Joint City / County Health Scrutiny Committee

Tuesday, 09 September 2014 at 10:15

County Hall, **County Hall, West Bridgford, Nottingham, NG2 7QP**

AGENDA

1	Minutes of the meeting held on 15 July 2014	3 - 8
2	Apologies for Absence	
3	Declarations of Interests by Members and Officers:- (see note below) (a) Disclosable Pecuniary Interests (b) Private Interests (pecuniary and non-pecuniary)	
4	Patient Transport Service	9 - 18
5	Nottingham University Hospitals Pharmacy Delay Update	19 - 22
6	NHS 111 Performance	23 - 34
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9	To note the change of date for the October meeting from 14th October to 7th October	

Notes

(1) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(2) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Julie Brailsford (Tel. 0115 977 4694) or a colleague in Democratic Services prior to the meeting.

(3) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(4) A pre-meeting for Committee Members will be held at 9.45 am on the day of the meeting.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

MINUTES

JOINT HEALTH SCRUTINY COMMMITTEE
15 July 2014 at 10.15am

Nottinghamshire County Councillors

Councillor P Tsimbiridis (Chairman)
Councillor P Allan
Councillor R Butler
Councillor J Clarke
A Councillor Dr J Doddy
Councillor J Handley
Councillor C Harwood
Councillor J Williams

Nottingham City Councillors

Councillor G Klein (Vice- Chair)
A Councillor M Aslam
A Councillor A Choudhry
Councillor E Campbell
Councillor C Jones
Councillor T Molife
A Councillor E Morley
A Councillor B Parbutt

Also In Attendance

Councillor Roberts - Member for Newark West
Julie Brailsford - Nottinghamshire County Council
Jane Garrard - Nottingham City Council
Martin Gately - Nottinghamshire County Council
Claire Grainger - Healthwatch Nottinghamshire
Simon Smith - Executive Director Notts Healthcare NHS Trust
Jenny Leggott - Executive Lead for Operations NUH
Nicki Pownall - Deputy Director of Operations NUH
Teresa Cope - Director of Quality & Delivery Nottingham City CCG
Ciara Scarff - Head of Contracts Mental Health & Learning Disabilities NC CCG

MINUTES

The minutes of the meeting held on 10 June 2014 were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors B Parbutt (other), E Morley (other), Dr J Doddy (other).

DECLARATIONS OF INTERESTS

None

DEVELOPMENTS IN ADULT MENTAL HEALTH SERVICES

Mr Simon Smith, Executive Director for Local Services, Nottinghamshire Healthcare NHS Trust gave a presentation to the committee detailing the 'Service Transformation Programme for Adult Mental Health'. The key strategic priority for this project was to provide care in an appropriate place, from 'in patient' beds to enhanced provision in the community and residential rehabilitation process. The Clinical Commissioning Group (CCG) were very supportive of this.

The provision of service needed to be changed to fit the £4.3m reduction of funding. Prevention and intervention at an earlier stage in a patient's life could change the way that the NHS Trust used their professional workforce.

Following the presentation the additional information below was provided in response to questions: -

- In relation to the consultation regarding the closure of both the wards at the Queens Medical Centre (QMC) and Enright Close in Newark Members were advised that there would be a 6 week consultation process taking place in August and September including engagement with hard to reach communities. The consultation would take place in conjunction with Clinical Commissioning Groups (CCGs) and Healthwatch. Consultations regarding ward closures at QMC and Enright Close would be undertaken separately.

- Enright Close was no longer providing for patients' needs and consequently was under occupied. There was a range of options, according to individual needs, for the patients from Enright Close, they would not be made homeless. Dovecote Lane and Macmillan Close had already been closed and patients were successfully transferred from those sites. 39 people were discharged from these sites and only one person required readmission, due to breakdown in their social care package. Each individual was monitored to ensure needs were met.

- The wider consultation regarding the Service Transformation had taken place over a two year period with patients, carers, Nottinghamshire County Council, Nottingham City Council and the CCG, and it had been as transparent as it could be in the context of the work. Young patients did not want to be institutionalised or the traditional services provided, they wanted support in the community.

- Community rehabilitation was based on treating the patient in their home and community rather than removing them from it, to help people move on, rather than be 'mentally ill' all of their lives. There was early intervention by 'Care Delivery Groups', comprising of integrated teams of social workers, Health and Social Care workers. There was a natural pool of staff from the wards due for closure and there would be skills training provided, there might be a short term problem with staff recruitment but medium-long term challenges were not expected.

- The staff consultation had consisted of meetings with staff both in groups and individually to keep them informed of the changes.

- The Mother and Baby Unit would be moved from the QMC and relocated but it would not be decided until May/June 2015 where it would be relocated to.

- There would be a dedicated team to monitor the impact of the changes and to provide timely access to services by patients.

- The transformation did have significant risks associated with it. For example there would be a £1m investment in the new approach but one of the risks was that the new model did not sufficiently reduce the number of inpatients, and this would have financial implications. The risk to the quality of patient care and patients' experiences was being monitored.

- £30m had been spent at Highbury hospital remodelling the rooms and £10m at Millbrook to modernise it and make it more appropriate for younger people.

- Sufficient inpatient beds would still be available at Highbury Hospital, the Millbrook Unit at Kingsmill Hospital and Bassetlaw General Hospital. Psychiatric intensive care beds would be split between Highbury Hospital and Millbrook.

The Committee requested that outcomes from the consultation regarding these proposals due to be carried out be reported back to this Committee in October.

The meeting adjourned from 11.25am until 11.30am.

MENTAL HEALTH SERVICES FOR OLDER PEOPLE

Mr Simon Smith, Executive Director for Local Services, Nottinghamshire Healthcare NHS Trust gave a presentation to the committee detailing the developments in Mental Health Services for Older People in Nottingham and Nottinghamshire. The presentation discussed proposals to close Bestwood and Daybrook wards at the St Francis Unit at City Hospital and expanding the community model of care supporting older people to remain in their homes known as Intensive Recovery Intervention Services (IRIS). Implementation of IRIS would enable effective care planning, encourage active intervention and rehabilitation and reduce the demand for acute beds both medical and mental health. The details of the consultation plan were outlined.

Following the presentation the additional information below was provided in response to questions: -

- Teaching about Access to Services was crucial in addressing care in the community issues. One in four people had or would experience mental health issues and research showed that this was now more likely to be one in three. The model of delivery was keeping patients in the community with the GP at the centre of this. Assessing carer needs and signposting to services were important in helping people to understand issues. Nottingham City offered to share their Awareness training with Nottinghamshire County.

- An analysis had been carried out for dementia patients who received care in the community. All patients with dementia were visited weekly by the Outreach Dementia Team. Tom Denning, Professor in Dementia had been researching interventions that a multi professional team could use in the environment that the patient is most likely to use.

- To monitor the change in care across the care homes within Nottingham and Nottinghamshire information would be gathered by the Outreach Dementia teams, who made weekly visits to those with ongoing healthcare needs. Clinical Commissioning Groups also carried out quality monitoring visits and information was shared with the Care Quality Commission. All care homes had been assigned a GP.

- The 'admission' of a patient was classed from when a patient was admitted for assessment; this was for a period of up to six weeks.

- Consultation had already been carried out with current users and carers and those who had used services within the last three months, and staff. A variety of responses had been received in response to the consultation which ranged from 'not wanting any change' to being positive about seeing the need for change. As expected a variety of responses had also been received from staff. This information would be fed into outcomes from wider public consultation about the proposed changes.

- The need for a skilled multidisciplinary workforce required intensive training in a variety of different ways and the Trust had an ongoing training plan in place. A play about dementia awareness was successfully shown to staff in the County and was now touring the Country.

The Committee requested that outcomes from the consultation regarding these proposals due to be carried out be reported back to this Committee in October.

NOTTINGHAM UNIVERSITY HOSPITALS PERFORMANCE AGAINST FOUR HOUR EMERGENCY DEPARTMENT WAITING TIME TARGETS

Jenny Leggott, Executive Lead for Operations, gave a presentation on the performance of Nottingham University Hospitals NHS Trust (NUH) against the operational standard for Accident and Emergency (95% of patients seen and admitted, transferred or discharged within four hours) and action that was being taken to improve performance. The Trust was currently at 93.3% against a target of 95%. A

number of factors affecting the ability to meet this target included capacity within the Emergency Department (ED), an increase in patients needing to be admitted and bed availability. QMC was at near full capacity (99-100%) and had difficulty admitting patients from ED in a timely manner. There had been an increase in patients aged 65-80 years and this had not decreased since the winter period. Their length of stay was also longer. Twenty more beds were occupied by patients over 65 this year compared to last. A team of analysts were looking at the data to find solutions to the bed occupancy issues.

NUH would be commissioning 41 extra beds and would be looking at commissioning a further 12 surgical beds.

NUH was struggling to recruit locum consultants who were being enticed away to other Trusts by better pay. Currently there were four consultant posts vacant. This was replicated throughout other staff groups. There has been some successful recruitment of nurses from Portugal and the Trust would also look at recruiting from Italy.

The Emergency Department would be redesigned to accommodate an extra 15 cubicles by December 2014 which should ease some pressures.

Other improvement plans included a discharge lounge so that patients could be moved from the wards as quickly as possible to free up beds. The Pharmacy Service would also have targets to help towards discharging patients before noon, and the Service was currently recruiting more pharmacists.

An ‘App’ was under development with GP colleagues which would help GPs see what alternative pathways are available, other than admission to hospital.

Following the presentation the additional information below was provided in response to questions: -

- To counter a perceived lack of communication between staff and patients the Trust was working with their Communications team and IT department to see if messages could be sent electronically, keeping people and patients informed about what was happening.

- Money has been allocated to support the opening of additional beds however recruiting nurses was a bigger issue as registered nurses, and not healthcare assistants, were required.

- Community services needed to work better to free up hospital beds. The majority of patients came in to hospital between 4pm and midnight. Patients waited a long time before being admitted and it was hoped that the opening of GP surgeries 7 days a week, in line with national Policy, would help to ease this.

- There was an urgent need for research in to medical recruitment and retention. The Local Education Board had done some work in to the requirements for health care, but nursing recruitment was a national problem with most Trusts having to go abroad to recruit. Problems had occurred with language but the nurses recruited from Portugal spoke good English and support was provided

with English classes. The National Nursing and Midwifery Council ensured tests were taken before potential staff were added to the register. NUH had obtained some benchmark data from Sheffield as they were having the same problems.

NEW HEALTH SCRUTINY GUIDANCE

The new guidance on Health Scrutiny issued by the Department of Health followed on from the changes to the regulations last year.

The Scrutiny officers from the City and the County Council would facilitate a more detailed discussion regarding the changes at the next meeting.

WORK PROGRAMME

The Committee was advised that the Work Programme was in a state of development. Following today's meeting the following items would be added to the Work Programme:

- Outcomes of the consultation on changes to Adult Mental Health Services
- Outcomes of the consultation on changes to Mental Health Services for Older People
- Discussion about the implications of the new health scrutiny guidance

The meeting closed at 12.55pm.

Chairman

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

9 September 2014

Agenda Item: 4

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

PATIENT TRANSPORT SERVICE

Purpose of the Report

1. To allow Members the opportunity to consider the latest information regarding the Patient Transport Service.

Information and Advice

2. Members will recall that the Joint Health Committee previously received information regarding Patient Transport Service on 11 February 2014 from Neil Moore, Director of Procurement and Market Development Mansfield & Ashfield CCG and Newark & Sherwood CCG, as well as representatives from Arriva.

3. Arriva Transport Solutions Ltd has been the provider for NHS Non-Emergency Transport Service since the contract was awarded to them in July 2012. The committee was concerned about the level of performance by Arriva, which fell short of expectations. However, the committee received reassurances that Arriva is a patient focussed company committed to making improvements in service delivery.

4. Members heard that a service improvement plan had been developed which detailed the steps to be taken to improve performance. In addition, a stakeholder group had recently been formed. Stakeholder group meetings will provide a forum for feedback and discussion aimed at promoting performance improvement.

5. At the end of 2013, a post of Head of Service for the East Midlands was created. Soon after appointment the post holder put in place a new management system, a new telephony system and a review of rotas. The online service for booking appointments via the internet was also promoted.

6. Key Performance Indicators were laid out in the contract and in respect of KPI 1 performance had been achieved. The committee were assured that not meeting the KPIs did not necessarily translate into poor patient experience; for example, Arriva might be kept waiting for up to half an hour when collecting a patient and that would mean that the KPI has automatically not been reached. Arriva's priority is always to transport patients safely to hospital.

7. Mr Neil Moore and colleagues will attend the Joint Health Committee to brief Members on the latest Patient Transport performance by Arriva and answer questions. A written briefing outlining Patient Transport Service is attached as an appendix to this report.

8. Members will wish to schedule further consideration of Patient Transport Service performance and determine what further action it is necessary to take in relation to Patient Transport Service performance.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:-

1) receive the briefing

2) schedule further consideration

3) determine any necessary further action

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Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil.

Electoral Division(s) and Member(s) Affected

All

Contract Performance Review Report

Nottinghamshire Non-Emergency Patient Transport Services

August 2014

Introduction

Arriva Transport Solutions Ltd (ATSL) is the provider of NHS Non-Emergency Patient Transport Services (NEPTS) in Nottinghamshire having been awarded a contract which commenced in July 2012. The contract is now two years into its five year term.

Current performance continues at a level short of expectations but Arriva is a patient focussed company and is committed to making improvements to the efficiency of its service delivery. Continuing pressure from contract managers, commissioners and councillors has focussed Arriva's attention on making the required improvements.

Performance Improvement

There has been some improvement to the achievement of Key Performance Indicators (KPIs) since January but the required standards are not being achieved and improvement has been modest. A service improvement programme has been revised and commissioners and contract managers meet monthly with representatives from Arriva to review progress against the plan.

Progress has been made in the following areas in the past 6 months:-

- There have been a number of changes to staffing within Arriva and the introduction of new posts, the purpose of which has been to improve the efficiency of the organisation and its operation. An Operations Director has been in post since 1 May 2014, an Area Control Manager took up post in February and the Head of Service for the East Midlands is now overseeing both the Nottinghamshire and Leicestershire contracts.

- Voluntary Car Service (VCS) drivers have been introduced to reduce the use of taxis and third party providers and to provide greater consistency to patients who travel regularly. Voluntary drivers are also used for journeys covering greater distances to avoid losing the capacity of a fleet vehicle for most, or part, of a working day. Commissioners have insisted that VCS drivers are recruited and trained to the same standards as a PTS crew.

- The review of rotas is continuing to match capacity to demand. The NHS continually changes, however, so this is an ongoing process. Hospitals are being encouraged to discharge patients before lunch instead of later in the afternoon. As this initiative is incrementally introduced rotas will need to be adapted to match the fact that the peak of demand for discharges will move to earlier in the day.

- Arriva's new telephone system was implemented successfully in February 2014. Since then upgrading has also taken place to the Cleric system which Arriva uses to book, plan and track patient journeys. This will assist with the provision of more accurate information.

- Arriva has been investigating the causes and reasons for delays. Once one patient has been delayed it tends to have a knock on effect for every journey undertaken by

that crew/vehicle thereafter. Delays for the first inward journey of the day are within the ability of Arriva to correct. Some delays thereafter are the result of patients not being ready when the PTS crew arrives to collect them. Arriva has started to collect data about delays of over 10 minutes while waiting for patients. While there is no hard and fast rule that a journey will be abandoned after ten minutes there has to be a limit when crews can wait no longer for a patient to be ready or for prescriptions to be delivered to the ward to take home with the patient. This information is collated and shared with NHS providers at Stakeholders' meetings. The efficiency of processes within the Trusts has a profound effect on the efficiency of the PTS service.

- Arriva has been keen to exclude journeys which are delayed for reasons beyond its control from the measurement of KPIs. This has not been agreed. The counting methodology for KPIs has been consistently applied since the contract commenced and to change the methodology now would mean that performance might improve but not necessarily the experience of patients in receipt of the PTS service. Some minor changes have been agreed in accordance with the contract which have had a marginal effect on the performance reported. For the renal KPI1 it has been agreed that journeys over 21 miles in length cannot be safely undertaken in 30 minutes or less. A caveat to KPI1 for time on vehicle will be shown in future to demonstrate the impact upon KPI achievement if these journeys were excluded.

It is expected that in addition to this report Arriva will be represented at the Joint Healthcare Committee meeting to respond to questions.

Quality

A monthly quality report is presented to commissioners and contract managers. This has been developed with the advice of an experienced NHS clinical quality manager and encompasses an analysis of complaints, concerns and incidents, staff sickness, turnover and vacancy rates, the proportion of staff who have received an appraisal, staff training and inductions courses, infection prevention and control reports and the outcome of audits.

The outcome from a staff survey and stakeholder engagement will be shared with commissioners in due course.

Commissioners were keen to learn the outcome of a Care Quality Commission (CQC) visit to Arriva's PTS service in Leicestershire during April. Unlike the CQC visit to Nottinghamshire in January 2014 which was a planned visit, the visit to Leicestershire was in response to a concern raised with the CQC and was unannounced. The visits took different formats and concentrated on different themes and while the outcome of the visit to Nottinghamshire was more positive there were some consistent themes across both reports particularly in relation to lateness and waiting times. As with the learning from the CQC visit to Nottinghamshire, there will be learning to share from the visit to Leicestershire.

On the 9th and 10th June 2014, the pressure on beds at the Nottingham University Hospitals was significantly higher than normal. Arriva was called upon to transport a higher than usual number of discharges in order to release beds for patients admitted via the Accident and Emergency Department. Arriva rose to the occasion and worked closely with the Hospital's

staff to move patients but required extra capacity to do so as many of the people requiring transport needed to be moved on a stretcher.

Key Performance Indicators

The Key Performance Indicators are set out within the contract and Arriva is expected to adhere to these standards which are subject to service deductions for failure to do so. These include time measured standards for the arrival and collection of patients, journey times, and patient satisfaction and information provisions.

KPI Performance (Excluding Renal)

The following tables provide details of current and historic performance against the KPIs which have the greatest impact upon patient experience.

1. **KPI1 - Time on Vehicle**

KPI Target: 90% for all three KPIs

KPI Summary - GEM, exc Renal			Std.	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
KPI 1	Time on Vehicle	Patients within a 10 mile radius of the point of care will spend no longer than 60 minutes on the vehicle.	90%	97%	97%	95%	96%	96%	96%	96%	96%	96%	96%	96%	95%
		Patients within a 10 – 35 mile radius of the point of care will spend no longer than 90 minutes on the vehicle.	90%	96%	95%	94%	95%	91%	94%	94%	95%	94%	94%	94%	94%
		Patients within a 35 – 80 mile radius of the point of care will spend no longer than 120 minutes on the vehicle.	90%	89%	97%	94%	93%	91%	91%	85%	96%	85%	97%	94%	93%

Despite concerns about traffic congestion in Nottingham and the impact of major road improvements and tram works, KPI1 standards have been consistently met since the outset of the contract for journeys up to 35 miles in length and achieved in most months for the longer journeys.

2. **KPI2 - Appointment arrival time - within 60 minutes prior to appointment time**

KPI Target: 95%

KPI Summary - GEM, exc Renal			Std.	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
KPI 2	Arrival Times at Point of Care	Patients shall arrive within 60 minutes prior to their appointment/zone time at the appropriate point of care.	95%	67%	71%	64%	67%	63%	66%	63%	67%	63%	75%	73%	76%

There has been some improvement to this KPI with achievements in April, May and June 2014 higher than those seen in the previous nine months. While this is a positive move in the right direction the improvement needs to continue and be sustained. Arriva has identified that if patients arrived 15 minutes earlier than they do currently then there would be a step change in performance. Commissioners have requested that Arriva shares its plan as to how this step change will be achieved.

KPI3 – Departure Times

KPI Target: 90%

KPI Summary - GEM, exc Renal			Std.	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
KPI 3	Departure times from Point of Care	Outpatient Return patients shall be collected within 60 minutes of request or agreed transport/or zone time.	90%	73%	69%	71%	69%	71%	71%	66%	68%	69%	73%	75%	74%
		Discharge patients shall be collected within 120 minutes of request or agreed transport/or zone time.	90%	65%	62%	58%	64%	62%	65%	67%	64%	67%	66%	69%	71%

Again, improvement against KPI3 has been marginal at most. The collection of patients for discharge within 120 minutes is challenging and is influenced by the working practices of Trusts, for example, the number of discharges for which transport is booked on the day of discharge, a peak of discharges being booked late in the day and the time constraints for admission of patients to care homes (usually before 8pm). These factors can contribute to Arriva's ability to plan and resource in advance, making the service very reactive during times where resources are committed elsewhere.

As part of the performance improvement plan, Arriva has committed to working with provider Trusts to review, understand and plan for these peaks in demand, whilst all providers are also working to improve their own respective processes to improve the discharge pathway.

Renal KPI's

1. **KPI1 - Renal Dialysis Journey Time**

KPI Summary - GEM, Renal only			Std.	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
KPI 1	Time on Vehicle	The patient's journey both inwards and outwards should take no longer than 30 minutes.	90%	67%	64%	62%	61%	56%	59%	59%	59%	59%	62%	60%	61%
		The patient's journey both inwards and outwards should take no longer than 30 minutes. (Excluding Patient over 21 miles away)	90%											64%	64%

Performance has remained static and is below that achieved in July of 2013. It is still considerably below the target of 90%. Timeliness and renal transportation is a topic that has generated a number of complaints. The 10% tolerance above the target of 90% allows for a number of patients who live a further distance from their Dialysis Unit than the Renal standard "provision of Dialysis unit within 30 minutes of the patient's home address". It has been determined with PTS providers, as indicated previously, that a patient cannot be safely transported a distance of over 21 miles in 30 minutes. The table above displays for May and June 2014 the impact upon KPI performance of excluding the journeys of over 21 miles. The 3% and 4% differences (between 60%/61% achievement and 64% achievement) is well within the 10% tolerance. The impact of the distance travelled will be more significant in a more rural county, for example, Lincolnshire.

2. KPI2 - Renal Dialysis inward journeys (by appointment time)

KPI2 targets 95% and 100% respectively

KPI Summary - GEM, Renal only			Std.	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
KPI 2	Arrival Times at Point of Care	Patients should arrive at the site of their appointment no more than 30 minutes before their appointment time.	95%	66%	68%	75%	72%	71%	74%	70%	71%	70%	74%	74%	77%
		Patients will arrive at the unit before their appointment time	100%	85%	84%	88%	86%	85%	86%	83%	87%	83%	90%	87%	89%

Performance against KPI2 – arrival no more than 30 minutes before appointment time - has seen some marginal improvement between April and June 2014. While renal transport would appear to be the easiest to plan and provide, since individuals travel 3 times per week throughout the duration of their time on dialysis, appointment times are changed by staff in the renal units and the rate of change of patients over the course of a year can be significant. More detailed analysis of performance for each of the 4 renal units and satellite units at Kings Mill Hospital, Lings Bar, Nottingham City Hospital and Ilkeston Community Hospital has shown that more people arrive more than 30 minutes in advance of their appointment time (but still fail to meet the KPI) than arrive late.

Arriva's performance improvement plan contains a 'Renal Specific' element in order to focus on this group of patients in recognition of the importance of this service to these regular users and therefore the potential to impact on their quality of life. The plan has delivered a more collaborative and transparent approach between Renal Units and Arriva in planning transport for this cohort of patients.

Arriva has also relocated some of its resources to reduce initial travelling time and reduce the risk of becoming caught in traffic congestion in order to minimise lost time in collecting patients.

3. KPI3 - Renal Dialysis outward time (Collection)

KPI Summary - GEM, Renal only			Std.	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
KPI 3	Departure times from Point of Care	Patients should leave the dialysis unit no later than 30 minutes after their booked ready time.	95%	68%	67%	70%	68%	71%	70%	63%	65%	63%	71%	71%	75%

Performance against this KPI is showing a marginal improvement (see comments above).

Further improvements anticipated in the near future

Arriva was requested to review and update its Service Improvement Plan. Shown below are some elements of the plan which are expected to impact on its performance against KPI standards in coming months:-

- Ensure that a replacement vehicle is available within 1 hour of a breakdown. Most of Arriva's vehicles are leased and the wear and tear on even new vehicles is significant in a PTS service because of the mileage undertaken. While vehicles are regularly serviced out of normal working hours, there will still be unforeseen breakdowns. Ensuring quick replacement of out of use vehicles maintains capacity.

- The contract encourages Arriva to call patients ahead of their date of travel to ensure that they still require transport and in order to reduce aborted journeys. Arriva intends to develop a process for its staff to call patients to ensure that they are reminded that transport has been arranged for them but also to check that the correct mobility and mode of transportation has been ordered for them. Patients' mobility requirements do change, not everyone who uses a wheelchair needs to transported in their chairs but may be able to transfer into the seat of a car if the wheelchair can be folded up, put in the boot and transported with them. This reduces the demand for wheelchair adapted vehicles and enables vehicles to be used more efficiently.

- Arriva has been working with Commissioners in Leicestershire to introduce additional questions to the script used to determine patients' eligibility for PTS for the purpose of gaining a better understanding of the patients' needs. If this proves helpful in Leicestershire, its use will be extended to Nottinghamshire with commissioners' approval.

- A discharge co-ordinator is to be introduced to work with hospital staff to encourage discharges taking place earlier in the day or being more evenly spread through the day, to ensure the correct mobility has been booked for the patient, to help to prioritise journeys when demand is at its peak and to deal with daily issues. There is still a myth in hospitals that by booking a higher mobility for the patient, ie a stretcher, that the patient will be given a higher priority for transportation.

- Introduce changes to Cleric, the system used by Arriva, to better identify patients who need to be given a higher priority for transportation because they fit into certain categories (end of life being the major one) or who need to be at home at a certain time because of a care package and staff from other agencies being there to meet them.

- Appoint dedicated planners.

- Encourage the use of on-line booking by staff to reduce the pressure of calls and to increase efficiency. Organise roadshows to train staff on the on-line booking system and to increase their understanding of the commissioned PTS service.

While these measures will increase efficiency, Arriva has given no indication in their draft updated plan of the likely impact upon performance as requested by commissioners.

Conclusion

The relationship between Arriva, commissioners, contract management staff, provider units and users continues to be positive and dynamic. Arriva has continually provided assurances of making further improvements to its quality standards, something Commissioners are closely monitoring in line with the contract parameters. Furthermore, Arriva is keen to actively improve its reputation for reliability, collaboration and responsiveness. As the contract term progresses Arriva has increased its understanding of the variable demands within the NHS and has demonstrated a flexible approach to addressing patient and commissioner needs.

The Contract Management Board continues to meet monthly with Arriva. No changes to the terms of the contract are expected for the third year which commences in July 2014.

SPS/SD/NM/20.06.14/updated 08.08.14

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

9 September 2014

Agenda Item: 5

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

NOTTINGHAM UNIVERSITY HOSPITALS PHARMACY DELAY UPDATE

Purpose of the Report

1. To allow Members to receive a briefing on the latest position on NUH pharmacy delay.

Information and Advice

2. Members will recall that the Joint Health Committee previously received information regarding Pharmacy Delay on 13 May 2014 when Ceri Charles, Deputy Programme Director, Better for You and Mohamed Rahman, Assistant Head of Pharmacy presented information in relation to improving the pathway for patients leaving hospital and delays waiting for medicine in hospital pharmacies.

3. In 2013/14, 10% of Nottingham University Hospitals (NUH) complaints were discharge related (a reduction from 13% in 2012/13. The main reason cited for delays was 'waiting for tablets' but this captured a variety of different issues and reasons for delay. In the past, there was no robust way of capturing and measuring waiting times and no single lead practitioner responsible for the discharge process which passed through a number of different staff at different times. A project was therefore set up to review the systems and processes, culture and communication with patients, and thereby identify areas for improvement.

4. Members heard that a service improvement plan had been developed which detailed the steps to be taken to improve performance. In addition, a stakeholder group had recently been formed. Stakeholder group meetings will provide a forum for feedback and discussion aimed at promoting performance improvement.

5. The priority 'fewer waits' which includes delays for drugs and medicines is a quality priority for NUH in its Quality Account for 2014/15.

6. The NUH target for outpatient pharmacy is a waiting time of less than 30 minutes, During April 2014 there were 5,704 outpatients seen at the pharmacy with 18,000 medications dispensed. The average wait during this period and 99% of prescriptions were dispensed within 60 minutes by the Queens Medical Centre and 93% by the City Hospital pharmacies.

   Members also heard that pharmacists accompanying doctors on ward rounds visits has not started yet. There will be a 20 ward pilot scheme and staffing resources are currently being sought to implement this proposal.

7. The pharmacy tells outpatients how long they may have to wait for their prescription as soon as it is handed in and there are television monitors which show the progress of each prescription and waiting times. The outpatient pharmacy waiting area at QMC is currently being refurbished and this will provide a more pleasant area to wait in.

8. Members suggested that a significant number of patients take their prescriptions to their GP surgery rather than waiting for it to be dispensed at the hospital pharmacy. NUH does not have any data on the number of prescriptions not taken to its pharmacy but would be interested in this information. The lead officer for this review is in the process of obtaining this information, but is not yet available and will have to be brought to a future meeting of the Joint Health Committee.

9. The NUH representatives undertook to take back the issue of outpatient pharmacy delay back to the project team for exploration.

10. Representatives of NUH will attend the Joint Health Committee to provide briefing and answer questions as necessary. Members will wish to schedule further discussion when further information is available.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:-

1) receive the briefing

2) schedule further consideration, as necessary

.

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil.

Electoral Division(s) and Member(s) Affected

All

UPDATE FROM NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST

Re: Pharmacy waiting times at NUH

August 2014

Following NUH attendance at the Joint Health Scrutiny Committee in May 2014, the Committee has requested a summary briefing in August ahead of the September 2014 meeting regarding progress in three specific areas.

1. **Pharmacy staffing increases**

Reducing delays and waits for patients (including medication, transport and parking delays) is one of the Trust's six quality priorities for 2014/15, as described in our Quality Account.

The Trust has a programme of work in place and ongoing to improve the timeliness of care transfers. Through our 'transfer of care' project we are working to reduce delays between patients knowing they are medically safe for transfer (discharge from NUH) and leaving the ward. Improving the electronic 'to take out' medication (eTTO) process is central to our improvement work.

A survey in 2003 found that 49 hospital trusts in the UK had pharmacist-written discharge prescriptions in place. Further evidence in 2005 from surgical wards showed that pharmacist-written TTOs are of a better standard than doctor-written TTOs. Our own pilot on a respiratory ward at City Hospital in 2013 found that fewer medication errors were made by pharmacists transcribing than by doctors. Pre-prescription enabled pharmacy to prepare drugs for discharge earlier.

As such, in May 2014 the Trust agreed to invest an additional £391,000 to increase the staffing levels in pharmacy to facilitate the e-TTO transcription prior to the day of patients' discharge. Nine additional Band 7 pharmacists will work across 20 wards at QMC to expedite the eTTO by transcribing prior to the day of transfer of care.

Recruitment to these new posts is underway. We will cover this work with locum support should recruitment to the 9 posts be unsuccessful to ensure this does not impact on our e-TTO improvement work.

2. **Update on performance for outpatient prescriptions**

99% of outpatient prescriptions are dispensed within an hour. Of the remaining 1% are there any extremely long waits?

- We continue to improve our performance.

- In July 2014, we processed 6,797 outpatient prescriptions and dispensed 19,300 medications (compared to 5,704 and 18,000 respectively in April).

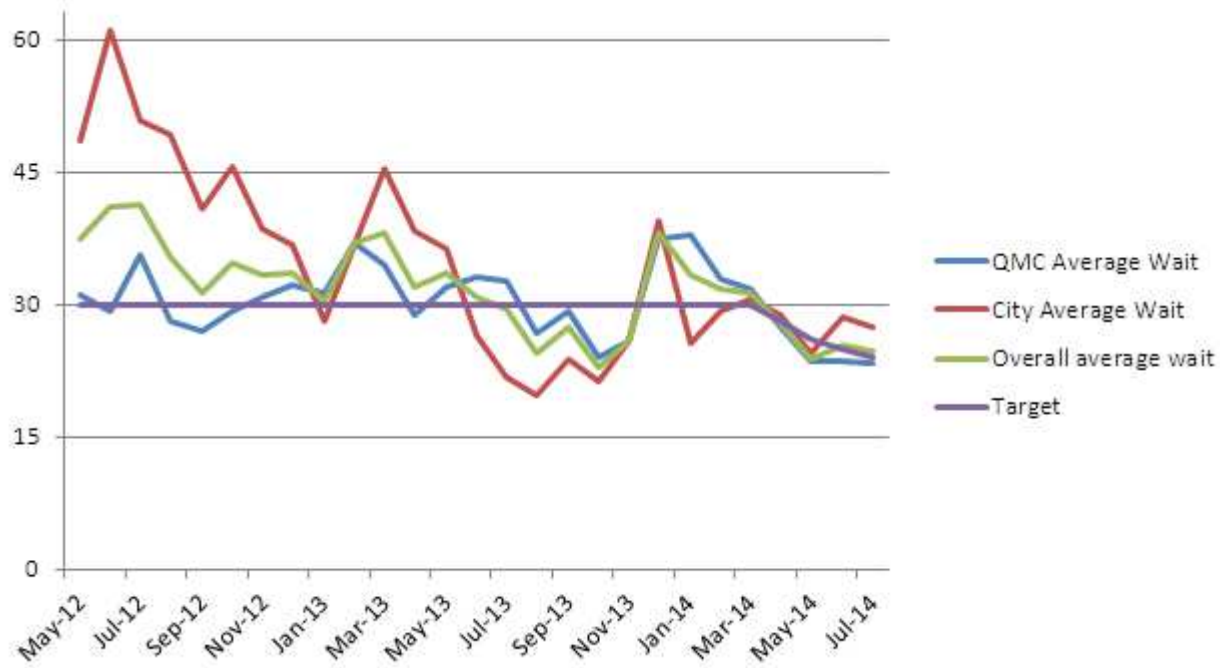
- In response to patient feedback we have sought to reduce our average waiting time further. In July, a new lower target of 24 minutes was met (compared with a target of 30 minutes and average wait of 26 minutes in April).

- 99% of patients waited less than 60 minutes at QMC and 96% at City in July 2014 (compared with 99% and 93% respectively in April). Of those who waited longer than 60 minutes, the

vast majority were completed within 90 minutes. 19 patients waited over 90 minutes on one date in July during a period of exceptional demand. Four patients with complex requirements waited over 2 hours in July.

- We did not receive any patient complaints regarding waiting times in July 2014.

CHART: Average waiting time graph by month



3. The Clinical Commissioning Group contact has been shared with the JHSC so that the concerns about hospital prescriptions being taken to GPs can be discussed further.

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

9 September 2014

Agenda Item: 6

REPORT OF THE VICE-CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

NHS 111 PERFORMANCE (UPDATE)

Purpose of the Report

1. To allow Members the opportunity to consider the latest position in relation to the NHS 111 Service with particular reference to workforce changes.

Information and Advice

2. Members will recall that the Joint Health Committee previously considered an update on NHS 111 services on 11 March 2014 when Mr Stewart Newman, Head of Performance at Nottingham City Clinical Commissioning Group informed Members of performance since the service went live in March 2013. Mr Newman explained that following the roll-out of the NHS 111 service nationally, the GP out of hours service for the populations of Mansfield, Ashfield, and Newark & Sherwood CCGs has continued to be answered by the GP out of hours service provider. The NHS 111 service provider started to answer these calls in April 2014.

3. Following the launch of the service, there were difficulties in meeting the call answering standard that 95% of calls should be answered within 60 seconds, and that no more than 5% of calls are abandoned. The service aims to deal with patient concerns within their first call, thereby minimizing the need for call-back. Around 65% of calls are concluded without the need for call-back.

4. Around 9% of calls end with an ambulance being dispatched, and 8% with the person being advised to attend the Emergency Department. Research indicates that these figures are in line with what is being achieved by other NHS 111 services across the country. The aim is that no more than 8% of calls should end with an ambulance being dispatched and no more than 5% of calls should end with the person being advised to attend the Emergency Department.

5. Members heard that in the first 3 quarters of 2013/14 four potential serious incidents had been reported in relation to the NHS 111 service. Three had been investigated and were no longer regarded as serious incidents. The fourth was still under investigation.

6. When problems were experienced at the start of the contract, Derbyshire Health United (DHU) recruited and trained additional staff in order to improve performance. This level of staffing is not sustainable and DHU is nearing the end of staff consultation on workforce

changes. It is intended that service quality be maintained by improving efficiency, for example by reducing call length. These changes should be in place by the end of May 2014.

7. A written briefing from Stewart Newman, Head of Performance Nottingham City CCG, is attached as an appendix to this report. Mr Newman and colleagues will attend the committee to provide the briefing and answer questions as necessary.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:-

1) receive the briefing

2) determine what further information is required

3) schedule further consideration

.

Councillor Parry Tsimbirdis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil.

Electoral Division(s) and Member(s) Affected

All

Joint Health Overview and Scrutiny Committee

UPDATE ON NHS 111 SERVICE

1. Introduction

Nottingham City PCT was one of five national pilots of the NHS 111 service; the service having been launched in November 2010. The NHS 111 service is free for people to call, it will assess and advise people what service they need when they think they have an urgent need for care and are unsure what to do.

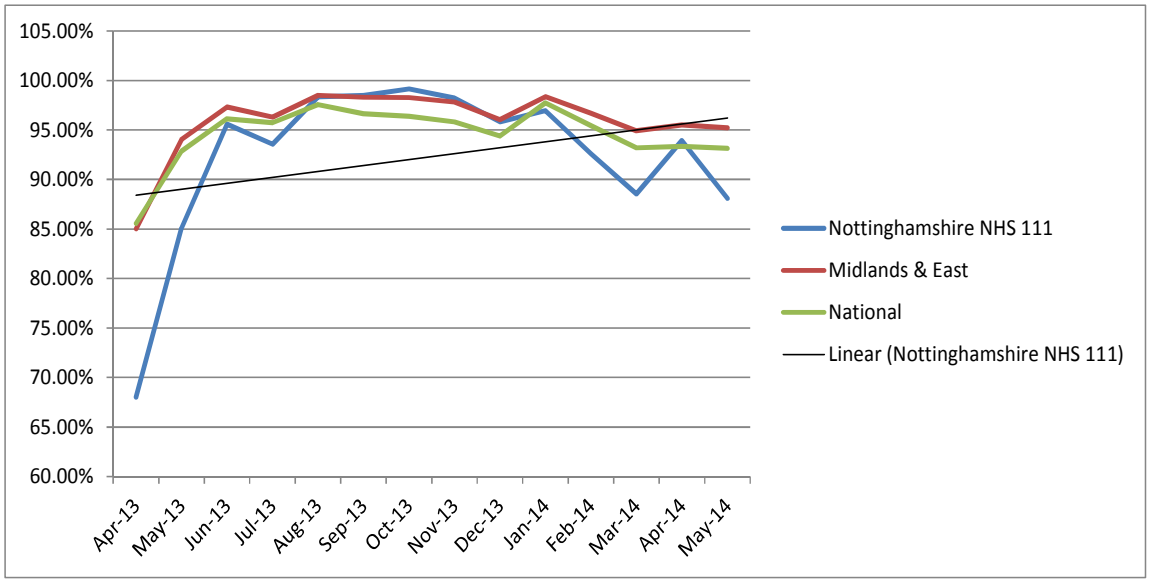
A procurement exercise for a service for the whole of Nottinghamshire (excluding Bassetlaw) was conducted as part of the roll out of the NHS 111 service nationally. The successful bidder in the procurement exercise was Derbyshire Health United (DHU) and the service went live in March 2013. From April 2014, the service started managing the calls to GP practices out of hours for Mansfield & Ashfield and Newark & Sherwood CCGs.

As part of a national review of urgent and emergency care, NHS England has published a revised set of service standards for NHS 111 that will be developed over time.

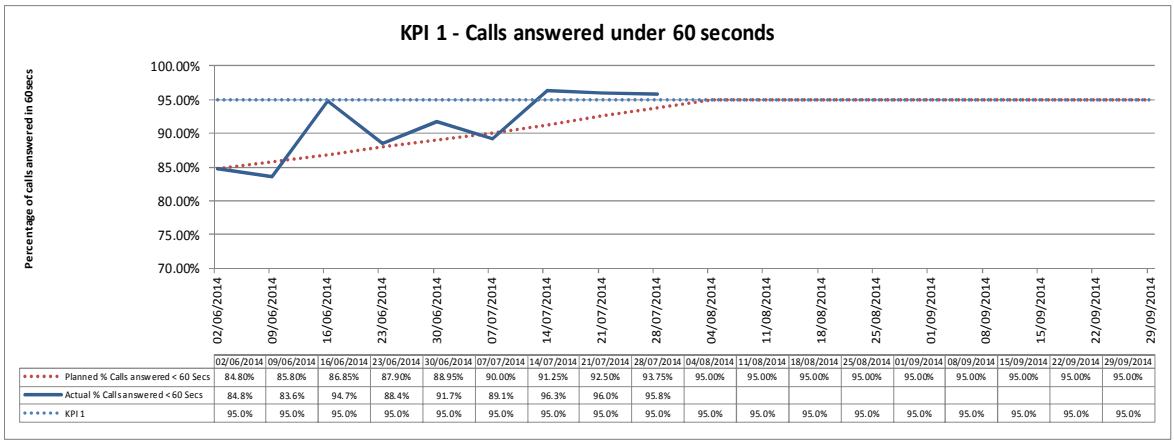
2. Performance

2.1 CALLS ANSWERED IN 60 SECONDS AND CALL BACKS

After performing better than the England average for much of 2013-14 and being regularly above the 95% standard, performance deteriorated in January as DHU initiated a workforce change process to increase the efficiency of the service and the matching of capacity to demand.



The improvement in performance in April was not sustained into May and as a result, DHU were asked to initiate a recovery plan. As average performance in June remained below the 95% standard, a contract query was issued by all of the commissioners of NHS 111 services from DHU. A revised recovery plan has been developed with associated improvement trajectories; the performance to date against the improvement trajectory (for all NHS 111 services provided by DHU) is shown below:



	02/06/2014	09/06/2014	16/06/2014	23/06/2014	30/06/2014	07/07/2014	14/07/2014	21/07/2014	28/07/2014	04/08/2014	11/08/2014	18/08/2014	25/08/2014	01/09/2014	08/09/2014	15/09/2014	22/09/2014	29/09/2014
Planned % Calls answered < 60 Secs	84.80%	85.80%	86.85%	87.90%	88.95%	90.00%	91.25%	92.50%	93.75%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%	95.00%
Actual % Calls answered < 60 Secs	84.8%	83.6%	94.7%	88.4%	91.7%	89.1%	96.3%	96.0%	95.8%									
KPI 1	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

As illustrated above DHU has achieved sustained improvement against the recovery plan and contract query for calls answered in 60 secs. For the last 3 weeks DHU has achieved the 95% KPI standard ahead of the mid-August target date.

In spite of the deterioration in the percentage of calls answered in 60 seconds since January 2014, the standard that no more than 5% of calls should be abandoned has been met every month since May 2013 and has not exceeded 2% in any one month.

Comparing the performance of the NHS 111 service in Nottinghamshire to national service performance, for the month of April and May 2014:

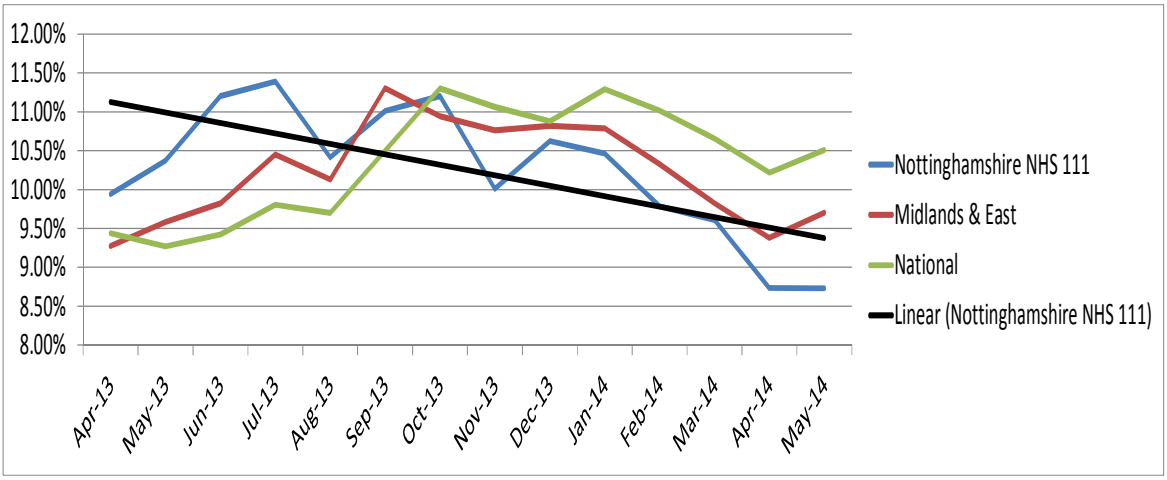
	Nottinghamshire	**National**
Calls Answered in 60 Seconds - April 2014 - May 2014	 93.9% 88.1%	 93.3% 93.1%
Calls Abandoned - April 2014 - May 2014	 0.68% 1.71%	 1.39% 1.23%

The contract query also required DHU to provide a recovery plan to address the increasing number of patients who have had to wait for a call back in recent months and the increasing average time that those patients have had to wait for a call back. The CCGs have been working with DHU to ensure that there is appropriate prioritisation of those patients awaiting a call back; ensuring that any clinical risk associated with the wait for a call back is minimised.

2.2. Patients Advised to Attend Emergency Departments or Sent an Ambulance

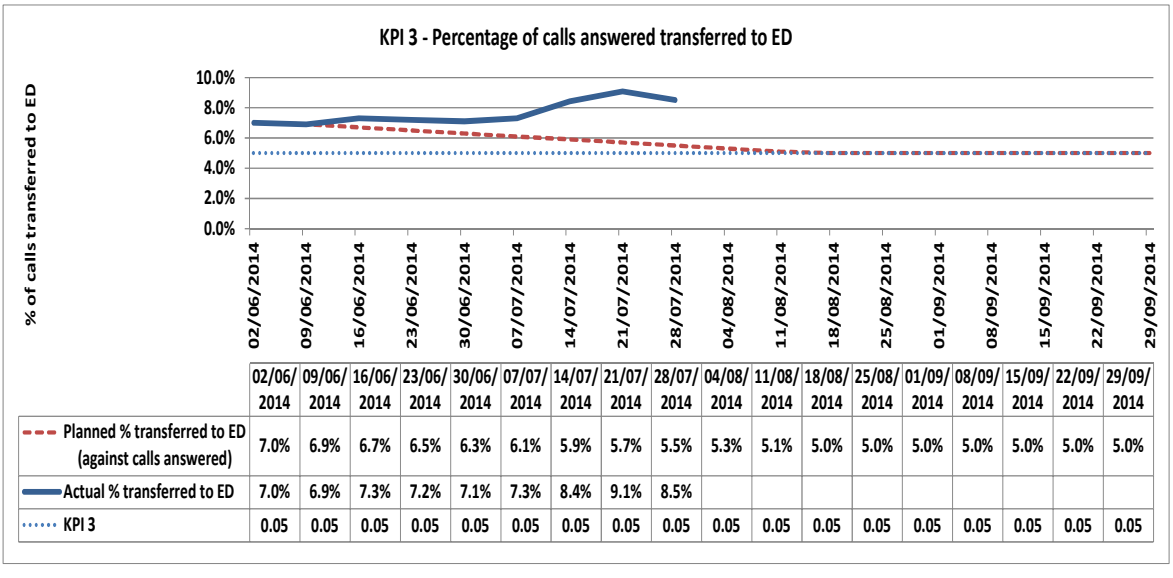
The main focus of concern, both nationally and locally, about the outcomes of calls to the NHS 111 service has been around the proportion of calls that end with the person being despatched an ambulance or advised to attend the Emergency Department.

Within Nottinghamshire, around 9% of calls end with an ambulance being despatched; which is around 0.5% better than the figure being achieved across the region and around 1.5% better than the figure being achieved nationally. In a month, if DHU were achieving the national average this would equate to around a further 300 ambulances being dispatched (within Nottinghamshire in May there were around 13,000 ambulance responses):



Within Nottinghamshire, around 8.5% of calls end with the person being advised to attend the Emergency Department. This is around 1% higher than that national average and is higher than the CCGs believe could be achieved based on historical experience; the aim being that no more than 5% of calls should end with the person being advised to attend the Emergency Department. If DHU were achieving the national average this would equate to around 200 fewer Emergency Department attendances per month (within Nottinghamshire in May there were around 29,000 Emergency Department attendances).

Improving performance on the percentage of calls directed to the Emergency Department is another focus of the revised recovery plan and the performance to date against the improvement trajectory (for all NHS 111 services provided by DHU) is shown below:



	02/06/2014	09/06/2014	16/06/2014	23/06/2014	30/06/2014	07/07/2014	14/07/2014	21/07/2014	28/07/2014	04/08/2014	11/08/2014	18/08/2014	25/08/2014	01/09/2014	08/09/2014	15/09/2014	22/09/2014	29/09/2014
Planned % transferred to ED (against calls answered)	7.0%	6.9%	6.7%	6.5%	6.3%	6.1%	5.9%	5.7%	5.5%	5.3%	5.1%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%	5.0%
Actual % transferred to ED	7.0%	6.9%	7.3%	7.2%	7.1%	7.3%	8.4%	9.1%	8.5%									
KPI 3	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05

Delivery of improvements in the proportion of calls being directed to the Emergency Department is not solely the responsibility of DHU as, in part, it will depend on the availability of alternative services within the health community. The CCGs are currently in the process of commissioning an alternative service from Nottinghamshire Healthcare Trust for people in crisis who are currently directed to the Emergency Department.

The CCGs have compared the number of emergency outcomes from the NHS 111 service between July and October 2013 with the number from the services that were managing calls between July and October 2012; the comparison suggests that the number of emergency dispositions has not increased as a result of the further roll out of NHS 111 in Nottinghamshire and may have reduced, largely due to the number of emergency dispositions that were resulting from calls to the NHS Direct 0845 46 47 service.

3. Service Improvement Plan

A copy of the Service Improvement Plan is attached at Appendix 1, the key features are:

- Staff consultation
    - completion of the workforce change program and implementation of the new staff terms & conditions and working patterns aimed at matching capacity with patient call demands

- Call forecasting and planning
    - reviewing the process and key assumptions for forecasting call volumes in line with actual patient call activity and contracted call volumes.
    - learn key lessons from NHS England and other 111 providers, and ensure regular weekly review carried out with 111 contract manager to agree call forecasts.

- UXL programme
    - implementation of a staff training and development programme across the 111 call centre aimed at improving patient outcomes, service performance and staff productivity in line with key contract KPI's

- Sickness absence
    - set of critical actions to address an on-going service delivery risk of high levels of short and medium term sickness absence. As at June 2014 the current levels of sickness within the 111 service was 12% for Call Advisors and 10% for Nurse Advisors against a target of 5%.

Stewart Newman
Head of Urgent Care
NHS Nottingham City

Stephen Bateman
Chief Operating Officer / Interim Chief Executive Officer
Derbyshire Health United

DHU NHS111 Service Improvement Plan (as @ 4/8/2014)

RAG Rating	
RED	< 50% Complete
AMBER	> 50 < 100% Complete
GREEN	100% Complete

Appendix 1

Category	Exec Lead	Issue	Support Required	KPI	Recommendations/Actions	Owner	RAG Status	Target Date
1.IT Resolution	Stephen Bateman (COO)	IT issues to be corrected by hard N3 connection ordered May 2013 to be installed and fully pressure tested	LHIS & DHIS [GEM]	KPI 1	**1.1 Involve GEM MD to ensure that local issues with DHIS are fully resolved.**	**LW/SB/ GRJ**	**Green**	**Completed**
2. Staff Consultation	Stephen Bateman (COO)	All call centre staff [400] were in 45 days consultation to change to seasonal shift patterns, reduce sickness T&Cs and move to rates of pay that incentivise OoH and weekend working.	HR Ops Mgt Rotas Shift Mgt	KPI 1 & 4	**2.1 Consult with staff reps re changes to T&Cs. : pay changed to enhance rates for unsocial shifts shift patterns altered seasonally flexible working to meet changes in call demand patterns changes to sick pay** **2.2 Undertaken 121's with all staff to confirm acceptance or not of change of terms and conditions / shift patterns to ensure Core, OoH/Weekends/BH are staffed appropriately.** **2.3 Ensure all rota/work patterns queries are resolved by 5/6/2014 and final status of staff groups agreed. As at 23/6/14 ALL rota queries have been addressed. However identified that there are clear gaps in the 4-week rota and now discussions taking place with CA's and NA's. See 2.7 below** **2.4 Agree new contracts of employment, including weekend working, BH and pay rates with NHS111 staff as part of consultation. Status as at 4.8.14 is:** • **YES – 249** • **NO – 0** • **TUPE Excluded – 10** • **Other e.g. Mat Leave – 10** **2.5 All staff that are UNDECIDED to be contacted in person to confirm if Y/N. Records to be maintained** **2.6 All "NO" staff to be contacted in person or via telephone to confirm their position and key reason(s), obtain signed paperwork and meetings to be held to dismiss and re-engage and actioned as per 2.4 above.** **2.7 Identify current status of staffing numbers/patterns and gaps in rota that will affect service performance for next 2 months. Agree management action plan on outcome.**	**SB/PH/ DW** **JD** **PT/SB** **JD** **KB/JD** **PH** **SB/PT**		**Completed** **Completed** **Completed** **Completed** **Completed** **Completed**

Category	Exec Lead	Issue	Support Required	KPI	Recommendations/Actions	Owner	RAG Status	Target Date
3. Rotaring & Scheduling	Stephen Bateman (COO)	111 roster management is currently manually intensive	Finance Ops Rota	KPI 1 & 4	**3.1 Purchase of new Workforce Management System**	**SB**	**Amber**	**Completed**
					3.2 Appoint project manager to support implementation	**SB**		**Completed**
					3.3 Agree revised deadline for implementation of Injixo system within 111 Call centre operation - 31 July 2014	**SB**		**Completed**
					3.4 Resolve all Rota queries as a result of consultation period and ensure gaps identified / resolved / actions agreed, e.g. recruit weekend / weekday staff. See 2.7 above.	**PT**		**Completed**
					3.5 WFM tool project team in place and scoping document/PM agreed but delayed due to consultation delay/rota patterns. Review 6-8 week implementation timescale.	**SE/JS**		**Completed**
					3.6 Project risk/issues log to be reviewed with SB/PH by 6.6.14	**SB**		**Completed**
					3.7 JS working in background to develop uploads to WFM tool, when required	**SB/PT**		**Completed**
					3.8 Assurance to be agreed regarding integration of WFM with HR/Payroll to improve control, VFM and define processes. Project review meeting with Injixo and DHU project team to be held on 15 August 2014 to complete.	**SB**		**15.8.14**
4. Staffing Contingency	Pauline Hand (DOO)	Ensure robust contingency for staffing provision to meet service standards	Finance Ops Rota	KPI 1 & 4	4.1 **Detail of all contingency staff (CSMs/SMs/Trainers/CQI audit etc.) broken down into NAs and CA numbers/contracted hours. Illustrate plan to deploy contingency as required against forecast.**	**LWat/JD**	**Green**	**Completed**
					4.2 **Agree additional On-call hours for NA/CA's – Paid to be on call and then take shifts at agreed premium rate if they work the shift. Put on hold due to performance improvement. None Viable – review 8 weeks if required**	**PH/JD**		**Completed**
					4.3 **Very clear instructions to contingency staff how they will be deployed and what we expect from them in our time of need. Utilise TV/WallBoard at Charlotte House**	**LW**		**Completed**
					4.4 **Clear communication to staff and also briefing to shift management.**	**PH**		**Completed**
					4.5 **Approved to review Pathways training programme including paid overtime, as well as key triggers to suspend training to support service delivery.**	**LWat**		**Completed**

Category	Exec Lead	Issue	Support Required	KPI	Recommendations/Actions	Owner	RAG Status	Target Date
5. UXL programme	Pauline Hand (DOO)	Service delivery KPIs of the financial envelope are currently all being exceeded. UXL is addressing all of these elements: Call speeds, productivity and transfer to NA.	Ops Management Performance Team Training Team	KPI 1, 3&4	**5.1 Implement UXL training to improve CA&NA's KPIs in line with return to bid case – still in progress with CA off-track and needs additional focus** **5.2 Main focus is to support Call Advisors and review in line with progress to date, staff consultation, and patient outcomes. Need to achieve below 7min consistently and current trajectory is 18/8/2014. To be agreed with commissioners 18/6/2014** **5.3 Undertake sensitivity analysis to assess impact of CA and NA what is impact with 25% triage/80% Productivity, e.g.** **a. CA - 7min, NA – 7.5min / CA – 6min45secs, NA – 7.5min** **5.4 Review trajectory for all key metrics and agree revised timescale to deliver back to bid case. To be agreed at Joint Collaborative 111 meeting.**	**LWat** **LWat** **SB** **SB/PH**	**Amber**	**Completed (Trajectory)** **Completed (Trajectory)** **Completed** **Completed**
				KPI 1 & 4	**5.5 UXL training to Nurse Advisors to use clinical validation against dispositions -– still in progress with NA achieved 8min target but set new milestone** **5.6 Complete 121 reviews with all NA's to recognise positive progress & role within the 111 service model, incorporating validation** **5.7 Recognise Top 6 NA performers from KPI's** **5.8 Review all processes that are impacting upon NA call lengths and outcomes e.g. safeguarding referrals, complaints, Use of make busy codes. Ensure correct policy/process is in place, monitored and patient outcomes documented.**	**LWat** **MM/KB** **PH/PT** **LWat**	**Green**	**Completed** **Completed** **Completed** **Completed (Trajectory)**
				KPI 4	**5.9 Deliver target of 25% transfer to NA – achieved as at end of May in line with target. 24.8% as at 25/5/2014**	**LWat**		**Completed**
				KPI 3	**5.10 Deliver 999 referrals to below 8% by reviewing individual CA dispositions outcomes with 999 and audit/ review Top/Bottom 10 CA's and identify root cause/actions e.g. retraining, shift, CMP3 - Achieved 6.6% - 7.9% in May/June 14, and 6.8%-8.4% in July NMDS submission** **5.11 Ensure we recognise Top 6 performers**	**LWat** **LW/PH**		**Completed & Ongoing** **Completed**
				KPI 3	**5.12 Deliver A&E referrals to below 6% by reviewing individual CA dispositions outcomes with A&E and audit/ review Top/Bottom 10 CA's and identify root cause/actions e.g. retraining, shift, disposition. Achieved between 5.8% – 7% May 2014, 6.1% - 8% in June 2014, 7.1%-8.1% July 2014 NMDS submission. Breakdown of A&E to be developed for review meetings** **5.13 Ensure we recognise Top 6 Performer**	**LWat** **LWat**	**Amber**	**31.8.14** **Completed**
				KPI 4	**5.14 Improve availability to 80% - still in progress as achieved at certain days/times for both CA / NA as we approached end of May through July 2014.** **5.15 Continue to monitor productivity of CA/NA and review Top 10/Bottom 10 identify root cause and address performance issues** **5.16 Ensure that we recognise Top 6 performers**	**LWat** **PH/LWat** **PH/LWat**		**Partially Completed** **Completed & On-going** **Completed**

Category	Exec Lead	Issue	Support Required	KPI	Recommendations/Actions	Owner	RAG Status	Target Date
6. Performance Management of employees	Pauline Hand (DOO)	Improve performance management of teams	HR Operations Managers Shift Managers	ALL	**6.1 Review team/shift management structure during consultation process** **6.2 Deliver training on managing performance for all Shift Management** **6.3 Provide shift managers with weekly individual/ team performance information [KPIs and call audit results]** **6.4 Call centre management team to set and agree SMART objectives with team leaders**	**DW/JD** **JD/VB** **MM/KB** **LWat/ JD**	Green	**Completed** **Completed** **Completed** **Completed**
7. Sickness & Absence Management	Stephen Bateman (COO)	Sickness is not managed effectively	HR Operations Managers Shift Managers Absence Manager	KPI 1,4 & 5	**7.1 Review T&Cs of sick pay during consultation. Updated Sickness/Absence Policy** **7.2 Clarify expectations of how shift managers are to manage sickness [SMART Objectives].** **7.3 Train Shift Managers to improve attendance management and to be timely in having difficult conversations with staff.** **7.4 Review progress and compliance with the policy of RTW and actions being taken with relevant staff. Daily monitoring and actions to be agreed/ taken/ recorded** **7.5 Undertake staff meetings to initiate performance management / disciplinary process** **7.6 Review of all staff that are on medium / long term sickness and agree individual action plan with HR** **7.7 Undertake weekly analysis of sickness trends in DHU services e.g. 111/OoH, Adastra disposition and local Health services to inform forecasting** **7.8 Implement operational changes to sickness reporting through HR/Payroll system for all 111/OoH service** **7.9 Discuss and agree additional support for sickness management with KC and permanent role moving forward to support DHU** **7.10 Reassign internal /HR resource or recruit external temporary support to target absence management action plan on priority cases and implement effectively across 111 call centre.** **7.11 Management briefing with all staff groups on the new Absence management policy.** **7.12 PH/JD/KC to attend / monitor all RTW interviews/disciplinary meetings for CA/NA staff. Ensure consistent policy implemented and ensure strong cohesive management through Ops and HR.** **7.13 Commence daily / weekly / monthly communication of sickness absence statistics for each area of the business. Align to performance impact.** **7.14 Ensure <5% sickness levels is key objective for each member of SMT.** **7.15 Implement Injixo WFM tool through robust project management and system integration to support management to implement absence management**	**SB/DW** **PH/JD/KC** **PH/DW/ KC** **SB/DW/ KC** **JD/** **SB/KC/VB** **JD/PT** **DW** **SB/DW** **SB** **DW/KC** **SB/DW** **SB/DW** **SB** **PH**	**Amber**	**Completed** **Completed** ~~**30.6.14**~~ **31.8.14** **Completed** **Completed & On-going** **Completed & On-going** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** **Completed** ~~**31.7.14**~~ **31.8.14**

Category	Exec Lead	Issue	Support Required	KPI	Recommendations/Actions	Owner	RAG Status	Target Date
8. Management Development	Pauline Hand (DOO)	Performance of shift managers	Snr Operations	ALL	**8.1 Agree SMART objectives and Performance manage the Shift Managers in line KPI's.** **8.2 Review role, responsibilities and structure of shift management within the 111 service, and implement any changes required.** **8.3 Review the shift management rota and partnering around weekend working to support service performance and clinical safety** **8.4 Develop and undertake a training and assessment programme for all Clinical and Non-clinical Shift management** **8.5 Utilise wallboards in call centre for better communication and mitel reporting e.g. staff on scheduled/unscheduled breaks, safeguarding, etc** **8.6 Ensure Shift Management and staff are aware of key reports/ tools/ triggers and subsequent actions to undertake to actively management the 111 service 24/7 e.g. calls waiting, staff idle/waiting**	**JD/DW** **PH** **JD/PH** **PH/DW** **LWat/NP** **PH/JD**	**Green**	**Completed** **Completed** **Completed** **Completed & On-going** **Completed** **Completed**
9. Service Improvement Processes	Pauline Hand (DOO)		CQI Lead Operations Managers Training Team	ALL	**9.1 Operational checklist / escalation plan to support active Clinical queue management to meet Patient safety, MDS KPIs and service performance.** **9.2 Review Call centre management folder and update/train/brief as required to all relevant staff** **9.3 Contingency queue management process to be agreed and implemented following Adastra changes**	**JDox/ LW** **MM/KB** **JDox/ PH**	**Amber**	**Completed** **~~13.6.14~~ 11.07.14** **Completed**
10. Management Information reporting	Stephen Bateman (COO)	Weekly reports inform performance management of individuals not teams	Operations Director/ Managers	ALL	**10.1 Review and revise reports suite to drive operational performance through improved team management**	**SB**	**Green**	**Completed**
11. Recruitment Baseline	Pauline Hand (DOO)	Turnover in call centres tends to be high	COO/HRD	ALL	**11.1 Establish rolling recruitment programme for CA / NA. To progress once consultation/rotering finalised; headcount v hours** **11.2 Ensure training programme agreed and timelines for pathways/ qualified/ competent staffing** **11.3 Clarification of accountabilities through setting SMART objectives**	**JD/PH** **PH** **PH**	**Amber**	**~~13.6.14~~ 15.8.14** **Completed** **Completed**
12. HR Support	Stephen Bateman (COO)	Support for recruitment	HR	ALL	**12.1 Appointment of dedicated HR recruitment and training lead.**	**DW**	**Green**	**Completed**

Category	Exec Lead	Issue	Support Required	KPI	Recommendations/Actions	Owner	RAG Status	Target Date
13.Communication improvement	Stephen Bateman (COO)	24/7 working x 3 sites creates difficulties ensure consistent messages to staff	Directors HR Operations Managers	ALL	**13.1 Leading on from consultation develop quarterly staff forums increasing engagement and improving information flows. Terms of reference agreed and Communications Manager appointed to take this forward with HRD**	**SB/DW**	**Amber**	~~**30.6.14**~~ **31.8.14**
14. Planning & Forecasting (Bank Holidays 2014/15 including World Cup)	Stephen Bateman (COO)	Robust forecasting of volumes and staffing required to enable service delivery	Directors Operations Managers Performance managers	KPI 1, 4 & 5	**14.1 Agree with JH to visit other 111 Providers to review best practice forecasting models and to implement lessons learned and implemented, i.e. YAS/Herts. Still outstanding as with JH NDCCG to organise.** ~~**14.2 AM to objectively review DHU forecasting model to identify recommendations for improvement. Feedback to Joint Collaborative group. No longer applicable as CCG conflict of interest**~~. **14.3 Track historical performance data and formulate staffing forecasts. Needs close monitoring by county against contract call volumes and forecasts for last 3 months, and form part of the regular staff communication. Macro level by week accuracy for first two then last month do it by Day of week and week total variance actual to forecast.** **14.4 Translate data from revised forecast into rota/call patterns to review against outcome of staff consultations. Actual CAs/NA's staffing / hours evidence of % of by hour, by day of the week to am/pm/evening.** **14.5 Review staffing levels on a weekly basis to address staffing gaps. This needs to be reviewed / agreed by Senior operations team & Director of Operations** **14.6 Diary Bank Holiday planning meetings with commissioners**	**PH** ~~**PH**~~ **SB/BH** **PT/BH** **PT/PH** **PH/PT**		~~**30.6.14**~~ **31.8.14** ~~**30.6.14**~~ **Completed** **Completed** **Weekly review Fri / Monday** **Completed & On-going**
15. Refresh Staff Recognition Scheme	Stephen Bateman (COO)	Ensure that positive staff communication and recognition programme improves the staff motivation	Human Resources Operations Managers	ALL	**15.1 Review and re-launch the Staff Recognition scheme and refine based on current organisational strategy / culture. To be developed by Staff forum.** **15.2 Develop the staff forum and look to align to the area of service development, communication strategy, staff briefings and staff surveys.** **15.3 Implement a staff social group that will take ownership of recreating the "family" culture within DHU.**	**DW** **DW** **DW/SB**	**Red**	~~**30.6.14**~~ **31.8.14** **Completed & on-going** ~~**30.6.14**~~ **31.8.14**

KPI 1				KPI 2				KPI 3				KPI 4				KPI 5				KPI 4.1 (inverse of KPI 4)			
Planned % Calls answered < 60 Secs	Actual % Calls answered < 60 Secs	Variance		Planned % Abandoned > 30 Secs	Actual % Abandoned > 30 Secs	Variance		Planned % transferred to ED	Actual % transferred to ED	Variance		Planned % Warm Transfers	Actual % Warm Transfers	Variance		Planned % call backs within 10mins	Actual % call backs within 10mins	Variance		Planned % of call backs	Actual % call backs	Variance	
		%	since last week			%	since last week			%	since last week			%	since last week			%	since last week			%	since last week

KPI 6		KPI 7		KPI 8			
Average wait for CH answer (min:sec)	Variance since last week	Longest wait for CH answer (min:sec)	Variance since last week	Planned average wait NA for call back (mins)	Actual Average wait for NA call back (mins)	Variance	
						%	since last week

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

9 September 2014

Agenda Item: 7

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

HEALTH SCRUTINY GUIDANCE – KEY MESSAGES

Purpose of the Report

1. To introduce discussion of the new Health Scrutiny Guidance.

Information and Advice

2. The People, Communities and Local Government Division of the Department of Health issued guidance on Local Authority Health Scrutiny in June 2014. This report reflects on the key messages of the guidance and invites Members to consider the implications of the guidance on the operation of the Joint Health Scrutiny Committee.

3. The guidance states that the primary aim of Health Scrutiny is to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services, and that services are effective and safe.

    - How can Health Scrutiny be better attuned to the concerns of local people?
    - How can Health Scrutiny ensure that health services are effective and safe?

4. The guidance states that Health Scrutiny has a strategic role in taking an overview of how well integration of health, public health and social care is working – relevant to this might be how health and wellbeing boards are carrying out their duty to promote integration – and in making recommendations about how it could be improved.

    - How should Health Scrutiny engage with health and wellbeing boards?
    - What information/evidence might Health Scrutiny need to enable it to make recommendations about how integration could be improved?

5. The guidance states that Health Scrutiny has a legitimate role in proactively seeking information about the performance of local health services and institutions; in challenging the information provided to it by commissioners and providers of services for the health service and in testing this information by drawing on different sources of intelligence.

    - Is Health Scrutiny sufficiently proactive in seeking information and challenging the information it receives?
    - How might Health Scrutiny best ‘reality check’ the information that it is provided with?

6. The guidance states that Health Scrutiny is part of the accountability of the whole system and needs the involvement of all parts of the system. Engagement with relevant NHS bodies and relevant health service providers is a continuous process. It should start early with a common understanding of local health needs and the shape of services across the whole health and care system.

    - Is Health Scrutiny sufficiently engaged with all parts of the health and care system (especially when substantial variations are taking place)?
    - Does Health Scrutiny share a common understanding with health service providers of the shape of services across the whole system?

7. The guidance states that Health Scrutiny requires a clarity at a local level about respective roles between the health scrutiny function, the NHS, the local authority, health, health and wellbeing boards and local Healthwatch.

    - Does Health Scrutiny currently have sufficient clarity around the roles of other bodies and organisations, and if not, how might this be obtained?

8. The guidance indicates that in the light of the Francis Report, local authorities will need to satisfy themselves that they keep open effective channels by which the public can communicate concerns about the quality of NHS and public health services to health scrutiny bodies. Although Health Scrutiny bodies are not there to deal with individual complaints, they can use information to get an impression of services overall and to question commissioners and providers about patterns and trends.

    - Do the public have sufficient lines of communication to Health Scrutiny?

9. Furthermore, in the light of the Francis Report, Health Scrutiny will need to consider ways of independently verifying information provided by relevant NHS bodies and relevant health service providers – for example, by seeking the views of local Healthwatch.

    - How else might Health Scrutiny seek to verify information?
    - Would seeking to use Healthwatch to verify information have the potential to tie up too much of Healthwatch's resources?

10. The guidance also indicates that Health Scrutiny should become outcome focused, looking at crosscutting issues including general health improvement, wellbeing and how well health inequalities are being addressed.

    - Is Heath Scrutiny sufficiently outcomes focused?
    - How should health inequalities be addressed?

11. The guidance states that when there are concerns about substantial developments and variations in health services local authorities (i.e. Health Scrutiny) will need to work together with the NHS to resolve issues locally if at all possible. If external support is required for this purpose, informal help is available from the Independent Reconfiguration Panel and/or the Centre for Public Scrutiny. If the decision is ultimately taken to formally refer the NHS's reconfiguration proposals to the Secretary of State for Health, then referral must be accompanied by an explanation of all steps taken locally to try to reach agreement.

- How will Health Scrutiny ensure that all possible efforts are made to resolve issues locally?
- How will Health Scrutiny Members judge when it is appropriate to refer to the Secretary of State?

12. The guidance also mentions that in considering substantial reconfiguration proposals that Health Scrutiny needs to take into consideration the resource envelope within which the NHS operates and therefore take into account the effect of the proposals on the sustainability of services, as well as quality and safety.

    - How will Health Scrutiny obtain sufficient information about the financial constraints across the NHS to properly inform its thinking?

13. The guidance indicates that Health Scrutiny functions should be carried out in a transparent manner which boosts the confidence of local people in Health Scrutiny. Health Scrutiny should be held in an open forum with local people allowed to attend meetings, with filming and tweeting allowed.

    - Health Scrutiny has previously operated 'study groups' where interested Members gather evidence in private and this method has tended to be quite effective. How might Health Scrutiny mitigate the loss of this method of operation?

14. The guidance also encourages the health and social care system as a whole to think about how the Health Scrutiny function is supported nationally, regionally and locally to enable the powers and duties associated with the function to be exercised appropriately.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

1) consider and comment on the new Health Scrutiny guidance
2) schedule further consideration of the guidance as necessary

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Local Authority Health Scrutiny: Guidance to support Local Authorities and their partners to deliver effective health scrutiny (Department of Health – June 2014)

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

9 September 2014

Agenda Item: 8

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To introduce the Joint City and County Health Scrutiny Committee work programme.

Information and Advice

2. The Joint City and County Health Scrutiny Committee is responsible for scrutinising decisions made by NHS organisations, and reviewing other issues which impact on services provided by trusts which are accessed by both City and County residents.

3. The draft work programme for 2014-15 is attached as an appendix for information.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee note the content of the draft work programme for 2014-15.

Councillor Parry Tsimbiridis
Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Joint Health Scrutiny Committee 2014/15 Work Programme

10 June 2014	• **Intoxicated Patients Study Group** To consider the report and recommendations of the Intoxicated Patients Study Group • **Terms of Reference and Joint Protocol**
15 July 2014	• **Developments in Adult Mental Health Services** To receive information about developments in adult mental health services (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust) • **NUH Performance Against Four Hour Emergency Department Waiting Time Targets** To receive the latest performance information (NUH) • **New Health Scrutiny Guidance** To receive briefing on the new Department of Health guidance on Health Scrutiny
9 September 2014	• **Greater Nottingham Urgent Care Board** To consider the progress of the Greater Nottingham Urgent Care Board (Nottingham City CCG lead) • **Patient Transport Service** To consider performance in delivery of Patient Transport Services (Arriva/ CCG lead) • **NUH Pharmacy Information** Information received as part of ongoing review (Nottingham University Hospitals/CCG) • **NHS 111 Performance** To receive the latest update on workforce change implementation (Nottingham City/Nottinghamshire County CCG)

	• **New Health Scrutiny Guidance – Key Messages** Further discussion
14 October 2014	• **Intoxicated Patients Review** To consider the response to the recommendations of this review (NUH) • **Developments in Adult Mental Health Services** To receive information in relation to the consultation response (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust) • **Mental Health Services for Older People** To receive information in relation to the consultation response (Nottingham City CCG/ Nottinghamshire County CCGs/ Nottinghamshire Healthcare Trust)
11 November 2014	• **Update on joint working to improve care for frail older people** To review progress in how partners are working together to improve the care of frail older people (Nottingham City CCG, Nottingham City Council, Nottinghamshire County Council, Nottingham University Hospitals)
9 December 2014	• **Approach to Child and Adolescent Mental Health Services** Initial Briefing (Nottinghamshire Healthcare Trust)
13 January 2015	• **NUH Environment & Waste** Initial Briefing (Nottingham University Hospitals)
10 February 2015	
10 March 2015	

21 April 2015	

To schedule:

NHS 111 – to consider outcomes of GP pilot and performance following workforce changes
Response to recommendations from the Intoxicated Patients Review
Report and recommendations of the Pharmacy Review
Nottingham University Hospital Maternity and Bereavement Unit
Health Scrutiny Guidance
24 Hour Services
Outcomes of primary care access challenge fund pilots

Visits:

EMAS
Urgent and Emergency Care Services (various date

Study groups:

Quality Accounts
Waiting times for pharmacy at Nottingham University Hospitals NHS Trust