Seeing the **bigger picture** – The *Dudley Health and Social Care Commissioning Framework and Strategy* 2008-2013
Foreword

Dudley Primary Care Trust (DPCT) and Dudley Metropolitan Borough Council (DMBC) both have commissioning responsibilities. This means that we have the responsibility to spend public money as effectively as possible on health and social care to meet the needs of local people. This is a challenging task as the resources are finite yet the demand for services continues to grow and new technology continues to advance. Consequently we have to make difficult choices. These pressures mean that it is essential that the PCT and the MBC develop a framework to guide how we will commission services over the next 5 years that is based on a robust assessment of need and should focus on achieving better outcomes and improving service quality.

Therefore Dudley PCT and MBC have agreed to work together to develop a consistent approach to agree the overarching vision of our organisations for the next five years and provide a framework to allow us to consider and agree priorities in a systematic way responding to the specific needs of our population through the commissioning process. In response we have developed are 3 key documents which contribute to our vision for the future. These are the Commissioning Framework, the Commissioning Strategy and the Compendium.

The Commissioning Framework outlines how we will commission services for local people and concentrates on the ‘rules’ and processes that we will use.

The Commissioning Strategy explains how these principles translate into our vision for the next 5 years and what we plan to commission over the next 5 years.

The Compendium is a reference point for a set of documents which supports the commissioning strategy and includes:

- Joint Strategic Needs Assessment – Executive Summary.
- The detailed feedback from our staff and public consultation.
- Feedback from the Dudley Commissioning Framework and Strategy Consultation.
- Demand Modelling Data Analysis.
- Dudley Commissioning Strategy Implementation Plans.
- Glossary of Terms.
Introduction

Dudley PCT and Dudley MBC have a good track record of working together, particularly in the joint commissioning of services for particular client groups such as mental health, learning disabilities and older people. However, there has not been a locally agreed over-arching framework to guide how we will commission future service, which takes into account new and emerging ways of working both within DPCT and DMBC and with other agencies, including the voluntary sector and independent providers of services.

In Dudley this work started in response to the government asking each local economy to set up a Local Strategic Partnership (LSP) to improve the quality of life of local people and ensure that public services work better together. The Dudley Community Partnership (DCP) was established as the Local LSP and in December 2005, launched a new Dudley Community Strategy. Accountable to the DCP, the Dudley Health and Well-Being Partnership (DHWP) is the body responsible for ensuring that the vision and aims of the Community Strategy are delivered to ensure that we provide high quality services that are responsive to the needs of the individual and the diverse nature of our community. In March 2007, the Health and Well-being Partnership approved a Health and Social Care Strategy which sets out the next steps in the journey. The document sets out how we will work in partnership and shows our vision and key priorities to provide even better quality of services by providing the right care, at the right time, and in the right place.

The next step in this process was to turn the vision into reality and consequently the PCT and MBC agreed to develop one consistent commissioning framework and strategy. Both of these build upon the Dudley Community Strategy and the Health and Social Care Strategy and aim to ensure that we spend public money as effectively as possible on health and social care to meet the needs of local people.

National Context

The development of the Dudley Commissioning Framework and Strategy is the local response to key Department of Health policy documents. The first is the White Paper, Our health, our care, our say whose aims were to put people in control, to make services more responsive, to focus on people with complex needs and to shift care closer to home.
The White Paper had four main goals for health and social care services:

- to provide better prevention services with earlier intervention.
- to give people more choice and a louder voice.
- to do more to tackle inequalities and improve access to community services.
- to provide more support for people with a long term illness.

Reconfiguring services and providing care outside hospitals is crucial to delivering these aims.

The second document, **Commissioning Framework for Health and Well-being** was all about action and gave practical proposals for the commissioning of health, care and well-being from 2008/09. It has been designed to reach the above four goals and enable commissioners to achieve:

- a shift towards services that are personal, sensitive to individual need and that maintain independence and dignity.
- a strategic reorientation towards promoting health and well-being, investing now to reduce future ill health costs.
- a stronger focus on commissioning services and interventions that will achieve better health, across health and local government, with everyone working together to promote inclusion and tackle health inequalities.

The framework has a particular focus on partnerships and stresses the importance of the contribution of all our providers, including those within the PCT or MBC, secondary care and the voluntary and independent sectors.

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1 Introduction

This Commissioning Framework sets out the agreed approach and “rules of engagement” outlining to providers and the public, in an open and transparent way, how we spend public money and make decisions on priorities.

2 Purpose of the Commissioning Framework

The Commissioning Framework has a number of key purposes as follows:

- It seeks to confirm the core values that we work to. These core values underpin and drive our discussions and decisions.
- It also outlines how we are going to be more open and transparent about what we do.
- It explains how we would like to involve the public, service users and patients in the planning, delivery and review of services.
- It explains our commitment to improving the quality of care.
- It explains how we plan to make priorities and choose between options.
- It gives advance notice to the providers of services to explain what we may want to do differently in future and what new services we will want to commission so that providers of services can start to plan accordingly.
- It explains how we will monitor the performance of services that we commission.

3 Our Vision and Values

The Health and Social Care Strategy defines our vision and the values by which we will operate.

Our vision as Dudley Health and Well-Being Partnership is that we will:

- promote good health and well-being for all through effective commissioning for health improvement.
- meet health and social care needs.
- recognise the diversity of local needs including for disease prevention and ill health management, targeting resources to improve health and well-being whilst recognising the responsibility of everyone in reducing inequalities.
- ensure that the citizens of Dudley receive quality local services that will protect and care for the vulnerable and those at risk from harm.
- improve the health of all children and the life chances of looked after children and care-leavers as a result of stronger partnership working.
• promote enhanced citizenship improving the ordinary life experiences of older people.
• improve mental health and well-being and actively promote independence and social inclusion.
• encourage and support innovation in developing better services for Dudley people through developing and supporting our workforce.

Fairness in commissioning is vital and we expect both commissioners and providers to agree to the following values (set out in Building Capacity and Partnership in Care).

1. To be fair to people using services - and to ensure that they get good quality care, in the right place, in the right quantity, at the right time.

2. To be fair to tax payers - and ensure that the services they are supporting are giving value for money and being targeted at the right priorities.

3. To be fair to providers - ensuring that they receive a fair return for their services and they have not been set impossible objectives or given tasks for which they are not funded.

4. To be fair to commissioners from Councils and Primary Care Trusts who are entitled to choose between the services on offer and pay a price that offers quality at a price they can afford.

4. Commissioning Process

Commissioning is a function of an organisation, in this case the PCT and the MBC, who have a responsibility on behalf of the population for spending the resources allocated to health and social care services. It is a set of linked activities required to assess the health care and social care needs of a population, specify the services required to meet those needs, within a strategic framework, secure those services, monitor and evaluate outcomes.

The Audit Commission has defined commissioning as:

“....the process of specifying, securing and monitoring services to meet people’s needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS or other public agencies, or by the private and voluntary sectors.”

—- Take Your Choice: A Commissioning Framework for Community Care, Audit Commission, 1997
4.1 Commissioning Cycle

The key activities involved in the commissioning cycle are therefore analyse, plan, do and review, as shown in the diagram below.

4.1 Commissioning Principles

We will also ensure that all commissioning decisions will be made based on the following principles:

**Outcome-focused** - All decisions will be based on a clear rationale for improving outcomes for all our population.

**Strategically directed** - All planning and commissioning activity will be in line with the priorities identified in the Commissioning Strategy and the improved outcomes which must be sustainable in the long term.

**Evidence-based** - All commissioning decisions will be based on robust evidence of need, and are made in a way that is clear and transparent to all.
Performance managed - Commissioners will performance manage to measure improvement.

Reduce inequalities - Commissioning activity will narrow the gaps, promote equity and diversity and reduce inequalities.

Early intervention and prevention - Commissioners will have a strategy to move resources to preventative and early intervention services.

Open and transparent - Commissioners will exercise independence of decision making from internal and external service providers.

Partnership - Commissioners will work collaboratively and co-operatively with providers and other key stakeholders, including the voluntary sector.

Participation - All people who access care, their families and carers and the wider community must participate meaningfully throughout the planning and commissioning process.

Value for money - All commissioning decisions will aim to improve efficiency and effectiveness.

Building capacity - Commissioners will seek to understand and proactively support the development of the market and look to expand the number of provider organisations.

Legally compliant - Commissioners will ensure that approaches are compatible with European Union and UK law, regulations and guidance.

5. Partnership Working
The relationship between commissioners and providers and service users/patients is centred around choice. The concept of choice is a key element that will ensure service development is responsive to needs. Commissioning needs to be done with service users and the key principle of this commissioning framework is one of partnership between service users, the general public, providers and commissioners. We recognise and support the need for service users to be involved effectively in all aspects of the commissioning process.
5.1 Our Governance Arrangements

The structure for partnership working has been outlined in the introduction and is represented in the following diagram.

6. Community Engagement

We think it is important to involve local people in decisions that are made about them. The future of health and care in Dudley is for everyone to decide. Local people have been involved from the beginning of the development of the Dudley Commissioning Framework and Strategy and there has been a comprehensive engagement programme to seek the views of the public. As well as the public, we are listening to people working in health and social care,
the many organisations and groups working in the community and the voluntary sector. The information we get from talking and listening to people in Dudley is used to improve our services and plan how we provide health and care. We also work with partners to make sure that health and care needs are being met and jointly commissioned where appropriate through our partnership arrangements. To this end, in June and July 2007, we actively engaged in three ‘Think Tank’ events with patients, service users and carers as well as with staff, managers and clinicians from our organisations. There is more detail on this in the Commissioning Strategy and the Compendium.

This is not the end of the conversation - this is just the beginning. In the future we will provide various ways for people to find out what we are planning and what we are doing. We will give people chances to get involved in lots of different ways, so that it is done in a way that suits the people of Dudley.

We will continue to involve people throughout 2008 and beyond. This will include going out to meet with groups in the community in Dudley. This might be a group of patients or carers or just a gathering of interested people, for example at a community centre, youth club, or a social event. It might be a local parent and toddlers group, or an elders meeting.

We will keep listening and adding detail to our plans. We want to keep hearing about the areas of health and care that matter to you. In return, we will keep learning lessons from what people tell us about their health and care services.

7. Practice Based Commissioning

Practice Based Commissioning (PBC) is a major government initiative to improve commissioning within the NHS. PBC places GPs, nurses and practice teams at the heart of decision making in determining how services are provided to their patients as agreed with the PCT. PBC provides information and incentives to improve services, and provide them outside a hospital setting, in response to the needs of local populations. Within Dudley, Practice Based Commissioning budgets account for nearly half, 47%, of total healthcare resources available within the borough. The budgets are held notionally by the practices, i.e. the money is retained by the PCT, who remain the responsible contracting body and is statutorily responsible for the financial position. Any financial savings generated by PBC must be reinvested in patient care.

The GPs in Dudley have grouped into 5 ‘clusters’ (groups), these are:

- Cluster One.
- Halesowen Cluster.
- Beacon and Castle.
- SLK Cluster.
- Worcester Street.

Each Cluster has a Board made up of nominated GPs, practice and community staff under the Chairmanship of an elected GP. The Boards are accountable to the PCT via the Clinical Executive Committee (CEC), which in itself is a

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4 The Dudley Community Partnership is currently consulting on a draft community engagement strategy called ‘In It Together’. The Voluntary Sector Council, the PCT and the Council have contributed to shaping this strategy and will be committed to ensuring that their work is guided by its principles and approach to community engagement.
sub-committee of the PCT’s main Board. The Practice Based Commissioners work with the public through various patient groups. All clusters were involved in the Think Tank Events which have informed this Commissioning Framework and the Commissioning Strategy.

8. Commissioning Planning Cycle

The Department of Health requires each PCT to produce a Local Delivery Plan (LDP) every three years. This is the vehicle for the PCT to describe what we will commission to deliver services to our population. The LDP also has to demonstrate how we will meet the key targets set by the Department of Health, exactly what new services we will commission to meet the needs of our population, and how the services will be funded within a fixed amount of money. We are in year 3 of the current LDP.

The next LDP, which will take us up to 2010/11, will be developed in accordance with the purpose and values of the PCT and will be planned to deliver the strategic priorities outlined in the PCT’s Commissioning Strategy.

A key driver of the LDP process is the NHS Operating Framework, which sets out the health and services priorities for the year ahead, further steps in NHS reform to occur the following year and the financial resources to support delivery of the plan. The Operating Framework is published in late November or early December each year.

When developing the LDP, we consider the increase in funding that we will receive in the subsequent year. The PCT received growth funding of 9.4% in 2006/7 and 9.1% in 2007/8, however the allocation for 2008/9 is expected to be significantly less. We will need to reflect this in our financial plans for next year, whilst ensuring that the funds that are available are commissioned and spent in the most appropriate way. The financial history of the PCT is one of achieving all financial targets, and financial balance is predicted for 2007/08. There are increasing funding issues within the PCT, however, that will need to be resolved in the formulation of the financial plans for future years.

As a Local Authority, the MBC has established its own Business Planning cycle that takes account of budgetary allocation by central government and the planning that assists the setting of the Council Tax for local services that is formally approved at the meeting of the full Council in March. In its planning, therefore, the Council takes account of its responsibility to Dudley people as well as the requirements of central Government departments or Inspectorates that are interested in the Council’s planning and use of resources to support its activity. The Council has a strong record in financial management that supports its service of people in Dudley.

In using Dudley people’s money wisely in the planning of its services, the Council recognises the need to work with its partners such as the PCT on the basis that the needs of people in Dudley are met through the work of many agencies. Like the PCT, the Council is planning to continue to provide high quality services alongside the need to demonstrate efficiencies required by the Comprehensive Spending Review 2007. This over-arching environment is the one in which all the Council’s activity that supports this commissioning framework will be working.
9. Procuring Services

It is recognised that there are different understandings around the terms ‘commissioning’, ‘procurement’, ‘contracting’ and ‘purchasing’.

We have previously defined commissioning. For the purpose of this framework we are using the following definitions for the remaining three terms.

**Procurement** is the process of identifying a supplier or provider of services and may involve, for example, competitive tendering, competitive quotation, single sourcing. It may also involve stimulating the market through raising awareness and education.

**Contracting** is the technical process once the provider has been selected and involves the negotiation and agreeing of the terms of the contract or Service Level Agreement for the services and the ongoing management of the contract including payment and performance monitoring, and agreeing any changes with the contract due to performance issues.

**Purchasing** is a transactional process where a supplier is reimbursed on usage of a service based on operational activity. It is becoming less common in the commissioning cycle.

9.1 Arrangements for Procuring Services in the PCT

The PCT is the responsible contracting body and has a responsibility to ensure that conflicts of interest are managed appropriately and that open, transparent processes are in place for procurement of services.

The PCT has developed a document describing the process by which clinical services will be procured by the PCT and Practice Based Commissioning Clusters. The document states that the PCT is recommended to follow an open, competitive process for all services commissioned under Practice Based Commissioning. The complexity and timescale associated with the procurement of an individual service is dependent on the value of the service being commissioned.

9.2 Arrangements for Procuring Services in the MBC

The Council aims to secure significant progress towards key corporate objectives by improving the effectiveness of its procurement activities across the organisation. The councilís Procurement Strategy (July 2004) outlines how it works, on behalf of local taxpayers, in acquiring services and supplies to support its services.

The Procurement Strategy is concerned with significantly improving the lives of people living in the Borough, related to specific issues identified in the Council Plan. These include:

- Social Inclusion.
- Equality and Diversity.
- Sustainability.
- Community Safety.
- Good Health.
- Value for Money.
It is important to make sure that the purchase of goods, services and work is done so cost effectively otherwise it can put the achievement of key objectives and services at risk.

10. Monitoring performance, including quality, finance and productivity

There is a requirement to establish contracts or Service Level Agreements with providers of services that determine service specification (what outcomes we wish to purchase), service volumes (the amount to be purchased), costs and how and when the services will be delivered. The success of the contract will require monitoring and this process needs to be considered within the context of an overall commissioning framework. This will ensure that contracts contribute to the achievement of efficient and effect services that meet the needs of service users. We will use the National Commissioning for Health and Well-being Outcomes Framework as our baseline and will work with all providers to ensure these outcomes are adapted to each service and carefully monitored.

11. Prioritisation

We wish to be more open about how we make decisions about what healthcare we purchase and which areas we prioritise. We have developed a tool to assist us in decision making to enable open and objective decisions about what we want to commission to be made. This tool is attached in the appendix. The tool has been developed from 2 key sources:

- Best practice from available evidence on prioritisation tools utilised elsewhere. Our thanks in particular to Portsmouth and Sandwell PCTs for sharing their thoughts.
- The things Dudley staff and members of the public have said are the most important things to them during our consultation process.

We do not want decisions to be based on a range of scientific factors and financial costings only. We want to ensure the decisions we make take account of what matters to local people and we hope this tool goes some way to delivering this.

This tool will assist us in our planning cycles and processes to ensure that our decisions remain focused on the priorities we have agreed.

12. Commissioning for Quality and Outcomes

We are committed to moving from commissioning processes that focus heavily on money and activity to processes which pay more attention to quality, the positive health outcomes and the actual experience of people receiving the services.

We have agreed to adopt the National Commissioning for Health and Well-being Outcomes Framework as our baseline and will work with all providers to ensure these outcomes are adapted to each service and carefully monitored. This framework is outlined below.
A patient-centred NHS that uses available resources as effectively as possible to promote health, reduce health inequalities and deliver the best and safest possible healthcare.

Services should be person-centred, seamless and proactive. They should support independence, not dependence, and allow everyone to enjoy a good quality of life, including the ability to contribute fully to our communities. They should treat people with respect, dignity and support in overcoming barriers to inclusion. They should be tailored to the religious, cultural and ethnic needs of individuals. They should focus on positive outcomes and well-being.

We will align the three outcome frameworks to create something clearer and more powerful.

The health and social care indicators and the joint indicators are from the Our health, our care, our say (OHOCOS) and the Every Child Matters (ECN) Department of Health documents respectively. We have compared these indicators and group them into five Dudley Outcomes (D1-D5) as indicated in the table below.

### Dudley Outcomes Framework

<table>
<thead>
<tr>
<th>Strategic Outcome</th>
<th>OHOCOS/ECM Outcome</th>
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<tbody>
<tr>
<td>D1 Be fair</td>
<td>H5, S5, S7</td>
</tr>
<tr>
<td>D2 Provide personal care</td>
<td>H1, H2, S1, S3, S4, C1, C3, C4</td>
</tr>
<tr>
<td>D3 Be effective</td>
<td>H3, S2</td>
</tr>
<tr>
<td>D4 Stay safe</td>
<td>H4, C2</td>
</tr>
<tr>
<td>D5 Achieve economic well-being</td>
<td>S6, C5</td>
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The main thrust of the outcomes framework is that specific targets will no longer be set from the centre. In future, consideration of priority outcomes, such as GP access or improved patient/user experience, will be for local determination, priority setting and delivery. We will adopt the following important themes:

- We will set our goals and performance targets so that they are more appropriate, more stretching and create a sense of local ownership. To do this we want to put the things that matter, to the people who matter, at the heart of our services. That means listening to, and reflecting, the things that patients, users, staff and the public find important and finding ways to focus on those things across all that we do.
- We will need to take greater ownership for continuous service improvement, and be accountable to our local communities for the outcomes.
- We will build on our effective partnership working to improve health and well-being and achieve a shift towards prevention of ill health.

13. Summary

This Commissioning Framework sets out the agreed approach and ‘rules of engagement’ outlining to providers and the public in an open and transparent way how the PCT and MBC spend public money and make decisions on priorities. We have outlined our vision and values by which we will operate and the commissioning principles that we will adhere to in providing future and reassessing current services. We acknowledge the importance of partnership working, not only between the PCT and the MBC, but also with the secondary care providers, the voluntary and the independent sector. We will ensure that the local decision making processes are subject to greater scrutiny. We will also ensure that changes are led by local clinicians through both practice based commissioning and support from clinical leads. The involvement of the public and wider community is key and this will be achieved through our community engagement strategy.

We have robust governance arrangements and performance monitoring arrangements, but we need to build on these to guarantee that all providers meet all our objectives to ensure high quality value for money services for the population we serve.

The accompanying Dudley Commissioning Strategy explains how we will use this Commissioning Framework to translate what we plan to commission over the next 5 years to improve our services.
1. Introduction and Purpose of document

The Commissioning Framework outlines how we will commission services for local people. The framework concentrates on the ‘rules’ and processes that we will use. The Commissioning Strategy explains how these principles translate into our vision for the next 5 years and what we plan to commission over the next 5 years. The strategy has been developed following significant engagement and involvement from members of the public, staff working in our organisations and many stakeholders that we are very pleased to have as partners, including colleagues from the voluntary sector. We believe that we can only have the greatest impact on the health and well being of local people by working together.

The purpose of the commissioning strategy is:

- To analyse the strategic health and social care issues facing Dudley Primary Care Trust (PCT) and Dudley Metropolitan Borough Council (MBC) and translate them into a commissioning framework.
- To identify the strategic direction for commissioning services for the next 5 years.
- To agree key strategic goals in terms of: population health, quality, patient experience and finance.
- To identify a clear set of commissioning priorities and actions that will enable the strategic health issues to be addressed.

2. Health and Social Care agreed Values, Principles and Commissioning for Outcomes

We have outlined our vision, the values by which we will operate and the commissioning principles for commissioning future services and reviewing current services in the Commissioning Framework. We are also committed to moving from commissioning decision making processes that focus heavily on money and activity to a process which pays far more attention to quality, the positive health outcomes and the actual experience of people receiving the services.

We will ensure that all commissioning decisions will be made based on the following principles:

**Outcome-focused** - All decisions will be based on a clear rationale for improving outcomes for all our population.

**Strategically directed** - All planning and commissioning activity will be in line with the priorities identified in the Commissioning Strategy and the improved outcomes which must be sustainable in the long term.

**Evidence-based** - All commissioning decisions will be based on robust evidence of need, are made in a way that is clear and transparent to all.
Performance Managed - Commissioners will performance manage to measure improvement.

Reduce Inequalities - Commissioning activity will narrow the gaps, promote equity and diversity and reduce inequalities.

Early intervention and prevention - Commissioners will have a strategy to move resources to preventative and early intervention services.

Open and transparent - Commissioners will exercise independence of decision making from internal and external service providers.

Partnership - Commissioners will work collaboratively and cooperatively with providers and other key stakeholders, including the voluntary sector.

Participation - All people who access care, their families and carers and the wider community must participate meaningfully throughout the planning and commissioning process.

Value for money - All commissioning decision will aim to improve efficiency and effectiveness.

Building capacity - Commissioners will seek to understand and proactively support the development of the market and look to expand the number of provider organisations.

Legally compliant - Commissioners will ensure that approaches are compatible with European Union and UK law, regulations and guidance.

2.1 Dudley Strategic Outcomes

We are clear that any commissioning that we undertake must have consistent strategic outcomes. We stated our five Dudley Strategic Outcomes in the Commissioning Framework. These are:

- Be fair.
- Provide personalised care.
- Be effective.
- Stay safe.
- Achieve economic well-being.

3. Dudley Health and Social Care Needs

The PCT and MBC have carried out a joint strategic needs assessment, to inform this strategy and support the planning of future services, to improve the heath and well being of our population.

Key drivers of future demand for services have been examined and their implications for the strategic direction of service delivery assessed should be to meet the identified needs. A complete set of the Needs Assessment documents can be provided on request.
3.1 Key Messages for future planning of services

3.1.1 Demography

Although the population of Dudley is forecast to increase by just 1% by 2020; the number of people aged over 75 years is forecast to double, giving 7-8,000 more over 75 year olds. Of these, 3,000 or so are forecast to be over 85 years. The ethnic population (6.3% 2001 Census) is also likely to increase and the age profile, which is currently younger than the white population, will change. This will add to the increasing demand for services for older people.

Births declined during the 1990’s from approximately 4,100 to a low point in the early 2000’s, with a small upwards fluctuation in 2004 and 2005. In 2005 there were 3,754 births. The published long term population projections for the Borough assume births to stable averaging 3,300 per year. However, this needs revision upwards to account for those born in 1989-93 period reaching child bearing age around 2020. Short term projects may also need to be revised if the recently observed small increase in annual numbers of births continues.

The number of people moving in and out of Dudley is expected to remain small compared with the total population, though as nationally, there is some expected increase in the number of migrants from the new European Union member countries.

Life expectancy in Dudley has risen in the last 20 years, but at a slower rate than nationally in recent years. There is still a gap of 6.6 years between Norton ward with the highest life expectancy and St James’ ward with the lowest. Whilst Dudley’s overall deprivation is similar to the national average, 8 wards fall into the most 25% deprived nationally.

3.1.2 Health Risks

Though showing a welcome decline over the last 20 years, circulatory disease and cancer have been the two leading causes of premature death in Dudley. Coronary heart disease is still the single biggest cause of premature death and is a major cause of health inequalities. Over a fifth of the population (21%) still smoke. Reduction in smoking rates will reduce both circulatory disease and cancer death rates and it remains the single most effective way of reducing inequalities in health outcomes.

However, there are now two new major threats to the health of the Borough - rising levels of obesity and rapidly rising rates of death and illness from alcohol related diseases.

Obesity increases the risk of ill health and early death from a range of diseases including some cancers, heart disease and diabetes. It can have an adverse effect on fertility and the outcomes of pregnancy. Local surveys have shown that obesity in Dudley's adult population has more than doubled over the 12 years from 1992-2004. Continuation of this trend would slow down and possible reverse the gains recently made in reducing premature death and lead to increased levels of ill health. This will put major pressures on, and overwhelm, existing services. Already, it is estimated that approximately 40,000 adults and 8,000 children in

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4 Circulatory disease is a wide-encompassing category that includes all conditions that affect the heart and the blood vessels.
Dudley are obese and face risks to their health now. Reversing this trend is a key imperative for the strategy.

Alcohol related ill health and premature death has show a recent rapid rise. Death rates have doubled in the last decade and a 2004 local survey suggests that nearly a quarter of population (24%) are now heavy drinkers. As with obesity, if continued gains in healthy life expectancy are to be made, strategic interventions are required to reverse the rising trend.

### 3.1.3 Work and the Economy

Comparisons regionally and nationally show that Dudley has a higher proportion of people of pensionable age and a lower proportion of people of a working age. Levels of employment are proportionately higher than national and regional levels, however the earnings are lower and this trend is increasing. This is mainly due to the high number of jobs in the service sector (shops, hotels and restaurants, public houses and public services), having increased from 48.9% in 1981 to 78% in 2004 and the reduction in the number people employed in manufacturing from 43.3% in 1981 to 16.8% in 2004.

### 3.1.4 Housing

The increase in the number of people on relatively low wages as put pressure on the housing market for affordable housing. The Dudley MBC Housing Needs and Demand survey 2005 showed that there was a need for more terraced housing rather than the more expensive houses and bungalows.

### 3.1.5 Social Care Provision

The number of people (per 1,000 population) contacting Dudley MBC adult social care for services tends to be higher than most other authorities both regionally and nationally. This increase is, in part, due to the high numbers of local people with physical disability, frailty and sensory impairment. In the 2001 census, 35,000 (11.5%) people identified themselves as being a carers\(^5\). On a conservative estimate this is worth over £97,000,000 based on the current minimum wage to the local economy. Carers provide a key contribution in supporting people with long-term illness or disability and due to the predicted increase in the numbers of older people, their role will become even more crucial in the future. With regards to children and young people, 1,179 children and young people out of a total of 74,030 (1.6%) in households are also carers.

### 3.1.6 Social Activities

In Dudley, 16.7% of the adult population reported that they partook in sport during 2005/6, which compares to a national average of 21% and a regional average of 19.3% (Sport England Study). This showed that Dudley was the 16th worst local authority in England and 5th worst in the region for participation in sport and recreation, with only 16% of the population participating in regular activity.

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\(^5\) A carer is a relative or friend who looks after a person with a disability, a long-term illness, mental health difficulties or who is older and frail.
3.1.7 Technology in Health and Social Care

Expanding knowledge and technological advances in all areas of science are leading to improvements in health and social care. Particularly, electronic assistive technologies, such as telecare, provide much more scope for supporting people to live more independently at home.

In the short term it is anticipated that these will lead to increased cost, mainly because the new treatments are now available for previously untreatable conditions. Also, many of the new high cost treatments are not one-off interventions and patients may need to continue the treatment for years. It also takes time for many for the benefits of new treatments or technology, both in terms and health and financial savings, to be realised. The pace and nature of technological change will present us with new ethical dilemmas about what we will fund and underlines the need for fair, open and robust priority setting arrangements.

4. Commissioning Priorities from Existing Strategies

Dudley PCT and MBC already have a number of existing strategies covering various areas for example the Children and Young People’s Plan, the Obesity Strategy and the Older Peoples Strategy. We have reviewed these strategies in light of the current health and social care service and identified the top three priorities for investment, areas for redesign and/or for disinvestment for the immediate future (2008-2011). We also identified services or developments that should be considered for longer term investment. A new Primary Care Commissioning Strategy will be developed which will look at how the strategic intentions presented here can be realised through redesigning primary care services. The outcome of the reviews of the existing strategies is detailed in the Compendium.

4 Circulatory disease is a wide-encompassing category that includes all conditions that affect the heart and the blood vessels.
5. The Dudley Model of Care

Over the last 4 years, Dudley PCT, Dudley MBC and Dudley Group of Hospitals have radically re-shaped the way we deliver health and social care in Dudley. Russells Hall Hospital, our flagship hospital, is at the centre of the modernisation of health in Dudley. It has been matched with a far-reaching redesign of community services to ensure that more and more personalised care can be delivered outside of a hospital setting. Many of the services we provide have been expanded and an increasing number are provided in the comfort of people’s own homes and in places closer to their homes.

The Dudley Model of Care remains at the core of our assumptions around provision and fundamentally promotes the integration of services around the individual. The model focused mainly on the needs of complex patients and we now feel it is time to expand this with a greater focus on the prevention of ill health and promotion of well-being.

We also recognise that the way in which the model is applied will vary across our localities and that each practice based commissioning cluster/locality will need to adapt the way in which the model is delivered to meet the needs of their patients.

The model is based on a pyramid approach which aims to provide different levels of care and support for people with different levels of need as outlined below:
Our approach to staying healthy is shown diagrammatically below:

- Individual
  - Food and Nutrition Programmes
  - Physical Activity Programmes
- Family
  - Drug and Alcohol Team
  - Sex Health Services
- Carers
  - Primary Care Team
  - Stop Smoking Service
  - Maintain a safe environment
- Lifestyle Services
  - Develop a health promoting environment
  - Enable children and adults to have increased educational opportunities
- Services
  - Develop healthy workplaces
  - Equitable access to services
  - Increase employment opportunities
  - Improve the standard of housing
  - Empower communities and support community networks

Our approach for the care of complex patients is shown diagrammatically below:

- Carer Support
  - Emergency Out-Patient Team HOTLINE Senior Consultant-Led
  - Rapid Care Team
  - General Practice
  - Primary Healthcare Team
  - Primary Healthcare Team
  - Old Age Community Team
  - Intermediate Care Services
  - Specific Disease Management Teams eg Respiratory Diabetes
- PATIENT
  - Nurse Consultant
  - Pathways Team
  - AHP Team
  - Discharge Co-ordinator
  - Mental Health Team
  - Stroke Pathway Team
  - PATIENT Social Services Rapid Access 'Normal Service'
  - AHP Team
  - Pathways Team
  - Rapid Care Team
  - Discharge Co-ordinator
  - Nurse Consultant
  - Pathways Team
  - AHP Team
  - Social Services Rapid Access 'Normal Service'
  - Specific Disease Management Teams eg Respiratory Diabetes
6. Demand and Capacity Modelling

6.1 Healthcare

We know from our needs assessments that there will be an increase of 24% in
the over 65s and 52% of the over 85s by 2020 and this will increase the
need for services for people with long term conditions including the use of
hospital services. If we continue to do ‘more of the same’ it is highly likely that
this will create a huge cost pressure that will not able to be met from the
available budget.

The PCT has already developed a range of new and innovative ways to ensure that
patients can get the best possible care and treatment when they need it. Through
our model of care we aim to reduce the need for hospital care and provide care as
close to people’s homes. Working with social services, we want to ensure that
people remain independent for as long as possible and are cared for in the
community and, where appropriate, make sure that supported housing and
residential care is available. We also need to move away from a system where we
wait for people to become ill and then admit them to hospital. The PCT plans
to develop more services in the community that focus particularly on
prevention. We believe that this change will best meet the needs of local
people and will be more effective in the use of our resources.

To help us decide where these changes in services could be made we have
undertaken an exercise to look at what services will be needed in the
future. To do this we have looked at all in patient hospital activity and
estimated how much this currently costs the PCT. We then looked at the
population changes expected over the next 10 years and the cost of
providing services they would require if the care was still provided in hospital.

This work showed clearly that the conditions related to the musculoskeletal
system (these are mainly orthopaedic conditions), the digestive system (for example
stomach and colorectal cancers and inflammatory bowel diseases), cardiac surgery
and primary cardiac conditions (resulting from coronary heart disease, heart failure,
deep vein thrombosis and hypertension), the respiratory system (lung cancer,
pneumonia, asthma and bronchitis) and the urinary tract and male reproductive
system (for example prostate problems, kidney disease, vasectomy procedures)
are not only high volume now but are projected to increase as the aging
population increases. The impact of rising levels of obesity and alcohol related
disease yet analysed and added in to these projections. Conversely we also need
to consider that some sections of the over 65 years ‘older’ population are likely to
enjoy better health than previously. As the ‘baby boomers’ reach pensionable age,
their call on health and care services will be both different and proportionately less
than earlier generations. So this too will need to be factored into our assessment.

If we take no further action then the costs of hospital care relating to these
conditions will escalate and we will be unable to afford them. We are currently
working on modelling the impact of an increasing focus on preventative care
and healthy lifestyles to identify the possible impact of these interventions on
our health and well-being and therefore reduce this future cost.

We believe most surgical procedures will need to continue within a hospital
environment which is able to offer a high standard of care. Many of these
diseases could be delayed, controlled and in some cases prevented by
appropriate early intervention health care services. A halt in the predicted rise in
obesity and alcohol related conditions would lead to a reduction in some of this activity, particularly with respect to cardiovascular disease and diabetes.

### 6.2 Social Care

With respect to social services, Dudley MBC provides services that are paid for from a mixture of local Council Tax, central Government funding and some income from charges for example, care or leisure services which amounts to a budget of over £500m. Central Government funding is calculated according to a formula that takes account of a range of characteristics at the local level such as deprivation. The combination of these sources creates the capacity for the Council to provide services that contribute towards the health and well-being of Dudley people. Against the background of the changing demands on services that we outline below, including factors such as increased citizen expectation, we know that we need to focus on enabling people to remain independent for as long possible and ultimately be cared for in the community.

In addition to the demands on healthcare mentioned above, it is predicted that the relatively large and growing older population will result in a marked increase in the number of people suffering from dementia. For those over 85, the prevalence of dementia is expected to more than double from 12.2% to 24.8%. As the people affected are most likely to require social care, this will have considerable impact on how partners work together to promote the independence of people and create more personalised services.

### 7. Existing Service Provision

The PCT and MBC commission health and social care from a number of providers. These are summarised in Appendix 3.

### 8. Public and Staff Consultations

The outcomes of our needs assessment and the key issues for the future have been discussed with a wide range of people including staff in provider organisations, members of the public and colleagues from partner organisations.

Various forums, including three ‘Think Tanks’ were used to seek the views of the public and staff about what they want, need and expect from services. Essentially the data were derived using three interlinked approaches:

1. A series of three Think Tanks where members of the PCT, MBC and Dudley Group of Hospitals (clinicians and service providers), representatives from the Voluntary Care Sector and Carers Networks and the public engaged in workshops to debate the needs of the population and their strategic priorities for the development of future services. Discussion was based on the findings of our Joint Strategic Needs Assessment and 3 scenarios were used to consider the response required for the future.
2. A standard proforma was used to seek views from the Voluntary Sector, staff, carers and the public.
3. Opportunity for comments on the Listen@dudley.nhs.uk website

The methodology used to analyse the responses from the consultation process is available in the Compendium.
9. Commissioning for the Future

9.1 What have you told us?

We received many comments about how good local services were. There were many individual stories around successful episodes of care and excellent working relationships with local clinicians. We do however want to always strive to be better and we really appreciate all of the comments and suggestions on how we could improve further.

Five key themes related to future improvements have come out of the consultation process. These are:

- The need for us to improve communication and information.
- The need for services to work better together.
- The need for faster and easier access to services.
- The need for some specific improvements to specific services.
- The need for greater health promotion and awareness raising.

9.1.1 Communication and Information

This was the top theme overall and refers to the availability of information and how it is provided to help people influence change and make choices. You have told us that sometimes you are confused about which service you should use and that you have heard a lot about changes but do not know why they are being made and how the changes affect you. You have also told us that sometimes you still feel that you are being treated like a number rather than a person.

“Information needs to be available about what should be expected with certain conditions - in plain English.”

“I would like to be able to seek support and advice when I need it and be aware of my health issues before my condition deteriorates.”
As a consequence of your comments we have included methods to improve communication and information in our prioritisation tool so that any future service developments will take these into account. We will also be developing a Joint Communication and Engagement Strategy and reaffirm our commitment to involve people in decisions that are made about them.

Commissioning Intention One
All future plans for commissioning of services will demonstrate how communication and information for people is improved to help people make choices.

9.2 Personalised Care

Lord Darzi in his Interim Report on the review of the NHS\(^6\) has the following vision:

“A personalised NHS must be tailored to the needs and wants of each individual, especially the most vulnerable and those in greatest need, providing access to service at the time and place of choice”.

This vision mirrors what you have told us already. There were five broad overlapping factors that you told us matters to support personalised care:

- Access to care.
- Choice.
- Service working better together.
- Your personal Involvement.
- Focused on your needs.

Specifically people have told us:

“Simplify administration and reduce bureaucracy. NHS is too complex from the patient’s perspective - call one number: get a quick answer: get transferred quickly to the right team.”

“People live their lives at a faster pace now-a-days. Allow people to book appointments at times convenient to them, rather than having the time dictated by the service provider.”

\(^6\) ‘Our NHS, Our Future’. Department of Health, October 2007
The care people received in hospital settings was seen to be of high quality, although the notion of being treated by consultants as a number rather than a person was highlighted as an area for improvement. Also people felt that their condition or treatment was not always explained to them in a simple way if indeed at all.

Specifically people have told us:

“Please change attitudes regarding explaining my needs and care so that I am involved and understand what is happening to me.”

“How do we ensure that clinicians really listen and are obliged to take notice of different voices?”

Service integration / services working better together was a dominant theme throughout, particularly between health and social care. Communication between health care professionals and sharing of information was highlighted as a specific area for improvement. People said that at times they were confused and frustrated as they came into contact with numerous different staff along their ‘care pathway’. They felt that they had to repeat their story many times and that they got conflicting advice from different people at different times.

Specifically people have told us:

“We would like to see schools, community centres, leisure centres used to provide services including GP’s surgeries.”

“Please improve co-ordination - reduce fragmentation - improve communication - duplication of services exists within and across boundaries.”

We have included service integration in our prioritisation tool so that any future service developments will take these into account. The PCT, MBC and the Dudley Group of Hospitals have already agreed that joint clinical work streams will be agreed and developed to redesign the pathways with a seamless integrated care pathway approach.

Designing and commissioning services via care pathways is the best way to ensure that the quality of care and the patient’s perspective are at the centre of care and that organisational boundaries do not impinge on service improvement.
Specifically people have told us:

“Services need to be more individual and person-centred.”

“Services to be developed with people not for people.”

Commissioning Intention Two
All future plans for commissioning of services must demonstrate that the service is patient centred and patient led and is tailored to the individual’s needs.

Commissioning Intention Three
All future plans for commissioning of services must demonstrate how services work together to improve the patient’s journey through the system.

9.3 Prevention is better than cure

Throughout the consultation process there was an increasing desire for greater support and advice to help people stay healthy and prevent ill health.

“Encourage personal responsibility for our own health.”

“Treat the cause and not the symptom. National Health Service is not a National Sickness Service.”

“Do more screening in the workplace.”

“More money for proactive preventative services so that people are helped to do and not be done to.”

We need to change services so that they engage people sooner and help them to understand their risk factors. We need to support people to take better control of their own health and the lifestyle factors that affect it, particularly smoking, diet, alcohol consumption and exercise. We need to do this before people become ill through a comprehensive primary prevention programme. We also need to target people who already have a long term condition as our needs assessment has demonstrated that we are under diagnosing the majority of chronic disease.
A report from the University of Birmingham\(^7\) suggests that less than 50% of patients eligible for treatment for cardiovascular disease, diabetes, dementia and chronic obstructive pulmonary disease were receiving the best appropriate treatment for their condition and we want to address this locally. People, both in their middle years and later life, were very clear that they would like access to health checks. We need to look innovatively how these can be conveniently provided and be easily accessible for older people.

Specifically people told us:

"Provide outreach health promotion and screening services in a variety of settings, particularly in the workplace."

"Provide cost-effective screening at all ages, taking advantage of new technologies and looking at incentives to ensure people get screened."

We need to continue our focus on prevention. We also need to be able to respond to new vaccines and new approaches to screening. This may have an affect on how these services are commissioned and who provides them.

**Commissioning Intention Four**

All future plans for commissioning of services must demonstrate how they promote people’s health and well-being, prevent ill health and help people stay independent for as long as possible.

**Commissioning Intention Five**

All future plans for commissioning of services must demonstrate how they promote equality and diversity and reduce inequalities.

9.4 **Supporting Factors**

Throughout the engagement programme people made reference to the wider, aspects of health and social care provision that would support people in their social environment. Specifically people wanted help to support family education, and make them feel safe with additional community policing. Factors supporting independence and help to support people to stay in their own home were key concerns. Broader interaction of services and support, including social and community networks and carer’s network were common themes cutting across all service provision.

Specifically people have told us:

"Neighbourhood watch and community spirit should be re-invented. People should take more responsibility for their neighbour."

"Put in place opportunities for Social Networking for people in isolation or living alone."

\(^7\) Harrison et al., The Effectiveness of healthcare systems in the UK. Department of Public Health and Epidemiology and HMSC University of Birmingham, July 2006.
Specifically people have told us:

There were numerous suggestions to how people could work differently within current services and how different roles could be developed. Developing family support mechanisms to improve understanding and tolerance using people who were good role models were also important themes.

Specifically people have told us:

The need for additional support for carers in all aspects of service provision was dominant theme throughout all discussions.

Specifically people have asked us to:

As mentioned previously, there was an increasing desire for greater support and advice to help people stay healthy and prevent ill health. A major contribution to achieving this goal is to improve the access to leisure facilities. This objective is outside this Strategy but increasing the number of adults participating in sport and physical activity is a key performance indicator in the Local Area Agreement for 2008-11 and inherently linked to the reducing obesity agenda.

Finally the public expressed their concern about what support needs to be available to help them to plan for the future. Reference was made particularly around how to manage their finances on retirement or when made redundant and more advice on how to access and understand what benefits people are entitled to.

Specifically people have told us:

Collectively, these supporting factors are often referred to as the wider determinants of health and well-being and addressing them will help to improve the quality of life for all.
Commissioning Intention Six

All future plans for commissioning of services must demonstrate how they contribute to improving the quality of life and help to build a sustainable community.

9.5 Commissioning process and prioritisation

Many service providers involved in our engagement programme, especially the Voluntary Sector, asked us what our commissioning process was and how could their voice be heard, how they could influence decisions and most importantly, for them, how they could access funding. We have made a commitment in our Commissioning Framework to involve a wide range of service providers, including voluntary sector organisations, in house, secondary care and the independent sector in developing innovative solutions to meet our strategic objectives. We recognise that the historical approach of offering short term one year contracts in particular to the voluntary sector has not been helpful and has prevented voluntary sector providers from effectively recruiting and retaining the best workforce and planning for the future. We wish to confirm our commitment to address this.

Specifically people told us:

“Remove barriers through commissioning systems - contracts, finding, monitoring and evaluation. Make commissioning process with voluntary organisations more effective/meaningful and valued.”

Commissioning Intention Seven

We will develop a transparent and innovative commissioning process that actively involves all our potential providers.

10 What we will do

In line with the ‘Darzi Review’ and the West Midlands document ‘Investing for Health’ we have outlined the key issues across the following areas of care. We will be identifying how these services provide personalised care, address health inequalities and clearly demonstrated how the service is integrated across the care pathway and between organisations.

- Staying healthy.
- Children and young people’s health.
- Mental health.
- Learning disabilities.
- Older people.
- Long-term conditions.
- Planned care.
- Acute care.
- End-of-life care.

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These areas will be considered in the overall context of the Dudley Model of Care.

All future plans for commissioning of services will be checked to ensure that they are compliant with the Seven Commissioning Intentions and will be delivered through our governance arrangements that support our partnership working, including how particular programmes are strategically commissioned and delivered through the relevant strategies.

11. Commissioning Priorities

We have identified the following commissioning priorities for the next five years.

11.1 General Issues

- We will commission services where possible which reduce health inequalities.
- We will support the delivery of National Service Frameworks.
- We will increase the quality indicators in all of our commissioned contracts increasing our focus on dignity, privacy and respect.
- We will ensure individuals waiting time for treatment and care is kept to a minimum and will strive for improvements where appropriate.
- We will shift the focus where possible to ‘upstream’ preventative interventions which prevent or reduce the incidence of ill health.
- We will target our efforts on specific communities and hard to reach groups where this will lead to a reduction in inequalities.
- We recognise the importance of listening to local people and staff and wish to have ongoing dialogue about the areas contained in this strategy.
- We will encourage all local providers to consider tendering for services in the future. We will welcome applications from the statutory, voluntary and independent sectors as we recognise the importance of the role each sector has and the strengths they can bring.
- We will expect all providers of care to give wider consideration to an individual's mental well being when the person is accessing all aspects of health and social care.
- We will disinvest if an intervention is clinically ineffective and poor value for money.
- Our priorities will be underpinned by an Estates Strategy which enables us to have modern buildings which are fit for purpose, a Workforce Strategy which recognises the workforce changes to deliver this agenda and Information Technology systems to support the deliver of services.
11.2 Staying Healthy

- We will expand and increase the commissioning of evidence-based services to improve physical and mental health and well being, including:
  - Nutrition
  - Smoking
  - Reduction in alcohol intake
  - Physical activity
  - Accident prevention
  - Sexual health
  - Sun awareness
  - Mental well-being

- We will particularly focus our energy on the reduction of obesity and alcohol consumption as we know these are 2 of our biggest risks.
- We will work with partner organisations to improve the safety of our environment.
- We will encourage developments which increase the skill levels of local people and encourage people back to work.
- We will work with local employers to promote the health and wellbeing of their workforce.
- We will lead by example as a PCT in being a good employer.
- We will target our efforts on specific communities where this will lead to a reduction in inequalities.
- We will invest in a health trainer service to support lifestyle intervention programmes particularly in disadvantaged areas.
- We wish to develop community based integrated sexual health services (including Genito-Urinary Medicine).

11.3 Children and young people’s health

As outlined in the Children’s and Young People’s Plan:

- We recognise that a child’s longer term health can be influenced by factors before they are born so will ensure effective antenatal care and maximise opportunities to support women who are pregnant or planning a pregnancy to make healthy choices.
- We will promote choice in childbirth.
- We will focus on initiatives which increase breast feeding rates and support mothers to maintain breastfeeding.
- We will provide a range of interventions that offer children the best possible start in life - this will include dietary advice, access to education provision and the promotion of a safe environment.
- We will work together with partners to raise the aspirations of children and young people.
- We will offer our services and support in a more flexible way to meet the needs of young people - Including greater use of technology.
- We will aim for greater integration of services for children with disabilities.
- We will focus on preventative health for young people particularly to reduce the incidence of drug and alcohol misuse.
• We will particularly focus on improving the range of services offered to support children and young people with autism and Asperger’s syndrome.
• We will strive to improve the arrangements for a smooth transition for children and young people with special needs into adult services.
• We will focus intensive targeted support for vulnerable families.

11.4 Support for people with Mental Health needs

• We will support improved access to early intervention in primary care including access to psychological therapies.
• We will work with providers to identify local alternatives which enable people with complex mental health needs currently being cared for a long way for home to return closer to their home and family and friends.
• We will develop a strategy for older people’s mental health to include improved support for people with dementia and their carers.
• We will assess the contribution and opportunity to use direct payments to enable people to have more control and choice over their care.
• We will challenge stigma and discrimination towards people with mental health needs and promote inclusion and independence.

11.5 Support for people with Learning Disabilities

• We will commission services which give people greatest control and influence over their own lives and promote independence as far as possible.
• We will focus on strengthening services to ensure that people with learning difficulties have equal access to preventative health care and screening and are treated with respect and dignity in an acute setting.
• We will support pilots for individualised budgets to enable people to tailor their care to meet their needs and fit in with their lives.
• We will particularly focus on improving the range of services offered to support children and young people with autism and Asperger’s syndrome.

11.6 Support for Older People

• We recognise that many older people are living with a long term condition and that a great number of them are also carers. We wish to target support at these groups whilst also maintaining independence of the wider group of older people.
• We wish to develop a range of initiatives to promote the health and well-being of older people in the borough.
• We will consider services which support older people to live at home and consider provision of schemes which promote independence such as Extra Care schemes and sheltered housing.
• We recognise the importance of reducing the waiting times for major adaptations in owner occupied housing.
• We will work with partners to promote opportunities such as community learning with the aim of reducing isolation and loneliness.
• We will develop a strategy for older people's mental health to include improved support for people with dementia and their carers.
• We will support specific initiatives which reduce the chance of older people experiencing falls.

11.7 Support for people with Long Term Conditions and Physical and Sensory Disability

• We will support an increase in Expert Patient Programmes but will also specifically consider tailored support programmes for carers which may include specifics of different conditions for example caring for someone with dementia.
• We will seek to invest more in assistive technology to enable more people to live independently and manage their own care where possible and desirable.
• We will work with primary care to identify specific areas where care can be provided closer to home in a primary care setting. This will include access to services out of hours were applicable for people who are working who have a Long Term Condition.
• We wish to increase and enhance support for carers as we recognise their crucial role.
• We will review our community based intermediate care provision to ensure effective and proactive rehabilitation is in place both in residential and community settings.
• We will develop a clear strategy for services for people with neurological conditions.
• We will consider alternative and innovative models of provision to enable and promote independence such as direct payments, telephone and e-mail consultations.

11.8 Planned care

We will work with colleagues in Dudley Group of Hospitals to re-design clinical pathways for conditions where we know from our projections that there is going to be significant increased demand in future. Specifically we will be looking to new service delivery models and improved patient pathways for conditions related to the:

• Musculoskeletal system (these are mainly orthopaedic conditions).
• Digestive system.
• Cardiology.
• Respiratory system.
• Urinary tract and male reproductive organs.
• Paediatrics.
• Ophthalmology.

This work will focus on ensuring that specialist activity is maintained in the acute sector whilst looking to move more interventions from the beginning of the pathway into primary care where appropriate.
We will achieve the 18 week RTT (Referral to Treatment Target) by December 2008. This will require significant time investment in service and pathway re-design.

We will work with Dudley Group of Hospitals colleagues to consider increasing models of pre-operative assessment in community settings.

We are interested in commissioning services which are flexible and where possible closer to the patient’s home. This may involve integrated services and outreach where hospital clinicians provide some elements of care in primary care settings.

We will continue to focus on reductions in length of stay and excess bed days ensuring people stay in hospital for the appropriate length of time and that discharge is facilitated as soon as people are medically fit and safe for discharge. We will aim to be in the top quartile for 50% of surgical procedures outlined in national productivity measures by 2009.

We will work together to review care pathways and will specifically review outpatient attendances as part of this pathway work.

We will continue to embrace the choice agenda offering local people a range of options / facilities from which to access care.

We will work to increase the percentage of cases for specific conditions completed as day cases where clinically appropriate.

We will agree a formal process for the introduction of new technologies.

We will seek to unbundled the tariff where appropriate but beginning with diagnostics to enable care to be provided in the most appropriate place.

We will work together as a health economy to reduce the incidence of Healthcare Acquired Infection.

We will seek support from the managed clinical networks to ensure effective and appropriate value for money in programme areas e.g. Cancer in line with the NHS Cancer Strategy.

11.9 Urgent care

We will promote ways to access urgent care services to the general public on an ongoing basis.

We will review the value of an increase in primary care based triage/urgent care services as an alternative to Accident and Emergency for minor injuries/illnesses.

We will work as a Health and Social Care economy to ensure appropriate options are in place to respond to people’s urgent care needs.

We will support the development of new roles - e.g. advanced practitioners and emergency care practitioners which support people to be cared for and treated close to home where appropriate.

We will specifically prioritise the findings of our review into the stroke pathway and any action that may be required.

We will identify clinically safe ways to avoid or reduce emergency admissions, including pathway redesign with the Ambulance Service.
11.10 End of Life Care

- We will seek to invest in community provision to enable intensive care at home so that people who choose to die at home can be supported to do so and we will expect a subsequent reduction of the number of people dying in hospital.
- We will encourage implementation of the Gold Standard Framework in all general practices across the borough to increase the experience of people with palliative care needs.
- We will give specific consideration to the availability of suitable palliative care support which meet the needs of people with mental health needs and specifically dementia.

12. Summary of Commissioning Intent

In response to the issues that are important to you we have identified **Seven Commissioning Intentions** through which we will commission services in the future. We have outlined our commissioning priorities across a range of service areas and checked them against our existing strategies to ensure consistency in approach. We have outlined our partnership and governance arrangements through which we will commission future services. We have also reaffirmed our commitment to involve you in our decision making process.

This Dudley Commissioning Strategy draws together and complements all existing Strategies and we propose that we can take this forward by working together, across, between and within all organisational boundaries to meet the our joint Health and Social Care mission statement.

**By 2010 we will improve health and well-being and reduce health inequalities through working together.**
## Appendix 1 Prioritisation Tool

<table>
<thead>
<tr>
<th>Factor</th>
<th>Very Low</th>
<th>Low</th>
<th>Mid scale</th>
<th>High</th>
<th>Top 5</th>
<th>Scale x ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strength of Evidence</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>How strong is the evidence available for this service in terms of demonstrating a better clinical outcome.</td>
<td>No evidence of benefit</td>
<td>There is a limited amount of emerging evidence / small scale or observational study</td>
<td>There is some evidence that the intervention works from at least one controlled study</td>
<td>There is evidence of effectiveness from at least one randomised control trial</td>
<td>There is strong evidence of effectiveness from meta-analysis or randomised control trials</td>
<td></td>
</tr>
<tr>
<td><strong>Magnitude of clinical benefit</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>What is the scale of the benefit in terms of Quality of Life improvements, cure, etc</td>
<td>Negligible improvement in health or life expectancy</td>
<td>A small improvement in health or life expectancy</td>
<td>Moderate improvements in health or life expectancy</td>
<td>Significant improvements in health or life expectancy</td>
<td>Large and proven improvements in health or life expectancy</td>
<td></td>
</tr>
<tr>
<td><strong>Number of people benefiting</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>How many people is this likely to benefit / how many people are affected.</td>
<td>One person in the borough would benefit</td>
<td>2-99 people would benefit</td>
<td>100-999 people would benefit</td>
<td>1000 – 4999 people could benefit</td>
<td>Over 5000 people could benefit</td>
<td></td>
</tr>
<tr>
<td><strong>Total cost</strong> of the development (If available to all those eligible)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>The cost is more £1,000,000</td>
<td>The cost is between £1,000,000 &amp; £500,000</td>
<td>The cost is between £500,000 – £250,000</td>
<td>The cost is between £250,000 – £50,000</td>
<td>The cost is less than £50,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient acceptability</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>There is demonstrable evidence that patients are likely to find it highly unacceptable</td>
<td>There is evidence that patients would find it somewhat unacceptable</td>
<td>There is evidence that patients would have no preference on acceptability</td>
<td>There is demonstrable evidence patients would find it acceptable</td>
<td>There is demonstrable evidence that patients would find it highly acceptable and desirable</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>National requirement or NHS target</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>as defined in the current years operating Framework and Healthcare Commission Indicators</td>
<td>Not a national requirement or NHS target</td>
<td>Addresses one target or national requirement</td>
<td>Addresses two targets or national requirements</td>
<td>Addresses three targets or national requirements</td>
<td>Addresses four or more targets or national requirements</td>
<td></td>
</tr>
<tr>
<td><strong>Health Inequalities</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Addressing health inequality or health inequity – ie where patients have not had service in the past or have had unequal access</td>
<td>Does not address an inequality or inequity</td>
<td>Partially addresses an inequality for a very small number of people</td>
<td>Partially addresses an inequality or inequity</td>
<td>Has the potential to make a significant impact on inequalities</td>
<td>Completely addresses an inequality or inequity for a specific group</td>
<td></td>
</tr>
<tr>
<td><strong>Wider benefits to Society</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>E.g. Provides local jobs for local people / contributes to raising the skill levels of local people</td>
<td>No wider benefits to society</td>
<td>Some benefit to society</td>
<td>Moderate benefit to society</td>
<td>Large benefit to society</td>
<td>Major benefit to society</td>
<td></td>
</tr>
</tbody>
</table>
# Appendix 1 Prioritisation Tool

<table>
<thead>
<tr>
<th>Factor</th>
<th>Very Low</th>
<th>Low</th>
<th>Mid scale</th>
<th>High</th>
<th>Top 5</th>
<th>Score</th>
</tr>
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<tbody>
<tr>
<td><strong>Only treatment or alternative</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are many other treatment options with good outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are alternatives with better outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are other alternatives with equivalent outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are limited alternatives with poorer outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no alternative treatment options</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Local Indicators agreed though consultation with local people and clinicians</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identified as a key local priority as published in the JSNA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This proposal/area is not identified as a local priority in the JSNA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This is identified but not as a key local priority</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This covers areas addressing one high priority area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This delivers on more than one high priority area</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Promotes greater service integration / seamless care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This does not improve service integration or provide more seamless care for patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This makes a small contribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This makes a moderate contribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This makes a significant contribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This radically re-designs care pathways to make a substantial impact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Improves Communication</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between services, professionals and with patients/public</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This proposal makes no effort to improve communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This proposal makes a small contribution</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This proposal makes a moderate improvement</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>This proposal makes a significant contribution</td>
<td></td>
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</tr>
<tr>
<td>This proposal makes a substantial and sustained improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Improves access for local people through reduced waiting times or care closer to home</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This proposal demonstrates no improvement to access</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small improvement demonstrated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate improvement potential demonstrated</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Significant improvement demonstrated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substantial improvement demonstrated</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Provides patient centred and patient led care demonstrating patient involvement and demonstrable improvements in care focused around the patient.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No potential improvement on care being centred around the patient demonstrated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some small potential improvements demonstrated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate potential improvements demonstrated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant potential improvement demonstrated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substantial potential improvements demonstrated with wider applications</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Promotes wider health and well-being and enables people to remain independent and feel safe</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appears to make no contribution to wider health and well being improvements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the potential to make some small improvements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the potential to make moderate improvements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the potential to make significant improvements</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the potential to make substantial improvements</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**TOTAL SCORE**

A score (1-5) for each Factor is given based on the evidence submitted and multiplied by the Weighted Ranking Value to give the Total Score.
Appendix 2 Summary of Clusters

BEACON & CASTLE CLUSTER

<table>
<thead>
<tr>
<th>PRACTICE &amp; GPs</th>
<th>PRACTICE LIST SIZE (1ST April 2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coseley Health and Family Centre: Dr I S Arsiwala</td>
<td>1824</td>
</tr>
<tr>
<td>Woodsetton Medical Centre: Drs S F Al-Rabban &amp; J Randall</td>
<td>6171</td>
</tr>
<tr>
<td>Coseley Medical Centre: Dr S Paramanathan &amp; Partners</td>
<td>5704</td>
</tr>
<tr>
<td>Lower Gornal Health Centre: Dr R W Gee &amp; Partners</td>
<td>8140</td>
</tr>
<tr>
<td>The Ridgeway Surgery: Dr S Irani &amp; Partners</td>
<td>8848</td>
</tr>
<tr>
<td>Masefield Road Surgery: Dr S K Jain</td>
<td>1308</td>
</tr>
<tr>
<td>Northway Surgery: Drs W T Hampson &amp; S J Pritchard</td>
<td>5358</td>
</tr>
<tr>
<td>Bath Street: Dr P K Sarkar</td>
<td>2948</td>
</tr>
<tr>
<td>Bilston Street Surgery: Dr N Shather</td>
<td>3024</td>
</tr>
<tr>
<td>St Thomas's Medical Practice: Dr S Basu</td>
<td>1296</td>
</tr>
<tr>
<td>Eve Hill Medical Practice: Dr A J Blackman &amp; Partners</td>
<td>7435</td>
</tr>
<tr>
<td>The Greens Medical Centre: Dr M H Smith &amp; Partners</td>
<td>8019</td>
</tr>
<tr>
<td>Central Clinic: Drs P B V Brettell &amp; P T T Brettell</td>
<td>3641</td>
</tr>
<tr>
<td>Keelinge House Surgery: Dr S T Cartwright &amp; Partners</td>
<td>5732</td>
</tr>
<tr>
<td>Netherton Health Centre: Dr D M Conlon &amp; Partners</td>
<td>7153</td>
</tr>
<tr>
<td>The Surgery: Dr S Das Gupta</td>
<td>2539</td>
</tr>
<tr>
<td>Grange Road Surgery: Drs N White &amp; B K Jalota</td>
<td>5317</td>
</tr>
<tr>
<td>Netherton Surgery: Drs P D Gupta &amp; E Abraham</td>
<td>2397</td>
</tr>
<tr>
<td>Quarry Road: Drs P R Ingle &amp; U P Ingle</td>
<td>2682</td>
</tr>
</tbody>
</table>
## CLUSTER ONE

### BEACON & CASTLE CLUSTER

<table>
<thead>
<tr>
<th>PRACTICE &amp; GPs</th>
<th>PRACTICE LIST SIZE (1st April 2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tinchbourne Street: Drs J Pall &amp; D Pall</td>
<td>1786</td>
</tr>
<tr>
<td>Grange Road Surgery: Dr W A B Porter</td>
<td>2137</td>
</tr>
<tr>
<td>Castle Meadows Surgery: Dr J S Rathore</td>
<td>3661</td>
</tr>
<tr>
<td>Cross Street Health Centre: Dr D G Parry &amp; Partners</td>
<td>4702</td>
</tr>
<tr>
<td>Stepping Stones Medical Practice: Dr N C C Welch &amp; Partners</td>
<td>6913</td>
</tr>
</tbody>
</table>

### CLUSTER ONE

<table>
<thead>
<tr>
<th>PRACTICE &amp; GPs</th>
<th>PRACTICE LIST SIZE (1st April 2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norton Medical Practice: Dr D J S Powell &amp; Partners</td>
<td>6034</td>
</tr>
<tr>
<td>Brierley Hill Health Centre: Dr M K M Sumaria &amp; Partners</td>
<td>6739</td>
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<tr>
<td>Wordsley Green Health Centre: Dr R Oliver &amp; Partners</td>
<td>10883</td>
</tr>
<tr>
<td>Quarry Bank Medical Centre: Drs M R Karim &amp; H Karim</td>
<td>4017</td>
</tr>
<tr>
<td>Brierley Hill Health Centre: Drs (Mrs) P K Sahni &amp; H S Sahni</td>
<td>2509</td>
</tr>
<tr>
<td>Greenfield Avenue: Drs I M Dingwall &amp; A Malhotra</td>
<td>3030</td>
</tr>
<tr>
<td>Rangeways Surgery: Dr J A Bloor &amp; Partners</td>
<td>4599</td>
</tr>
<tr>
<td>Quincy Rise Surgery: Dr S K Merota</td>
<td>3229</td>
</tr>
<tr>
<td>Chapel Street: Dr B K Prashara</td>
<td>1926</td>
</tr>
<tr>
<td>Thorns Road: Drs R M Shah &amp; S Balu</td>
<td>4036</td>
</tr>
<tr>
<td>Summerhill: Dr N Plant &amp; Partners</td>
<td>6805</td>
</tr>
<tr>
<td>Meriden Avenue: Dr J Firth</td>
<td>2418</td>
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</table>
### Halesowen

<table>
<thead>
<tr>
<th>PRACTICE &amp; GPs</th>
<th>PRACTICE LIST SIZE (1ST April 2008)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meadowbrook: Dr M J Cooke &amp; Partners</td>
<td>7745</td>
</tr>
<tr>
<td>Lapal Medical Practice: Dr R A Lewis &amp; Partners</td>
<td>6324</td>
</tr>
<tr>
<td>Feldon Lane Surgery: Dr C S Bamford &amp; Partners</td>
<td>8129</td>
</tr>
<tr>
<td>Halesowen Central Medical Centre: Drs R A Johnson &amp; J K Modi</td>
<td>5125</td>
</tr>
<tr>
<td>Clement Road: Drs T Vamadevan &amp; K F K Chan</td>
<td>3067</td>
</tr>
<tr>
<td>St Margarets Well Surgery: Dr J H Darby &amp; Partners</td>
<td>8574</td>
</tr>
<tr>
<td>Coombs Road: Dr H N Akufo-Tetteh</td>
<td>2422</td>
</tr>
<tr>
<td>Alexandra Medical Centre: Drs N A Shameem &amp; M Shameem</td>
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</tr>
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</table>

### SLK Cluster

<table>
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<tbody>
<tr>
<td>Moss Grove: Dr S J Parnell &amp; Partners</td>
<td>12750</td>
</tr>
<tr>
<td>Kingswinford Medical Centre: Dr A B Skilbeck &amp; Partners</td>
<td>9264</td>
</tr>
<tr>
<td>The Limes Surgery: Dr M Price &amp; Partners</td>
<td>8502</td>
</tr>
<tr>
<td>Pedmore Road Surgery: Dr W P Killin &amp; Partners</td>
<td>3857</td>
</tr>
<tr>
<td>Crestfield: Dr V K Mittal</td>
<td>1731</td>
</tr>
<tr>
<td>Albion House (including Withymoor): Dr M A Bundred &amp; Partners</td>
<td>16907</td>
</tr>
<tr>
<td>(Withymoor): Dr C Fernandes &amp; Partners</td>
<td></td>
</tr>
<tr>
<td>Wychbury Medical Group: Dr C H Yarwood-Smith &amp; Partners</td>
<td>20973</td>
</tr>
<tr>
<td>Cradley Road: Dr M R Wiesand &amp; Partners</td>
<td></td>
</tr>
<tr>
<td>Three Villages: Dr J S Issitt &amp; Partners</td>
<td>8660</td>
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</tbody>
</table>

### Worcester Street Cluster

<table>
<thead>
<tr>
<th>PRACTICE &amp; GPs</th>
<th>PRACTICE LIST SIZE (1ST April 2008)</th>
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<tbody>
<tr>
<td>Worcester Street Surgery: Dr A J Watt &amp; Partners</td>
<td>20959</td>
</tr>
</tbody>
</table>
Appendix 3

Services currently commissioned

Primary Care Services - who operate as Independent Contractors

- 55 general GP practices, 40 dental surgeries, 40 ophthalmic premises, 60 pharmacy premises.

Community Services - Provided by the PCT

- This includes 24 hour district nursing, health visiting, learning disability services, podiatry, audiology, school nurses, continence, speech and language therapy, occupational therapy, community dental services.

Mental Health Services

- Provided by the PCT in house provider services, voluntary organisations and specialist mental health providers.

Secondary Care Services

- Provided by a range of acute providers including Dudley Group of Hospitals, Royal Wolverhampton Hospital, Birmingham Children’s Hospital and University Hospital Birmingham NHS Foundation Trust.

Tertiary Care Services

- These are specialist services that are provided on a regional basis by a range of acute providers and specialist centres. Some of these services are commissioned by a Collaborative Board with representatives from all PCTs in the West Midlands. Examples include neonatal intensive care, blood and marrow transplantation and specialist rehabilitation for accidental brain injury. In addition, services are also commissioned collaboratively by Dudley, Wolverhampton and Walsall PCTs for the whole of the Black Country population. Examples include cardiac surgery, specialised children’s services e.g. cleft lip and palate and renal dialysis.

Dudley Metropolitan Council

The way in which the Council commissions and provides services that promote the health and well-being of Dudley people is distinctive in its coverage and influences its contribution to this Commissioning Strategy.

We provide our services through community-based services across the five districts of the Borough. The total number of people receiving social care services (including Housing with Care) in 2006 was over 11,500, with over 10,000 people helped to live at home through a community based service.
either through in house provision or purchased from the private or independent sectors. Our care services include:

- Community social work teams for older people and adults with physical disabilities or sensory impairments, hospital based social work teams, multi-agency teams working in the integrated mental health service and multi-agency teams working with adults with learning disabilities.
- Care Homes and sheltered housing schemes.
- Domiciliary care services.
- Re-enablement services (both at home and in residential settings).
- Services for carers.
- Occupational therapy services.
- Falls service.
- Day opportunities for older people and disabled people.
- Emergency services such as the social care Emergency Duty Team or the Emergency Home-Call Service for vulnerable people who need assistance in an emergency.
- Library housebound services for those who cannot access the services provided in library buildings.

The Council provides social work and wider care services for children and young people through community based teams and other support services to children who are in need or looked after by the Council. The education of children and young people also contributes to their ability to maintain and enhance their health and well-being.

The Council also promotes the well-being of Dudley people through the work of its environmental health services in ensuring the health and safety of our environment.

**Third Sector**

- The PCT and the MBC have a range of contracts with charitable and voluntary sector organisations.
- The PCT has a contract with the independent private provider Care UK for direct access to a range of diagnostic services.