Herefordshire Council

AGENDA

Health Scrutiny Committee

Date: **Monday 1 March 2010**

Time: **10.00 am**

Place: **The Council Chamber, Brockington, 35 Hafod Road, Hereford**

Notes: Please note the **time, date** and **venue** of the meeting.

For any further information please contact:

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Agenda for the Meeting of the Health Scrutiny Committee

Membership

Chairman	**Councillor PM Morgan**
Vice-Chairman	**Councillor AT Oliver**
	Councillor WU Attfield
	Councillor PGH Cutter
	Councillor MJ Fishley
	Councillor RC Hunt
	Councillor P Jones CBE
	Councillor G Lucas
	Councillor GA Powell
	Councillor A Seldon
	Councillor AP Taylor

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AGENDA

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The purpose of the Committees is to ensure the accountability and transparency of the Council's decision making process.

The principal roles of Scrutiny Committees are to

- Help in developing Council policy
- Probe, investigate, test the options and ask the difficult questions before and after decisions are taken
- Look in more detail at areas of concern which may have been raised by the Cabinet itself, by other Councillors or by members of the public
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- Conduct Best Value reviews
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Statutory functions for adult social services including:
Learning Disabilities
Strategic Housing
Supporting People
Public Health

Children's Services

Provision of services relating to the well-being of children including education, health and social care.

Community Services Scrutiny Committee

Libraries
Cultural Services including heritage and tourism
Leisure Services
Parks and Countryside
Community Safety
Economic Development
Youth Services

Health

Planning, provision and operation of health services affecting the area
Health Improvement
Services provided by the NHS

Environment

Environmental Issues
Highways and Transportation

Overview and Scrutiny Committee
Corporate Strategy and Finance
Resources
Corporate and Customer Services
Human Resources

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HEREFORDSHIRE COUNCIL

BROCKINGTON, 35 HAFOD ROAD, HEREFORD.

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HEREFORDSHIRE COUNCIL

MINUTES of the meeting of Health Scrutiny Committee held at The Council Chamber, Brockington, 35 Hafod Road, Hereford on Monday 30 November 2009 at 10.00 am

Present: **Councillor PM Morgan (Chairman)**
Councillor AT Oliver (Vice Chairman)

Councillors: WU Attfield, MJ Fishley, DW Greenow, RC Hunt, Brig P Jones CBE, G Lucas, A Seldon and AP Taylor

In attendance: Councillors PA Andrews, WLS Bowen and PJ Edwards

9. APOLOGIES FOR ABSENCE

Apologies were received from Councillors PGH Cutter and GA Powell.

10. NAMED SUBSTITUTES

Councillor D W Greenow substituted for Councillor PGH Cutter.

11. DECLARATIONS OF INTEREST

There were none.

12. MINUTES

RESOLVED: That the Minutes of the meeting held on 25 September 2009 be confirmed as a correct record and signed by the Chairman.

13. SUGGESTIONS FROM MEMBERS OF THE PUBLIC ON ISSUES FOR FUTURE SCRUTINY

There were no suggestions from members of the public.

14. EFFICIENCY REVIEW OF WEST MIDLANDS AMBULANCE SERVICE NHS TRUST

The Committee considered the outcome of the efficiency review of the West Midlands Ambulance Service NHS Trust (WMAS).

The report noted that the Regional Specialised Commissioning Team, responsible for commissioning the ambulance service on behalf of the 17 Primary Care Trusts (PCTs) in the West Midlands Strategic Health Authority area, had commissioned an independent review looking at the operational and financial effectiveness of the ambulance service across the region.

The findings of the efficiency review undertaken by Lightfoot Solutions (the Lightfoot Review) had been published on 30 September 2009. A summary and analysis by NHS Herefordshire was appended to the report. The Lightfoot Review had been circulated separately to Members of the Committee.

Representatives of WMAS attended the meeting to present the findings of the Lightfoot Review.

The presentation provided some background statistical information on the service and some of its recent achievements, including being Ambulance Service of the Year 2007, 2008 and 2009.

It was reported that the main issues to be addressed by the Independent Review had included demand, performance, the implications of the urban/rural mix of services, ambulance resources, the Paramedic skill mix, the status of urgent care provision and the cost of the service.

Demand on WMAS was consistently above both the contract level and previous year April '08 to March '09: +3.5% above previous year and 1.9% above contract, April - October '09: +7.2% above previous year and 4.5% above contract. There were not enough ambulances across the region

In terms of performance, despite achieving national targets for the last three years WMAS performance was not sustainable due to high demand and was not consistent across the region.

Performance varied between urban and rural areas. In Herefordshire performance against the national target of responding to Category A calls within 8 minutes of 75% was 72% and the Lightfoot review recommended a target of 68%. This compared with performance across the Region as a whole of 75% with the Lightfoot Review recommending a target of 80%. It was stated that WMAS was still seeking to hit the 75% target in Herefordshire and had not adopted the Lightfoot recommendation of a target of 68%.

The fact that demand was above the level provided for in WMAS contract with the commissioning bodies meant there were not enough front line ambulance staff and WMAS was unable to complete mandatory training updates.

The Paramedic skill mix of 52% meant WMAS could not put a paramedic on every ambulance. This meant too many patients were taken to hospital and there was insufficient use of alternative care pathways

Urgent care provision varied across the region. Emergency ambulance demand increased when patients could not access urgent care

WMAS costs were amongst the lowest in England. Rural costs would always be higher than urban costs but there was a wide variation in payments made by PCTs with some paying proportionately more than others.

The main recommendations of the review were summarised. Immediate action taken in response to the review included the establishment of PCT/WMAS Task & Finish Groups to implement recommendations; investment by PCTs of c£11m to recover performance by deploying additional ambulances; a Regional Clinical Support Desk in Emergency Operations Centres to manage non-life threatening category C calls; increased use of alternative pathways; a healthcare Referral Tier for Urgent Referrals introduced; 25 additional ambulances and 100 staff trained

By March 2013 it was planned to increase the number of paramedics by 300, improving the paramedic skill mix to 69% from 52%. This would be achieved by a major increase in training and development of the existing workforce, direct entry from university and direct recruitment of qualified people.

Ongoing action included agreeing commissioning PCT intentions and the WMAS response, agreeing ongoing funding arrangements; the proposed replacement of the

"block" contract with tariffs; agreeing a response model and performance management arrangements.

In discussion the following principal points were made:

- It was noted that a move from a block contract to a tariff based system would be the first such arrangement in the Country and would require the agreement of all 17 PCTs in the region. The ambulance service had been seeking such a change for a number of years. It believed that a tariff system encouraged efficiency as well as a good quality service.

- A question was asked seeking clarification of the costs of the proposed increase in the number of paramedics. Assurance was sought that the plan would deliver value for money and better care for patients. WMAS acknowledged that there would be increased costs but the review had highlighted the need for increased funding of WMAS, recognised already by the additional investment made by the PCTs in the current financial year in response to the review. Increasing the number of paramedics had a number of service and cost benefits, for example, permitting care to be provided locally in a community setting such as a primary care centre, Minor Injuries Unit or GP surgery, which was what most patients preferred, reducing the number of patients taken to hospital. The PCTs had a key role in performance managing the service and ensuring patient care was appropriate. Because facilities varied across the region it was important that the operation control centres had a directory that detailed the facilities available. It was requested that in reporting on progress in response to the review WMAS should include comment on the outcomes for patients and the costs.

- One of the findings of the Committee's own scrutiny review of the ambulance service in Herefordshire had been that there was a need to improve ambulance clearance procedures at hospitals. Disappointment was expressed that this finding, and others of the Committee's review, did not appear to have been acted upon. In reply it was acknowledged that waiting to book patients into hospitals was an issue and WMAS did pursue this with the PCTs. Other actions taken had included putting more ambulances on the road and developing a workforce plan.

- The importance of Community First Responders was acknowledged.

- The proposition in the Lightfoot Review that the target for responding to Category A calls within 8 minutes should be set at 68% for rural areas was discussed. WMAS assured the Committee that, whilst it was a struggle to hit the 75% target in rural areas WMAS would continue to seek to meet the 75% target.

- There was criticism of the dip in WMAS performance. WMAS replied that demand for the service had increased so dramatically that the service had not been able to cope as it would wish.

- In response to concern that good performance in urban areas could provide good performance statistics on a regional basis, masking poor performance in Herefordshire, WMAS replied that each PCT was provided with an assessment of performance in its area.

- In response to a question about service integration the Director of Public Health said that this was at the forefront of service planning in Herefordshire.

- WMAS acknowledged that targets were not outcome based and there was an aim to move towards this position.

- In response to a suggestion that that not all ambulances available to WMAS were in service, WMAS said that it could take time to commission vehicles and resource needed to be managed to ensure cover. All vehicles available to WMAS were being deployed.

RESOLVED:

That (a) a report be made to the next meeting setting out progress in response to the findings of the Lightfoot Review, performance against targets in Herefordshire the cost implications for the NHS as a whole of the improvements proposed in the Lightfoot review and the projected outcomes;

(b) the report should also include commentary on action in response to the findings of the Committee's review of the ambulance service in the light of the Lightfoot Review; and

(c) **the Committee's disappointment at the time taken to address the recommendations in its scrutiny review be recorded.**

15. RESULTS OF ANNUAL HEALTH CHECK 2008/9 - WEST MIDLANDS AMBULANCE SERVICE NHS TRUST

The Committee noted the performance of the Ambulance Trust in relation to the Annual Health Check results for 2008/9.

16. RESULTS OF ANNUAL HEALTH CHECK 2008/9 - NHS HEREFORDSHIRE

The Committee considered the performance of the Primary Care Trust in relation to the annual health Check results for 2008/9.

This showed that the Health Check conducted by the Care Quality Commission had given the Trust a rating of fair for both quality of commissioning and for financial management. A table showed how the ratings compared with other Primary Care Trusts within the West Midlands Region.

The Director of Public Health presented the report, the findings of which had highlighted nothing unexpected. He acknowledged that some targets had proved challenging but emphasised that there was clear commitment to deliver improvement. The planning and integration of services provided an opportunity to achieve this aim.

He expressed particular concern about smoking, as one of the major preventable issues; the provision of mental health services and stroke care and commented briefly on work underway to address each of these areas.

In discussion the following principal points were made:

- In response to a question about the PCT's commitment to maintaining local hospital provision at Bromyard the Director of Public Health stated that he was unaware of any change in approach but would clarify the position.

  The Chief Executive of the Hospitals Trust commented that an exercise was underway on the integration between the community hospitals and the acute hospital and if there were under-utilisation this would be picked up as part of this exercise.

- It was requested that further detail be provided on performance against targets summarised on page 32 of the agenda papers, describing the various targets and providing a progress report on those targets that had not been met and plans to generate improvement.
- It was noted that the health service performance framework was to be changed and proposed that a seminar be arranged for Members when details had been confirmed.

Resolved:

That (a) the Chief Executive's update to the next meeting include a progress report on targets in the Health Check that had not been met and plans to generate improvement; and

(b) a seminar be arranged for Members on the new health service performance framework when that is confirmed.

17. RESULTS OF ANNUAL HEALTH CHECK 2008/9 HEREFORD HOSPITALS NHS TRUST

The Committee considered performance of the Hospitals Trust in relation to the Annual Health Check results for 2008/09.

The report stated that the Health Check, conducted by the Care Quality Commission had given the Trust a rating of good for quality of services and fair for use of resources.

Since the publication of the agenda papers the Annual Hospital Guide, produced by Dr Foster, an independent provider of information, analysis and communications to health and social care organisations, had been published (on 29 November 2009) and received national publicity. This had included a ranking of hospitals for patient safety which had ranked Hereford Hospital as the twelfth worst in England.

Mr Woodford, Chief Executive of the Trust, presented the report on the Health Check. He noted that it was an exception report and did not therefore include comment on a range of areas where the Trust had improved.

In terms of areas for improvement he considered Stroke Care was the one requiring most attention. The Health Community Stroke Pathway was being reviewed by the Hospital Trust and the Primary Care Trust as Commissioner. It had been agreed that additional resources would be made available. He agreed to provide an update to the Committee on Stroke Care.

Members asked Mr Woodford to comment on the publication by Dr Foster. Mr Woodford commented that the assessment covered the same period as the Health Check but had looked at different things. In 2008/09 the hospital's mortality rate had been 93.4, the national average being 100. He therefore considered that overall safety at the hospital was very good. The report by Dr Foster did raise some issues and the Trust would consider these and seek to understand the basis for the findings and respond constructively to them. It was proposed that the Trust's response should be submitted to the Committee's next meeting.

The Director of Public Health commented on the importance of there being a safe, local hospital providing a range of care. There was a clear quality assurance framework in place and the Dr Foster's report needed to be viewed within that context. It was important to acknowledge the service areas where improved outcomes were being achieved and to ensure the hospital remained safe by working collectively on those areas where it was recognised there was a need to improve.

RESOLVED:

That (a) once an action plan has been prepared in response the findings of the Dr Foster survey this be circulated to Members and reported to the next meeting; and

(b) an update on Stroke services be provided to the next meeting.

18. INTERIM TRUST UPDATES

The Committee considered interim updates from Hereford Hospitals NHS Trust, and NHS Herefordshire.

West Midlands Ambulance Service NHS Trust had no additional information to submit.

In discussion the following principal points were made:

Mr Woodford, Chief Executive of the Hospitals Trust acknowledged that the significant increase in A&E attendances for August 2009 looked odd and reported that it was being investigated.

It was asked what progress had been made in determining a site for the GP led walk in health centre. The Director of Public Health reported that interim arrangements had been made to provide a walk in GP service at the ASDA store in Hereford. Discussions were continuing on the location of a permanent site and what services could be integrated within it.

Consultant cover at the A&E Unit was raised. It was replied that consultant cover was available 24 hours a day at the A&E Unit. The Trust was seeking to develop the role of nurse practioners and increase their skills to enhance cover.

It was requested that the Committee should be provided with an update on the procurement of a strategic partner to deliver mental health services.

A Member reported concerns that the "Choose and Book" system being used by all Herefordshire GP practices was cumbersome to use. The Director of Public Health replied that it was a national system and he was not aware of any particular difficulties locally.

Asked for an update on swine flu the Director of Public Health said that whilst measures remianied in place locally it appeared that the worst case scenario had not materialised. The Director of Quality Assurance reported on progress with the vaccination programme.

19. WORK PROGRAMME

The Committee considered its work programme.

The following additions to the work programme were noted: provision of mental health services, Stroke care, Hereford Hospital Trust's response to the findings of the Dr Foster's Annual Hospital Guide, progrees in response to reviews of the ambulance service; and the need for a seminar on the new health service performance framework.

RESOLVED: That the Work Programme as amended serve as a basis for further development.

The meeting ended at 12.40 pm **CHAIRMAN**

Herefordshire Council

MEETING:	**HEALTH SCRUTINY COMMITTEE**
DATE:	**1 MARCH 2009**
TITLE OF REPORT:	**SCRUTINY REVIEW OF GENERAL PRACTITIONERS (GP) SERVICES**
REPORT BY	**DIRECTORATE SERVICES OFFICER (HEALTH)**

CLASSIFICATION: Open

Wards Affected

County-wide

Purpose

To consider the report of the scrutiny review of General Practitioners (GP) Services.

Recommendation(s)

THAT:

(a) the Committee considers whether it wishes to agree the findings of the review of GP Services; and

(b) subject to (a) above, the Committee invites GPs to discuss the findings with the Committee prior to requesting a formal response from NHS Herefordshire.

Key Points Summary

Alternative Options

1 The Committee could decide not to agree the findings or propose amendments.

2 The Committee could decide to refer the agreed findings directly to NHS Herefordshire.

Reasons for Recommendations

3. The Committee is required to formally consider and approve the findings of scrutiny reviews.

Introduction and Background

4. The Committee agreed a scoping statement for a review of GP Services in March 2009 and appointed a Review Group to conduct the Review.

Further information on the subject of this report is available from
Sara Siloko, Directorate Services Officer (Health) on 01432 344344 X3851

5. The report of the Review Group is appended.

6. It would generally be the case once a Scrutiny Review is approved for the report to be submitted to the NHS and other bodies to whom the recommendations are addressed, with a written response and an action plan then being submitted to the Committee's next meeting. In this case it is proposed that GPs will be invited to the Committee's next meeting to discuss the findings. A formal response to the findings of the report would then be invited having regard to the outcome of that discussion.

Appendices

Scrutiny Review of GP Services

Background Papers

- None identified.

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Herefordshire Health Scrutiny Committee

Report by the Herefordshire GP Services Review Group

(For Presentation to the Health Scrutiny Committee on 1 March 2010)

Contents

Acronyms

A&E ..... Accident and Emergency
BMA ..... British Medical Association
CAMHS ..... Child and Adolescent Mental Health Services
DMHOP ..... Department of Mental Health for Older People
GMS ..... General Medical Services contract
GP ..... General Practitioner
HSJ ..... Health Service Journal
IT ..... Information Technology
LMC ..... Local Medical Committee
NHS ..... National Health Service
NICE ..... National Institute for Clinical Excellence
OOH ..... Out of Hours services
PBC ..... Practice Based Commissioning
PCT ..... Primary Care Trust
PMS ..... Personal Medical Services contract
PWLD ..... People with Learning Disabilities
QOF ..... Quality and Outcomes Framework
WCC ..... World Class Commissioning
WRVS ..... Women's Royal Voluntary Service

A note on terminology used in this report:
Two different terms are used synonymously throughout this report:
1 'PCT' and 'NHS Herefordshire' and
2 'surgeries' and 'practices'.
This is because GP and patient sources tended to refer to 'PCT' and 'surgeries', whereas NHS Herefordshire staff tended to refer to 'NHS Herefordshire' and 'practices'.

Introduction

I have pleasure in presenting this health scrutiny review of General Practitioners' (GP) services in Herefordshire.

May I start by thanking the review group members, Cllr Philip Cutter, Cllr Brigadier Peter Jones, Cllr Gordon Lucas, Cllr Glenda Powell and Cllr Peter Watts for all their help, input and support during the review process.

I would also like to thank every GP practice in the county and the Local Medical Committee. They have all contributed in one way or another and to those who hosted us and gave of their time, a very special thanks indeed. The staff of NHS Herefordshire also supplied many of the demands we have made of them. Finally, a very special thanks to the greatest supporter of our work during the review, Sara Siloko. This document would have been much harder to produce without her tireless enthusiasm and extremely hard work.

The GP's surgery is the first point of contact with the health service for most people. It was satisfying to find that GPs, almost universally, enjoy a very high standing in the communities they serve. The theme that emerged was that of the importance of continuity of personal contact in nearly all aspects of the service. From the relationship between GPs and NHS Herefordshire to the services provided by community nurses, social workers and mental health nurses, continuity proved to be a vital part of any treatment programme.

One area that is cause for some concern is in the field of mental health care. You will find a number of references to this subject throughout the report. The group is aware that changes in the delivery of this service are being made. However, when a GP stated that they had been told only to refer patients in crisis, some alarm bells rang. The question of how this situation came about should be asked so it may be avoided in future.

It may seem that the report has overly focused on the relationship between GPs and NHS Herefordshire. This issue dominated some conversations we had at surgeries and with NHS officers. The group felt that this was an area of concern even though this relationship has not yet had a significant impact upon the service GPs provide. It was thought that there were issues in the longer term that would eventually be felt by patients and that it would be better to highlight these issues now rather than wait for a crisis.

Finally, there may be some that find an over emphasis on anecdotal evidence. I make no apology for this. The aim of the report is bring together all strands of opinion as they may all be of equal validity.

I commend our report and its findings to you.

Councillor Alan Seldon
Chairman of the Herefordshire GP Services Review Group

Executive summary

The review group believes that the **qualitative evidence** it has gathered and analysed for this report has its own great power in illuminating issues that may otherwise be swept aside in the quest for hard data. It has used statistics where relevant and available. Its recommendations are suggested in the light of these findings.

This report reflects the group's conclusions, and sets them in context. The review group wishes to emphasise that this is a **complex area of work** and would not claim that its report is comprehensive. It does, however, hope that the report provides some useful and impartial observations on the service and basic recommendations for improving the excellent work already undertaken by GPs in Herefordshire.

One overall recommendation is that NHS Herefordshire and GP practices more openly acknowledge, support and resource the entrenched and much-respected role of **GPs as key community gatekeepers**. One way of achieving this might be to locate an advocacy/co-ordination/signposting worker in each surgery who would act as a 'key worker' for patients, or by co-located multi-disciplinary team working. This is especially important because more local/community resilience could be an effective weapon to combat the growing economic pressures under which services are provided. In conjunction with the above, GP surgeries could offer more effective signposting to housing services, nutrition advice and other wellbeing information.

Continuity of care has emerged as one of the most vital cross-cutting themes among the review group's more specific findings. Patients, GPs and other service providers alike acknowledge that it is a key element in achieving patient satisfaction and good outcomes. Lack of continuity between GPs and NHS Herefordshire, between patients and their doctors, and between GPs and other services, have all been raised as issues of concern which inhibit the effective delivery of GP services to their patients.

Most GPs interviewed stated that the **relationship between GPs and NHS Herefordshire** was cause for some concern but that this was not having a tangible adverse affect at this stage on patient outcomes. It is clear from both sides that there is friction between them. However it is clearly not in anyone's interests to continue in a state of barely restrained antagonism when managing and delivering one of the most important services to the citizens of Herefordshire. So it is vital that better partnership working, to improve that relationship, be undertaken effectively without delay. Continuity of contact between staff would go some way towards improving this.

Budget 'silos' - particularly the divisions between health and social care budgets – should be dismantled where possible. This would help avoid confusion and misguided attempts to conserve money in a particular 'pot', and would be in the interests of a smoother patient pathway.

Related to **preventive activity**, GP practices could routinely add more minutes to their appointment times in order to ask more opportunistic questions of patients, and offer advice, on issues such as risk of falling, diet, exercise etc. Public education programmes that are properly targeted could help prevent some conditions, such as obesity, and some unnecessary visits to A&E.

As NHS Herefordshire rethinks how to strengthen **vulnerable mental health services**, health scrutiny and service user groups should be involved in throughout this process, which should have begun before consultation even started, before the tender process got under way, to ensure the questions asked are those that are important to service users and family carers.

Apart from participating in statistical surveys, **patient and public involvement** in shaping GP services appears minimal. GP surgeries could ask patients to contribute the questions they consider important, when formulating their annual patient surveys, in order to ensure real concerns are addressed. More surgeries could also form patient groups which have sufficient independence to act as 'critical friends'.

GP practices should work more closely with school clinics and youth-led organisations to improve access to services for **young people.**

Rationale for review

The health scrutiny committee decided to undertake this review of GP services in Herefordshire at its meeting on 23 March 2009 because it was keen to determine if these highly-regarded services were able to meet equitably the needs of all groups and individuals in the county in the light of changing county demographics, changing service provision and resourcing levels, and of organisational changes affecting the county. The committee also wanted to find out the extent to which GP services were meeting the preventive challenges outlined in the Director of Public Health's 2008 report.

Methodology

The review is based on a scoping document (see Appendix C) that outlines desired outcomes, key questions, timetable and members of the review group. As the group's investigations proceeded, it became apparent that some of the questions set in the original scoping document were less relevant than others in terms of achieving the review's overall outcomes.

The principal work of the review was conducted between April and November 2009.

This report reflects the conclusions reached, and sets them in context. The review group wishes to emphasise that this is a complex area of work and would not claim that its report is comprehensive. It does, however, hope that the report provides some useful and impartial observations on the service and basic recommendations for improving the excellent work already undertaken by GPs in Herefordshire.

The review group is aware that the quality of Herefordshire's GP services are contingent upon many related aspects of health and social care provision – such as acute (hospital) care, residential and intermediate care, out of hours medical provision, public health education, minor injuries units, communications technology, NHS local, regional and national influences, etc – which are beyond the scope of this review to examine in detail.

See Appendix A for a full list of visits and interviews undertaken, and data and information supplied, for this review.

Background to Herefordshire – a rural county

Herefordshire is a predominantly rural county of 840 square miles situated in the southwest corner of the West Midlands region bordering Wales. The city of Hereford is the major location in the county for employment, administration, health, services, education facilities and shopping. The five market towns of Leominster, Ross-on-Wye, Ledbury, Bromyard and Kington are the other principal centres.

Herefordshire has limited access to the motorway network via the M50, which starts near Ross-on Wye and joins the M5 north of Tewkesbury in Gloucestershire. The other main road links which all pass through Hereford City are the A49 (running from north to south) the A438 (running from east to west) and the A4103.

The most recent estimate of the population of Herefordshire is 178,400. This is the Office for National Statistics' (ONS) 2007 mid-year estimate, published in August 2008. It is the most sparsely populated unitary authority in England and only two other English counties have lower population densities. About one third of the population lives in Hereford city and a little more than a fifth in the market towns. However, using the official rural definition, 55% of the population live in a rural area.

Many key services therefore are further away from residents compared to other parts of the country. Only about half of Herefordshire’s residents are within 4km of a cash-point (56%) or GP surgery (48%). NHS Herefordshire has undertaken a service mapping exercise to identify those areas where travel times and access to services is particularly challenging.

Herefordshire has an older age population than England and Wales as a whole. The county has become a popular destination for relocation, particularly from the southeast, and there is net out-migration of young adults probably in search of wider employment opportunities and higher education. Between 2004 and 2011 Herefordshire’s population is expected to increase at roughly the same rate as that of England and Wales as a whole.

Both nationally and locally the population aged 60 and over is expected to grow more rapidly than the total population, but the rate of growth of this age group in Herefordshire is expected to be higher (21%) than in England and Wales as a whole (13%). Most dramatically, the number of people over 80 is expected to rise by a further 20%, to 11,800 residents, compared with a national increase of 11%. However, the number of under 18s is expected to fall by 12% (nationally 4%). Herefordshire’s working population is approximately 85,000, of whom 15% work outside Herefordshire.

There are areas of poverty and deprivation within the county concentrated in Hereford city (South Wye and Central wards), Leominster and Bromyard. The least deprived areas tend to lie to the east of the county, on some of the fringes of Hereford city, directly north of and west of the city, and around Ross-on-Wye. However most parts of the county fall within the 10% most deprived nationally in terms of geographical access to services.

Background to Herefordshire GP services

- GP services in Herefordshire are commissioned by NHS Herefordshire (formerly the Primary Care Trust, or PCT).
- Each of the 24 GP practices in the county is a signatory to the national GP services contract and is obliged through this to provide certain services.
- Each is an independent business which can choose to take on additional services beyond the basic contract if it wishes and is able to.
- Herefordshire has 113 GP principals (partners in a GP practice), 20 salaried GPs (working in GP practices), 98 non-principals (not a partner/locum), and 19 GP registrars (May 2009).
- There is approximately one GP per 830 people in Herefordshire (0.73 per 1000 – national median 0.58 per 1000).
- The number of registered patients in Herefordshire is over 180,000. This figure exceeds the population of Herefordshire because the county's GPs also serve out-of-county residents, travellers and migrant workers.
- QOF (Quality and Outcomes Framework) is the set of indicators by which GPs earn their funding. NICE (National Institute for Clinical Excellence) is reviewing QOF indicators but BMA (British Medical Association) and NHS Employers will have the final say. NICE says it is opposed to axing exception reporting (the system which allows GPs to exclude certain patients from the scheme without missing out on bonuses).
- All practices must provide management of patients who are ill or believe themselves to be ill, with conditions from which recovery is generally expected, for the duration of that condition, including relevant health promotion advice and referral as appropriate, reflecting patient choice wherever practicable.
- They must also provide general management of patients who are terminally ill, and management of chronic disease in the manner determined by the practice and in discussion with the patient.
- All Herefordshire practices also provide 'additional services' which comprise cervical screening, contraceptive services, childhood vaccinations, child health surveillance, maternity services and minor surgery.
- NHS Herefordshire also commissions other services from GP practices: directed enhanced services such as flu vaccinations; national enhanced services such as fitting contraceptive coils; and local enhanced services such as extended hours' opening.

Links to the Herefordshire Community Strategy, and legal and policy framework

The GP service is integral to the delivery of an effective health service. The review therefore supports the Community Strategy theme of “Safer and Stronger Communities” by improving the availability of sustainable services and facilities and access to them, particularly in rural areas. It also supports the theme of “Healthier Communities and Older People” by helping vulnerable people to live safely and independently in their own homes. These important links are also reflected in the main themes of the Council’s Corporate Plan namely; ‘Health and Well-being’, ‘Older People’, ‘Safer and Stronger Communities’ and ‘Sustainable Communities’.

The review group is cognisant of national mandates and policies such as the Department of Health’s Constitution (2009), Darzi’s Next Stage Review (2008), World Class Commissioning (WCC) (2007), Practice Based Commissioning (PBC), Choose and Book, and National Service Frameworks. It is also mindful of regulatory bodies and mechanisms such as the General Medical Council (GMC), the Quality and Outcomes Framework (QOF), the Care Quality Commission (CQC), and of the role of regional bodies such as the West Midlands Strategic Health Authority. The review also takes into account Herefordshire’s Joint Strategic Needs Assessment, Local Area Agreement, and Director of Public Health Annual Report 2008.

Findings and recommendations

Findings - Continuity of care
Continuity of care – meaning personal contact for patients throughout their pathway along the health and social care system - has emerged as one of the most vital cross-cutting themes among the review group's more specific findings. Patients, GPs and other service providers alike acknowledge that it is a key element in achieving patient satisfaction and good outcomes. Lack of continuity between GPs and NHS Herefordshire, between patients and their doctors, and between GPs and other services, have all been raised as issues of concern which inhibit the effective delivery of GP services to their patients.

Recommendations – Continuity of care
One overall recommendation is that NHS Herefordshire and GP practices more openly acknowledge, support and resource the entrenched, familiar and much-respected role of GPs as key community gatekeepers. One way of achieving this might be to locate an advocacy/co-ordination/signposting worker in each surgery who would act as a 'key worker' for patients. This is especially important in the light of the increasing need for local/community resilience as one effective weapon to combat the increasing economic pressures under which services are provided.

Findings - Equitable access

1. Herefordshire's Place Survey 2008 (see page 13) found that 17% of respondents found it difficult to access GP services. It does not ask why they find access difficult. See Table 1 below for further analysis. The survey has no data to explain why there are discrepancies, for example, between genders or between certain wards.

2. There is also anecdotal evidence that some population groups do not enjoy equitable access to GP services in the county. These include:

- working people who are unable to attend appointments at their 'home' surgeries during GP opening hours;
- young people who fear for their confidentiality by meeting family or friends while at the surgery, or who do not attend for other reasons. There are 4US young people's clinics at six secondary schools and the Sixth Form College, with three more in development;
- travellers;
- people who do not understand or are unable to use the appointments system so resort to attending Accident and Emergency (A&E) at the hospital;
- men (who are less likely than women to consult a GP)
- patients who wish to see a female GP – there are fewer female GPs (see below)

	Male	*Female*
Total	114	89

- the 'currently well' who do not attend surgery but might benefit from preventive screening or advice;
- those who need out of hours (OOH) services. A number of respondents to GP patient surveys express dissatisfaction with OOH and surgery opening hours;
- people at the end of life – 80% of people want to die at home but only 40% do at present. The Palliative Care Bill, currently on its second reading in Parliament, would make provision for patients to request where they received palliative care: in a hospital or specialist hospital, in a hospice or at home. It would require the relevant NHS body to take all reasonable steps to fulfil such requests;
- migrant workers;

Case study – a GP's experience of a migrant worker patient

'Once we had a Chinese worker from a farm who was in his 50s. We found he had severe liver failure. He spoke no English and had no interpreter. We got him referred to Birmingham where he had a transplant. They wanted him back here, where he had no support system at all. As a temporary resident, we deregistered him and didn't have to pick up the tab.'

- carers (a recent Adult Social Care scrutiny review of support to carers found their access to GP services was 'patchy')
- the housebound elderly with multiple needs;
- people with mental health problems;
- people who live in rural areas;
- people with disabilities

Feedback from staff and public for the Disability Equality Scheme 2009

- Training needed for GPs around disability issues – especially mental health.
- Disabled people get a standard 7 min slot at the GP*, when they may need longer. Flexibility in GP and hospital appointments (eg. allow 12 mins instead of 7).
- GPs' attitudes to people with learning disabilities. Some GPs are very good and do know that some patients need a longer appointment. Others seem to think they can give a lower standard of care, and can get impatient.
- Inability to book GP annual reviews in advance (very frustrating when working).
- Sometimes there is an urgency to see doctors (my allocated GP) but find I have to wait over a week.
- Making contact with GP/nurses - answer phones unanswered. Doctors do not return calls. Staff attitude is that the professional always knows best.
- GP appointments: 'I know myself better than anyone when I need to see Dr, and not be fobbed off with a nurse practitioner eight hours later. I am not assertive enough'.

* *The review group found that most GPs offer 10 minute slots*

3. GP comments included:
   - 'We are prolonging people's lives but then failing to look after them at the end of life'.
   - 'Local services should be kept local. Continuity and neighbourhood care is important to sustain an adequate support network for vulnerable people living at home'.

4. 10% of those registered with GP practices across the county take up 40% of their time. A risk stratification tool is to be trialled in two practices shortly: this will identify patients at highest risk to that practices can work with their local teams to manage their needs proactively. Initially this will look at specific long term conditions where the practices believe early identification and active management could pay dividends in terms of health gain and need in the medium to long term. NHS Herefordshire says most practices can probably readily identify their top 10 patients but it is hoped this tool will enable identification of those in the next 10-20 to minimise their risk in future.

5. A senior NHS Herefordshire officer said 'Patient feedback always favours continuity of care – they want to see doctors that they know. There is also evidence that this leads to better patient outcomes'.

6. One practice pointed out that it offers 10 minute appointment time as standard, and that patients can book at least one month in advance.

Table 1 (pages 13 and 14)
Difficulty in accessing GP services
By gender, age group, disability, ward group, rurality and deprivation quartile

Overall result

Find it difficult to access GP	17%

By gender

Male	Female
20%	15%

By age group

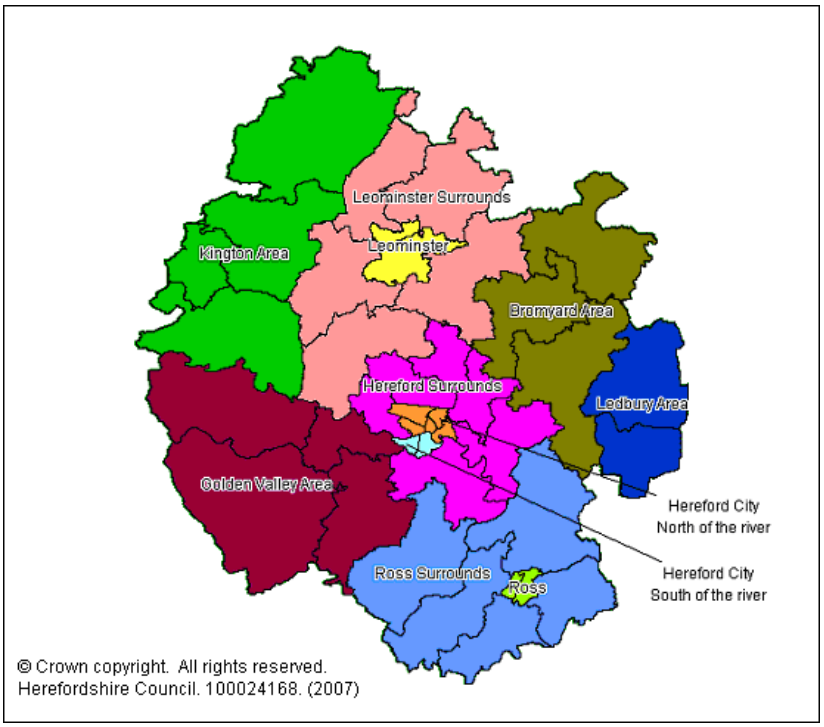
18 to 44	45 to 64	65 to 74	75 and over
22%	15%	14%	18%

By disability

Disabled	Not disabled	Mobility difficulties
16%	18%	18%

By ward group

Bromyard Area	Golden Valley Area	Hereford City North of the river	Hereford City South of the river	Hereford Surrounds	Kington Area	Ledbury Area	Leominster	Leominster Surrounds	Ross	Ross Surrounds
18%	13%	16%	24%	17%	24%	20%	19%	18%	4%	13%



By rurality

Urban	Town & fringe	Village	Hamlet & isolated dwelling
16%	18%	18%	19%

By deprivation quartile

1st quartile - most deprived	2nd quartile	3rd quartile	4th quartile - least deprived
15%	21%	17%	17%

By deprivation quartile, amongst those living in urban areas

1st quartile - most deprived	2nd quartile	3rd quartile	4th quartile - least deprived
12%	30%	18%	15%

By deprivation quartile, amongst those living in rural areas

1st quartile - most deprived	2nd quartile	3rd quartile	4th quartile - least deprived
17%	15%	14%	17%

Rurality by deprivation quartile

	1st quartile - most deprived	2nd quartile	3rd quartile	4th quartile - least deprived
Urban	34%	14%	21%	32%
Town and fringe	23%	9%	24%	44%
Village	9%	38%	27%	26%
Hamlet and isolated dwelling	14%	48%	27%	10%
Rural	14%	36%	27%	23%

Source of information for Table 1 above: Herefordshire Place Survey 2008 (Herefordshire Council)

Recommendations - Equitable access

1. Ensure the GP-led walk-in centre, when open, offers a full range of services with excellent communications between it and the patient's registered practice to ensure continuity of care, to cater better for workers who commute to Hereford city – without destabilising vulnerable rural practices

2. GP practices should more closely with school clinics and youth-led organisations to improve access to services for young people.

3. Sustainable funding should be secured to enable school clinics to run in every secondary education establishment.

4. GP practices should simplify, streamline and better publicise their appointments and triage systems and make patients more aware that the practice is their 'first port of call', and that they will be welcomed and seen by a doctor that day if patients consider it necessary

5. GP practices should issue more frequent invitations to registered patients who have not attended the surgery recently, for preventive consultations, where resources allow, after undertaking cost/benefit analysis

6. NHS Herefordshire should work closely with hospices, the individualised health budget pilot, hospitals, social care and GPs to ensure people can die at home if they wish to

7. As above with reference to the housebound elderly with multiple needs

8. GP practices should facilitate people with learning disabilities to monitor and evaluate the new arrangements for working with them to establish if they are meeting needs

9. As above with reference to people with mental health problems

10. NHS Herefordshire should move with all possible speed and in consultation with service users to improve the services available to people with mental health problems, with a view to making them more robust, more joined-up between medical and social models, more readily available, and more accessible to people who are not in crisis (e.g. talking therapies)

Findings - Preventive services

1. GP comments included:
    - 'GPs play a small part in people's health – what really determines their health is their housing, their jobs, their education, their relationships, their diet …'
    - 'It is of concern that the amount of money we get in future might be partly dictated by how many fat people we have on our books. The reasons people overeat are very complex and GPs can't have much impact on this on their own.'
    - 'We are now (September 09) told not to refer anyone to mental health services unless they are in crisis, due to staff shortages'. If this is true, it must be asked how people in need of services can access them? And further, how did the service reach such a stage without sufficient warning to enable pre-emptive action to forestall shortage of services?
    - 'We have been told that counselling services for 19-25 year olds will no longer be paid for by NHS Herefordshire'.

2. An officer in provider services told the review group 'Definitions between social care and health are very unclear – for example when does a housing issue become a health issue? Deprivation leads to poor health. The lack of a coherent accommodation strategy is making for disjointed working.'

3. GPs offer regular screening clinics. All practices contact registered patients who haven't been in for a certain number of years, offering them a check-up. Opportunistic screening is done by most GPs e.g. blood pressure checks and smoking cessation advice (but not, for example, to ascertain/advise those at risk of falling). Practices will also be introducing health checks under the vascular health checks scheme for people 40+ starting from 2010.

4. All GP practices receive guidance on who should be referred to mental health services.

5. No GPs in Herefordshire have a Special Interest in mental health issues.

6. CLD, a local youth counselling service, is commissioned to provide a service for young people who are pregnant, substance misusers or with a particular level of need in terms of Child and Adolescent Mental Health Services (CAMHS). NHS Herefordshire says over the last couple of years the service had also been accepting referrals for young people outside these parameters, but this service had not been formally commissioned or funded, and CLD has identified that it cannot continue to provide this service without additional funding.

7. All GP practices now have a counsellor who provides talking therapies. The hours allocated are proportional to the size of the practice. However, some practices have waiting lists. Each practice also has a link person within Community Mental Health services, to close the gap between social care and medical health.

8. Mental health service users started to be consulted on their views in December 2009, when the tender process had already been narrowed down to five potential new host organisations.

9. Regarding general preventive activities, one GP said 'It would be difficult to take on monitoring of patients for extra issues during regular appointments. Already (average nationally) doctors deal with 3.5 problems during each 10 minute appointment, so there is little opportunity to do more'.

Recommendations - Preventive services

1. GP surgeries, acknowledging their role as an important community gatekeeper, should offer more effective signposting to housing services, nutrition advice, obesity, alcohol abuse, smoking cessation and other information about well-being.

2. GP practices should routinely add more minutes to their appointment times in order to ask more opportunistic questions of patients, and offer advice, on issues such as risk of falling, diet, exercise etc.

3. Public education programmes that are properly targeted could help prevent some conditions, such as obesity, smoking cessation, alcohol abuse, and some unnecessary visits to A&E. Community engagement must be undertaken, as it is important in the context of achieving good public health behaviour change.

4. As NHS Herefordshire rethinks how to strengthen vulnerable mental health services, health scrutiny and service user groups should be consulted in throughout this process, which should have begun before tender documentation was finalised and bidders chosen, to ensure that the questions asked and the solutions that are proposed are those that are important and useful to service users and family carers.

Findings - Rurality

1. Targets and procedures seem to take little account of sparsity and rurality. Little account is taken of the extra cost involved in providing services to remote rural communities.

2. Care must be taken not to impose urban solutions on a rural area when considering initiatives such as the GP-led walk-in centre, or GP extended hours. We need to be able to freely adapt, or reject, national agenda according to our Herefordshire context.

3. GPs in rural practices have to spend more time undertaking home visits than urban GPs.

4. Patients visiting rural surgeries face particular challenges if they lack private transport. One surgery said they would not be able to manage without the assistance of voluntary associations such as WRVS (Women's Royal Voluntary Service), Ride and Dial and Age Concern.

5. 11 out of 24 practices have dispensaries. They are all rural.

Recommendations – Rurality

1. Account must be taken of the extra transport needs rural people have in accessing GP services.

2. Public transport needs to be planned with the needs of vulnerable rural people – especially elderly people – in mind.

3. A study should be undertaken of their future community and transport needs, as demands on these increase with a growing elderly population.

4. GP practices should consider being more flexible with their opening hours to help increase access for some rural patients.

Findings - Extended hours

1. Access to GP services outside normal working hours is not similar across rural and urban parts of the county. A recent national initiative to encourage extended opening hours has not been taken up enthusiastically in Herefordshire. Only 50% of the county's surgeries now offer this service (West Midlands average 70%, South West average 85%). According to NHS Herefordshire, of the 16 surgeries outside Hereford city, 9 offer extended hours and seven do not. Of the city surgeries, four offer extended hours and four do not.

2. According to Pulse magazine (25 Feb 09) 'the extended hours initiative has deprived small GP practices and those in the poorest areas of the country, of millions in funding … some groups of patients miss out twice over, because they don't get access to longer hours, and neither does their practice get as much money for their health care. It is often the poorest patients who are missing out, and it is they who often find it hardest to take time off work to see a GP'.

3. The LMC told the review group that the national 'offer' regarding extended hours was 'inflexible and dogmatic', and inappropriate for many surgeries in Herefordshire.

4. If the GP-led walk-in centre in Hereford city finds premises and opens, as now hoped, in March 2011, this could improve access to services for a number of groups who are in the city for other reasons, such as working people, young people, migrant workers, inappropriate A&E attenders. An interim walk-in centre was opened in December 2009.

5. Some GPs fear their patients will use the walk-in centre in preference to their registered surgeries, thus depriving the surgery of business, as well as jeopardising the patient's continuity of care. Some GPs fear the walk-in centre could be more expensive than envisaged through having to serve many 'second-opinion seekers' and the 'worried well'.

Recommendations - Extended hours

1. Further consideration be given to encouraging rural practices who have patients with access problems in particular to offer extended opening hours

2. Further research may need to be undertaken to establish why 17% of people find it difficult to access GP services

Findings - Out of hours services

1. One patient said: 'Since GPs opted out of working weekends and after 6pm, many people who need medical help are confused as to who to call and just call 999 for an ambulance, resulting in unnecessary A&E attendance'.

2. The review group asked NHS Herefordshire for information on the current cost of Herefordshire's out of hours (OOH) service, but this was not available. Nationally, there is a threefold variation in costs across various parts of England – with rural areas being the most expensive. For the OOH contract that expired in 2008, the cost to NHS Herefordshire was £2.2 million per year. In 2006, Herefordshire PCTs' OOH service cost marginally more, at approximately £11 per head of population, than the average £10.76 for rural PCTs. The national average is given as £8.65 but that includes major conurbations.

3. One GP told the review group that their Monday morning surgeries were over-subscribed because the OOH provider tells patients over the weekend to go and see their GP on Monday. However, OOH is an urgent care service and if patients do not require urgent care it is appropriate they see their GP on the next available working day.

4. GP comment: 'Our doctors are no longer retiring early in poor health because of the extra work entailed by OOH duties, but the current OOH service does give a poorer quality of service to patients. For example, the provider is trying to use more nurses and fewer doctors'.

5. 'By sacrificing £6,000 a year GPs have been able to hand over OOH care to PCTs. We regularly hear of patients experiencing difficulties in obtaining a GP appointment or a poor service when trying to access out OOH care.' (national data from the Patients Association)

6. The introduction of separate OOH services may have reduced the personal investment of GPs in ensuring patients were seen in hours and that OOH requests were 'reasonable', and may have compromised the role of the GP in core urgent care.

7. The GP patient survey 2008-9 for Herefordshire found, regarding OOH services: easy to contact 77%, right speed of response 59%, good care received 60%. However, there were many comments in surveys conducted by individual GP surgeries that expressed dissatisfaction with OOH services.

Recommendations - Out of hours (OOH) services

1. Undertake a more effective education programme to make the public aware of the differences between GP services, A&E services, and OOH services

2. Improve the effectiveness of the OOH provider. Would it be preferable, for example, to recruit more local GPs to serve it, with the aim of improving both quality and continuity of care for patients?

3. That every effort be made to maintain the stability of the OOH workforce, both clinical and non-clinical

4. That NHS Herefordshire undertake more work to investigate whether it is fully capturing the patient experience of the OOH service

5. That the OOH service continues to be subject to ongoing careful monitoring, evaluation and review

Findings - Appointments

1. Herefordshire Council's 2009 research among the public for its Disability Equality Scheme found that disabled people (see page 12) felt GP appointments for them should be more flexible and longer. Most of the comments on GPs related to difficulties with the appointments system.

2. Inappropriate attendance at A&E is currently over 30%. The review group found some reasons for this are: people don't know about the OOH service and think their GPs are only open Mon-Fri; the OOH service may refer people to A&E if they have no-one available to see patients; patients may have tried to make an appointment at their GP and failed, or do not understand the appointment system; people don't know there are minor injuries units and some OOH services at community hospitals.

3. A Herefordshire Patient and Public Involvement Forum survey in 2007 found that out of 145 A&E attendees, 33 had tried their GP first. 38 said they would have used a 'sit and wait' surgery had one been available at their GP practice.

4. Even conditions that are not severe may demand an early response. Anecdotal evidence suggests that some surgeries operate triage systems which appear to cause patients to resort to A&E, some do not have enough telephone operators to cope with demand for appointments.

5. A recent national survey by the Primary Care Foundation (June 09) suggested that one third of practices 'appear to have insufficient staff to respond reliably and quickly' to calls on a Monday morning, a time of peak demand. However, the National Patient Survey 2009 found that 91.85% of Herefordshire patients were satisfied with phone access to their GP practice. Herefordshire is in the top 20% of this survey's results. However, negative GP surgery patient survey results have prompted several surgeries to improve their phone systems.

6. One GP practice made the distinction that patient need must be met, but that it may not be possible to meet patient demand with limited health care funds.

7. The Primary Care Foundation survey also says some practices have no same-day slots left within 30 minutes of the practice opening, leading to some friction with patients, difficulties for reception staff and clinicians, and to patients developing techniques to get round the system. Reforming the approach to in-hours urgent care can reduce avoidable admissions and A&E attendances (Primary Care Foundation research June 2009). The review group obtained anecdotal evidence that appointment systems cause similar difficulties in several Herefordshire GP practices.

8. The review group asked surgeries for the number of patients who failed to keep appointments, but this information was not available in sufficient quantity to detect any trends or issues.

9. It is thought there may have been an increase in referrals from GPs, but the review group has been unable to obtain information about this from NHS Herefordshire.

Recommendations – Appointments

1. GP practices should review call handling and access to urgent appointments

2. Public education and/or improvements in urgent care services are needed to reduce inappropriate attendance at A&E

3. To avoid a patient ending up in hospital or resorting to A&E, it is important to regard any request for same-day care as potentially urgent until assessed by a clinician, so basic access to general practice is vital

4. GP practices should review who handles incoming calls and ensure adequate training to ensure staff spot and accommodate potentially urgent cases

5. GP practices should review number of appointments available each week to ensure they meet patient demand, and ensure balance of same-day slots matches the pattern of demand

Findings - Quality of service/patient experience

1. The Royal College of GPs has been piloting an accreditation scheme which will test 'organisational' quality (Health Service Journal (HSJ) May 08) and the Care Quality Commission is to require GPs to register with it for the first time. But neither organisation will be analysing quality of care explicitly from a patient's perspective.

2. The King's Fund has started an 18-month enquiry which will attempt to define the most appropriate role for GPs in delivering high quality patient care. Royal College of GPs chair Steve Field hopes the enquiry will also help unpick some of the reasons why GPs are less engaged with Practice Based Commissioning than they could be. A member of the enquiry Ursula Gallagher (director of quality and clinical practice at Ealing PCT) says there is considerable variation in the quality of GP services that is not picked up robustly in the QOF.

3. Patient surveys undertaken nationally and locally give consistently high scores to GP services in Herefordshire. The 2009 National Patient survey questions include: whether patients find receptionists helpful (very helpful 64%), if they had confidence in the doctor they saw (yes definitely 79%), and how they rate the overall care they receive (very satisfied 67%).

4. In 2008, Herefordshire was in the national top 20 per cent in the country in terms of access to and quality and safety of local NHS services. Patients scored GPs particularly highly for their communication and listening skills, treating patients with respect and dignity, getting an appointment quickly and the cleanliness of GP centres.

5. The only issue raised by patients in 2008 was that a sizeable minority - nearly one in five - wanted better access to their GP outside of normal office hours.

6. However one practice said its extended hours services are the last to be booked and the first to be cancelled, often without notice.

7. The 2008 Herefordshire Place Survey (see page 13) found that 83% of respondents did not have difficulty in accessing GP services in the county.

8. Three GP surgeries in Herefordshire have patient groups. Is the patient voice really being heard, beyond pointing out that the door needs oiling? Some GP practices told the review group that the results of patient surveys, comments books, verbal feedback etc are regarded as valuable indicators of quality and are acted on appropriately. Some GP practices have, for example, taken on a salaried GP to improve access to a doctor, bought new telephone systems to improve call handling, begun to establish a patient group, extended their opening hours, applied for funding and planning permission for extra car parking, etc, as a result of patient feedback.

9. PALS (Patient Advice and Liaison Services) has dealt with 26 cases concerning GPs since April 2009. Of those, two patients went on to make a formal complaint and one other may do so.

10. Numbers of complaints:

2007-8 complaints against GPs	
Subject	*Total 133*
Communication/attitude	18
Premises	0
Practice/surgery management	30
General practice administration	20
Clinical	38
Other	27

2008-9 complaints against GPs	
Subject	*Total 174*
Communication/attitude	42
Premises	1
Practice/surgery management	25
General practice administration	21
Clinical	61
Other	23

- *It has not been possible to obtain information to explain the variation in numbers of complaints from 2007-8 to 2008-9.*

Recommendations - Quality of service/patient experience

1. Local services should be delivered as close to residents as possible. This has major implications for the safe delivery of services locally. Herefordshire Public Services is reviewing the way local NHS and social care services are provided. The review describes a new 'landscape' for local services focused on a more integrated, effective and efficient local service across public service providers in the county (see panel below). Many of its proposals are similar to the independently-made recommendations of this review. It is hoped the new Transition Board will ensure that the process of implementing new ways of working will be led not only by clinicians but by patients, service users and carers.

Excerpt from Herefordshire Provider Services Review – Next Steps (October 2009)

It is proposed that:

- integration of primary and secondary health and social care services in and around a local team will be best placed to deliver effective joint working, a simplified system of access and a shared focus on achieving wellbeing for the local population;
- to deliver the high levels of care for specialist services in mental health and learning disability proposed in these models we will need to seek the expertise and greater capacity of a specialist provider who will offer a local service to our specification;
- while proposals on possible configurations that will support our service aims are explored we need to begin to put in place our new models of care;
- a programme of work to develop, commission and implement some of the models in the next 12 months will be started, including opportunities for staff, service users and their families / carers to contribute their own experience and suggestions for improvement to service delivery;
- locality groups will have a role to play in the review, planning, commissioning and delivery of some of these processes.

2. GP surgeries should ask patients to contribute the questions they consider important, when formulating their annual patient surveys, in order to ensure real concerns are addressed. This could be done by a non-medical staff member canvassing patients in the waiting room.

3. GP surgeries should form patient groups which have sufficient independence to act as ‘critical friends’.

Findings - Collaboration/co-ordination/integration/communication

1. The need for care and services for older people is set to increase. Particular challenges for service planning will include how to maintain adequate access to services and facilities, and how to promote inclusion and avoid isolation of older people living alone or in rural areas.

2. It is also clear that there is a need to 'add life to years' in our elderly population by promoting health and wellbeing and preventing injuries and ill-health. Herefordshire residents, in their feedback to both the Council and NHS Herefordshire, are keen to see an increased level of support and personalised care for people with long-term conditions.

3. There is a disconnect between acute services and GPs (discharge notes are often late or illegible), and between them and intermediate care services. After-hospital procedures are poorly co-ordinated and inadequately resourced. Funding 'silos' between health and social care can work to the detriment of patients when neither health nor social care bodies will take responsibility for payment of services.

4. GP comment: 'A whole team approach is vital – not only within the surgery (nurses, GPs, admin) but with other health and social service workers – to ensure patients' needs are met'.

Case study – Harry

Harry worked as a packer in Hereford until five years ago. He was doing really well and was up for promotion, but his colleagues started bullying him. After a while he couldn't take it any more and he left. Harry hasn't really worked since. He's been anxious, depressed and unable to cope with much of the outside world. He has a mild learning disability and lives in supported housing.

In 2008 Harry was assessed by a doctor at an assessment centre. He told the assessor he had been feeling a bit better recently. On the basis of this information, the doctor told the benefits office to stop Harry's benefits. The worry of this made Harry ill. What would he live on? His support worker contacted Harry's regular GP, who wrote to the benefits office explaining Harry's situation and asking them to reverse their decision.

There was a lot more suffering to come for Harry. It was a long and anxious time of unnecessary delays and poor communications between the benefits office, the assessment centre, mental health services workers, his GP and support worker, and Harry himself before his benefits were restored and he felt secure again.

Why was Harry assessed by a non-specialist doctor, and not a specialist worker in mental health and/or learning disability issues? Why was Harry assessed by someone who knew nothing about him or his history? Why is communication so poor between the various agencies that have such power over vulnerable lives? What would Harry have done without the support of his regular GP and his support worker?

5. A senior adult social care officer said 'Budgetary pressures are immense and increasing, and there is insufficient understanding among both health and social care staff, and the public, of this'.

6. It was also stated that better integration is needed between private facilities (such as care homes) and others such as GPs and community hospitals, and that caution is needed so as not to draw workers into using the medical model – social care focuses on independence, whereas NHS Herefordshire focuses on medical issues.

7. GP comment: 'Services should be returned to GPs with integrated teams working under the control of the practice (especially including social care)'.

8. Incompatibility of computer systems and data protection issues impede the flow of smooth patient pathways through the system. GPs have told the review group that patient matching,

for example, goes awry between the hospital and surgery information technology (IT) systems – this is confusing and potentially dangerous. Also social care and health IT systems do not 'talk' to each other.

9. Barriers to effective co-working between GPs and other parts of the health and social care system include lack of communication between them. For example, the lack of GP-based social workers means it is more difficult to co-ordinate patient care. One surgery has a practice liaison nurse (funded from PBC) who performs some of these functions: she keeps a vulnerable patient list, and checks how patients are after discharge from hospital. Another surgery said sometimes there are 3-4 social workers per patient, which makes it hard to work out who is responsible for that patient. Workers are not physically co-located, which adds to the communications challenges. A further surgery said it had fought tooth and nail to retain its social worker, who works one day a week from the surgery and performs a vital liaison/advocacy/signposting role for patients.

10. Lack of communication between NHS Herefordshire and the Council is a problem. At a local level, one surgery told the review group that it had to organise a meeting between DMHOP (Department of Mental Health for Older People) and Adult Social Care to get them to make a joint visit to a patient. Another said when NHS Herefordshire had its own chief executive there was a stronger sense of leadership, and that a clearer definition of the organisation and firmer management are needed.

Recommendations – Collaboration/co-ordination/integration/communication

1. With continuity in mind, patients and service users would benefit from a) co-located multi-disciplinary team working and/or b) a single key worker who would be the patient's main contact and would co-ordinate all the other work needed for that patient. This concept and its costs should be investigated/quantified as soon as possible,

2. Care tracking and management could be organised within GP catchment areas, possibly using a predictive tool that identifies people at most risk of needing medical or social care.

3. If the number of people in residential care reduces, the efficiency of intermediate and domiciliary care will have to be improved to enable vulnerable people to live safely and in dignity in their own homes.

4. The Welsh Assembly government is developing a 'rural practitioner' role that would make GPs in parts of Wales responsible for social care services as well as health. The proposal is that the primary care workforce would be re-evaluated so that practitioners could fulfil more than one role for the convenience of the patient.

5. 16 pilots started in April 09 to have GPs working with care homes, social services, acute trusts and charities to improve patient care in areas ranging from improving the co-ordination of end of life care, preventing cardiovascular disease and encouraging more self-care for people with long-term conditions. This could be investigated with a view to replication in Herefordshire.

6. NHS Herefordshire needs to clearly define the role it envisions for community services, its priority areas for expansion and any important partnerships it wants – such as joint health and social care teams for older people, greater links with GPs and the appropriateness of GP referrals.

7. Involve patients and service users in the whole cycle of planning, commissioning, and delivery through to review of GP services

8. Budget ‘silos’ - particularly the divisions between health and social care budgets – should be dismantled where possible. This would help avoid confusion and misguided attempts to conserve money in a particular ‘pot’, and would be in the interests of a smoother patient pathway

9. Information ‘silos’ also should be dismantled

10. Effective use of IT systems could provide so many opportunities for improved patient outcomes. Therefore, throughout the patient pathway, IT systems should be made practicable and compatible, and data protection/confidentiality issues preventing this should be resolved with all speed

Findings - Relations between GPs and NHS Herefordshire and how they affect patients

1. Surgeries' comments included: 'hit and miss', 'deteriorating', 'unclear funding streams', 'frequent personnel changes', 'fewer visits' (eg contract monitoring, Practice Based Commissioning (PBC) reviewing), 'unclear communications', 'lack of support', excessive bureaucracy', 'NHS Herefordshire is governed by national priorities'.

2. NHS Herefordshire comments included: 'wear a flak jacket before going into LMC meetings', 'there is always lively debate at locality meetings', ….

3. Innovative surgeries have obstacles put in their way – 'NHS Herefordshire is nervous of innovation because it fears establishing inequalities'. One surgery ran a programme in collaboration with a leisure centre to tackle obesity, funded by a pharmaceutical company because 'to get the money from PBC would have taken for ever', and funds a prescription delivery service from bequests for the same reason. GP comment: 'PBC has stalled. The PCT is reluctant to let go of control. Innovation is stifled. GPs try hard to deliver new ideas appropriate for their localities but the PCT fears change, and making mistakes'.

4. 'Despite the rhetoric of "quality" "safety" and "equality", the Next Stage Review (Darzi) is underpinned by the levers of a market based system i.e. Payment by Results, Choose and Book, purchaser/provider split, World Class Commissioning, Foundation Trusts, patient-held budgets …' (Clive Peedell, GP, Health Service Journal 14 July 09)

5. 'PCTs will be restricted to the lowest score in World Class Commissioning unless they can prove they are supporting PBC' (David Colin-Thome, national clinical director for primary care). GPs have told the review group that they have had PBC business cases turned down for inexplicable reasons, agreements changed without notice so PBC payments are not made, proposals sent in and no feedback given by NHS Herefordshire about them.

6. A senior NHS Herefordshire commissioner told the group that of 109 PBC applications currently outstanding, some 70% of them had been approved.

7. A senior commissioner told the review group 'As adult social care and health services increasingly integrate, GPs will have a widening role which could include care tracking and management within their catchment areas, increased awareness of personalisation and individualised budgets and eligibility criteria, input into the development of an effective Single Assessment Process, GPs to have provision of records on all treatment or services given to their patients'.

8. Mental health teams try to work closely with GPs, to close the gap between social care and medical health. Each practice now has a counsellor (hours depend on size of practice), and a link person in the Community Mental Health team. The review group requested data on numbers of referrals to the community mental health team but these were unavailable.

9. GPs have said that mental health services are so depleted at present in one geographical area that they have been told to refer only crisis cases, and that 'virtually the whole department has left'. Community alcohol and youth counselling services are also said to be understaffed. The review group asked NHS Herefordshire for information on the current staffing levels against established structure (how many staff there should be) in mental health services, but were unable to obtain this. This lack of information was a cause of considerable concern for the review group, especially when need for services appears to be increasing, such as the increasing prevalence of alcohol-related issues, for example.

10. NHS Herefordshire says it is aware that Herefordshire's mental health services are too small to be robust, and are vulnerable to staff changes. In view of this, it is planned to join forces

with others in the region to create a Mental Health Trust which will see the county's local services continue, strengthened by the increased governance a larger organisation can provide.

11. A mental health services manager said that the recent staff shortage in one particular geographical area was a temporary problem only while new staff were recruited.

12. LMC would like to see smoother pathways for patients and reduced delays between social care and medical services. Closer links between social care services and medical services would be the best way to achieve success in preventive work.

13. GP comment: 'The restructure is a nightmare. There is no institutional memory left. There are not enough staff to cope – for example there has not been a meeting about governance and quality since February, which is a risky gap. The restructure looks good on paper but the organisation is now process-driven and there is not enough concern for outcomes'.

14. Some of the governance and quality meetings involving GPs that take place are: QOF visits yearly; Family Health Service contractor panel quarterly; GP clinical governance leads twice yearly (as of October 09, the second one for 2009 had not yet taken place).

15. Herefordshire is one of 68 pilot sites for personal health budgets. The county will focus initially on people with long term conditions.

Recommendations - Relations between GPs and NHS Herefordshire and how they affect patients

Most GPs and NHS Herefordshire officers interviewed stated that this relationship gave cause for concern but that, so far, this was not having a tangible adverse affect on patient outcomes. It is clear from both sides that there is friction between them. However it is clearly not in anyone's interests to continue in a state of barely restrained antagonism when managing and delivering one of the most important services to the citizens of Herefordshire. So it is vital that better partnership working to improve that relationship be undertaken effectively without delay. Continuity of contact between staff would go some way towards improving this.

Recommendations

The review group believes that the qualitative evidence it has gathered and analysed for this report has its own great power in illuminating issues that may otherwise be swept aside in the quest for hard data. It has used statistics where relevant and available. Its recommendations are suggested in the light of these findings.

Continuity of care
One overall recommendation is that NHS Herefordshire and GP practices more openly acknowledge, support and resource the entrenched, familiar and much-respected role of GPs as key community gatekeepers. One way of achieving this might be to locate an advocacy/co-ordination/signposting worker in each surgery who would act as a 'key worker' for patients. This is especially important in the light of the increasing need for local/community resilience as one effective weapon to combat the increasing economic pressures under which services are provided.

Equitable access
1. Ensure the GP-led walk-in centre, when open, offers a full range of services with excellent communications between it and the patient's registered practice to ensure continuity of care, to cater better for workers who commute to Hereford city – without destabilising vulnerable rural practices

2. GP practices should work more closely with school clinics and youth-led organisations to improve access to services for young people

3. GP practices should simplify, streamline and better publicise their appointments and triage systems and make patients more aware that the practice is their 'first port of call', and that they will be welcomed and seen by a doctor that day if patients consider it necessary

4. GP practices should issue more frequent invitations to registered patients who have not attended the surgery recently, for preventive consultations, where resources allow

5. NHS Herefordshire should work closely with hospices, the individualised health budget pilot, hospitals, social care and GPs to ensure people can die at home if they wish to

6. As above with reference to the housebound elderly with multiple needs

7. GP practices should facilitate people with learning disabilities to monitor and evaluate the new arrangements for working with them to establish if they are meeting needs

8. As above with reference to people with mental health problems

9. NHS Herefordshire should move with all possible speed, involving service users at the earliest possible stage, to improve the services available to people with mental health problems, with a view to making them more robust, more joined-up between medical and social models, more readily available, and more accessible to people who are not in crisis (e.g. talking therapies)

Extended hours

3. Further consideration be given to encouraging rural practices who have patients with access problems in particular to offer extended opening hours

Out of hours (OOH) services

6. Improve effectiveness of OOH provider. Would it be preferable, for example, to recruit more local GPs to serve it, with the aim of improving both quality and continuity of care for patients?

Preventive services

5. GP surgeries should offer more effective signposting to housing services, nutrition advice, obesity, alcohol abuse, smoking cessation and other information about well-being

6. GP practices should routinely add more minutes to their appointment times in order to ask opportunistic questions of patients, and offer advice, on issues such as risk of falling, diet, exercise etc

7. GPs should 'weight' referrals to A&E by severity, thus helping smooth the path and reduce unnecessary waiting times for patients

8. Public education programmes that are properly targeted could help prevent some conditions, such as obesity, smoking cessation, alcohol abuse, and some unnecessary visits to A&E. Community engagement is important in the context of achieving good public health behaviour change.

9. As NHS Herefordshire rethinks how to strengthen vulnerable mental health services, health scrutiny and service user groups should be consulted in throughout this process, which should have begun before public consultation even starts when the tender documentation was being devised, to ensure the questions asked are those that are important to service users and family carers

Appointments

6. GP practices should review call handling and access to urgent appointments

7. GP practices should review who handles incoming calls and ensure adequate training to ensure staff spot and accommodate potentially urgent cases

8. GP practices should review number of appointments available each week to ensure they meet patient demand, and ensure balance of same-day slots matches the pattern of demand

Quality of service/patient experience

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Collaboration/co-ordination/integration/communication

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16. NHS Herefordshire needs to clearly define the role it envisions for community services, its priority areas for expansion and any important partnerships it wants – such as joint health and social care teams for older people, greater links with GPs and the appropriateness of GP referrals.

17. Involve patients and service users in the whole cycle of planning, commissioning, and delivery through to review of GP services

18. Budget 'silos' - particularly the divisions between health and social care budgets – to be dismantled where possible. This would help avoid confusion and misguided attempts to conserve money in a particular 'pot', and would be in the interests of a smoother patient pathway

19. IT systems throughout the patient pathway should be made practicable, and data protection/confidentiality issues preventing this should be resolved with all speed

Relations between GPs and NHS Herefordshire and how they affect patients
Most GPs interviewed stated that this relationship gave cause for concern but that, so far, this was not having a tangible adverse affect on patient outcomes. It is clear from both sides that there is friction between them. However it is clearly not in anyone's interests to continue in a state of barely restrained antagonism when managing and delivering one of the most important services to the citizens of Herefordshire. So it is vital that better partnership working to improve that relationship be undertaken effectively without delay. Continuity of contact between staff would go some way towards improving this.

Appendix A
Visits and interviews

- Ann Hughes, Head of Primary Care Governance, Quality and Clinical Leadership Directorate
- Catherine Blackaby, Head of Locality Support, Integrated Commissioning Directorate
- Chris Bull, Chief Executive Officer Herefordshire Council/NHS Herefordshire
- Dr Akeem Ali, Director of Public Health
- Dr Richard Dales, Secretary, Herefordshire Local Medical Committee
- Euan McPherson, Interim Head of Customer Experience, Quality and Clinical Leadership Directorate
- Paul Edwards, Associate Director, Integrated Commissioning Directorate
- Sally Simmonds, Operational Manager, Community Mental Health Services
- Sara Keetley, Head of Adult Social Services, Provider Services Directorate
- Simon Collings, Associate Director of Information,
- Wendy Fabbro, Associate Director, Integrated Commissioning Directorate
- Yvonne Clowsley, Head of Planning, Integrated Commissioning Directorate

The review group interviewed GP principals, practice managers, practice nurses and patient group representatives at:

- Fownhope Surgery
- Greyfriars Surgery
- Nunwell Surgery
- Pendeen Surgery
- St Katherine's Surgery
- Weobley Surgery

Data and other information

- *Better, Safer Doctors: Implementing Medical Revalidation*, NHS Employers, 2009
- *General Practices offering Extended Opening Hours under a Local Enhanced Service Agreement in Herefordshire*, NHS Herefordshire, May 2009
- *GP Earnings and Expenses Enquiry* 2006/07 Report, NHS Information Centre, May 2009
- *Health Select Committee Alcohol Report*, House of Commons, March 2009
- *Hereford A & E Pre-Reception Triage* 2nd Pilot Report, NHS Herefordshire, August 2008
- *Hereford Hospitals Trust Board Paper*: Market Report (incorporating GP Survey Results), Quarter 1 2009/10
- *Herefordshire Disability Equality Scheme*, Herefordshire Council, 2009
- *Herefordshire Place Survey*, Herefordshire Council, 2009
- *Herefordshire Provider Services Review*, Herefordshire Council and NHS Herefordshire, April 2009 (accessed on Herefordshire Council Intranet October 2009)
- *Survey of Patients Attending A&E*, Herefordshire PPI Forums, 2007
- *Survey of Local Health Services Herefordshire PCT*, Healthcare Commission, 2008
- *Personal Health Budgets: Expression of Interest*, Herefordshire Council, March 2009
- *Practice Based Commissioning GP Practice Survey*: Wave 1-8 Results, Dept of Health, September 2009
- *Primary Health Care for Social Excluded Groups, Call for Evidence*, Cabinet Office, April 2009
- *Quality and Outcomes Framework Guidance for GMS contract*, NHS Employers, 2008/09
- *Rural Health Planning – Improving Service Delivery across Wales*, Welsh Assembly consultation document, April 2009
- *Rural Proofing for Health: A Guide for Primary Care*, Institute for Rural Health, 2005
- *Use of Resources Profile Herefordshire PCT*, Audit Commission, Nov 2008
- *Results of various GP surgeries' annual patient surveys 2007-8-9*

Appendix B

Hereford A & E Pre-Reception Triage
2nd Pilot August 1,2,3 &4 2008

An analysis of 327 attendances/presentations at the DGH A&E is below.
For the purposes of the analysis, in hours is defined as 08.30 to 19.00 weekdays (despite GP hrs finishing at 17.30, GPOOH does not start until 19.00. This is unfortunate as on weekdays there is a definite peak in inappropriate attendance at 18.00)

Only 327 pts accepted for triage as due to staff sickness and pt workload a full 24hr triage presence could not be maintained from within existing staffing.

In Hours Attendances Disposals

A&E	Eye Cas	GP	OPD	Nil needed	TOTAL
65	36	16	3	2	122

This suggests **17.2% inappropriate A&E attendances**.
2 pts were sent by GP receptionists (according to pts) with abdo pain and diarrhoea !!

Out of Hours A&E Attendance Disposals

A&E	Eye Cas	GPOOH	GP/Pharmacy	OPD	TOTAL
126	13	30	34*	2	205

* it is accepted that of 34 patients referred to their own GP or pharmacy a percentage may well and probably did contact GPOOH services despite advice given.

Further to the above, 4 pts were incorrectly triaged to A&E and 7pts refused to leave A&E!
4 further pts were sent by Primecare to A&E as no doc present:

1 toothache
1 needed tetanus injection
1 had noticed BP had risen
1 had hip pain for 6 months

2 were sent back by Primecare as deemed inappropriate for them, I do not concur.

1 old pencil wound to face
1 allergic dermatitis

This gives a figure of at least 36.6% inappropriate attenders in A&E at least.

Further to this, several pts after further A&E assessment were deemed GP pts
(12-15 in total). This leads to a figure of **at least 40% inappropriate**.

Looking at hourly attenders >45% were non A&E at peak times – Sat & Sun afternoons.
The main reasons for inappropriate attendances were:

Pregnancy related

Old Injury (maximum over 6 mnths!)
Insect bites and stings
Abdo Pain
Soft tissue infection

During the period of study 6 medically expected and 4 surgically expected pts were excluded from analysis.

Conclusions

The study replicates the findings of the previous pilot.

Patients do not appear to know (or do not wish to know) how to access the appropriate care pathway…

At least 35% of A&E attendances are inappropriate and better dealt with by other HCPs.

Public Education of how to access the health service is not getting through.
(Of those asked why they did not contact the GP service, the standard answer was “they only work Monday to Friday”, there appears to be ignorance of the OOH service.)

Few patients had taken self medication or sought other advice.

Only 1 pt admitted to having contacted NHS Direct and had been wrongly sent to A&E.

Proposal

Funding should be sought for an extended trial of the 24 hour pre-reception triage, preferably over a 6 month period.
Funding would be available from savings to PCT made by not booking in 35-40% of pts in A&E (@£54 each). It is accepted that this would cause a loss of income to HHT but partially offset by less investigations due to inexperienced docs outside their remit.
The word would soon spread that going to A&E is not the correct way to gain access to all HCPs.
Reducing inappropriate attenders to A&E would allow better care to true A&E pts.
(The Sunday of the trial, despite being in August, reduced the workload of A&E to 100. The staff of the dept remarked that this was the best Sunday in A&E for some time.)

NB
The present design of A&E does not lend itself to full pre-reception triage (lack of confidentiality).
Consideration of utilising present GP OOH desk for such or similar at entrance to A&E would be preferable.
Ideally combining A&E and GP reception/triage would be the best solution but would require some limited building alterations.

Can I thank my nursing staff for their hard work and also for putting up with abusive patients trying to short circuit the system.

A.Ballham 06.08.2008

Appendix C
Scoping document

REVIEW:	**GP Services in Herefordshire**	
Committee:	Health Scrutiny Committee	**Chair:** Councillor Patricia Morgan
Lead support officer:	Sara Siloko	

SCOPING

Terms of Reference

This review assesses the service levels and subsequent performance of General Practitioner (GP) services in Herefordshire, with particular focus on the provision of extended practice hours and the provision of preventive intervention measures and screening initiatives for their registered patients.

Desired outcomes

- To assess levels of overall service provided to Herefordshire residents by GPs under the Herefordshire Primary Care Trust (PCT) contract in order to:
    - seek assurance that the county's residents are receiving the level of service they need and deserve
    - identify and analyse any particular areas for improvement in the county's GP service provision
- To ascertain the current level of access to GP services across Herefordshire with particular emphasis on identifying issues pertaining to access to out-of-hours across population groups and localities
- Given the increasing emphasis on lifestyle choices and population wellbeing the review will examine GP involvement in preventive activities particularly for the major causes of disease and premature death in the county
- To ascertain the governance arrangements for performance managing and changing the service when necessary
- To ascertain the level of involvement of GPs in planning services

Key questions

- Do all population groups in Herefordshire enjoy a similarly high level of satisfaction as suggested by the overall figures from recent surveys?
- Are there specific population groups dissatisfied about their experience of GP services in Herefordshire?
- Do all population groups and localities enjoy equitable access to GP services in the county?
- Is access to GP services outside normal working hours similar across rural and urban parts of the county?
- Are there specific areas or population groups experiencing difficulties with accessing GP services in the county?
- Are there specific areas or groups in the county that are disadvantaged by the current arrangements for extended opening hours for GP services?
- Are there national targets relating to preventive services, and if so what are they?
- How are Herefordshire GPs involved in delivering effective preventive actions aimed at reducing diseases and premature deaths due to cancers, stroke and diabetes?
- What specifically are GP practices throughout the county doing to support the effort to reduce smoking, promote sensible alcohol use, and reduce the levels of obesity and sexually transmitted infections?
- How are local GPs currently engaged in the delivery of services such as social care and mental health in their communities?
- What impact will ongoing and planned changes in health and social care service provision - such as the push to reduce numbers in residential care, individualised budgets, etc - have on GP services?
- To what extent are local GP practices involved in identifying and meeting the extended needs of the patient population they serve by using the opportunities offered by Practice Based Commissioning?
- How do GPs in the county interact and support the community hospitals, nursing homes and Intermediate Care Units in their locality?
- How, and how often, do the commissioners of the service assess the needs of the county's population for GP services?
- How are resources to meet these needs allocated to GP surgeries in Herefordshire and how does this process compare with national guidelines?
- What is the process for meeting needs above and beyond those identified in the basic GP contract?
- How are local GP services financed, and how is that money allocated to basic services and

other services?

- What criteria have to be met in order for a GP surgery to agree to provide a new service?
- How does the PCT ensure and monitor that there is equitable access to services for all?
- How does the PCT measure the outcomes for Herefordshire patients?
- Are there any plans locally or nationally (intended or already under way) which will change the preventive and/or screening services provided by GPs for Herefordshire? What are these plans, and when and how will they be implemented?
- Are there any plans intended or already under way to change extended hours GP service provision for Herefordshire? What are these plans, and when and how will they be implemented?
- What feedback do GPs receive from the PCT regarding the results of its annual patient survey?
- If there are discrepancies in service levels in different parts of the county, what action do GP surgeries take, or propose others take, to ensure that more equitable and efficient services can be achieved?
- How does the PCT interact with the Local Medical Council (LMC) and ensure involvement of the local GPs in the planning of future services?
- How could communication between GP providers and the commissioners of services be improved?

Links to the Community Strategy

The review group will identify how the outcome of this review contributes to the objectives contained in the Herefordshire Community Strategy, including the Council's Corporate Plan and other key plans or strategies.

Links to the PCT commissioning of GP services

The review will include questioning of the PCT management on the level of commissioning for GP services and their evaluation of the service provider.

Proposed Methodology
• Desk based review of evidence, data and source documents • Evidence review sessions and briefing from key informants • Briefing from expert witnesses, officers, and selected informants • Identification, collation, analysis and interpretation of locally available data • Visits to model GP practices of renowned excellence outside the county • Visits to a selection of GP practices in the county • Focus group discussions with key informers, community members, patients and selected groups • Obtaining the views of all GP practices directly via written response

Timetable

Activity	*Timescale*
Agree approach, programme of consultation/research/provisional witnesses/dates	By Friday 10 April 2009
Brief review group	By Friday 24 April 2009
Collect current available data	By Friday 1 May 2009
Collect outstanding data	By Friday 15 May 2009
Analysis of data	By Friday 29 May 2009
Final confirmation of interviews of witnesses	By Friday 15 May 2009
Carry out programme of interviews	During first two weeks of June 2009
Agree programme of site visits	By Friday 15 May 2009
Undertake site visits as appropriate	During June 2009
Final analysis of data and witness evidence	By Friday 10 July 2009
Prepare draft report including options/recommendations	By Friday 17 July 2009
Test assumptions with informants	By Friday 31 July 2009
Prepare final report	By Friday 14 August 2009
Present final report to Health Scrutiny Committee	On ?? September 2009
Implementation of agreed recommendations	

Members	Support Officers
Councillor Brigadier P Jones Councillor P J Watts Councillor A Seldon - chairman Councillor G Lucas Councillor G Powell Councillor P Cutter	Sara Siloko

Appendix D
World Class Commissioning data

Attach
1) WCC 2009 diagram portrait.pdf
2) Appendix wcc1.pdf
3) WCC toolkit 2.pdf
4) WCC toolkit 3.pdf

Appendix E
Herefordshire GP access survey results (supplied by NHS Herefordshire in July 2009)

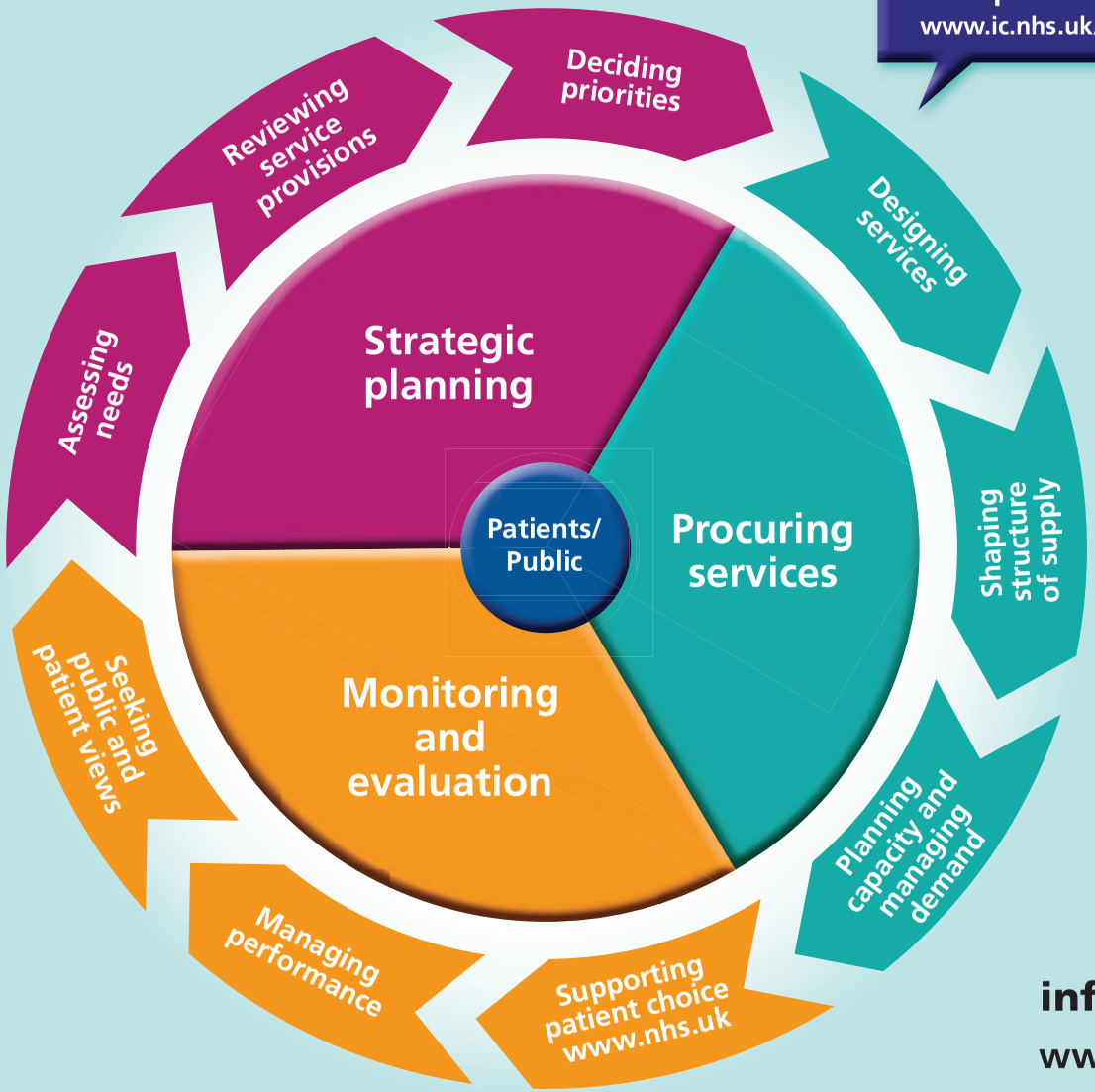
Attach
1) WMSHA patient survey results Hfdshire PCT-GP access.pdf

Information for World Class Commissioning 2009

NHS

The Information Centre for health and social care

Data packs coming soon:
www.ic.nhs.uk/commissioning



Strategy planning

Assessing needs

WCC Data Packs
Benchmarking for national, regional and most comparable PCT activity for the World Class Commissioning assurance process

NHS Comparators
Supports practice-based commissioning and primary care by understanding local activity, costs, and outcomes and comparisons with others

Health Poverty Index
Compare areas on factors influencing health inequalities

Compendium of Public Health Indicators
See how you're performing against over 250 public health indicators

Lifestyle publications
Insight into alcohol consumption, obesity, smoking, drug misuse, and a range of specialist surveys including those relating to young people, infant feeding, mental health and dental health

National Diabetes Audit
With the National Diabetes Information Service you can examine local population profiles, risk factors, service provision and outcomes

Reviewing service provisions

Programme Budgeting
Plan budgets using NHS Comparators and Compendium of Public Health Indicators

Social Care publications and statistics
Examine how much is being spent on social care services in your area

Deciding priorities

Joint Strategic Needs Assessment (JSNA)
JSNA core dataset focussing on a list of indicators, cross-tabulated against Vital Signs and the National Indicator Set

Monitoring and evaluation

Supporting patient choice

National Clinical Audit Support Programme
Compare clinical conditions and treatment received for cancer, heart disease, diabetes and renal

Over 120 health and social care publications
Comprehensive insight into disability, older people, screening, eye care, dentistry and maternity

Managing and monitoring performance

WCC Data Packs
Regularly refreshed data with an organisational dashboard to monitor trends and evaluate services

NHS Comparators
Appraise local in/outpatient disease area activity, costs, outcomes, and identifying prescribing activity

Quality and Outcomes Framework
Resourcing healthcare based on practice-level prevalence data

Seeking public and patient views

Health Survey for England
Annual snapshot of the nation's health and local health needs

Social care user experience surveys
Annual surveys to get feedback from different groups of service users

Patient Reported Outcome Measures (PROMS)
Collect information on the clinical quality of care as perceived by patients themselves

Procuring services

Designing services

Workforce
Resource enabling NHS workforce planning, using statistics on NHS staff numbers, earnings, turnover, and vacancies

Hospital Episode Statistics (HES)
Data on all patients admitted to NHS hospitals in England

Mental Health Minimum Data Set (MHMDS)
Data on patients accessing secondary mental health services

Shaping structure of supply

18 Weeks Reporting Tool
Informs resourcing based on tracking of patient progress through 18 week treatment pathways

Healthcare Resource Groups (HRGs)
Supports delivery of future patient care based on current patient need

Planning capacity and managing demand

WCC Data Packs
Data from multiple sources providing individual organisational profiles against national averages

NHS Comparators
Identifying patterns of referrals from primary to secondary care and comparisons with others

General Practice, dentistry and optometry
Insight into workforce; levels and types of activity; earnings and expenses

Secondary Uses Service (SUS)
Identifies the cost of provider activity against the national tariff – highlights coding activity, ensuring accuracy in provider payments

Estates and Facilities Management
Resources showing estate size, condition, energy use, food costs, parking availability and so on

Access these information resources at:

www.ic.nhs.uk/commissioning

The central, authoritative source of health and social care information

World Class Commissioning Toolkit

Indicator Groups (#): Primary Care (24)

West Midlands (Q34) | Herefordshire PCT (5CN) | PCT's SHA Cluster (Q34 - West Midlands)

Indicator (graphs)	Description	Trust Value	Peer Median	Quintile
5.01 H Q	GP per 1000 weighted population	0.73	0.57	
5.02 H	Non GP clinical staff per 1000 weighted population	1.63	1.41	
5.03 H	Percent single handed GP practices	0.00%	20.21%	
5.04 H	Percent practitioners aged 65 and over	0.48%	3.43%	
5.05 H Q	Percent of adults seen by a dentist	45.10%	54.00%	
5.06 H Q	Percent of children seen by a dentist	69.10%	69.70%	
5.07 H	Total sight tests per weighted population	0.23	0.23	
5.08 H Q	Prescription items dispensed per month per weighted population	0.85	1.17	
5.09 H Q	Pharmacies per 100,000 population	14	20	
5.10 H	Percentage offered choice of provider	98.08%	90.50%	
5.11 H	Percentage satisfaction with phone access	91.85%	85.04%	
5.12 H	Percentage able to get appointment within 48 hours	90.95%	84.61%	
5.13 H	Percentage able to book 2 + days ahead	73.81%	72.85%	
5.14 H	Percentage able to book appointment with a specified GP	89.83%	88.17%	
5.15 H	Percentage satisfaction with opening hours	82.82%	85.59%	
5.16 H	Percentage offered additional Services: child health surveillance	100.00%	96.88%	
5.17 H	Percentage offered additional Services: maternity services	100.00%	100.00%	
5.18 H	Percentage diabetes in whom the last blood pressure is 145/85 or less (ages 17+)	75.18%	76.39%	
5.19 H	Percentage of diabetics with HbA1c or equivalent 15 months	98.17%	97.08%	
5.20 H	Percentage of patients with smoking related conditions offered smoking cessation advice or referral	92%	93%	
5.21 H	Percentage of patients with TIA or stroke who have a record of total cholesterol 15 months	90.50%	91.97%	
5.22 H	Percentage of patients with newly diagnosed angina who were referred for exercise testing/specialist advice	95.05%	93.91%	
5.23 H	Percentage of patients with hypertension in whom there is a record of the blood pressure	94.25%	92.59%	
5.24 H	Percentage of GPs with Special Interests	6.25%	4.60%	

World Class Commissioning Toolkit

Indicator Groups (#): Primary Care (24)

West Midlands (Q34) | Herefordshire PCT (5CN) | PCT's ONS Cluster (Prospering Smaller Towns B)

Indicator (graphs)	Description	Trust Value	Peer Median	Quintile
5.01 H Q	GP per 1000 weighted population	0.73	0.67	
5.02 H	Non GP clinical staff per 1000 weighted population	1.63	1.69	
5.03 H	Percent single handed GP practices	0.00%	6.80%	
5.04 H	Percent practitioners aged 65 and over	0.48%	0.59%	
5.05 H Q	Percent of adults seen by a dentist	45.10%	53.90%	
5.06 H Q	Percent of children seen by a dentist	69.10%	72.10%	
5.07 H	Total sight tests per weighted population	0.23	0.23	
5.08 H Q	Prescription items dispensed per month per weighted population	0.85	1.09	
5.09 H Q	Pharmacies per 100,000 population	14	15	
5.10 H	Percentage offered choice of provider	98.08%	95.01%	
5.11 H	Percentage satisfaction with phone access	91.85%	87.20%	
5.12 H	Percentage able to get appointment within 48 hours	90.95%	88.14%	
5.13 H	Percentage able to book 2 + days ahead	73.81%	73.09%	
5.14 H	Percentage able to book appointment with a specified GP	89.83%	89.06%	
5.15 H	Percentage satisfaction with opening hours	82.82%	84.72%	
5.16 H	Percentage offered additional Services: child health surveillance	100.00%	100.00%	
5.17 H	Percentage offered additional Services: maternity services	100.00%	100.00%	
5.18 H	Percentage diabetes in whom the last blood pressure is 145/85 or less (ages 17+)	75.18%	78.75%	
5.19 H	Percentage of diabetics with HbA1c or equivalent 15 months	98.17%	97.94%	
5.20 H	Percentage of patients with smoking related conditions offered smoking cessation advice or referral	92%	93%	
5.21 H	Percentage of patients with TIA or stroke who have a record of total cholesterol 15 months	90.50%	91.90%	
5.22 H	Percentage of patients with newly diagnosed angina who were referred for exercise testing/specialist advice	95.05%	95.05%	
5.23 H	Percentage of patients with hypertension in whom there is a record of the blood pressure	94.25%	92.61%	
5.24 H	Percentage of GPs with Special Interests	6.25%	6.25%	

World Class Commissioning Toolkit

Indicator Groups (#): Primary Care (24)

West Midlands (Q34) | Herefordshire PCT (5CN) | National Peer

Indicator (graphs)	Description	Trust Value	National Median	Quintile
5.01 H Q	GP per 1000 weighted population	0.73	0.58	
5.02 H	Non GP clinical staff per 1000 weighted population	1.63	1.47	
5.03 H	Percent single handed GP practices	0.00%	18.04%	
5.04 H	Percent practitioners aged 65 and over	0.48%	2.52%	
5.05 H Q	Percent of adults seen by a dentist	45.10%	53.00%	
5.06 H Q	Percent of children seen by a dentist	69.10%	71.35%	
5.07 H	Total sight tests per weighted population	0.23	0.21	
5.08 H Q	Prescription items dispensed per month per weighted population	0.85	1.14	
5.09 H Q	Pharmacies per 100,000 population	14	20	
5.10 H	Percentage offered choice of provider	98.08%	93.42%	
5.11 H	Percentage satisfaction with phone access	91.85%	84.48%	
5.12 H	Percentage able to get appointment within 48 hours	90.95%	84.29%	
5.13 H	Percentage able to book 2 + days ahead	73.81%	72.33%	
5.14 H	Percentage able to book appointment with a specified GP	89.83%	87.18%	
5.15 H	Percentage satisfaction with opening hours	82.82%	84.62%	
5.16 H	Percentage offered additional Services: child health surveillance	100.00%	97.14%	
5.17 H	Percentage offered additional Services: maternity services	100.00%	100.00%	
5.18 H	Percentage diabetes in whom the last blood pressure is 145/85 or less (ages 17+)	75.18%	78.73%	
5.19 H	Percentage of diabetics with HbA1c or equivalent 15 months	98.17%	97.19%	
5.20 H	Percentage of patients with smoking related conditions offered smoking cessation advice or referral	92%	93%	
5.21 H	Percentage of patients with TIA or stroke who have a record of total cholesterol 15 months	90.50%	91.66%	
5.22 H	Percentage of patients with newly diagnosed angina who were referred for exercise testing/specialist advice	95.05%	93.78%	
5.23 H	Percentage of patients with hypertension in whom there is a record of the blood pressure	94.25%	92.48%	
5.24 H	Percentage of GPs with Special Interests	6.25%	4.44%	

Universe

Strategic Health Authority (SHA):	West Midlands SHA
Primary Care Trust (PCT):	HEREFORDSHIRE PRIMARY CARE TRUST
Practice name:	All
Practice Size (Banded):	All
Gender:	All
Age group:	All
Ethnicity:	All
Working status:	All
Break-down variable 1:	« None »
Break-down variable 2:	« None »
Break-down variable 3:	« None »

Crosstables

Question: Q1 - How easy do you find it to get into the building at your GP surgery or health centre?
Base: All

	-	-	-
Very easy	80%	4,842	
Fairly easy	18%	1,086	
Not very easy	2%	123	
Not at all easy	0%	26	
Total		6,077	

Question: Q2 - How clean is your GP surgery or health centre?
Base: All

	-	-	-
Very clean	80%	4,878	
Fairly clean	18%	1,118	
Not very clean	0%	21	
Not at all clean	*	*	
Don't know	1%	60	
Total		6,083	

Question: Q3 - In the reception area, can other patients overhear what you say to the receptionist?
Base: All

	-	-	-
Yes, but I don't mind	65%	3,942	
Yes, and I am not happy about it	20%	1,238	
No, other patients can't overhear	10%	598	
Don't know	5%	284	
Total		6,062	

Question: Q4 - How helpful do you find the receptionists at your GP surgery or health centre?
Base: All

	-	-	-
Very helpful	64%	3,832	
Fairly helpful	32%	1,873	
Net very helpful	3%	202	
Not at all helpful	1%	39	
Total		5,946	

Question: Q5a - In the past 6 months, how easy have you found the following?... Getting through on the phone
Base: All

	-	-	-
Haven't tried	8%	508	
Very easy	39%	2,344	
Fairly easy	38%	2,275	
Not very easy	10%	632	
Not at all easy	4%	225	
Don't know	1%	65	
Total		6,049	

Question: Q5b - In the past 6 months, how easy have you found the following?... Speaking to a doctor on the phone

Base:	All	
	-	
	-	
	-	
Haven't tried	41%	2,409
Very easy	14%	796
Fairly easy	21%	1,235
Not very easy	9%	534
Not at all easy	5%	291
Don't know	10%	595
Total		5,860

Question:	Q5c - In the past 6 months, how easy have you found the following?... Speaking to a nurse on the phone	
Base:	All	
	-	
	-	
	-	
Haven't tried	51%	2,984
Very easy	11%	635
Fairly easy	15%	883
Not very easy	5%	293
Not at all easy	3%	154
Don't know	15%	869
Total		5,818

Question:	Q5d - In the past 6 months, how easy have you found the following?... Getting test results on the phone	
Base:	All	
	-	
	-	
	-	
Haven't tried	41%	2,390
Very easy	22%	1,256
Fairly easy	17%	999
Not very easy	5%	289
Not at all easy	3%	202
Don't know	12%	691
Total		5,827

Question:	Q6 - In the past 6 months, have you tried to see a doctor fairly quickly? By 'fairly quickly' we mean on the s	
Base:	All	
	-	
	-	
	-	
Yes	65%	3,895
No	34%	1,996
Can't remember	1%	62
Total		5,953

Question:	Q7 - Think about the last time you tried to see a doctor fairly quickly. Were you able to see a doctor on the s	
Base:	All patients who say they tried to see a doctor fairly quickly in the past 6 months	
	-	
	-	
	-	
Yes	89%	3,440
No	10%	391
Can't remember	1%	23
Total		3,854

Question:	Q8 - If you couldn't be seen within the next 2 days the GP surgery or health centre was open, why was that'	
Base:	All patients who couldn't be seen within the next two days the surgery was open	
	-	
	-	
	-	
There weren't any appointments	72%	*
The time offered didn't suit me	12%	*
The appointment was with a doctor I didn	23%	*
I could have seen a nurse but I wanted to	4%	*
Another reason	8%	*
Can't remember	*	*
Total		388

Question:	Q9 - In the past 6 months, have you tried to book ahead for an appointment with a doctor? By 'booking ahe
Base:	All

	-	
	-	
	-	
Yes	57%	3,366
No	41%	2,463
Can't remember	2%	106
Total		5,935

Question: Q10 - Last time you tried to, were you able to get an appointment with a doctor more than 2 full days in adv
Base: All patients who tried to book ahead for an appointment with a doctor in the past 6 months

	-	
	-	
	-	
Yes	78%	2,585
No	20%	646
Can't remember	2%	80
Total		3,311

Question: Q11 - When did you last see a doctor at your GP surgery or health centre?
Base: All

	-	
	-	
	-	
In the past 3 months	56%	3,385
Between 3 and 6 months ago	21%	1,250
More than six months ago	23%	1,370
Never	1%	39
Total		6,044

Question: Q12 - If you haven't seen a doctor in the past 6 months, why is that?
Base: All patients who say they haven't seen a doctor in the past 6 months

	-	
	-	
	-	
I haven't needed to see a doctor	93%	*
I couldn't be seen at a convenient time	2%	*
I couldn't get to the GP surgery or health	2%	*
I didn't like or trust the doctors	1%	*
Another reason	3%	*
Total		1,378

Question: Q13 - How long after your appointment time do you normally wait to be seen?
Base: All

	-	
I don't normally have appointments at a p	1%	80
I am normally seen at my appointment tin	12%	693
Less than 5 minutes	12%	708
5 to 15 minutes	53%	3,202
16 to 30 minutes	15%	889
More than 30 minutes	4%	244
Can't remember	3%	177
Total		5,993

Question: Q14 - How do you feel about how long you normally have to wait?
Base: All

	-	
	-	
	-	
I don't normally have to wait too long	74%	4,408
I have to wait a bit too long	15%	898
I have to wait far too long	5%	276
No opinion/doesn't apply	6%	360
Total		5,942

Question: Q15 - Is there a particular doctor you prefer to see at your GP surgery or health centre?
Base: All

	-	
	-	
	-	
Yes	70%	4,195
No	30%	1,818
There is usually only one doctor in my GI	0%	15
Total		6,028

Question: Q16 - How often do you see the doctor you prefer to see?
Base: All patients who have a doctor they prefer to see at their surgery

Always or almost always	61%	2,518
A lot of the time	21%	866
Some of the time	15%	620
Never or almost never	3%	128
Not tried at this GP surgery or health cen	*	*
Total		4,139

Question: Q17 - How satisfied are you with the hours that your GP surgery or health centre is open?
Base: All

Very satisfied	42%	2,567
Fairly satisfied	39%	2,390
Neither satisfied nor dissatisfied	9%	545
Fairly dissatisfied	5%	274
Very dissatisfied	2%	96
I'm not sure when my GP surgery or heal	3%	182
Total		6,054

Question: Q18 - Would you like your GP surgery or health centre to open at additional times?
Base: All

Yes	54%	3,070
No	46%	2,595
Total		5,665

Question: Q19 - Which one of the following additional times would you most like the GP surgery or health centre to be
Base: All patients who would like their surgery to be open at additional times

Before 8am	5%	128
At lunchtime	3%	92
After 6:30pm	23%	620
On a Saturday	66%	1,793
On a Sunday	3%	72
Total		2,705

Question: Q20 - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at each of t
Base: All

Very good	63%	3,757
Good	30%	1,822
Neither good nor poor	5%	299
Poor	1%	55
Very poor	0%	22
Doesn't apply	1%	35
Total		5,990

Question: Q20 - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at each of t
Base: All

Very good	60%	3,552
Good	32%	1,926
Neither good nor poor	5%	280
Poor	1%	80
Very poor	0%	14
Doesn't apply	1%	79
Total		5,931

Question: Q20 - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at each of t
Base: All

	-	
	-	
	-	
Very good	63%	3,730
Good	30%	1,777
Neither good nor poor	5%	270
Poor	2%	108
Very poor	0%	22
Doesn't apply	1%	42
Total		5,949

Question: Q20 - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at each of t
Base: All

	-	
	-	
	-	
Very good	55%	3,252
Good	28%	1,655
Neither good nor poor	6%	371
Poor	2%	105
Very poor	0%	20
Doesn't apply	8%	475
Total		5,878

Question: Q20 - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at each of t
Base: All

	-	
	-	
	-	
Very good	50%	2,946
Good	27%	1,586
Neither good nor poor	8%	465
Poor	2%	111
Very poor	1%	37
Doesn't apply	12%	706
Total		5,851

Question: Q20 - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at each of t
Base: All

	-	
	-	
	-	
Very good	61%	3,587
Good	29%	1,716
Neither good nor poor	6%	349
Poor	2%	95
Very poor	1%	33
Doesn't apply	2%	108
Total		5,888

Question: Q20 - Last time you saw a doctor at your GP surgery or health centre, how good was the doctor at each of t
Base: All

	-	
	-	
	-	
Very good	61%	3,586
Good	28%	1,642
Neither good nor poor	6%	369
Poor	2%	125
Very poor	1%	52
Doesn't apply	2%	129
Total		5,903

Question: Q21 - Did you have confidence and trust in the doctor you saw?
Base: All

	-	
	-	
	-	
Yes, definitely	79%	4,709
Yes, to some extent	18%	1,088
No, not at all	2%	122

Don't know	1%	74
Total		5,993

Question: Q22 - Have you seen a practice nurse at your GP surgery or health centre in the past 6 months?
Base: All

Yes	58%	3,494
No	42%	2,500
Total		5,994

Question: Q23 - How easy is it for you to get an appointment with a practice nurse at your GP surgery or health centre
Base: All patients who have seen a practice nurse at the surgery in the past 6 months

Haven't tried	2%	55
Very easy	63%	2,165
Fairly easy	33%	1,134
Not very easy	2%	79
Not at all easy	*	*
Don't know	0%	13
Total		3,455

Question: Q24 - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice n
Base: All patients who have seen a practice nurse at the surgery in the past 6 months

Very good	70%	2,394
Good	26%	906
Neither good nor poor	2%	80
Poor	1%	21
Very poor	*	*
Doesn't apply	1%	37
Total		3,443

Question: Q24 - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice n
Base: All patients who have seen a practice nurse at the surgery in the past 6 months

Very good	56%	1,882
Good	27%	912
Neither good nor poor	5%	174
Poor	1%	24
Very poor	*	*
Doesn't apply	11%	362
Total		3,360

Question: Q24 - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice n
Base: All patients who have seen a practice nurse at the surgery in the past 6 months

Very good	61%	2,078
Good	29%	980
Neither good nor poor	4%	127
Poor	1%	29
Very poor	0%	16
Doesn't apply	5%	155
Total		3,385

Question: Q24 - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice n
Base: All patients who have seen a practice nurse at the surgery in the past 6 months

Very good	58%	1,937
Good	28%	934
Neither good nor poor	5%	166
Poor	1%	23

Very poor	*	*
Doesn't apply	8%	277
Total		3,346

Question: Q24 - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice n
Base: All patients who have seen a practice nurse at the surgery in the past 6 months

	-	
	-	
	-	
Very good	49%	1,617
Good	26%	854
Neither good nor poor	7%	225
Poor	1%	32
Very poor	0%	12
Doesn't apply	17%	579
Total		3,319

Question: Q24 - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice n
Base: All patients who have seen a practice nurse at the surgery in the past 6 months

	-	
	-	
	-	
Very good	65%	2,199
Good	28%	928
Neither good nor poor	4%	122
Poor	1%	29
Very poor	0%	11
Doesn't apply	3%	85
Total		3,374

Question: Q24 - Last time you saw a practice nurse at your GP surgery or health centre, how good was the practice n
Base: All patients who have seen a practice nurse at the surgery in the past 6 months

	-	
	-	
	-	
Very good	59%	1,973
Good	26%	873
Neither good nor poor	5%	152
Poor	1%	21
Very poor	*	*
Doesn't apply	10%	326
Total		3,355

Question: Q25 - In general, how satisfied are you with the care you get at your GP surgery or health centre?
Base: All

	-	
	-	
	-	
Very satisfied	67%	4,054
Fairly satisfied	27%	1,662
Neither satisfied nor dissatisfied	4%	216
Fairly dissatisfied	1%	85
Very dissatisfied	0%	28
Total		6,045

Question: Q26 - Do you have any long-standing health problem, disability or infirmity? Please include anything that h
Base: All

	-	
	-	
	-	
Yes	51%	3,007
No	48%	2,808
Don't know	2%	89
Total		5,904

Question: Q27 - In the past 6 months, have you had a discussion with a doctor or nurse about managing your long-st
Base: All patients who have a long-standing health problem, disability or infirmity

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	-	
	-	
Yes	76%	2,208
No, I don't want a discussion	17%	506
No, I would have liked a discussion	5%	149

Can't remember	2%	56
Total		2,919

Question: Q28 - Following this discussion, did a doctor or nurse agree a plan about how you wanted to manage your
Base: All patients who had a discussion with a doctor or nurse about managing their long-standing health problen

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	-	
Yes	88%	1,913
No	9%	195
Can't remember	3%	55
Total		2,163

Question: Q29 - Do you think that having a discussion or plan has helped improve the care you receive?
Base: All patients who had a discussion with a doctor or nurse about managing their long-standing health problen

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	-	
Yes, definitely	55%	1,167
Yes, to some extent	35%	747
No, not at all	6%	124
Don't know	4%	87
Total		2,125

Question: Q30 - If you wanted to, would you know how to contact an out-of-hours GP service when the surgery or hea
Base: All

	-	
	-	
	-	
Yes	72%	4,337
No	28%	1,666
Total		6,003

Question: Q31 - In the past 6 months, have you tried to call an out-of-hours GP service when the surgery or health ce
Base: All

	-	
	-	
	-	
Yes, for myself	6%	*
Yes, for someone else	10%	*
No	84%	*
Total		5,993

Question: Q32 - How easy was it to contact the out-of-hours GP service by telephone?
Base: All patients who tried to call an out-of-hours GP service in the past 6 months

	-	
	-	
	-	
Very easy	34%	321
Fairly easy	43%	410
Not very easy	14%	130
Not at all easy	7%	67
Don't know/didn't make contact	2%	18
Total		946

Question: Q33 - Were you prescribed or recommended any medicines by the out-of-hours GP service you contacted'
Base: All patients who tried to call an out-of-hours GP service in the past 6 months

	-	
	-	
	-	
Yes	52%	491
No	41%	386
Don't know	7%	66
Total		943

Question: Q34 - How easy was it to get these medicines?
Base: All patients who were prescribed or recommended medicines by the out-of-hours GP service

	-	
	-	
	-	
Very easy	36%	176
Fairly easy	41%	200

Not very easy	16%	79
Not at all easy	7%	32
Total		487

Question: Q35 - How do you feel about how quickly you received care from the out-of-hours GP service?
Base: All patients who tried to call an out-of-hours GP service in the past 6 months

	-	
	-	
	-	
It was about right	59%	547
It took too long	37%	339
Don't know/doesn't apply	5%	42
Total		928

Question: Q36 - Overall, how do you feel about the care you received from the out-of-hours GP service?
Base: All patients who tried to call an out-of-hours GP service in the past 6 months

	-	
	-	
	-	
Very good	23%	215
Good	37%	345
Neither good nor poor	20%	187
Poor	10%	90
Very poor	8%	72
Doesn't apply	3%	31
Total		940

Herefordshire Council

MEETING:	**HEALTH SCRUTINY COMMITTEE**
DATE:	**1 MARCH 2010**
TITLE OF REPORT:	**QUALITY ASSURANCE FRAMEWORK**
REPORT BY:	**DIRECTOR OF QUALITY AND CLINICAL LEADERSHIP**

CLASSIFICATION: Open

Wards Affected

County-wide.

Purpose

To update the Committee on the Quality Assurance Framework and the processes and systems in place to ensure quality services are being commissioned and directly provided.

Introduction and Background

1. A report by the Director of Quality and Clinical Leadership is attached for consideration.

Background Papers

- None identified.

Further information on the subject of this report is available from
Sue Doheny, Director of Quality and Clinical Leadership, on (01432) 383255

QUALITY ASSURANCE FRAMEWORK

1. Introduction

The purpose of this paper is to update Health Scrutiny Committee on the Quality Assurance Framework. This is in conjunction with a presentation on the processes and systems in place to ensure quality services are being commissioned and directly provided by NHS Herefordshire and Herefordshire Council.

2. Background

NHS Herefordshire and Herefordshire Council, through the Commissioning for Quality Strategy (Appendix 1), are committed to ensuring high quality services are commissioned and provided to the people of Herefordshire. The Quality Assurance Framework provides a mechanism to report on the success of the strategy. The framework ensures quality is the cornerstone of every stage of the commissioning process.

In view of national reviews such as The Next Stage Review conducted by Lord Darzi and policy direction of World Class Commissioning it is critical that there is clear evidence that quality is the focus of commissioning.

3. Quality Assurance

3.1 Commissioning Services

Lord Darzi in The Next Stage Review is very clear that there are three distinct components to a high quality service; clinical effectiveness, customer experience and safety. All three components have to be evidenced to be assured that a quality service has been commissioned and consequently provided.

The following provides a brief overview of areas to be considered when commissioning high quality services:

3.1.1 Clinical/care Governance

This area covers commissioned and independent contractors; in

- Clinical and care cost effectiveness
    - Care Pathways
    - Professional development
    - Audit
    - QOF
    - Medicines Management
- Governance

  - Re-validation
  - Post registration workforce development
- Risk assurance
  - Clinical risk
- Compliance with Standards
  - National eg Standards for Better Health
  - Local eg Stroke
- Compliance with guidelines
  - National eg. NICE, NPSA
  - Local eg. Falls

3.1.2 Safety

It is important that there is an appropriate level of assurance that people in Herefordshire feel safe when accessing services.

- Notification of, and learning from, events and incidents
  - SUI (Serious Untoward Incidents)
  - Incident Reporting
  - RIDDORs
- Cleanliness and healthcare associated infections
  - Directly provided services and commissioned services
  - Health Economy wide responsibility
- Safeguarding both vulnerable adults and children
  - Adult safeguarding across Health and Social Care
  - Children Safeguarding across the Health economy

- Medicine Management
  - Controlled Drugs
  - High Cost Drugs
  - Monitoring prescribing

3.1.3 Customer Experience

The customer experience and/or view should be at the centre of the commissioning process. This enables expectations to be managed and appropriate outcomes developed and measured. The formation of the Public Experience and Feedback Committee ensures that information on experience is gathered from all sectors and provides a mechanism to inform commissioners of the quality of services being commissioned from a users perspective.

3.2 <u>Quality Schedules</u>

The strategy ensures that every contract has a quality schedule that can be monitored and reviewed to ensure a level of assurance to be established and risks identified for every contract. This is undertaken by a monthly Quality Review Forum with all main providers. The purpose is to drive continuous

service improvement where appropriate and also more reactive commissioning if necessary.

The schedule (Appendix 1) is very comprehensive and can be adapted to suit the provider contract as necessary.

A quality report is presented to the Performance and Quality Committee.

4. Conclusion

There has been significant progress in the development of a Quality Assurance framework. The Quality Schedule provides a comprehensive process for ensuring all contracts address the quality of services being provided. Robust monitoring of contracts ensures a culture of continuous service improvement and an effective commissioning process.

SUE DOHENY
DIRECTOR OF QUALITY AND CLINICAL LEADERSHIP

17th February 2010

Herefordshire Council

NHS Herefordshire

Appendix 1

COMMISSIONING FOR QUALITY STRATEGY

Commissioning for Quality Strategy

1. Background

NHS Herefordshire and Herefordshire Council, through the partnership of Herefordshire Public Services (HPS) are committed to four key aims:

1. Improved outcomes for local people
2. Excellence in service delivery
3. Focus on customers' experience
4. Being efficient and delivering value for money

HPS through NHS Herefordshire and Herefordshire Council commissions a range of services and care provision for local people; delivering their health and social care needs and health improvements (for individuals and the wider community) by securing the highest value within limited resources. A fundamental goal of the NHS is to deliver high quality care and is a priority for NHS Herefordshire. It is therefore essential to develop a strategy to ensure a consistent approach to commissioning for quality and to achieve the aims of HPS.

2. Purpose of the Strategy

The purpose of the strategy is to support the HPS aims by ensuring that quality is at the heart of the commissioning process. The framework to support the strategy sets out the approach that HPS will use to ensure that health and social care services commissioned on behalf of the people of Herefordshire are of the highest quality. The framework will apply to all commissioned and contracted health and social care services including the Provider Arm.

It is envisaged that the Commissioning for Quality Strategy and framework will provide positive assurances with regards quality standards to the HPS Steering Group, Board, relevant committees, external inspectors and regulators and to services users and wider population.

The outcome is that all commissioned and contracted services will provide the highest quality of service. It is intended that all contracts and service level agreements will include a quality schedule based on the framework, to include service specific quality performance indicators, which will be monitored as part of the contract monitoring process. It is the intention that the quality strategy will provide a framework for commissioners to work with providers to continually improve the quality of services for the people of Herefordshire.

3. Links to other documents

The Commissioning for Quality Strategy is designed to compliment other essential strategies and plans that are in place or are in development; for example Customer Services Strategy, World Class Commissioning Strategic Plan, Community Engagement Strategy, Children's and Young People's Plan.

4. What is Quality?

There are many definitions of quality and it is clear that quality may mean something different for a manager, professional/clinician and service user.

The Next Stage Review, (DOH, 2008) helpfully described quality as being made up of three key components all of which have to be evidenced to assure quality service provision:

1. Clinical Effectiveness
2. Patient Safety
3. Patient experience

This description of quality encompasses the different perspectives of service provision and therefore would appear to be a comprehensive explanation. These descriptors are very broad however and it is understood there is a greater level of complexity to each one. It is also recognized that the components describe a medical model and would need to be adapted to ensure health and social care are reflected.

The Herefordshire people that were asked have defined quality services as those that:

- Treat people professionally and with courtesy and respect at all times.
- Respond to all enquiries in a timely fashion, at the first point of contact or call people back.
- Provide easy to understand information about what support we can be offered and what people can expect.
- Ensure people are involved in key decisions about their life, with support from an advocate if required.
- Treat people fairly and equally and do not discriminate against them.
- Ensure that people have access to all the available benefits and services that they are entitled to.
- Make sure people know what to do if they are not satisfied with the services they are getting.
- Use people's comments and views and involves them to help improve services and opportunities.

5. Implementing the strategy

To successfully implement the strategy there needs to be a consistent approach to commissioning. It is suggested that a framework for the quality schedules is adopted for all service specifications and contracts. This will facilitate commissioners to work with providers to ensure all providers are clear about the quality that is expected; how that will be measured and how this will result in continuous service improvement.

Key Components of the Framework

The Next Stage Review (DOH, 2008) components of quality have been slightly adapted to ensure the framework is comprehensive and addresses all aspects of the quality agenda from a National and Local perspective.

The framework is divided into three key components;

1. Care Governance
2. Safety
3. Customer experience

Each component then has several dimensions:

Key Component	Dimension
Care Governance	a. Compliance with Standards • National • Local b. Effectiveness • Evidence based practice • Compliance with pathways (National and Local) • Outcome Measures • Performance targets (National and Local) • CQUINs c. Risk Management d. Efficiencies • Staffing mix • Service Line Economics • Resource utilization e. Workforce • Planning • Training • Recruitment

Safety	f. Safeguarding Children • Policies, Procedures and processes • Audit Plans • Training • Employment checks g. Safeguarding Adults • Policies, Procedures and processes • Audit Plans • Training • Employment checks h. HCAI (Health care associated infections) • Compliance with Health and Social Care Act • Registration with CQC i. Medicines Management j. Incident Reporting • Processes • Learning
Customer Experience	k. Complaints l. Compliments m. Equality and Diversity n. Engagement/Involvement o. Consultation • National • Local p. Feedback • Formal • Informal

6. How will quality be measured?

All contracts and service level agreements will include a **quality schedule** (Appendix 1) which is based on the framework. All the contracts and service level agreements will be monitored for compliance with the quality schedule and appropriate actions taken for compliance and non-compliance.

The quality schedule will be developed with the commissioner and provider. There will be agreement on definition, source of information or data and levels of assurance for each aspect of the schedule. There will be a test of 'reasonable assurance' applied to the information supplied as evidence for each quality indicator.

In order to ensure sufficient evidence is collected to provide comprehensive intelligence and therefore hopefully positive assurance on the high quality of service provision there are two aspects to data collection and therefore measurement of compliance:

1. Quality Performance Indicators that may be derived at different levels
    - National
    - Regional
    - Local

    Service specific quality indicators or targets will be established and agreed with the provider for each of the key quality components and included in the quality schedule.

2. External Reports, for example;
    - Surveys
    - Audits
    - Inspections
    - Links
    - User groups
    - Public Consultations
    - Real time stories

7. Monitoring and Reporting

The quality of the services being commissioned on behalf of the people of Herefordshire will be monitored through the quality schedules, all of which will follow the framework. The quality schedules will be agreed by the Quality Monitoring Group. The individual quality schedules will then be monitored by the Clinical Quality Forums for each of the main contracts and/or the contract monitoring meetings. The reporting will then be to the Quality and Performance sub-group of the PCT Board and appropriate Council committee.

The Quality Monitoring Group will provide reports to the Quality and Performance Group and any other group or committee on overall or specific quality issues as required and/or requested.

8. Review

This strategy will cover the period of 2009-10 to 2012-13 and will be reviewed by a working group and a report sent to the Joint Management Team by December 2010.

Herefordshire Council

NHS Herefordshire

Appendix 1

Quality Schedule

Introduction

The Quality Schedule sets the standards by which quality should be evidenced and will be monitored in all contracts. However not all sections will apply to all contracts, each contract will clearly set out those aspects of the quality that apply to that individual organisations.

FHS Independent Contractor Services

Commissioning primary care is complex. Some factors are broadly common to all primary care contractors (ie GP practices, dental practices, community pharmacies and optometry practices); whilst others are unique to GP services. Some of these factors can make commissioning of GP services more challenging, but they can also provide greater opportunities to make sure that services meet people's needs.

All 4 of the FHS Independent Contractors work under **nationally** negotiated contracts which **do not have a fixed duration**, however local negotiated agreements such as PMS, APMS, PDS contracts map across core requirements of the national negotiated contracts they do allow the PCT greater **local** flexibility.

Customer Experience			
Objective	**Evidence**	**Monitoring**	**Comments**
1) Clear strategy for gaining feedback from customers about the quality of services and their experiences of those services.	a) An up to date strategy document that all staff are aware of b) Timely annual reviews which evidence user / carer feedback on services provided. c) Up to date strategy for ensuring staff adopt person centred practice including feedback from customer	Visits Evidence for customer satisfaction recorded on framework Contract review meetings Announced/unannounced visits Mystery shoppers Commissioner survey (Staff/customer) Audit of person centred reviews monitoring of use of advocacy including IMCA	N.B. the term 'Customer' covers Service users, carers, patients, family members and potential customers.

2) The organisational culture is customer focused and values customer feedback.	a) An annual plan of how customer feedback will be sought. b) Customer feedback made available to commissioners. c) Action plan relating to changes introduced as a result of customer feedback. d) Evidence of implementation of service change/improvement e) Evidence of monitoring and review of any service change/improvement f) The organisation uses a range of mechanisms of gain feedback from its customers g) Feedback is gained from a cross section of customers h) Clearly identified lead within the organisation i) Systematic process for customer feedback j) All providers to maintain up to date person centred care plan in respect of individuals k) Customer experience targets form part of appraisal for key staff l) Providers systematically provide evidence of changes in demand, service shortfalls and customer unmet need to commissioners m) Reviews of safeguarding protection plans evidence outcomes achieved and better risk management	Contract review meetings. Quarterly report from provider. Near real time customer feedback to Customer Experience Team on a regular basis. Customer Experience Trackers Routine analysis of care plans and reviews by commissioners Care management routinely provides evidence on the 'customer experience' as identified through the review process Analysis of safeguarding reviews and feedback from the quality concerns triumvirate provided quarterly	

3) Organisations have robust, up to date Complaints, Comments and Compliments policies and procedures in place	a) Up to date policy and procedure b) Customer experience feedback c) Promotional/public information material. d) Staff have a good understanding of policy and procedure. e) Evidence of staff training.	Visits Commissioner survey (Staff/customer) Mystery shoppers Announced/unannounced visits Evidence of active implementation through care management reviews Contract review meetings	
4) Staff trained in the value of customer feedback.	a) Evidence of staff training b) Customer experience feedback c) Staff have a good understanding of the value of customer feedback	Visits Announced/unannounced visits Mystery shoppers Commissioner survey (Staff/customer) Surveys of person centred planning and evidence of improves outcomes from annual reviews Contract review meetings	

5) Customer/Public Involvement	a) Customers and or the public are involved in policy, service, planning and delivery b) Specific involvement activities c) Promotional/public information material. d) Evidence of staff training e) Analysis of unmet needs identified by customers with recommendations for improvement	Commissioner survey (Staff/customer) Announced/unannounced visits Mystery shoppers Visits Contract review meetings Commissioning intelligence reporting to Board	
6) Organisations have processes in place to respect service user's privacy and dignity.	a) Up to date protocol/policy in place b) Annual service user/patient survey c) Complaints policy and monitoring d) Up to date person centred plans in place	Receipt of survey Receipt of action plans in respect of complaints regarding breaches in privacy/dignity Analysis from care management reviews and contract monitoring visits	
7) Organisations must ensure that equality of opportunity and outcomes is at the heart of all its work.	a) Equality Impact assessments b) Impact assessment action plan. c) Providers evidence improved outcomes for individuals on a routine basis	Self declaration Random audit of Equality Impact Assessments. Outcomes based contract monitoring in place Regular outcome based reviews	

8) Access - To ensure that all patients/clients can access services commissioned and there is equity of access according to need.	a) Access policy or referral criteria b) Information with regard to service which is accessible to all	Analysis of complaints with reference to access Available to view	

Safety			
9) Organisations must have a clear statement of intent specifying that the organisation does not tolerate any abusive practices and safeguards vulnerable people.	a) A clear statement which is available for both staff members and service users. b) Information available to staff users, carers and advocates about how to raise alerts	Visits/web sites Access to public information and up to date training audited	
10) Organisations have robust, up to date policies and procedures in place to ensure that staff know how to prevent abuse, identify abuse once it has occurred and understand the process to be followed should they have safeguarding concerns about an individual. (All child safeguarding policies and procedures must contain a cross reference to LSCB procedures, all adult safeguarding policies and procedures must contain a link to the relevant Adult Safeguarding Board). Whistle blowing policy and process are promoted by organisations.	a) Copies of policies and procedures are available for both staff and service users b) The ability to demonstrate that staff are aware of the policy and understand its content through regular audit c) Evidence that an individual's care plan has been reviewed to ensure they are properly supported following and allegation of abuse d) Evidence that staff are aware of whistle blowing policy and confident in how to proceed e) Evidence that following an investigation, appropriate protection planning is implemented f) Evidence that outcomes of protection plans are routinely reviewed	Self declaration Random audit Audit of policies received Reviewed anonymised care plans Audit of outcomes from safeguarding investigations, protection planning and reviews provided to commissioners Contract monitoring to quality assure improvements from safeguarding investigations	
11) Organisations have an information sharing governance framework to provide clarity to all staff of the organisation's position on information sharing	a) Evidence of information sharing protocols in place b) Evidence of audits regarding the organisation's information sharing governance	Self declaration Random audit Audit received	

12) The organisation contributes to the effectiveness of multi agency working when safeguarding vulnerable people	a) Contributing to safeguarding investigations b) Attendance at Case Conferences when requested c) Attendance at CAF training and involvement d) Attendance at safeguarding training e) Contribution to protections planning and implementation f) Contribution to training needs audit to adult safeguarding board training strategy	Evidence of contribution Audit received Audit of CAF attendance Audit evidence of improves competency as outlines in ASB training strategy.	
13) Evidence that the organisation has policies to ensure that any concerns/allegation of a safeguarding nature made against a member of staff are responded to appropriately. Fulfilment of alerting agency responsibility within stated timescales	a) A whistle blower policy b) A complaints policy and a process in place to ensure complaints are responded to c) A policy and guidance on how to report and manage any allegations against a member of staff d) Evidence of handling such an allegation	Self declaration on policies Random audit of policies Anonymised evidence Routine performance reports on safeguarding	

14) The organisation has a policy on restraint which enables staff to: a. Know whether restraint is permitted within the service in which they are working b. Know and understand the different forms that restraint can take. c. Understand when restraint is or is not appropriate.	a) An organisational policy on restraint b) Evidence that staff are aware of the policy c) Evidence that an audit has taken place regarding the policy. d) Evidence of staff attending training with regard to restraint e) Evidence of incident reports being completed with regard to constraint f) Evidence of DOLS applications where necessary g) Evidence of MCA and DOLS training for all staff h) The organisation has a policy and procedure on the implementation of MCA and OLDS	Self declaration on policies Random audit of policies Commissioning site visits to triangulate with staff Audit received Training matrix received Completed incident forms Analysis of DOLS applications Audit of policy and procedure Evidence of up to date staff training and competency	
15) The organisation ensures that the environment in which service users are cared for is safe and service users are protected from the effects of a person's challenging behaviour.	a) The facilities are DDA compliant b) COSHH reports c) Complaints received from service users or their families d) Completion of Incident reports e) Monitoring of peer on peer safeguarding alerts	Self declaration Commissioning visits Learning from COSHH reports Learning from Complaints Learning from Incident reports Routine performance analysis	
16) Patient/Client Safety- Incident Reporting and Learning from Incidents. To ensure that the organisation has appropriate systems and processes in place to protect patients, clients and staff from untoward incidents and to	a) Incident reporting system, policy and procedures in place b) Evidence that incidents are monitored c) System for Reporting serious untoward incidents (SUI)	Receipt of policy/protocol/guidelines Review of evidence as required - announced /unannounced visits SUI database kept - audit of	

learn from local and national investigations following incidents	immediately to PCT following protocol - SUI flowchart d) Evidence that incident trends are analysed and action plans developed for areas that are either rising or are higher than national trends e) Evidence that serious incidents are investigated (Root Cause Analysis) action plans developed and lessons learn disseminated f) Policy/protocol/guidelines in place detailing the dissemination of NPSA alerts, and system for ensuring actions are completed. g) National Patient Safety Agency Alerts implementation processes and procedures (if applicable to service/organisation) h) Annual audit of SABS/System process. Report submitted i) Monitoring tool in place detailing dissemination, and implementation progress of SABS alerts actions j)	response time. 1/4ly report Receipt of annual incident report Copies of all RCA's for SUIs within time frame set out in SUI flowchart monitored individually Receipt of policy/protocol/guidelines Available to view on request - announced visits Random audit of audit Random Audit	
17) Infection Prevention and Control. To ensure that the organisation has appropriate systems and processes in place to protect patients, clients and staff from healthcare associated infections.	a) Policies and protocols- relevant should be available Implementation of policies Audit of policy compliance Annual audit report to include scores achieved and relevant action plans with timeframes Audit tools used b) Hand hygiene -programme of hand	View documents on request announced and unannounced visits Receipt of report receipt of annual audit report/ summary Receipt of tools Receipt of educational	

	hygiene education Monitoring systems in place eg audit, observation Provision of policy c) Decontamination- decontamination lead identified Audit programme Policy in place and implemented Training programme for relevant staff d) Implementation of National guidance- Evidence that current applicable national guidance has been applied - hygiene act, CQC registration, etc e) Training / education- system of identification of training needs and frequency required. f) Staff training records and any competencies achieved g) Education programme h) Design and maintenance of the environment Provision of relevant policies, protocols. Evidence of regular monitoring i) Surveillance/ reporting- System for reporting mandatory surveillance system for reporting RCA/ SUI j) laboratory support- relevant support provided/	programme Receipt of audit results/ summary Report, Random audits Receipt of policy Job description Annual report View documents on request, Announced and unannounced visits Review training programme Registration, Receipt of results of Inspections actions plans View on request View on request. Annual report View on request View documents on request receipt of report(annual) Announced and unannounced visits MRSA, C diff surveillance data? Frequency Reports received - Random audits SLA on request	

	available k) Communication-provides information to patients, staff and public eg internet, leaflets	View on request. Patient surveys	
Medicines			
18) Organisations must have appropriate medicines policies with regard to good practice and compliant with legislation and regulations	a) Copy of medicines related policies b) Medicines formulary which adheres and contributes to local NHS economy c) Ongoing medicines audit d) Controlled drugs policies e) CD occurrence reports f) Safeguarding alerts / investigations	Audit of policies The ability to demonstrate that staff are aware of the policy and understand its content through regular audit Review records of staff medicines management training Contribution to CD local intelligence network and reports to Accountable Officer Quantification of medication errors raised through safeguarding process	
19) Organisations have robust risk management of medicines	a) Copies of policies and procedures are available b) Regularly send NPSA incident reports c) share learning locally from incidents	audit of policies review summary of medicines incident reports and shared learning examples	

	d) Medicines reconciliation policy in line with NICE		
	e) Discharge information audits	provides required discharge/ admission data sets	
	f) Provide appropriate prescribing and monitoring information in line with NPSA and NICE	provides timely medicines supplies and information to relevant health care professionals ie GPs (in future to community pharmacists) relevant monitoring information eg anticoagulation	
	g) Provide agreed shared care documentation in priority areas such as unlicensed and high risk medicines		
	h) Provide appropriate medicines risk assessment for patients	provides appropriate medicines support for patients with identified needs or referral ie reminder charts, monitored dosage systems	
	i) Care standards regulations fully adhered to		
	j) Safeguarding alerts referred by regulated services of CQC	CQC pharmacy audits contract monitoring Contract monitoring with PCT pharmacy Medication errors referred to PCT pharmacist on a routine basis	
20) Organisations endeavour to seek cost effective medicines management solutions in terms of	a) Invest to save proposals b) Joint working on medicines management guidance	Review/audit Joint guidance Adherence to guidance	

medicines and systems across the local health and social care economy	c) Provide systems/data to monitor and flag high cost medicines and subsequent audit d) Joint work to reduce specials e) Have a policy on commercial sponsorship and clinical trials in line with NHS policy f) Policy on non medical prescribing issues and other related documentation eg PGDs g) Contribute to joint meetings	Monitor costs Provide feedback to commissioner in agreed format and audit where appropriate Attend appropriate meetings eg Hfs Medicines management Committee Provide cost saving solutions	
21) Organisations provide seamless medicines management solutions in terms of patient quality and experience across the local health and social care economy. Reduction in use of medication to manage behaviour	a) Provide and contribute to joint policies b) Participate in national and local medicines management campaigns c) Assess patient feedback d) Alternative strategies in place	Review joint policies, participation in campaigns, patient feedback incidents Review of individuals care plan indicating improves outcomes	

Effectiveness			
22) Clinical audit. To ensure that organisation/service have a robust system in place to undertake clinical audit ensuring that the full clinical audit cycle is completed.	a) Annual audit programme in place b) Annual clinical audit report incorporating the documentation of outcome from audits. c) Monitoring system in place (i.e. database) to ensure full audit cycle completed d) Up to date clinical audit protocol/policy/guideline in place e) Conducting of an annual audit of the protocol/policy/guidelines to ensure compliance with the system specified in document.	Receipt of annual audit programme report Receipt of annual clinical audit report Available to review on request including supporting relevant documentation (i.e. action plans) - Announced visits. Receipt of document Receipt of audit report, random spot check audit	
23) NICE guidance and standards implementation (*Technology Appraisals, Clinical Guidelines, Public Health Intervention Guidance, Public Health Programme Guidance, Interventional Procedures and Cancer Service Guidance*). To provide assurance that the organisation/service have systems and processes in place to assess, implement and monitor NICE guidance (if applicable to organisation/service)	a) Up to date protocol/policy/guideline in place detailing the process for assessment, implementation and monitoring within the organisation/service (based on the NICE document "How to put NICE guidance into practice) b) Monitoring tool in place relating to the assessment, implementation and monitoring of NICE guidance within the organisation/service (i.e. database) c) Variance reporting on guidance not obtaining full assurance. d) Evidence of evaluation/review of the implementation of guidance (i.e. through audit)	Receipt of documents Available to view on request Announced visits. Report quarterly or more frequent if risk. Random spot check audits on specific NICE guidance	

24) Benchmarking -To ensure all organisations/services benchmark themselves against best practice and develop action plans which support continuous quality improvements	a) System of benchmarking practice in place (e.g. essence of care tool). Reports or monitoring tool detailing progress review of benchmarking and any subsequent actions b) System to review completed benchmarking practice in place c) Evidence that all services provided participate in benchmarking	Receipt of quarterly report Available to view on request - announced /unannounced visit. Random audit Annual report received	
25) Professional and Clinical Education and Training- to ensure all staff within organisations are appropriately trained for the roles that they undertake.	a) A system of identifying the training needs of staff and the frequency which this should be undertaken b) System and processes which record staff training undertaken, competencies achieved with dates c) Competency frameworks for clinical skills are available and recorded either at an organisational or service level.	Annual Report Available to review - announced visits Available to review - announced visits	
26) Supervision and leadership - To ensure that supervision and professional/clinical leadership is available to all staff	a) Evidence of clearly identified roles and responsibilities within the service with clear lines of accountability b) Audit of appraisals/ supervision c) Policies protocols and implementation (audit)	Job descriptions and structures available to view Receive audit, random check audit Random audit	
27) Care Governance Arrangements To ensure that care services have adequate care governance arrangements	a) Evidence of systems and processes to ensure that the clinical governance arrangement are explicit in all clinical pathways	Random review of services and/or clinical pathways as part of announced and unannounced visits.	

	and service delivery b) Evidence that the care governance structure supports the board assurance programme c) Record keeping policies/protocols and evidence of implementation (audit)	Available to review Random and or risk audits	
28) Care Pathways, To ensure organisations participate in the development of and implement Herefordshire wide care pathways. Contributions to be development of multi-agency care pathways.	a) Evidence of participation in the development of care pathways b) Care pathways are followed and any variance reported c) Evidence of participation in multi-agency care pathways.	Review of care pathways Exception reports received Process established for care pathway development and monitored	

Workforce Development			
29) Providers have robust and systematic approaches to workforce planning to meet commissioned service delivery.	a) Senior managers can demonstrate an understanding of the importance and value of workforce planning. b) There is a named senior manager lead for workforce planning and development who performance manages the activity. c) There is an named operational lead who has a recognised competency to deliver the workforce planning function. d) The locally used workforce planning approaches are known by staff and in evidence. e) The workforce plan is refreshed routinely and no less frequently than annually. f) Workforce plans include innovative and creative solutions demonstrating how the provider can meet the changing nature of service delivery. g) The local workforce plan is understood across the organisation and embedded within the service plan as core business. h) Workforce data and progress is reviewed routinely by the senior management team.	Workforce plans are reviewed as part of contract monitoring. Key providers will be required to submit annual workforce plans for quality assurance by Integrated Commissioning. • Reporting of defined metrics on a monthly / quarterly / annual basis – tbc. • Self-assessment • Submission of plans • Contract monitoring • Unannounced visits • Announced audit	Completion of standard workforce planning tool. Key providers will be expected to fully engage with and inform workforce planning across the wider health and social care economy. Inc. attendance at events and meetings.
30) Providers have comprehensive workforce development mechanism in place to maximise capacity and	a) The organisation can evidence that employees are appropriately trained for the roles they	Sample review by Workforce Team within Integrated Commissioning	

capability.	undertake b) All employees receive an annual appraisal and regular 1-2-1 support and supervision. c) Evidence of a routinely undertaken training needs analysis is available. d) Evidence of mandatory training for all relevant staff is routinely available.	• Reporting of defined metrics on a monthly / quarterly / annual basis – tbc. • Self-assessment • Submission of plans • Contract monitoring • Unannounced visits • Announced audit.	
31) Providers actively engage with their employees to obtain feedback and formally respond to that feedback.	a) The organisational culture seeks, values and positively responds to employee feedback. b) Clear mechanisms are in place to obtain employee views. c) A staff driven action plan is produced annually to respond to issues, concerns and experiences.	Sample review by Workforce Team within Integrated Commissioning. • Reporting of defined metrics on a monthly / quarterly / annual basis – tbc. • Self-assessment • Submission of plans • Contract monitoring • Unannounced visits • Announced audit.	Minimum requirement to respond to six key questions.
32) Providers have robust recruitment and retention practice to attract and retain a high quality, competent workforce.	a) A recruitment and retention strategy is in place to reflect delivery of commissioning intentions. b) Up-to-date policies and procedures for all aspects of recruitment and retention c) Equality and diversity d) National occupational standards,	Sample review by Workforce Team within Integrated Commissioning. • Reporting of defined metrics on a monthly / quarterly / annual basis – tbc. • Self-assessment	

	KSF and competences are used to develop and review roles. e) Risks to recruitment and retention are identified, analysed and action is taken to mitigate. f) Evidence of compliance with legislation is routinely available g) Evidence of compliance with registration is routinely available.	• Submission of plans • Contract monitoring • Unannounced visits • Announced audit.	
33) Evidence that organisations have adopted effective measures to minimise the risk of employing (in a voluntary or paid capacity) a person who would present a risk to vulnerable people (either children or adults).	a) A robust recruitment policy which contains details of which positions require a CRB check (and ISA check when established), due regard given to gaps in employment, references to be requested and scrutinised and any professional registration to be checked. b) An audit of the above policy	Self declaration Random audit of agency's policies Audit received Outcomes of contract monitoring visits feeds back to care management and CQC through quality concerns process	
34) Organisations provide access to role appropriate training (for the children's workforce appropriate is defined by Safeguarding Children and Young People:Roles and Competencies for Health Care Staff Intercollegiate Document 2006) for their staff to ensure that there is a competent workforce who understands the signs of abuse and take effective action when they have safeguarding concerns for an individual.	a) A copy of the organisation's training matrix or plan with both adult and child safeguarding as mandatory training b) Evidence of staff attendance at safeguarding training c) Evidence of 3 yearly updates on safeguarding d) Evidence that attendance at safeguarding training has influenced practice e) Evidence of appropriate referrals to ISA	Copy or training matrix/plan received Audit of staff who have attended training Evidence of improved outcomes Monitoring of mandatory checks	

Organisations to provide appropriate training to ensure competence to provide quality care and take effective preventative action to reduce incidence of abuse. Organisations to make staff aware of duties / responsibilities under the independent safeguarding authority.			
35) Professional Education and Training- to ensure all staff within organisations are appropriately trained for the roles that they undertake.	d) A system of identifying the training needs of staff and the frequency which this should be undertaken e) System and processes which record staff training undertaken, competencies achieved with dates f) Competency frameworks for clinical skills are available and recorded either at an organisational or service level.	Annual Report Available to review - announced visits Available to review - announced visits	

FHS Independent Contractor Services. Locally negotiated agreements (PMS, APMS and PDS)			
Objective	**Suggested evidence**	**Monitoring**	**Comments**
36) Each practice has clear negotiated objectives and a development plan which demonstrates organisational quality (including safety),effectiveness and patient experience. Objectives are linked to the PCT's commissioning strategy for primary care eg specifics linked to individual practices - extended opening hours, increased patient satisfaction.	a) Achievement of the clinical domain of the Quality and Outcomes Framework (QOF). QOF exception rates and comparison between reported prevalence and expected prevalence of long-term conditions. Practice data, eg prescribing, referrals, clinical governance. b) Compliance against Standards for Better Health criteria	Annual practice clinical governance visits Quarterly reports from provider Formal mid year review meetings with each practice National surveys	
37) The development plan includes key areas in relation to **access and responsiveness:**	a) Each practice has mapped its core services and can demonstrate: • Capacity • Opening times • Wheelchair access • Consultation facilities • Languages spoken	Annual practice clinical governance visits Quarterly reports from provider Formal mid year review meetings with each practice National surveys	

38) The development plan has a section dedicated to the practice **premises** which demonstrates compliance against national standards.	a) Result of patient surveys b) Patients should be seen in premises that are pleasant, accessible and meet the relevant national standards. c) Information governance requirements should be accommodated within the design of workspaces, for example computer screens positioned to protect patient confidentiality, and security of sensitive information. d) Feedback from site visits by local involvement networks (LINks) e) Compliance against Standards for Better Health criteria	Annual practice clinical governance visits Quarterly reports from provider Formal mid year review meetings with each practice National surveys	
39) Each practice can demonstrate that they empower and support **patient choice**	a) Use of the choose and book system and NHS choices website b) Survey results on offer of choice of hospital c) Results of new GPPS d) That GP practice has an open list and accept new registrations e) Practice Boundary	Annual practice clinical governance visits Quarterly reports from provider Formal mid year review meetings with each practice National surveys	

Herefordshire Council

MEETING:	**HEALTH SCRUTINY COMMITTEE**
DATE:	**1 MARCH 2010**
TITLE OF REPORT:	**PROVIDER SERVICES INTEGRATION – PRE CONSULTATION**
REPORT BY:	**Project Manager**

CLASSIFICATION: Open

Wards Affected

County-wide

Purpose

To note the progress of the project and the pre-consultation on provider services integration.

Recommendations

THAT:

(a) the Committee notes the work of the Transition Board on service integration and the proposed future full public consultation;

(b) the Committee notes that an early stage of consultation is about to draw to an end; and

(c) the views of the Committee are sought at this early stage.

Key Points Summary

- NHS Herefordshire has begun a project to review the way health and social care is provided
- This could result in the creation of a single, integrated Health and Social Care organisation
- A full formal consultation is scheduled to begin in June 2010
- At this early stage, stakeholders views are being sought on how services could be improved in the future

Alternative Options

1 No alternative options – there is a statutory requirement to consult.

Further information on the subject of this report is available from
Alan Dawson, Project Manager on (01432) 364000

Reasons for Recommendations

2 An early consultation on the project is drawing to an end and there is a statutory requirement to involve the Health Scrutiny Committee at an early stage. Full consultation is scheduled to begin in June 2010.

Introduction and Background

3 In August 2009 the Herefordshire health and social care community formed an independently-chaired Transition Board with multi-disciplinary membership drawn from health and social care to develop detailed proposals for service integration. The objectives of the Transition Board are to:

- Develop options for the organisation and delivery of health and social care services
- Recommend a preferred option for consideration and approval by the relevant statutory bodies
- Prepare public consultation documents (pre and full) and organise/lead public consultation on behalf of NHS Herefordshire
- Ensure that the proposals will contribute to maximising health and well being and reducing health and social inequalities in Herefordshire.

Significant work has been achieved since August 2009 that has been overseen by the Transition Board. This report serves to update the Committee on progress to date. Pre-consultation has been running since November 2009.

At this early stage, views are being sought from key stakeholders about:

1. How health and social care services could be improved across Herefordshire
2. Preferences and suggestions for methods for formal consultation,

Key Considerations

4 Hereford Hospitals NHS Trust (HHT) completed a PFI deal and moved into the new County Hospital building in 2002. The plans for the new hospital building were predicated upon a significant shift of bed based activity into the community through a major reorganisation of services.

In 2008, HHT and Herefordshire Primary Care Trust (HPCT) commissioned the Health Services Management Centre (HSMC) to work with them in a strategic 'Provider Services Review' that was designed to 'ensure that provider services are fit for purpose and organised in sustainable configurations which are able to both drive service improvement and deliver real efficiency'.

A headline outcome of the Provider Services Review was significant consensus from clinical teams that participated for the development of integrated care pathways delivered by an integrated hospital, community health and adult social care organisation.

Following the conclusion of the Provider Services Review in 2009, KPMG were commissioned by the West Midlands Strategic Health Authority (SHA) in conjunction with the PCT and HHT to:

- Assess the viability of HHT and the PCT Provider Arm as stand alone organisations

- Determine the potential clinical and financial viability of a single integrated healthcare provider

The main conclusion of this work was that HHT and the HPCT Provider Arm, as currently configured, are facing a substantial combined cumulative financial deficit for the forecast period ending 31st March 2014.

Provider Services currently face significant challenges related to delivering safe, high quality services that are sustainable, meet government initiatives (e.g. Care Closer to Home, Patient Choice) and are deliverable within limited resources e.g. inpatient beds, staffing, finance. These challenges are further complicated by the rural nature of Herefordshire and the changing demographic of the Herefordshire population with an older age population predicted to rise above national and regional averages. There is a requirement to focus health and social care provision on the Illness Prevention/Health and Well Being agenda (encouraging empowerment of the population in reducing illness) whilst recognising personal choice and challenges faced by the geographical and demographic nature of Herefordshire.

KPMG's early work pointed to the opportunity to achieve significant clinical and financial benefit through the redesign and integration of services, shifting work from bed-based settings to the home (potentially via a single organisation) and recommended this approach as a way forward.

The Project is being delivered through the Transition Board, supported by the following sub groups:

- Clinical Task Group
- Finance Group
- Workforce Development Group

The Clinical Task Group is leading the work to provide recommendations on the potential for integrated health and social care through:

- Designing new pathways of care across health and social care
- Designing new locality teams to provide more care closer to patient's homes
- Re-designing the overall unscheduled care system for those that need treatment as an emergency
- Reviewing those highly specialised services where there are questions about their continued viability

The Transition Board will report to sponsors in April 2010 based on the objectives it was set and incorporating the early consultation feedback from stakeholders. If approval from the sponsor organisations is achieved, proposals will be subject to full consultation in June 2010 and phased implementation from October 2010.

Community Impact

5 The following list illustrates the initial benefits (and potential impact) to stakeholders and the

community of closer integration of services across health and social care.

For service users

• Sustainable local services
• Services that maximise choice, personalisation and independence
• Improved health, well-being, quality of care and greater clinical effectiveness through:
  o Simplified care pathways, with single point of access, clear referral and access routes, shared assessment and management plans and a shared focus on achieving maximum well being
  o Reducing the focus on inpatient and institution-based care
  o Timely availability and seamless care from healthcare professionals
• For social care users, better integration with health services with improved outcomes for individuals and their carers

For health and social care staff
• Increased clinical productivity and responsiveness to service users • Increased operational flexibility by better integrated working practices, maximising the skills and knowledge available • Development of a workforce strategy across the health and social care economy • Creation of interesting and developmental career pathways between hospital, community and social care leading to improved recruitment and retention • Ability to train staff across different agencies to raise awareness of well being issues
For the health and social care community

• Increased public confidence
• More viable and cost effective services with perverse financial incentives removed
• Better outcomes for health and social care service users, via more efficient delivery of safe and high quality care through:
  o Better integration of preventative advice and services with consistent messages to service users and the wider community
  o Consistent support to carers and integrated mechanisms to seek and to receive feedback from service users and carers
  o Identifying and managing risks and measuring the effectiveness of targeted intervention and longer term outcomes
  o Achieving the optimum balance as to where services are provided
• Improved business continuity
• Increasing the input from locality groups in the review, planning, commissioning and delivery of services
• Improved business processes, as information will be more available and

shared across organisations and services

- Meeting local and national requirements relating to personalised care and individual choice

Financial Implications

6 Detailed activity and financial analysis by the dedicated Finance Group is underway. The Group is in the process of identifying accurate costs for the new pathways (shifting of provision from a bed based to community based service) and developing a new payment mechanism to enable commissioners to purchase services based on clinical outcomes and patient experience rather than historic systems that are based on contracted activity levels.

Legal Implications

7 Any changes made as a result of this project could face legal challenge if a consultation process is not correctly followed.

Risk Management

8 The project is on schedule and risks are maintained within the project risk log which is reported to the Transition Board and is available on request.

Consultees

9 The Provider Services Integration Project will impact on a wide range of stakeholders across multiple organisational boundaries. Engagement and involvement of stakeholders will be crucial to the successful delivery of the project.

10 A consultation and communication plan was produced at the outset of the project and is being delivered. This is available on request. This report is part of the pre-consultation process set out in the plan.

11 Stakeholders are identified within the project documents as:

Category	**Stakeholders**
Key Partner Organisations	Hereford Hospitals NHS Trust
	Herefordshire Primary Care Trust
	Herefordshire Primary Care Trust Provider Services
	West Midlands Strategic Health Authority
	Herefordshire Council
Clinical Engagement	Local Medical Committee
	Clinical Reference Group
	GPs – Practice based
	GP Locality Groups

	Hospital Medical Committee
	Local Dental Committee
	Provider Services medical staff
	Pharmacists
	Nursing & Allied Health Professionals
Health & Social Care Internal Groups	Staff Groups
	Boards
	Joint Negotiating Committee
	Clinical Reference Group
External Stakeholders and Groups	Service Users & Public
	Community and voluntary groups
	Herefordshire LINk
	West Midlands Ambulance Service
	Powys Local Health Board
	Worcestershire Acute Hospital NHS Trust and PCT
	Gloucestershire Hospitals NHS Foundation Trust & PCT
	Local media
	MPs
	Local councillors
	PFI Partners
	HHT Members
	Patient Representative Groups
	Herefordshire Council Health Scrutiny Committee
	Service User Groups
	Trades Unions

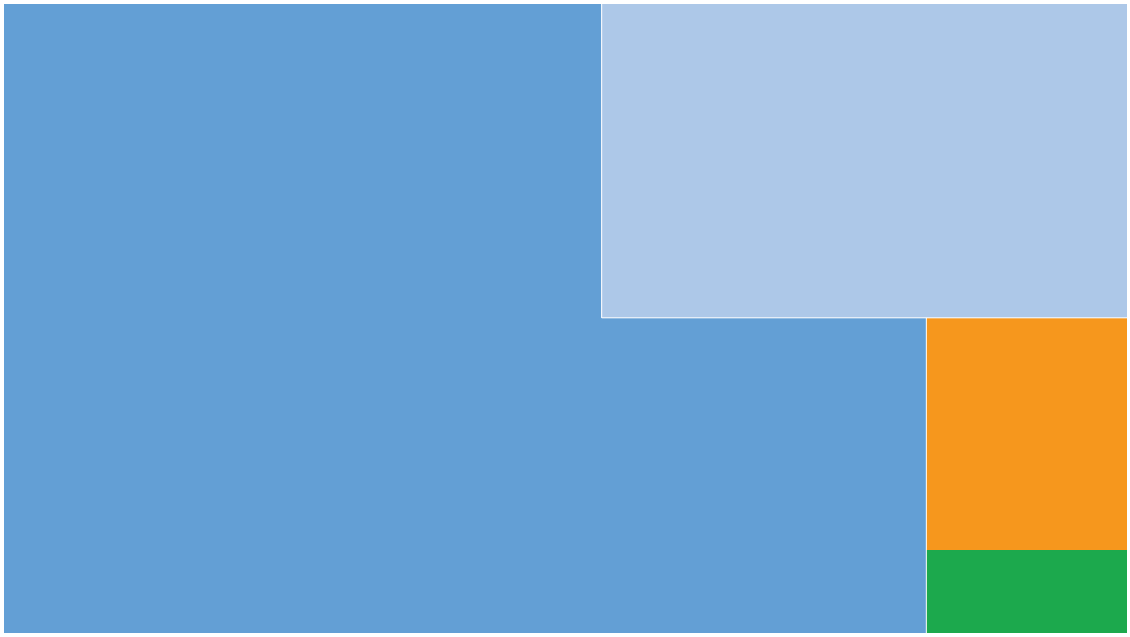
Appendices

12 The pre-consultation document that has been shared widely with staff and the public is attached as an appendix.

Background Papers

- None identified.

‘A Local Solution for Herefordshire’
Provider Services Integration
Leading up to public consultation



Herefordshire Council

NHS Herefordshire

Hereford Hospitals NHS
NHS Trust

‘A Local Solution for Herefordshire’

Introduction

This document seeks your views as NHS Herefordshire starts to look at how health and social care services across the county can be improved to provide the best possible service for local people.

By asking for your opinion now we can involve you at every step of the planning process, to make sure that our changes are acceptable and supported by you, our clients.

This is a process which could result in a major change to the way we manage social care alongside healthcare, and could result in the creation of a single, integrated NHS organisation for providing these services for the county, instead of the existing range of providers.

The current GP structure would remain as it currently is, independent, and close links would be developed between GP practices and any integrated service.

The new integrated service provider would take on responsibility for the vast range of services currently provided by teams from across community care, hospital care, women’s and children’s services and social care.

Your thoughts will play a vital part in building the service of the future, and in deciding how it is to be delivered.

The full formal consultation, which will begin in the summer of 2010, will be an opportunity to comment on detailed proposals that arise from this preliminary consultation phase.

These proposed changes do not include mental health services. We will consult with you separately in the future on mental health services in Herefordshire. However, we will work closely with the provider of mental health services to ensure that they are fully involved in these proposals, and that any new structure and services are fully compatible.

‘A Local Solution for Herefordshire’

Why we are consulting now?

The services we provide in Herefordshire face a number of challenges. Maintaining our services to a small population of around 179,000 people in a large rural area presents difficulties in terms of:

- Making sure everyone receives the same high quality of care;
- Providing care closer to people’s homes;
- Providing cost effective care.

The age profile in Herefordshire is already higher than elsewhere in England, and older people tend to have a much greater need for our services than the young. We estimate that by 2012, our population aged 65 or over will have increased by nearly 15% from 2008, almost a third more than the rest of England.

The care we currently provide to the elderly relies heavily on a significant number of hospital beds in institutions such as Hereford County Hospital and the community hospitals. By contrast, the NHS as a whole is moving more towards providing care in the community, to enable service users to remain in their own homes for longer, and we are looking to move closer to this model.

In general, public services nationally face a difficult future. The economic downturn means that constraints on public spending are likely to be severe in the coming years. We therefore have a duty to ensure that the services we provide for everybody in the county are safe, sustainable and the best value for money possible. A recent report suggests that, if nothing changes, we will face a financial deficit locally.

Recent reviews of our services in Herefordshire have highlighted significant improvements in quality and efficiency that could be gained from the closer integration of services. As a result, we have set out a vision of the sort of services we expect to be provided now, and in the future:

- Personalised high quality care;
- Joined-up services delivered closer to the client’s home at all stages of their care;
- Simplified internal communications to allow all our specialist staff to work together for a client’s maximum well-being;
- Support for self management, prevention and early intervention;
- Integrated health and social care services which support health, well being and independence through appropriate care and the efficient use of resources;
- A community-based model of care;
- Local access to Women’s, Children’s and Accident and Emergency services;
- Fair access for all across the community.

‘A Local Solution for Herefordshire’

What changes are proposed?

We are proposing to bring community, hospital and social teams together to harmonise and create the best possible health and social services provision for local people. To do that we are looking to develop individual ‘pathways of care’ – joining together the different steps in each individual’s route to the different social and health services they require. As these proposals develop they will also build on the close links with general practitioners.

Quality of care and service excellence will therefore be at the heart of any proposal which is put forward, and, in order to achieve this, we need to be willing to look at how the services can best be built and delivered – even if that means changing the ways in which organisations have worked together in the past.

We are open to ideas about how best to achieve this aim, but we believe that an integrated NHS provider organisation that manages social care alongside healthcare potentially provides the best opportunity to achieve our aim for excellence.

As we work together over the coming months to plan these new pathways of care in line with our requirements, we need to understand how you believe our services should be improved.

The work around pathways may result in a combined health and social care provider organisation instead of the current set up of a number of separate but interlocking organisations. For this to happen it will need to:

- Be able to provide consistently high quality care;
- Ensure that local people have access to the fullest range of services as close to home as possible;
- Have the support of the public;
- Have the broad support of our staff;
- Be financially sustainable.

‘A Local Solution for Herefordshire’

What happens next?

We will seek your views during November 2009 through to February 2010. The responses that you provide will help inform the teams planning the new pathways of care.

In March/April 2010 we will present your feedback, together with an option appraisal and preferred option to the Boards of Hereford Hospitals NHS Trust (HHT), Primary Care Trust (PCT), PCT Provider Services and NHS Herefordshire Council’s Health Scrutiny Committee (HSC) for consideration.

Once they have agreed a preferred option, a full 12-week formal consultation will begin in June 2010, finishing at the beginning of September 2010.

What will the full consultation look like?

This preliminary consultation explains why changes are needed, how we are considering making those changes, and it gives us an opportunity to receive, reflect upon and incorporate your views.

The full consultation in 2010 will invite you to comment on a more detailed proposal, containing the preferred option. We will make this consultation document widely available and, where possible, mail it directly or email it to a range of individuals and groups, including:

- Carers groups
- General public
- Health Scrutiny Committee
- Herefordshire Council/Parish and Town Councils
- Herefordshire LINk
- HHT members
- Hospital Medical Committee and Local Medical Committee
- Local politicians (Council and MPs)
- Patient representative groups (Age Concern etc.)
- Partnership agencies
- PFI partners
- Service users/service user groups
- Staff
- Statutory bodies
- Trades unions
- Voluntary organisations and community groups

‘A Local Solution for Herefordshire’

We will also hold meetings to give individuals, groups and organisations the opportunity to contribute to the discussion. An up to-date schedule of meetings will be available on the project website and will be widely publicised.
We will conduct the consultation through formal consultation documents and a variety of mechanisms to ensure that we receive a wide range of responses.

To bring the consultation to the maximum number people and organisations, consultation activities are expected to include:

Consultation website;
Stands and presentations in local health and social care buildings;
Council and NHS newsletters to staff and public;
Press releases and adverts;
Presentations to local health groups;
Roadshows across the county;
Focussed events for patients, carers, the voluntary sector and under-represented groups.

We will keep a full account of all responses to this preliminary consultation document. All contributions will be acknowledged and comments responded to, so please include full contact details. Representative groups will be asked to provide a summary of the people and organisations they represent when responding. The analysis of the responses will be made available to all respondents and made available on the website. Individual responses will be made available to anyone who requests one.

How you can help

At this stage we want to know your views on the services that we provide and how they could be improved. Your views on our plans for the full consultation phase are also required. We will also be pleased to attend meetings of local groups to explain our proposals and answer questions. We will include information on our website about the meetings we are organising or attending.

You can tell us what you think directly via the eConsult website at:

http://pctconsult.herefordshire.gov.uk/inovem/consult.ti/integration/consultationHome

Or by e-mail to: psipconsult@hhtr.nhs.uk

Send your responses by post to:

Provider Services Integration Project
Trust Headquarters
Hereford Hospitals NHS Trust
County Hospital
Union Walk
Hereford HR1 2ER

Or by telephone: 01432 355444 ext 2928

Date of publication: November 2009
Ref: 'A Local Solution for Herefordshire'

Herefordshire Council

MEETING:	**HEALTH SCRUTINY COMMITTEE**
DATE:	**1 MARCH 2010**
TITLE OF REPORT:	**MENTAL HEALTH PROCUREMENT PROJECT**
Report By	**PROJECT MANAGER**

CLASSIFICATION: Open

Wards Affected

County-wide

Purpose

To provide an update on the Mental Health Procurement Project being undertaken by NHS Herefordshire and Herefordshire Council.

Recommendations

That the report be noted subject to any comments the Committee wishes to make.

Introduction and Background

1. The current Herefordshire Mental Health Services are provided by Provider Arm of NHS Herefordshire supported by Herefordshire County Council. Whilst the services provided are satisfactory, the advantages of economies of scale offered by large specialist mental health providers are unavailable. Additionally there are issues of capacity when required to implement national initiatives and governance.

   NHS Herefordshire has taken the view that these services would be best provided by a specialist mental health provider who would provide services and take on the staff under a TUPE transfer.

   NHS Herefordshire requires its mental health services to reflect its rural environment and must remain as a local service. A franchise or federation model whereby Herefordshire Mental Health is an operating division of a specialist mental health provider is seen as particularly attractive.

   In line with the national policy 'Transforming Community Services' ethos, NHS Herefordshire is keen to develop a contractual relationship with their providers, consider what would best meet the future needs of patients and local communities, and develop change mechanisms to support the transformation of services to patients.

Key Objectives

2. The key objectives of the project are:

- To provide patients with greater access to Mental Health Services;
- To improve the quality of Mental Health care available to patients;
- To deliver affordable and Value for Money (VfM) Mental Health services; and
- To deliver on national initiatives and clinical governance.

Key Issues

3. Herefordshire PCT requires the Provider to address the following key issues throughout the life of the Contract:

    - Access – The services procured must be provided in locations and facilities that meet local patient access preferences.

    - Capacity – The aim of the Procurement is to provide sufficient Mental Health Service capacity and to meet national targets and local commissioning KPIs

    - Quality – Patient-centred services delivered in a safe and effective manner and delivered through a learning environment that includes the training of doctors and other healthcare professionals.

    - Value for Money and Affordable – The Herefordshire Mental Health Service procured through the Procurement must be affordable and provide VfM.

    - Integration – Providers will be expected to integrate with, and positively contribute to, the wider local healthcare community and current integration agenda inc. the acute medical sector, local health and social care community.
    - Technology – The provider is expected to have the ability to integrate technology/systems to support continued partnership working with Hereford Hospitals Trust, Herefordshire Local Authority, Herefordshire PCT and Herefordshire GPs.

    - Governance – the provider is expected to manage and maintain clinical and non clinical governance procedures and systems, adhering to national guidance and supporting local mechanisms.

Mental Health Procurement Project – Board Members

4. Sue Doheny — Director of Quality and Clinical Leadership

    Wendy Fabbro — Associate Director of Integrated Commissioning

    Richard Carroll — Managing Directory of Provider Services

    John O'Grady — Medical Director – Provider Services

    Diane Jones — PCT Non Executive Director

    Nigel Seller — PCT Non Executive Director

Progress and Timeline

5. The Mental Health Procurement Project has completed the initial stages of the procurement process resulting in four clear bidders moving into the next phase.

   Documentation is being developed and gathered which will support the bidders in their development of a proposal to take on the service. The documentation will be released to the bidders late in January 2010, with an initial draft proposal scheduled for late February 2010.

   These initial proposals will be assessed by an Evaluation Team. The Evaluation Team is made up from Herefordshire Commissioners, Providers and Clinical staff from within the service. This team will meet with the bidders to consider their findings and make recommendations.

   The bidders will be given equal opportunity to visit the service and meet staff to discuss current practice and procedures. They will also be given the opportunity to discuss corporate issues with HR, IT, Finance etc. This process will run throughout March into April 2010 with a second draft proposal to be assessed by the Evaluation Team.

   The final proposal submission date for this Procurement Project is planned for the beginning of May with recommendations going to the PCT Board on 27th May.

Background Papers

None Identified

Herefordshire Council

MEETING:	**HEALTH SCRUTINY COMMITTEE**
DATE:	**1 MARCH 2010**
TITLE OF REPORT:	**HEREFORD HOSPITALS NHS TRUST UPDATE**
REPORT BY:	**CHIEF EXECUTIVE OF THE TRUST**

CLASSIFICATION: Open

Wards Affected

County-wide.

Purpose

To receive an update from the Trust.

Introduction and Background

1. Health Trusts are asked to provide regular reports to update the Committee on key issues. A report is attached.

Background Papers

- None identified.

Further information on the subject of this report is available from
Martin Woodford, Chief Executive, on (01432) 364000

Hereford Hospitals
NHS Trust

HEALTH SCRUTINY COMMITTEE MEETING
1st MARCH 2010

CHIEF EXECUTIVE'S UPDATE REPORT
MARCH 2010

1) Introduction

This report provides committee members with an update on the operational and financial performance of the Trust for the period ending January 2010. A summary briefing on key developmental issues for the organisation is also provided.

2) Operational Performance

2.1 Patients treated

The County Hospital has been under extreme pressure during December and January as a result of increased emergency admissions and adverse weather conditions. Emergency activity continues in line with A & E activity and January admissions continued to exceed expected levels. Daycase activity reduced in month and elective inpatients remained at the same level as December. However, the weather conditions hindered progress against plan with higher than normal cancellations of surgery. Continued increases in emergency activity remain a challenge for capacity and impact on the hospital's ability to undertake elective work. Outpatients were significantly down for both new and follow ups:-

- Emergency inpatients +8.4% against plan
- Daycases: -1.0% against plan
- Elective inpatients: -17.1% against plan
- New outpatients: -6.1% against plan
- Follow up outpatients -1.8% against plan

2.2 Accident & Emergency (4 hour waits)

Accident and Emergency attendances in January continued to remain high with 190 more attendances for January 2010 compared with January 2009 and a year to date increase of 3.3% (1204 actual) compared to the same period last year. The increase in activity and knock on effect on emergency admissions has put considerable pressure on achieving the four hour A&E target and on bed capacity.

The national target is that 98% of patients should be seen within 4 hours in A&E. Performance during January slipped to 94.7% and a year to date position of 97.6%.

2.3 18 week access target

The national target is that 90% of admitted and 95% of non admitted patients should be treated within 18 weeks from referral by their GP.

In January 2010, the Trust treated 99% of admitted patients (which is an improvement on the previous month) and 98% of non admitted patients within 18 weeks.

2.4 Healthcare Associated Infections (HCAI's)

There were 0 MRSA bacteraemia during January 2010 but the Trust has had 2 bacteraemia since April 2009 compared to 7 recorded for the same period during last year. During January there was 1 post 48 hour C-Difficile case compared to 5 cases for the same period last year and there was 1 death attributed to Clostridium difficile on the death certificate in January 2010.

The Trust continues with a range of measures to combat infections as part of its zero tolerance approach:-

- Hand hygiene compliance
- MRSA screening for all admissions (including daycase and surgery)
- Appropriate antibiotic prescribing
- General compliance with the Hygiene Code

2.5 Finance

At the end of January 2010 the Trust reported a £1,328k surplus. The position deteriorated by £828k in month due to four main factors – significant underperformance against the revised income plan, high expenditure on agency medical and nursing staffing and costs associated with the integration project of provider services.

The Trust is still currently forecasting a £1.1m year end surplus as per the plan however, there still remains a gap of £233k that has to be bridged in order to achieve this.

3) Service and Site Development

3.1 Reprovision of Kenwater Ward (part of the ward reprovision programme)

The conversion of the Day Case Unit to function on a 23 hour basis and the reconfiguration of wards on the first floor of the main hospital will be completed by the end of July. Overall, the Trust will have gained 4 new beds. Completion of this project will in turn allow the closure of Kenwater Ward (the site of which is required for the Macmillan Renton Unit development).

3.2 Macmillan Renton Unit (MRU)

The MRU is on track and on budget. There have been some technical problems with the diversion of the Victorian sewer and there remain some issues to be resolved with Welsh Water. However, the scheme is still programmed to be completed by Christmas 2010.

3.3 Equitable Access Centre (primary care and walk in centre)

The Trust has now taken over the management of the project having had the capital allocation made by the Strategic Health Authority transferred from the PCT. The design continues to be refined to take account of factors such as the needs of the ambulance service and car parking Further work is required to understand how the development 'fits' with HHT's plans to develop a Clinical Decisions Unit (CDU) and change the layout of A&E. All of these various factors will need to be reconciled in a Full Business Case which will set out the proposed solution in detail and confirm costs and timelines. At the present time, the projected deadline for opening in Q2 2011 remains robust

3.4 Business Plan 2010/11

The Trust's business plan for next year includes commitments to the replacement of the CT and MRI scanners and the development as a priority of the CDU which will allow the closure of Dore Ward. This closure is part of the ward reprovision programme. The site is also required for the development of the radiotherapy facility. It is also envisaged that the business plan will include a commitment to increase nurse staffing levels, taking account of patient dependency across the hospital.

3.5 Scoping studies

Scoping studies are planned for changes to the pathology laboratory, the development of a permanent 'home' for the planned High Dependency Unit, the upgrading/reprovison of staff accommodation and the development on site of a nursing home.

4) Response to Dr Foster Report and PCT and SHA Assurance Visits

Dr Foster formally published its annual Hospital Guide, entitled 'How safe is your hospital' on 30th November 2009. In the report HHT was placed in the lowest band for safety, along with 11 other Trusts. A score or ranking had been derived by statistical methods applied to a variety of information including HSMR (Hospital Standardised Mortality Ratio), HSMR for particular conditions, readmission rates, incident reporting to NRLS, the national patient survey and answers to a questionnaire distributed earlier in the year.

Subsequently the Trust received assurance visits from Herefordshire PCT and the West Midlands SHA. Detailed below are areas that have been or need to be addressed as a result of all of these reports.

HSMRs

Our overall HSMR was good at 93.41 but it was higher than the 'average' of 100 for three particular conditions – Stroke 125.1, Myocardial Infarction 105.84 and Fractured Neck of Femur 107.37. These have all improved since then; in particular the SMR for stroke over the last 6 months stands at 95.8. We have also added to our programme of mortality analysis all deaths in those groups identified on the Dr Foster website. We have joined the West Midlands Provider Mortality Protocol (WMPMP) programme to enable us to focus our attention on the elderly over 85 with respiratory illnesses. They will provide monthly information. Both systems will be used in parallel initially with the expectation of the whole region moving to WMPMP as the main analytical tool by the end of the year

Infection Control

We were marked down for having no isolation ward; it is our view that at present this is neither necessary nor affordable. Where isolation is required we have appropriate side rooms which are used and actively managed for this purpose. The number of side rooms in the Trust will increase by 7 in the ward re provision work at the closure of Kenwater ward.

National Reporting and Learning Services (NRLS)

Our turnaround in reporting incidents to the NRLS, which is a national safety reporting system, was slow; this has being remedied.

Never Events

We were marked down for not having an approved definition for 'Never Events'; this was remedied at Board level in April 2009.

Training on 'Being Open'

After its initial launch further training on 'Being Open' was not sustained. This is being addressed by the Department of Clinical Quality and Safety and is being re-launched in March 2010.

Good practice

It should be noted that for readmissions we scored well, i.e. had low rates, particularly for fractured neck of femur and hysterectomy where we 'exceeded expected'.

5) Improving Stroke Services

The Trust is making a concerted effort to improve its stroke services and is reviewing progress made with implementing NICE guidelines and the West Midlands Service Specification for the Management of Stroke Thrombolysis and Acute Care 2009.

The focus is on ensuring consistent compliance with national and regional guidelines, particularly with regard to:-

- Ensuring that a minimum of 80% of patients are directly admitted to the Stroke Unit (Frome Ward)
- Ensuring that a minimum of 80% of patients spend at least 90% of their time on the Stroke Unit

- Providing access to CT scans within 24 hours for urgent patients with stroke symptoms
- Ensuring appropriate access to thrombolysis where required

Recent performance data demonstrates that we are achieving significant improvement against the key standards - for example in November 2009 over 55% of patients were directly admitted to Frome Ward and over 70% spent more than 90% of their on the Stroke Unit.

To ensure that the improvements to our stroke service are sustained the following steps have or are being taken:-

- Additional night nursing and therapy staffing on the Stroke Unit
- One bed on the Unit kept free to enable stroke patients to be rapidly admitted
- A review of clinical decision making particularly in relation to authority to request CT scans or deliver thrombolysis

6) Care Quality Commission (CQC) Registration Requirements

From April 2010 all health and adult social care providers will be required by law to register with the CQC if they provide 'regulated activities'. To register with the CQC, all health and adult social care providers must show they are meeting the new regulations – essential standards of quality and safety – across all of the registered activities they provide.

The Trust's registration application was submitted in January 2010. The Trust has declared itself compliant with all registration outcomes and provided the CQC with a response to specific areas of risk highlighted in the Quality & Risk Profile for Hereford Hospital.

Martin Woodford
Chief Executive
Hereford Hospitals NHS Trust

Herefordshire Council

MEETING:	**HEALTH SCRUTINY COMMITTEE**
DATE:	**1 MARCH 2010**
TITLE OF REPORT:	**NHS HEREFORDSHIRE PERFORMANCE REPORT**
REPORT BY:	**Head of Business Support (NHS Herefordshire)**

CLASSIFICATION: Open

Wards Affected

County-wide.

Purpose

To provide an update on progress against health related Local Area Agreement (LAA) targets and Vital Signs indicators.

Introduction and Background

1. A report by the Head of Business Support is attached for consideration

Background Papers

- None identified.

Further information on the subject of this report is available from
Mike Emery, Head of Business Support on (01432) 344344 Ext 3757

NHS PERFORMANCE REPORT

Purpose

1. To provide information to the Health Scrutiny Committee for an update on progress against health related Local Area Agreement (LAA) targets and Vital Signs indicators. It focuses, in particular, on those areas that are deemed as underperforming.

Recommendations

2. That: the Committee note progress in managing performance towards achieving targets.

Reasons for Recommendations

3. To enable the Scrutiny Committee to carry out its function in relation to the associated Corporate Plan targets and Local Area Agreement (LAA) targets.

Background

4. The report card in appendix 1 provides an overview of progress against Vital Signs and LAA targets. The card shows our performance against Vital Signs targets, and indicates which of these are also LAA targets.

5. The PCT board and its Quality and Performance committee receive this report on a regular basis. The information in this document is based on the report that was sent to the last Quality and Performance committee. The report received by the Committee on the Annual Healthcheck in November indicated that these boards are one of the key mechanisms by which Performance is reviewed and underperformance challenged.

6. In addition the Health and Well-being policy and delivery group, part of the LSP, leads on the delivery of several key LAA targets. The key LAA targets that relate to the Health Scrutiny Committee are:

- NI 39 - Alcohol harm related admission rates
- NI 121 - Mortality rate from all circulatory diseases at ages under 75
- NI 123 - Stopping smoking

7. Further developments will be happening over the coming months too ensure that the reports the PCT board, its sub-committees and Council Scrutiny Committee receive take account of the new World Class Commissioning Strategy and the agreed outcomes. In the future it will indicate how this will impact on the PCT's Annual Healthcheck, this will include more comprehensive benchmarking data.

Further information on the subject of this report is available from Mike Emery, Head of Business Support, 01432 344344 ext 3757

Performance

LAA Indicators

8. NI 39 – alcohol harm related admission rates

Tolerance	Performance	Target	Latest Performance	Direction of Travel	
	2008-09	2009-10		November	December
Smaller is better	1,274	1,237	671.9 (to September) YTD	▼	▼

Commentary

Performance continues to be in excess of target, an action plan has been developed (Appendix 2). Our projected outturn is 1343.8 .

9. NI 121 - mortality rate from all circulatory diseases at ages under 75

Tolerance	Performance	Target	Latest Performance	Direction of Travel	
	2008-09	2009-10		November	December
Smaller is better	65.6 (2008)	57 (2009)	Data not available until the end of 2010	n/a	n/a

- An action plan has been developed and is being implemented. Outturn for 2009 is not available until late 2010. Performance in the previous years was 61.53 (2006), 58.14 (2007) and 65.59 (2008). In order to achieve the final LAA target, performance in 2010 needs to be 56.
- Projected performance for this indicator is that outturn will be around 50 by the end of the year.

10. NI 123 - stopping smoking (prevalence rate)

Tolerance	Performance	Target	Latest Performance	Direction of Travel	
	2008-09	2009-10		November	December
Bigger is better	823.7	815	231 (to September)	▼	▼

Commentary

Appendix 3 is the action plan that has been developed and is in the process of being implemented. Performance should improve in the final quarter and be closer to target, with further activity planned for 2010 which should lead to achievement of the final LAA target.

Vital Signs/local indicators - area of concern or improvement

11. Appendix 1 provides an overview of performance for each Vital Signs indicator (N.B. Vital signs is the National Health Services key 'indicator set', several of the indicators 'double' as National Indicators in the local authority framework). The following section, where there is seemingly underperformance, outlines the context and where appropriate the improvement plans in place. The information provided is the latest verified information to date.

    The level of knowledge and understanding, at all levels, of the waiting time targets e.g. when waiting times are counted, stopped, etc.

12. HC2a - % seen within 48 hours in GUM clinic

Target	Reporting Period - YTD	Target	Actual YTD	Perf. Trend	Director
% seen within 48 hours in GUM clinic	Nov-09	90%	**75.83%**	↑	RC

Commentary

Provider and commissioner are still in negotiation with the SHA about reducing the "seen" component of the 48hr. access target. The provider continues to achieve well with the offer component (98%) and is averaging 75% for seen. The main issues are;

- The amount of current resources to meet demand.
- Patient choice (Patients do not want to attend within 48 hours)
- A revised target of 80% has been agreed in principle subject to confirmation from the SHA lead. Extra funding is available from the SHA subject to the sexual health needs assessment which Public Health has recently completed.
- Internal auditors have just completed a piece of work, the results of which could assist the department in further improvement of the seen component.

Improvement Actions

- The SHA will consider the revised target once they have reviewed the Sexual Health Needs Assessment.
- The Sexual Health Needs Assessment has been completed by Public Health and signed off by Public Health.

13. VSA08 - Breast Symptom 2 week

Target	Reporting Period - YTD	Target	Actual YTD	Perf. Trend	Director
Breast Symptom – 2 week wait	Dec-09	93% - Dec 2009	**30.39%**	↑	IW

Commentary

National issues remain on how this target is to be achieved. It is recognised that this will be difficult to achieve given the impact on capacity for the previous target of 2 week wait from

referral to first seen. Work is ongoing to improve on all cancer activity monitoring from all providers through the 3 Counties Cancer Network and the cancer reform strategy.

The main issues in the provision of this service locally are

- Hereford Hospitals NHS Trust has capacity issues which have arisen as a result of the change nationally to the 2 week wait target.
- Given the impact of the change in national expectation a service review is needed to ensure compliance with the new national requirements.
- The existing local access policy does not meet the requirements of the new targets.

  Initial figures suggest that for the month of December, HHT achieved 90% against the target of 93%. A validation process of the data is currently underway and the results are expected before the end of January.

Improvement Actions

Hereford Hospitals NHS Trust has developed a short term action plan in order to achieve the national target of 93% by December 2009. A draft of the revised local access policy has been completed.

14. VSA14 - Stroke Care

Target	Reporting Period - YTD	Target	Actual YTD	Perf. Trend	Director
Quality stroke care - +90% of time spent on stroke unit	Dec-09	70% by Mar 2010	**40.00%**	↑	IW
Quality stroke care - % of people with TIA scanned and treated within 24 hours	Dec-09	45% by Mar 2010	**10.64%**	↔	IW

Commentary

It was noted in the previous report that a CQUIN incentive has been offered to Hereford Hospitals Trust (HHT) as a financial incentive to meet the DH set target. The Improving Stroke Services Project Group (NHSH and HHT) meets regularly to discuss performance. Actions taken to improve performance along the whole stroke pathway include:

- Faster access to TIA clinics to increase the number of people benefiting from early intervention to prevent full stroke.
- Ring-fencing of one bed in the acute stroke unit
- Direct admission of stroke patients to the Acute Stroke Unit from A&E
- Additional investment in stroke rehabilitation, which is now moving to the implementation stage.
- Raising public awareness to encourage faster and more effective response to stroke.

The TIA referrals received at HHT are booked for an appointment in chronological order rather than an ABCD2 of 4 or above (high risk). The majority of patients are seen within a week which complies with the low risk target and is in line with the NICE guideline 68.

Improvement Actions

One area of improvement currently under review is to expand the clinics to cover a seven day service, an evaluation of how other areas with a similar geography are able to achieve this has resulted in the need to find adequate specialist resources to cover the clinic, this has been highlighted to the Business Manager.

15 VSC10 - Delayed Transfers of Care

Target	Reporting Period - YTD	Target	Actual YTD	Perf. Trend	Director
Number of delayed transfers of care per 100,000 population (aged 18 and over)	Dec-09	30 per wk ave	**39.00**	↑	SD
Rate of delayed transfers of care per 100,000 population (aged 18 and over)	Dec-09	20.67	**27.22**	↑	SD

Commentary

Hereford Hospitals Trust is currently underperforming against expectation in terms of the local health economy. This is being addressed with the trust through the Quality Review Forum who has requested a report on why delays are higher than expected.

Community Hospitals and Intermediate Care Facilities

Improvement Actions

The Head of Community Hospitals & Intermediate Care Facilities now receives a weekly update of delayed patients which identifies the length of the delay. It has been agreed that any delays greater than 7 days should be escalated for immediate intervention.

A whole systems review of the delayed transfers of care issue needs to be initiated including the existing policy for 'eviction' with HHT, Adult Social Care and PCT Commissioners to ensure that delayed discharges are minimised, and areas for improvement are identified and managed across the whole care pathway:

- Major Alterations to patients residence
- Re-housing

It is planned to engage with Integrated Commissioning to explore whether interim beds could be used to ensure we maximise safe patient throughput in Community Hospitals.

There has been a significant drop in the length of stay and number of delays since the introduction of the above changes as of 1st December 2009. However it must be noted that recent winter pressures, in the form of adverse weather and closure of wards due to D&V, will have had an impact on early promising figures.

In order to validate the above perception a comparative study of the delay data for a four month period prior to and post the changes and for the period December 08 to March 09 will be undertaken.

15. VSB03 - Cancer Mortality Rate

Target	Reporting Period - YTD	Target	Actual YTD	Perf. Trend	Director
Cancer Mortality Rate	Feb-10	93 (2007 - 3yr ave.)	**102.31 (est. 2009)**	↓	AA

Commentary

Performance issues in relation to this indicator have been addressed as part of the Cancer Services report presented to this committee in October.

Improvement Actions

Public Health has developed the Health Improvement Plan which influences lifestyle risks, which includes those factors associated with cancer. The plan is awaiting final sign off which should be completed by the end of January.

16. VSC 17 - % of Adults and older people receiving self-directed support

Target	Reporting Period - YTD	Target	Actual YTD	Perf. Trend	Director
% of Adults and older people receiving self-directed support who are supported to live independently (aged 18 and over)	Nov-09	20.00%	**8.65%**	↑	IW

Commentary

This target has been measured differently from previous years and the new measurement is having an impact on current performance. However it should be noted that our current performance is in line with other West Midland authorities.

Improvement Actions

- A Programme Manager has been appointed to drive forward the uptake of services associated with this indicator.
- A robust programme plan is in place.
- A suite of key tasks aligned with improved performance has been developed and will be implemented in 2010/11 e.g.

- A project around external brokerage has been started supported by the Joint Improvement Partnership to increase the level of personal budgets - to report by Q4 2009/10

- The council are currently upgrading the Resource Allocation System in line with other councils, to be completed Q4 2009/10.

18. VSB08 - Teenage conceptions

Target	Reporting Period - YTD	Target	Actual YTD	Perf. Trend	Director
Teenage pregnancy	Dec-09	28	**35.8 (Jun 2008)**	↔	IW

Commentary

The DCSF commissioning support team has been focussing on teenage pregnancy. The National Support Team for teenage pregnancy were due to visit Hereford in December, however this has been postponed until May 2010.

An audit of Sex and Relationships Education (SRE) began in November/December 2009 of the remaining schools, pupil; referral units and further education facilities. This process should be completed by the end of January 2010. Visits to support implementation of action plans are underway. This will prepare schools for compulsory SRE education in 2011.

We have had a number of confirmed pregnancies in a teenage pregnancy hotspot area and are exploring a community development approach to address this issue, starting with the mapping of services.

Improvement Actions

- Visit by National Support Team, planned for May, to assess and review the following:

  a) Current service delivery and structure

  b) Review local strategy for teenage pregnancy

  c) Review governance of current service

  d) Review the impact of local initiatives – condom scheme

  e) Assist in development of an action plan to improve performance

- The overarching Relationship & Sex Education policy will be presented to DLT in the next month for ratification. Hereford College of technology has adopted the policy.

- *Methodology to address hotspot areas* – the aim is to take the Teenage Pregnancy Unit's self assessment framework model and develop it to use locally, mapping services to hotspot areas.

APPENDIX 1

Further information on the subject of this report is available from Mike Emery, Head of Business Support, 01432 344344 ext 3757

Performance Dashboard 2009-10

NHS Operating framework	
VSA	Vital Signs Tier 1
VSB	Vital Signs Tier 2
VSC	Vital Signs Tier 3
HC	Healthcare Commission Proposed Indicator (Not included in Vital signs)
DH	Existing Department of Health Commitments (Not included in Healthcare Commission indicators or Vital signs)

Performance rating	
Red	Under-performing & unlikely to achieve
Amber	Under-performing but can achieve with corrective action
Green	On plan & likely to deliver
*	An asterisk in the detailed report column indicates more detail is provided in section 3 of

Trend in performance	
Up	Improved since last measured
Down	Deterioration since last measured
Level	Remained the same
X	Not previously measured

Improving Access

NHS Operating framework		Performance rating				Trend in performance		
No.	Target	Reporting Period - YTD	Target	Actual YTD	Projected Outturn	Perf. Trend	Director	Detailed Report
VSA04	18 week waits admitted - NHS-reported waits for elective care	Nov-09	90%	98.5%		Up	IW	
VSA04	18 week waits non-admitted - NHS-reported waits for elective care	Nov-09	95%	99.0%		Leve;	IW	
VSA04	6 week waits for diagnostic tests	Sep-09	0	5		Up	IW	*
HC1	4 hour maximum A&E wait	As at 3rd Jan 2010 - YTD	98%	98.54%		Up	IW	
DH1	Maximum wait of 13 weeks for outpatient appointment	Nov-09	0	0		Level	IW	
DH2	Maximum wait of 26 weeks for inpatient appointment	Nov-09	0	6		Level	IW	*
DH3	3 month maximum wait for revascularisation	Nov-09	0	0		Level	IW	
HC2a	% seen within 48 hours in GUM clinic	Nov-09	90%	75.83%		Up	RC	*
HC2b	% offered appointment within 48 hours in GUM clinic	Nov-09	98%	98.73%		Up	RC	
HC3a ***(WCC)***	Cancer waits – 2 week maximum wait from urgent GP referral	Oct-09 YTD	93%	92.92%		Up	IW	
HC3b ***(WCC)***	Cancer waits – 1 month maximum wait from diagnosis to treatment	Oct-09 YTD	96%	98.19%		Down	IW	
VSA08 ***(WCC)***	Breast Symptom Two Week Wait	Dec-09 YTD	93% - Dec 2009	30.39%		Up	IW	*
VSA09 ***(WCC)***	Proportion of women aged 47-49 and 71-73 offered screening for breast cancer (36-38 mths)	Jun-09	90% within 36 mths	97.4% within 38 mths		Up	AA	
VSA10 ***(WCC)***	Proportion of men and women aged 70-75 taking part in bowel screening programme	Jan-10	**Screening began Sept 2009 - awaiting first report from Regional Hub**			Level	AA	
VSA11 ***(WCC)***	31-Day Standard for Subsequent Cancer Treatments (Chemotherapy and Surgery)	Oct-09 YTD	94%	95.76% (Surgery Only)		Up	IW	
VSA12 ***(WCC)***	31-Day Standard for Subsequent Cancer Treatments (Radiotherapy)	Oct-09 YTD	100% - Jan 2010	100%		Up	IW	
VSA13 ***(WCC)***	Extended 62-Day Cancer Treatment Targets	Oct-09 YTD	90%	100%		Up	IW	
HC4	Time to reperfusion following a MI	Nov-09	68%	70.00%		Down	IW	
HC5	Access to crisis services for all patients who need them	Sep-09	272	240		Down	RC	*
HC6	Early Intervention in psychosis	Sep-09	20 New Cases	10		Up	RC	
HC8a	Ambulance Response targets – CAT A calls in 8 mins – West Mids Ambulance Trust	Nov-09	75%	70.4%		Up	IW	*
HC8a	*Ambulance Response targets - CAT A calls in 8 mins - (Herefordshire)*	Nov-09	75%	71.7%		Down	IW	*
HC8b	Ambulance Response targets – CAT A calls in 19 mins – West Mids Ambulance Trust	Nov-09	95%	97.3%		Level	IW	*
HC8a	*Ambulance Response targets - CAT A calls in 19 mins - (Herefordshire)*	Nov-09	95%	93.0%		Up	IW	*

		Performance rating			Trend in performance	
No.	Target	Reporting Period - YTD	Target	Actual YTD	Perf. Trend	Director
VSA01	MRSA number of infections - Acute only	Sep-09	12	0	?	SD
VSA03 Comm	Incidence of C. Difficile - Commissioner	Sep-09	171	24	?	SD
VSA07	Practices offering extended opening	Sep-09	54% by Mar 2010	58%	?	IW
VSB18	Access to primary dental services - year-on-year improvements in number of patients accessing NHS dental services	Sep-09	93,551	93,436	?	IW
VSA14 - 01 *(WCC)*	Quality stroke care - +90% of time spent on stroke unit	Dec-09	70%	40.00%	?	IW
VSA14 - 02 *(WCC)*	Quality stroke care - % of people with TIA scanned and treated within 24 hours	Dec-09	45%	10.53%	?	IW
VSC10	Number of delayed transfers of care per 100,000 population (aged 18 and over)	Dec-09	30 per wk ave	39.00	?	SD
VSC10.1	Rate of delayed transfers of care per 100,000 population (aged 18 and over)	Dec-09	20.67	27.22	?	SD
MHPI 01	Data quality on ethnic group	Sep-09	85%	100.00%	?	RC
MHPI 02	Care Programme Approach - CPA 7-Day follow up	Sep-09	95%	85.44%	?	RC
MHPI 03 *(WCC)*	Best Practice in Mental Health Services for People with Learning Disabilities (Green Light Toolkit)	Jan-10	No info available at time of report		?	IW
MHPI 04	Patterns of Care from the Mental Health Minimum Data Set	Sep-09		98.73%	?	RC
MHPI 05	Completeness of Care from the Mental Health Minimum Data Set	Mar-09	98.28%	99.73%	?	RC
MHPI 06	CAMHS Services - protocols in place (1-6)	Jan-10		Yes	?	IW
VSB01-a	All-age all cause mortality (AAACM) rate - males	Mar-09	650	658.2	?	AA
VSB01-b	All-age all cause mortality (AAACM) rate - females	Mar-09	409	428.7	?	AA
VSB02 - LAA - NI 121	CVD Mortality Rate (*LAA target - All circulatory diseases under 75*)	Mar-09	77 (2007 - 3yr ave.)	61.7	?	AA
VSB03 *(WCC)*	Cancer Mortality Rate	Feb-10	90 (2008 - 3yr ave.)	102.31 (est. for 2009)	?	AA
VSB05 - LAA - NI 123	Smoking Prevalence (Smoking Quitters)	Oct-09	1220	442	?	AA
VSB06	Early Access for Women to Maternity Services	Sep-09	80%	86.82%	?	IW
VSB08	Teenage pregnancy	Dec-08	28	38.8 (Jun 2008)	?	IW
VSB09 *(WCC - LAA - NI - 56)*	Childhood Obesity	Jan-10 (Sept' 09 measure)	85%	87.15%	?	AA
VSB10 - 1	Immunisation rate for children aged 1 who have been immunised for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) - (DTaP/IPV/Hib)	Sep-09	95%	94.16%	?	AA
VSB10 - 2	Immunisation rate for children aged 2 who have been immunised for Pneumococcal infection (PCV) - (PCV)	Sep-09	85%	94.61%	?	AA
VSB10 - 3	Immunisation rate for children aged 2 who have been immunised for Haemophilus influenza type b (Hib), meningitis C (MenC) - (Hib/MenC)	Sep-09	85%	89.89%	?	AA
VSB10 - 4	Immunisation rate for children aged 2 who have been immunised for measles, mumps and rubella (MMR) - (MMR)	Sep-09	89%	88.43%	?	AA
VSB10 - 5	Immunisation rate for children aged 5 who have been immunised for Diphtheria, Tetanus, Polio, Pertussis (DTaP/IPV)	Sep-09	94%	95.42%	?	AA
VSB10 - 6 *(WCC)*	Immunisation rate for children aged 5 who have been immunised for measles, mumps and rubella (MMR)	Sep-09	88%	86.26%	?	AA
VSB11 - 1	Breastfeeding at 6-8 weeks - Prevalence	Sep-09	52.90%	46.21%	?	RC
VSB11 - 2	Breastfeeding at 6-8 weeks - Coverage	Sep-09	90.10%	80.46%	?	RC
VSB12 - LAA - NI 51	Emotional health and well being and child and adolescent mental health services (CAMHS)	Jan-10		Yes	?	IW
VSB13	Chlamydia Prevalence (Screening)	Nov-09	4956 - 25% of 15 to 24 yr olds	64.09% of target fig	?	RC
VSB14 - LAA - NI 40	Number of Drug Users recorded as being in effective treatment	Jul 08 - Jun 09	530	528	?	IW
VSC02	Proportion of people with depression and/or anxiety disorders who are offered psychological therapies - IAPT Implementation	Jan-10	In shadow form - Programme will commence once completion of 3rd wave		?	IW
VSC15 *(WCC)*	Proportion of all deaths that occur at home	Mar-09	21% - 2008	20.10%	?	IW
VSC17 - LAA - NI 130	% of Adults and older people receiving self-directed support who are supported to live independently (aged 18 and over)	Nov-09	20%	8.65%	?	IW
VSC26 - LAA - NI - 39	Rate of hospital admissions per 100,000 for alcohol related harm	Jun-09	1237	335.7 estimated	?	IW
VSC27	Patients with diabetes in whom the last HbA1c is 7.5 or less from Quality Outcomes Framework (QOF)	Mar-09	66%	69.13%	?	IW
VSB15 - 1	Self reported experience of patients/users	Mar-09		84.22	?	SD
VSB15 - 2	Self reported experience of patients/users	Mar-09		86.44	?	SD
VSB15 - 3	Self reported experience of patients/users	Mar-09		68.47	?	SD
VSB15 - 4	Self reported experience of patients/users	Mar-09		65.51	?	SD
VSB17	NHS staff survey based measures of job satisfaction	Mar-09	3.55	3.56	?	SD

APPENDIX 2

Herefordshire Population Health Improvement Business Plan 2010/11

Strategic objective III: Reduce harmful alcohol consumption

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
1.	**Promote safe alcohol consumption to Children and Young People**									
1.a	Effective PSHE teacher delivered programmes; specialist teacher support to PHSE teachers;	In conjunction with new mandatory PSHE requirements all primary and secondary schools to have good practice PSHE	Sept 2011	DCS	Area Based Grant	Children's Trust		NI 39	WCC 1,2,7, 8,9,10	
1.b	Provision of external resources as part of a teacher delivered programme.	External support to schools to deliver PSHE to be reviewed and co-ordinated and enhanced as necessary	Sept 2011	DPH	Area Based Grant	Children's Trust		NI 39	WCC 1,2,7, 8,9,10	
1.c	Locally enhance national social marketing campaigns targeted at 11 to 17 year olds to increase awareness of the potential harm from alcohol consumption and to promote sensible drinking	Develop and deliver a campaign in all secondary school and sixth form settings	June 2011	DPH Head of Communications	Choosing Health	Children's Trust		NI 39	WCC 1,2,7, 8,9,10	
1.d	Locally enhance national social marketing campaigns targeted at 18 –	Develop and deliver a campaign using	March	DPH	Choosing	Health and		NI 39	WCC 1,2,7,	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
	30 year olds using local communication channels and local demographic knowledge to increase awareness of the potential harm from alcohol consumption and to promote sensible drinking	communication methods used by young adults, and in places they congregate.	2011	Head of Communications	Health	Wellbeing Partnership			8,9,10	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.	**Support people to reduce their alcohol consumption if drinking unsafe amounts of alcohol**									
2.1	**Support pregnant women to reduce their alcohol consumption if drinking unsafe amounts of alcohol for their baby by:**									
2.1a	NHS Herefordshire staff to routinely ASK pregnant women about their weekly alcohol consumption.	All pregnant women asked about alcohol consumption and the answer recorded in the patient record.	March 2011	CEO HHT	Midwifery budget	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	
2.1b	NHS Herefordshire staff to routinely ASSESS the willingness of pregnant women to reduce their alcohol consumption if drinking unsafe amounts.	All pregnant women drinking unsafe amounts of alcohol assessed at booking for willingness to reduce their alcohol consumption and the result recorded in the patient record.	March 2011	CEO HHT	Midwifery budget	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	

2.1c	NHS Herefordshire staff to routinely ADVISE pregnant women drinking unsafe amounts of alcohol of the risks to their baby's health	All pregnant women drinking unsafe amounts of alcohol advised at booking about the risk to their baby's health and the advice given recorded in the patient record.	March 2011	CEO HHT	Midwifery budget	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.1d	NHS Herefordshire staff to routinely ASSIST pregnant women to reduce their alcohol consumption if drinking unsafe amounts by giving written advice to support them to reduce their consumption	All pregnant women drinking unsafe amounts of alcohol to be offered standardised written advice to support them to reduce their alcohol consumption and the response to the offer recorded in the patient record.	March 2011	CEO HHT	Midwifery budget	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	
2.1e	NHS Herefordshire staff to routinely ARRANGE referral to specialist alcohol treatment services for pregnant women drinking amounts of alcohol likely to harm their baby..	All pregnant women drinking amounts of alcohol likely to harm the baby to be offered a referral to specialist alcohol treatment services and the response to the offer recorded in the patient record.	March 2011	CEO HHT	Midwifery budget	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.2	**Support people with an alcohol related admission to hospital to reduce their alcohol consumption by:**									
2.2a	NHS Herefordshire staff to routinely ASK patients with an alcohol related admission about their weekly alcohol consumption	Alcohol consumption to be recorded at time of admission for all alcohol related admissions and recorded in the patient record.	March 2011	CEO HHT	Medical and Surgical budgets	Health and wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	
2.2b	NHS Herefordshire staff to routinely ASSESS the willingness of patients with an alcohol related admission to reduce their alcohol consumption.	Willingness to reduce alcohol consumption to be assessed before discharge for all alcohol related admissions and recorded in the patient record.	March 2011	CEO HHT	Medical and Surgical budgets	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	
2.2c	NHS Herefordshire staff to routinely ADVISE patients with an alcohol related admission of the risks to their personal health of their alcohol consumption	Advice on the personal risks to their health from their alcohol consumption to be given before discharge to all patients with an alcohol related admission and the advice recorded in the patient record.	March 2011	CEO HHT	Medical and Surgical budgets	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	
2.2d	NHS Herefordshire staff to routinely ASSIST patients with an alcohol related admission to reduce their alcohol consumption. by giving written advice to support them to reduce their consumption .	All patients with an alcohol related admission to be offered before discharge standardised written advice to support them to reduce their alcohol consumption and the response to the offer recorded in the patient record.	March 2011	CEO HHT	Medical and Surgical budgets	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.2e	NHS Herefordshire staff to routinely ARRANGE referral for patients with an alcohol related admission to specialist alcohol treatment services.	All patients with an alcohol related admission to be offered a referral to specialist alcohol treatment services and the patient's response recorded in the patient record.	March 2011	CEO HHT	Medical and Surgical budgets	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	
2.2f	All alcohol related admissions to be entered on a database and each patient's follow up and treatment monitored by the alcohol liaison nurse service to prevent readmission	• Create a database • Produce a quarterly report on follow up, treatment and readmission rates for alcohol related admissions	June 2010 July 2010 Oct 2010 Jan 2011 April2011	CEO HHT CEO HHT	Alcohol + Choosing Health	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.3	**Enhance the capability and capacity of NHS Herefordshire to provide Identification and Brief Advice and treatment for harmful alcohol consumption**									
2.3a	Plan and implement a programme to train NHS Herefordshire frontline staff to undertake systematic Identification and Brief Advice (IBA) about harmful alcohol consumption following the ASK, ASSESS, ADVICE, ASSIST, ARRANGE approach	NHS Herefordshire staff working in primary care, midwifery, surgical and medical services to be offered training.	March 2011	DPH	Choosing Health	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	
2.3b	Identification and Brief Advice following the ASK, ASSESS, ADVICE, ASSIST, ARRANGE approach to be offered to patients newly registering with a General Practice	Records of newly registered patients to contain current weekly alcohol consumption, and if above safe limits a record of willingness to reduce, advise given on risks, and assistance and/or support to quit arranged.	March 2011	Director of Integrated Commissioning	DES	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	
2.3c	Increase the capability and capacity of front line NHS Herefordshire staff to conduct a motivational interview to increase the willingness to reduce their alcohol consumption of a patient drinking above safe limits.	Offer training in motivational interviewing to frontline NHS Herefordshire staff working in primary care, midwifery, surgical and medical services.	March 2011	DPH	Choosing Health	Health and Wellbeing partnership		NI 39	WCC 1,2,7, 8,9,10	

2.3d	Provide NHS Herefordshire frontline staff with standardised written information to support patients drinking above safe limits to reduce their alcohol consumption.	Disseminate written patient information to NHS Herefordshire frontline staff	June 2010	DPH	Choosing Health	Health and wellbeing partnership		NI 39	WCC 1,2,7, 8,9,10	
2.3e	Carry out a needs assessment and service review for specialist alcohol treatment services in Herefordshire and commission services to provide sufficient capacity, capability and flexibility of access to meet an increase in the number of patients referred by NHS Herefordshire staff.	• Complete a needs assessment • Complete a service review • Commission new services as necessary	Sept 2010 Sept 2010 Oct 2010	DPH Director of Integrated Commissioning Director of Integrated Commissioning	Choosing Health Alcohol + Choosing Health Alcohol + Choosing Health	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	

Ref	Actions	Success Measures	Completion Date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
3.0	**Protect the public from harm to their health and provide an environment that supports people to drink alcohol safely**									
3.a	Carry out test purchases to detect under age alcohol sales and enforce legislation	Safer Herefordshire to advise	March 2011	Director of Environment and Culture	Directorate budget	Children's Trust		NI 39	WCC 1,2,7, 8,9,10	
3b	Reduce under age alcohol sales by promoting collaboration to reduce with neighbouring schools by Off Licences and supermarkets, and enforcing legislation in the area of a school as necessary	Safer Herefordshire to advise	March 2011	Director of Environment and Culture	Directorate budget	Children's Trust		NI 39	WCC 1,2,7, 8,9,10	
3c	Develop a multiagency action plan to reduce accidents and injuries related to alcohol consumption	Safer Herefordshire to advise	Sept 2010	Director of Environment and Culture	Directorate budget	Safer Herefordshire		NI 39	WCC 1,2,7, 8,9,10	
3d	Consider additional licensing requirements if alcohol is to be sold at less than 50 pence per unit of alcoholic strength to require alcohol to be sold in an in store alcohol zone, and to ban promotion of cheap alcohol in doorways	Safer Herefordshire to advise	March 2011	Director of Environment and Culture	Directorate budget	Safer Herefordshire		NI 39	WCC 1,2,7, 8,9,10	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
4.0	**Reduce inequalities in rates of harmful alcohol consumption**									
4.a	Locally enhance national social marketing campaigns using local communication channels and local demographic knowledge, and by providing events and services in deprived communities to support the campaign.	Develop and run two sequential campaigns in deprived communities in Herefordshire.	September 2010 April 2011	Director of Public Health Head of Communications	Choosing Health	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	
4.b	Enhance the health trainer service to provide community initiatives in deprived communities in Herefordshire as well as individual lifestyle interventions	Develop and run a programme of community initiatives that enhance and support national social marketing campaigns to enhance the impact of the campaigns.	September 2010	Director of Public Health	Choosing Health	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	
4.c	Realise the benefits of the Herefordshire Public Services partnership to increase access to support to reduce their alcohol consumption in deprived communities by using the whole range of facilities owned by Herefordshire Public Services	Increase the number of locations in deprived communities where people can access support to reduce their alcohol consumption	March 2011	Director of Public Health	Choosing Health	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
5.0	**Advocate for action and prioritisation of resources to reduce harmful alcohol consumption**									
5.a	Raise awareness of the risk of brain damage to the baby if a mother drinks unsafe amounts of alcohol while pregnant.	Promote the message through the DPH Annual Report, corporate plans and at corporate events, and the democratic process	April 2011	Director of Public Health Head of Communications	Choosing Health	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	
5.b	Raise awareness of the cost to public services in Herefordshire of the rapidly increasing number of hospital attendances and admissions as a consequence of harmful alcohol consumption.	Promote the message through the DPH Annual Report, corporate plans and at corporate events, and the democratic process	April 2011	Director of Public Health Head of Communications	Choosing Health	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	
5.c	Raise awareness of the cost to the economy in Herefordshire of sick leave from work due to the health consequences of harmful alcohol	Promote the message through the DPH Annual Report, corporate plans and at corporate events, and the	April 2011	Director of Public Health	Choosing Health	Health and Wellbeing Partnershi		NI 39	WCC 1,2,7,	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
	consumption	democratic process		Head of Communications		p			8,9,10	
5.d	Advocate for licensing requirements to be strengthened to ban promotion of cheap alcohol in store doorways	Advocate through the DPH Annual Report, corporate plans and at corporate events, and the democratic process	April 2011	Director of Public Health CEO PCT/HCC CEO HHT	Choosing Health	Health and Wellbeing Partnership		NI 39	WCC 1,2,7, 8,9,10	

APPENDIX 3

Herefordshire Population Health Improvement Plan 2010/11

Strategic objective I: Reduce Smoking Prevalence.

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
1.	**Prevent Children and Young People starting to smoke by:**									
1.a	Effective PSHE teacher delivered programmes; specialist teacher support to PHSE teachers;	In conjunction with new mandatory PSHE requirements all primary and secondary schools to have good practice PSHE	Sept 2011	DCS	Area Based Grant	Children's Trust		NI 123 NI 121	WCC 1,2,6, 8,9	
1.b	Provision of external resources as part of a teacher delivered programme.	External support to schools to deliver PSHE to be reviewed and co-ordinated and enhanced as necessary	Sept 2011	DPH	Area Based Grant	Children's Trust		NI 123 NI 121	WCC 1,2,6, 8,9	
1.c	All schools to be smoke free premises	Identify and support all schools that are not yet smoke free premises to become smoke	Sept 2011	DCS	Directorate budget	Children's Trust		NI 123	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
		free						NI 121		
1.d	Provide evidence based smoking prevention interventions in school settings	Complete pilot of peer support smoking prevention programme in secondary schools	July 2011	DPH	Choosing Health	Children's Trust		NI 123 NI 121	WCC 1,2,6, 8,9	
1.e	Run a social marketing campaign targeting young people 11–17 to prevent them starting to smoke	Locally enhance national Smokefree campaign and deliver in all secondary school and sixth form settings	July 2011	DPH	Choosing Health	Children's Trust		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.	**Support Smokers to Quit**									
2.1	**Support pregnant smokers to quit by:**									
2.1a	NHS Herefordshire staff to routinely ASK pregnant women if they smoke, ASSESS their willingness to quit, ADVISE of the risks of smoking in pregnancy, ASSIST smokers to quit and ARRANGE smoking cessation support for pregnant women who smoke.	All pregnant women offered CO test at booking by midwives trained to take a Carbon Monoxide (CO) reading, and the result recorded in the patient record.	March 2011	CEO HHT	Midwifery budget	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
2.1b	NHS Herefordshire staff to routinely ASSESS the willingness of pregnant smokers to quit	All pregnant smokers assessed at booking for willingness and the result recorded in the patient record.	March 2011	CEO HHT	Midwifery budget	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

2.1c	NHS Herefordshire staff to routinely ADVISE pregnant smokers of the risks to their baby's health of them smoking	All pregnant smokers advised about the risk to their baby's health and the advice given recorded in the patient record.	March 2011	CEO HHT	Midwifery budget	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.1d	NHS Herefordshire staff to routinely ASSIST pregnant smokers to quit including written advice on increasing the chances of quitting, signposting to NRT and signposting to Stop Smoking Herefordshire or other smoking cessation support	All pregnant smokers to be offered standardised assistance to quit and the response to the offer recorded in the patient record.	March 2011	CEO HHT	Midwifery budget	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
2.1e	NHS Herefordshire staff to routinely ARRANGE referral to smoking cessation services for pregnant smokers seeking support to quit.	All pregnant smokers to be offered a referral to smoking cessation services and the response to the offer recorded in the patient record.	March 2011	CEO HHT	Midwifery budget	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.2	**Support smokers on elective surgery waiting lists to "Stop Before the Op by":**									
2.2a	NHS Herefordshire staff to routinely ASK patients if they smoke at the time of entry on a surgical waiting list.	Smoking status to be recorded for all patients at time of entry on to an elective surgery waiting list	March 2011	CEO HHT	Surgical budgets	Health and wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
2.2b	NHS Herefordshire staff to routinely ASSESS the willingness of smokers to quit at the time of entry on a surgical waiting list.	Willingness to quit to be recorded in all patient records of smokers at time of entry on a surgical waiting list	March 2011	CEO HHT	Surgical budgets	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
2.2c	NHS Herefordshire staff to routinely ADVISE smokers at the time of entry on a surgical waiting list of the additional individual risks of their operation due to their smoking	Advice given about additional risks of smoking to be recorded in all patient records of smokers at time of entry on a surgical waiting list	March 2011	CEO HHT	Surgical budgets	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

2.2d	NHS Herefordshire staff to routinely ASSIST smokers to quit at the time of entry on a surgical waiting list including written advice on increasing the chances of quitting, signposting to NRT and signposting to Stop Smoking Herefordshire or other smoking cessation support	All smokers to be offered standardised assistance to quit at time of entry on a surgical waiting list and the response to the offer recorded in the patient record.	March 2011	CEO HHT	Surgical budgets	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.2e	NHS Herefordshire staff to routinely ARRANGE referral to smoking cessation services for smokers seeking support to quit while on a surgical waiting list	All smokers to be offered a referral to smoking cessation services at time of entry on a surgical waiting list and patient's response recorded in the patient record.	March 2011	CEO HHT	Surgical budgets	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
2.2f	Surgical referral letters from General Practitioners to routinely include the patient's current smoking status, their willingness to quit, ADVISE given about additional risks, ASSISTANCE to quit given, and smoking cessation support ARRANGED.	All surgical referral letters to contain current smoking status, willingness to quit, advise given on risks, and assistance and/or support to quit arranged.	March 2011	Director Integrated Commissioning	GMS	Health and wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.3	**Support smokers with chronic disease to quit:**									
2.3a	NHS Herefordshire staff to routinely ASK patients with chronic disease if they smoke	85% of patient records of patients attending Chest, Diabetic & Cardiac OPD clinics to include current smoking status	March 2011	CEO HHT	Surgical budgets	Health and wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
2.3b	NHS Herefordshire staff to routinely ASSESS the willingness of smokers with chronic disease to quit	85% of patient records of smokers attending chest, cardiac, and diabetic OPD clinics to contain a record the patient's willingness to attempt to quit	March 2011	CEO HHT	Surgical budgets	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
2.3c	NHS Herefordshire staff to routinely ADVISE smokers with chronic disease of the individual risks to their health from smoking	85% of patient records of patients attending chest, cardiac & diabetic OPD clinics to contain a record of advice given about the individual risks to their health from smoking.	March 2011	CEO HHT	Surgical budgets	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

2.3d	NHS Herefordshire staff to routinely ASSIST smokers with chronic disease to quit including written advice on increasing the chances of quitting, signposting to NRT and signposting to Stop Smoking Herefordshire or other smoking cessation support	85% of smokers attending chest, cardiac, & diabetic OPD clinics to be offered standardised assistance to quit and a record of the assistance given recorded in the patient record.	March 2011	CEO HHT	Surgical budgets	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.3e	NHS Herefordshire staff to routinely ARRANGE referral to smoking cessation services for smokers with chronic disease seeking support to quit.	85% of smokers attending chest, cardiac, and diabetic OPD clinics to be offered a referral to smoking cessation support services and a record of the offer made in the patient record.	March 2011	CEO HHT	Surgical budgets	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
2.3f	General Practice chronic disease registers to routinely include the patient's current smoking status, ASSESSMENT of their willingness to quit, ADVISE given about individual risks from smoking, ASSISTANCE to quit given, and smoking cessation support ARRANGED.	95% of records of patients on QOF chronic disease registers.	March 2011	Director Integrated Commissioning	QOF	Health and wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion Date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.4	**Enhance the capability and capacity of NHS Herefordshire to provide smoking cessation support services:**									
2.4a	Plan and implement a programme to train NHS Herefordshire frontline staff to undertake systematic brief intervention with smokers following the ASK, ASSESS, ADVICE, ASSIST, ARRANGE approach	NHS Herefordshire staff working in primary care, midwifery, surgical, Diabetic, Cardiac, and Chest services offered training.	March 2011	DPH	Choosing Health	Health and Wellbeing Partnership		NI 123 NI121	WCC 1,2,6, 8,9	
2.4b	Increase the capability and capacity of front line NHS Herefordshire staff to conduct a motivational interview with a smoker to increase their willingness to quit.	Provide training in motivational interviewing to frontline NHS Herefordshire staff	March 2011	DPH	Choosing Health	Health and Wellbeing partnership		NI 123 NI 121	WCC 1,2,6, 8,9,	
2.4c	Provide NHS Herefordshire frontline staff with standardised written information for patients on how to increase the chances of successfully quitting, how to access Nicotine Replacement Therapy and how to access the Stop Smoking Herefordshire service for specialist support	Disseminate written patient information to NHS Herefordshire frontline staff	June 2010	DPH	Choosing Health	Health and wellbeing partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion Date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.4d	Enhance the capacity and access to smoking cessation services in Herefordshire and ensure sufficient capacity and flexibility to meet an increase in the number of smokers self referred and referred by NHS Herefordshire staff.	• Introduce a revised LES with primary care • initiate a service in Hereford County Hospital • initiate a range of new services out of office hours • initiate a workplace service	April 2010 April 2010 Sept 2010 Sept 2010	DPH	Smoking Cessation budget	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.5	**Support NHS Herefordshire and Herefordshire Council employees who smoke to quit:**									
2.5a	All NHS Herefordshire and Herefordshire Council premises to be smoke free at all times.	Identify and support any NHS Herefordshire and Herefordshire Council premises not yet smoke free to become smoke free	April 2011	Deputy Chief Executive	Directorate budget	Health and wellbeing partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
2.5b	Run a social marketing campaign targeting NHS Herefordshire and Herefordshire Council staff, including contractors, to promote the benefits of quitting smoking and to raise awareness of services available to support smokers to quit	Develop campaign and deliver to all NHS Herefordshire and Herefordshire Council staff	Sept 2011	DPH	Choosing Health	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
2.5c	Offer paid time to attend workplace smoking cessation services to NHS Herefordshire and Herefordshire Council staff, subject to status as a smoker who has quit being confirmed on attendance.	Communicate offer to all staff	Sept 2011	CEO PCT/HCC/HHT	All Directorate Budgets	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
2.5d	Provide workplace smoking cessation services for NHS Herefordshire and Herefordshire Council staff	Initiate workplace smoking cessation service in NHS Herefordshire and Herefordshire Council premises	Sept 2011	DPH	Smoking Cessation	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
3.0	**Protect the public from harm to their health and provide an environment that supports people not to smoke**									
3.a	Carry out test purchases to detect under age tobacco sales and enforce legislation	Safer Herefordshire to advise	March 2011	Director of Environment and Culture	Directorate budget	Children's Trust		NI 123 NI 121	WCC 1,2,6, 8,9	
3b	Make it difficult for young people to start to smoke, and easier to choose not to smoke, by promoting voluntary collaboration with neighbouring schools by tobacconists and supermarkets, and enforcing legislation in the area of a	Safer Herefordshire to advise	March 2011	Director of Environment and Culture	Directorate budget	Children's Trust		NI 123	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
	school as necessary							NI 121		
3.c	Raise public awareness of the dangers of buying contraband tobacco products	Safer Herefordshire to advise	March 2011	Director of Environment and Culture	Area Based Grant	Safer Herefordshire		NI 123 NI 121	WCC 1,2,6, 8,9	
3.d	Detect contraband tobacco sales and enforce legislation	Safer Herefordshire to advise	March 2011	Director of Environment and Culture	Directorate budget	Safer Herefordshire		NI 123 NI 121	WCC 1,2,6, 8,9	
3e	Form a Tobacco Control Alliance for Herefordshire	Develop Terms of Reference, Membership and a business plan for 2010/11	September 2010	Director of Environment and Culture	Directorate budget	Safer Herefordshire		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
4.0	**Reduce inequalities in smoking rates**									
4.b	Locally enhance national Smokefree campaigns using local communication channels and local demographic knowledge, and by providing events and services in deprived communities to support the campaign.	Develop and run two sequential campaigns in deprived communities in Herefordshire.	September 2010 April 2011	Director of Public Health Head of Communications	Choosing Health	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
4.c	Enhance the health trainer service to provide community initiatives in deprived communities in Herefordshire as well as individual lifestyle interventions	Develop and run a programme of community initiatives that enhance and support national Smokefree campaigns to enhance the impact of the campaigns.	September 2010	Director of Public Health	Choosing Health	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
4.d	Realise the benefits of the Herefordshire Public Services partnership to increase access to smoking cessation services in deprived communities by using the whole range of facilities owned by Herefordshire Public Services	Increase the number of locations in deprived communities where smokers can access smoking cessation services	March 2011	Director of Public Health	Smoking Cessation	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
5.0	**Advocate for action and prioritisation of resources to reduce smoking as the biggest preventable cause of premature death in Herefordshire**									
5.a	Raise awareness that smoking remains the biggest preventable cause of premature death in Herefordshire	Promote the message through the DPH Annual Report, corporate plans and at corporate events, and the democratic process	April 2011	Director of Public Health Head of Communications	Choosing Health	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
5.b	Raise awareness of the increased risk of a baby dying before one year old if they live in homes where adults smoke	Promote the message through the DPH Annual Report, corporate plans and at corporate events, and the democratic process	April 2011	Director of Public Health Head of Communications	Choosing Health	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
5.c	Raise awareness of the cost to public services in Herefordshire of the health consequences of smoking	Promote the message through the DPH Annual Report, corporate plans and at corporate events, and the democratic process	April 2011	Director of Public Health Head of Communications	Choosing Health	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
5.d	Raise awareness of the cost to the economy in Herefordshire of sick leave from work due to the health consequences of smoking	Promote the message through the DPH Annual Report, corporate plans and at corporate events, and the democratic process	April 2011	Director of Public Health Head of Communications	Choosing Health	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
6.0	**Early identification and treatment of Cancer and Coronary Heart Disease**									
6.a	Provide high-quality screening services	As per PCT Commissioning	March	Director of Integrated	As per PCT Financial	Health and Wellbeing		NI	WCC	

Ref	Actions	Success Measures	Completion date	Lead Director	Budget	Reports to	Progress Update [RAG]	Targets		
								LAA	WCC	Other
	in accordance with national guidance	Strategy 2010/11	2011	Commissioning	Plan	Partnership		123 NI 121	1,2,6, 8,9	
6.b	Provide evidence based effective treatment including chemotherapy and radiotherapy, aspirin and statins	As per PCT Commissioning Strategy 2010/11	March 2011	Director of Integrated Commissioning	As per PCT Financial Plan	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	
6.c	Introduce an NHS Health Checks (known as vascular checks) screening programme to identify people at high risk of CHD	Offer an NHS Health Check to 20% of the population age 40 to 74 years	March 2011	Director of Integrated Commissioning	As per PCT Financial Plan	Health and Wellbeing Partnership		NI 123 NI 121	WCC 1,2,6, 8,9	

Herefordshire Council

MEETING:	**HEALTH SCRUTINY COMMITTEE**
DATE:	**1 MARCH 2010**
TITLE OF REPORT:	**WORK PROGRAMME**
REPORT BY:	**COMMITTEE MANAGER (SCRUTINY)**

CLASSIFICATION: Open

Wards Affected

County-wide.

Purpose

To consider the Committee's work programme.

Recommendation

THAT subject to any comment or issues raised by the Committee the Committee work programme be approved and reported to the Overview and Scrutiny Committee.

Introduction and Background

1. The Overview and Scrutiny Committee is responsible for overseeing, co-ordinating and approving the work programmes of the Committee, and is required to periodically review the scrutiny committees work programmes to ensure that overview and scrutiny is effective, that there is an efficient use of scrutiny resources and that potential duplication of effort by scrutiny members is minimised.

2. The work programme may be modified by the Chairman following consultation with the Vice-Chairman and the Director in response to changing circumstances.

3. Should any urgent, prominent or high profile issue arise, the Chairman may consider calling an additional meeting to consider that issue.

4. Should Members become aware of any issues they consider may be added to the scrutiny programme they should contact the Directorate Services Officer (Health) to log the issue so that it may be taken into consideration when planning future agendas or when revising the work programme.

Background Papers

- None identified.

Further information on the subject of this report is available from
Tim Brown Committee Manager (Scrutiny) on 01432 260239

Health Scrutiny Committee Work Programme 2009/11

The agenda will be based on:

- Quarterly Updates – Service Development
- Statutory Business including consultations
- Quality Assurance and Public Engagement
- Population Health and Equalities

	• To be scheduled – seminar on new performance framework when framework known
29 March	
	• Follow up points from previous meeting and "need to know" information from Health Trusts • Population Health (Housing and Health in Herefordshire) • NHS Hereforshire Update • WMAS Update • Report on progress against the Lightfoot review and action in response to the findings of the Committee's review of the ambulance service in the light of the Lightfoot Review of the West Midlands Ambulance Service in Herefordshire – Progress Report • Joint Strategic Needs Assessment
Scrutiny Review	• Discussion of Scrutiny Review of GP Services in Herefordshire
18 June	
	• Updates by Chief Executives of Health Trusts • Population Health • Examination of response to Swine Flu • Response to Scrutiny Review of GP Services
	•
	30 July
20 September	
	• Follow up points from previous meetings and "need to know" information from Health Trusts. • Quality assurance
22 November	
	• Updates from Chief Executives • Population health
21 January	
	• Follow up points from previous meetings and "need to know" information from Health Trusts. • Population Health

18 March
Updates by Chief Executives of Health Trusts