Members are reminded that they must declare all relevant pecuniary and non-pecuniary interests relating to any items of business to be discussed at this meeting

BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

TUESDAY, 22 MARCH 2016 AT 10:00 HOURS
IN COMMITTEE ROOM 6, COUNCIL HOUSE, VICTORIA SQUARE, BIRMINGHAM, B1 1BB

A G E N D A

1 **NOTICE OF RECORDING**

The Chair to advise/meeting to note that this meeting will be webcast for live and subsequent broadcast via the Council's Internet site (www.birminghamnewsroom.com) and that members of the press/public may record and take photographs.

The whole of the meeting will be filmed except where there are confidential or exempt items.

2 **APOLOGIES**

3 - 12

3 **MINUTES**

To confirm and sign the Minutes of the meeting held on 23 February 2016.

4 **DECLARATIONS OF INTERESTS**

13 - 24

5 **BIRMINGHAM DENTAL HOSPITAL - UNSCHEDULED CARE - 1000-1040AM**

Angie Wallace (Acting Chief Operating Officer), Marie Ward (Director - Specialist Services Division), Kate Cullotty (Service Lead - Unscheduled Care) and Mike Murphy (Consultant Oral Surgeon and Head of Service), Birmingham Community Healthcare NHS Trust.

25 - 52

6 **CROSSCITY CCG PRIMARY CARE STRATEGY 2016/20 - 1040-1120AM**

Karen Helliwell (Director of Primary Care and Integration) and Carol Herity (Associate Director of Partnerships), Birmingham CrossCity Clinical Commissioning Group.

53 - 70

7 **DIABETES PREVENTION - 1120-1150AM**

Dr Andrew Coward (Chair), Simon Doble (Senior Commissioning Manager) and Richard Mendelsohn (Clinical Head of Commissioning), Birmingham South Central Clinical Commissioning Group.

71 - 82

8 **ENHANCED ACCESS TO GPS - 1150AM-1220PM**

Dr Andrew Coward (Chair), Simon Doble (Senior Commissioning Manager) and Richard Mendelsohn (Clinical Head of Commissioning), Birmingham South Central Clinical Commissioning Group.

83 - 92

9 **WORK PROGRAMME 2015/16**

For discussion.

10 **REQUEST(S) FOR "CALL IN"/COUNCILLOR CALLS FOR ACTION/PETITIONS RECEIVED (IF ANY)**

To consider any request for "call in"/Councillor calls for action/petitions (if received).

11 **OTHER URGENT BUSINESS**

To consider any items of business by reason of special circumstances (to be specified) that in the opinion of the Chair are matters of urgency.

12 **AUTHORITY TO CHAIR AND OFFICERS**

Chair to move:-

'In an urgent situation between meetings, the Chair jointly with the relevant Chief Officer has authority to act on behalf of the Committee'.

BIRMINGHAM CITY COUNCIL

HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE 23 FEBRUARY 2016

MINUTES OF A MEETING OF THE HEALTH AND SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE HELD ON TUESDAY 23 FEBRUARY 2016 AT 1000 HOURS IN COMMITTEE ROOMS 3 AND 4 COUNCIL HOUSE, BIRMINGHAM

PRESENT: - Councillor Majid Mahmood in the Chair; Councillors Mohammed Aikhlaq, Sue Anderson, Maureen Cornish, Andrew Hardie, Mohammed Idrees, Karen McCarthy, Eva Phillips, Robert Pocock and Sharon Thompson.

IN ATTENDANCE:-

Les Williams, Director of Performance and Delivery, Birmingham CrossCity Clinical Commissioning Group

Desmond Jaddoo (Birmingham Empowerment Forum) and Ian Hamilton (who worked with him on prostate cancer in the local community); Roger Wheelwright (Prostate Cancer Nurse Specialist) and Gerard Scandrett (Programme Manager), John Taylor Hospice

Maria Gavin, Assistant Director of Commissioning Centre of Excellence, BCC

John Denley (Assistant Director - Commissioning) and Max Vaughan (Commissioning Manager), BCC; Dr Keith Radcliffe (Clinical Lead) and Andrea Gordon (Assistant Director), Umbrella (UHB); Kymm Skidmore (Project Manager), Umbrella

Candy Perry, Interim Chief Executive, Healthwatch Birmingham

Rose Kiely (Group Overview and Scrutiny Manager), Gail Sadler (Research and Policy Officer) and Paul Holden (Committee Manager), BCC

****

NOTICE OF RECORDING

300 It was noted that the meeting was being webcast for live or subsequent broadcast via the Council's Internet site (www.birminghamnewsroom.com) and that members of the press/public may record and take photographs. The meeting would be filmed except where there were confidential or exempt items.

APOLOGIES

301 Apologies were submitted on behalf of Councillors Sir Albert Bore and Margaret Waddington.

At this juncture, the Chair also welcomed Councillor Eva Phillips to her first meeting since having been re-appointed to serve on the Committee.

MINUTES

302 The Minutes of the meeting held on 19 January, 2016 were confirmed and signed by the Chairperson.

DECLARATIONS OF INTERESTS

303 Councillor Andrew Hardie declared that he worked as a GP at surgeries in Birmingham; Councillor Karen McCarthy that she served as a city stakeholder governor on the Birmingham Women's Hospital; and Councillor Mohammed Aikhlaq that he was a governor on the board of the Heart of England NHS Foundation Trust.

(This report was brought forward on the agenda)

BIRMINGHAM CROSSCITY CLINICAL COMMISSIONING GROUP (CCG) DRAFT OPERATIONAL PLAN 2016/17

304 Les Williams, Director of Performance and Delivery, Birmingham CrossCity CCG presented the following PowerPoint slides:-

(See document No. 1)

During the discussion that ensued the following were amongst the issues raised and responses further to questions:-

a) Members were advised that Aspiring to Clinical Excellence (ACE) was concerned with giving General Practices the opportunity and the funding to work together and develop services in their surgeries and community settings to reduce the need for patients to be referred to hospital or for consultant out-patient appointments. It was highlighted that ACE was especially being looked to as a way through which to reduce the number of premature deaths by addressing conditions that shortened life expectancy.
b) The Director of Performance and Delivery acknowledged that the overlap of the Sandwell and West Birmingham CCG into the west of Birmingham did give rise to some problems in terms of looking at Birmingham as a whole. Consequently, this was why they were pursuing Associate status for that CCG and the Sandwell and West Birmingham NHS Foundation Trust in respect of the Sustainability and Transformation Plan (STP). It was reported that all the local CCGs did share their Operational Plans and that there would be a meeting in the next few weeks to identify which areas should be aligned and where a greater impact would be achieved by pursuing the issues through the STP.
c) The Committee was informed that at a meeting the previous day there had been consensus that across the Birmingham and Solihull STP footprint the first priorities that they should work on were maternity and children services and developing with the Local Authorities and other agencies a much broader based offer around prevention.

d) In relation to earlier diagnosis of cancer, the Director of Performance and Delivery considered that General Practices working together at scale was part of the answer; mentioned ensuring that GPs were made aware of the latest evidence; and referred to looking at making diagnostics more accessible through 24/7 Urgent Care Centres, for example.

e) It was reported that an Urgent Care strategy was currently being developed which included looking at how the NHS 111 service would be procured and how Birmingham CrossCity CCG out-of-hours services would be configured alongside Urgent Care Centres / existing Walk-in Centres. The Director of Performance and Delivery informed Members that at this stage he could not confirm how many Urgent Care Centres there would be and highlighted that a range of options were being investigated aimed at persuading service users that they were a viable alternative to going to Accident and Emergency. He indicated that the types of services that they were looking to provide at the locations were diagnostics, a GP and Advanced Nurse Practitioner presence on a 24/7 basis; minor procedures etc. Once the options had been developed a full public consultation process would be embarked upon. He also gave an assurance that they would not be looking to close any existing facilities until it had been established what might replace them.

f) The Director of Performance and Delivery considered that the approach being taken nationally was that personal health budgets were an area to expand as they promoted choice but acknowledged that they made the potential for funding to flow through to existing services more uncertain. He highlighted that he had only heard earlier in the day about the proposals to have personal health budgets for maternity services and was not therefore in a position to report in detail on the issue. However, he felt that this was an issue that would be debated through the STP given pressures on maternity services in and around Birmingham and Solihull.

g) In relation to engagement with patients and the public, the Director of Performance and Delivery informed Members that the CCG now had a Patients' Health Panel involving around 3,000 members and highlighted that as part of the work on formulating the Urgent Care strategy an online survey had been carried out. In referring to a debate that existed on whether Urgent Care Centres should be co-located with hospitals or not he highlighted that accessibility and car parking had been raised as major issues in the feedback. He also reported that it was planned to hold an engagement event on their draft Operational Plan within the next month and that he was aware that with regard to the STP discussions had taken place around establishing a workstream to address the issue of engaging with patients.

h) The Director of Performance and Delivery indicated that the CCG would welcome working with the Local Authority on wider determinants of health problems (e.g. poor quality housing, air pollution) which had been omitted from the plan on a page and undertook to pursue this issue.

i) Members were advised by the Director of Performance and Delivery that quality measures (that included patient reported outcome measures) concerning providers were monitored on a monthly basis and that a Quality Surveillance Group met on a monthly basis which included representatives of the Local Authority, CCG and providers. In relation to building-in a systematic way of listening for the unintended consequences of change he indicated that he would welcome discussing this further outside the meeting.

j) The Director of Performance and Delivery highlighted that tackling diabetes was amongst next year's priorities; undertook to give consideration to the findings in a report that had been submitted to the Licensing and Public

Protection Committee on air pollution in and outside shisha bars; and, in relation to prostrate cancer, indicated that his understanding was that the general medical view was that there was not the firm evidence to justify a national screening programme. However, he undertook to look further into the issue of local communities and especially the Afro-Caribbean population in Birmingham being at greater risk.

The Chair thanked the Director of Performance and Delivery for reporting to the meeting.

PROSTATE CANCER – IMPLICATIONS FOR THE BIRMINGHAM POPULATION

The following report was received:-

(See document No. 2)

Desmond Jaddoo (Birmingham Empowerment Forum) and Ian Hamilton (who worked with him on prostate cancer in the local community) together with Roger Wheelwright (Prostate Cancer Nurse Specialist) and Gerard Scandrett (Programme Manager), John Taylor Hospice were in attendance. The Chair advised the meeting that Dr Richard Viney, Consultant Urological Surgeon and Senior Lecturer in Urology, UHB was unable to attend because he had been called into theatre.

The following were amongst comments made by Roger Wheelwright and Desmond Jaddoo in the course of introducing the agenda item:-

a) Members were advised that prostate cancer was a slow growing cancer but there was now a prevalence of younger men coming through (that had not been seen before) who were presenting with the disease in an advanced stage. However, if detected early it was very treatable through surgery or radio-therapy.
b) The Prostate Cancer Nurse Specialist reported that their work with partners was aimed at raising awareness with the Afro-Caribbean population where the risk of a men developing prostate cancer at some point in their lives was 1:4, as against 1:7 nationally. However, if there was a family history of prostate cancer / female relatives who'd had breast cancer the risk doubled. He considered that there was therefore a case for raising awareness and proactively screening in respect of the Afro-Caribbean group and highlighted that Birmingham had the largest population outside of Kingston, Jamaica.
c) Desmond Jaddoo referred to the Hear Me Now programme and two reports that had been presented to Parliament highlighting the inequality in tackling prostate cancer, particularly in respect of Afro-Caribbean men. He reported that in 2013 the Hear Me Now report had been launched in Birmingham as there was no awareness programme or local screening programme. The initial aim of the work had been to develop a local action plan.
d) The Committee was advised that one of the biggest issues found in Birmingham was that Afro-Caribbean men around 50 years of age seeking screening were being turned away by their GPs. Data was currently being collected in this regard.

e) Desmond Jaddoo indicated that the following were amongst their recommendations / aims: developing Community Champions to raise awareness of prostate cancer locally; educating the wider community, such as faith leaders; the Health and Wellbeing Board recognising the importance of the issue; increasing knowledge of how to access funding for community initiatives; facilitating partnerships with the NHS and Urology Teams (Desmond Jaddoo highlighted that his organisation was now partnered with Cancer UK); and increasing knowledge about prostate cancer within families. In referring to socio-economic issues, he pointed out that a white person would normally die with prostate cancer where as an Afro-Caribbean person died because of prostate cancer.
f) Members were advised that a service that they were looking to provide was drop-in screening centres. Furthermore, it was reported that they were canvassing for prostate cancer to be covered by 'Health MOTs' with the issue being on the same agenda as diabetes, blood pressure, heart disease etc.
g) Desmond Jaddoo reported that men of Asian origin had a 1:6 risk of developing prostate cancer and considered that due to integration their prostate cancer concerns was not a niche issue. He underlined that lives could be saved if the disease was caught early. In pointing out that there was no national screening programme, he nevertheless advised the Committee that they were looking for a screening programme to be developed locally through the Clinical Commissioning Groups (CCGs).

During the discussion that ensued the following were amongst the issues raised and responses further to questions:-

a) Desmond Jaddoo advised Members that the risk of a Caucasian developing prostate cancer was 1:8 and reported that the Hear Me Now was a national initiative and operated in Bristol, Leeds, London and Nottingham.
b) A Member highlighted that the PSA test though useful was not an actual screening test for prostate cancer. However, he considered that a debate about how screening was carried out in the health service might be a good idea e.g. could it be done in a better way that helped General Practice.
c) Desmond Jaddoo informed the Committee that Hear Me Now in Nottingham had launched a drop-in clinic and carried out PSA tests and digital rectal examinations.
d) The Chair asked that Desmond Jaddoo provide data on the issue of men seeking screening who had been turned away by their GPs with a view to the Council or Healthwatch Birmingham potentially taking-up the issue with the GP services.
e) In response to a question from a Member concerning the information in the penultimate paragraph on page 2 of the report it was highlighted that there were potential side effects of prostate cancer treatment. Consequently, for those at low risk, there was a need to carefully balance these side effects with the consequences of not screening.
f) Desmond Jaddoo advised the Committee that his main recommendations to the Local Authority and partners would be for a city-wide awareness programme to be developed alongside some form of local screening programme and a 'Health MOT' at 40 years of age, particularly for Afro-Caribbean men.
g) Members were advised that work carried out in raising awareness of prostate cancer had resulted in individuals going to their GP and had saved lives; however there were many citizens who did not know what a prostate

was and therefore still a tremendous amount of work to do. It was highlighted that educating mothers, wives and partners (creating messengers) was an approach that was beginning to work in terms of encouraging more Afro-Caribbean men to visit their GPs. Mention was also made of work that they were looking to do around creating health activists in community groups and the health sector and in respect of spreading the message across the city: a model that could then be replicated in other cities.

h) The Prostate Cancer Nurse Specialist informed that Committee that he was working with some of the universities with a view to increasing young people's awareness of the risk for men of prostate cancer when they became older. In relation to the PSA test, he acknowledged that this on its own was not enough to predict prostate cancer and therefore he would also advise that a digital rectal examination be carried out and a patient's family medical history considered. He re-iterated that Afro-Caribbean men were a higher risk group and that the type of prostate cancer that they faced, at a younger age than typically seen in Caucasians, was a more aggressive strain.

i) In referring to previous work that had taken place, Desmond Jaddoo highlighted that there had been changes at the CCGs and that he was seeking to convene a meeting with them to take the agenda forward and bring all the partners together. In relation to Public Health, he indicated that the service did not at present seem keen on prioritising the issue of raising the awareness of the risk of prostate cancer.

j) Desmond Jaddoo reported that he had recently taken up a position at a church in Lozells and that they were looking to hold monthly health and wellbeing sessions covering a whole range of health issues (e.g. diabetes, blood pressure, heart disease, breast cancer) and placing prostate cancer on the same agenda. The intention was to take the model, as a complete roadshow, out to multicultural events.

In relation to individuals being turned away by their GPs, the Chair asked that the representatives liaise with Healthwatch Birmingham in terms of examining what data was available and whether there was a case for the Council taking this matter up with GP surgeries.

The Chair also proposed that arrangements be made for letters to be sent along the following lines and this was agreed by Members:-

1) To the Chair of the Health and Wellbeing Board to see if there was a possibility of including prostate cancer in 'Health MOTs' and setting-up drop-in clinics.

2) To the Head of Events asking that the representatives be included on the circulation list in respect of events scheduled to take place in the City to give them the opportunity of raising awareness of prostate cancer.

The Chair thanked the representatives for reporting to the meeting.

305 **RESOLVED**:-

That letters be sent to the Chair of the Health and Wellbeing Board and Head of Events, as outlined above.

TRANSFORMING CARE IN BIRMINGHAM FOR PEOPLE WITH LEARNING DISABILITIES WITH OR WITHOUT AUTISM WHO DISPLAY BEHAVIOUR THAT CHALLENGES

306 The following report was received:-

(See document No. 3)

Maria Gavin, Assistant Director of Commissioning Centre of Excellence, BCC introduced the information contained in the report.

In the course of the discussion the following were amongst the issues raised and responses further to questions:-

a) The Assistant Director reported that a stakeholder day had been held at the end of January and that the commissioners were currently linking-in with the Autism Partnership Board; the Learning Disabilities Partnership Board; Experts by Experience Patient Panels; Children's Forums and also utilising the engagement functions across the City Council and health service aimed at having as wide a dialogue as possible. Mention was also made of a suggestion that had been made by a carer of having more focused discussions with families who had experienced care and treatment reviews and commented that this was at the heart of what was planned.

b) Members were advised that since the closure of assessment and treatment units it had become apparent that there were a very small number of providers with the right level of skill to support individuals with challenging behaviour in the community. The Assistant Director indicated that addressing this was a strong strand within their plans and that one of the workstreams related to learning and development for professionals and families / carers who supported people in their own homes. It was reported that notwithstanding the relatively low number of service users, mainly owing to the complexity of their care, there was a large shortfall at present particularly on the adult side in respect of the availability of services and therefore a need to expand provision.

c) The Committee was informed that there was £30m capital funding available to the 150+ Clinical Commissioning Groups (CCGs) across the country and that Birmingham had put in a bid of £1.2m for 2016/17 to develop wrap-around service provision (e.g. acquire accommodation, carry out adaptation works, fund trial service arrangements) and that, as the City's work was further ahead than some other areas, the bid might be more likely to succeed. It was reported that NHS England had not confirmed the size of the main transition fund (figures having varied between £50m -£70m) but that Birmingham had put in a bid of nearly £900,000 to support the development of services for next year; £1.3m the following year; and a further £1.3m the year after that: around £3.6m in total. It was highlighted that at present there were 21 people in CCG and 57 in NHS England assessment and treatment units at a cost £14.7m; however most of that money would not follow the patient when stepped-down with a lot of the cost falling on the Local Authority and CCGs to fund.

d) Members were informed by the Assistant Director that as joint commissioners they influenced the purchase all the specialist disability healthcare services. However, in relation Primary Care / GP services and the hospitals in general, though improvements had been made, there was

still a need to work to improve the care that individuals with learning disabilities and autism received.

e) The Assistant Director advised the meeting that there were robust safeguarding arrangements in place that linked-in with step-down activity and that where concerns were raised these were acted upon quickly. Furthermore, it was reported that the care and social work teams who worked with clients were very well sighted in respect of what would trigger an alert and how to process it.

f) In relation to listening for any unintended consequences of changes taking place, the Assistant Director reported that a range of views (e.g. those of the Clinical Advisory Panel, Partnership Boards) were listened to on an ongoing basis and fed into their plans as appropriate. In addition, she reiterated that one of the discoveries of removing funding from a hospital setting and using it to fund community services had been the skills and training development gap mentioned earlier. It was therefore now recognised that there had to be more focus on ensuring that the care provided in the community was effective and sustainable and that re-admissions were avoided. Mention was made, for example, of the need for good behavioural support programmes written by psychologists who could analyse behaviour and home-in on what triggered someone's behaviour to escalate.

The Chair thanked the Assistant Director for reporting to the Committee and asked that she keep Members informed of developments on the transformation programme and capital funding position.

(At this juncture, the meeting briefly adjourned for a comfort break)

BIRMINGHAM SEXUAL HEALTH SERVICES, UMBRELLA (UHB) – 6 MONTHS INTO NEW CONTRACT

307 The following report was received:-

(See document No. 4)

John Denley (Assistant Director - Commissioning) and Max Vaughan (Commissioning Manager), BCC; Dr Keith Radcliffe (Clinical Lead) and Andrea Gordon (Assistant Director), Umbrella (UHB); and Kymm Skidmore (Project Manager), Umbrella were in attendance.

In the course of the discussion the following were amongst the comments made and responses further to questions:-

a) The Assistant Director indicated that he considered that the delivery and community partners identified in the report showed the success that a systems-wide approach had been in creating stability for the Third Sector partners and helping to achieve outcomes.

b) Members were assured by the Assistant Director that there had been no disruption in respect of any of the GP services since the commencement of the contract and underlined that those services were part of work taking place aimed at setting-up longer term arrangements that addressed the 10 key sexual health outcomes.

c) The Committee was informed that the online ordering and return of sexually transmitted infection (STI) testing kits which had not been available before

was a major part of the new model and improving access to services. It was also highlighted that, in addition to GP surgeries, community pharmacies were a considerable part of the service and that there was also a network of clinics across Birmingham and Solihull that were open now for longer hours. In terms of overall access to services the meeting was informed that this was greater than it had been in the past.

d) Reference was made to feedback from partners being positive and it was highlighted that to get everyone 'on the same page' there had been focus on outcomes not on the need for any particular organisation or service.

e) Members were advised that it would be a while before the Umbrella service would be in a position to report on progress against the set outcomes. However, in testimony to the availability of online STI testing kits, it was commented that initial indicators were showing improvements in both the overall and the positive identification testing rates for chlamydia.

f) In relation to reaching hard to reach groups and covering the diverse population in Birmingham the meeting was informed that it was believed that the Umbrella service had linked-in to a number of communities; however the partners were continually asked who else they worked with and whether there were any other further avenues that the Umbrella service should explore.

g) Further to comments made by Members concerning the student populations around Edgbaston / Selly Oak, the Chair asked if the representatives could look at providing a mobile clinic in the area. The Assistant Director referred to needs based analysis work that they carried out and confirmed that this was something that they could consider and report back upon.

h) A Member indicated that he considered that when the Umbrella service next reported to the Committee it would also be helpful to hear from some of the delivery and community partners and look at the effectiveness and efficiency of the processes being used to achieve the outcomes.

i) Further to h) above, the meeting was advised that the Umbrella service structured its work around their Partnership Board where they focused on such matters as the available evidence, Key Performance Indicators (KPIs) and the actions required to achieve the set outcomes. The Assistant Director advised Members that he felt that if a contract monitoring as opposed to outcome based approach was pursued it would impact adversely on partnership working.

j) In referring to the great number of contracts each with their own KPIs that had been in place in the past, the Assistant Director indicated that he considered that the adoption of 130 indicators as part of a systems-wide approach based on 10 key sexual health outcomes was about right and not too many.

k) Members were advised that the delivery partners had been commissioned to provide posts / carry out pieces of work whereas the community partners though not paid were offered training as part of their links to the Umbrella service. The arrangements would be monitored over the course of the contract and if any gaps were identified these would be investigated.

l) The Committee was informed that though there was not a delivery partner specifically focused on the homeless the Umbrella service's work with homeless charities including the YMCA and St Basils was developing well. The identification of a delivery partner for the homeless was something moving forward that they could consider. Reference was also made to wider work that was brought to the table through the Partnership Board e.g. connections with the Council and contracts in place with organisations such as Sifa Fireside. Mention was made for example of activity that had started

in the evenings around the provision of food and work taking place to ensure that there was advice on sexual health as well. The approach being taken was that every contract counts which given budget pressures was probably the best way of making the most of the limited resources available.

The Chair thanked the representatives for responding to questions and advised them that they would be invited back to provide a further update in 6-9 months' time.

2015/16 WORK PROGRAMME

The following Work Programme was submitted:-

(See document No. 5)

308 **RESOLVED**:-

That the Work Programme be noted.

AUTHORITY TO CHAIR AND OFFICERS

309 **RESOLVED**:-

That in an urgent situation between meetings, the Chair jointly with the relevant Chief Officer has authority to act on behalf of the Committee.

The meeting ended at 1250 hours.

……
CHAIRPERSON

Birmingham Community Healthcare NHS
NHS Trust

Unscheduled Care
Birmingham Dental Hospital

22nd March 2016

Kate Cullotty

Service Lead Unscheduled Care

Background

From service specification aim:

- To provide triage and treatment service for patients who are in pain and/or seeking emergency and urgent care who cannot access a GDP
- Demand driven (capped in line with contract)
- To provide a steady stream of patients for University dental student teaching clinics whilst acting as a ‘safety net’ for unregistered patients

Accessible, Responsive Community Healthcare

Historic Provision

- Ticket system, capped numbers first come first served
- Reality - patients started to queue from very early morning in all weathers and may not be seen
- Triage for those who didn't get tickets
- Numerous complaints

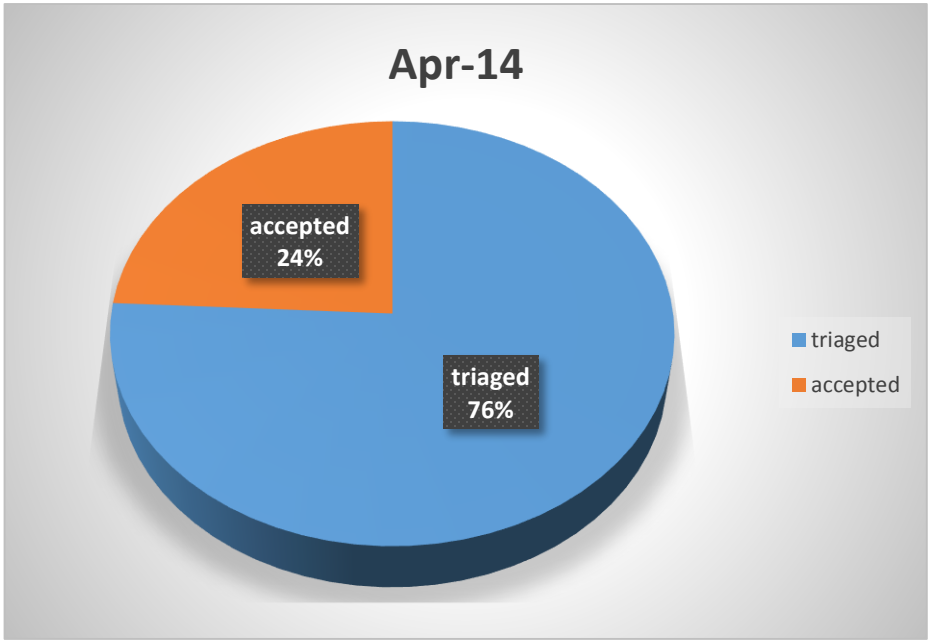
Examples of Numbers booked and triaged

April 14:

- tickets 528

in addition

- 570 triaged,
- 182 accepted



Accessible, Responsive Community Healthcare

Staged Change

- Review of service in light of Francis report and planning for new build
- Initial employment of a triage dental nurse
- Work with 111
- Communication with Commissioners, LDC and GDPs

Accessible, Responsive Community Healthcare

Current System

- Service change from 10/8/15 in line with recommended process.
- Access via 111 triage into available ‘slots’, appointments dependent on capacity
- On site triage still available in certain circumstances

Accessible, Responsive Community Healthcare

Department set up

- Exam/diagnostics and dressings
- Staffing duty officer, experienced and junior staff and students
- Teaching opportunities
- Variety of outcomes – primarily relief of pain

Journey So far - Challenges

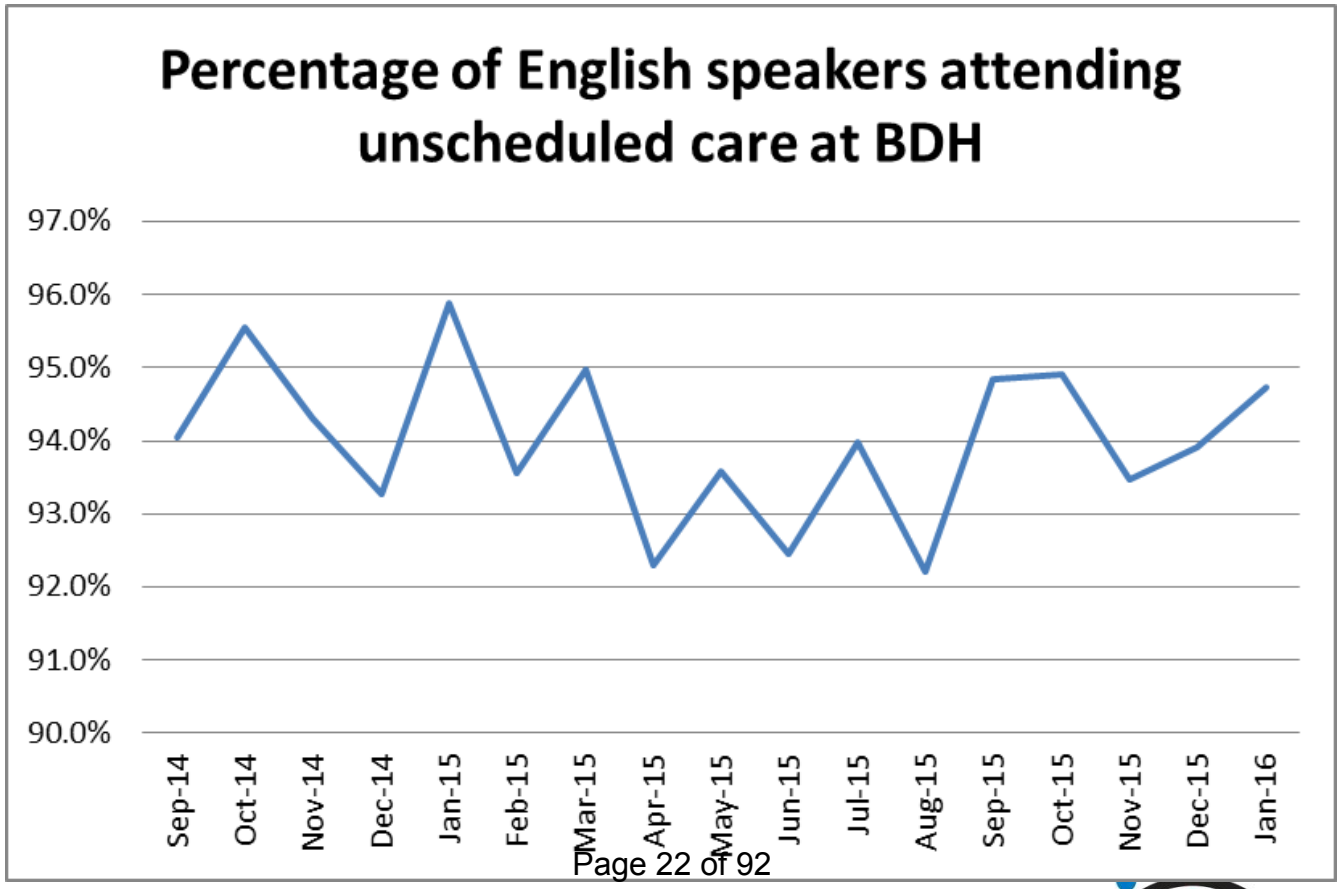
Numbers seen and the type of treatment remains unchanged.

- Change
- Expectations public/staff/managers
- IT
- Hard to reach groups (commissioning guide)
- Established Dispositions /pathways

Journey so far - Benefits

- No early morning queues in bad weather
- All patients are triaged
- All patients coming to the hospital have appointments – no wasted journeys
- Less complaints
- Quicker treatment for patients in greatest need
- Less inappropriate cases

Demographics



Accessible, Responsive Community Healthcare

Next Steps

- Hard to reach groups
- Continuous improvement process
- Ongoing monitoring of demographic data and case mix
- Further work on clinical elements of the 111 triage algorithm including dental nurse triage

Accessible, Responsive Community Healthcare

The care and the numbers seen remain the same and the service is better.

Thank you for listening.

Questions?

Accessible, Responsive Community Healthcare

NHS

Birmingham CrossCity
Clinical Commissioning Group

Primary Care Strategy 2016/20

Our commitment

We will commission an enhanced and high-quality primary care service; one that delivers an increased range of services to all local patients, regardless of where they live in Birmingham.

Patients will be able to access primary care services easily; for both urgent and planned care. As far as possible, we will strive to ensure that patients complete their episode of care, with all appropriate tests and investigations, undertaken at their first point of contact with the NHS. It is also crucial, that a clear and ongoing plan is developed in partnership with them.

Patients will receive joined-up care across the range of general practice, community care, intermediate care, mental health services and social care. We will reduce unnecessary duplication across administrative and clinical services, by making services more efficient and reducing the need for patients to repeat their story.

Primary care will be responsible for improving health and wellbeing and preventing illness. This will help to reduce health inequalities across our city.

We will support the development of new and emerging provider organisations, as well as working with existing organisations, to develop fully accountable partners. We will work together to improve the health of local people and ensure the delivery of a sustainable primary care system.

We fundamentally believe that general practice should continue to treat all patients, with a wide range of medical conditions. This is achieved by using their expert communication skills and ability to assess and manage patients, in a timely way, whilst recognising when patients would benefit from more specialist input. We need to build on this generalist expertise; not change it into an overly specialist service.

The story so far

NHS Birmingham CrossCity Clinical Commissioning Group has the fourth largest population of all clinical commissioning groups (CCGs) in England. We have 100 member practices and commission healthcare service for around 715,000 people.

As a GP led membership organisation, we have always recognised the importance of strong primary care and a thriving GP service.

In April 2013, we launched our Aspiring to Clinical Excellence (ACE) scheme for practices; ACE started with a foundation level, which focused on improving the quality of general practice across the city. Through this scheme we have improved both adult and children's safeguarding, now screened over half our population over the age of 65 for atrial fibrillation, identified and supported thousands more carers and improved the quality and safety of our prescribing.

From this initial building block, we developed ACE Excellence, which delivers a universal and enhanced service for all patients in general practice, close to where patients live. ACE Excellence has acted as a major catalyst; motivating practices to work together in larger groups to deliver a universally enhanced level of patient care. We have 100 practices working together in 15 ACE provider groups. All of our patients now have local access to quality assured diagnostics; ECGs, spirometry, 24 hour blood pressure monitoring and injectable treatments for diabetes.

Through ACE Excellence we have also focussed on improving management for a range of long-term conditions, with a holistic patient-centered approach at the core of these services. ACE provider groups have started to work much closer with community services and mental health services to deliver this more integrated care.

The Five Year Forward View, published in October 2014, and the vision of primary care at-scale, with the plan for multispecialty community providers and ultimately fully accountable care organisations, has confirmed our local aspirations.

This national direction of travel has given further impetus for practices to look to work even more closely together and consider the structures that might best support them to do so. The CCG supported this further development and out of facilitated workshops and discussions; a GP provider group, a new corporate partnership and federations have since emerged. These different models reflect the CCG's approach to support all our practices to develop in the way that they choose, but always with a focus on high-quality care.

Listening to local people and our members

In December 2015, an independently commissioned primary care survey of 1000 residents across Birmingham told us that the majority of patients would like to be able to access primary care on a Saturday and most would like to have a drop-in session service at their practice, in order to guarantee obtaining an appointment.

In addition, people told us that they feel it is more important to see the same GP and go to the same building, as opposed to having access to a range of services that may be located in different settings, with the possibility of getting an earlier appointment. Telephone consultations would help patients to more effectively communicate with their GP and patients are happy to see other clinical or medical professionals, instead of a GP.

In January 2016, we asked local people for their views on the accessibility of urgent care. Patients told us that they want to be able to access urgent medical advice and treatment in Birmingham more easily; 24 hours a day, seven days a week, in easily accessible locations, with good transport links.

Dedicated membership events in January 2016, have acted as the main catalyst for facilitating discussions for shaping and agreeing the priorities for primary care in Birmingham and the overall development of this strategy.

The challenge

The biggest challenge, and opportunity, for Birmingham CrossCity CCG is to ensure we are offering consistently high-quality care to our diverse local population.

Birmingham has an ethnically diverse population; with over one million residents in total. People living here are also younger than the national average, and we have a very large student population. Birmingham is ranked the ninth most deprived local authority in the UK.

Over three quarters of the city is in the most deprived 40% areas nationally. Nearly half of our under 18's live in the most deprived 10% areas in the country. Life expectancy is lower than the national average, the variation in life expectancy across the city ranges from 85 to 76 years.

We understand and appreciate that this diversity and variation requires us to work differently, to ensure that local people are receiving consistently high-quality care that is responsive to their needs. We would like to address the health inequalities across the city and reduce the gap in life expectancy.

The variability in GP services across our city, especially in terms of good and consistent access and the overall level of provision, is another challenge. There are also workforce challenges, with large numbers of GP leaving the profession for a variety of reasons. The primary care estate is variable too, with state of the art facilities in some areas, whilst other areas require improvement and development.

Our strategy

This focussed strategy has been developed in consultation with local patients, clinicians and organisations; it will be delivered through a detailed operational plan to be developed in the coming months, and implemented over the next four years.

This strategy outlines the vision for the next four years and sets out some clear steps that will need to be taken on the way, both by us as commissioners, and also by providers of primary care.

The strategy also sets out the rationale about our key areas of focus, why these are important, what we expect services to look like and the model of care that we will deliver. It then goes on to outline the steps that will need to happen to get there, as well as how we will know that we have delivered what we know to be important to people in terms of improved outcomes. These are reducing health inequalities and developing a high-quality primary care service that people can access quickly, in time of need, and with confidence that their needs will be met.

The key areas of focus are:

1. **Access:** accessible primary care, which is responsive to people's needs.

2. **Whole person:** person centred care, delivered seamlessly.

3. **Support:** empowering patients to have more control and respond to the current challenge in primary care provision.

4. **Treat:** providing the right care, quickly, close to home.

1 Access

Accessible primary care, which is responsive to people's needs.

Why is this important?

It is really important to patients to have good access to local primary care services.

Good access is the foundation to a high performing and functioning local NHS health economy.

Small changes in primary care have big impacts. For example, for every person that attends an accident and emergency department, 17 people are seen in general practice.

General practice and wider primary care services are currently under pressure and the current inequity of access for people in different parts of the city needs to be addressed.

What will this mean for you?

When someone needs medical advice and treatment, they need care they are able to access at the right time, in the right place.

There will be faster access for children who are acutely unwell.

Medical advice will be available in different ways, such as phone and online, as well as face-to-face to meet patients' different needs.

There will be 24 hours a day, seven days a week access to high-quality, urgent primary care services.

A service that continues to deliver continuity of care, to the patients who need it.

Improved access and preventative treatments for vulnerable people, such as the homeless, patients with learning disabilities or severe mental health problems, and other people who currently struggle to access primary care.

High-quality care, which meets your individual needs.

What we need to do

Ensure that we set high standards of access to services and make local people aware of the services that are available to them.

Ensure that information provided to patients is in an accessible format, which meets their individual needs.

Develop direct access pathways into defined services, to enable patients to self-refer where appropriate e.g. physiotherapy and podiatry services.

Ensure that staff are working to the limits of their competency and ensure that competencies are defined and understood by whole team.

Build teams with a wider range of health and care professionals.

Encourage smarter working across across the whole general practice team.

Adopt appropriate technology, to help signpost patients to most appropriate services.

Explore new contracting models that enable practices to work together.

Define and agree outcomes for patients that link together the responsibility for delivering these across pharmacy, community services and community mental health.

Lead the way in securely sharing patient information, to provide a more efficient service, as well as better and safer care.

Develop services that reach people who have the poorest health outcomes, who may not currently access full primary care services.

Commission a fully integrated primary care and urgent care service.

Ensure that as far as possible, health problems are dealt with by the first medical professional seen by the patient.

Develop and implement a wide ranging estates strategy, with a view to reducing the total number of buildings and maximising the use of remaining assets.

How will we measure success?

We will:

Set standards for access, which can be measured. For example, accessible information about the next available GP appointment and the ability to receive telephone advice.

Achieve reductions in health inequalities, by committing to specific aspirations for particular patient groups and medical conditions.

See improved patient satisfaction regarding access to primary care. We will make a commitment to a specific aspiration and will measure ourselves against this.

Have improved feedback from the Friends and Family Test and the national GP patient survey; both of which are independent and statistically reliable sources of information.

See reductions in non-elective admissions and people attending accident and emergency departments.

See higher levels of satisfaction, through a nationally mandated and locally implicated GP workforce survey.

Have higher levels of workplace satisfaction and a reduction in sickness absence across whole team, through an improved primary care staff survey.

2 Whole person

Person-centred care, delivered seamlessly.

Why is this important?

People rightly want and expect seamless care delivered around them, as an individual, and not around an organisation or outdated way of providing care.

Holistic care delivers improved outcomes in terms of quality, but also patient reported measures, such as quality of life scores.

Looking at the whole person reduces the potential for crises and the non-elective admissions that can occur as a consequence. This is a benefit for both the patient and the NHS.

It reduces duplication and the frustration of a patient telling their story multiple times, to different healthcare professionals.

Mental health and physical health problems frequently co-exist. They need to be managed together, in order to improve the overall health and wellbeing of an individual.

Social care and other factors that affect wellbeing, such as isolation and environment, need to be integrated with health. This will help to ensure all a person's needs are being met.

We need to ensure that at-risk and vulnerable patients do not fall in-between services and opportunities to intervene are missed.

We recognise that people want to remain independent and in their own homes, for as long as possible.

What will this mean for you?

Continuity of care, by having a named health professional and a local GP practice.

A single patient record, and plan, for your medical and social care needs.

Having your broader health needs addressed, such as social isolation or lifestyle.

Patients who have complex needs will receive the specialist input quickly, when it's needed.

Improved access to a wide range of mental health services, which will be available in primary care.

Faster access to a wider range of diagnostic assessments.

Every at risk, or vulnerable person, will have a named professional who will be accountable to them for the delivery of individualised care that meets their needs.

Services in place that support people to live independently.

The ongoing development of services for people with dementia, their families and carers; as set out in the multi-agency Birmingham and Solihull dementia strategy.

End-of-life care that addresses all the needs of the person, their family and carers, in-line with the CCG's strategy.

What we need to do

Develop integrated teams, including social care, with single line management structures in a progressive and managed way.

Create primary care organisations that are of sufficient scale to deliver an integrated team approach to care.

Develop alternative funding models for patients with complex needs.

Explore a new contracting model with third sector organisations, to help us deliver outcomes such as reduced social isolation.

Work more closely with Birmingham Public Health to improve people's lifestyles, promote the benefits of physical exercise and reduce smoking, especially amongst pregnant women.

Improve access to specialist opinion and advice, working with colleagues in secondary care, to redefine the role of a consultant.

Lead the way in securely sharing patient information, to provide a more efficient service, as well as better and safer care.

Have a single budget for out of hospital health and social care.

Design a primary care mental health service, which is fully integrated with other NHS services, to provide seamless care for our patients.

Further develop our relationships with key strategic partners, whose areas of speciality have an impact on health and wellbeing. Such as; housing associations, the Department of Work and Pensions, relevant third sector and community organisations.

Fully implement the CCG's end-of-life strategy, working in close partnership with hospices and other care relevant providers.

How will we measure success?

We will see:

Improved patient satisfaction across all services.

A reduction in childhood and adult obesity.

A reduction in the number of people who smoke.

A reduction in non-elective admissions.

Fewer people entering long-term residential care and more people living independently.

More end-of-life patients dying in their place of choice.

3

Support

Empowering patients to have more control and respond to the current challenge in primary care provision.

Why is this important?

Patients want to be empowered to have more control over how their care is provided, and be able to confidently self-care.

Many families may need additional support during pregnancy and in the early years of a child's life. This support helps improves the current health of a child, as well as when a child grows up.

There is a current workforce crisis in primary care, with increasing numbers of professionals either leaving general practice, or choosing to work overseas. Morale is low and this needs urgently addressing, this is compounded by a lack of doctors and nurses entering primary care.

Due to the current workforce crisis, larger groups of GP practices need to be supported to be able to develop into organisations that can deliver new models of care, and also become accountable for improving the health and health outcomes of all of their patients.

The full potential of the voluntary and third sectors need to be developed to be able to offer services to people wherever they live in Birmingham, with the same improved outcomes. This may mean working in a very different way.

Support needs to be provided to existing community and mental health services, so they can move towards delivering a fully accountable care model.

What will this mean for you?

You will be able to make more confident and informed choices about your own health and social care.

Parents will be equipped with the skills and confidence to raise healthy children.

The primary care workforce will adapt to new ways of working and delivering care. They will be supported to develop new skills and continuously maintain their full professional competency.

New providers of primary care will be developed, with a view to becoming multispecialty community providers. They will then become organisations who are accountable for delivery of improving the health and the health outcomes of all of their patients.

Third sector and other organisations will work within the new providers, in an integrated and unified way, all focussed on delivering the same outcomes for patients.

What we need to do

Lead the way in securely sharing patient information, to provide a more efficient service, as well as better and safer care.

Support accessible technology and information that enables patients to self-care.

Work with Birmingham City Council's service for children, young people and families department, alongside other agencies, to identify and work with families most at risk.

Expand personal health budgets and make them available to more patients, with appropriate advice and support.

Provide support to help patients make a decision, before any medical intervention.

Work with new and existing providers to develop new models of care and support their response to the primary care strategy.

Increase capacity in primary care, by streamlining processes and working smarter.

Support practices to become more efficient, through improved working practices and the use of technology.

Provide regular education and personal development opportunities to the primary care workforce.

Define the limits of clinical competency and support all people to work to this level.

Work with practices and Health Education England, to describe the future of the primary care workforce.

How will we measure success?

We will see:

More patients who feel more supported and are able to make decisions about care.

More patients who are in receipt of personal health budgets.

Positive feedback from GP workforce survey, with an increase in job satisfaction.

Increased retention of current staff and more people applying to work in primary care.

New organisations flourishing, as a result of appropriate support.

4 Treat

Providing the right care, quickly, close to home.

Why is this important?

People who are at particular risk of illness need to be identified, in both primary and secondary care settings. By treating people early, this reduces morbidity and improves the health of the whole population.

Every patient should receive the same high-quality and local of care, regardless where they live in Birmingham.

Treating all patients according to the best available evidence, will both improve clinical outcomes and reduce non-elective admissions and accident and emergency attendances.

Patients, when unwell, want and need rapid investigation. By receiving treatment quickly, this reduces uncertainty and the associated anxiety.

Patients want to be treated as close to home as possible, in an appropriate and clean setting, with the right equipment.

Patients want to be treated by a professional who has access to the correct and up-to-date information about them.

Care that is appropriately delivered and resourced in primary care frees up specialist capacity for patients, when they need it.

What will this mean for you?

Targeted focus on the conditions that are responsible for the health inequality gap. Specifically; diabetes, respiratory and cardiovascular disease.

A universal offer of an extended, locally based, primary care service.

You will receive evidence based treatment and specialist opinion rapidly, when required.

Consultants working within an enhanced primary care team, to support the high-quality delivery of care. This will result in improved outcomes to a whole population of patients, in areas such as; diabetes, heart failure, rheumatology and elderly care.

Clinicians, who work in both primary and secondary care, will have increased knowledge of services available in primary care. This will result in better patient experience.

Modern buildings and infrastructure, providing an appropriate setting for delivering high-quality care, that is fit for purpose.

Quality assured enhanced primary care provision.

What we need to do

Continue to develop the ACE programme, in order to deliver local investigations in primary care. This must be available to all patients in their local area, but larger than local practice scale.

Identify the most effective treatment interventions in the ACE programme and ensure that they are available to all patients.

Undertake a review of diagnostic capacity across primary and secondary care.

Build capacity in primary care to treat more people in their own homes when unwell, and if admission to hospital is required, support patients to recover in their own home.

Ensure that standardised approaches based on best evidence to common conditions, are embedded across primary care, to reduce clinical variation.

Work with local hospital trusts, to establish new ways of consultants working across primary and secondary care.

To obtain the clinical opinion of a consultant, we need to have access to real-time advice, guidance and referral support. Consultants need to be mapped to local areas on rotation, to establish good working relationships and access support and advice.

Develop a financial and contracting model for primary care, which aligns patient outcomes, supports prevention and early treatment.

Invest in high-quality clinical support and decision aids, to ensure patients are treated effectively.

Develop and implement a wide ranging estates strategy, with a view to reducing the number buildings and maximising the use of remaining assets.

Fully implement and support the Your Care Connected programme, to facilitate safe and effective sharing of patient information.

Work with Care Quality Commission (CQC), to define the standards of quality assured primary care.

How will we measure success?

We will see:

A reduction in non-elective admissions.

Reduced lengths of stay for both non-elective and elective admissions.

An overall reduction in readmissions.

A shorter time for referral to treatment.

Improved clinical outcomes, such as reduction in diabetic complications and strokes.

Validated quality questionnaires, which are condition specific.

A reduction in people who are absent from work, due to ill health.

All premises being fully CQC compliant.

Next steps

The delivery of this four year strategy will be supported by the development of a detailed operational plan.

The operational plan will be a dynamic document, which will evolve over the course of time. We will ensure appropriate governance arrangements are in place to oversee this.

This strategy will also inform our urgent care strategy, as there are significant interdependencies between both documents.

We are developing a sustainability and transformation plan in Birmingham; primary care provision will be a major component of this plan, which will be developed in conjunction with all of our providers.

We will implement the strategy in collaboration with our providers, working with local people throughout, to ensure that as services are developed and refined they deliver the higher quality services we are aspiring to.

In terms of measuring our success; aspirations, baseline information and key metrics will be included in the operational plan, to ensure that we are successfully achieving what we set out to.

We are ultimately accountable to the people of Birmingham and are committed to reducing health inequalities and ensuring high-quality and local care for our patients in the city. We believe that when fully implemented, this strategy will deliver what our population needs from a high-quality primary care service. It will also be fundamental in supporting the long-term sustainability of our health and social care system in Birmingham. We are committed to putting our patients at the heart of this.

Excellence in Commissioning
Through Excellent Primary Care

NHS Birmingham CrossCity Clinical Commissioning Group
Bartholomew House
142 Hagley Road
Edgbaston
Birmingham
B16 9PA

Telephone: **0121 255 0700**
Fax: **0121 682 0090**
Email: **bhamcrosscity@nhs.net**

NHS
Birmingham South Central
Clinical Commissioning Group

NHS Birmingham South Central

National Diabetes Prevention Programme - Demonstrator Site

NHS Five Year Plan: Responding to the Prevention Challenge

Public Health England

DIABETES UK
CARE. CONNECT. CAMPAIGN.

NHS England

National Diabetes Prevention Programme

The NHS Diabetes Prevention Programme is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale, an evidence based behavioural programme to support people to reduce their risk of developing Type 2 diabetes.

The NDPP has identified seven local areas, known as demonstrator sites, to learn practical lessons from delivery. The demonstrator sites are:

- Birmingham South and Central CCG
- Bradford City CCG
- Durham County Council
- Herefordshire CCG/LA
- Medway CCG/LA
- Salford CCG/LA
- Southwark Council and CCG

Birmingham South Central

- Across our CCG there is a mix of both high Black and Minority Ethnic (BME) populations and social deprivation.
- The percentage of people 17+ diagnosed with diabetes is higher in each of the Birmingham CCGs than the England average
- There is a gap in diagnosed prevalence and estimated prevalence in adults that requires investigation
- By 2025 the projected prevalence of diagnosed and undiagnosed diabetes could increase to over 90,000 (with an increase in prevalence from 8.5% to 10.3%)
- Obesity is also increasing in Birmingham and there is a strong relationship with diabetes

BSC's CVD LIS

- BSC CCG established a CVD Local Improvement Scheme (LIS) in 2014 with an emphasis on identifying and managing patients at risk of developing type II diabetes mellitus.

- Local Improvement Scheme including:

  - Case finding and management of patients with pre-diabetes
  - Promote self care through individual management plans, including in-practice care education and the offer of referral for structured education programmes
  - Designed by GPs for GPs
  - Uses Practice List as resource for case finding

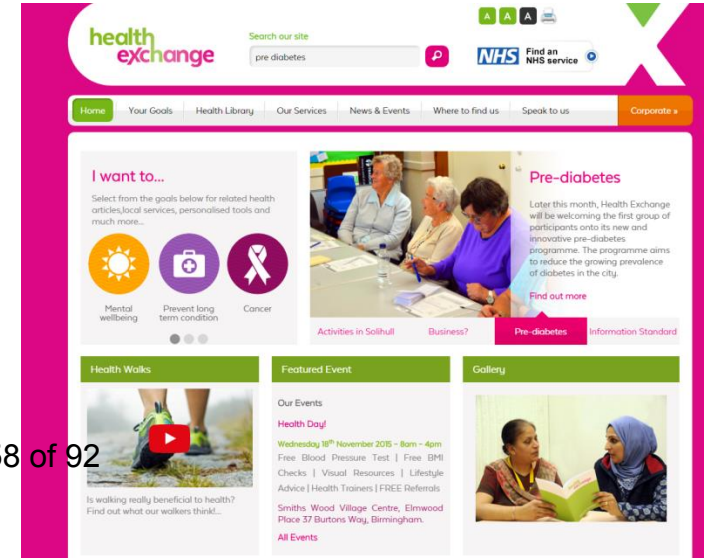
The Service

Components of the scheme include:

1. **Community Engagement** – in development and being rolled into first wave
2. **Motivational Interviewing** - Training in motivational interviewing for front line clinical staff and brief intervention techniques for lifestyle change.
3. **LIS Development** - Enhanced CVD Local Improvement Scheme that provides for structured capture (template/read coded) of lifestyle change preferences and referral route.
4. **Core Intervention** - Commissioning a pilot local structured programme for people at risk of diabetes from existing providers - to include nutrition and exercise (in line with national evidence base).
5. **Feedback** – ensuring feedback and tracking
6. **Local evaluation** - to support the wider local authority led lifestyle services re-procurement process. Including preferences and barriers to accessing services from BME groups.

Third Sector Providers

We have worked with two local well established third sector providers of lifestyle interventions, Gateway Family Services and Health Exchange:



Provider Arrangements

- Specification completed and agreed with our two Providers
  - Matched to the nationally developed evidence
- Contract agreed with two providers – Compromise agreement regarding distribution of funding across the length of the programme/ ongoing dialogue regarding the number of patient questionnaires supporting the programme
- Insight support used to finalise referral letters
- Activity plans agreed
- Builds on history of providing health trainers , ensured strong liaison between providers and practices building on existing working relationships

Provider Activity – at end of January 2016

- 6,118 at risk patients mailshotted by practices inviting them to attend an intervention
- 1,116 patients have contacted the providers following the letter to book on to the intervention
- 344 patients have attended their first session
- Health Exchange have had 38 people complete first block of 6 weeks of intervention
  - 25 people have lost weight in the programme so far.
  - The average weight loss is 1.41kg
  - Total amount of weight lost is 35.2kg.
- 95% plus retention rate at present

PATIENTS AT THE MAYPOLE TAKE FIRST STEPS TOWARDS DIABETES PREVENTION

POSTED ON 13TH NOVEMBER 2015 BY MICHELLE SMITTEN

Please leave a comment

This week we delivered the first of our pre-diabetes training sessions.

The programme has been commissioned by Birmingham South Central Clinical Commissioning Group so the first session was held in one of their surgeries, Maypole surgery in south Birmingham, with the support and help of surgery GPs.

The surgery sent a mailshot out to patients with pre-diabetes, and we were pleased to find it had a good response rate, with 29 patients expressing interest. So a session was held for the first 12 on Wednesday morning, at the surgery.

Susan Hannaby is leading the training sessions

Pre-diabetes, also referred to as "borderline" diabetes, is when someone's blood glucose (sugar) levels are above the normal range, but not high enough for them to be diagnosed as having diabetes. If someone's blood sugar levels are consistently higher than normal then they may be at risk of Type 2 diabetes if they don't take the preventative steps. It's an important warning sign that lifestyle changes need to be made. The point of the course is to educate people about their condition and to get people taking steps towards making those changes.

The course is run over 13 sessions and looks at all sorts of preventative action, including healthy eating, physical activity, food preparation, and managing portion sizes. For this first session, Trainer Susan Hannaby (pictured) was joined by Health Trainer Josh and EAST Admin Assistant Jennie, who will be the main point of communication for the group.

The activities and topics covered are based on who is in the group – what their needs are and the issues they would like to focus on – so it's a flexible format. The sessions will include a lot of group work and include practical, hands-on activities, but also some private one-to-one time for each patient.

Susan gave an example of the practical activities they did on Wednesday: "This week we looked at portion sizes – we got people to serve a 'typical' plate of food, then looked at what a serving actually is. We were all surprised at how small cereal portions are!

"We are also encouraging the group to work together and help each other. For example one woman said she used to walk a lot but had lost confidence after falling over. One of the men in the group had been planning to start walking more, but felt unmotivated on his own. So they have made plans to go walking together."

Living Well, Taking Control

min. 9 month journey

13 sessions

6 Sessions
1 x week
90 minutes
Over 6 weeks
Face-to-face

Ongoing
Support Session

3 months
Email/ Telephone or
optional face-to-face

Post 3rd
Session

Ongoing Support
Session

GRADUATE!!!
12 month
Group sign-off
Session

If needed
ongoing
support

Telephone
Text & Mail
Facebook Group
Twitter

6 month
90 minute Group
Session face-to-face

Ongoing Support
Session

Ongoing
Support
Session

8 month
Email / Telephone
or optional face-
to-face

Ongoing
Support Session

10 month
Email / Telephone
or optional face-to face

Development: App for Healthy Lifestyle Support Buddy
Link into Health Fabric
Underpin all sessions with mobile support

Development Launch
of Mobile App Support
approx 6 months

Provider data collection

- Blood Pressure
- Dietary change (assessment tool)
- HbA1c (indicating average blood sugar levels over 3 months)
- Weight
- Perceived importance of and confidence in achieving healthy levels of activity and a healthy diet
- Quality of life (EQ5D);
- Self-reported physical activity (GPPAQ)

Patient Feedback – First 6 sessions

- “These sessions have been very useful and have helped me make healthier choices in my life. I have increased my physical activity. The facilitator is very helpful and I would definitely recommend her sessions.”
- “I have learnt so much from the programme i.e. making healthier choices, looking at labelling, better ways of cooking to cut out fats/sugars, more exercise. Loved the group experience and our facilitator was very informative and friendly. Very knowledgeable.”
- “I have enjoyed the course very much and it has changed my attitude to diet completely, the sessions were excellent.”
- “Very useful and educational.”
- “I was so impressed. This programme was very interesting, informative and enjoyable. So helpful! It gave me the incentive to lose a little weight and cut down on sugar and salt.”

Primary Care Arrangements

- NDPP LIS agreement approved and launched on 1st October
- Roll out of LIS to all member practices to support identification, case finding and referral
- 55 of the 55 CCG practices have signed up to deliver the LIS
- Practices currently mailshotting pre diabetes register patients to refer to intervention but some practices are ringing patients directly
- Primary Care motivational Interview training taking place

Local Evaluation

- CSU/CLAHRC agreed data collection format (included in contract spec)
- CSU/CLAHRC – early discussions on evaluation/quality improvement-track and intervene to improve uptake
- Evaluation logic meeting took place 7th December
- Discussing with incoming CSU

NDPP First Wave Implementer

- Successfully chosen as a first wave implementer for the National Provider Roll Out in 16/17
- First Wave footprint includes Birmingham, Sandwell and Solihull CCGs/LAs
- Provider should be in place end of April 2016
- Indicative activity in first year approximately 900

Summary

- Went live late October
- Patient enrolment via primary care with good retention
- Internal target to recruit 1500 by March
- Proof of concept of intervention pathway
- Secured first wave implementer status for national provider roll out
- Need to evaluate and understand uptake rates across demographics
- Waiting on economic case model from SchARR

Thank You - Questions

MyHealthcare PM GP Access Fund Scheme

Presentation to the Health Overview & Scrutiny Committee

22nd March 2016

NHS England

THE NHS CONSTITUTION
the NHS belongs to us all

myhealthcare

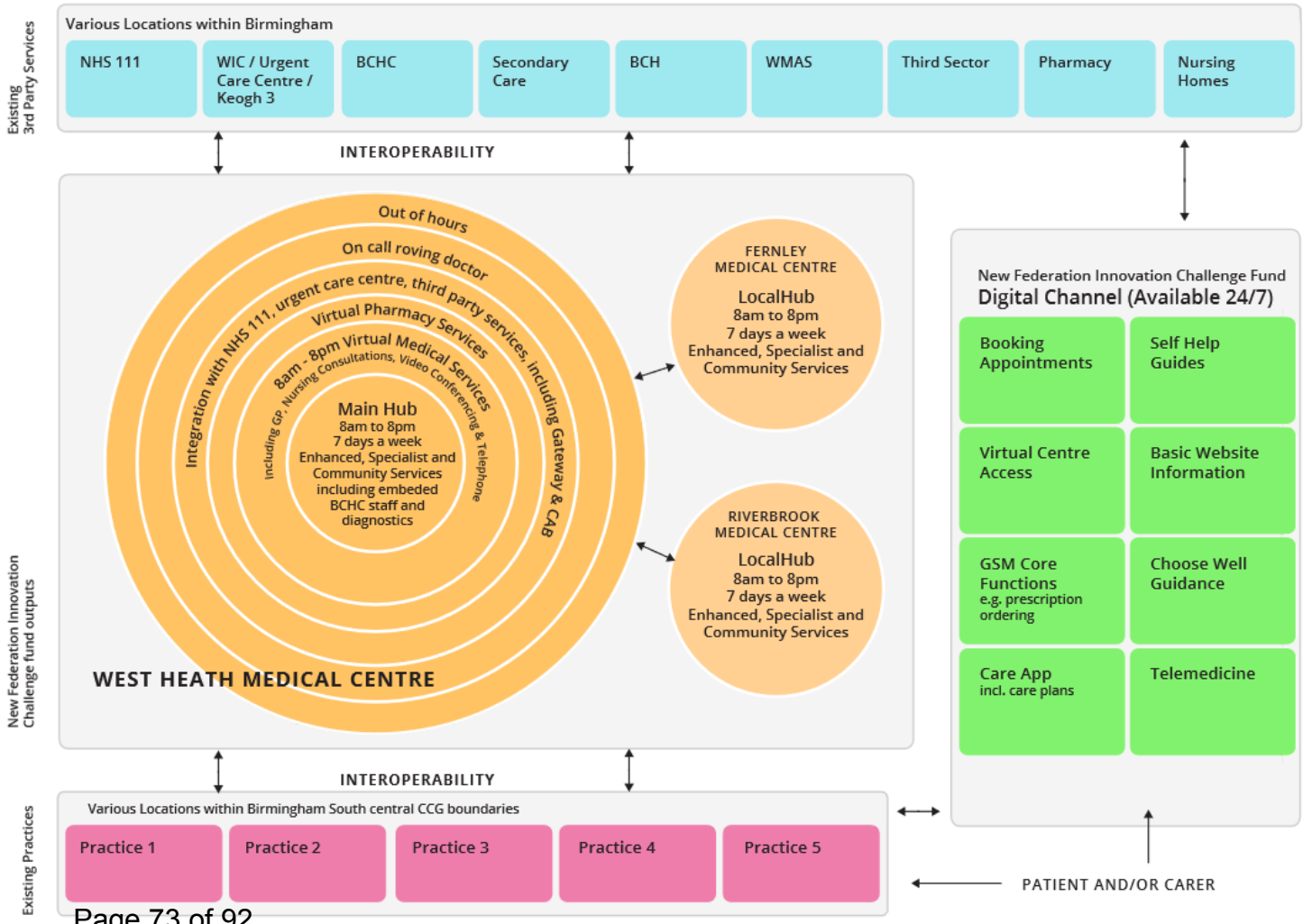
Background
How we began and who we are

- 23 General Practices serving 123,000 patients across locations in South & Central Birmingham
- Initial funding of £2.4million from the Prime Minister's GP Access Fund for a 12 month Wave 2 pilot – to improve access to General Practice and stimulate innovative ways of providing primary care service
- Matched funding and support from Birmingham South Central CCG
- Working in collaboration with South Doc Services Ltd, a GP co-operative that has been providing primary, community and secondary care services since 1996
- Other partners include:
    - Birmingham Community Healthcare
    - Vocare
    - NHS 111
    - South Birmingham GP Walk In Centre
    - Gateway Family Services
    - Substrakt Health

Background

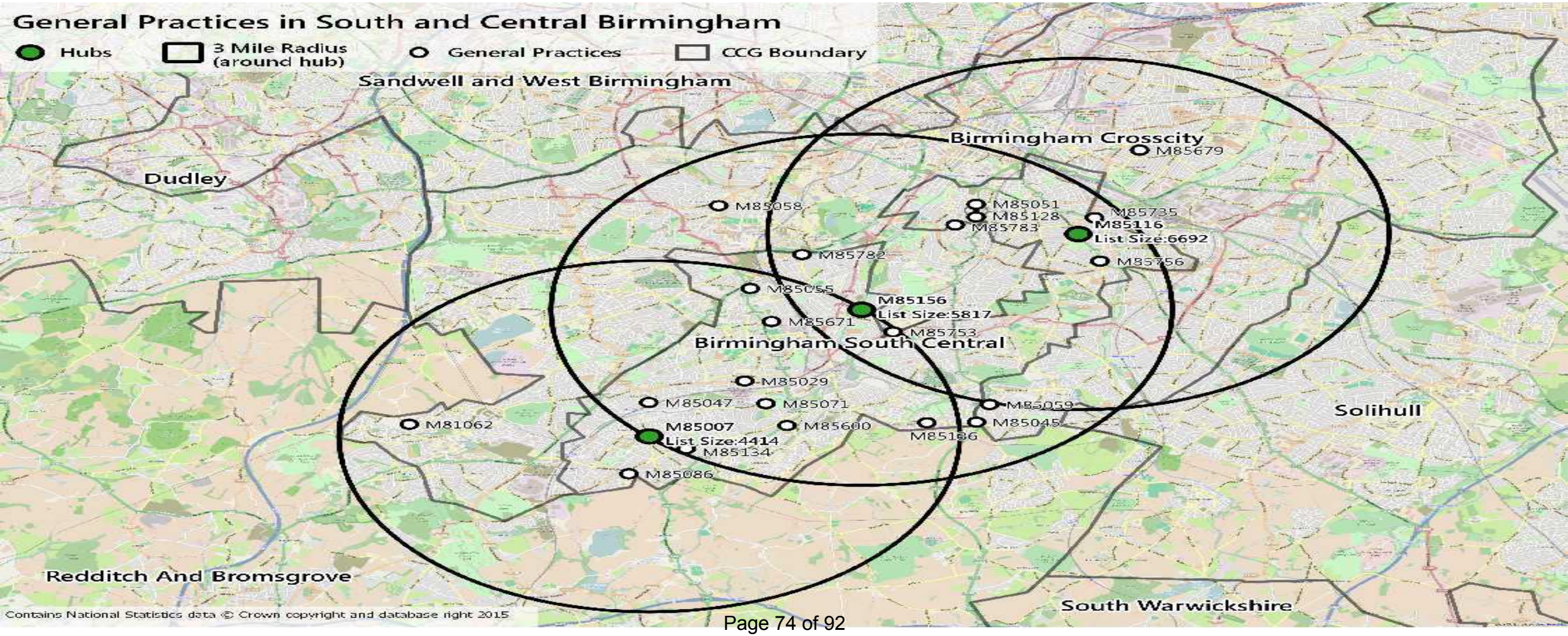
PM GP Access Fund model

- West Heath Medical Centre, River brook Medical Centre, and Fernley Medical Centre developed as hubs delivering face to face appointments 7 days per week up to 12 hours a day. All 23 practices able to view the hub and book patients into hub appointments.
- Clinicians treating patients in the hubs have access to their medical records once explicit consent has been gained.
- 8am to 8pm virtual provision of medical services. MDT in place that includes GPs, Pharmacists, Advanced Nurse Practitioners and community nurses. Roving Doctor provision in place for home visits.
- Service integration with NHS 111. New web and app capability that provides improved patient access to services via hubs or virtual centre. Contains front and back office capabilities and includes New Contact centre operational with call centre management and reporting technology.



myhealthcare

MyHealthcare Hubs and Practices

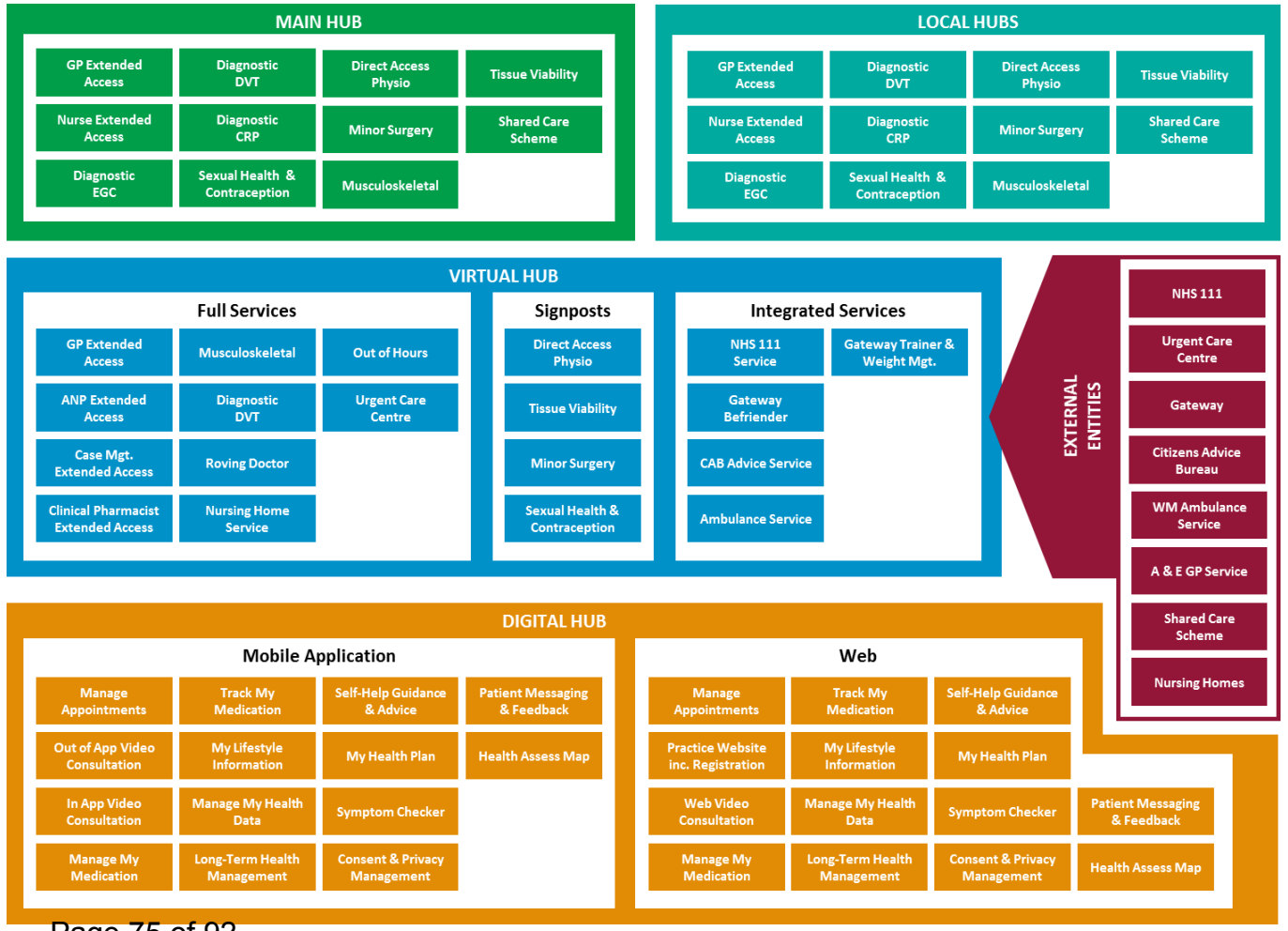


myhealthcare

Background

Full Service Model

- The original PM GP Access Fund service model has been deconstructed to include greater definition of clinical / operational services and digital services
- The full service model has helped support planning and tracking of the delivery
- The delivery of the services within the model are underpinned within detailed planning work stream planning and tasks and resources



Delivery Progress

Programme Highlights & Achievements

The MyHealthcare team have achieved the following since commencement of the programme:

Main & Local Hubs

- Our main hub at West Heath Medical Centre successfully went live in July 2015
- Our two local hubs at Fernley Medical Centre & River Brook Medical Centre followed in Sept 2015.
- All 23 practices are now able to view and book the extended hours appointments in the 3 Hubs.
- Patients are able to choose which hub they prefer to attend.
- Feedback from our practices and patients is extremely positive.

Virtual Centre & Integration

- The Roving Doctor service within our virtual hub went live in Sept 2015. Evidence suggests that the service is already ensuring that patients are more effectively managed in primary care thus avoiding the need to use emergency services.
- The Virtual Hub went live on 1st Nov 2015. All 23 practices can view and book the GP, Advanced Nurse Practitioner and Pharmacist appointment slots, and the patient will receive a call back from the clinician at the agreed time.

Digital / Technology

- Connected patient records for all 23 practices to the hubs enabling fully informed consultations & feedback from hub consultations.
- Robust IG Agreement produced in conjunction with the BSCCCG / CSU and reviewed by National Team enabling clear consenting model for patient access to services.
- Commenced detailed specification and design of initial digital services within our Service Model Roadmap

Benefits to Practices

- Able to meet the Government agenda of offering 12/7 services
- Access to additional face-to-face appointments delivered from local hub
- Access to Virtual GP, Pharmacist and Advanced Nurse Practitioner services
- Access to Roving Doctor Service
- Clinicians delivering services are able to 'see' patients full medical records
- Add details of consultations into patient's records
- Part of a coordinated Winter Pressures Plan
- Better management of periods of peak demand

Benefits to Patients

- Wider choice of face-to-face appointments delivered at convenient times
- All sites within 3 miles of patient's registered practice
- Access to additional advice and support via virtual services
- Access to wider range of services which may not be available at registered practice
- Medication reviews and advice from Pharmacists (including prescriptions)
- Rapid assessment and treatment of housebound patients by the Roving Doctor during the busy working day is reducing the numbers of avoidable admissions to secondary care
- High patient satisfaction levels

Delivery Progress

Patient Feedback

Main & Local Hubs Patient Feedback Forms generated the following comments from based on our available services?

Great service and handy due to extended hours as would not be able to attend GP…

I work full-time and your opening hours are perfect…

Fantastic service, quick and efficient, Dr and Nurse really good manner…

Came for blood test, painless and friendly service, very quick…

Next Steps

- The MyHealthcare website went live this month and electronic self help apps are being developed
- Gateway Healthy Futures service is being rolled out across all MyHealthcare practices
- Physio First and Wound Management Clinics are being trialled at the West Heath Hub before being rolled out across all MyHealthcare practices
- ECG and Minor Surgery (cyro, cautery and joint injections) will be available from all 3 hubs later this month
- DVT & CRP services are being developed
- Virtual links with Care Homes are being established to improve clinical care and reduce avoidable admissions to secondary care

Expansion of the model

- MyHealthcare and Birmingham South Central CCG are working collaboratively to improve access to all patients registered with their practices.
- Joint working across the 2 organisations has led to the expansion of the scheme as part of the Seasonal Pressures initiative
- Additional appointments have been made available at the 3 existing hubs, and 2 mini hubs have been established in Edgbaston and Small Heath. The 5 hubs offer a combination of in-hours and out of hours appointments and the scheme has been extended across an additional 18 practices
- The Seasonal Pressures initiative was initially scheduled to operate from mid December until the end of March but has recently been extended until the end of May 2016
- This approach not only ensures that patients have a much wider choice of services delivered from their preferred location by clinicians who have access to their full medical records but also represents the best possible use of the financial and human resources available to us

Any Questions?

Health and Social Care Overview & Scrutiny Committee
2015/16 Work Programme

Committee Members: Chair: Cllr Majid Mahmood

Cllr Mohammed Aikhlaq
Cllr Sue Anderson
Cllr Albert Bore
Cllr Maureen Cornish
Cllr Andrew Hardie
Cllr Mohammed Idrees
Cllr Karen McCarthy
Cllr Eva Phillips
Cllr Robert Pocock
Cllr Sharon Thompson
Cllr Margaret Waddington

Committee Support:

Scrutiny Team: Rose Kiely (303 1730) / Gail Sadler (303 1901)
Committee Manager: Paul Holden (464 4243)

Schedule of Work

Meeting Date	Committee Agenda Items	Officers
23 June 2015 10.00am	Part 1: Informal Meeting Part 2: Formal Meeting	Rose Kiely/Jayne Power, Scrutiny Office
21 July 2015 1.00pm	Petition – Budget cuts to Supporting People Mental Health and Disabilities Services Care Quality Commission – Quality Ratings Regime Healthwatch Annual Report	*Lead Petitioner, Lucy Beare, Student* Barbara Skinner/Donna Ahern, CQC Brian Carr, Acting Chair Candy Perry, Interim CEO
29 September 2015 10.00am	Primary Care and Community Mental Health Redesign Progress Report on the 'Falls Prevention' Inquiry Tracking of the 'Tackling Childhood Obesity in Birmingham' Inquiry Tracking of the 'Mental Health: Working in Partnership with Criminal Justice Agencies' Inquiry (DEFERRED)	Joanne Carney/ Dr Aqil Chaudary/ Ernestine Diedrick, Joint Commissioning Manager Dr Adrian Phillips, Director of Public Health Dr Adrian Phillips, Director of Public Health/Charlene Mulhern/Dr Andrew Coward, Chair, B'ham South Central CCG Michael Kay/Louise Collett/ Suman McCartney

20 October 2015 10.00am	Birmingham Substance Misuse Recovery System, CRI (Crime Reduction Initiative) – 6 months into new contract Tracking of the 'Homeless Health' Inquiry Tracking of the 'Mental Health: Working in Partnership with Criminal Justice Agencies' Inquiry	John Denley, AD People Directorate, Nic Adamson, Director CRI John Hardy, Policy & Development Officer / Jim Crawshaw, Integrated Service Head Homeless & Pre-Tenancy Services Michael Kay/Louise Collett/ Suman McCartney
24 November 2015 10.00am	Better Care Fund Update to include: • Links to independent living • Direct Payments 2014/15 Safeguarding Adults Annual Report Tracking of 'Living Life to the Full with Dementia' Inquiry Progress Report on the 'Adults with Autism and the Criminal Justice System' Inquiry Customer Care & Citizen Involvement Team Comments, Compliments and Complaints Annual Report 2014-15	Alan Lotinga, Service Director, Health and Wellbeing / Judith Davis, Project Manager Alan Lotinga, Service Director, Health and Wellbeing Mary Latter, Joint Commissioning Manager Dementia/ Cllr Paulette Hamilton/Suman McCartney, Cabinet Support Officer Maria Gavin, Assistant Director Commissioning Centre of Excellence / Louise Collett, Service Director – Policy & Commissioning / Martin Keating, West Midlands Police Charles Ashton-Gray, Strategic Performance & Engagement Manager /Melanie Gray, Performance Management Officer

15 December 2015 10.00am	Cabinet Member – Health and Social Care Local Performance Account 2014-15 (Adult Social Care Services) including an update on the West Midlands Peer Review Action Plan.	Cllr Paulette Hamilton/ Suman McCartney, Cabinet Support Officer Alan Lotinga, Service Director, Health and Wellbeing David Waller, AD
19 January 2016 10.00am	Healthwatch Birmingham Update (Including implementation of new strategic approach and HWE Quality Standards) People with Learning Disabilities: Support with Employment and Housing Smoking Cessation including e-cigarettes Infant Mortality in Birmingham - Intelligence Update	Brian Carr, Acting Chair Healthwatch Birmingham Kalvinder Kohli, Service Lead Prevention & Complex, Commissioning Centre of Excellence Dr Adrian Phillips, Director of Public Health Dr Adrian Phillips, Director of Public Health
23 February 2016 10.00am	Prostate Cancer and Health Inequalities – Information Briefing CrossCity CCG Draft Operational Plan 2016/17 Transforming Care for People with Learning Disabilities (Adults and Children) Update on the Sexual Health Services in Birmingham and Solihull – Umbrella - 6 months into the new contract	Mr. Richard Viney Consultant Urological Surgeon and Senior Lecturer in Urology, UHB Les Williams, Director of Performance & Delivery, CrossCity CCG Maria Gavin, Assistant Director Commissioning Centre of Excellence Max Vaughan, Head of Service, Universal and Prevention
22 March 2016 10.00am	CrossCity CCG Primary Care Strategy 2016/20	Karen Helliwell, Director of Primary Care & Integration, Carol Herity, Associate Director of Partnerships, B'Ham CrossCity CCG

	Birmingham Community Healthcare NHS Trust - Update on new telephone triage system to access unscheduled dental care appointments at Birmingham Dental Hospital. Diabetes Prevention Enhanced Access to GPs	Angie Wallace, Acting Chief Operating Officer, Marie Ward, Director – Specialist Services Division, Kate Cullotty, Service Lead – Unscheduled Care, Mike Murphy, Consultant Oral Surgeon and Head of Service, Birmingham Community Healthcare NHS Trust Dr Andrew Coward, Chair, Simon Doble, Senior Commissioning Manager, Richard Mendelsohn, Clinical Head of Commissioning, South and Central CCG.
26 April 2016 10.00am	West Midlands Ambulance Service NHS Foundation Trust • General Trust Overview • Operational/Clinical Performance Update for 2014/15 (including winter) • WMAS 5 Year Strategy and Initiatives • Demonstration of an Automated External Defibrillator Shisha smoking and the impact on health	Diane Scott, Deputy CEO Nathan Hudson, General Manager Birmingham Division Mark Docherty, Director of Nursing, Quality and Clinical Commissioning Dr Adrian Phillips, Director of Public Health, Janet Bradley, Alcohol & Tobacco Control
June 2016	Tracking of the 'Tackling Childhood Obesity in Birmingham' Inquiry Tracking of the 'Mental Health: Working in Partnership with Criminal Justice Agencies' Inquiry	Dr Adrian Phillips, Director of Public Health/Charlene Mulhern/Dr Andrew Coward, Chair, B'ham South Central CCG Michael Kay/Louise Collett/ Suman McCartney
July 2016	Tracking of the 'Living Life to the Full with Dementia' Inquiry	Mary Latter, Joint Commissioning Manager Dementia/ Cllr Paulette Hamilton/Suman McCartney, Cabinet Support Officer

	Tracking of the 'Homeless Health' Inquiry Healthwatch: Update	John Hardy, Policy & Development Officer / Jim Crawshaw, Integrated Service Head Homeless & Pre-Tenancy Services Candy Perry, CEO, Healthwatch Birmingham
September 2016		
October 2016		
November 2016	Update on Umbrella - the Sexual Health Services in Birmingham and Solihull contract	Max Vaughan, Head of Service, Universal and Prevention
December 2016	15/16 Local Performance Account Report West Midlands Challenge of Birmingham Adult Care	Alan Lotinga, Service Director Health & Wellbeing Alan Lotinga, Service Director Health & Wellbeing
January 2017		
February 2017		
March 2017		
April 2017		

Items to be scheduled in Work Programme	
• Urgent Care Strategy (To be confirmed)	
• Mental Health Strategy (To be confirmed)	
• Congenital Heart Disease Review – outcome from consultation on standards and service specification and next steps	
• Tuberculosis Update	
• Move of Health Visitors to Local Authority	
Suggested items	**Link to Council Priority**

Joint Birmingham & Sandwell Health Scrutiny Committee Work		
Members	Cllrs Majid Mahmood, Mohammed Aikhlaq, Sharon Thompson, Andrew Hardie, Sue Anderson	
Meeting Date	**Key Topics**	**Contacts**
1 July 2015 2.00pm in Birmingham	• Urgent Care • Cardiology and Acute Services • End of Life Care	Jayne Salter-Scott, Andy Williams
22 September 2015 2.00pm in Sandwell	• Urgent Care • End of Life Care • Primary Care Listening Exercise	Jayne Salter-Scott, Head of Engagement, Sandwell & West Birmingham CCG
15 December 2015 2.00pm in Birmingham	• Urgent and Emergency Care Programme Update • End of Life Care	Dr Manir Aslam, Urgent Care Clinical Lead, SWBCCG, Nighat Hussain, Sandwell Programme Director Jon Dicken, Chief Operating Officer – Operations, SWBCCG, Sally Sandel, Senior Commissioning Officer
11 February 2016 2.00pm in Sandwell	• End of Life Care • Oncology Services, Sandwell & West Birmingham Hospitals NHS Trust	Jon Dicken, Chief Operating Officer – Operations, SWBCCG, Sally Sandel, Senior Commissioning Officer Dr Roger Stedman, Medical Director, Sandwell & West Birmingham Hospitals NHS Trust
June 2016 TBC in Birmingham	• End of Life Care	Jon Dicken, Chief Operating Officer – Operations, SWBCCG, Sally Sandel, Senior Commissioning Officer

Joint Birmingham & Solihull Health Scrutiny Committee Work		
Members	Cllrs Majid Mahmood, Mohammed Idrees, Sir Albert Bore, Robert Pocock, Andrew Hardie, Margaret Waddington, Sue Anderson	
Meeting Date	**Key Topics**	**Contacts**
21 July 2015 5.30pm in Birmingham	• Non-Emergency Patient Transport • HoEFT CQC Inspection Report	Carol Herity, CrossCity CCG Sam Foster, Chief Nurse, NoEFT
6 October 2015 4.30pm tea 5.00pm start in Solihull	• Non-Emergency Patient Transport – results of consultation and proposed model • HoEFT Surgery Reconfiguration Update – Site Plans for all 3 Trust Hospitals and update on CQC inspection issues. • CCGs on Surgery Reconfiguration public consultation	Carol Herity, CrossCity CCG Ruth Paulin, Lisa Thompson, Richard Steyn
10 February 2016 5.00pm in Birmingham	• HoEFT – ○ Report on the outcome of the Monitor financial investigation. • Non-Emergency Patient Transport (NEPT) Consultation ○ Further information around the feasibility of a fee paying service in the new contract	Dame Julie Moore, Interim Chief Executive, HoEFT, Rt Hon Jacqui Smith, Chair, HoEFT Carol Herity, Associate Director of Partnerships, Mark Lane, Head of Planning & Delivery, Gemma Coldicott, Senior Communications & Engagement Manager, CrossCity CCG
24 March 2016 5.30pm tea 6.00pm start in Solihull	• NHS Procedures of Lower Clinical Value – Solihull and Birmingham CCGs Public Engagement Process • Mental health for young people across Birmingham and Solihull	Dave Rowson, NHS Midlands and Lancashire CSU

West Midlands Regional Health Scrutiny Chairs Network		
1 July 2015	• NHS England – West Midlands Neonatal Service Review • Integrating Health and Social Care • CQC – Update on Primary Medical Services	
7 October 2015 9.30am	• NHS 111 Contract – Dr Anthony Marsh, CEO WMAS, Mr Jon Dicken, Chief Officer SWBCCG (Lead Commissioners for NHS 111) • NHS England – Updates on Specialised Commissioning and Neonatal Review • Update on developments within the Centre for Public Scrutiny	Dr Anthony Marsh, CEO of WMAS, Jon Dicken, Chief Officer SWBCCG Christine Richardson, AD Dr Geraldine Linehan, Regional Clinical Director Brenda Cook, CfPS Regional Advocate & Expert Adviser
3 February 2016 10.00am	Session facilitated by the Centre for Public Scrutiny	Brenda Cook, Regional Advocate, CfPS
15 June 2016 10.00am	Mental Health (Changes taking place with primary and secondary care)	

CHAIR & COMMITTEE VISITS		
Date	**Organisation**	**Contact**
18 January 2016	HEFT Reconfiguration of Surgery Services – Visit to new centres at:- • Solihull (Dermatology) • Heartlands (Minor Injuries Unit alongside A&E) • Good Hope (Medical Assessment Unit)	Professor Matthew Cooke, Deputy Medical Director, Strategy and Transformation
Feb/March	West Midlands Ambulance Service – Visit to an Ambulance Hub.	Diane Scott, Deputy CEO
Feb/March	Birmingham Substance Misuse Recovery System:- Visit to CRI premises, Scala House, Birmingham.	John Denley, AD Commissioning Centre of Excellence / Nic Adamson, Director CRI
To be advised	Visit to The Bromford – a Supported Living Scheme in East Birmingham	Kalvinder Kohli, Head of Service, Prevention and Complex, Commissioning Centre of Excellence

INQUIRY:	
Key Question:	
Lead Member:	
Lead Officer:	
Inquiry Members:	
Evidence Gathering:	
Drafting of report	
Report to Council:	

Councillor Call for Action requests

Cabinet Forward Plan - Items in the Cabinet Forward Plan that may be of interest to the Committee

Item no.	Item Name	Portfolio	Proposed date
000298/2015	Public Health Grant Reduction	Health & Social Care	16 February 2016
000355/2015	Public Report - Purchase of a Home Support Visit Monitoring System Full Business Case and Contract Award	Health & Social Care	28 June 2016
000542/2015	Policy for the Use of Private Rented Sector to Meet Housing Needs	Health & Social Care	19 April 2016
001045/2016	Extension of Community Equipment Service Contract (C0115) - Public	Health & Social Care	22 March 2016
001551/2916	Approval to Consult – Personal Budget Allocation System	Health & Social Care	22 March 2016