URGENT EXTRAORDINARY MEETING

AGENDA

MAIDSTONE AND TUNBRIDGE WELLS JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE MEETING

Date: Thursday 17 June 2010
Time: 2.30 pm
Venue: Town Hall, High Street, Maidstone

Membership:

Councillors: Atwood, Crowhurst Cunningham, Elliot, Marchant, D Mortimer, Paterson and Mrs Stockell

Reason for Urgency This meeting has been called as an urgent meeting because of the deadline for consultation for Item 7

Page No.

1. Apologies.

2. Notification of Visiting Members.

Continued Over/:

Issued on 11 June 2010

The reports included in Part I of this agenda can be made available in **alternative formats**. For further information about this service, or to arrange for special facilities to be provided at the meeting, **please contact Les Smith on 01622 602524 or Kat Hicks on 01892 554085**.To find out more about the work of the Overview and Scrutiny Committees, please visit www.maidstone.gov.uk/osc or www.tunbridgewells.gov.uk

Alison Broom

Alison Broom, Chief Executive, Maidstone Borough Council, Maidstone House, King Street, Maidstone, Kent ME15 6JQ

3. Notification of Substitute Members.

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4. a) Election of Chairman
b) Election of Vice-Chairman

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5. Disclosure by Members and Officers:

a) Disclosures of interest.
b) Disclosures of lobbying.
c) Disclosures of whipping.

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6. To Consider whether any item should be taken in private because of the possible disclosure of exempt information.

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7. Maidstone and Tunbridge Wells NHS Trust: Quality Report 2009/10 **1 - 34**

Interview with:

- Glenn Douglas, Chief Executive;
- Claire Roberts, Head of Quality; and
- Darren Yates, Head of Communications

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8. Department of Health Consultation on registering with a GP practice of your choice **35 - 88**

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9. Joint Working Protocol **89 - 96**

The protocol for Joint Committees as agreed by the Scrutiny Chairmen at Tunbridge Wells and Maidstone in 2007 is attached for noting. The Kent protocols for National Health Service Overview and Scrutiny are also attached for information.

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10. Future Work Plan **97 - 98**

MAIDSTONE AND TUNBRIDGE WELLS JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

17 JUNE 2010

REPORT OF HEAD OF CHANGE AND SCRUTINY

Report prepared by Les Smith & Kat Hicks

1. MAIDSTONE & TUNBRIDGE WELLS NHS TRUST DRAFT QUALITY ACCOUNT

1.1 Issue for Consideration

1.1.1 To consider the draft Quality Account and prepare a response to be submitted to the NHS by 25 June 2010.

1.2 Recommendation of Head of Change and Scrutiny

1.2.1 That Members:

- Interview representatives from the NHS Trust about the Quality Account to establish;
  - Progress on targets in 2009-10
  - The problems faced by the Trust in trying to meet those targets
  - Why the measures to be adopted in 2010-11 to improve those targets were chosen
- Consider the response they wish to make to the NHS Trust in response to the draft Quality Account.

1.3 Reasons for Recommendation

1.3.1 The Local Government Act 2000 and the Health and Social Care Act 2001 set out statutory functions for local authorities to review and scrutinise matters relating to the planning, provision and operation of health services in the area of its local authority

1.3.2 The Quality Account sets out the NHS Trust's performance over 2009-10 in various areas of patient safety and the patient experience, including:

- Rates of avoidable Hospital acquired infections
- Patient slips, trips and falls;
- Caring for stroke patients;
- Improving the patient's experience of their stay in Hospital; and
- Improving communication and access to information.

1.3.3 The following representatives from Maidstone and Tunbridge Wells NHS Trust will be in attendance to answer Members questions about the draft Quality Account:

- Glenn Douglas, Chief Executive;
- Claire Roberts, Head of Quality; and
- Darren Yates, Head of Communications

1.3.4 Interviewing the representatives from the NHS Trust will enable the Committee to fulfill its statutory function and get an understanding of the problems faced by the Trust and the reasons for choosing the actions identified to improve performance for the coming year.

1.4 Alternative Action and Why Not Recommended

1.4.1 The Committee could choose not to consider the NHS Quality Account. However that would be contrary to its statutory function and would prevent Members from commenting on matters that affect the health and well-being of the residents of Maidstone and Tunbridge Wells Boroughs . Surely this has already been agreed at the last meeting and so is not relevant here.

1.5 Risk Management

1.5.1 There are no risks involved in commenting on the Trust's draft Quality Account.

1.6 Other Implications

1.6.1

1.	Financial	
2.	Staffing	
3.	Legal	
4.	Equality Impact Needs Assessment	
5.	Environmental/Sustainable Development	
6.	Community Safety	
7.	Human Rights Act	
8.	Procurement	
9.	Asset Management	

1.7 Relevant Documents

Appendix A – Maidstone and Tunbridge Wells NHS Trust draft Quality Account.

Maidstone and Tunbridge Wells NHS
NHS Trust

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QUALITY REPORT 2009/10

Introduction

The provision of safe quality services and experience for patients, staff and the public is central to Maidstone and Tunbridge Wells NHS Trust (the Trust).

The Health Act 2009 requires all NHS healthcare providers in England to provide an annual Quality Account from April 2010.

A Quality Account is intended to aid the public's understanding of what the organisation is doing well; where improvements in service quality are required; what the priorities for improvement are for the coming year; and how the organisation has involved service users, staff and others with an interest in the organisation in determining those priorities for improvement.

Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of services, explaining both what the organisation is doing well and where improvement is needed. But they also look forward, explaining priorities for improvement over the coming financial year, and how these will be achieved and measured.

In addition to being published as part of this annual report, Quality Accounts will be published electronically on the Trust's section of the NHS Choices website.

Part 1 : Chief Executive's statement

Thank you for reading Maidstone and Tunbridge Wells NHS Trust's Quality Account and for taking an interest in the local health services we provide throughout Kent and East Sussex.

MTW is an open and publicly accountable organisation and we are pleased to share with you an overview of our ongoing journey to improve standards of patient care.

Everything we have achieved in 2009 and have set out to achieve in 2010 shares a single, simple focus and that is to improve the patient experience. It is a common aim for us all to follow.... it is a common aim for us all to share.

MTW has faced significant public challenges in the past. These have now been largely overcome. Last year we recorded the lowest rate of infection for Clostridium difficile, per thousand patient bed days, of any acute hospital in the south east.

Infection control stands at the heart of all that we do. Our patients deserve nothing less. We want, can and will always do more to better ourselves.

The trust faces a new set of challenges in the future to meet the changing health needs of the people we serve. We are developing two hospitals of national standing at Maidstone and Pembury, to continue to provide modern, high standards of care safely, in all that we do for all who we see.

We are proud to be developing the country's first NHS hospital to offer every inpatient their own single room with en-suite facilities. We have also invested over £100,000 million in service improvements at Maidstone in the last decade.

All of the achievements that you see in our Quality Account could not have happened without our highly skilled staff. As an organisation, we will work together on turning our future challenges into further accomplishments for our patients.

Thank you for reading our Quality Account. We look forward to working with our local communities further this year to identify new opportunities and ways of working to improve patient care further still.

CEO signature

Part 2
How we have prioritised our quality improvement initiatives for 2010/ 2011

The Trust's plans for quality improvement have been developed in line with various stakeholder groups and align with, or compliment the Commissioning for Quality (CQUIN) scheme agreed with our commissioners.

Within the Trust's annual report we have already highlighted:

Our goals for 2010-11

- ❖ Infection rates will be the lowest in the South
- ❖ Financial break even – every month our income will be greater than our costs
- ❖ All access (waiting times) standards will be met
- ❖ Patient feedback will be collected daily
- ❖ Staff and stakeholders will know where services are to be located
- ❖ Location of the birthing centre at Maidstone will be agreed

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- ❖ Work to be started on refurbishing the Nurses' Home at Maidstone
- ❖ Laparoscopic training centre will be open
- ❖ Stroke unit at Maidstone will be fully functional
- ❖ Detailed planning for Pembury changes to be completed

In setting our key priorities for 2010/2011 the Trust has consulted with patients, services users, LINkS, commissioners and staff to identify the priorities for the next year. In reviewing those that had been put forward we considered areas that had already been highlighted by external reports as well as the impact on quality improvement for patients that each would have and the required implementation plan.

The following have been identified as our key priorities for quality improvement:

- Continuing to reduce the number of hospital acquired infections
- Reducing the number of ward to ward moves for patients
- Improve the quality of communication and information given to patients and the public.
- Help deliver improved quality through local and national quality targets (CQUIN measures). These measures are included within Part3 – Quality Statistics. Highlighted priorities include the following patient groups:
    - stroke patients
    - reducing the number of patient incidents in relation to falls

To enhance our engagement with patients and the public, in line with our new strategy for Patient and Public Involvement we will build upon these 4 key elements:

- Involving the individual patient and their families and carers in their treatment and care
- Involving patients and the public in the design, planning and development of trust services
- Involving patients, the public and their representatives in the development of trust strategies
- Valuing the contribution of patients, their carers and families and the public

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Our selected priorities and proposed initiatives

<u>Patient safety</u>

Infection control

Continuing to reduce the number of avoidable healthcare associated infections

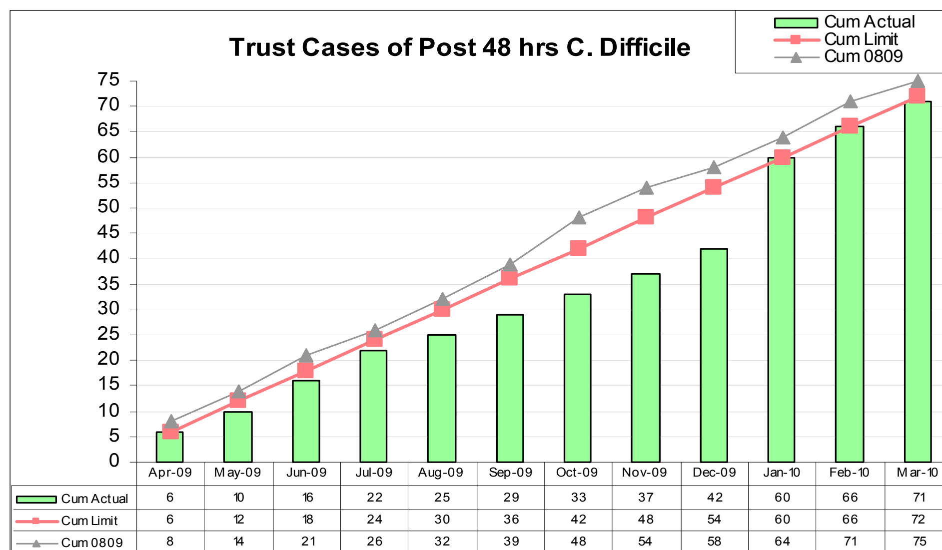
Our current rates of C. difficile infection are the lowest in the south east for 2009/10 for acute trusts. Our MRSA bacteraemia rate has reduced by 60% over the last

seven years but requires further reduction, as you will note from the graphs below the MRSA rates were outside of the limits by the end of the year. As a Trust we have a zero tolerance approach to healthcare associated infection (HCAI) and aim to have no avoidable HCAI.

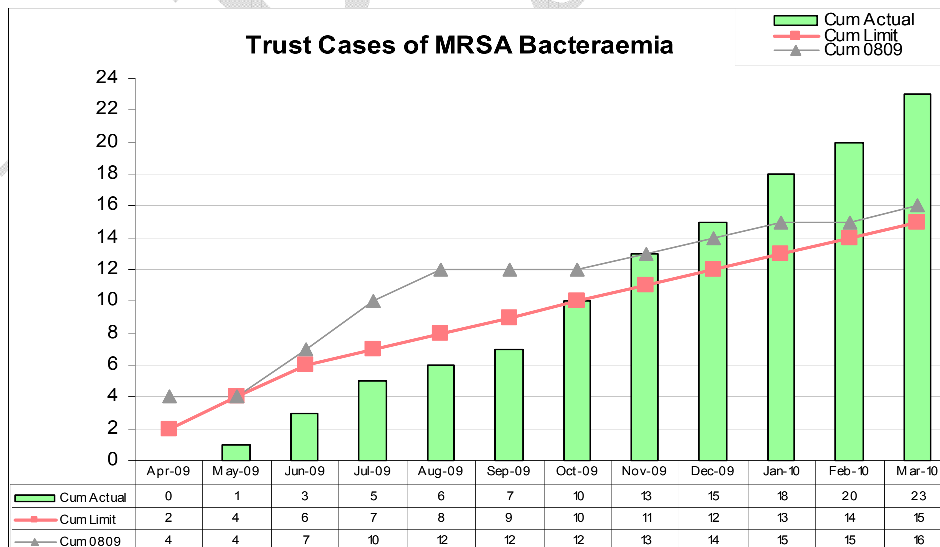
Aim/Goal

To reduce our C. difficile rate by 5% and MRSA bacteraemia by 60% in the next year

Current Status



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Cum Actual	6	10	16	22	25	29	33	37	42	60	66	71
Cum Limit	6	12	18	24	30	36	42	48	54	60	66	72
Cum 0809	8	14	21	26	32	39	48	54	58	64	71	75



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Cum Actual	0	1	3	5	6	7	10	13	15	18	20	23
Cum Limit	2	4	6	7	8	9	10	11	12	13	14	15
Cum 0809	4	4	7	10	12	12	12	13	14	15	15	16

Identified areas for improvement

- Line-associated and device-associated infections identified in root cause analysis.

- Training in line insertion and management

Initiatives in 2009-10

- Implementation of non-elective MRSA screening
- Comprehensive audit plan implemented
- Opening of C. difficile isolation ward at Kent and Sussex Hospital
- Reintroduction of Saving Lives programme

New initiatives to be implemented in 2010-11

- Implementation of MRSA action plan
- Prophylaxis for insertion and removal of lines and devices
- Ongoing monitoring of MRSA screening
- Recognition of MRSA as a diagnosis in its own right
- Appointment of an specialist trainer for the management of IV lines
- Further improvement in antibiotic management

Board Sponsor: Dr Sara Mumford, Director of Infection Prevention and Control
Implementation Lead: Gail Locock, Deputy Director of Infection Prevention and Control

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Reducing the incidence of patient falls

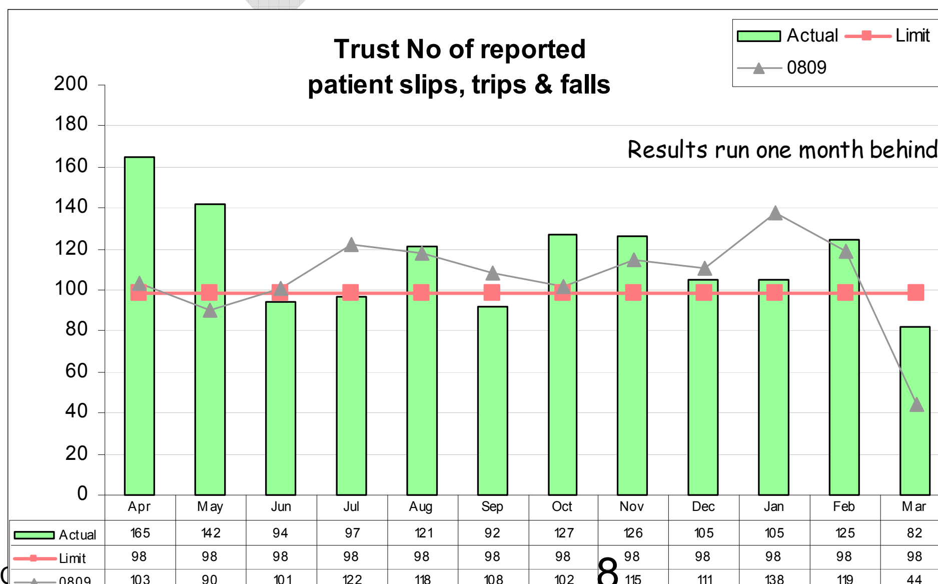
Slips, trips and falls can:

- result in loss of confidence and self-esteem
- result in cuts, bruises, broken bones or other injuries
- lead to a longer hospital stay

Aim / Goal

We have challenged our teams to reduce patient falls (resulting in injury) by 7.5% this year

Current status



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	165	142	94	97	121	92	127	126	105	105	125	82
Limit	98	98	98	98	98	98	98	98	98	98	98	98
0809	103	90	101	122	118	108	102	115	111	138	119	44

Identified areas for improvement

- Feedback from learning

Initiatives in 2009/10

- Revised our risk assessment tool
- Updated our patients and relatives leaflet.
- Trialled movement alert systems on our high risk areas
- Introduced weekly review of all patient falls via the Key Performance Indicator (KPI) forum
- Shared good practice with poster campaigns
- All wards have height adjustable chairs and beds and have access to equipment and therapy staff trained to help with patient mobility
- Staffing levels are regularly reviewed to ensure the highest standards of patient safety
- Staff follow strict guidelines in the correct use of bedrails
- All new electric profiling beds have integrated side rails
- Purchase of specialised low rise beds which enables them to be lowered to floor level

New initiatives to be implemented 2010/11

- Developing a root cause analysis tool to help identify further learning
- Review footwear for patients at risk
- E reporting will deliver comprehensive live data re falls in clinical areas
- Business case for falls Co-ordinator

Board Sponsor - Flo Panel-Coates, Director of Nursing
Implementation Lead - Siobhan Callanan, Associate Director of Nursing

Clinical Effectiveness

As well as monitoring our performance in line with CQUIN measures as a whole, from our consultation, there are clear priorities in relation to the care of our stroke patients in order to meet the nine key national indicators.

Caring for stroke patients

To improve the quality of care and consequently health outcome for patients who have suffered a stroke.
There is research evidence that prompt admission to a stroke unit will optimise the patient's outcome.

Aim / Goal:

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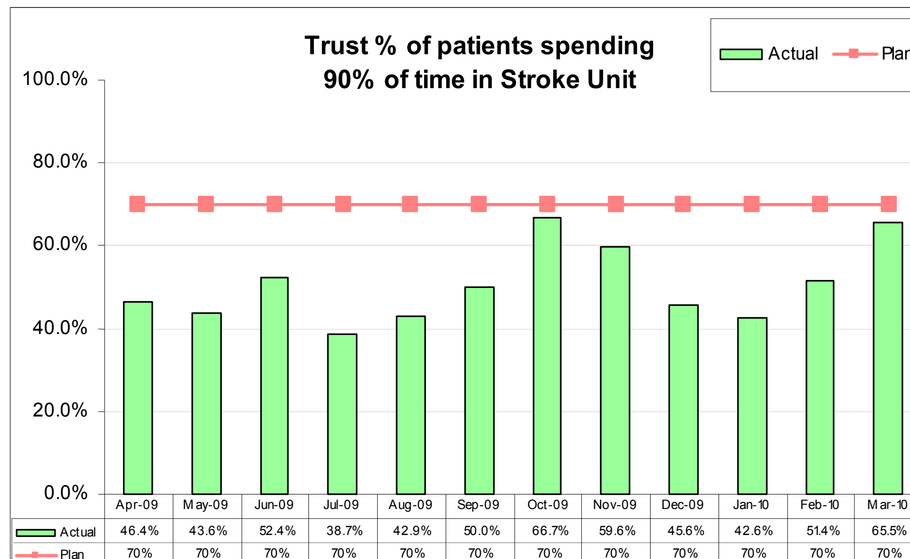
To ensure stroke patients are admitted directly to the designated stroke units in order to ensure that we can implement the nine key actions identified as leading to improved patient outcomes.

Current Status:



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Identified areas for improvement:

- To improve compliance rates with the 9 key targets that have been set nationally (see above) and those additional stroke related measures within the CQUIN targets.

Initiatives in 2009/10

- Implementation of designated stroke units on both Kent and Sussex and Maidstone Hospital sites
- Implementation of monitoring tools for the review of compliance with the 9 key indicators:
  - % of patients where all 9 indicators below (Sentinal Audit) were achieved
  - % Screened for swallowing disorder < 24hrs of admission
  - % given Brain Scan <24hrs of admission
  - % having Aspirin Administered <24hrs of admission
  - % with Rehab goals set by MDT
  - % Weighed during admission
  - % had mood assessed by discharge
  - % assessed by physiotherapy <72hrs of admission
  - % had OP Assessment <7days of admission
  - % had home visit planned before discharge
- Multidisciplinary cross-site meetings to enhance review and shared learning
- Active participation at the stroke network board and stroke forums

New initiatives to be implemented 2010/11

- Implement the fast track stroke policy to ensure stroke patients are admitted to a designated stroke bed
- Ensure, through adherence to policy and monitoring of compliance that we achieve the 9 key targets in line with national guidelines.

Board Sponsor – Nikki Luffingham , Chief Operating Officer
Implementation Lead – Linda Summerfield, Associate Director of Nursing

Patient Experience

Reducing the number of ward to ward moves for patients.

This is a new issue which was raised by patients through our consultation process and reviewing of complaints.

As one of their Key Performance Indicators, Ward Managers are being asked to provide information on the number of moves that their patients experience. The patient Experience Matrons are working closely with the Associate Directors of Nursing to identify why patients are moved from ward to ward and to put processes in place to reduce this. In supporting the 'Dignity Challenge' patients will be treated as individuals by respecting them and offering a personalised service.

Aim

To ensure patients do not move more than three times (including A&E to MAU / AAU , and MAU/AAU to the ward) unless for clinical care / infection control reasons.

Current status

This is a new quality initiative for us – we do not yet have a baseline but will expect to see improvements month on month.

Identified areas for improvement

- To reduce the number of moves a patient makes during their stay in hospital in order to optimise the care and treatment they receive.
- To obtain real time patient feedback on the number of moves

Board Sponsor – Flo Panel-Coates, Director
Implementation Lead – Chris Steele and Claire Spence, Patient Experience Matrons

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Communication and Information

We want to improve the quality of communication and information given to patients and the public.
The Trust has patient survey scores comparable to other trusts in how well we communicate with our patients. However, there is still room for improvement and patients tell us that they want more information. This is also highlighted by some of the complaints we receive.

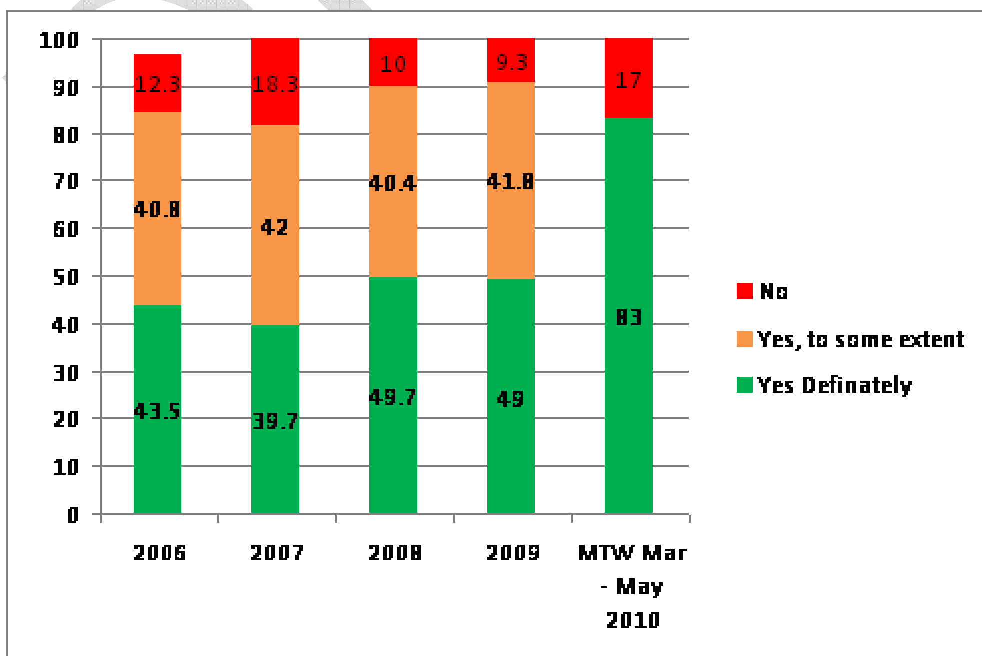
Aim / Goal

To increase patient satisfaction about how they receive communication and information through an increase in the national and local patient surveys, and to see a reduction in the number of complaints in which communication and information is highlighted as an area of concern.

Current status

Below are some graphs relating to the national patient survey results highlighting issues in relation to communication and information. The column on the right shows data from our live patient experience tracker (we will further align these to map them to the national survey.) These will be some of the areas of information and communication that we will be seeking to improve.

Were you involved as much as you wanted to be in decisions about your care and treatment ?



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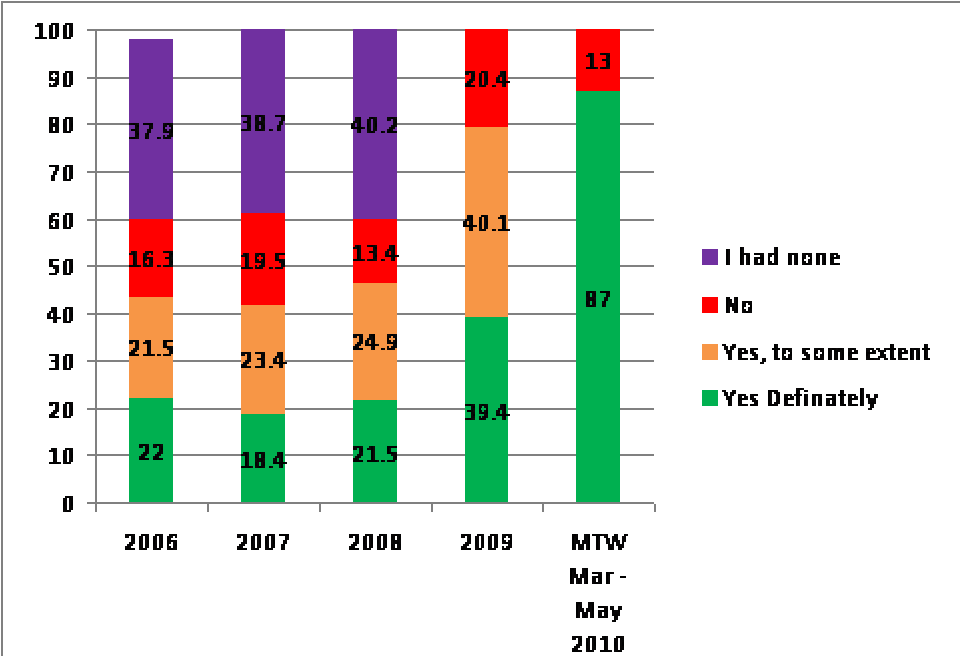
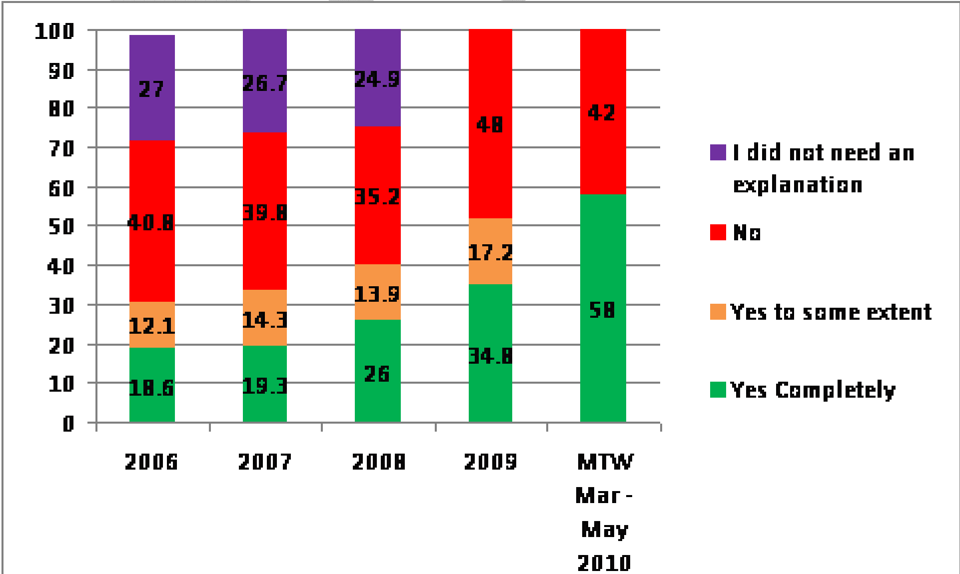
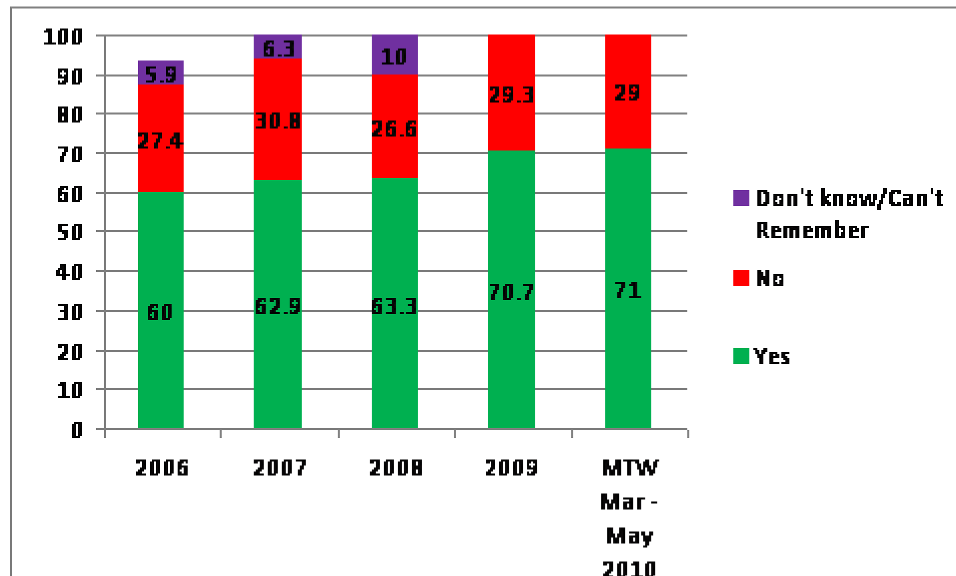
Did you find someone on the hospital staff to talk to about your worries and fears?



Did a member of staff tell you about medication side effects to watch for when you went home?



Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?



Identified areas for improvement

- Enhanced quality of patient information leaflets
- Enhanced communication between patient and staff, relatives and staff and between different staff groups

Initiatives in 2009/10

- The introduction of electronic hand held devices given to patients prior to discharge to enable real time feedback – includes questions relating to communication and information
- Patient Experience Committee (PEC) set up to champion improving all aspects of the patients' experience.
- PEC monitors progress against the national and local patient survey action plans
- Patient Information and Letters Group reviewing quality of all patient information leaflets in line with prescribed standards

New initiatives to be implemented 2010/11

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- Linking of local patient experience questionnaires to national patient surveys to enable prompt action to be taken in relation to specific issues
- Full review of patient information leaflets
- Introduction of new bedside folders for patients
- Refresh training in relation to "customer care" to be rolled out across the trust, prioritising areas of most concern highlighted via survey results and complaints
- Improve information available to patients relating to medication

Board Sponsor Flo Panel-Coates, Director of Nursing
Implementation Lead Claire Roberts, Head of Quality and Governance

The Quality and Safety Committee, a sub-committee of the Trust Board, will monitor progress against the actions and targets set for each of the priorities.

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Statements of Assurance from the Board

NHS services

During the year 2009/2010 the Trust provided and/or subcontracted 120 different NHS services across 32 specialties from our hospitals.

The Trust has reviewed all the data available to them on the quality of care in all 120 of these services.

The income generated by the NHS services reviewed in 2009/10 represents 100% of the total income generated from the provision of services by the Trust for 2009/10.

Clinical Audit

During the period April 2009 to March 2010 22 national audits and 2 national confidential enquiries covered NHS services that the Trust provides.

During that period the Trust participated in 86% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to and actually participated in during 2009/10 are illustrated in the table below:

2.3 National Audits and Confidential Enquiries which Trust was eligible to participate in	Those the Trust participated in:
National neonatal audit	x
National diabetes audit	NO
Adult critical care units	x
National elective surgery (PROMS)	x
CEMACH perinatal mortality	x
Hip and knee replacements	x
Head and neck cancer	x
Lung cancer	NO
Bowel cancer	x
MINAP (myocardial infarction)	x
Heart failure	x
National hip fracture registry	x
National adult cardiac interventions	x
Heart failure	x
UK national hip fracture registry	x
TARN – severe trauma	NO
Sentinel stroke audit	x
National audit of dementia	x
Falls and bone health in older people	x
British thoracic society	x
College of emergency medicine- pain in children, asthma, fractured neck of femur	x
National mastectomy and breast reconstruction audit	x
National oesophago-gastric cancer	x
Continence care	x
National Confidential Enquiry into Patient Outcome and Death	x
Centre for Maternal and Child Enquiries	x

National Audits for quality accounts (Not submitted)	Reasons why data not submitted
NDA: National Diabetes Audit	Participation in audit delayed whilst data system (Diabeta3) installed in trust. This will be in place in 2010. Paediatric aspect registered this year.
NLCA: Lung Cancer	Development of a new data capture system needed to be developed to accurately record patients who receive treatment across the network. In 2010/11 audit

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	programme, system in place and Cancer Data Analyst submitting data.
TARN: severe trauma	To be confirmed.

2.4 The national clinical audits and national confidential enquiries that the Trust participated in and for which data collection was completed during 2009/10 are listed below alongside the number of registered cases required by the terms of that audit or enquiry.

National Audit	Cases submitted as %	Notes
National neonatal audit	100%	
Adult critical care units	100%	
National elective surgery (PROMS)	47%	Based on information from IC website April-November 2009
CEMACH perinatal mortality	100%	
Hip and knee replacements	70%	
Head and neck cancer	98 patients	Unable to quantify total patients eligible until new system is installed. New system in place for 2010/11
Bowel cancer	100%	
MINAP	100%	
Heart failure	37%	
National hip fracture registry	27%	
National adult cardiac interventions	100%	
Sentinel stroke audit	83%	
National audit of dementia	100% (estimated)	
Falls and bone health in older people	100%	
British thoracic society	100%	
College of emergency medicine- pain in children, asthma, fractured neck of femur	87%	
National mastectomy and breast reconstruction audit	100%	
National oesophago-gastric cancer	88%	
Continence care	50% (so far)	
National Confidential Enquiry into Patient Outcome and Death	100%	
Centre for Maternal and Child Enquiries	100%	

National benchmark being sort

2.5 The reports of eight national clinical audits published were reviewed by the provider 2009/10 and the Trust intends to take the following actions to improve the quality of healthcare:

2.5 AUDIT TITLE	2.6 ACTION

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National Diabetes Audit - Fulfilling the requirement for the Diabetes NSF.	Introduction of diabetes database (Diabeta 3) will transform MTW's ability to contribute usefully to future audits. Re-audit
National Mastectomy and Breast Reconstruction Audit. (RCN/NCASP)	None needed as Trust met standards Noted by division and presented to Trust Board
NCEPOD - For better or Worse? Review of the care of patients who died within 30 days of receiving systemic anti-cancer therapy	None needed as Trust met standards. Noted by division and presented to Trust Board
NHS Patient Survey - Adult Inpatient Survey 2008	The Trust has introduced a real time feedback monitoring system to enable us to respond quickly to trends that have been identified. The Trust has worked with Department of Health and NHS West Kent to address deficits relating to the provision of single sex accommodation – work is ongoing but nearly complete. Communication and information remains a key issue and is one of our priorities for 2010/11.
Mandatory National Audit: Head & Neck Cancer (DAHNO)	Continue to participate in the National comparative study. Ensure more cases are submitted next year when new data-capture software is introduced. Continue to work with colleagues across Kent and Medway to improve data capture and sharing for patients who are treated in more than one institution across the network
Mandatory National Audit: Bowel Cancer (NBOCASP)	Continue to submit data. Present to the Standards Committee for discussion across divisions.
National Mandatory audit: Oesophago-gastric (stomach) cancer (AUGIS/NCASP)	Continue to submit data. Present to the Standards Committee for discussion across divisions.
National audit of the Liverpool Care Pathway 2nd round.Care of the dying	Improve monitoring and measurement of LCP data to mark improvements, Improve skills for medical and nursing staff in delivery of end of life care, Improve spiritual and psychological care provided to patients and next of kin/carers

The reports of 69 local clinical audits were reviewed by the provider in 2009/10 and Maidstone and Tunbridge Wells NHS Trust intends to take the following actions to improve the quality of healthcare provided (appendix 2).

Research
Commitment to research as a driver for improving the quality of care and patient experience

The number of patients receiving NHS services provided or sub-contracted by Maidstone & Tunbridge Wells NHS Trust in 2009/10 that were recruited during that period to participate in research approved by a research ethics committee was 1,669.

This increasing level of participation in clinical research demonstrates Maidstone & Tunbridge Wells NHS Trust commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Maidstone & Tunbridge Wells NHS Trust was involved in conducting 62 clinical research studies. Maidstone and Tunbridge Wells NHS Trust completed 70% of these studies as designed within the agreed time and to

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the agreed recruitment target. Maidstone & Tunbridge Wells NHS Trust has used national systems to manage the studies in proportion to risk. Of the 62 studies given permission to start, a 60% percentage were given permission by an authorised person less than 30 days from receipt of a valid complete application. 48% of the studies were established and managed under national model agreements and 8% of the 62 eligible research involved used a Research Passport. In 2009/10 the National Institute for Health Research (NIHR) supported 28 of these studies through its research networks.

In the last three years, 20 publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experience across the NHS.

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Income

Within the new commissioning payment framework 0.5% of the Trust's income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the CQIN (Commissioning for Quality and Innovation) payment framework.

Within the new commissioning payment framework for 2010/11 1.5% of the Trust's income will be conditional on achieving quality improvement and innovation goals as indicated in the table below:

		Plan
CQUINs		
1	**% of Adult Inpatients that have a VTE Risk Assessment - June 2010 onwards**	90%
2	**% Positive Response to: Were you involved as much as you wanted to be in decisions about your care and treatment?**	68.29%
	% Positive Response to: Did you find someone on the hospital staff to talk to you about your worries and fears?	68.29%
	% Positive Response to: Were you given enough privacy when discussing your condition or treatment?	68.29%
	% Positive Response to: Did a member of staff tell about medication side effects to watch for when you went home?	68.29%
	% Positive Response to: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	68.29%
3a	**% Slips, Trips & Falls resulting in an injury per 10,000 admissions**	7.5%
3b	**% of Falls with Risk Assessment & relevant action completed**	80%

4a	% of Stroke patients receiving all 9 Key Setinal Audit Indicators	75%
4b	% of Stroke patients with EDD <7 days of admission	80%
4c	% of Stroke referral letters sent to next provider at least 24hrs before discharge	90%
5a	% of inpatient discharge summaries sent electronically	90%
5a	% of outpatient letters sent within 2 weeks of clinic and conforming to revised template	85%
6a	Pre-Op Process % Positive Response to: Did a member of staff explain what would be done during the operation or procedure?	78%
	Pre-Op Process % Positive Response to: Were you told how you could expect to feel after you had the operation or procedure?	62%
6b	Food & Nutrition % Positive Response to: How would you rate the hospital food?	tbc
	Food & Nutrition % Positive Response to: Did you get enough help from staff to eat your meals?	tbc
7	Referrals to Stop Smoking Service	1500
8a	Diabetes - Audit of Insulin Medication Errors - TBC	tbc
8b	Diabetes - Audit re patients admitted that got a foot check - TBC	tbc
9a	% eligible staff trained in Dementia Awareness	10.0%
9b	Attendance at WK Dementia Forum	80.0%
10	Improve Quality of patient care - process milestones for 4 key areas: Myocardial Infarction, Community Acquired Phneumonia, Heart Failure, Hip & Knee Replacements	Process mile stones to be met in 2010/11
11	Improve Performance % of patients receiving pathway metrics for 4 key areas: Myocardial Infarction, Community Acquired Phneumonia, Heart Failure, Hip & Knee Replacements	Different for each area

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Further details of the agreed goals for 2009/10 and for the following 12 month period are available on request from the Trust Director of Finance:

Paul Turner, Director of Finance
Maidstone Hospital, Hermitage Lane, Maidstone ME16 9QQ

Regulatory Requirements
CQC Registration

The Trust is required to register with the Care Quality Commission (CQC) and it has been registered to provide the following activities without conditions:

- Treatment of disease, disorder and injury

- Surgical procedures
- Diagnostic and screening procedures
- Maternity and midwifery services
- Termination of Pregnancy
- Patient Transport

In addition no conditions were attached to the Trust's registration in relation the hygiene code.

The CQC has not taken enforcement action against the Trust during April 2009 to March 2010.

CQC Periodic reviews
The Trust is subject to periodic reviews by the CQC. In 2009 it was the subject of an unannounced hygiene code inspection and we were found to be fully compliant.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

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Data Quality

Figures for end March 2010 will be inputted prior to publication – not yet received. Similarly benchmarking figures will be included once they have been released. (Expected end of May)

We do not anticipate these will be significantly different.

NHS number and medical code validity

The Trust submitted records during April 2009 to January 2010 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

93.6% for admitted patient care;

96.3% for out patient care; and

76.5% for accident and emergency care.

— which included the patient's valid General Medical Practice Code was:

100% for admitted patient care;

100% for out patient care; and

99.9% for accident and emergency care.

The Trust score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 60%.

The Trust was subject to the Payment by Results clinical coding audit by the Audit Commission during the reporting period and the error rates reported in

the latest published audit for that period for diagnoses and treatment coding (clinical coding) was 7.7% from the specialties sampled and audited – the national average was 8.1% and our SHA average was also 8.1%.

Area Audited	Specialty / Sub Chapter / HRG	% procedures Coded Incorrectly		% Diagnosis Coded incorrectly		% of Episodes Changing HRG
		Primary	Secondary	Primary	Secondary	
Theme	Paediatrics	6.7	0.0	5.0	9.9	4.0
Specialty	Endocrinology	24.4	11.8	15.0	6.5	16.0
Sub Chapter	General Surgery	4.8	4.8	11.4	6.0	1.4
HRG	ENT	8.0	10.0	3.3	0.0	6.7
Overall		**11.6**	**7.8**	**9.7**	**6.3**	**7.7**

Information taken from PbR Assurance Audit Sept 2009 (produced by the audit commission)

Part 3
Quality Overview

The Trust has made significant improvements in key quality measures over the last year.

There have been a number of important initiatives, such as those to reduce infection rates, reduce the length of stay in hospital for patients, and the refurbishment of a stroke unit for patients at both Maidstone and the Kent and Sussex Hospitals.

Patient Safety
Infection Control

Actions to maintain low levels of Healthcare Associated Infections (HCAIs) in 2009/10 include:

All elective admissions are screened for MRSA and the Trust has carried out a phased introduction of MRSA screening for emergency admissions which was fully implemented by March 2010.
Over the last seven years we have reduced MRSA blood stream infections by 60% in our hospitals.
This year we have also achieved a reduction of C. difficile infection by 5% in our patients which means that we have seen an 86% reduction in cases since 2005/6. The Trust has opened a new isolation area at Kent and Sussex hospital for patient's with C. difficile ensuring they receive specialist nursing care.

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To give assurance of the maintenance of high standards of infection control and cleaning we have implemented a comprehensive audit programme.
All cases of MRSA bacteraemia or C. difficile are subject to a root cause analysis to ensure learning and best practice is carried forward.
The Trust fully implemented the Pandemic Influenza plan and can report that no cases of cross infection were seen in the Trust.

The Trust continues to have a zero tolerance approach to all avoidable infections. As mentioned previously infection control remains a key priority area for the Trust.

Safeguarding

In addition to the existing systems to ensure we safeguard children, in 2009 the Trust has set up a Multi-agency Safeguarding Adults Committee. Its task is to prioritise the Safeguarding Agenda and develop work streams to meet it.

This Committee is chaired by one of the Trust non-executive Directors, alternating with the Director of Nursing, both of whom are well placed to bring to the Trust Board's attention areas of good work and where further commitment and work is required to meet the national and local agendas.

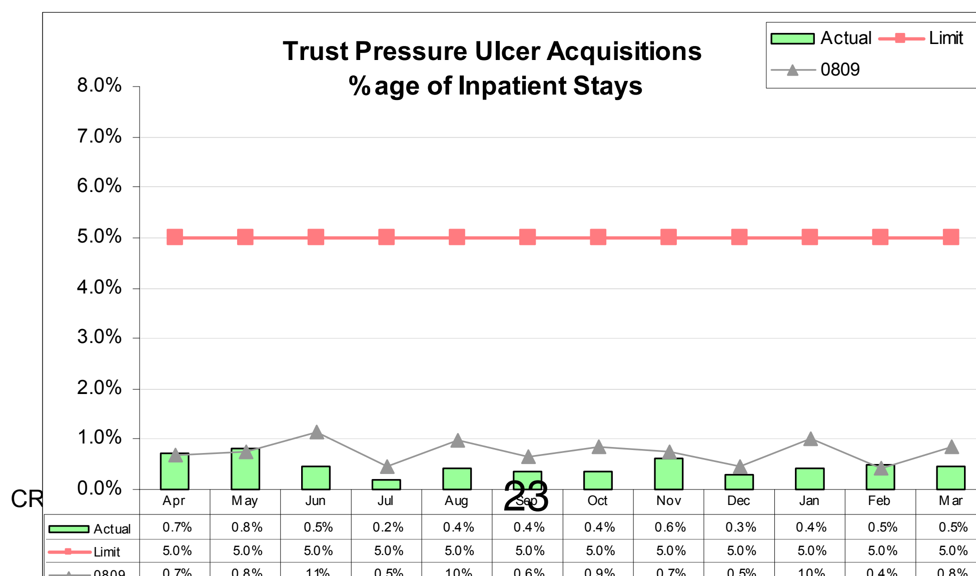
Clinical Effectiveness

Fractured Neck of Femur Pathway

As part of our Improvement Programme the orthopaedic team worked to streamline the Fractured Neck of Femur Pathway. A key aspect of this is to build up patients' strength and stamina with high energy drinks *before* they have their operation. It also includes fast-tracking from A&E; standardising pain control; improving communication at every stage in the patient's journey; prioritising their surgery; and ring-fencing beds.

Hospital acquired pressure ulcers

We monitor the number of pressure ulcers that patients acquire while in hospital. We have a specialist nurse who works with the wards to investigate the cause of these and take action to reduce the risk of these happening again. All grade 4 pressure ulcers are now considered by our panel which reviews serious incidents to ensure that all possible action is being taken to help reduce the risk of these incidents further.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	0.7%	0.8%	0.5%	0.2%	0.4%	0.4%	0.4%	0.6%	0.3%	0.4%	0.5%	0.5%
Limit	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
0809	0.7%	0.8%	1.1%	0.5%	1.0%	0.6%	0.9%	0.7%	0.5%	1.0%	0.4%	0.8%

Patient Experience

Real Time Patient Feedback

We have introduced a system which gives our patients the opportunity to tell us how satisfied they are with the care they receive. Patients are offered the opportunity to answer questions and input their views onto an electronic touch screen. The information received is completely anonymous and the results are available to be viewed by Ward Managers, Matrons and the Trust Board immediately. This enables us to respond to our patients' concerns much more quickly than previous methods allowed.

Eating well

We introduced the Red Tray system and Protected Meal Times both of which are designed to ensure that ward staff create a quiet atmosphere in which patients can eat their meals without interruption and staff can easily identify patients that need assistance. Previously meals were often interrupted by ward rounds, drug rounds, cleaning and other activities. Patients are at risk of becoming malnourished in hospital which can result in impaired wound healing, increased risk of infection, physical weakness, depression, lethargy and a longer stay in hospital. Eating well is an important part of any patient's overall hospital care, and this new system of protected meal times and the Red Tray system improves our patients' experience and reduces the possibility of malnutrition.

As part of our emphasis on ensuring that our patients eat well the Patient Experience Committee held a blind food tasting event in December 2009, testing the 'in-house' food provided by the Maidstone Hospital caterers against food bought in for Kent and Sussex patients. Both suppliers of food were judged to be tasty and good quality by the tasters

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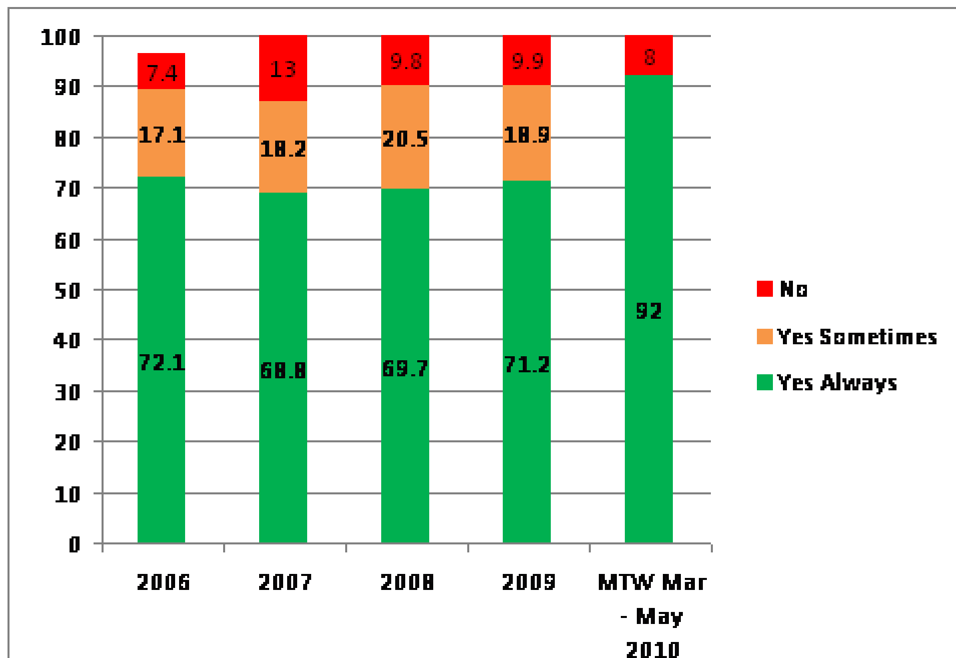
Were you given a choice of food? (Information from the National Patient Surveys and from the in-house real time patient feedback system.)



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Privacy and Dignity

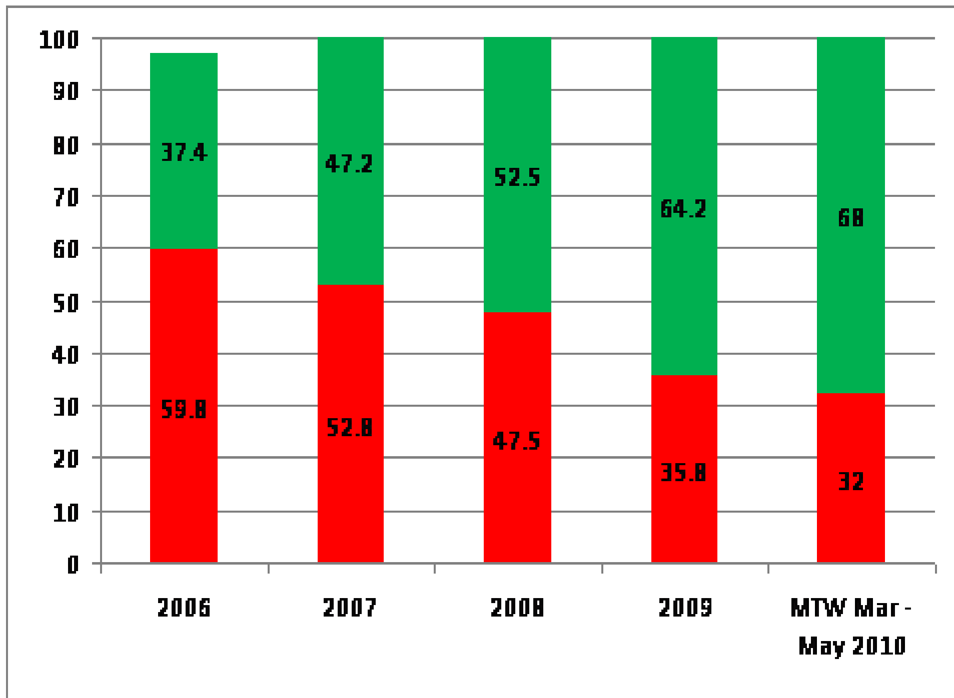
We have been working hard to improve the privacy and dignity of our patients and deliver same sex accommodation. We have:

- increased privacy in bathrooms and toilets
- increased the number of en-suite rooms and the number of toilets and bathrooms
- ensured that every bathroom and toilet door has a privacy sign
- introduced improved privacy gowns to all our X-ray departments
- designed a new gown for inpatients

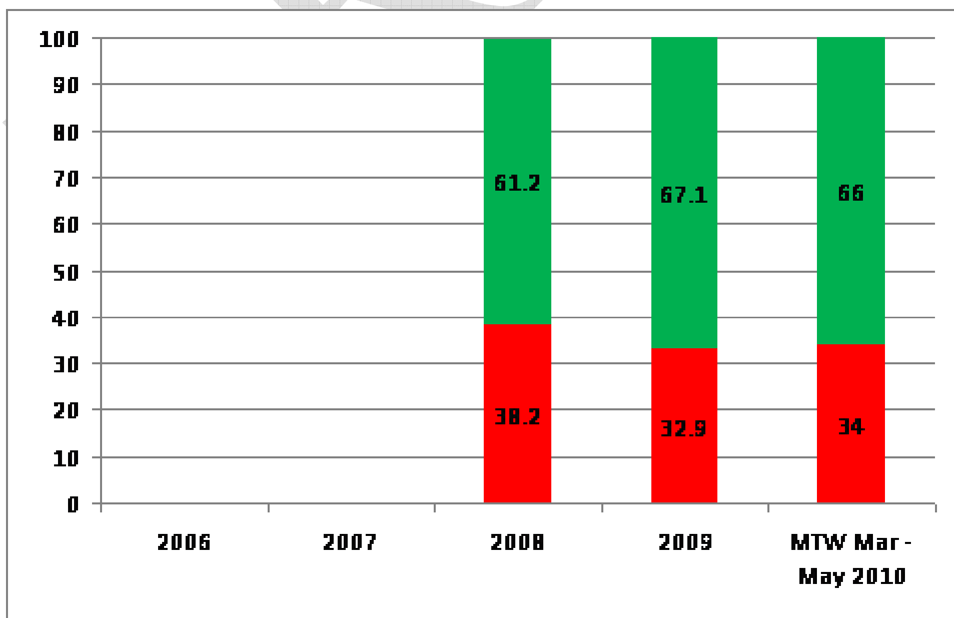
The real time feedback system explained above enables our patients to tell us how well we are achieving our aims.

We are proud to confirm that mixed sex accommodation has been virtually eliminated in all our hospitals. This allows us to focus on avoiding breaches for nonclinical reasons.

When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay with patients of the opposite sex?



When you were first admitted , did you mind sharing a sleeping area, for example a room or bay with patients of the opposite sex?



Environment

As well as the progress to ensure we can deliver same sex accommodation throughout the trust, there is a planned programme for upgrading areas of Maidstone Hospital and the exciting development of the new hospital in Pembury. This hospital will begin taking patients in 2011 and be able to provide state of the art facilities for all.

Productive Ward

We have been rolling out the productive ward programme, which aims to promote a continuous improvement culture leading to real savings in materials, reducing waste and vastly improving staff morale, providing them with more time to spend with patients. Ten wards are currently on the programme.

To date we can report the following successes:
100% of the staff asked on the showcase wards said that since the introduction of Productive Ward the quality of work and patient care they have been able to deliver has improved.

7.3 fewer miles walked per commode clean saved per year.

116 miles saved per year as a result of moving the ward office.

Waiting time targets

Patients not attending out patient appointments

As you will see from the graph below we have a number of patients who do not turn up for their outpatient appointments. We realise that there may be many valid reasons for this, we would seek to work with you to reduce this number, however. We need to ensure that patients notify us as far in advance as possible if they are not able to attend an outpatient appointment so that we can book someone else in their place. This will help to ensure that appointments times are not wasted and that all patients can be seen as quickly and efficiently as possible.

We have just introduced a system whereby all patients will be reminded about their appointments via land line telephone, mobile voice or text message, which we hope will help to reduce the wasted appointments.

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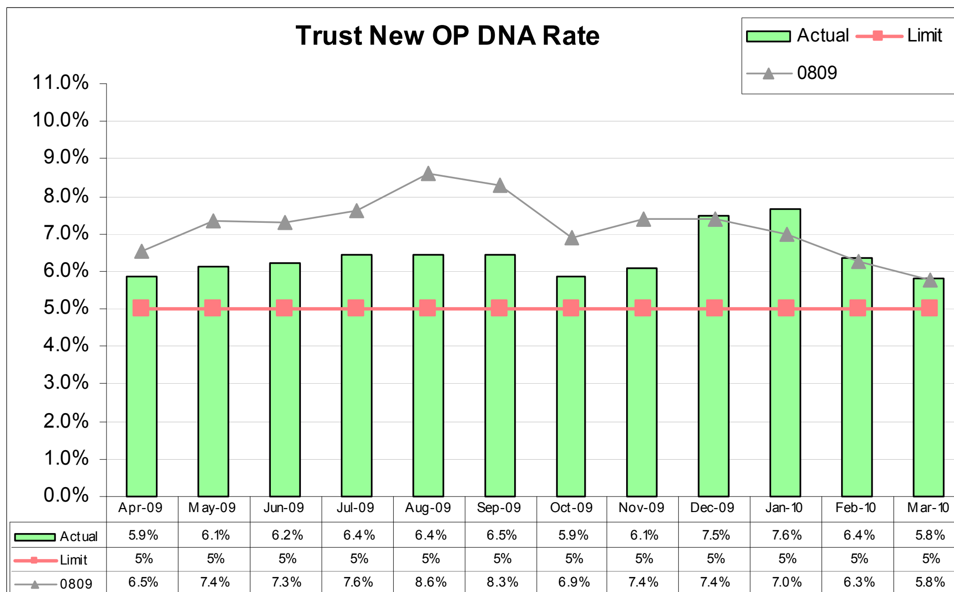

	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Actual	5.9%	6.1%	6.2%	6.4%	6.4%	6.5%	5.9%	6.1%	7.5%	7.6%	6.4%	5.8%
Limit	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
0809	6.5%	7.4%	7.3%	7.6%	8.6%	8.3%	6.9%	7.4%	7.4%	7.0%	6.3%	5.8%

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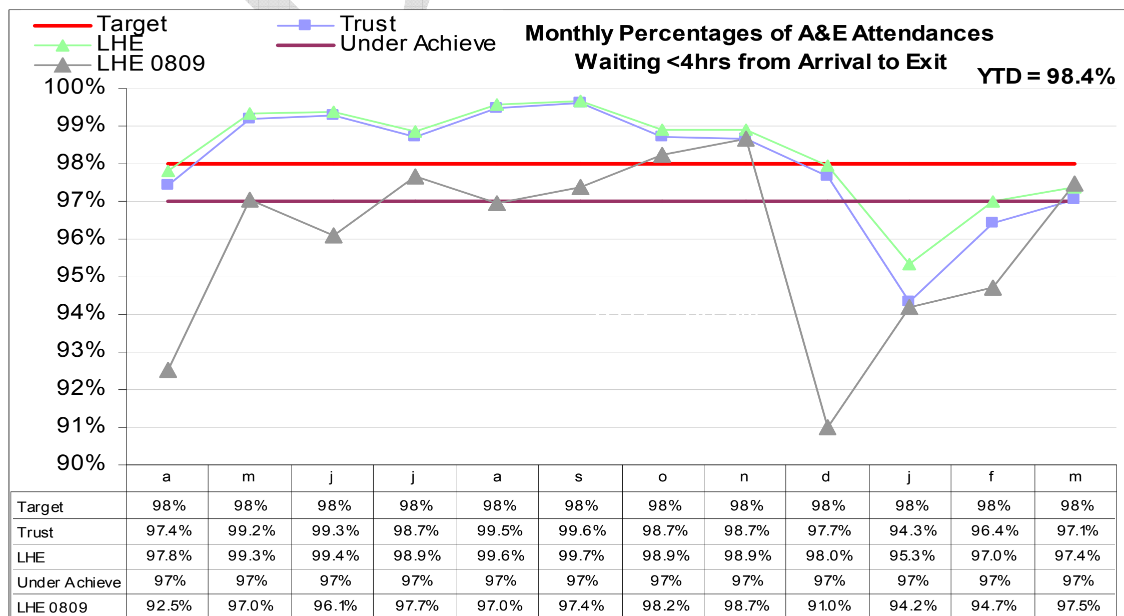
Waiting times in Accident and Emergency

There are peaks and troughs in waiting times in A&E. You can see the impact that severe weather conditions and the winter vomiting bug had on these in January. We continue to seek ways to minimise the waits patients have and so improve the efficiency of the services we offer, however, there are occasions when the 4 hour target will be breeched. We keep these times under constant review. The target for the year is that 98% of patients should be seen within 4 hours – our year end achievement was 98.4%.

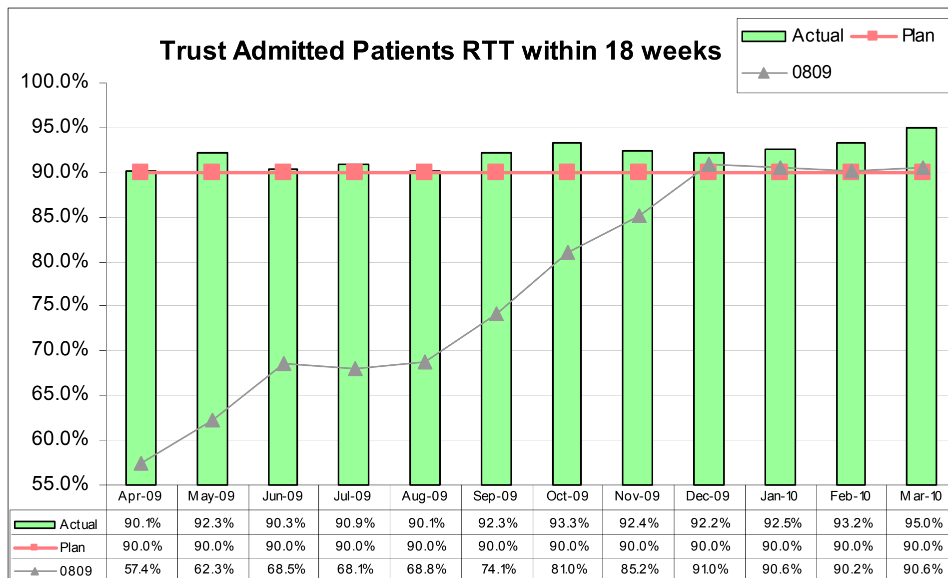
Again we would like to ask you to help us to help those who are real emergencies by ensuring that you seek to use other sources of health care if your situation is not an emergency, such as your GP, out of hours services or NHS Direct.



	a	m	j	j	a	s	o	n	d	j	f	m
Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Trust	97.4%	99.2%	99.3%	98.7%	99.5%	99.6%	98.7%	98.7%	97.7%	94.3%	96.4%	97.1%
LHE	97.8%	99.3%	99.4%	98.9%	99.6%	99.7%	98.9%	98.9%	98.0%	95.3%	97.0%	97.4%
Under Achieve	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%
LHE 0809	92.5%	97.0%	96.1%	97.7%	97.0%	97.4%	98.2%	98.7%	91.0%	94.2%	94.7%	97.5%

Patients admitted for treatment within 18 weeks of referral by their General Practitioner

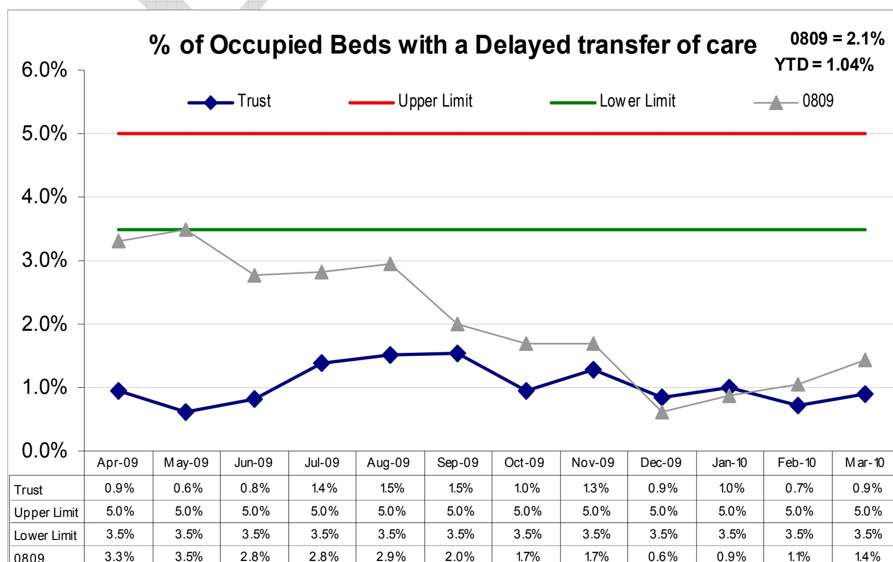
These figures are again under constant review to ensure that we can provide patients with care as soon as possible. The national target is that 90% of patients should be seen and treated within 18 weeks of referral by their GP. You can see the considerable improvements that we have made in achieving this target from under 60% in April 2008 to 95% in March 2010.



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Actual	90.1%	92.3%	90.3%	90.9%	90.1%	92.3%	93.3%	92.4%	92.2%	92.5%	93.2%	95.0%
Plan	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
0809	57.4%	62.3%	68.5%	68.1%	68.8%	74.1%	81.0%	85.2%	91.0%	90.6%	90.2%	90.6%

Delay in transferring patients from the acute hospital to home or another care setting

The graph below demonstrates how, through working with other health and social care providers we have managed to ensure that patients are discharged from hospital in a timely way – this is obviously of benefit to both the patient, by ensuring that they are in the best place for them as well as for the Trust as it ensures that other patients' admissions are not being delayed.



	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10
Trust	0.9%	0.6%	0.8%	1.4%	1.5%	1.5%	1.0%	1.3%	0.9%	1.0%	0.7%	0.9%
Upper Limit	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Lower Limit	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
0809	3.3%	3.5%	2.8%	2.8%	2.9%	2.0%	1.7%	1.7%	0.6%	0.9%	1.1%	1.4%

Staff awards

A number of our staff have received national recognition for awards resulting in enhanced quality of services delivered:

- The Chemotherapy nurses were awarded the runner up prize for their nurse led services in conjunction with East Kent Hospital Trust at the Pfizer Clinical Excellence Award during 2009.

- During 2009 our Midwifery nursing team won both a prestigious Royal College of Midwifery award and a runner-up recognition in a separate category. The award for Excellence in Recruitment and Retention was presented for the work the team did in tackling the chronic shortage of midwives affecting all trusts in the South East, and so enhancing quality and safety for women using the services.

From our staff survey the following areas have been recorded as above average when compared with the national benchmark:

- % staff satisfied with the quality of work and patient care that they are able to deliver
- % staff receiving job related training
- % staff receiving health and safety training
- % staff motivation at work

Areas that we need to be working on as a result of the staff survey include:

- Supporting our staff in the management of violence and harassment of staff by patients and relatives.

- Involve staff more in making improvements at work – consultation events such as those held to develop this document have contribute

- Process of reporting errors and incidents - in 2010/11 we will be rolling out e-reporting which will enhance the accessibility of reporting incidents and an electronic system to monitor and audit investigations and actions taken will be implemented at the same time.

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Challenges

To further enhance quality we are reviewing our processes to further develop our learning from incidents, complaints and claims to improve care delivery. We will be rolling out an electronic incident reporting system and an audit tool to aid with investigations later this year. These will help to enhance the quality of data received and actions developed as a result of investigation, as well as ongoing monitoring of progress against the action plans.

Continuous contributions by, and development of, our workforce is central to improving services for patients. We have developed a robust action plan in response to our staff survey to address the concerns of our staff. One of these

has been the area of involving staff more in making improvements at work. One of the recent actions taken has been the consultation with staff to contribute to the setting of the key priorities highlighted in this document.

The new cancer strategy commitments are now in place and whilst the Trust is committed to this process it has not quite met the all the new targets. A key factor for the underperformance is that as a major tertiary centre MTW receives high levels of referrals from other NHS Trusts. Often, due to the complex nature of these patients, they have either breached the target or are close to breaching by the time they are sent to MTW for treatment.

On the NHS performance framework the Trust is seen to be "performing" – this indicates that we are meeting all the standards outlines by the CQC in line with access to healthcare by our patients.

Overview of the organisational effectiveness initiatives

There have been a number of initiatives over the last year to increase organisational effectiveness around quality and to embed quality throughout internal structures and processes.

They have included:

- Enhanced reporting on quality and governance issues to the Board and Board subcommittee (chaired by a non-executive director who is a past president of the Royal College of Nursing) by which they can monitor the quality of care provided through scrutinising performance reports.

- The HR subcommittee has developed reporting tools to enable robust monitoring of workforce activities and policies, linking to regulatory requirements and trust objectives.

- A complete revision of the presentation of quality targets to ensure detailed discussions can be had and acted on at Divisional level as well as feedback through the governance committees.

- The introduction of panels, headed up by executive and non-executive Board members to review serious incidents and complaints to optimise and oversee the implementation of actions to drive improvements.

- The development of weekly nursing meetings to review quality outcomes at individual ward level so that early action can be taken if any concerning trends are noted.

- The introduction of a real time patient satisfaction survey in ward and outpatient areas. The questions can be changed so that we can target

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any specific issues that may have been raised through, for example the Patient Experience Committee or from complaints.

- Review of the mandatory training to ensure all staff have access to relevant training to enhance the safety and quality of care provision. The Trust has its largest ever prospectus of training courses available to staff.

- The implementation of equality schemes, and training to support these, to ensure we provide safe services from a patient and staff perspective.

- Joint quality meeting with the Trust and Commissioners

We continued to improve in our compliance with the Health Care Commission core standards, from 20 not met in 2007/08 to eleven in 2008/09 to three in 1009/10 – all of which were compliant by the end of March 2010. These core standards have been replaced by the registration requirements within the new regulatory framework. These are monitored by the Care Quality Commission, and the Trust has been registered to provide the following services across the three sites:

- Treatment of disease, disorder and injury
- Surgical procedures
- Diagnostic and screening procedures
- Maternity and midwifery services
- Termination of Pregnancy
- Patient Transport

Aligning Quality with the wider business strategy

The Trust is in the process of implementing a clinical strategy that is founded upon clear objectives to improve quality of care and clinical outcomes. This involves the reconfiguration of some services to ensure the best possible clinical services are sustainable into the future, the opening of a brand new single room acute hospital at Pembury and major improvement work and investment in new technology being done at Maidstone Hospital.

New design of services and the environments from which we will provide them are predicated on productivity and innovation.

The Trust has worked, and will continue to work, hard to ensure patients and stakeholder groups are informed about the improvements and innovations happening in and around their local hospitals. Developments in local services such as a new diabetes day centre in Tunbridge Wells have had great support and valuable input form patient groups. We have also had extensive

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engagement with stakeholders in relation to our reconfiguration of consultant led maternity services; this has been revisited with Kent County Council (KCC) and the Health Overview and Scrutiny Committee.

The Trust is working with the Strategic Health Authority, NHS South East Coast, in relation to the new national programme – QIPP – Quality, Innovation, Productivity and Prevention.

Locally the Trust is working closely with NHS partners and KCC as part of a QIPP Board for the whole of Kent and Medway. The focus is on quality, innovation, productivity and improvement as key means to sustain quality of services in years ahead in a more challenging economic climate.

NHS Constitution

The rights, pledges and principles outlined in the NHS constitution are wide-ranging and cover many areas of operational work. MTW has adopted an approach of raising general awareness and taking opportunities to link rights and pledges into aspects of care in an ongoing manner.

MTW has reviewed its own organisational values and these are consistent with the NHS values. The rights and pledges in the NHS constitution are well articulated aspects of providing good day-to-day management and experience for patients, the public and staff. As such they are part of the common infrastructure within the organisation.

The Board confirmed its vision as being to provide excellent patient care and experience. Board also reviewed organisational objectives and these have been adopted and turned into six areas, each with priority actions to be implemented as part of a five year plan. These priority areas, covering all aspects of the NHS constitution, are reviewed twice a year.

Each of the rights and pledges are linked to a variety of external agency scrutiny and assurances such as Care Quality Commission core standards or to Auditors' Key Lines of Enquiry, or other duties such as those under Health and Safety and bodies such as the Kent Safety and Children's Board.

MTW is a signatory to the NHS Code of Practice and to specific contracting arrangements with PCTs. These arrangements ensure that commissioning agreements are consistent with NHS principles, Codes of Conduct, good Governance and the rights and pledges outlined in the NHS constitution.

All contracts are subject to regular scrutiny and are consistent with external monitoring through Core Standards and now CQC registration, to give commissioners assurance that MTW is delivering services in line with best practice, health needs and commissioning intentions. The NHS Constitution rights and pledges form part of this scrutiny process.

MTW uses external and internal scrutiny mechanisms to be assured that patients are receiving the best care, the public are well engaged and staff are being treated fairly and in accordance with good management practice.

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Key aspects of scrutiny include:

- NHS West Kent
- Care Quality Commission – annual health check, registration, periodic reviews
- Royal College accreditation of training posts
- Annual staff survey
- Annual patient survey
- Real-time patient experience tracker
- Local Authority Health Overview and Scrutiny Committee challenge
- Serious Untoward Incident root cause analysis and feedback of change to practice
- Complaints and PALS processes
- Delivering Same Sex Accommodation fortnightly returns to PCT and SHA

Statements to be added following review of the draft quality account by partner organisations: PCT, OSC, LINk

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MAIDSTONE AND TUNBRIDGE WELLS JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

17 JUNE 2010

REPORT OF HEAD OF CHANGE AND SCRUTINY

Report prepared by Les Smith & Kat Hicks

1. DEPARTMENT OF HEALTH CONSULTATION ON REGISTERING WITH THE GP PRACTICE OF YOUR CHOICE

1.1 Issue for Consideration

1.1.1 To consider the consultation document published by the Department of Health on options for patients registering with the GP Practice of their choice and prepare a response to be submitted to the Department of Health by 2 July 2010.

1.2 Recommendation of Head of Change and Scrutiny

1.2.1 That Members consider the consultation document and, in particular:

- the options proposed for providing patients with better choice of which GP practice to register with
- The reasons those options are being considered; and
- Whether they wish to respond to the consultation and, if so, the areas they wish to comment on.

1.3 Reasons for Recommendation

1.3.1 The Local Government Act 2000 and the Health and Social Care Act 2001 set out statutory functions for local authorities to review and scrutinise matters relating to the planning, provision and operation of health services in the area of its local authority.

1.3.2 The consultation document sets out proposals for widening the choice of registering with a GP. Most people are registered with a GP Practice relatively close to their home. The document sets out options that would enable people who, for example, work a long distance from home, to register with a GP in another locality that would be more convenient for them.

1.3.3 Commenting on the consultation document is an opportunity for the Committee to influence central Government policy that could have an impact on the health choices for residents of the Boroughs.

1.4 Alternative Action and Why Not to Recommended

1.4.1 The Committee could choose not to comment on the consultation document. However this would prevent Members from commenting on matters that affect the health and well-being of the residents of Maidstone and Tunbridge Wells Boroughs.

1.5 Risk Management

1.5.1 There are no risks involved in commenting on the Department of Health's consultation document.

1.6 Other Implications

1.6.1

1.	Financial	
2.	Staffing	
3.	Legal	
4.	Equality Impact Needs Assessment	
5.	Environmental/Sustainable Development	
6.	Community Safety	
7.	Human Rights Act	
8.	Procurement	
9.	Asset Management	

1.7 Relevant Documents

Appendix A – Department of Health consultation document "Your choice of GP practice".

Contents

Foreword by the Secretary of State for Health, Andy Burnham 3

Chapter 1: Where are we now? 4

Introduction 5

Registering with a GP practice: how does it currently work? 7

What are the problems? 9

What are we already doing? 11

Engagement so far 13

Summary 14

Chapter 2: Removing the current system of practice boundaries 16

Introduction 17

Home visits 18

Urgent care 26

Coordination with community-based services 28

Access to hospital and specialist services 30

Information technology and access to medical records 31

Implications for PCT resource allocations and accountability 32

Chapter 3: Supporting choice 34

Simplifying open and closed lists 35

Supporting practice expansion 36

A more explicit right to choose 37

Better and more comparative information 37

Simpler registration 39

Chapter 4: The consultation process and next steps **40**

Next steps 41

Criteria for consultation 41

Comments on the consultation process itself 42

Confidentiality of information 42

Annex A: Consultation response form **44**

Foreword by the Secretary of State for Health, Andy Burnham

General practice has always been the cornerstone of the National Health Service. Choosing a GP was the first thing people had to do when the service was founded in 1948. Over sixty years later it remains one of the most important and personal decisions that we make about our health care.

Society today is far more complex than it was in the 1940s. People are used to making choices about almost every aspect of their lives. They expect services that are not just of the highest quality but are flexible and responsive to their needs.

Around the country, the NHS is increasingly developing more innovative, patient-centred services. It is often in primary care that some of the most dynamic and creative reforms are taking place, helping to move services out of more traditional hospital settings into more convenient community settings to improve both quality and efficiency. Giving people greater choice of GP practice will provide more momentum to these exciting changes in primary care.

While most people are happy with their GP – more than nine out of ten say they are satisfied or very satisfied with the quality of the services they receive – a significant minority say that they would like to move to a different practice. This could be for reasons of convenience or, for example, because their current practice does not offer more specialised services that meet their individual needs.

In a great NHS people should be able to choose the best care for themselves and their families, and that means the freedom to choose their own GP practice. But, at present, this choice is often limited by a confusing and outdated system of practice boundaries.

We took our first steps towards reforming this system in 2008 with the NHS Constitution, which enshrined a person's right to register with the practice of their choice. Last September I announced our intention to abolish the current system of practice boundaries altogether. Now this consultation is looking at how we should go about doing so.

The proposals set out in this document will allow people to choose a GP practice outside their local area, for instance near where they work. This will bring with it some challenges such as organising home visits, but none are insuperable.

To make this work for patients and the NHS, we need your help. We want to hear your views – whether you are a member of the public, from a patient group, or someone who works in the NHS. Together we can build on the best aspects of the current system to give everyone the high quality, flexible primary care service that they expect and deserve.

Chapter 1: Where are we now?

Introduction

1.1 When the National Health Service (NHS) was launched in 1948, the Minister for Health, Aneurin Bevan, offered the British public the ability to choose a family doctor. By the end of that summer, 97% of the public had registered with a general practitioner (GP) of their choice.

1.2 Over sixty years later, 91% of patients say they are satisfied or very satisfied with the care they receive at their GP practice. The last ten years have seen major improvements both in access to primary care and in quality of care. In a recent survey of primary care doctors in developed countries conducted by the Commonwealth Fund,[1] the UK was identified on a number of measures as having the best primary care services.

1.3 We are continually working to improve the quality of primary care in many different ways. There have been major investments over the last decade in new premises and refurbishments of older ones, new technology and more doctors, nurses and other healthcare professionals.

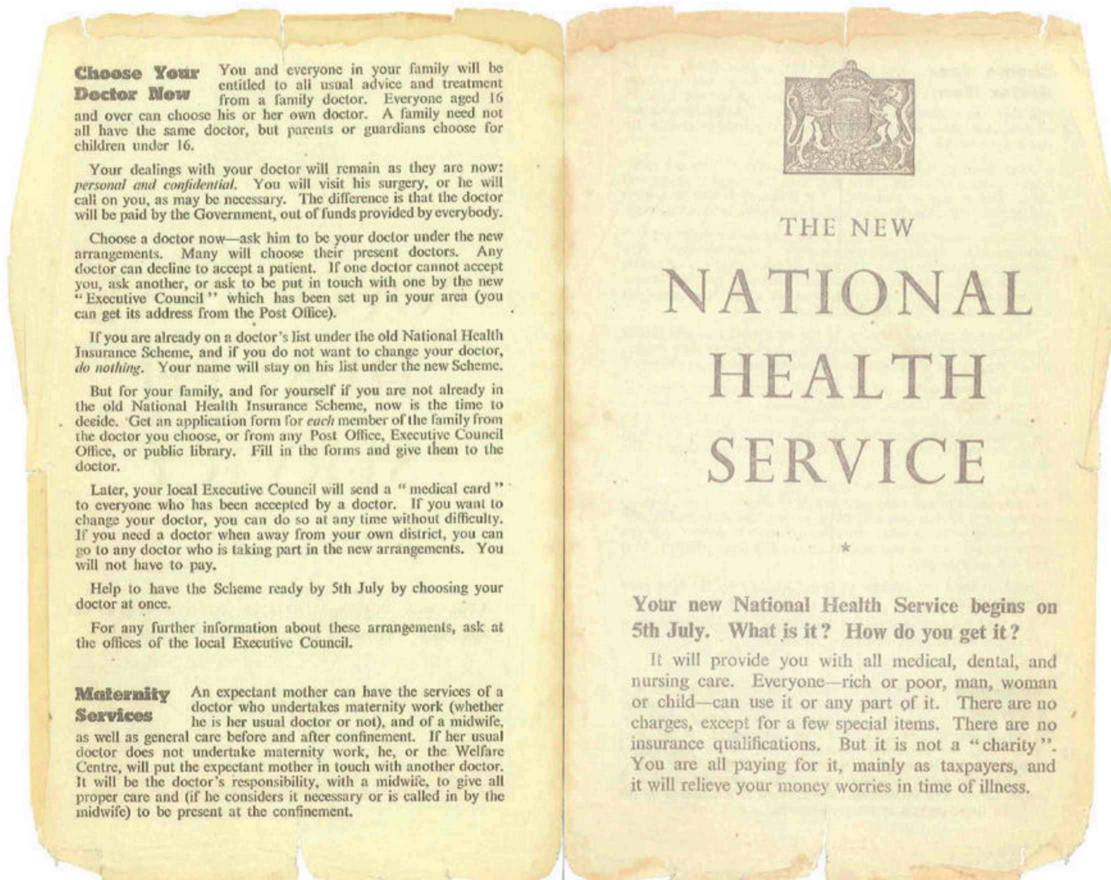
1.4 The NHS has expanded and improved. Over the last decade, it has gone from struggling to good. But it could be better. For all its strengths, the service can at times put its own convenience before that of its patients. Our aim is to go from good to great – to ensure services are designed around the needs of the individual and are accessible to all.

1.5 A minority of patients do not experience the same high-quality care as the majority, and some find it difficult to access their GP practice because it is open only when they are away from home. Yet, when patients try to find a GP practice that provides better quality of care or is more accessible and convenient for them, they often find that they are prevented by practice boundaries, or catchment areas, that typically allow only a narrow group of local residents to register.

1.6 For the minority of patients who are unhappy with their current practice, this lack of choice matters. It matters also for patients who have built up a relationship with their GP but find they have to leave the practice when they move house, even if it is only a few miles away.

1.7 The proposals in this consultation document are designed to let people choose the GP practice that is right for them, not just because the service is easy to access but because it is a high-quality service that responds to their individual needs. This in turn will encourage services to respond even better to patients' needs.

1 Commonwealth Fund International Health Policy Survey, 2009: www.commonwealthfund.org/Content/Publications/In-the-Literature/2009/NOV/A-Survey-of-Primary-Care-Physicians.aspx



Choose Your Doctor Now You and everyone in your family will be entitled to all usual advice and treatment from a family doctor. Everyone aged 16 and over can choose his or her own doctor. A family need not all have the same doctor, but parents or guardians choose for children under 16.

Your dealings with your doctor will remain as they are now: *personal and confidential*. You will visit his surgery, or he will call on you, as may be necessary. The difference is that the doctor will be paid by the Government, out of funds provided by everybody.

Choose a doctor now—ask him to be your doctor under the new arrangements. Many will choose their present doctors. Any doctor can decline to accept a patient. If one doctor cannot accept you, ask another, or ask to be put in touch with one by the new "Executive Council" which has been set up in your area (you can get its address from the Post Office).

If you are already on a doctor's list under the old National Health Insurance Scheme, and if you do not want to change your doctor, *do nothing*. Your name will stay on his list under the new Scheme.

But for your family, and for yourself if you are not already in the old National Health Insurance Scheme, now is the time to decide. Get an application form for *each* member of the family from the doctor you choose, or from any Post Office, Executive Council Office, or public library. Fill in the forms and give them to the doctor.

Later, your local Executive Council will send a "medical card" to everyone who has been accepted by a doctor. If you want to change your doctor, you can do so at any time without difficulty. If you need a doctor when away from your own district, you can go to any doctor who is taking part in the new arrangements. You will not have to pay.

Help to have the Scheme ready by 5th July by choosing your doctor at once.

For any further information about these arrangements, ask at the offices of the local Executive Council.

Maternity Services An expectant mother can have the services of a doctor who undertakes maternity work (whether he is her usual doctor or not), and of a midwife, as well as general care before and after confinement. If her usual doctor does not undertake maternity work, he, or the Welfare Centre, will put the expectant mother in touch with another doctor. It will be the doctor's responsibility, with a midwife, to give all proper care and (if he considers it necessary or is called in by the midwife) to be present at the confinement.

THE NEW

NATIONAL HEALTH SERVICE

*

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

Image of 1948 leaflet offering British public the ability to choose a GP

1.8 Most people want a GP practice that is near to where they live. This is particularly true for older people, including those in nursing and residential care homes, and for people with more complex health problems who are more reliant on home visits. The GPs and nurses at the practice are used to working with district nurses, health visitors, local mental health teams, social care teams and other community-based services and can play a vital role in coordinating care and promoting continuity of care.

> **"Medical treatment should be made available to rich and poor alike in accordance with medical need and no other criteria."**
> **Aneurin Bevan, 1948**

1.9 The measures proposed in this consultation document, by taking away narrow and inflexible boundaries, are designed to benefit those who want to choose a local GP practice just as much as those who want to choose a practice further afield. This is likely to be particularly valuable for people living in more deprived communities that have traditionally had fewer GP practices and less responsive primary care services. There should also be benefits for people from socially excluded and vulnerable groups, such as the homeless or travellers, who have the poorest access to primary care and often find it difficult to see a GP.

1.10 For a smaller but still significant number of people, however, it does not make sense to choose a local practice if they are almost always away from home when it is open. The continuity of care that their local practice could in theory provide is simply not available to them. In some cases, these people may be happy to use walk-in services near where they work, such as those offered by the growing number of GP health centres opening around the country that offer access to GP services to any member of the public (whichever GP they are registered with) from 8am to 8pm, seven days a week. In other cases, however, they may prefer to register with a practice near work, so that it can hold their patient record and provide greater continuity of care.

1.11 Enabling people to choose a GP practice away from home raises a number of questions. What should happen if they are taken ill at home and are too unwell to travel to the GP practice? Who will arrange for them to access other community-based services near their home? What are the implications for how NHS resources are allocated and how money flows around the system to pay for their healthcare? And how do we best ensure that patients make fully informed decisions about the choices available to them?

1.12 Some of these questions raise difficult issues, but the problems are not insuperable. By tackling these issues, we will ensure that – for the first time – no one finds artificial barriers put in their way when they seek to choose the GP practice that best meets their needs.

Registering with a GP practice: how does it currently work?

1.13 The system of patient registration with a GP practice is one of the cornerstones of the NHS. Health commentators around the world admire it for enabling patients to build up and maintain a long-term relationship with a GP practice and for this practice to hold a continuous patient record for each individual on its list, supporting vital public health interventions like immunisation and vaccination programmes.

1.14 Any member of the public is free to approach a GP practice and apply to join its list of NHS patients. At present, the practice can use its discretion in deciding whether or not to accept someone onto its list. But if it refuses an application, it must have reasonable grounds for doing so that do not relate to race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition. Someone who is in the area for more than 24 hours but less than three months may register as a temporary resident.

1.15 A practice can refuse an application where the PCT has agreed that it should close its patient list, typically because it has reached full capacity.

1.16 The most common reason for refusing an application, however, is that the patient does not live within the practice's boundary area.

1.17 Practice boundaries have been enshrined in legislation since the start of the NHS. They define the area – sometimes called the catchment area – in which a GP practice operates. Ordinarily patients can register with a practice only if they live within this area, though the GP contract does not in itself prevent a practice from registering a patient from outside its boundary. Each practice's boundary will have been agreed with the local primary care trust (PCT) or a predecessor organisation when the practice was established and can currently be changed only by mutual agreement between the PCT and the practice.

1.18 The traditional purpose of these boundaries has been to help practices control their workload, particularly in relation to home visits – both during normal surgery hours and during the out-of-hours period (which all GP practices were previously required to cover) – and to help practices keep below the cap on the number of patients they could register.

1.19 When the new GP contract was introduced in 2004, GPs were given new abilities to control their workload, in particular by opting out of responsibility for out-of-hours care, by being able to close their lists, and by being able to withdraw from providing certain additional services like contraceptive or maternity services.

1.20 Since 2004, the most significant remaining feature of practice boundaries is that they enable practices to limit the area in which they have to visit patients at home (during the normal surgery hours of 8am to 6.30pm, Monday to Friday) if there is a clinical need to do so. Home visits make up an estimated 4% of overall GP consultations[2] but (because of the travel time involved) account for a greater proportion of GPs' time. They can be an essential part of the family doctor service for some patients, particularly those who are housebound, those living in nursing or residential care homes, and young children. In other cases, patients can go for years without needing home visits, and yet remain tied to a local practice that they find it inconvenient to use for routine care.

2 2006/07 UK general practice workload survey, NHS Information Centre, 2007: www.dhsspsni.gov.uk/gp_workload_survey_2006_07.pdf

What are the problems?

Tracy Jones, aged 27, lives with her parents in York. She works in Leeds. She has had diabetes for six years. It is very difficult for her to get to her GP practice as it is closed by the time she is home from work. Her last HbA1c test (to check her diabetes is under control) was two years ago and her cholesterol has never been checked. Her home glucose monitoring is good. She sees an optician down the road from where she works. There is a GP practice next door to the optician, but she cannot register there.

Joyce Jones, aged 74, lives in Bath. Like her granddaughter she has diabetes, which she has had since she was 23. Her GP practice is round the corner. Dr Smith has been her GP for the last 13 years. She has got to know the practice nurse very well and often goes to see her, especially about her diabetes. She attends the diabetic community group which takes place at lunchtime in the practice every fortnight. On the last occasion, she attended the diabetic one-stop clinic where she had an eye check, a blood test, podiatry and diabetic advice; and she adjusted her insulin dose after speaking to the diabetic nurse.

- **Why might people want to choose a different practice?**

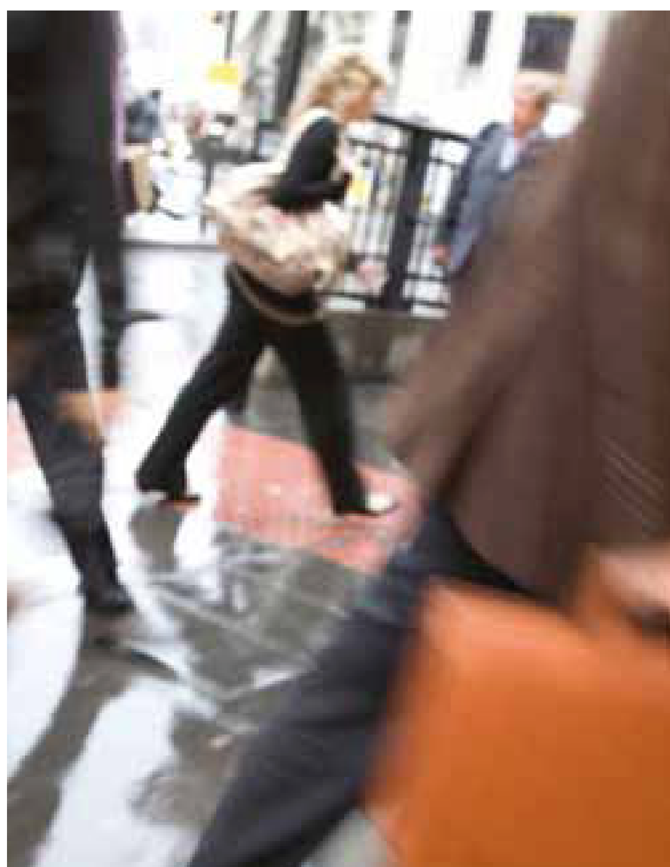
1.21 The examples on this page illustrate how one individual is benefiting from several positive features of a local GP practice, but another is not. If the two patients were allowed to choose their GP practices, Joyce Jones is very likely to stay with her practice, but her granddaughter might prefer to register near work. She could then make appointments with minimal disruption to her work and benefit from the same range of services as her grandmother.

1.22 While the majority of patients are happy with their current GP practice, there are still significant variations in patient experience. Of the two million patients who responded to the 2009 GP Patient Survey, 19% said they had trouble contacting their practice on the phone; 22% said they could not book for an appointment more than two days in advance; and 15% said they were unable to get an appointment within two working days when they last tried. Overall, 91% of patients were satisfied or very satisfied with the overall quality of care.

1.23 The most dissatisfied patients tend to be young and in full-time employment, particularly where they find it difficult to take time off work to see a GP. Patients from some ethnic minority groups are also less likely to be satisfied with GP services: patient satisfaction among some South East Asian communities is up to 15% less on average than for white people. This may be because some patients want to register with a practice where they can see a doctor who speaks a particular language or because they only want to see a female doctor.

1.24 In some cases, patients who find it difficult to see their GP may find it more convenient to register with a practice near work. But the evidence[3] suggests that an even greater number of patients would like the opportunity to choose a different practice close to where they live. This could be because they want a practice that offers longer opening hours or has more convenient systems for making appointments. It could be because they have had an unsatisfactory experience at their current practice. Or it could be because they want a practice that provides a greater range of services.

1.25 Sometimes patients don't see their GP when they want to because it is too inconvenient to get to their practice.[4] These patients may be using other more costly services like A&E. Some people have suggested that by giving people more choice and better access to their registered practice, there might be fewer demands on acute and urgent care services.



1.26 Interest in switching GP practice is not confined to younger, more mobile patients. In a small survey recently commissioned from Ipsos MORI, the proportion of over-55s who had considered switching practice was only slightly below the average.[5]

1.27 In other cases, patients may want to stay with their practice when they move house locally. Around three million people move house every year, with most moving only a relatively short distance.[6] Many of these patients will be required to change practice simply because they have moved a little outside the old practice's catchment area. This can be very frustrating and difficult to understand.

3 GP choice online survey, Ipsos MORI, November 2009: 6% of people in this survey said they would want to register with a practice near their work and 18% would want to be able to register with a different practice in their local area.
4 GP Patient Survey, 2009, Ipsos MORI.
5 GP choice online survey, Ipsos-MORI, November 2009: 20% of people in this survey had considered changing practice without moving house, including 16% of those aged over 55.
6 Royal Geographical Society and Institute of British Geographers, *Local learning: migration*, 2003/04: on average three out of five moves are less than 5km.

• What stops people from exercising choice?

1.28 The most common factor that prevents people from registering with the GP practice of their choice is the positioning of practice boundaries. Boundaries may be drawn very narrowly in a way that inhibits patient choice. In some areas, boundaries do not overlap at all, giving local residents no choice.[7] There are vast differences in the size of practice catchment areas, both nationally and locally. One study[8] has shown that, for one urban PCT, they range from 0.2 to 28 square miles.

What are we already doing?

• Improving access to GP services

1.29 In October 2007, the NHS next stage review interim report[9] gave a commitment to introduce extended opening in at least 50% of GP practices, and to establish over 100 new GP surgeries in areas of greatest need and over 150 GP health centres, to give the public more flexibility and choice in accessing GP services.

1.30 Thanks to the hard work of GP practices and local NHS organisations, over three-quarters (77%) of practices now offer extended hours, compared with 12% in April 2008, giving the public more flexibility and choice in seeing a GP at times that are convenient to them.

1.31 PCTs have already established over 90 new GP surgeries in areas that have long had too few doctors and above-average health needs, helping to increase capacity and choice for local patients. They have also so far established over 120 new GP health centres that are open from 8am to 8pm, seven days a week, and can be used by any member of the public who wishes to see a GP or nurse, either on a walk-in basis or by booking an appointment, while remaining registered at their local practice. These new services are proving popular with the public, especially at weekends and evenings when traditional GP practices are closed.

1.32 These new primary care services build on the previous success of NHS walk-in centres, which were first established in 1999 to provide convenient access to nurse-led primary care and – in later cases – some GP-led services. Walk-in centres tend to be popular with patients who are away from home or have difficulty accessing the GP practice where they are registered.

7 GP choice online survey, Ipsos-MORI, November 2009: of those who had changed practice within the last five years, 11% said the practice to which they moved was the only practice in their area they could register with.
8 John Campbell and Clare Jenkins, *British Medical Journal* 313 (1996), 1189–920. Catchment areas in general practice and their relation to size and quality of practices and deprivation: a descriptive study in one London borough.
9 Department of Health, *Our NHS our future: NHS next stage review – interim report*, October 2007.

• **Making primary care more responsive to patients**

1.33 Alongside improving access to primary care services, we are working with professional and patient groups to support the NHS in making primary care more responsive to the needs of individuals. These improvements are designed to make a real difference to patients' experience, and include making it easier for patients to contact the practice by telephone, enabling more people to book appointments online and improving the welcome patients receive from receptionists and practice staff, as well as specific interventions to improve the experience of patients from black and minority ethnic groups and those with a disability.

Some practices are now teaming up with a GP software supplier and a UK charity for deaf people, Sign Health, to improve clinicians' ability to communicate with patients with hearing difficulties. They are using a computer programme called Sign Translate, which converts text, including a number of standard clinical phrases, into sign language.

• **Ensuring that money follows the patient**

1.34 The NHS in England spends around £7 billion a year providing GP services for patients, but not all of this money follows patients who switch practice. In particular, some £300 million a year was (until 2008/09) spent on a Minimum Practice Income Guarantee introduced as part of the new GP contract in 2004 to preserve existing levels of basic practice income, regardless of changes in the numbers of patients on the practice list.

1.35 The income guarantee reduces incentives for GP practices to take on new patients or to seek to retain existing patients and therefore acts as a barrier to patient choice. In 2008, we agreed with the British Medical Association (BMA) to start phasing out reliance on these income protection payments, and in 2009/10 around £130 million was moved into capitation payments that move with the patient. We are committed to continuing the erosion of these payments, so that practices receive greater rewards for expanding and taking on new patients.

• **Promoting choice**

1.36 Ten years ago, there was almost no information available about local health services. The public now has access to a range of sources – local PCT guides, the NHS Choices website, GP practice websites – that provide comparative information about GP practices.

1.37 The NHS Choices website, for example, lets the public compare GP opening hours and what patients think about different practices (as measured through the GP Patient Survey), and lets them leave comments on the site for others to see. This facility is already proving popular as patients log on to see what other services might be available. Over 6,000 people have left comments so far and the site has seen an increase of over 60,000 people visiting the GP directory pages every month.

Engagement so far

1.38 Since September 2009, we have been engaging with a number of organisations and individuals to discuss our proposals and to explore the challenges that need to be overcome to open up choice for patients.

1.39 This initial engagement culminated at the end of January 2010 with a stakeholder event facilitated by the NHS Institute for Innovation and Improvement. The event brought together over 100 people from a range of backgrounds, including patient representatives, GPs, practice managers, nurses and PCT managers, to discuss the challenges and explore possible solutions. Delegates also worked to identify how best to frame the consultation so that we can help as many people as possible engage in the process.

1.40 Engagement to date has shown widespread support for widening choice for patients. At the same time, a number of people have voiced concerns about the potential impact on continuity of care, including arrangements for in-hours urgent care and for other community services, if people do not register with a local practice. People have also underlined the importance of preserving good access for those who continue to register with local practices near where they live.

1.41 Engagement has also highlighted increasingly numerous examples of local health systems already seeking to offer patients more choice. In some areas, for instance, clusters of GP practices (often brought together through practice-based commissioning) are seeking to give patients more opportunity to choose between them. A growing number of PCTs are using innovative ways to help patients make the right decision about their choice of GP practice.

1.42 The proposals set out in this document build on the existing strengths of primary care and on these emerging examples of innovation in opening up patient choice.

Summary

1.43 We consider that the simplest and most effective way of opening up choice is to abolish the current system of practice boundaries. Chapter 2 sets out our proposals. It is likely that some administrative system would be needed to distinguish between local patients (for whom current home visiting arrangements would continue as normal) and patients living further away (for whom separate arrangements would need to be made for acute, in-hours care if they are ill at home). However, the key difference from now is that the system would not prevent people from registering with the GP practice of their choice.

1.44 There are other, secondary factors that can reduce patient choice. Chapter 3 sets out additional proposals to enhance choice in these areas. For instance:

- Some GP practices do not accept new registrations even from patients within their boundaries. In some cases (an estimated 2% of all GP practices), this is because they have reached full capacity and have agreed with the PCT to close their lists to new registrations. These arrangements will be necessary in any system to ensure patient safety and quality of service provision. However, an estimated 10% of practices, often bunched in the same areas, tell patients that they are 'full' without agreement from the PCT on closing their lists, in contravention of their contractual arrangements.

- Some GP practices would like to expand to take on more patients but are put off by the initial costs involved in expanding their premises or taking on new staff.
- Members of the public are not always aware of the choices already available to them[10] or of how to switch practice.[11]

10 Jo Ellins and Shirley McIver, *Systematic provision of information on quality of primary care services*, University of Birmingham Health Services Management Centre and NHS West Midlands, August 2008.

11 Ipsos MORI omnibus survey undertaken on behalf of the Department of Health, 2009: 21% of people in this survey said that they thought it would be difficult to change practice and 7% of these people did not know that they could change practice.

Changing GP

Isabel, aged 38, moved house in July 2008 and wanted to register with a GP close to her new home.

"The first thing I did was to ask a friend who lives in the same area for advice. She recommended a practice, but it wasn't within walking distance of my house. Although I have a car and could drive to the doctor's, I preferred to be registered with one closer to my home.

"I went online to locate the practices closest to me. I knew there was an NHS facility to search for GPs, so I went on Google and typed in 'find NHS GP' plus 'N19', which is my postcode.

"It came up with the 'find services' page of the NHS Choices site. I entered my postcode, and the site produced a list of GP practices, in order of distance from my house. This was very useful because my main criterion was distance.

"My other preference was to find a practice with several GPs, including at least one woman doctor. The first entry was a sole practitioner who was a man, so I discounted that one. There was only one practice with several GPs within walking distance, so I registered there.

"Shortly after registering, I went to see one of the doctors. I was happy with the GP himself, but I wasn't impressed by the practice. It felt dark and dingy, and the reception area didn't seem clean. It was also a relatively small practice, with only one woman GP who worked part-time. I felt that I wouldn't always be able to see a female doctor when I wanted to.

"For these reasons, I decided that the practice wasn't right for me. At this point, I decided that it wasn't so important to find somewhere within walking distance. So I checked out the practice that my friend had recommended.

"Various things impressed me. They have a very efficient phone system that clearly signposts the different options: 'Press 1 for emergencies, 2 for appointments,' and so on. When you've chosen your option, you're told where you are in the queue, and you're given updates as you move up the queue. At my previous practice, you had to keep ringing until someone answered, and the line was often engaged.

"The practice also has its own website with detailed information about the appointments system, the services available and the staff. Having access to all this information was reassuring. It helped me to build a clearer picture of the practice.

"A big advantage of the practice is that it has ten GPs, including several women. Because it's a larger practice, it has several clinics, which gave me confidence that it would meet all my family's needs.

"When I visited the surgery, I noticed how clean and airy the reception area was. There's a touch-in screen for registering your arrival, which means you don't have to wait to tell the receptionist that you've arrived. There are also overhead screens telling patients when to see the doctor or nurse.

"Overall, it seemed a better-organised and more dynamic practice. I strongly felt that it would be the right place for me.

"In the end, I had changed GPs twice in a year, but it was very easy. When I registered with the second practice, they didn't even ask for my NHS number. They took my details and found my number for me.

"I'm pleased with my decision. I think that when you go to the doctor's with concerns about your health, you need to feel confident that the practice is well run."

Chapter 2: Removing the current system of practice boundaries

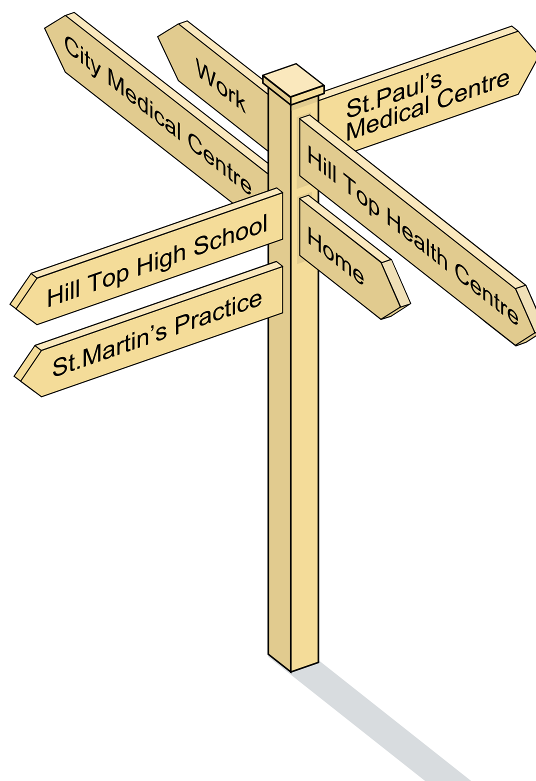
Introduction

2.1 At present, the system of GP registration is based on the requirement to register with a practice near where you live. For some patients, this is important as a way of ensuring the same GP practice can provide home visits if necessary and can coordinate care with other local services and professionals.

2.2 This chapter sets out proposals and options for enabling people to choose their GP practice without being constrained by practice boundaries. These proposals are designed to ensure that we simultaneously:

- preserve the strengths of existing general practice for the majority of people who want to stay registered with their current practice
- open up greater choice for those who want to choose a different practice but want it to be a local practice that is well placed to coordinate care with other local services and, where necessary, arrange home visits
- allow more people to stay with their current practice when they move house
- allow people, where they wish, the freedom to register with a practice elsewhere in the country if this is a better way of giving them convenient access to high-quality services.

2.3 It is important to clarify that, in proposing to remove the current system of GP practice boundaries, we are not talking about changing the list-based system upon which general practice is founded. It is precisely because the relationship between patient and practice is so important that we want to ensure people can choose practices that they can access conveniently and that provide the services that are right for them.



2.4 Nor are we seeking to create a system that requires patients to use GP practices as walk-in centres where they turn up and wait to be seen by any GP. We would not expect patients to re-register frequently or to have to re-register if they are away from home for short periods of time, for example when on holiday. There is a range of existing services, including temporary residence arrangements, that enable people to see a GP when they are temporarily away from home.

2.5 All the options under consideration in this consultation preserve the principle of a single GP practice having overall responsibility for the care

of a patient, for maintaining continuity of care and for coordinating that care. This continuity does not have to mean seeing the same GP on each occasion. But it does mean that the same practice is responsible for maintaining the patient's health record, for ensuring the necessary review and management of any long-term conditions (such as diabetes or asthma) and – if it is a practice-based commissioner – for helping to use NHS resources to secure the best wider healthcare services when a patient needs them.

2.6 The proposals and options are grouped under the following headings:

- home visits: how to ensure that patients continue to receive home visits when clinically necessary
- urgent care: how to ensure access to care when a patient has an acute or urgent need during the day and is unable to visit their GP practice
- coordination of care: how to ensure continued coordination between GP services, and other community-based services, including social care
- access to hospital and specialist services
- information technology and access to patients' medical records
- implications for PCT resource allocations and accountability.

2.7 For some proposals, there will be implications for GPs' contractual duties and for the funding of GP practices, which will need to be considered at a later date by those responsible for negotiating changes to the GP contract. The purpose of this consultation is not to pin down these contractual changes, but to seek views on how the new system should work from the point of view of the patient and on the principles that should inform subsequent decisions on contracts and funding.

Home visits

2.8 One of the main issues that has arisen in our engagement so far is the contractual obligation for GPs to undertake a consultation in a patient's home if medically required during normal surgery hours. (All primary care trusts (PCTs) have separate arrangements for home visits and other urgent care during the out-of-hours period from 6.30pm to 8am and at weekends.)

2.9 Despite the downward trend in numbers of home visits in recent years (from around 14 million in 1995 to six million in 2006[12]), many patients still rely on home visits, for chronic and end-of-life care and in cases of acute illness. It is essential that we preserve this service for patients who cannot attend the practice, for example those in nursing and residential care homes.

12 2006/07 UK general practice workload survey, NHS Information Centre, 2007.

2.10 GPs may also arrange home visits when someone is discharged from hospital. It is particularly important for older patients and those from other vulnerable groups that they are seen by a doctor whom they know and who understands their background and medical history.

2.11 Where it is important to patients that their own GP practice is responsible for carrying out home visits, it is reasonable to expect them to choose a practice within a reasonable travelling distance of where they live, so that GPs do not have to incur a disproportionate amount of travel time. It is frustrating, however, for patients who seek to register at a local practice but are told they are outside the area boundary.

2.12 Other patients will have had no need for or experience of home visits. For them, the benefits of choosing a practice that they can conveniently access for routine care may far outweigh the fact that the same practice is unable to carry out a home visit on the rare occasion (if any) that it is needed.

2.13 Our proposed approach, therefore is:

Option A: to allow people to register with any practice in England with an open list, but to have a simple set of rules or principles to distinguish between patients who are registering locally (for whom the local practice should retain the duty to provide or arrange home visits where necessary) and patients who are registering further away from home (for whom the PCT covering the patient's home would be responsible for providing home visits).

2.14 The three alternative options considered below – on which we would also welcome views – are:

Option B: to maintain the requirement for GP practices to provide or arrange home visits for all patients on their list, regardless of where they live

Option C: to allow people to register with two separate GP practices ('dual registration')

Option D: to remove all home visiting obligations from GP practices and make PCTs responsible for establishing home visiting arrangements.

Option A: GP practices to continue to have responsibility for home visiting for local patients; PCTs to make arrangements to provide home visits, where necessary, for patients who register further away from home.

2.15 **Option A** would enable people to make an informed choice as to whether they wanted to register with a local practice that had the same home visiting duties as now or to register with a practice further away from home. In the latter case, that practice would be allowed to transfer responsibility for arranging any home visits to the PCT where the patient lives.

2.16 Unlike the current system of practice boundaries, this system would include a consistent set of principles to enable the NHS to decide whether or not a practice is responsible for home visits.

Strengths	Weaknesses
Creates a clear offer to patients, i.e. if you choose a local practice, your practice will be responsible for arranging any home visits; if you choose a more distant practice, your home PCT will have this responsibility.	PCTs would have to set up new arrangements for home visiting for what could be low levels of need.
Opens up greater choice, both for people who want a local practice that is responsible for home visits and for people who want a practice further away from home.	If patients do not use or understand the arrangements put in place by PCTs, this might place additional demand on A&E departments and ambulance services.
Clear differentiation of two groups of patients for funding purposes.	Until the Summary Care Record is in place, the clinician making a home visit for out-of-area patients will not have access to patients' health information.

• **How would PCTs secure home visits for patients registered further away?**

2.17 PCTs would have the option of commissioning a dedicated home visiting service for patients who live at a distance from their GP practice. It is very unlikely, however, that patients who require regular home visits would register with a practice far from where they live, so a dedicated service might not have sufficient demand to justify its costs. PCTs could therefore secure home visiting in a variety of other ways, including:

- making arrangements with local GP practices or GP health centres to provide home visits, e.g. on a fee-per-visit basis

- making similar arrangements with consortia of local practices (some areas already have cooperative arrangements for acute home visiting,[13] which have resulted in visits being handled more quickly and effectively, as well as a reduction in hospital admissions)
- arranging for the local out-of-hours service to provide home visits during the daytime period as well.

2.18 It would obviously be essential that patients who register with a practice away from home understand whom to contact if they become acutely ill at home, so that a home visit can be made swiftly if necessary.

2.19 We know that some people already live outside the area boundary of their GP practice. Some practices still offer home visits to these patients, while others seek an informal understanding that the patient will not ask for home visits but will use other services (such as A&E or the ambulance service) if they develop acute symptoms at home and do not feel well enough to get to the GP surgery. This goes against a practice's contractual duties. It would theoretically be possible to formalise these arrangements, so that a patient who registers away from home effectively opts out of an entitlement to home visits. We do not, however, support this approach. The NHS has a clear duty of care to people who fall ill at home and, in the absence of another service, there is a risk of an increase in expensive 999 calls and/or of patients failing to seek help because they are not sure of their entitlements.

• How would we distinguish between local and out-of-area patients?

2.20 It is essential to this option that when an individual registers with a GP practice, everyone concerned – the patient, the GP practice and the PCT – is clear whether the individual practice has responsibility for home visits, or whether this duty rests with the PCT.

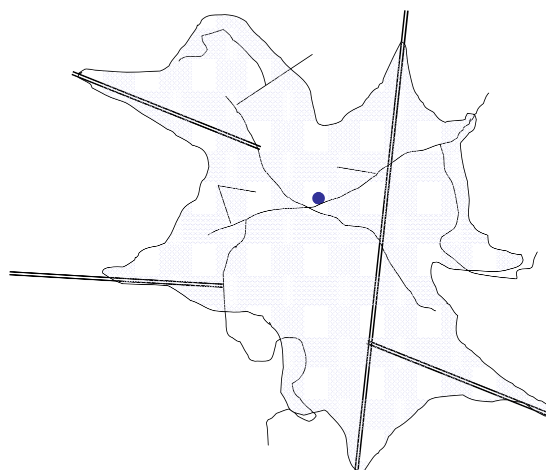
2.21 Using the current system of practice boundaries to distinguish between these two types of registration would be unfair for patients and for practices. Patients living in areas with narrow boundaries would still be left with an unduly small choice of practices. It would be unfair to allow practices with narrow boundaries to start opening up their doors to other local patients but without the responsibility of home visits.

13 e.g. the Acute Visiting Scheme designed by United League Commissioning Consortia for Halton and St Helens, 2006.

2.22 We therefore propose to establish a set of guidelines that PCTs would use, in consultation with local practices and patients, to define the area beyond which a practice can cease, if it wishes, to be responsible for home visiting. These guidelines could take into account factors such as travel time, patient demographics and population density.

The travel time system

Based on private car travel time in normal traffic, the travel time system creates equal time–distance contours, clearly extending along routes that offer quicker, easier access. There are already various computer software packages that can work out these areas, taking into account individual travel times.



2.23 The advantage of a system based on travel time is that, unlike one based on distance (as the crow flies), it takes into account factors that will affect the ability of GP practices to arrange home visits without detriment to other areas of patient care.

2.24 In some cases, PCTs could agree with practices to set this area to correspond with the PCT boundary. This would mean that a patient living in that PCT could choose any practice in that PCT without arrangements for home visiting being affected. Where a patient lived outside the PCT area, alternative home visiting arrangements would apply. This approach could work well where groups of GP practices (e.g. practice-based commissioning consortia, or in federated groups) set up collaborative arrangements for home visiting. But this approach is unlikely to work well in particularly large or rural PCTs such as Cornwall, Hampshire or North Yorkshire.

- **Who would meet the costs of home visits for patients registered further away?**

2.25 The details of funding arrangements would need to be discussed in more detail as part of GP contract negotiations, but we would welcome views on the principles that should inform these discussions.

2.26 If a GP practice registers an out-of-area patient and decides to transfer responsibility for arranging home visits to the PCT, there is an argument that the GP practice should meet or contribute to the costs of any home visits needed, i.e. receive less funding for out-of-area patients. This would recognise the fact that the practice does not have the same range of

responsibilities as it would for a more local patient; it would avoid or reduce additional financial costs for the PCT; and it could provide incentives for the practice to make its own arrangements for securing home visits, for instance through reciprocal arrangements with another practice.

2.27 We have also heard arguments that GP practices should receive the same funding for an out-of-area patient as for any other patient, or even that they should receive additional funding for registering out-of-area patients, on the grounds that there will be more time involved in coordinating care with other agencies. This would mean that PCTs had to bear the full cost of arranging any home visits needed. We would welcome your views on the likely balance between the reduced cost of fewer home visits and increased costs associated with coordination of care.

2.28 The GP practice could meet or contribute to the costs of home visits through:

- having an amount top-sliced from the annual capitation payment that they receive for having the patient on their list; or
- a system whereby the cost of an individual visit is charged back to the practice.

2.29 The potential advantages of the first option (top-slicing) are, first, that it would avoid additional transaction costs and, second, that it would effectively allow financial risk to be pooled between practices, rather than a practice losing income if its out-of-area patients received an unusually high number of home visits in a given year.

2.30 We would welcome views on these or any other approaches, without prejudice to the wider question of how funding responsibility should be apportioned between the practice and the PCT.

Option B: Maintain the requirement for GP practices to provide or arrange home visits for all patients on their list, regardless of where they live.

2.31 Under **Option B**, GP practices would be responsible for home visits, where they are needed, regardless of where the patient lived. As now, GP practices could choose whether to carry out home visits themselves, or whether to make arrangements with GP practices or other organisations closer to the patient's home. There are similarities with Option A, but the key difference is that the GP practice would decide for itself whether a patient lived sufficiently close to visit itself and, if not, what other arrangements it should make.

Strengths	Weaknesses
No need to establish new rules to distinguish between local and out-of-area patients.	GP practices would need to establish multiple agreements with other practices/ providers across the country, with potential for significant administrative and cost burdens. PCTs would be likely to have to help broker these arrangements.
GPs remain clinically responsible for all home visiting.	Some practices might be more reluctant to take on patients who live far away, or might encourage patients to use other services (e.g. A&E) when they are ill at home.
No need to top-slice capitation payments to contribute to costs of home visits for out-of-area patients.	Until the Summary Care Record is in place, the clinician making a home visit for out-of-area patients will not have access to patients' health information.
Could encourage practices to work more collaboratively and enter into federated arrangements.	

2.32 This approach would have the benefit of encouraging collaborative and innovative arrangements between GPs and practice staff in different areas. However, one of the drawbacks is that a practice would become clinically responsible for home visiting (where needed) as soon as it accepted a patient onto its list. In some cases, the patient might be from an area in which the practice had already established reciprocal or collaborative arrangements. In other cases, the practice might have to delay accepting a new patient until it had put such arrangements in place, which could leave the patient in limbo. Under Option A, by contrast, PCTs could ensure from the start that they had arrangements in place for any patient living in or moving into their area.

2.33 For some practices, the administrative burden of establishing a number of arrangements with different practices, very possibly in different PCTs, could be considerable. If practices were to have trouble securing the appropriate services, we might expect PCTs to broker arrangements between practices.

Option C: Allow patients to register with two separate GP practices ('dual registration').

2.34 Under **Option C**, patients would continue to choose a local practice, which would provide a full range of services, including (where necessary) providing home visits or coordinating care with other local services, but they could also choose to register with a second practice elsewhere, for example near their place of work.

2.35 To reduce additional costs, there could be certain restrictions on the range of services that could be accessed from the secondary provider. It is also likely that there would need to be a limit on the distance between the two practices to ensure patients were genuinely benefiting from dual registration. It would, for instance, be inappropriate and unnecessary for a patient to register with two practices on the same street.

Strengths	Weaknesses
Local GP practice would provide better coordination of care with other local services and be available for home visits and other urgent care needs. Within certain clinical systems, medical records can already be shared between two or more practices. Could particularly benefit students who spend fixed periods of time away from home.	Potentially serious risks to clinical safety, e.g. through patients seeking or inadvertently being prescribed duplicate medication. Potentially significant extra costs, either for GP practices or for the NHS. Potential for unnecessary cost drift: for example, there would be no need to de-register when moving house, so a practice would continue to receive funding even if it received only rare visits from the patient. Would create complications for practice-based commissioning – how would the budget for wider services (including prescribing and referrals) be apportioned between the two practices?

2.36 Although this approach is superficially attractive, we think it has major disadvantages. It would breach the current principle of a single practice being responsible for coordinating a patient's overall care. Without excellent coordination between the two practices, it would risk duplication, errors and confusion over which practice was clinically responsible for which aspects of a patient's case.

2.37 It could also carry additional costs because patients are likely to make greater use of services, even to the extent of seeking two medical opinions for the same complaint. If the normal annual funding for a registered patient were simply split between the two practices, then the costs arising from this greater use of services would have to be borne by the two practices. If, on the other hand, each practice received more than 50% of the normal annual funding (to recognise the likelihood of additional costs) this would increase the costs to the NHS for each patient who registers with two practices.

Option D: remove all home visiting obligations from GP practices and make PCTs responsible for establishing home visiting arrangements.

2.38 In theory, PCTs could become responsible for commissioning or arranging a separate home visiting service for all patients who need it, regardless of whether they live near to their GP practice. This would have to be funded by making a corresponding deduction from the funding currently paid to GP practices.

2.39 We have included this option for completeness and to invite debate, but we think it has major disadvantages. For patients with complex health conditions, including a number of older people, it would significantly erode continuity of care – and mean that they would be unable to see their local GP when they were most ill. It is possible that, in some areas, groups of existing GPs would want to provide the home visiting service on a collaborative basis. But for many housebound people and people in residential and nursing homes, it could end the current relationship they have with their GP and GP practice. This would be unacceptable.

Urgent care

2.40 Where a person has registered with a practice some distance from where they live, they may on occasion develop an illness or injury when they are at home that, while it does not necessitate a home visit, makes it difficult to travel to be seen at their GP practice. With the exception of dual registration, the options set out above would all therefore cause some increase in demand for local urgent care services, including A&E departments, minor injury units, walk-in centres and GP health centres.

2.41 This does not in our view detract from the advantages of being able to register with a practice away from home. If this new arrangement enables a patient to have convenient access to the practice of their choice for the majority of their primary care, with all the advantages this brings for continuity of care, this will be an improvement on the current system for those patients who find it difficult to access their local GP practice and instead rely on a range of different services for primary medical care.

2.42 It does, however, mean that the PCT where the patient lives may face some increase in urgent care costs, except in so far as the additional demand can be absorbed within the existing capacity of services such as walk-in centres and GP health centres. By contrast, the practice with which the patient is now registered may face correspondingly fewer demands on its time and resources than it would for a local patient.

2.43 There is therefore an argument (as in respect of home visits) for paying GP practices a slightly lower annual amount in respect of out-of-area patients (compared with the annual funding they would receive for a local patient). On the other hand, it would be difficult to ascertain how far these urgent care costs would have arisen in any case, given that patients are free at present to use these other services if they wish. As indicated above, there is also an argument that practices registering out-of-area patients will incur additional time and resource coordinating care with other agencies. The extent of any adjustment to the capitation payments for out-of-area patients will, as with home visits, need to be discussed as part of GP contract negotiations. We would, however, welcome views in the meantime on the likely impact on the workload of GP practices.

2.44 Whatever the funding arrangements, it will be important to ensure that patients who have chosen a GP practice away from home have good information and advice about how to access urgent care services closer to where they live, including:

- whom to contact if they think they need a home visit
- where to go if they are unwell and want to get urgent care at a local primary care service, e.g. a GP health centre, walk-in centre or A&E department
- the arrangements for accessing urgent care during the out-of-hours period.

Coordination with community-based services

2.45 GP practices often help to refer or direct people to other services within the community, such as district nursing, health visitors, mental health teams, maternity services and physiotherapy, and to help coordinate care between these services. These community services are often fixed within particular localities or practice boundaries.

2.46 These community services tend to be used most by people with a range of health needs, particularly older people, who are also likely to set particular store by registering with a local GP practice. We must not, however, ignore the possibility that some patients who choose a practice away from where they live may also on occasion need to use these services: for instance, someone with a long-term condition such as diabetes or asthma may need to attend a regular clinic, and a pregnant woman or new mother will need maternity services.

2.47 Where an out-of-area patient required community-based services, a GP would essentially have two options which they would need to discuss with the patient:

- to use the community healthcare teams attached to the practice, which (like the practice) will be at some distance from where the patient lives, or
- to contact the community services that cover the area in which the patient lives and, where necessary, to coordinate care with these other services.

2.48 In some cases, patients may well wish to access these services in the same area as their GP practice, for example a specialist diabetes or asthma clinic near their place of work. In other cases, such as a health visiting service, they will want to receive the service in the area where they live.

2.49 We consider that these challenges are soluble, provided that the solutions follow a number of key principles:

- The GP practice should remain responsible for discussing the options with the patient and for agreeing with them the most appropriate service for their needs.
- PCTs should ensure that there is a single point of initial access to community services in their area, so as to ensure as smooth a process as possible for clinician and patient in cases where it makes sense to access a service in the area where the patient lives.
- Funding for these wider services should, as far as possible, follow the patient, so that the cost of the service can be charged to the budget of the PCT and the practice-based commissioner in whose area the patient is registered. This will be made increasingly possible by the development of tariffs for community services.

In April 2009 the Department launched a two-year pilot programme designed to explore different ways in which health and social care could be provided to drive improvements in local health and well-being. Within these integrated care pilots, PCTs such as Cumbria and Tower Hamlets are working with local practice-based commissioners to develop new care pathways and create specialist community teams that allow doctors, nurses, therapists, geriatricians and social services to care for more people over a wider area in the community.

2.50 Social care services – such as domiciliary or residential care, equipment and adaptations – are arranged and funded through local authorities, subject to their eligibility criteria and rules on charging. Many GPs build up long-term relationships with social care workers and provide patients with advice and information about local social care services. In some areas, the GP practice and social services share premises to allow for more integrated working.

2.51 In the great majority of cases where someone needs ongoing social care, they are likely to choose a local GP practice that will be well placed to help coordinate their health and social care. In other cases, someone might be registered with a GP practice outside the area where they receive social care services. This would not, however, be a new phenomenon. There are already GP practices that successfully coordinate care with a range of neighbouring local authorities.

Community care

David has been registered at the same GP practice all his life. His first GP retired and he now enjoys an excellent relationship with his present GP. He has minor complications resulting from an injury he received some years ago and largely treats these himself, with support from his GP when necessary. David recently married and moved from his parents' house to a new home seven miles away from his GP practice. He didn't tell his practice about the change of address because he didn't want to have to change GP.

Recently David made an appointment with his GP and had to be referred for a minor operation as a day case. The practice nurse, who was managing the referral, asked if David would be at his address after the operation so that a district nurse could visit to change his dressings. He informed the nurse of his new address and was told that this was a major problem because he had moved outside his practice's catchment area.

The practice nurse said that the district nursing service didn't cover the area David had moved to and that they would have to find someone else to do it. They suggested that he would need to be at his father's address (which did fall within the catchment area) to get the dressing changed, which wasn't very convenient for David.

In the end, David had to be kept in hospital overnight so a visit from the district nurse was not required, but he couldn't understand why the district nurse wouldn't travel the additional couple of miles to see him. Afterwards, David was told that he would have to change practice because he lived beyond his current practice's boundaries. He thought this was unreasonable and unnecessary. He's now registered with a good practice close to his home but doesn't feel as comfortable speaking to his current GP as he did with his former doctor.

Access to hospital and specialist services

2.52 GP practices play an essential role in deciding when to refer patients for more specialist treatment or diagnosis, in particular by referral to a consultant-led outpatient service in hospital.

2.53 Patients already have free choice of provider when they are referred to hospital for a first outpatient appointment, and are supported in making this choice by information available both to GPs and to patients on the services available in each hospital, on comparative waiting times and other relevant factors. The 'payment by results' tariff system means that the cost of the hospital services they receive is charged back to their PCT and to the indicative budget held by their GP practice in its capacity as a practice-based commissioner.

2.54 Subject to the forthcoming adjustments to financial allocations discussed later, these arrangements should not be significantly affected by a patient's decision to choose a practice outside their area of residence. Some PCT areas have, with the help of local clinicians, developed different care pathways, for instance to decide in what circumstances someone should be ordinarily be referred to a hospital specialist and in what circumstances they would benefit more from a community-based alternative. Under our proposals, GP practices would continue to follow these pathways wherever possible. In the event that the normal pathway was unsuitable for the patient by virtue of where they lived, the PCT and GP practice would need to ensure that the pathway was sufficiently flexible for them to be referred to an alternative specialist service near to where they lived.

2.55 The other factor that has been raised with us during engagement to date is the possibility that some patients might choose to register with a practice outside the PCT where they live because of different eligibility criteria for certain specialist treatments, for instance in vitro fertilisation (IVF), or drug treatments that are awaiting decisions by the National Institute for Health and Clinical Excellence (NICE). This could, however, lead to reduced variation in the eligibility criteria used by PCTs in these cases.

Information technology and access to medical records

2.56 If people are able to register some distance away from home and have to rely on a local service for urgent care, including home visits, the need for a more accessible clinical record will increase.

2.57 This is not in itself an argument against allowing people to register away in home. At present, people who struggle to access their local GP practice during normal opening hours are likely to be accessing care in a range of other settings, including A&E, walk-in centres and out-of-hours providers. Enabling them to register with a more convenient GP practice will mean that they will more often be able to see a GP who has access to their medical record. Greater choice will nonetheless increase the importance of shared medical records.

2.58 Connecting for Health's Summary Care Record is providing an electronic clinical record to support clinicians nationally when patients present for care. It is designed to contain summary information from the GP practice on medication allergies, significant medical history and treatment plans. In due course it will also contain key hospital discharge letters and out-of-hours contact information. Patients are able to open a HealthSpace account so that they can access their own summary record, and they can then show this to any clinician they wish, so that they control access to this information themselves.

2.59 The NHS is due to roll out the Summary Care Record online by the end of March 2011 where technically possible.

Implications for PCT resource allocations and accountability

2.60 We are already moving to a system under which PCT resource allocations will be determined by the number of people who are registered with GP practices in each PCT area. We expect this to be in place from April 2011. This means that money will follow the patient and that the PCT in question – and the practice-based commissioner where the patient chooses their GP practice – will receive the funding associated with that patient.

2.61 Where a patient is registered with a GP practice in one PCT but receives other NHS services in a different PCT, the relevant costs can in many cases be charged back to that PCT and practice-based commissioner. This is the case for hospital services, other tariff-based services and prescribing, and it will increasingly become so for community services.

2.62 This will leave a certain proportion of costs that fall to the PCT in which a patient is resident, including the costs of out-of-hours services, other urgent care services and (until tariffs are introduced) community services. This already happens to some extent when patients living in one PCT area register with a practice in another. As greater choice is initially introduced, we would not expect the use of these other (non-tariff) services to have a material effect on relative PCT costs, in other words a sufficient impact to warrant any adjustment to PCT allocations. As the new arrangements bed down, we will, however, be able to assess the numbers of patients choosing to register with GP practices in PCTs other than those in which they live and to evaluate the impact on the use of non-tariff services in the PCTs where they are resident.

2.63 PCTs are responsible for planning services to meet the needs both of their local populations and of other people who use health services in that area. We would expect that, with the majority of people choosing to remain with a local GP practice, there should not be a significant impact on the process of overall planning and commissioning. PCTs will, however, need to work, as now, with local GP practices and with patients and the public to ensure that they address the needs of all people using health services in their area, not just those resident in the area.

Chapter 3: Supporting choice

3.1 Choice can sometimes be constrained not only by practice boundaries, but also by the capacity of practices to take on more patients, by closed or 'open but full' lists, by the right of practices to refuse registration, and by the public not understanding or having sufficient information about the choices already available to them. This chapter sets out additional proposals to help overcome these constraints and further open up patient choice.

Simplifying open and closed lists

3.2 Under our proposals for opening up choice, it is possible that some practices, particularly those in city and town centres, would experience an increase in the number of patients wanting to register with them. These practices might then reach maximum capacity and have to close their lists to new patients, even if only as a temporary measure while they consider how to expand their services.

3.3 Where a practice is at full capacity, it is important that it is able to declare its list closed, so that it can maintain high-quality services for everyone on its patient list. However, at present some practices say they are 'full' despite having not formally agreed with the PCT on closure of their lists. Estimates suggest that up to 10% of practices, over 800, are operating in this way. This creates confusion and lack of transparency.

3.4 We think that any practice with an open list should not be attempting to deter patients by saying it is 'full', and in doing so is acting in breach of its contract.

3.5 PCTs already have legal powers to tackle such instances, but there are ways in which we could simplify the arrangements for formal list closure to ensure that genuinely full practices go through the proper procedures rather than declaring themselves 'open but full'. We would welcome views on this. We could, for instance:

- remove the stipulation used by some PCTs that practices must remain closed for at least six months if they go through the closed list procedure
- more tightly define the circumstances in which a practice with a closed list is prevented from carrying out – and receiving additional income for – enhanced services.

3.6 Some people have also expressed concerns that a popular local practice could attract significant numbers of patients from other areas and could then find itself unable to take on new patients living in the area. One potential safeguard, on which we would welcome views, would be to say that practices approaching full capacity should close their list to out-of-area patients first in order to protect access for local residents.

3.7 Some people have also raised concerns about the impact on their GP practice of a significant number of current patients choosing to register with practices elsewhere, for example closer to where they work. Where this happens, the GP funding system means that the funding associated with the patients leaving the practice (the weighted capitation fee) will follow

them to their new practices. This mechanism is designed to ensure that the funding received by a practice is proportionate to the number of patients it has to serve and the volume of services it has to provide. Changes in the size of the patient list should not therefore have an adverse impact on practices' ability to provide services for their continuing patients. Indeed, we would expect greater patient choice to provide additional incentives for practices to offer more responsive services in order to retain the maximum number of existing patients and attract new ones.

Supporting practice expansion

3.8 In areas where high-quality, popular practices reach maximum capacity, there may be a case for PCTs helping these practices to expand and take on more patients who can benefit from the responsive services on offer.

3.9 PCTs can, for instance, offer an 'expanding practice allowance', i.e. a one-off grant to help a practice invest in increased infrastructure – staff and/or premises – in anticipation of a larger patient list. This provision recognises that there will be a delay between investing in increased capacity and attracting more patients to the practice with the additional funding they bring with them.

3.10 These are usually time-limited and exceptional measures designed to help with the initial challenges a practice may face when it wants to expand. PCTs have in the past been reluctant to offer additional funding for practice expansion, partly because they have been concerned that it could undermine the choice and competition principles. However, additional support of this type is permitted under the National Health Service Act 2006.

Section 96 of the National Health Service Act 2006

Assistance and support: primary medical care services

(1) A Primary Care Trust may provide assistance or support to any person providing or proposing to provide –
(a) primary medical services under a general medical services contract, or
(b) primary medical services in accordance with section 92 arrangements.

(2) Assistance or support provided by a Primary Care Trust under subsection (1) is provided on such terms, including terms as to payment, as the Primary Care Trust considers appropriate.

(3) "Assistance" includes financial assistance.

A more explicit right to choose

3.11 GP practices can currently refuse new patient registrations provided the grounds for doing so are reasonable and non-discriminatory. Being outside the practice boundary is currently one justification for refusing a patient, but not the only one.

3.12 We would welcome views on introducing a more explicit patient right to choose. Even with the abolition of practice boundaries, there is a risk that practices could apply inconsistent criteria in deciding whether or not to accept a patient, particularly if that patient lives in a different area. To reduce inconsistency and to promote patient choice, we would propose to work with the British Medical Association (BMA) and the profession to develop a more transparent and limited set of circumstances in which practices could reasonably refuse an application for registration. This would include a closed list agreed with their PCT. It could also include other exceptional circumstances, such as where a patient has previously been violent towards staff. We would welcome views on whether there are any other circumstances where a practice could reasonably refuse an application for registration.

Better and more comparative information

3.13 In today's society, people expect to be able to access reliable and comparative information to help them make important decisions

3.14 In the past, it has been very difficult for people to find out how GP practices differ. Over the last couple of years, we have taken the first steps to improve the provision of information on local health services. People can now rate and compare GP practices through the NHS Choices website, and this facility has generated a really good response from the public. But there is still much further to go.

3.15 To help people make the right decision about their choice of GP practice and to provide equal access for all, we need to provide patients with a more comprehensive and accessible range of clear, accurate and understandable information. We propose to work with the public and the profession during 2010 to enhance the variety of information on GP services that the NHS publishes, both on the NHS Choices website and through other sources.

In 2008 NHS West Midlands Strategic Health Authority carried out a survey of its residents which showed that more than 30% lacked knowledge about how to access information on GP services. As a result, NHS West Midlands asked the Health Services Management Centre at the University of Birmingham to carry out a review of the information available to public about primary care. It found that:

- **to empower people to use information, content needs to be relevant**
- **most current health information is at too high a reading age**
- **formats need to be accessible to people with different literacy levels**
- **people want stories as well as data**
- **many people will need support to access and use information services.**

NHS West Midlands conducted a review of information currently available both on the NHS Choices website and on individual GP websites, about GPs and the services they offer. They found that very few practices had their own website and that patient leaflets were often out of date and not widely available.

Six PCTs are now planning to make radical improvements to information for the public and to test different ways to support people in making informed choices about where and when to access their care.

Warwickshire, Walsall and Dudley are improving the quality and range of information about their GP practices on the PCT and practice websites and on NHS Choices. Other projects in Coventry, Heart of Birmingham and Walsall are using different methods – peer educators, health navigators and community connectors – to get information on primary care services over to groups who don't use traditional sources of information.

3.16 In doing so, we must recognise that different people want different ways of accessing information, and not everyone has the opportunity to use the internet. We shall make sure that the most vulnerable and hard-to-reach patients are given extra help and advice in making the right choices and navigating through the system. This will mean PCTs using a range of ways to target different patient groups. Some areas are already embracing new approaches.

Simpler registration

3.17 We know that some people find the process of registering with a GP practice difficult. The process itself can therefore act as a barrier to choice. A significant number (43%) of people who answered the GP Choice online survey conducted by Ipsos MORI in November 2009 said that being able to register on the internet or via email could have made the process easier.

3.18 Alongside greater choice, a simpler registration system – by phone or online – could also be beneficial by:

- enabling people to choose a practice without being refused inappropriately
- giving PCTs and the public unambiguous information about which practices are accepting patients and which are not.

3.19 There are, however, a number of associated risks, particularly around security and the potential for people to exploit the system by creating multiple registrations, though these can be mitigated with today's technology.

3.20 Given recent developments that allow patients to book appointments and order repeat prescriptions online, we think electronic registration would be a natural development. We would welcome your views on this.

Chapter 4: The consultation process and next steps

Next steps

4.1 A number of engagement activities will be held during the 12-week consultation period so that key groups can contribute to the debate. There will be a strong local focus to the consultation, with the local NHS playing its part in engaging with local people and staff. More details will be available on the consultation website at www.gpchoice.dh.gov.uk.

4.2 If an election is called during the 12-week consultation period, we will extend the consultation, to ensure that everyone has the opportunity to get involved.

4.3 A summary of the responses, along with the Government's proposed way forward, will be made available before or alongside any further action, such as laying legislation before Parliament, and will be placed on the consultation website at www.gpchoice.dh.gov.uk.

4.4 Subject to future contractual negotiations and discussions around potential funding arrangements, we envisage confirming the new arrangements before the end of September 2010. This would allow the NHS to make the necessary preparations for national implementation from April 2011.

4.5 As well as responses to the questions at Annex A, we would also welcome any evidence or data that may help us to further assess the impact of any particular option.

Criteria for consultation

4.6 This consultation follows the Government Code of Practice on Consultations. In particular, we aim to:

- consult at a stage when there is scope to influence the policy outcome
- consult for at least 12 weeks with consideration given to a longer period if feasible and sensible
- ensure the consultation documents are clear about the consultation process, what is being proposed, the scope to influence, and the expected costs and benefits of the proposals
- ensure the consultation exercise is accessible to, and clearly targeted at, those people the exercise is intended to reach
- keep the burden of consultation to a minimum so that consultations are effective and consultees are encouraged to participate
- carefully analyse responses and give clear feedback to participants following the consultation.

4.7 The full text of the code of practice is on the Better Regulation website at: www.berr.gov.uk/whatwedo/bre/consultation%20guidance/page44420.html.

Comments on the consultation process itself

4.8 If you would like to voice concerns or comments relating specifically to the consultation process itself, please contact:

Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds LS2 7UE
consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

Confidentiality of information

4.9 We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter.

4.10 Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

4.11 If you want your information to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation – but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, in itself, be regarded as binding on the Department.

4.12 The Department will process your personal data in accordance with the DPA and, in most circumstances, this will mean that your personal data will not be disclosed to third parties.

Annex A:
Consultation response form

Questions – how to have your say

This form can be posted to the below address but we would prefer respondents to access the online consultation form at **www.GPchoice.dh.gov.uk**

Your Choice of GP Practice
Primary Medical Care
Department of Health 2E42
Quarry House, Quarry Hill, Leeds, LS2 7UE

Freedom of Information

1 Is it all right if your responses to the consultation are published in a summary of responses?

☐ Yes ☐ No

Questions about you

Please give us some information about yourself. This will help us to tell how widely we have captured views from the public and other stakeholders. All the information we receive will be kept confidential. No identifiable information will be passed on to other bodies, members of the public or the media.

2 What's your name? ....

3 Your contact address? ....

....

4 Your postcode? ....

5 Your contact phone number? ....

6 Your email address? ....

7 In what capacity are you responding?

☐ As a member of the public ☐ As a healthcare professional

☐ On behalf of an organisation (please write in name) ....

....

8 Have you ever thought about changing your GP practice?

☐ Yes ☐ No

9 If you have thought about changing your GP practice, what's been the reason?

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Your general views

10 Should people be allowed to register with any GP practice they choose unless it has reached full capacity and cannot take on any more patients?

☐ Yes ☐ No

Comments ....

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Your specific views

Home visits

11 If you need to be visited at home by a GP or nurse, how important is it that they should come from your own GP surgery?

☐ Very important. I would always want to be seen by a practitioner I know

☐ Fairly important. However, it's not necessary if I need an urgent home visit

☐ Not very important. I wouldn't mind who I see

12 If you choose a GP practice a long way from where you live and you need a home visit, who should be responsible for arranging it?

☐ Your local Primary Care Trust

☐ The GP practice (regardless of how far away you live)

☐ A second GP practice of your choice, closer to where you live

Comments ....

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Funding principles

13 If someone chooses a GP practice some distance from where they live, they may not use it for urgent care if they become unwell at home. Under most of the options being considered, the GP practice would also not be responsible for arranging home visits for this patient. But they may have more work to do if they have to liaise with other health and social care services near where the patient lives. How much annual funding should the GP practice get for this patient compared to a patient who lives nearby?

☐ More funding ☐ Less funding ☐ Same funding

Comments ....

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Community-based services

14 If you choose a GP practice that's not in your local area, would you still want to use local community-based services (eg health visitors, mental health teams, physiotherapy services)? Or would you prefer to use services which have links with your chosen GP practice, even though it would mean travelling further to use them?

☐ Use community services near where you live

☐ Use community services that have closer links with your GP practice

Comments ....

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Patient lists

15 A GP practice should not deter people from registering with them by saying they are 'full' when they are not. To discourage GP practices from doing this and to make the system more transparent, should it be easier for GP practices to close their patient lists once they are actually full?

☐ Yes ☐ No

Comments ....

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16 Local residents should always have the right to choose a local GP practice. If a GP practice is nearing full capacity, should it close its patient list to people who live further away before closing it to local residents?

☐ Yes ☐ No

Comments ....

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Right to choose

17 A GP practice can currently refuse to register a new patient so long as they show the decision is fair and non-discriminatory. We propose that a practice should be able to refuse to register a new patient if their list is full or if the patient has previously been violent or abusive to staff. Are there any other grounds on which GP practices should be able to refuse people?

☐ Yes ☐ No ☐ Please suggest what these other reasons might be

Comments ....

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17 *comments continued* ....

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Information

18 What information do you think would people find useful when choosing their GP practice?

Comments ....

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Registration

19 How would you prefer to register with a new practice?

- ☐ In person
- ☐ By phone
- ☐ Online
- ☐ Other (please describe below)

Comments ....

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Further comments

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The following questions are optional. Any information you provide will be stored without your name attached to it, and will be helpful to us in evaluating the potential impact on any group or community.

1 What is your sex? (Tick one box only)

☐ Male ☐ Female

2 Which age group do you belong to? (Tick one box only)

☐ below 15 yrs ☐ 16-24 yrs ☐ 25-34 yrs ☐ 35-44 yrs

☐ 45-54 yrs ☐ 55-64 yrs ☐ 65-74 yrs ☐ 75-84 yrs

☐ 85 yrs and over

3 Do you have a disability as defined by the Disability Discrimination Act (DDA)? (Tick one box only)

☐ Yes ☐ No

4 What is your ethnic group? (Tick one box only)

A White ☐ British ☐ Irish ☐

Any other White Background, please write below

....

B Mixed ☐ White and Black Caribbean ☐

White and Black African ☐ White and Asian ☐

Any other Mixed Background, please write below

....

C Asian or Asian British ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐

Any other Asian Background, please write below

....

D Black or Black British ☐ Caribbean ☐ African ☐

Any other Black Background, please write below

....

E Chinese or other ethnic group ☐ Chinese ☐

Any other, please write below

....

5 What is your religion or belief? (Tick one box only)

Christian ☐ Buddhist ☐ Hindu ☐ Jewish ☐

Muslim ☐ Sikh ☐ None ☐

Any other, please write below

....

6 Which of the following best describes your sexual orientation? (Tick one box only)

Only answer this question if you are aged 16 years or over.

Heterosexual/Straight ☐ Lesbian/Gay ☐ Bisexual ☐

Other ☐ Prefer not to answer ☐

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Protocols for Joint Working between Tunbridge Wells and Maidstone Scrutiny Committees

Meeting Dates and Venues

Once nominations from both sides have been received for joint committees a meeting date should be agreed that the majority of members can attend. The venue should be in between the two town halls or at a mutually agreed location between the scrutiny teams in absence of a chair being appointed.

Chairing Joint Committees

Chairmanship should be firstly according to location or if not the on the basis of best person for the job, and nominations should be taken at the first meeting of the Committee. If it is a joint meeting of two scrutiny committees to hear evidence relating to a review that is being pursued separately the Chairman should be appointed for the duration of the meeting in the usual manner.

Voting Rights

All committee members would be entitled to vote at meetings

Reports, information and support

The Joint Committee should expect the same level of support in terms of administration, reports and information as any other Committee. The Overview and Scrutiny Offices will ensure that work is split between the two teams evenly and identify a lead officer for each joint review as the Chair’s point of contact. Reports from joint committees will be developed with the Committee and in particular the scrutiny Chairmen.

KENT ASSOCIATION OF LOCAL AUTHORITIES

KENT PROTOCOLS FOR NATIONAL HEALTH SERVICE OVERVIEW AND SCRUTINY

1. These protocols are agreed within a context that assumes **organisationally:**

- the bringing into force of the Health and Social Care Act 2001
- the continued development of partnership working, especially between Social Services and NHS bodies
- the continued existence at District/Borough level of local overview and scrutiny committees concerned with NHS matters
- the continued existence of Community Health Councils or representative organisations operating at sub-county level
- a partnership approach working with not against NHS bodies in the county

2. The protocols are based on the **principles** that:

- Overview and Scrutiny should focus on supporting the improvement of health services to Kent residents.
- Overview and Scrutiny should minimise the additional administrative burdens on local authorities or NHS bodies.
- Overview and Scrutiny agendas need to be developed jointly by the local authorities and the NHS bodies.
- Overview and Scrutiny needs to operate at different levels within Kent;

3. Overview and Scrutiny **structures** will comprise:

Community Health Councils

To continue as now till replaced by new patient bodies but with more support form local authorities and integration into the Overview and Scrutiny system to pave their way for the way for their successor bodies:

- Dialogue focused on service providers (acute trusts and PCT provider units)

District Council Overview and Scrutiny Committees

To look at local service issues:

- Local co-ordination (or joint committees) to ensure cross-district issues dealt with jointly
- Local KCC Members and CHC representatives to have rights of participation
- Focused on PCTs

KCC Health Service Scrutiny Committee

To look at broad and wide area issues, including from the viewpoint of the County Council's Social Service responsibilities:

- An emphasis on working through themed (topic) reviews conducted by Select Committees (smaller ad hoc groups) including District and Patient members
- DC and CHC representatives to have rights of participation
- Service reconfigurations to be looked at through Select Committees (ad hoc time limited sub-committees including District Council and CHC participation) reporting to the KCC Health Service Scrutiny Committee to consider reference to the Reconfiguration Panel (when the legislation is brought into force)
- Focused on Health Authorities

Medway Overview and Scrutiny Committee

To combine both levels of operation within the Medway area but linked into the co-ordinated system.

CO-ORDINATION

4. Overview and Scrutiny activity at local and Kent level needs free exchange of information and protocols for co-ordination of work and resolution of conflicts. To facilitate this there will be

- a regular (six-monthly?)meeting of Committee Chairmen and NHS representatives to agree a programme of work across the county and Medway
- a similar officer forum to support and advise the Chairmen on the work programme and co-ordinate requests for NHS officers to provide papers, information or attend committee meetings

5. The KCC Committee membership allows for District and CHC membership:

(The following three points are proposed for discussion but have yet to be

considered by the KCC Health Service Scrutiny Committee)

- a permanent representation of three District/Borough Members nominated by KALA and two CHC representatives nominated by the CHCs
- a right for the Chairmen of each District/Borough Overview and Scrutiny Committee and each CHC to attend and speak at the KCC Committee (or send a representative) on a matter particularly affecting that area
- appointment of members of relevant District Overview and Scrutiny Committees and CHCs to individual topic reviews (agreed through the chairmen's meeting)

6. District Committees will allow local KCC Members and CHC representatives to attend and speak at the Committee.

7. KCC and District members on CHCs will be briefed by and feed back to their appointing Councils.

REVIEW PLANNING

8. Overview and Scrutiny will take the form of a programme of reviews. Each review should be preceded by a Review Plan discussed within the officer forum and agreed with the relevant NHS bodies . Any disagreement should be considered by the relevant Overview and Scrutiny Committee after the NHS representative has attended the Committee to express the NHS view and answer member questions**.**

9. The Review Plan should:

- set the terms of reference for the review including the general nature of the expected outcome
- set an approximate timetable of meetings and a reporting date
- state the officers supporting the review within the local authority, the NHS and the CHCs and estimate the time commitment required of them
- state the main witnesses and information sources expected to be involved

REVIEW ADMINISTRATION

10. The arrangements for meetings of Overview and Scrutiny Committees shall ensure that:

- Dates for witnesses to attend Committee meetings are agreed with witnesses as far in advance as possible
- NHS Chief Executives and other local authorities' Chief Officers arrange for officers chosen by them to attend to give evidence on the identified topics (subject to any provision to be made in statutory regulations)
- Advance notice is given of the areas to be covered in questioning
- Information is wherever possible distributed to the Committee in writing before the witness attends

MEETING PROTOCOLS

11. All Overview and Scrutiny Committees should incorporate in their procedural rules or otherwise ensure that:

- Committee Members should endeavour not to request detailed information from officers of the NHS or another local authority at meetings of the Committee, unless they have given prior notice through the Clerk. If, in the course of question and answer at a meeting of Committee, it becomes apparent that further information would be useful, the officer being questioned may be required to submit it in writing to members of the Committee through the Clerk.

- In the course of questioning at meetings, officers of the NHS or another local authority may decline to give information or respond to questions on the ground that it is more appropriate that the question be directed to a more senior officer or Authority Member.

- Officers of the NHS or another local authority may decline to answer questions in an open session of the Committee on the grounds that the answer might disclose information which would be exempt or confidential as defined in the Access to Information Act 1985. In that event, the Committee may resolve the exclude the media and public in order that the question may be answered in private sessions.

- Committees may not criticise or adversely comment on any individual officer of another local authority or of an NHS body by name.

REPORTING

12. All local authorities should ensure that:

- A record is made of the main statements of witnesses appearing before the Committee and agreed with the witness prior to publication or use by the Committee (Committee meetings may be electronically recorded)

- Drafts of Committee reports and recommendations should be made available for comment by the relevant NHS body (or local authority) whose operations might be commented on and any adverse comments or concerns reported to the Committee before the final report is published

- The Chief Executive of any NHS body and/or the Chief Officer of any other local authority involved with the review is given advance notice of the date of publication of the report and consulted on the text of any accompanying press release

- Reports should include an agreed timetable for any NHS body and/or other local authority involved to publish a response to the report's recommendations once confirmed by the appropriate Overview and Scrutiny Committee

SERVICE RECONFIGURATIONS

13. NHS bodies remain responsible for public and other consultation on service reconfiguration proposals.

14. The intention to carry out a consultation will be discussed in the officer forum.

15. The KCC Health Service Scrutiny Committee will consult District/Borough Councils and CHCs for the areas affected by each proposal on whether to:

- consider the matter at a full meeting of the Committee
- set up a KCC Select Committee to consider the proposal
- request a District/Borough Overview and Scrutiny Committee to consider the proposal

16. If a Select Committee is established or a District/Borough Overview and Scrutiny Committee requested to carry out a review:

- paragraphs 9 -12 above shall apply to its work programme and proceedings
- the review plan shall as far as possible be integrated with the NHS body's consultation programme
- consideration shall be given to:-

  - including one or more members of District/Borough Councils on the Select Committee or KCC members on the District/Borough Overview and Scrutiny Committee

  - including CHC members on the Committee

- other arrangements for ensuring all local authorities and CHCs may express their views and seek information on the proposal

- the review report shall be submitted to the KCC Health Services Scrutiny Committee who will consider the recommendations together with any response by the NHS body and decide whether to refer the proposal to the national Reconfiguration panel

MAIDSTONE AND TUNBRIDGE WELLS JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

17 JUNE 2010

REPORT OF HEAD OF CHANGE AND SCRUTINY

Report prepared by Les Smith & Kat Hicks

1. Future Work Programme

1.1 Issue for Consideration

1.1.1 To consider the Committee's future work programme.

1.2 Recommendation of Head of Change and Scrutiny

1.2.1 That Members note that the only planned work at this stage is a joint meeting with the Primary Care Trust to discuss the recent Overview and Scrutiny Mental Health report. Members will be advised when a date for this has been set.

1.3 Reasons for Recommendation

1.3.1 Members are asked to consider the Future Work Programme at each meeting to ensure it remains appropriate and covers all issues Members currently wish to consider within the Committee's remit.

1.4 Alternative Action and Why Not to Recommended

1.4.1 The Committee could choose not to consider its Future Work Programme, however considering it ensures it remains appropriate, relevant and covers all issues Members currently wish to consider within the Committee's remit. .

1.5 Risk Management

1.5.1 There are no risks involved in noting the current work programme

1.6 Other Implications

1.6.1

1. Financial	
2. Staffing	
3. Legal	

4. Equality Impact Needs Assessment
5. Environmental/Sustainable Development
6. Community Safety
7. Human Rights Act
8. Procurement
9. Asset Management