. Mann, Clinical Executive**  
**Mr. N. Bucktin, Head of Commissioning**  
**February 2015**
### ROLE OF PRIMARY CARE

<table>
<thead>
<tr>
<th>No.</th>
<th>Priority</th>
<th>Action</th>
<th>Lead</th>
<th>Timescale</th>
<th>Cost</th>
<th>Measures</th>
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| 1.  | To increase referral rates from primary care into physical activity schemes | 1. Introduce targets for exercise referrals for inclusion in a CCG Dashboard  
2. Ensure performance information is reviewed at CCG locality meetings  
3. Review trigger opportunities to flag physical activity and systemise into EMIS  
4. Ensure primary care practitioners have access to the most up to date information and systems support this  
5. Monitor referral rates against targets | CCG    | February 2015  
CCG    | Commence February 2015  
CCG    | on going  
CCG    | on going | N/A | Rate of referral per 1000 pts |
| 2.  | Incorporate physical activity into a future Long Term Conditions (LTC) Framework | 1. Incorporate physical activity and weight loss into future LTC Framework | CCG/DMBC | April 2015 – March 2015 | To be resourced as part of LTC Framework | To be developed as part of LTC Framework |

### CHILDREN

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<th>No.</th>
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<th>Measures</th>
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2. Establish a ‘task and finish’ group with key school leaders to | CCG/DMBC | November 2015 | £100K | Primary school activity measurement |
| 4. | Increasing Physical Activity Fund – Grants to Voluntary / Community Sector Organisations | 1. Conduct a review of the previously funded programmes to look for opportunities for further expansion of successful programmes 2. Make recommendations to CDC for future funding in a pooled arrangement with OPH 3. Work with CVS to sustain infrastructure through volunteers | CCG Dudley CVS/BCC Ltd CCG PAT & F group CCG/DCVS | March / April 2015 May 2015 April 2015 – June 2015 | £150K | Number of new people doing physical activity (1x30) No. of people continuing participation (2+x30/150mins) Ditto |}
| 5. | Specific Interventions – a. Skyride & Rowing | 1. Continue to monitor delivery and impact. 2. Review impact 6 months prior to completion. | OPH CCG/OPH/ British Rowing & Cycling | February 2015 To be confirmed | N/A | No. of new people taking part in rowing and cycling (1-4x30/150mins) |
| 6. | Specific Interventions – b. My Activity Tracker | 1. To investigate local application | CCG/OPH | April – September 2015 To be confirmed | To be confirmed |
| 7. | Specific Interventions – c. Beat the Street | 1. To investigate local application | CCG/OPH | April – September 2015 To be confirmed | To be confirmed |
| 8. | Let’s Get Campaign | 1. To adopt the Let’s Get Campaign as a platform to promote physical activity  
2. With Let’s Get, use social media to influence behaviour which encourages more people to be active | CCG  
CCG Comms | January 2015  
January – March 2015 | N/A | To be confirmed |

**WORKPLACE HEALTH AND WELLBEING**

| 9. | GP Practice and CCG Workplace | 1. Encourage GP practices to sign up to the ‘Let’s Get’ Dudley Moving Charter, setting out actions that they will undertake  
2. Promote and establish a CCG workplace programme which encourages staff to become more physically active  
3. Explore the potential to establish physical activity equipment such as fitness gyms at GP Practices and review impact on patients and staff | CCG  
Dudley MBC and CCG comms  
CCG/Practices | June – July 2015  
November 2014 – March 2016  
April – September 2015 | £10k | No. of practices signed to the Charter.  
No. of Staff participating & No. of staff increasing physical activity levels (1-4x30/150mins)  
Assessed through the use of survey monkey |
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Report:** 12 March 2015  
**Report:** Report from the Communications & Engagement Committee  
**Agenda item No:** 10.1

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<tr>
<th>TITLE OF REPORT:</th>
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<tr>
<td>PURPOSE OF REPORT:</td>
<td>To update the Board on the activity of the Communications &amp; Engagement Committee. To provide the Board with assurance that the committee is responding to its delegated duties as set out in the Scheme of Delegation</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Laura Broster- Head of Communications and Public Insight</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Laura Broster- Head of Communications and Public Insight</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr David Hegarty - Chair</td>
</tr>
</tbody>
</table>
| KEY POINTS: | • The committee held its most recent bi monthly meeting on Tuesday 10 February 2015  
• 61 requests for information under the Freedom of Information Act  
• New campaign planning encouraging people to make the right choices and, ‘Do it Right, Dudley!’  
• Discussion on committee effectiveness  
• Assurance on Annual Report production |
| RECOMMENDATION: | That the Board:  
• Note the contents of this report  
• Be assured that the committee is overseeing the production of the Annual report for final sign off at Audit Committee  
• Be assured that the committee is fully functioning and that statutory duties are being met with regard to Engagement with the Public & Patients. |
| FINANCIAL IMPLICATIONS: | The CCG has a statutory duty to involve. Failure to do so could result in costly judicial proceedings. All activity reported is covered by the existing communications & engagement activity unless it states otherwise. AVE is a method of estimating the value of editorial media coverage, which is widely used throughout the PR industry. |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | The committee is responsible for ensuring that appropriate mechanisms are in place for Engagement to take place. Progress on this is included in the report. |
| ACTION REQUIRED: | ✓ Assurance  
Decision  
Approval |
DUDLEY CLINICAL COMMISSIONING GROUP BOARD – 12 MARCH 2015
REPORT FROM THE COMMUNICATIONS & ENGAGEMENT COMMITTEE

1.0 INTRODUCTION

This is a report to the CCG Governing Body (Board) from the Communications & Engagement Committee. The Committee had its latest meeting on 10th February 2015.

Also included is the Key Performance Indicator Summary (section 2.0)

2.0 KEY INDICATOR SUMMARY (Produced 24th Feb 2015)

<table>
<thead>
<tr>
<th>Communications and Engagement Strategy Summary Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Patient Participation Groups (PPGs)</td>
</tr>
<tr>
<td>Number of Prospective PPGs</td>
</tr>
<tr>
<td>Date and agenda of next Patient Opportunity Panel (POPs)</td>
</tr>
<tr>
<td>Date and agenda of next Healthcare Forum (HCF)</td>
</tr>
<tr>
<td>Twitter Followers</td>
</tr>
<tr>
<td>Facebook Likes</td>
</tr>
<tr>
<td>Advertising Value Equivalent (AVE)</td>
</tr>
<tr>
<td>Media Coverage Topics</td>
</tr>
<tr>
<td>Collaborative Work</td>
</tr>
<tr>
<td>Key Projects</td>
</tr>
<tr>
<td>Next GP Membership Meeting</td>
</tr>
</tbody>
</table>
3.0 ITEMS DISCUSSED

3.1 Freedom of Information (FOI) Update
The Freedom of Information (FOI) Update was presented to the committee. The purpose of this report is to provide the Communication and Engagement Committee with an overview of the CCG activity in relation to Freedom of Information requests received and to provide assurance that this legislation is being adhered to.

- Dudley CCG has received a total of 61 requests for information between 31st October 2014 – 26th January 2015
- All requests were completed within the time and 2 requests required the use of a Public Interest Test Meeting.
- No trend in terms of request topics
- Proportionally more requests from the public than other sources
- The average days it takes to complete a Freedom of Information request is 6, well within the statutory 20 working day limit.

3.2 Communications & Engagement Committee Effectiveness Report
There was a discussion at committee with Paul Capener, Effectiveness Governance Support, who has been conducting a review into the CCG Committees. Interestingly, in the feedback he has received, there was a polarity of views expressed by committee members and attendees into whether the committee was the best way for the CCG to meet its statutory duties.

There will be a report to Board from Mr Capener which will take into account the views of Committee Members and will make a recommendation for Board to consider how the duties of the Committee are best delivered.

3.3 ‘Do It Right Dudley’ Campaign
The committee received information on the ‘Do It Right Dudley’ campaign. This campaign is in development at the moment with the ambition to find a campaign banner to hook all of the different ‘winter/ appropriate use of services’ messages on.

The start of this campaign would be a letter from Dudley GPs to the public. This was approved by committee and would be published in the local newspaper. The letter would act as a prompt to start conversations with local people on some of the campaign ideology.

Over the spring, conversations and education roadshows would continue, linking in with partners. The full campaign to include outdoor advertising, i.e. buses, large advertising boards etc., would be ready for next winter.

3.4 Young Health Champions
Committee received a verbal update on Young Health Champions.

Dudley CCG held the #MeFestival in November 2014. One of the outcomes of this event was a proposal to have Young Health Champions (YHCs) in schools across Dudley Borough. The CCG Engagement Manager, has since met with colleagues in Shropshire, where Young Health Champions are working well and we will be meeting some of the champions soon.

Shropshire CCG and Altogether Better secured Big Lottery funding for the YHC project over a 2 year period. The Engagement Manager is now working with Dr Tim Horsbourgh, Dr Linda Cropper & partners in the Office of Public Health to develop a business case for Dudley.

A proposal will be presented to April’s Communications & Engagement Committee.

3.5 Media Report
The media log was tabled at Committee for information and detailed the Advertising Value Equivalent (AVE) as £79,300 with £40,000 of this relating to positive coverage.
There was £5,677 negative and £32,709 neutral.

3.6 Annual Report Plan
The Committee were informed that discussions had started with individuals on the content of the Annual Report which would be a ‘word’ friendly document for the public. In addition discussions with design companies about the digital format of the Report for the website had commenced and the Membership event in February would be used to begin to capture the views of GPs for the Members report.

A document setting out the structure of the report will be presented to the next Audit Committee on 27 March, where External Audit have agreed to review the proposed structure of the report to ensure that it met audit’s requirements.

The Annual Report will be available for 28 May Audit Committee. The published version would be available for the Annual General Meeting on 18 June.

The Committee were assured that this year's Annual Report is currently being planned effectively and that processes are in order to ensure this is done in a timely manner. A paper has already been presented to Audit committee detailing any lessons learnt from last years production, which has been taken into account for this years production.

3.7 Risk Report
The Board Assurance Framework (BAF) currently shows 2 risks relating to the Communications & Engagement Committee.
- Failure to ensure meaningful public engagement (19)
- Failure to fully engage with HOSC (38)

The committee discussed the current risks and ratings and decided that:
- Risk 19 is to be reduced as the Committee is formed to ensure that the CCG engage effectively
- Risk 38, level to stay the same as this will always be a risk

3.8 Patient Experience Transition Funding
Committee were assured that significant progress has been made towards openness and transparency of patient experience data with Dudley Group NHS Foundation Trust. The CCG is now a member of the Patient Experience Group meeting at DGNHSFT, chaired by their Chief Executive.

4.0 DECISIONS TAKEN BY COMMITTEE UNDER DELEGATED POWERS FROM BOARD
None

5.0 DECISIONS REFERRED TO THE BOARD
None

6.0 RECOMMENDATION
That the Board:
- Note the contents of this report
- Be assured that the committee is overseeing the production of the Annual report for final sign off at Audit Committee
- Be assured that the committee is fully functioning and that statutory duties are being met with regard to Engagement with the Public & Patients.

Laura Broster
Head of Communications & Public Interest
**TITLE OF REPORT:** Report from Audit Committee

**PURPOSE OF REPORT:** To advise the Board of the key issues discussed and agreed at the Audit Committee on 5th February 2015

**AUTHOR OF REPORT:** Mr M Hartland, Chief Finance Officer

**MANAGEMENT LEAD:** Mr M Hartland, Chief Finance Officer
Mrs J Jasper, Chair – Audit Committee

**CLINICAL LEAD:** Dr J Rathore, Clinical Lead for Finance and Performance

**KEY POINTS:**
- Report and update from Information Governance and Internal Audit
- EMIS Web Standardised Material Governance Policy approved
- Year-end 2014/15 - Updates on CCG Annual Report; AGM; Annual Governance Statement; 3rd Party Assurance for CSU; Audit Committee Annual Report
- Update on Review of Committee Effectiveness
- Combined BAF & Risk Register as at 5th January reviewed
- Update on Co-Commissioning submission and governance arrangements
- Prime Financial Policies-Assurance received
- Other matters considered–Evaluation of Consultants; Update on FOI Activity

**RECOMMENDATION:**
- The Board is asked to receive this report on the issues discussed and the decisions taken under delegated powers at the Audit Committee on 5th February 2015

**FINANCIAL IMPLICATIONS:** None

**WHAT ENGAGEMENT HAS TAKEN PLACE:** None

**ACTION REQUIRED:**
- Decision
- Approval
- ✔ Assurance
1.0 INTRODUCTION
The report summarises the key issues discussed at the Audit Committee on 5th February 2015.

2.0 KEY INDICATOR SUMMARY
The following items are indicators of the current position in relation to the main responsibilities and obligations of the Committee as defined in the CCG Constitution and Terms of Reference.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Position</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Regulation and Control</td>
<td>Good progress</td>
<td></td>
</tr>
<tr>
<td>CCG Governance Arrangements – Constitution</td>
<td>Changes in respect of Co-Commissioning agreed by NHSE. Awaiting formal confirmation of changes.</td>
<td></td>
</tr>
<tr>
<td>Scheme of Delegation</td>
<td>No issues</td>
<td></td>
</tr>
<tr>
<td>Compliance with Prime Financial Policies</td>
<td>No issues</td>
<td></td>
</tr>
<tr>
<td>Board &amp; Committee Effectiveness</td>
<td>Board &amp; Committee effectiveness reviews underway. Board development session April 2015</td>
<td></td>
</tr>
<tr>
<td>2. Annual Report and Accounts – CCG 2014/15</td>
<td>Regular updates on Annual Report; AGS; Accounts progress. Grant Thornton session attended 02/02/14. NHSE Workshop 25/02/14</td>
<td></td>
</tr>
<tr>
<td>3. Operational &amp; Risk Management</td>
<td>Good Progress</td>
<td></td>
</tr>
<tr>
<td>Counter Fraud and Security</td>
<td>Committee updated</td>
<td></td>
</tr>
<tr>
<td>Risk Management Arrangements – Combined BAF &amp; Risk Register in place; Chairs/Management Leads of committees attending &amp; updating Audit Committee; Annual Review July 2014</td>
<td>Good Progress</td>
<td></td>
</tr>
<tr>
<td>Report newly commissioned services</td>
<td>Revised Procurement Strategy approved by CCG Board 13/03/14</td>
<td></td>
</tr>
<tr>
<td>External Audit</td>
<td>Interim audit completed December – no significant issues raised.</td>
<td></td>
</tr>
<tr>
<td>- Other Policies – 6 of total of 7 received and approved</td>
<td>Good progress</td>
<td></td>
</tr>
<tr>
<td>- Other Policies – Business Continuity Policy</td>
<td>Work progressing</td>
<td></td>
</tr>
<tr>
<td>4. Information Governance</td>
<td>Good progress</td>
<td></td>
</tr>
<tr>
<td>Information Governance Group established</td>
<td>Meetings to be established once CSU IG Team fully in place.</td>
<td></td>
</tr>
<tr>
<td>Information Governance Breaches – Provider</td>
<td>Updates to be followed up</td>
<td></td>
</tr>
<tr>
<td>Compliance with Information Governance toolkit</td>
<td>Improvement Plan agreed &amp; work progressing</td>
<td></td>
</tr>
<tr>
<td>Information Asset Management structure to be established with IAOs and IAAs identified from CCG staff</td>
<td>IAOs identified, IAAs identified by IAOs. Training starting shortly.</td>
<td></td>
</tr>
<tr>
<td>IG Policies – 18 policies replaced by overarching IG policy supported by handbook. FOI and Engagement with the Pharmaceutical Industry policies approved 02/12/14.</td>
<td>Policies being regularly reviewed and updated.</td>
<td></td>
</tr>
</tbody>
</table>
3.0 ITEMS DISCUSSED – 5th FEBRUARY 2015

3.1 Information Governance
The Audit Committee received a report from Information Governance, Midlands & Lancashire CSU for assurance. The main focus was on the outstanding areas to ensure compliance with the IG Toolkit. It was noted that there had been good progress in the numbers of staff receiving training and that the CCG’s toolkit score was one of the best in the area. Clarification was being sought about whether Board members needed to be included in the numbers trained.

The Committee expressed their disappointment that once again much of the work was loaded towards the end of the financial year and whilst they acknowledged the resourcing issues the CSU IG team faced due to restructuring, this was creating risks and pressures within the CCG.

The next significant steps in the annual work programme were considered which included:

- Circulation of IG Policy & handbook to all staff
- Training for all Information Asset Owners (IAOs) and Information Asset Administrators (IAAs)
- Completion of Information Asset Registers and Data flows
- Delivery of training to CCG Board at Board Development Session
- Completion of IG training to all other staff
- Spot check and information security audits
- Approval of IG annual report
- Completion of IG Toolkit during the final week in March

Mr Hartland as SIRO and Mrs Jasper as Chair of the Audit Committee were given delegated responsibility to sign off the toolkit submission in March.

3.2 Policies
The Committee considered and approved the EMIS Web Standardised Material Governance Policy. This policy was required to ensure that any CCG recommended templates, protocols and pathways were effectively managed and that a robust governance framework was in place to mitigate any potential clinical risk to the CCG. The policy provided the necessary assurances.

The Committee also received an update on the work being done to develop EMIS.

3.3 Freedom of Information (FOI) Activity Report
The Committee received the FOI Activity report for the period 31 October 2014 to 26th January 2015. The Committee was assured that the FOI function was being managed within the legislation and agreed that all contract information in excess of £25,000 should be included in the CCG’s Publication scheme.

3.4 Annual Report 2014/15
The Committee received a report from the Head of Communications and Public Insight on progress with determining the content and design of the Annual Report. It was noted that the Member’s Event being held on the 10th February was being used as an opportunity to capture the views of GPs. A document setting out the structure of the Annual Report was to be brought to the next Audit Committee. The Committee received assurance that the Annual Report would be ready for approval at the Audit Committee on the 28th May and the final published version would be available for the Annual General Meeting, now confirmed as 4pm on the 18th June.

3.5 Board Assurance Framework and Risk Register
The Committee received the Combined Board Assurance Framework (BAF) and Risk Register as at 6th January 2015 for assurance.

Mr Bucktin, Head of Commissioning, attended the meeting to discuss the risks assigned to the Clinical Development Committee (CDC). He explained that the committee’s attention was focussed on the three particular risks: the Urgent Care centre; the Rapid Response Team and more recently delayed transfers of care from intermediate care bed. The Audit Committee was assured that the CDC was satisfactorily managing its risks.

A separate report to the Board provides further details.
3.6 Co-Commissioning Governance Update
The Committee received an update on the Co-Commissioning submission to the NHSE Area Team for assurance. It was noted that the submission assumed a certain budget level and the CCG had reserved the right to review its submission should this budget not be received. There had been very little amendment to the draft document prior to submission although the most important was that the Co-Commissioning Committee would meet in public.

In preparation for full delegated responsibility the CCG was required to review and amend its conflicts of interest policy. It was agreed that an action plan to do this be presented to the March Audit Committee.

3.7 Internal Audit
The Committee received the Progress Report January 2015 from Internal Audit for information, assurance and approval. The current cumulative position on the Head of Internal Audit Opinion continued to be significant assurance. The Committee noted the current status in terms of recommendation tracking. It was noted that the Continuing Healthcare report, which had only just been finalised, had again been given moderate assurance. Internal Audit confirmed that the audit plan would be delivered to the agreed profile.

3.8 Year-end 2014/15 Issues
The Audit Committee received an update on the Annual Governance Statement (AGS) and noted that guidance was imminent. It agreed that updates on any outstanding actions for 2013/14 should be obtained and an action plan for the development of the AGS be presented to the next Committee.

The Committee also received for assurance the Deloitte Report on internal controls within the Midlands & Lancashire CSU for the six months 1 April 2014 to 30 September 2014.

3.9 Evaluation of Consultants
The Committee received an update on the consultancy assignment with Privileged Conversations from the Organisational Development Practitioner. The Committee indicated that it was expecting a full evaluation once the assignment had been completed.

It was noted that the Audit Committee had already asked the CCG to develop a robust, transparent and open process for the engagement of all future consultants, contractors and agency staff, setting out key deliverables and expected outcomes, to ensure value for money and be clear about the rationale for any appointment. The procedures would be prepared building on the evaluation forms and the Committee was assured that a procedure would be developed for the appointment of all future off payroll engagements.

The Committee received a report on the evaluation of consultants paid for the period 1st April to 30th September 2014. Members made a number of observations and agreed to:
- feedback on the responses made and any specific queries would be directed to the relevant management lead
- confirm if they considered all the relevant data was being requested as this would inform the process for appointing consultant and interim staff.

3.10 Other Issues
The Audit Committee considered and received assurance in respect of:
- Chairs action relating to an ex-gratia payment.
- Governance review progress.
- Audit Committee Annual Report 2014/15 progress.
- Audit Committee revised Terms of Reference approval by the January Board.
- Waivers and No Orders authorised.
- Authorisations outside the Scheme of Delegation.
- Revised Operational Scheme of Delegation considered and approved except for amendment in respect of budget virements. Authority delegated to Chair for final approval.
- Aged Receivables and Payables.
- Compliance with laws and regulations governing the NHS.
4. **DECISIONS TAKEN BY COMMITTEE UNDER DELEGATED POWERS FROM BOARD**
   - Approval of Chairs action taken in respect of an ex-gratia payment.
   - Approval of the EMIS Web Standardised Material Governance Policy.
   - Approval of revised Operational Scheme of Delegation excluding change in respect of budget virements.

5. **DECISIONS REFERRED TO THE BOARD**
   - None.

6. **RECOMMENDATION**
   - The Board is asked to receive this report on the issues discussed and the decisions taken under delegated powers at the Audit Committee on 5th February 2015 for assurance.

M Hartland
Chief Finance and Operating Officer
March 2015
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Board:** 12 March 2015  
**Report:** Combined Board Assurance Framework and Risk Register  
**Agenda item No:** 11.2

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Combined Board Assurance Framework and Risk Register</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To update the Board on the combined Board Assurance Framework (BAF) and Risk Register and present it as at 6th February 2015.</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
</tbody>
</table>
| MANAGEMENT LEAD: | Mr M Hartland, Chief Operating and Finance Officer  
Mrs J Jasper, Chair – Audit Committee |
| CLINICAL LEAD: | Dr D Hegarty, Chair |
| KEY POINTS: | • Update on combined BAF & Risk Register including feedback from the Clinical Development Committee  
• Summary of risks as at 6th February 2015 presented  
• Details provided of changes made since 5th December 2014 |
| RECOMMENDATION: | • The Board is asked to receive the report for assurance |
| FINANCIAL IMPLICATIONS: | None direct. Potential consequence if risks materialise. |
| WHAT ENGAGEMENT HAS TAKEN PLACE: | None |
| ACTION REQUIRED: | Decision  
✓ Approval  
✓ Assurance |
1.0 INTRODUCTION

In accordance with the CCG’s Risk Management Strategy, the combined BAF and Risk Register for those risks scored 16 and over (which comprise the Board Assurance Framework) is presented to the CCG Board. This is based on the position as at 6th February 2015.

The Audit Committee considered the overall combined BAF and Risk Register as at 6th January 2015 at its meeting on 5th February. It noted that there was an expectation that one of the outcomes of the committee effectiveness review that was underway would be a re-focus on the BAF & Risk Register. Also that the CCG needed to consider its risk appetite given that it was now a more mature organisation.

The management lead for the Clinical Development Committee attended the meeting to update the Audit Committee on the discussions and actions the Committee was taking around the BAF and Risk Register. Mr Bucktin noted that the CDC’s focus was on three particular risks - the Urgent Care Centre, Rapid Response Team and more recently, delayed transfers of care from the intermediate care beds, all of which had a significant impact on system performance.

With regard to the remaining risks, some had been on the register for some time and related to issues faced by the health and social care economy, for example tackling health inequalities. Recent discussions had taken place within the Health and Wellbeing Board about measuring the impact of actions and holding the system to account for this. The recent planning guidance also expected CCGs to have joint targets with local authorities around smoking, alcohol and obesity, which would have an impact on health inequalities.

The Committee agreed that it would be useful to have sight of the risks register of the Local Authority and DGFT in order to identify if their risks mirrored those of the CCG.

2.0 COMBINED BOARD ASSURANCE FRAMEWORK (BAF) & RISK REGISTER

Those risks with an initial or residual score (after actions having been taken and controls implemented) of 16 or higher are presented to the Board in detail at Appendix 1. These risks are also summarised in the table below.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Initial Risk</th>
<th>Residual Risk</th>
<th>Accountable Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Failure of a main provider (Dudley Group NHS FT) due to financial pressures will result in inadequate care for the local population (note: this accounts for legacy risk brought forward from Cluster regarding failure to manage demand, creating financial pressures within the local health system).</td>
<td>20</td>
<td>20</td>
<td>Finance &amp; Performance</td>
</tr>
<tr>
<td>10. Failure of the health economy to work together to implement service changes which will adversely impact commissioning and delivery of health services.</td>
<td>16</td>
<td>12</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>14. Failure to engage with Public Health, Health and Well Being Board and the Local Authority will limit the effectiveness of health care commissioning.</td>
<td>16</td>
<td>6</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>16. Providers may be reluctant to develop and implement alternative approaches to service delivery</td>
<td>16</td>
<td>12</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>17. Tensions between innovation, quality and financial pressures could limit the innovation shown by the CCG</td>
<td>16</td>
<td>12</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>19. Failure to ensure meaningful public engagement will prevent effective commissioning and patient centred services</td>
<td>16</td>
<td>8</td>
<td>Communications &amp; Engagement</td>
</tr>
<tr>
<td>22. The delivery of efficiency savings could impact the drive for quality in health care</td>
<td>20</td>
<td>20</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>Risks 16 or higher as at 6th February 2015</td>
<td>Initial Risk</td>
<td>Residual Risk</td>
<td>Accountable Committee</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>---------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>26. Risks to women and neonates as a result of increased volume of patients which has led to inadequate staffing levels at certain times with particular issues around specialist medical staffing and capacity issues in triage area.</td>
<td>16</td>
<td>4</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>34. Being unsighted on significant performance issues identified by the Area Team in relation to primary medical services that could result in removal of GP member from the Performers' List.</td>
<td>16</td>
<td>6</td>
<td>Primary Care Development</td>
</tr>
<tr>
<td>36. Failure to achieve whole of Quality Premium resulting in lost income and reputational damage.</td>
<td>16</td>
<td>16</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>39. Lack of a systematic approach to ascertaining the quality of the care in our commissioned nursing homes, potentially resulting in harm to vulnerable adults.</td>
<td>16</td>
<td>12</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>41. Lack of capacity in the right place for patient access to phlebotomy services.</td>
<td>16</td>
<td>6</td>
<td>Clinical Development Committee</td>
</tr>
<tr>
<td>43. Failure to deliver significant QIPP targets in 14/15 and 15/16 puts the future financial stability of the CCG at risk.</td>
<td>25</td>
<td>20</td>
<td>Finance &amp; Performance</td>
</tr>
<tr>
<td>45. NHS England terminating primary medical service contracts of member practices leading to a gap in primary care service provision or pressure on other primary care providers.</td>
<td>16</td>
<td>9</td>
<td>Primary Care Development</td>
</tr>
<tr>
<td>48. Failure of Black Country Partnership FT due to financial pressures will result in inadequate care for the local population.</td>
<td>20</td>
<td>15</td>
<td>Finance &amp; Performance</td>
</tr>
<tr>
<td>58. The JAC electronic system is not operating efficiently which has resulted in an unspecified number of Discharge Letters not being received by GPs. This risk affects patients returning to primary care following changes in treatment medication. Detail to medication changes following review, in some cases, inaccurate.</td>
<td>20</td>
<td>20</td>
<td>Quality &amp; Safety</td>
</tr>
<tr>
<td>65. Risk that contracts with healthcare providers will not be signed by NHSE deadline with delay due to: 1. Tariff consultation process 2. Late issue of National Contract 3. Late issue of National CQUINS</td>
<td>20</td>
<td>8</td>
<td>Finance &amp; Performance</td>
</tr>
</tbody>
</table>

**NEW RISK**

### 3.0 RECENT AMENDMENTS TO THE BAF AND RISK REGISTER

The following amendments to risks 16 and over have been made since the Board received the BAF and Risk Register as at 5th December at its meeting on the 8th January:

**New Risks** – One new risk was approved for inclusion in the BAF & Risk Register by the Finance & Performance Committee:

- **Risk 65** – This risk was added due to concerns that the contracts with health care providers would not be signed by the national deadline due to provider challenges about the new tariff and late guidance in respect of the National Contract and CQUINS. This is a time-limited risk and the residual score has since been reduced by the Committee following NHSE proposal to providers about a choice between two revised tariffs, the Default Rollover Tariff or an Enhanced Tariff.

**Changes to Risks** – No changes to the scores or description of the risks listed have been made.
Closed Risks/Risks Proposed for Closure – Risk 21 relating to CSU support in respect of the quality agenda has been closed following approval at the last Board meeting.

4.0 RECOMMENDATIONS

- The Board is asked to receive the report for assurance

5.0 APPENDICES

Appendix 1 – Combined BAF & Risk Register as at 6th February 2015 (risks 16 and over)

M Hartland
Chief Operating and Finance Officer
March 2015
**CORPORATE OBJECTIVES**

1. Reducing health inequalities
2. Delivering best possible outcomes
3. Improving quality and safety
4. System effectiveness

**NOTE: TRENDS IN RESIDUAL RISK AGAINST PREVIOUS MONTH IS SHOWN**

<table>
<thead>
<tr>
<th>ID</th>
<th>Created Date</th>
<th>Updated Date</th>
<th>Licence</th>
<th>Component</th>
<th>Risk Description</th>
<th>Accountabilities</th>
<th>Sponsor / Owner</th>
<th>Management Lead</th>
<th>F</th>
<th>Initial Risk Score (%)</th>
<th>Action Plan</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>01/05/2013</td>
<td>01/05/2013</td>
<td>Dudley CCG Combined Board Assurance Framework and Corporate Risk Register 2014/15</td>
<td>5/6</td>
<td>Initial Risk Score (%)</td>
<td>Action Plan</td>
<td>Notes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Score</td>
<td>Risk Trend</td>
<td>Risk Description</td>
<td>Accountable Committee</td>
<td>Accountability Sponsor or Officer</td>
<td>Management Level</td>
<td>Internal Risk (PxI)</td>
<td>P</td>
<td>Risk Trend</td>
<td>Internal Assurance Plan</td>
<td>External Assurance Plan</td>
<td>Actions</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
<td>------------</td>
<td>-----------------</td>
<td>----------------------</td>
<td>-------------------------------</td>
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<td>-----</td>
<td>------------</td>
<td>-----------------------</td>
<td>------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>04/05/2014</td>
<td>14/06/2014</td>
<td>3</td>
<td>Failure of Black Country Partnership FT due to CCG to identify further clarification</td>
<td>Jas Rathore</td>
<td>20/01/2015</td>
<td>Ruth Edwards</td>
<td>Matrix devised for CCG and NHSE Interface</td>
<td>3</td>
<td>3</td>
<td>Group established: Work with CCG PCD on quality and safety and contractual performance</td>
<td>Reports to NHSE Area Team on quality and safety and contractual performance</td>
<td>Regular review of performance</td>
</tr>
<tr>
<td>ID</td>
<td>Original Date</td>
<td>Last Update</td>
<td>P</td>
<td>Key Controls</td>
<td>Gaps in Assurance</td>
<td>Risk Trend</td>
<td>Actions</td>
<td>Remarks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----</td>
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<td>--------</td>
<td>---------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>07/10/2014</td>
<td>29/01/2015</td>
<td>2</td>
<td>1. Discharge letters and paper copies of discharge details not being sent to all GPs to support treatment</td>
<td>Patients with inaccurate details relating to prescribing not yet identified. Provider to carry out retrospective &amp; prospective reviews</td>
<td>NEW</td>
<td>Escalated to trust risk register</td>
<td>Added delays in updating to the NHS spine. BOTH INITIAL &amp; RESIDUAL RISK INCREASED TO 20 FROM 16.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65</td>
<td>29/01/2015</td>
<td>29/01/2015</td>
<td>2</td>
<td>Risk that contracts with healthcare providers will not be signed by NHSE deadline due to:</td>
<td>Second year of two year contract in place and can proceed on the basis of this. Plans are in place to ensure the financial and contracting teams can respond rapidly to guidance and tariff when released.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**DUDLEY CLINICAL COMMISSIONING GROUP BOARD**

**Date of Report:** 12 March 2015  
**Report:** Finance and Performance Committee Report  
**Agenda item No:** 12.1

<table>
<thead>
<tr>
<th>TITLE OF REPORT:</th>
<th>Finance and Performance Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE OF REPORT:</td>
<td>To advise the Board of key issues discussed at the Finance and Performance Committee on 29 January 2015 and 26 February 2015.</td>
</tr>
<tr>
<td>AUTHOR OF REPORT:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
<tr>
<td>MANAGEMENT LEAD:</td>
<td>Mr M Hartland, Chief Operating and Finance Officer</td>
</tr>
<tr>
<td>CLINICAL LEAD:</td>
<td>Dr J Rathore, Clinical Executive for Finance and Performance</td>
</tr>
<tr>
<td>KEY POINTS:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• CCG expects to meet all its statutory financial duties by 31 March 2015.</td>
</tr>
<tr>
<td></td>
<td>• CCG expects to achieve its revised control total of £6,295,000 as agreed with the Area Team, which reflects the carry forward of the surplus achieved in 2013/14, and the additional continuing healthcare payback.</td>
</tr>
<tr>
<td></td>
<td>• CCG is achieving all its Area Team assurance indicators.</td>
</tr>
<tr>
<td></td>
<td>• Shortfall identified against the QIPP target in 2014/15 which will increase the value of the target in 2015/16.</td>
</tr>
<tr>
<td></td>
<td>• QIPP target for 2015/16 revised to £7.190m</td>
</tr>
<tr>
<td></td>
<td>• Performance exceptions noted and discussed</td>
</tr>
<tr>
<td></td>
<td>• Scorecard report presented and the position of practices against key indicators noted.</td>
</tr>
<tr>
<td></td>
<td>• Reports from IT Strategy Group and Estates Strategy Group received.</td>
</tr>
</tbody>
</table>

**RECOMMENDATION:** The Board is asked to approve the report.

**FINANCIAL IMPLICATIONS:** As described in the report.

**WHAT ENGAGEMENT HAS TAKEN PLACE:** None

**ACTION REQUIRED:** ✓ Decision  
✓ Approval  
✓ Assurance
1.0 INTRODUCTION
The report summarises the key issues discussed by the Finance and Performance Committee at its meetings on 29 January 2015 and 26 February 2015.

The following items are indicators of the current position in relation to the main responsibilities and obligations of the Committee as defined by the CCG Constitution and Terms of Reference. The finance indicators summarise the CCG’s key financial indicators and performance against its statutory financial duties to 31 January 2015 and 26 February 2015.

2.0 KEY INDICATOR SUMMARY
The table below identifies key financial indicators as at 31 January 2015.

---

**DUDLEY CLINICAL COMMISSIONING GROUP FINANCIAL PERFORMANCE DASHBOARD JANUARY 2015**

<table>
<thead>
<tr>
<th>Performance Item</th>
<th>Plan £000's</th>
<th>Year To Date £000's</th>
<th>Forecast Variance £000's</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statutory Financial Duties</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Achieve Revenue Resource Limit Control Total</td>
<td>(6,295)</td>
<td>(5,006)</td>
<td>(6,295)</td>
<td></td>
</tr>
<tr>
<td>Capital Resource Limit</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Running Costs</td>
<td>8,370</td>
<td>(567)</td>
<td>(723)</td>
<td></td>
</tr>
<tr>
<td>Cash Limit</td>
<td>0</td>
<td>237</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Better Payment Practice Code - NHS</td>
<td>95%</td>
<td>99.66%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>Better Payment Practice Code - Non NHS</td>
<td>95%</td>
<td>99.16%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td><strong>LAT Assurance Indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underlying Recurrent Surplus</td>
<td>(11,937)</td>
<td>(9,500)</td>
<td>(11,403)</td>
<td></td>
</tr>
<tr>
<td>Programme Surplus - Year to date performance</td>
<td>(4,436)</td>
<td>(4,439)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Running Cost Surplus - Year to date performance</td>
<td>(560)</td>
<td>(567)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme Surplus - Full year forecast</td>
<td>(6,295)</td>
<td></td>
<td>(5,572)</td>
<td></td>
</tr>
<tr>
<td>Running Cost Surplus - Full year forecast</td>
<td>0</td>
<td></td>
<td>(723)</td>
<td></td>
</tr>
<tr>
<td>Management of 2% Non Recurrent funds within agreed processes</td>
<td>Yes</td>
<td>YES</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>QIPP - Year to date delivery</td>
<td>(4,774)</td>
<td>(4,774)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>QIPP - Full year forecast</td>
<td>(7,166)</td>
<td></td>
<td>(7,166)</td>
<td></td>
</tr>
<tr>
<td>Activity trends - Year to date (IP/ OP / A&amp;E)</td>
<td>474</td>
<td>472</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activity trends - Full year forecast (IP/ OP/ A&amp;E)</td>
<td>569</td>
<td>567</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear identification of risks against financial delivery and mitigations</td>
<td>Met in full</td>
<td>Met</td>
<td>Met</td>
<td></td>
</tr>
<tr>
<td>Internal &amp; External Audit Opinions and an assessment of the timeliness and quality of returns</td>
<td>There were no exceptions to report this month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance Sheet indicators including cash management and BPCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Local Indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue Resource Limit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Care</td>
<td>170,904</td>
<td>3,747</td>
<td>4,195</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>80,595</td>
<td>3,599</td>
<td>4,267</td>
<td></td>
</tr>
<tr>
<td>Preventative Care</td>
<td>38,270</td>
<td>425</td>
<td>(11)</td>
<td></td>
</tr>
<tr>
<td>Reablement</td>
<td>22,140</td>
<td>567</td>
<td>573</td>
<td></td>
</tr>
<tr>
<td>Corporate</td>
<td>8,370</td>
<td>(567)</td>
<td>(723)</td>
<td></td>
</tr>
<tr>
<td>Non Recurrent</td>
<td>7,439</td>
<td>(1,148)</td>
<td>(1,527)</td>
<td></td>
</tr>
<tr>
<td>Reserves including Surplus</td>
<td>12,663</td>
<td>(8,552)</td>
<td>(10,692)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>46,168</td>
<td>(3,077)</td>
<td>(2,379)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>386,549</td>
<td>(5,006)</td>
<td>(6,295)</td>
<td></td>
</tr>
</tbody>
</table>

---
3.0 EXCEPTION REPORTING

3.1 Statutory Financial Duties
The CCG is on target to achieve all statutory duties by 31 March 2015 and is expected to achieve its control total of £6,295,000 at the year-end as agreed with the Area Team.

The CCG achieved its financial performance target of ensuring the month end cash balance was within 1.25% of the cash drawn down from NHS England (NHSE).

3.2 Area Team Assurance Indicators
The CCG is currently achieving all its Area Team Assurance indicators.

3.3 Local Indicators
Urgent care and planned care were reported as red mainly due to over-performance in emergency activity and the purchase of additional walk in centre activity. Planned care was due to the forecast overspend on prescribing.

Kingswinford, Amblecote and Lye Locality has reported a forecast over-performance of 7.1% and therefore rated red. The main reason for the over-performance was an increase in urgent care costs. Sedgley, Coseley and Gornal Locality has reported a forecast over-performance of 1.3% and rated amber.

4.0 ITEMS DISCUSSED – FINANCE

4.1 Revenue Resource Limit
At the end of January 2015 the CCG’s commissioning budget was £386,549,481.

4.2 Capital Resource Limit
The CCG has submitted a nil return for capital plans and therefore is not planning to receive a capital allocation for 2014/15.

4.3 Running Costs
The CCG is reporting a year to date underspend against budget of £567,000 with a year-end forecast of £723,000. This is mainly due to NHSE’s treatment of quality premium funding which is categorised as administration resource.
4.4 **Cash Limit**
The CCG is required to meet two targets in relation to cash management - to remain within the allocated cash limit and to ensure that monthly cash balances are within 1.25% of the cash requested from NHSE. The CCG achieved its cash target at February.

4.5 **Better Payment Practice Code**
Compliance with the prompt payment code requires the CCG to pay all NHS and non-NHS trade payables within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed. The CCG has a target of 95% for these transactions, which are both being achieved as described below:

4.5.1 **Better Payment Practice Code – NHS**
At the end of January 2015 the CCG’s cumulative performance was 99.66%.

4.5.2 **Better Payment Practice Code – non-NHS**
At the end of January 2015 the CCG’s cumulative performance was 99.16%.

4.6 **QIPP 2014/15**
The QIPP target for 2014/15 is £7.166m. A shortfall of £1.98m has been identified against schemes in the plan, which is being covered non-recurrently by releasing funding from the QIPP reserve. This is not a sustainable position for the CCG and it is imperative that QIPP savings are achieved in full in future in line with the original plan. The QIPP position for next year is described in section 5.0 of this report.

4.7 **Statement of Financial Position**
The Committee noted the statement of the financial position of the CCG at the end of January 2015. No areas of concern were reported.

4.8 **Workforce**
An establishment register has been constructed with employees and contracted staff reported against the funded established posts. Workforce issues pertinent to provider organisations are managed by the Quality and Safety Committee.

4.9 **Localities**
Kingswinford, Amblecote and Lye Locality has reported a forecast over-performance of 7.1% and therefore rated red. The main reason for the over-performance was an increase in urgent care costs. Sedgley, Coseley and Gornal Locality has reported a forecast over-performance of 1.3% and rated amber.

4.10 **Risks**
The main risks facing the CCG financial position relate to further slippage in the QIPP programme; cost pressure relating to NHS 111; increased prescribing costs and over-performance on acute service level agreements. As the year is almost concluded these risks reduce. None of the risks are expected to have a material impact on the CCG meeting its financial duties should they arise.

4.11 **Non-Recurrent Spend/Balance of Reserves**
Uncommitted funds are held in a contingency reserve should there be further slippage against QIPP plans or deterioration in acute over-performance over the remaining months of the financial year. This is not expected to be material and will not have an impact on the reported position.

5.0 **QIPP REPORT 2014/15 – 2015/16**
The 2014/15 position is reported under item 4.6.

The 2015/16 QIPP target has been revised to £7.190m and an outline plan has been developed for next year which includes a number of contingency schemes outside the main QIPP programme. Project Initiation Documents will be established by commissioning leads and signed off by clinical and financial leads during March 2015.
6.0 NEW FINANCIAL FRAMEWORK 2015/16
The Committee approved a new framework for financial management from 2015/16 onwards. It would delegate further responsibility and accountability to commissioners and budget holders in the organisation. The intention is that commissioners and budget holders will be empowered to take full responsibility and accountability for their areas of work. This is on the basis that 2015/16 will be significantly more challenging financially than originally anticipated in the five year financial plan due to two main issues; non-delivery of QIPP savings in the current financial year and the transfer of funds to Dudley MBC for the Better Care Fund in 2015/16. It will be necessary to align clinical leads with management and finance leads around each budgetary portfolio. An organisational development programme will be implemented to support the process.

7.0 FINANCIAL PLAN 2015/16
The Committee received a report based on the 2015/16 Financial Plan submitted to NHS E in accordance with the national timetable and key planning assumptions around growth and inflation. Initial feedback from the Area Team on the quality of the plans was extremely complimentary. The final plan submission is required by 10 April following approval of the budget book by the Board.

The draft Financial Plan is presented to the Board in a separate paper.

8.0 CALL ON FINANCIAL RISK SHARE POOL
In October 2014 the Committee approved a call upon the risks share pool as requested by Wolverhampton CCG. This was based on the value being repaid in full in 2015/16. We have since received a request from NHS England/Wolverhampton CCG to review the payback of the pool equally over the next two years. The impact on the 2015/16 financial plan has been assessed and whilst affordable it emphasises the need for stricter financial controls next year. The proposal also protects funding for the CCG into 2016/17. The Committee approved the deferral of 50% of the funding subject to written confirmation from Wolverhampton CCG that the payback is guaranteed in the next two years, which has been received.

9.0 PRESCRIBING AND MEDICINES MANAGEMENT REPORT
The Committee received a report on the increase in the forecast outturn between September and October and the overspend position in the Kingswinford, Amblecote and Brierley Hill locality. The significant overspend was noted as a rise in ‘Category M’ prices, which is a basket of generic medicines that act as a regulator for retained profit for community pharmacists.

The Committee expressed concern at the escalating cost of both primary and secondary care prescribing and the Medicines Management Team have been asked to develop a robust plan to ensure the prescribing budget is balanced and the medicines management element of the QIPP target is achieved next year.

10.0 COMBINED BOARD ASSURANCE FRAMEWORK AND RISK REGISTER
The risks assigned to the Committee were reviewed and accepted. The Committee added an additional risk regarding the overspend on prescribing expenditure.

In the context of a discussion around the long term financial viability of the health economy, the Committee discussed potential risks associated with the workforce reduction at DGFT and suggested that this be added to the Quality and Safety Committee risk register.

11.0 7 PRINCIPAL PERFORMANCE INDICATORS
The Committee considered a report regarding performance on the 7 Principal Performance Indicators - A&E 4 hour waits; Non-Elective Admissions; Referral to Treatment times (RTT); Winterbourne View; Improving Access to Psychological Therapies; Dementia and Cancer waits. All are detailed in the next section of this report.

12.0 KEY INDICATOR SUMMARY – PERFORMANCE
The table below identifies key performance indicators as at December 2014, (January 2015 where available) the last period for which validated data has been received.
### The Dudley Group NHS Foundation Trust

#### National Quality Requirements

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Target/Performance</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>YTD</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA Acute</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clostridium difficile Acute</td>
<td>&lt;=48 Annum</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td></td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>RTT waits over 52 weeks</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Ambulance Handover between 30mins &amp; 60mins</td>
<td>0</td>
<td>277</td>
<td>337</td>
<td>306</td>
<td>207</td>
<td>196</td>
<td>306</td>
<td>294</td>
<td>288</td>
<td>335</td>
<td>322</td>
<td>2868</td>
<td></td>
</tr>
<tr>
<td>Ambulance Handover &gt; 60mins</td>
<td>0</td>
<td>29</td>
<td>28</td>
<td>24</td>
<td>9</td>
<td>7</td>
<td>13</td>
<td>35</td>
<td>9</td>
<td>22</td>
<td>20</td>
<td>196</td>
<td></td>
</tr>
<tr>
<td>Trolley Waits in A&amp;E over 12 hours</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Cancellations of Operations (Urgent)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Publication of Formulary</td>
<td>Yes/No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Duty of Candour</td>
<td>Yes/No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>18 Weeks RTT (Admitted)</td>
<td>90%</td>
<td>90.15%</td>
<td>90.04%</td>
<td>90.06%</td>
<td>90.03%</td>
<td>90.31%</td>
<td>91.73%</td>
<td>92.08%</td>
<td>90.90%</td>
<td>93.53%</td>
<td>90.98%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Weeks RTT (Non Admitted)</td>
<td>95%</td>
<td>99.22%</td>
<td>99.17%</td>
<td>99.21%</td>
<td>99.19%</td>
<td>98.97%</td>
<td>99.10%</td>
<td>98.88%</td>
<td>98.66%</td>
<td>98.62%</td>
<td>99.01%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Weeks RTT (Incomplete)</td>
<td>92%</td>
<td>93.60%</td>
<td>95.40%</td>
<td>95.20%</td>
<td>96.00%</td>
<td>95.93%</td>
<td>95.61%</td>
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<td>91.6%</td>
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<td>95.80%</td>
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<td>Cancer 2 Week Waits</td>
<td>93%</td>
<td>97.7%</td>
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<td>96.27%</td>
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<td>Breast Symptoms 2 Week Waits</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>87.7%</td>
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<td>91.67%</td>
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<td>62 day - RTT (Upgraded Priority)</td>
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<td>100%</td>
<td>99%</td>
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<td>Cancellations of Operations</td>
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#### Operational Standards

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<th>2014</th>
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<td>1.00</td>
<td>1.13</td>
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<td></td>
<td>1.11</td>
<td>1.08</td>
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<td>1.07</td>
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#### Dudley & Walsall Mental Health

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<th>May</th>
<th>Jun</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
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<tr>
<td>Improved Access to Psychological Therapies</td>
<td>Trust T05E (182 mth)</td>
<td>1003</td>
<td>925</td>
<td>1055</td>
<td>847</td>
<td>797</td>
<td>1094</td>
<td>1057</td>
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<td>938</td>
<td>8836</td>
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<tr>
<td>IAPT - 2 Sessions completed Dudley</td>
<td>50.5%</td>
<td>50.8%</td>
<td>50.8%</td>
<td>50.8%</td>
<td>53.6%</td>
<td>43.3%</td>
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<td>52.5%</td>
<td>56.3%</td>
<td>60.3%</td>
<td>49.7%</td>
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<tr>
<td>IAPT - 2 Sessions completed Walsall</td>
<td>50.5%</td>
<td>62.8%</td>
<td>59.2%</td>
<td>61.0%</td>
<td>53.3%</td>
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#### West Midlands Ambulance Service

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<th>May</th>
<th>Jun</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
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<th>Feb</th>
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<td>92.3%</td>
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<td>72.5%</td>
<td>72.3%</td>
<td>77.8%</td>
<td>81.5%</td>
<td>81.4%</td>
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<tr>
<td>Category A Red 2 Response</td>
<td>75%</td>
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<td>76.6%</td>
<td>76.3%</td>
<td>76.9%</td>
<td>77.4%</td>
<td>71.6%</td>
<td>71.2%</td>
<td>67.5%</td>
<td>72.9%</td>
<td>74.5%</td>
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<td>Category A 19 Minute Response</td>
<td>95%</td>
<td>99.3%</td>
<td>99.5%</td>
<td>99.5%</td>
<td>99.3%</td>
<td>99.2%</td>
<td>99.1%</td>
<td>99.0%</td>
<td>98.9%</td>
<td>98.0%</td>
<td>99.0%</td>
<td></td>
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<tr>
<td>Ambulance Crew Readiness (30-60mins)</td>
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<td>11</td>
<td>10</td>
<td>11</td>
<td>13</td>
<td>7</td>
<td>7</td>
<td>8</td>
<td>6</td>
<td>16</td>
<td>8</td>
<td>97</td>
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<tr>
<td>Ambulance Crew Readiness (over 60mins)</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
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</table>
13.0 EXCEPTION REPORTING

13.1 National Quality Requirements - Dudley Group NHS Foundation Trust

- Ambulance Handovers >30 minutes
- Ambulance Handovers >60 minutes
- RTT waits over 52 Weeks

13.2 Ambulance Handover
The breaches at +30 minutes and +60 minutes have continued at the previous levels. A&E turnaround measures are likely to have a positive impact on this performance. The Trust has been fined based on previously agreed methodology.

13.3 RTT Waits over 52 Weeks
There is one remaining patient at the time of reporting who has waited longer than 52 weeks. This patient has a treatment date booked. All patients who wait longer than 40 weeks are reported to the CCG who then monitor progress on these patients weekly until treatment dates are confirmed.

13.4 National Operational Standards
DGFT is failing one National Operational Standard relating to Diagnostics.

13.5 Diagnostics
The 6 week Diagnostic target was not achieved in December with the following tests failing to achieve:

- CT Scans
- Sigmoidoscopy
- Colonoscopy
- Gastroscopy

Rectification plans have been received from DGFT that indicate improvements in performance over the next quarter, but capacity to deliver on a sustained basis remains a concern.

13.6 Other Key Measures

13.6.1 18 Weeks Referral to Treatment (RTT) Performance (DGFT)
As previously reported to the Board, DGFT are achieving the aggregate RTT targets year to date, but at specialty level are failing the 90% target in Ophthalmology, Trauma and Orthopaedics and Urology for admitted patients. Trauma and Orthopaedics continue to improve but Ophthalmology and Urology performance has not met the expected recovery trajectory. All but Urology are expected to meet the standard in March 2015.
13.6.2 Winterbourne View
The CCG continues to monitor Tier 1 CCG funded placements ensuring patients within a hospital setting with a learning disability who no longer require this level of care are transferred to care within a community setting. There are no areas of concern to date.

13.6.3 Improving Access to Psychological Therapies (IAPT) (Dudley and Walsall Mental Health Trust)
Dudley and Walsall Mental Health Partnership are achieving the service targets for this indicator. However the Black Country Partnership Trust and Big White Wall IAPT providers do not currently submit IAPT information to UNIFY. Dudley CCG is exploring how such data can be recorded on UNIFY. The CCG’s also procuring additional capacity in order to meet the target set by NHS England, which is expected to be achieved.

13.6.4 Dementia
NHSE figures show that Dudley CCG has increased the dementia diagnosis against estimated prevalence rate from 50% to 53%. The year-end target is 67%, which will be a challenging target. Targeted support for practices is underway to understand and correct coding variances and the commissioner is undertaking additional actions to improve performance. Achievement of the target by year end is a risk.

13.6.5 Other indicators
Mortality Indicator (DGFT) - the (SHMI) shows DGFT within normal variance of the number of expected deaths. Mortality as an issue is discussed in detail at the Quality and Safety Committee.

13.6.6 Quality Premium Indicators (CCG Focused Indicators)
For 2014/15 the likely achievement will be 55% to 60%. However, due to WMAS potentially not meeting the Category Red 1 Ambulance response standard a reduction may be applied. The full year’s data will need to be assessed before these achievements can be confirmed.

14.0 SCORECARD REPORT
The CCG Scorecard Report was received by the Committee.

14.1 Community Indicators
Almost all of the aggregated practice scores for localities demonstrated performance at the Platinum or Gold levels. However, it is worth noting that many of the percentage achievements at practice level were derived from very low levels of activity. This is less of an issue with the aggregated locality view, but is important when comparing individual practices.

14.2 Secondary Care Indicators
Emergency admissions are the one indicator which demonstrated a Red category performance.

14.3 Primary Care Indicators
All localities performed between the Silver and Platinum standard for primary care indicators.

14.4 Finance Indicators
There is a forecast over performance of 2.5%. This is predominantly due to urgent care over-performance.

Balanced scorecard performance exceptions are reported at the Finance and Performance Committee and addressed in the Practice Performance reviews. The scorecard is being reviewed and a revised version is to be submitted to Committee and localities in due course.

15.0 REPORTS FROM GROUPS ACCOUNTABLE TO THE COMMITTEE

15.1 IT Strategy Group
The Committee received a report on the issues discussed by the IT Strategy Group and noted good progress on implementing projects within the strategy. Orders have been placed for the GP mobile solution and practices replacement servers, and the Urgent Care Centre system contract with EMIS
has been signed. The Group is reviewing priorities for 2015/16 with the aim of a refreshed implementation plan for next year to be presented to the Committee.

15.2 Estates Strategy/Operational Group
The development of the Health Infrastructure Strategy is progressing well, with the scope extended to include provider organisations where appropriate. This will have a slight impact on the publication date, but it is felt important to ensure the strategy reflects a delivery mechanism for the integration model of care. The strategy is expected to be presented to the Board in May.

15.3 Re-procurement of Commissioning Support Services
The Committee received for information a report on progress being made by the Project Board on behalf of the Birmingham, Solihull and Black Country CCGs to co-ordinate the procurement of commissioning support services.

16.0 DECISIONS TAKEN UNDER DELEGATED POWERS
None

17.0 RECOMMENDATION
The Board is asked to approve the report.

Matthew Hartland
Chief Operating and Finance Officer
March 2015
TITLE OF REPORT: Report from Primary Care Development Committee

PURPOSE OF REPORT: To advise the Board on key issues discussed at the Primary Care Development Committee on 16th January 2015 and 20th February 2015

AUTHOR OF REPORT: Mr D King, Head of Membership

MANAGEMENT LEAD: Mr D King, Head of Membership

CLINICAL LEAD: Dr J Rathore, Clinical Executive for Finance and Performance

KEY POINTS:

**Productive General Practice**
- The Committee received the full evaluation on the ‘productive general practice’ pilots that have taken place in 6 member practices in Dudley.
- The evaluation demonstrated a positive and significant impact was achieved in the practice that received project support and backfill.
- The Committee recommended the roll out of a project support package and backfill for a further cohort of 6 practices.
- The Finance and Performance Committee has subsequently approved the Midlands & Lancashire Commissioning Support Unit (CSU) being commissioned to provide this package commencing in 2015-16.

**Training and Development**
- The Committee agreed to the pharmaceutical team undertaking prescription management training for reception staff as part their work plans in 2015/16 following successful evaluation of training in 2014/15.
- The Committee noted that Blue Stream Academy CQC online training had delivered nearly 5000 modules completed by member practices.
- A training fair is being organised for May 2015 for GPs coming off the Vocational Training Scheme.

**Personal Medical Services (PMS Review)**
- All PMS practices received supportive visits by the CCG in December to understand the impact of the PMS review and premium reduction.
- All PMS practices have agreed to return to GMS from 1st April 2015.
- The PMS review results in the CCG having £1.8M returned from PMS contacts to re-invest into Primary Care over 7 years with effect from 1st April 2015.
- Dr Tim Horsburgh is leading the work to determine how the PMS premium is re invested.
- There is no risk to the delivery of primary care services in year 1 but further work is being undertaken to qualify the risks in year 2
Feedback to NHS England on the Pharmacy Flu Immunisation Pilot
- The Committee received the outcome from the NHS England commissioned pilot.
- NHS England will be re-commissioning flu immunisation from pharmacies again in 2015-16
- The Committee noted that the pilot had resulted in an increase of 0.3% to the immunisation rate to all patients.
- The Committee noted and will be feeding back concerns about the need to ensure effective planning and implementation of the scheme in 2015-16 based on learning from 2014/15.

Pharmacy First
- The Committee received the evaluation from NHS England and agreed to consult members via locality meetings on extending the scheme to all member practices

Extended Hours Enhanced Service
- The Committee noted that the 1650 additional appointments had been delivered by the 7 practices participating in the extended hour’s enhanced service commissioned by the CCG over the winter.

Performance Issues
- The Committee were apprised of performance issues discussed with NHS England in the Interface Group. There are no contractual breaches with any Dudley member practice from NHS England.

Audit of GP referral letters for emergency assessment on EAU
- The Committee received the audit and supported the development of an EMIS referral template for GP referrals in 2015/16.

Risks
- The Committee reviewed and updated its risks as reported in the risk register.
- Updating risk 51 to reflect the risks of Co Commissioning implementation

RECOMMENDATIONS: The Board is asked to note, for assurance, the issues discussed at the Primary Care Development Committee.

FINANCIAL IMPLICATIONS: None

WHAT ENGAGEMENT HAS TAKEN PLACE: None

ACTION REQUIRED:
- ✔ Assurance
- ✔ Approval
- ✔ Decision
1.0 INTRODUCTION
This report summarises the key issues discussed at the Primary Care Development Committee on 16th January 2015 and 20th February 2015.

2.0 ITEMS DISCUSSED

2.1 Productive General Practice – Full Evaluation
The Committee received the final evaluation of the productive general practice pilot programme.

The pilot demonstrated that the greatest benefits were achieved where the CCG had provided and funded project support and backfill. In these circumstances the following was evidenced:

- improved practice efficiency – saving GP time and reducing staff stress
- improved knowledge and skills for clinical and non-clinical staff
- improved leadership and change management skills
- improved communication, relationships and staff morale
- creating and embedding the skills within primary care to lead and manage change

The Committee approved the submission of a best practice case study to NHS England Midlands and East Primary Care transformation work programme.

The Committee supported the roll out of the Productive General Practice support package and backfill to a further cohort of 6 practices. The Committee referred the decision on procurement of the service and provider to the Finance and Performance Committee.

2.2 Training and Development

- **Repeat Prescribing Management Training for Reception Staff**
The Office of Public Health Pharmaceutical Team agreed to deliver a training session focusing on repeat prescribing and prescription management best practice within Dudley. This session delivered to 15 reception staff from GP practices who are currently working on the Productive General Practice Development Programme.

Following positive evaluation the Committee agreed that build Repeat Prescribing Management into the work programme for the Office of Public Health Pharmaceutical Team for 2015/16 and offer the same training to reception staff at all practices during 2015/16.

- **Blue Stream Academy Online Training**
The Committee received an update on the interactive training modules commissioned on behalf of member practices that provide proof of competency for clinical and non-clinical staff for Care Quality Commission (CQC) requirements. As of 31st January 2015 member practices have completed 4,970 modules of online training. The membership team are working with all practices to encourage uptake.

- **Careers Fair for Vocational Training GPs**
The membership team is organising a training fair for doctors leaving the Vocational Training Scheme in Dudley. The event will be held in May and all practices will be invited.

2.3 Personal Medical Services (PMS) Review
The Committee received an update on the PMS review process. The CCG agreed a joint approach to PMS with NHS England for the PMS review. The CCG

- Held a joint event with NHS England in December to which all PMS practices were invited.
- Produced additional information over and above that provided by NHS England setting out the financial impact for each practice of returning to GMS. The summary included aspects of
income that practices could claim for under a GMS contract that formed part of the PMS baseline.

- Visited and discussed the PMS review with all PMS practices in Dudley throughout December.

The impact of a PMS review is effectively a reduction of £1.8M for Dudley PMS practices tapered over 7 years which is equivalent to £257k per year. The variation of the PMS premium over and above GMS ranges from £1.67 to £53.77 per patient.

All PMS practices in Dudley have decided to return to GMS. The Committee were aware of the need to ensure stability and sustainability of all local practices and re investment of the £1.8M across all GMS practices will need to take this into account. The Committee agreed that plans would be developed in consultation with member practices commencing from 1st April 2015. This process is being led by Dr Tim Horsburgh.

The transitional funding arrangements agreed by NHS England during the PMS reviews however undermines the CCG's premises strategy and may require additional premises investment funding to be set aside in the 2015/16 financial plan and on-going. This will be subject to agreement of the overall CCG financial plan.

2.4 Feedback to NHS England on the Pharmacy Flu Immunisation Pilot

This pilot was commissioned by Birmingham, Solihull and Black Country Area Team of NHS England with the aim of increasing rates where national targets and in particular in at risk adults. The pilot was intended to complement and not replace Primary Care. The pilot was commissioned because the Area Team was not meeting flu vaccination targets especially in those adults at increased risk of influenza, and there was positive feedback from other areas where such programmes have already developed similar pilots. NHS England has sought feedback from CCGs on the continuation of the programme for 2015/16.

The outcome from the pilot for Dudley showed no statistically significant result – in that the vaccination rate had increased by 0.3%.

The outcome from the pilot across the Area Team showed that from 376 accredited pharmacies, there were 315 active pharmacies. 8744 vaccines given, broken down by eligible groups

- Under 65s at risk – 3536 (40.4%)
- 65s and over – 4928 (56.4%)
- Main carer – 280 (3.2%)

Previous flu vaccination
- No – 666 (7.6%)
- Yes – 8078 (92.4%)

The Committee supported the continued commissioning of the service, but would be formally feeding back concerns about the need for appropriate and timely consultation and planning with NHS England to realise the benefits of the pilot.

2.5 Pharmacy First

The Committee received an update in that NHS England is recommending the continued commissioning of the scheme between 1st April 2015 and 31st March 2017, subject to a “mid-point” review in January 2016.

Currently Dudley is the only CCG that offer the scheme in areas of deprivation rather than universally across all practices. The outcome for Dudley during 2014/15 is that

- 504 Community Pharmacy MAS consultations undertaken for Dudley
- 405 (80%) would have booked a GP appointment if scheme had not been available
- 65 (13%) would have accessed a walk-in centre if scheme had not been available
- 34 (7%) would have either purchased the medicines or gone without

therefore, between 398 (79%-applying Area Team findings) and 405 (80%-applying Dudley-specific findings) of all Community Pharmacy MAS consultations shown to shift workload from local General Practices to Community Pharmacy
• Between 4.5% (Area Team findings) and 13% (Dudley findings) of all Community Pharmacy MAS consultations shown to shift workload from Urgent Care to Community Pharmacy

The Committee asked that the members were consulted for their view on supporting a universal roll out of the scheme. The Committee noted that the costs in 2014/15 for the 31 practices providing the service were minimal at £700.

2.6 Extended Hours Enhanced Service
The Committee noted that the 1650 additional appointments had been delivered by the 7 practices participating in the extended hour’s enhanced service commissioned by the CCG over the winter.

The Committee noted that this scheme was funded non-recurrently as a winter initiative and therefore would not be continued beyond 31st March. As part of the evaluation it was agreed that the impact on A&E attendances during the extended hours would evaluated.

2.7 Performance Issues
The Committee received an update from the Interface Group. There are no contractual breach notices from NHS England against any member practices. There were two practices that were discussed and actions agreed for support.
• Practice 1: a meeting was held with all doctors in the practice, Healthwatch and the CCG with a positive outcome where learning was shared and action plan agreed to the satisfaction of Healthwatch and the CCG.
• Practice 2: is subject to a co-ordinated approach between NHS England and the CCG to facilitate a partnership dispute and support succession planning within the practice. This is being supported by the CCG Chief Executive Officer and the GP Engagement Lead.

2.8 Audit of GP referral letters for emergency assessment on EAU
The Committee received the summary of small audit of GP referral letters for emergency assessment on EAU. The audit has been presented to the Clinical Quality and Review Meeting (CQRM). The Committee concluded that an electronic referral template provided to all practices via EMIS should be developed and would feed this back to both the CQRM and the IT Strategy Group.

2.9 Risk Register
The Committee reviewed and updated its risks as reported in the risk register. The Committee updated risk 51 to reflect the risks of Co Commissioning implementation as follows:

The need to ensure that the functions transferring to from NHS England to the CCG as a result of delegated commissioning are planned and managed safely - including an agreed memorandum of understanding signed and agreed between the CCG and NHS England.

The Committee agreed to removing risk 56 relating to Minimum Income Practice Guarantee (MPIG) adjustments applied to practices by NHS England as NHS England no longer considered this to be a risk.

3.0 DECISIONS TAKEN BY THE COMMITTEE UNDER DELEGATED POWERS FROM BOARD
None

4.0 DECISIONS REFERRED TO BOARD
None

5.0 RECOMMENDATION
The Board is asked to note the issues discussed at the Primary Care Development Committee on 16th January 2015 and 20th February 2015.

Dr J Rathore
Clinical Executive, Finance and Performance
March 2015