Joint City / County Health Scrutiny Committee

Tuesday, 10 March 2015 at 10:15

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

AGENDA

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
10th February 2015 at 10.15am

Nottinghamshire County Councillors

Councillor P Tsimbiridis (Chair)
Councillor N Brooks
Councillor R Butler
Councillor J Clarke
A Councillor Dr J Doddy
Councillor C Harwood
Councillor J Handley
Councillor J Williams

Nottingham City Councillors

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

Also In Attendance

Lucy Allsop	- Consultant Psychiatrist at Thorneywood
Julie Brailsford	- Nottinghamshire County Council
Catherine Cook	- Strategy and Partnerships manager, Housing Liason Group (HLG)
Sharon Creber	- Programme Director, Notts Healthcare Trust
Martin Gawith	- Healthwatch, Nottingham.
Martin Gately	- Nottinghamshire County Council
Claire Grainger	- Healthwatch Nottinghamshire
Gavin Orr	- Head of Service for Eye Casualty, Nottingham University Hospitals
Kim Pocock	- Nottingham City Council

MINUTES

The minutes of the last meeting held on 13th January 2015, having been circulated to all Members, were taken as read and were confirmed and signed by the Chair.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor E Campbell, Councillor Dr J Doddy (other), Councillor T Molife and Councillor B Parbutt.

DECLARATIONS OF INTERESTS

There were no declarations of interest.

Eye Casualty

Mr Gavin Orr, Head of Service for Eye Casualty at Nottingham University Hospitals gave a briefing to the committee about Eye Casualty and the triage system used. There had been extensive consultation prior to the release of the triage tool by the Commissioning Group but it was still in the early stages of use and work was being undertaken to improve the communication between all parties concerned.

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

- Mr Orr stated that there was a lack of confidence in the 111 service to advice patients correctly and it was unclear if the 111 service had the triage tool.

- It was unclear to Mr Orr who had commissioned the 111 service and he had not had any contact with them.

- The Eye Casualty phone number was available for public use but there was a still a need for the public to be provided with more information to assist them with eye problems.

After Mr Orr had left the meeting the committee decided that when NHS 111 returned they should pursue the issues around Eye Casualty and in particular triage and communication.

Information Gathering From The Third Sector

Catherine Cook, Strategic and Partnership Manager from HLG gave a presentation to the committee on HWB3, the Third Sector Health and Wellbeing Provider Forum. One hundred and twenty one member organisations form HWB3, all of whom deliver a diverse range of health and wellbeing services. HLG were contracted by Nottingham City Council to develop and administrate this work.

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

- HLG was founded in 1986 and HWB3 had been running since 2012, it had been developed by the City Council and then HLG had taken it over. There were City specific but lots of providers were providing services in the County. HWB3 had offered their services to the County but the offer had not been accepted yet. The offer was still open but funding would be required.

- The practice around consultation with HWB3 was patchy and very much depended on who was dealing with the consultation. The message was not always getting through to the correct people and when HWB3 had flagged up issues they were not always listened to.

- HWB3 were accountable to the Health and Wellbeing Board and funding was provided by core contract money of £8k per annum.

- Third sector providers were becoming more important as services were privatised. The public used 3rd sector services, it was some health professionals that were not aware of them and the services that they provided.

- HWB3 had helped to raise awareness of the difficulties that the Deaf Group, in particular, were facing. They were always looking to increase their network membership and the suggestion that the Ear Foundation could join the network was welcomed.

- They had a mailing list of over 200 people and a website. They surveyed their membership and asked them questions and opinions. They also had a steering group who facilitated questions and discussions.

The committee thanked Catherine Cook for her presentation and offered their help in promoting HWB3.

TRANSFORMATION PLANS FOR CHILDREN, YOUNG PEOPLE AND FAMILIES

Sharon Creber, Programme Director, Notts Healthcare Trust and Lucy Allsop, Consultant Psychiatrist at Thorneywood gave a presentation to the committee on transformation plans and early proposals in relation to Child and Adolescent Mental Health Services and Perinatal Psychiatric Services. The aim being to bring the specialist services together within a single site.

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

- There were currently 12 beds, due to rise to 13 beds in 2015, for 12 to 18 year olds in Nottinghamshire and Derbyshire, fewer beds than anywhere else in the Country. Young people and their families had to travel long distances in times of need, this fractured their community health links and lengthened their stay in hospital. The average stay was 55 days, shorter than the national average.

- Thorneywood was an isolated ward that did not have enough space for visitors, the temperature was never right and the whole environment did not help patient care. The ward environment needed to be able to manage short, as well as long, patient stays of up to a year.

- The Cedars, one of the proposed sites, was a very therapeutic environment with lots of established trees but moving there would mean that they lost the educational gardens currently at Thorneywood.

- The CCG commissioned area would have a perinatal unit, one in Nottingham and one in Derby.

- There was the need for flexibility for patient use of the beds. There was no evidence that specialist units for specific presentations, including eating disorders, helped patients to recover quicker.

- Presentations by young people at Accident and Emergency department were often due to self-harm but these patients did not always require the Services of the Mental Health team. There was a need for a high quality Outpatient Service.

- Public transport and car parking facilities at the new site were an important consideration for patients and their families.

- Consultation was currently being undertaken, including patients, former patients and their families to help shape the planning, design and implementation of the new unit.

- Healthwatch would be helping and supporting the whole process.

- The business plan was due to go before the board for approval at the end of March 2015, following this the preferred site would be known.

The committee requested that Sharon Creber and Lucy Allsop return to the June meeting for a further update once the preferred site was agreed.

WORK PROGRAMME

The contents of the Work Programme were noted.

The meeting closed at 12.08pm.

Chairman

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

10 March 2015

Agenda Item: 4

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

DERMATOLOGY CONTRACT

Purpose of the Report

1. To introduce briefing on the operation of the dermatology contract at Nottingham University Hospitals NHS Trust (NUH) and other associated issues.

Information and Advice

2. Vicky Bailey, Chief Officer of NHS Rushcliffe Clinical Commissioning Group (and lead officer for dermatology commissioning) will attend the meeting to brief Members and answer questions accompanied by senior colleagues from the organisations involved; including Circle and NUH.

3. Briefings from the CCG and NUH are attached as appendices to this report.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

1) Receive the briefing and ask questions as necessary
2) Schedule further consideration, if required.

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

Appendix 1

Circle Nottingham submission to Joint Overview and Scrutiny Panel

In support of the papers that have been submitted by Commissioners and Nottingham University Hospitals NHS Trust (NUH) and response to the issue raised by this Committee regarding Dermatology, Circle wishes to provide the following additional information.

Service History

Circle has been providing adult dermatology services since 2008 which includes outpatients, diagnostics and treatments such as surgery, topical therapies and light therapy. This is a full and comprehensive service which includes specialised services. Since 2008 we have treated 344,000 patients. This service is presently delivered by 61 staff that includes 13 doctors, 34 nurses and 12 administrators. When the contract for services (including dermatology) at the Treatment Centre was renewed in 2013, many of the seconded NUH consultants were directly employed by Circle in accordance with TUPE rules triggered by the terms of the procurement. Consideration was given to whether the consultants could remain employed by NUH but it was concluded that this was not legally possible.

We have high patient satisfaction and have consistently been recommended to friends and family by 97%[1] of patients. Our skin cancer service has been of a high standard and we consistently have achieved 95% of patients seen within 2 weeks and 98.82% treated within the national 62 day target of 85%[2].

NUH recently announced their decision to cease the provision of acute dermatology. Circle were keen to help the patients affected by this decision and have therefore provided dedicated appointment slots for these patients to be urgently seen. This solution supports the majority of the acute dermatology patients.

Service Developments

There is an increased demand for dermatology services and therefore innovative models of service delivery are required. This is mainly due to the increase in skin cancers and an aging population. Since the re-procurement of the Treatment Centre contract in 2012/3 we have been working with commissioners and primary care providers to implement an integrated care model across GP and hospital settings. We are at the point of implementing teledermatology which means that fewer patients will need to travel to hospital. GPs can take images and send them to a specialist for advice and then direct patients to the right place if they require specialist treatment. Combining the use of new technology and skilling up [training] nurses and GPs is a key solution to ever-increasing demand.

[1] 97.2% in January 2015

[2] Data for the calendar year 2014

Consultant specialists have an important role but increasingly their role will be supervising the care offered by the whole team.

Staffing

Circle Nottingham has a growing, high quality direct hire medical workforce across a number of specialities. There have been recent Consultant appointments in Anaesthetics, Gynaecology, Orthopaedics and Respiratory Medicine, as well as Dermatology. However, there is a shortage of Dermatology clinical staffing in the UK affecting both doctors and nurses, with over 200 of 1000 posts vacant across the country. Like many units across the country, Circle has utilised Locum doctors as and when required to sustain high quality patient care and delivery of the service. We have also expanded the use of specialist nurses, providing a holistic, appropriately qualified team in line with best practice.

There is considerable commitment to training and development within Circle, with the Treatment Centre supporting over 300 Specialist Trainee sessions every month across all specialities. Unfortunately, there has been considerable loss of specialist trainees in Dermatology, despite there being a number of permanent Consultants at Circle who can support some teaching and training. Circle is keen to do more and have been vocal about welcoming more specialist trainees.

Collaborative Working

We welcome integration with all providers across primary and secondary care. We have no objection to other providers delivering dermatology services. This has been highlighted to commissioners and NUH. If new providers are introduced, we believe that there should be a coordinated and integrated solution that avoids duplication. Also, any change to the current provision of service across the health community should ensure that where the transfer of patients between providers is required, that this is undertaken in a seamless and appropriate way. We support our Commissioners in developing new ways of delivering high quality care and value for the patients of Nottingham.

Appendix 2

NUH Commentary on dermatology services in Nottingham and on the review proposed by the CCG

1. Nottingham's dermatology services face severe and immediate challenges. Unless these are quickly and satisfactorily mitigated there will be significant contraction in the range of services available locally, notably in emergency specialist advice for adults and children.

2. Proposed response(s) to the challenges must address the depth and urgency of the situation, and the root causes.

3. NUH wishes to maintain a consultant delivered dermatology service for adults and children.

4. Notably from 2 February 2015 NUH have 4 Consultant Dermatologists (vs 11 in 2013). One of the four is a joint academic post. It is no longer feasible for NUH to provide an inpatient adult dermatology service, nor a 24/7 urgent service for ED or inpatients of other specialities.

5. From May 2015 NUH will have three consultant dermatologists (one a p/t academic). At that time the scaled-back adult service from February 2015 will no longer be feasible.

6. At least one of the remaining three NUH consultants has already (January 2015) received offers of appointment elsewhere. Any further reduction in NUH consultant numbers will immediately compromise the paediatric service.

7. The Nottingham Treatment Centre (Circle) has (January 2015) described that is will no longer provide services for young adults (14-17)[1]. The remaining NUH paediatric (and adult) services will be unable to accept transfer of this substantial cohort of patients[2] (though NUH recognises that non-consultant clinicians can provide some of this service).

8. NUH was prevented by commissioners from providing even a limited planned (outpatient) dermatology service for local patients (autumn 2014). This severely curtailed NUH's ability to retain (and recruit) consultant dermatologists.

9. The reduction in consultant dermatologist numbers at NUH has prompted withdrawal of specialist trainees[3], further compromising the doctor capacity available for the NUH-based service.

[1] the Independent Sector guidance suggests a change may be appropriate for 14-15yr olds
[2] estimated as1200 patients per year
[3] this will likely compromise recruitment to Nottingham consultant posts

10. The reduction in NUH adult dermatology consultants has had a knock-on effect for adult MDTs, notably those for skin cancer (to which non-dermatology NUH services are significant contributors).

11. The reduction in NUH dermatology has meant wholesale change in the delivery of dermatology teaching for Nottingham undergraduate and local general (and specialist) postgraduate training. This is not yet securely placed in other clinical units.

12. The previous national (and indeed international) reputation of Nottingham as a centre for research in dermatology (adult and paediatric) is seriously compromised.

13. NUH agrees that a review of Nottingham dermatology services is required, but its ToR and timescale should reflect the extant risk to the service (and its patients).

14. NUH considers the prospects of recruiting to 'replacement' NUH consultant dermatology posts to be extremely remote.

15. The clinical sustainability of an NUH dermatology service (adult or paediatric) with fewer than four consultant dermatologists is questionable.

16. The financially sustainability of the current NUH complement of dermatology consultants (four) is questionable.

17. Without appreciation of the extant challenges and recent changes in the local dermatology services, it is difficult to meaningfully consider the medium and longer term service provision and models of care.

18. The service strategy will of course require an understanding of population need and of possible service models.

19. In developing an option appraisal for the service model, one domain needs to be 'feasibility' or deliverability, notably of the necessary workforce.

20. A second domain will be the degree to which dermatology services might be delivered by clinicians without specialist (or super-specialist qualification), and indeed by non-doctor clinicians.

21. The strategy needs to consider the experience of separating (1) planned from unplanned dermatology and (2) adult and paediatric services.

22. The strategy needs to consider the experience of models of employment on the local community of consultant dermatologists (and hence on the service and on the feasibility of future models). NUH consultants were obliged (by Circle) to TUPE to Circle against their wishes.

23. The strategy must recognise the national shortfall in consultant dermatologists.

24. NUH is unaware of any significant relocation of planned dermatology to ‘community’ facilities in past 2 years, although NUH understands this was one objective of commissioning the current service.

25. The CCG paper of mid-January 2015 describes one ambition as ‘an agreed position across providers for future collaboration’. As a provider NUH is keen to collaborate to develop higher quality services. But such collaboration between providers, who are invited to compete for contracts, requires clarity of commissioning intent and appreciation by commissioners of the conditions in the commissioning and contracting environment necessary for such effective collaborations.

Appendix 3

Briefing for the Joint Overview and Scrutiny Committee

February 2015

This briefing is prepared by CCGs in Nottinghamshire. In addition, an overview of the perspectives of Nottingham University Hospital NHS Trust and Circle are provided. The proposed scope of the review referred to in the final paragraph of this briefing is attached at Appendix A.

1. Background

The Nottingham Treatment Centre was nationally procured 7 years ago (2007) by the Department of Health as part of the national Independent Sector Treatment Centre (ISTC) programme. The first contract was nationally held and for 5 years. In the national ISTC programme NHS staff were enabled to work in ISTC centres under a staff supply agreement.

NHS Nottinghamshire County initiated the re-procurement of the contract, although in practice this was undertaken by the CCGs as it was during the time of their establishment and authorisation. The new contract was to be let by July 2013.

The 2013 specification included services that were defined as core – in that they had been in the treatment centre for the previous five years. On this basis the majority of adult dermatology day case and outpatient and 2 week wait cancer was defined as core.

Reprocurement

The tender for, and the selection of the preferred bidder for the Nottingham Treatment Centre, was managed by an open procurement that allowed bids from both NHS and independent sector organisations, as is allowed by current national and EU procurement policy. Bids were received from organisations in both sectors. Criteria were developed for a range of factors: workforce, training and clinical criteria having high weighting in the bid assessment process. All the criteria were published to all bidders.

Guidance was sought during the procurement process regarding the continuation of the staff supply agreement. It was confirmed to the commissioners both by legal advisors and by the Department of Health that the staff supply agreement applied only to the national ISTC programme (here the 2007 procurement) and that TUPE applied to all subsequent procurements (here the 2013 procurement).

Circle was successful in the 2013 procurement. As part of the tender, and in the contract mobilisation phase, those staff to whom TUPE would apply were identified.

Following contract award to Circle and during the mobilisation phase the consultant dermatologists wrote to the commissioners to highlight their concerns about TUPE.

What any procurement process does is specify the services needed for a population. What the process does not do is evaluate the preferences of any individual employee about their employment. Although the dermatologists had worked in the treatment centre for the previous 5 years, their concerns highlighted that they did not wish to TUPE to the employment of Circle, and thus may

choose to seek posts elsewhere, and hence create a service risk. This was an unintended consequence of the procurement

2. The NUH consultant dermatologist workforce 2007 – 2015

All NUH consultants described below are UK CCT-accredited dermatologists.

At the time of the original contract award in 2007 there were 10 NUH consultant dermatologists.

Several provided sessions to Circle under a staff secondment agreement. Two consultants retired and three were appointed to NUH in the interval to the 2013 contract. At the time of the second contract award in 2013, therefore, there were 11 NUH consultant dermatologists:

Of these eleven:

One TUPEd to Circle and remains in post

Two TUPEd to Circle, and have subsequently left to work elsewhere in the NHS

Six refused to TUPE. NUH job plans were revised to legitimately maintain NUH employee status while providing sessions for Circle. Of these 6; three left to work elsewhere in the NHS, one to work abroad, one retired (now 'direct hire' at Circle), & one remains NUH employee

Two (predominantly paediatric dermatologists) did not meet criteria for TUPE. Both remain at NUH. One of these consultants has substantial academic commitments and p/t clinical commitments

In spring 2015 there will therefore be three remaining NUH consultant dermatologists, providing no more than 2.5 WTE clinical sessions.

3. The Circle consultant dermatologist workforce 2007 – 2015

There are 5 substantive consultants – 3 full time and two part time. One has recently resigned to relocate but will continue to provide teledermatology services to Circle.

There are 6 locum consultants – all with contracts of approximately a year. Some also work in other hospitals in the UK.

4. The National Consultant dermatologist workforce 2015

In the UK there are circa 1000 consultant dermatology posts. We understand circa 200 are currently vacant.

5. Current local dermatology services

NUH served notice to commissioners that with the most recent resignation from NUH they would no longer be able to offer a service to adult patients with an acute dermatological condition from 1 February 2015. An interim solution has been put in place: Circle is providing a same or next day advice/appointment service to GPs, within working hours which covers the majority of the patients

affected (estimate 7 per day). It is estimated that one patient per month may need intensive in patient dermatological care and those patients will be transferred to Leicester. These changes are being monitored

In Spring 2015, when the resignation of a further consultant becomes effective, the remaining 2.5 WTE NUH consultants will be unable to sustain a comprehensive paediatric dermatology service. NUH is exploring a scaled-back service for inpatient children, and working with partner organisations to identify options to provide the fullest practicable range of paediatric dermatology with the available specialist workforce. NHS England is the commissioner for paediatric dermatology services.

There have been two freedom of information requests to commissioners. We are not aware of any patient complaints. CQC has recently inspected (routinely) the Nottingham Treatment Centre. CQC did not inform Circle or CCG of serious concerns at the time of the visit. We anticipate publication of the report in March 2015

6. Future local dermatology services

The CCGs and NHS England are working with the East Midlands Senate to commission an independent review of the adult and children's service to recommend sustainable service and employment models for the future provision of specialist dermatology for the population on Nottingham (children and adult). The review will also include a review of training, the wider workforce, and where possible the position elsewhere in England. The review will take place in April 2015 due to the availability of the senior reviewer.

Appendix 3a

Review of Dermatology Services in Nottinghamshire

The purpose of this paper is to outline the scope of the review that has been commissioned by Nottinghamshire CCGs and NHS England to ensure a sustainable, efficient and effective adult and children's dermatology service is commissioned to serve their populations.

This review will seek a medium to long term view based on the needs of the population and the availability of the appropriate workforce, including training.

The review will be forward looking. It will not seek to undo the previous procurements or decisions regarding placements of staff or services.

The review will cover:

- Staffing
    - Workforce planning
    - Access to education and training needs for all clinical staff (medical, nursing and AHPs)
    - Recruitment and retention of clinical staff
- Benchmarking of services with other providers/CCGs
    - Clincal outcomes
    - Patients experience
    - GP referral rates, BADs, DC - OPPROC, New: FU ratio, Standardised Admissions Rates (SARs), Drugs
- Pathways
    - Identify the current treatments delivered within the service and their outcomes
    - Ensure appropriate reimbursement for treatments
    - Identify specialised and non-specialised commissioning responsibilities
    - Review current services in line with national guidance
    - Review how the services are delivered in other health communities similar to Nottingham ie links to plastics, cancer services
- Models of delivery
    - Use of technology
    - Different contracting models

Outputs of the review:

Recommendations regarding the future service model ensuring outcomes based, good patient experience and value for money, ability to recruit and retain workforce and trainees. An agreed position across providers for future collaboration.

January 2015

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

10 March 2015

Agenda Item: 5

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

HEALTHWATCH – RENAL PATIENT TRANSPORT REVIEW

Purpose of the Report

1. To introduce the presentation of information from Healthwatch's Renal Patient Transport Review.

Information and Advice

2. Healthwatch Nottinghamshire has undertaken an Insight Project into renal patients' experience of the patient transport service transporting people to and from the Nottingham City Hospital renal dialysis units

3. Healthwatch Nottinghamshire had received a number of negative comments about patients' experience of the Arriva Renal Transport Service. Issues that are reported to Healthwatch Nottinghamshire are discussed by the Prioritisation Panel, a group of volunteers who help the Healthwatch Nottinghamshire Board make decisions about where to focus their work. The Prioritisation Panel scored these comments as a high priority and asked the staff to undertake an Insight Project so that that Healthwatch could understand more about patients' experiences of this service and to identify if and how the service could be improved over the remaining term of the contract.

4. Healthwatch wanted to gain a deep understanding of patient's experiences and perceptions of how this experience impacts on their wider life, so the main focus of the project was on talking to patients face to face. Working with the renal dialysis unit staff, a week in November 2014 was identified when Healthwatch Nottinghamshire staff and volunteers could go into the units and talk to the patients whilst they were receiving their dialysis treatment.

5. During the week Healthwatch Nottinghamshire staff and volunteers spoke to 45 people who use the transport service, collecting over 12 hours of feedback.

6. In addition they:

   - Gathered diaries of journeys from 7 patients covering 50 journeys;
   - Collected 50 completed surveys from renal dialysis patients;
   - Collected surveys from 17 members of the renal unit staff for their experiences of the service.

7. Every effort was made to encourage all patients to participate, but as this was voluntary it is possible that some patients not engaged in the project had different opinions of the patient transport service.

8. The provider of the renal patient transport service, Arriva, and the commissioners will be invited to comment on the report before it is presented to the Joint Health Committee in March. The findings and recommendations of the report will be made public for the first time at this meeting of the Joint Health Committee.

9. Claire Grainger, Chief Executive of Healthwatch Nottinghamshire will attend the committee to present the information and ask questions as necessary.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee receive the briefing and ask questions 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

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

10 March 2015

Agenda Item: 6

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

PATIENT TRANSPORT SERVICE PERFORMANCE UPDATE

Purpose of the Report

1. To provide the latest information on Patient Transport Service performance.

Information and Advice

2. Members will recall that information on Patient Transport Service performance was last presented to the Joint Health Committee on 9 September 2014 when Mr Derek Laird, Arriva's Director of Operations (UK) gave a presentation to the committee detailing the Contract Performance Review Report. At that time, the contract was two years into a five year term and performance was at a level short of expectations. Mr Laird had only been in post for four months when he attended the committee.

3. The committee heard that a wide range of external factors impacted performance. These included: an increase in the average age of patients, patients not being ready at pick-up time having a knock on effect on other patients.

4. 'On time' arrival at hospital had been improved and had increased by 19%. In addition, wards were informed if a patient was going to be late.

5. The committee also heard that two new posts had been introduced in order to improve the service: dedicated discharge co-ordinator and renal co-ordinator.

6. The use of private hire taxis is not specific to Nottinghamshire. Arriva had a clear Service Level Agreement with the taxi companies used. The drivers were approved subject the required checks and receiving training. The patients required to use taxis were the most mobile. A Voluntary Car Service had been introduced to reduce the use of taxis and third party providers.

7. The most recent performance information for Patient Transport Services is attached as an appendix to this report.

8. Senior representatives from Arriva and the commissioners will again 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 and ask questions as necessary

2) Schedule further consideration.

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

December 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 three 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:-

- 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.

- A discharge co-ordinator has been 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, i.e. a stretcher, that the patient will be given a higher priority for transportation.

- 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.

- It is clear that the ongoing road and tram works around Queens Medical Centre present a significant challenge to Arriva and other ambulance services. Congestion on the inner hospital ring road and queueing traffic entering the car parks are causing delays to patient drop off and collection. QMC staff are trying to keep traffic flowing around the site but have found the car drivers are reluctant to move on.

- Some minor changes have been agreed to the reporting of one of the renal KPI's but contractual performance will still be measured on the old method. 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 is shown below 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.

Commissioners were keen to learn the outcome of a Care Quality Commission (CQC) visit to Arriva's PTS service in Leicestershire in November 2014 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.

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.	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
KPI 1	Time on Vehi	Patients within a 10 mile radius of the point of care will spend no longer than 60 minutes on the vehicle.	90%	96%	96%	96%	96%	96%	95%	96%	96%	95%	95%	94%	95%
		Patients within a 10 – 35 mile radius of the point of care will spend no longer than 90 minutes on the vehicle.	90%	94%	95%	94%	94%	94%	94%	94%	95%	95%	94%	93%	93%
		Patients within a 35 – 80 mile radius of the point of care will spend no longer than 120 minutes on the vehicle.	90%	85%	96%	85%	97%	94%	93%	94%	98%	98%	96%	90%	92%

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.	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
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%	63%	67%	63%	75%	73%	76%	77%	82%	82%	79%	79%	78%

There has been no improvement to this KPI since September. The widely publicised pressures on NHS services which began in November have continued through December and into the New Year. Arriva have experienced unprecedented volumes during this period and this has put severe strain on the service. Arriva have been working with QMC and other hospitals to try and balance patient flows in and out of the hospitals.

3. KPI3 – Departure Times

KPI Target: 90%

KPI Summary - GEM, exc Renal			Std.	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
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%	66%	68%	69%	73%	75%	74%	77%	80%	76%	78%	74%	74%
		Discharge patients shall be collected within 120 minutes of request or agreed transport/or zone time.	90%	67%	64%	67%	66%	69%	71%	78%	78%	88%	85%	85%	76%

Again, improvement against KPI3 has been marginal at most. As noted above the pressures on A&E departments in Nottinghamshire has had a major impact on performance. Arriva constantly work with the hospitals to coordinate patient discharges and release beds for the incoming patients. Arriva have worked hard to try and minimise the longest delays for patients. They improved their collection of patients within 120 minutes from September to November but this fell back in December. As the same vehicles are used for inward and outward journeys, high demand on discharges can delay the next group of inward journeys with a consequent impact on the KPI.

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.	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
KPI 1	Time on Vehicle	The patient's journey both inwards and outwards should take no longer than 30 minutes.	90%	59%	59%	59%	62%	60%	61%	58%	61%	58%	65%	61%	60%
		The patient's journey both inwards and outwards should take no longer than 30 minutes. (Excluding Patient over 21 miles away)	90%					64%	64%	62%	65%	61%	65%	64%	63%

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 from May to December 2014 the impact upon KPI performance of excluding the journeys of over 21 miles. The differences between 58 to 65% achievement and the restated KPI excluding journeys over 21 miles of 61 to 65% are 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.	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
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%	70%	71%	70%	74%	74%	77%	70%	81%	81%	76%	72%	70%
		Patients will arrive at the unit before their appointment time	100%	83%	87%	83%	90%	87%	89%	85%	92%	92%	91%	90%	86%

Performance against KPI2 – arrival no more than 30 minutes before appointment time - had seen some improvement in August and September but fell away as the winter pressures increased. 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 over 90% of patients from August to November were not late for their appointment.

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.	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
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%	63%	65%	63%	71%	71%	75%	65%	88%	86%	86%	82%	73%

Performance against this KPI showed improvement in August, September and October but has declined with the increase in winter pressures (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, i.e. 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.

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 commenced in July 2014.

SD/NM/SLC13.02.15

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

10 March 2015

Agenda Item: 7

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

NHS 111 PERFORMANCE UPDATE

Purpose of the Report

1. To provide the latest information on NHS 111 performance.

Information and Advice

2. Members will recall that information on NHS 111 performance was last presented to the Joint Health Committee on 9 September 2014 when Mr Stewart Newman, Head of Performance at NHS Nottingham City and Ms Pauline Hand NHS 111 Programme and Operations Director, Derbyshire Health United.

3. The committee heard the delays in calls being answered within sixty seconds and speaking to a nurse within ten minutes required improvement. Although only a quarter of calls required nurse intervention and the call back time of ten minutes was not being met. However, the nurses do monitor the call list in order to prioritise call backs.

4. In relation to staff development, the committee heard that the call advisors received training on NHS Pathways, the software used by all NHS 111 providers. This was followed by 20 hours shadowing an experienced call advisor and the call advisor then shadowed them for 20 hours. Levels of competence were constantly being monitored.

5. Staff sickness absence levels were very high. A staff survey was undertaken in January 2014 and concluded that they had been through a very difficult six month period, but the improved training and early intervention was helping to reduce the absence rates.

6. A large number of calls were received regarding emergency dental care. A lack of emergency dental provision was impacting on the service. The public perception was that GPs were free but dentists incur a charge.

7. In addition, the level of resources that would be required to support the direct transfer of calls from mental health patients to a skilled mental healthcare practitioner were in the process of being agreed. It was expected that this service would be in place by the end of 2014.

8. The latest performance information and the service improvement plan are attached as appendices to this report.

9. Mr Newman, Ms Hand and other senior colleagues will attend the committee to brief Members and answer questions as necessary.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

1) Receive the briefing and ask questions as necessary

2) Schedule further consideration.

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 Overview and Scrutiny Committee

UPDATE ON NHS 111 SERVICE

1. Introduction

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.

The provider of the NHS 111 service for the whole of Nottinghamshire (excluding Bassetlaw) is Derbyshire Health United (DHU). The service went live in March 2013 and 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 in June 2014 and a further iteration is expected after the General Election.

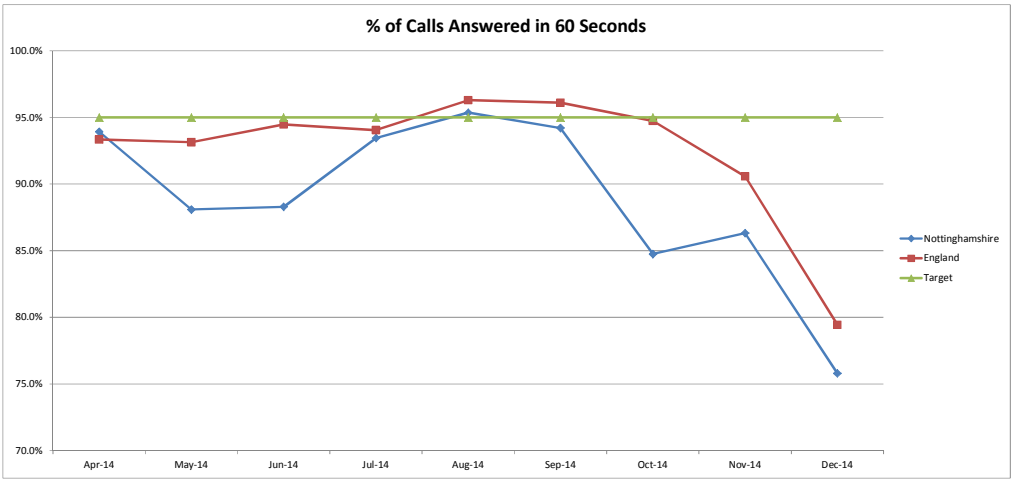
The current contract with DHU runs until March 2016 and therefore, a competitive procurement process is likely to be initiated in the near future.

2. Performance

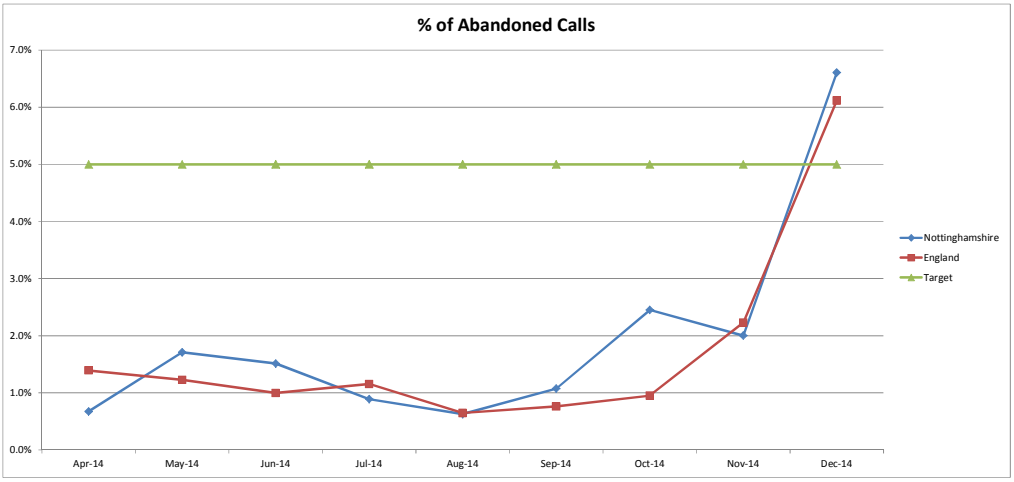
2.1 CALLS ANSWERED IN 60 SECONDS AND CALL BACKS

The update to the Overview and Scrutiny Committee in September identified that the performance of the NHS 111 Service for Nottinghamshire on the proportion of calls answered in 60 seconds, the number of patients who require a call back and the time they wait for that call back were of particular concern.

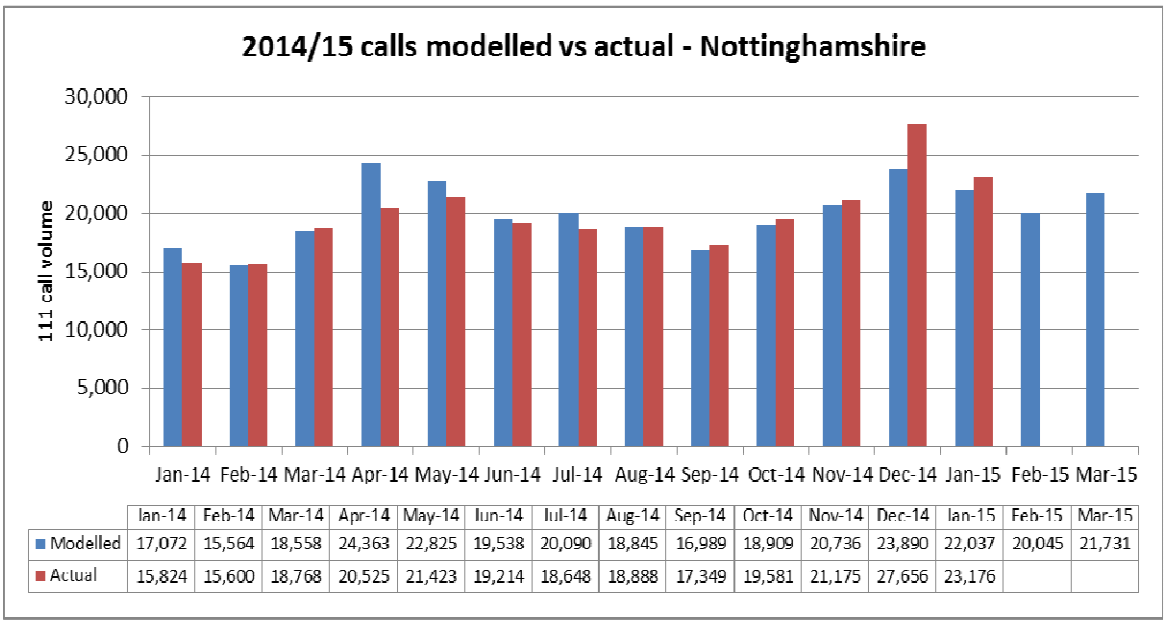
As can be seen, the target for 95% of patients to have their calls answered in 60 seconds has only been achieved in one month in 2014-15 to date. Performance has deteriorated over the winter months as activity levels have increased.



In spite of this, the target that no more that 5% of calls should be abandoned has largely been met:



The exception to this was December 2014 when performance was affected by unprecedented demand every weekend from the start of the month and then over the Christmas period. The activity levels at these times were between 25% and 40% higher than had been predicted based on the experience of December 2013 and the 8 weeks leading up to the beginning of December 2014. Excluding the impact of NHS 111 having taken over responsibility for answering calls to the GP out of hours service in the north of the county, overall, activity in December was around 35% higher than in the same month in 2013.

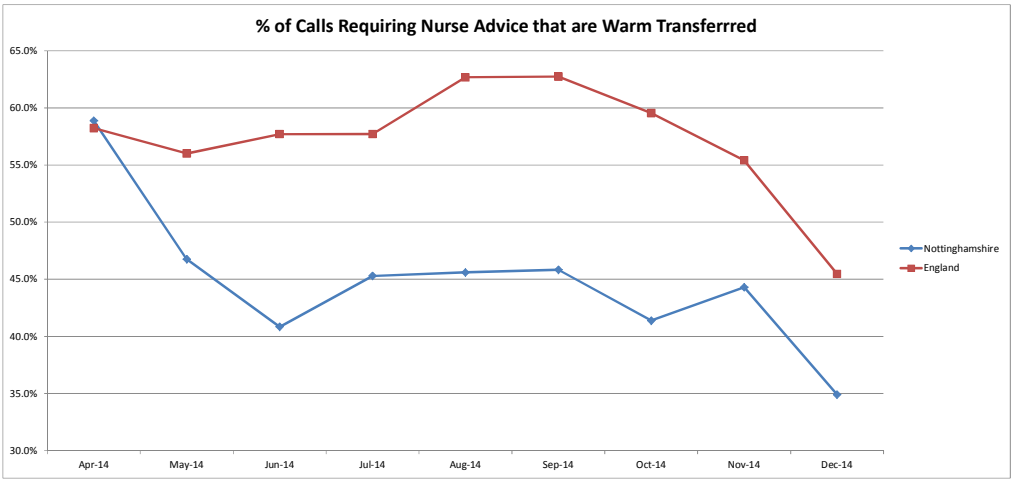


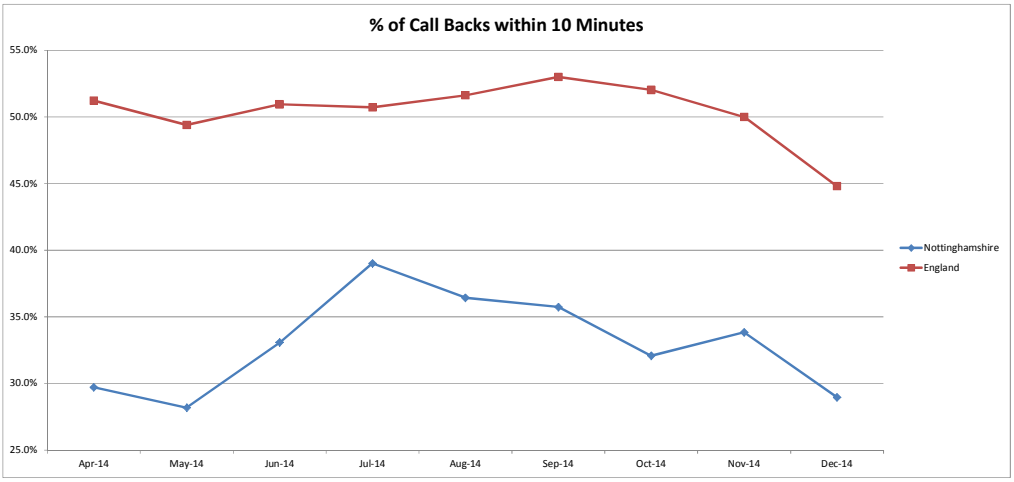
	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Modelled	17,072	15,564	18,558	24,363	22,825	19,538	20,090	18,845	16,989	18,909	20,736	23,890	22,037	20,045	21,731
Actual	15,824	15,600	18,768	20,525	21,423	19,214	18,648	18,888	17,349	19,581	21,175	27,656	23,176		

Whilst there are no specific national targets relating to call backs, locally we have agreed targets that:

- at least half of patients who need to speak to a nurse should have their call warm transferred (i.e. they are passed straight to the nurse as part of the same initial call)
- the majority of patients who require a call back should receive the call back within 10 minutes

Performance in these two areas in Nottinghamshire and England as a whole is contained in the graphs below:

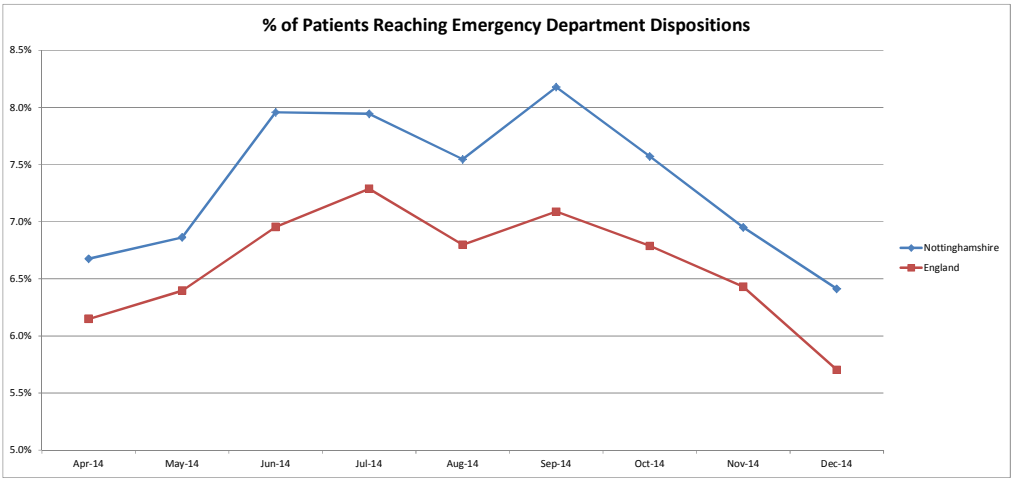


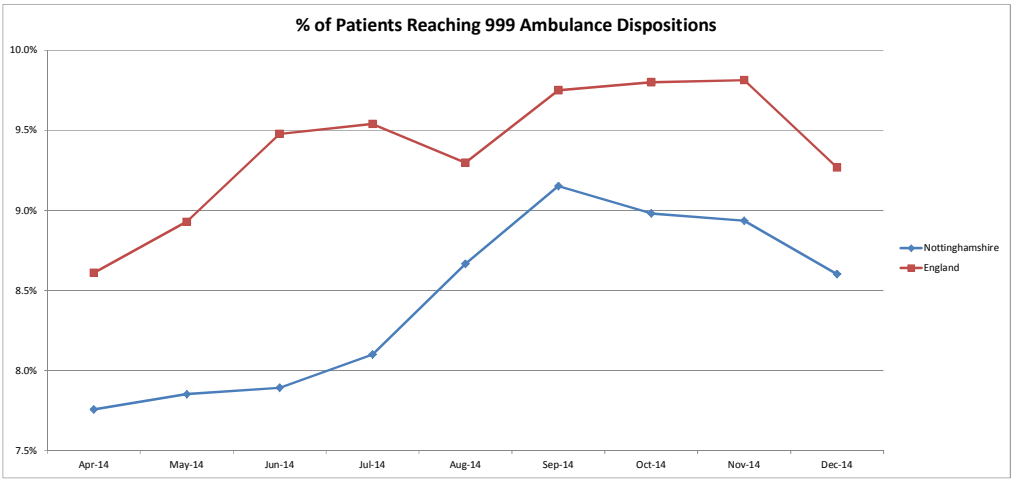


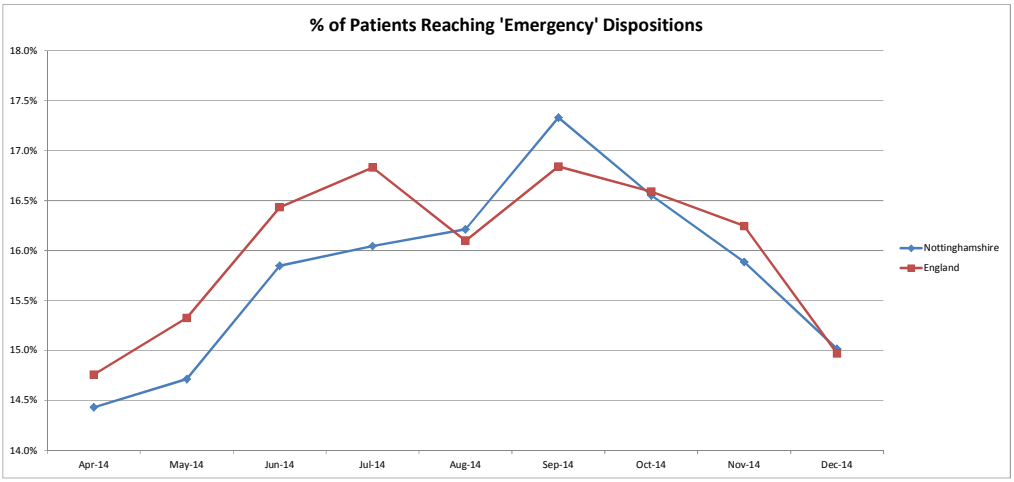
2.2. Patients Advised to Attend Emergency Departments or Sent an Ambulance

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.

The graphs below show the % of patients referred to the Emergency Department or a 999 ambulance response in Nottinghamshire compared to the national average; plus a chart showing the combined number of referrals to these emergency services.







Between April 2014 and December 2014, the average national rate of referral to emergency services was 15.9%, within Nottinghamshire it was 15.7%; this equates to around 250 fewer referrals to emergency services than would have been the case at the national average.

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 have an alternative service from Nottinghamshire Healthcare Trust for people in crisis who were historically directed to the Emergency Department; the Area Team have commissioned additional capacity in emergency dental services and the CCG is in the process of commissioning an urgent care centre that will provide an alternative to the Emergency Department in a number of areas.

3. Performance Improvement Plan

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

- recruitment of additional call advisors and nurse advisors
- recruitment of dental nurse advisors to better support patients with dental issues
- source additional nurse advisor capacity via agency and / or other NHS 111 providers
- source contingency capacity from another NHS 111 provider
- improving the efficiency and effectiveness of workforce management systems and processes (including the management of absence)
- provide additional training to help staff reduce both call length and emergency dispositions

Implementation of the Performance Improvement Plan should ensure that targets are achieved from week commencing 2nd March. The difficulty in recruiting and retaining nurse advisors means that this is the area where there is most risk that the plan can not be implemented; this would impact on the warm transfer rates and percentage of call backs taking place within 10 minutes.

4. Quality and Patient Experience

A copy of the most results of the most recent patient experience survey is attached at Appendix 2, as can be seen:

- 97% of callers reported that they followed some (10%) or all (87%) of the advice from NHS 111
- 87% of callers were fairly (14%) or very (73%) satisfied with the service
- 34% of callers said they would have gone to A&E or called 999 if they hadn't contacted NHS 111

In 2014 there were 0 serious incidents relating to the NHS 111 service in Nottinghamshire.

On average, the service receives around 4 complaints and 4 compliments each month and handles around 9,000 calls each month. NHS 111 also gathers feedback from healthcare professionals working in other services (e.g. ambulance crews, GPs and GP out of hours service providers). All the calls that generate a complaints or healthcare professional feedback are reviewed by DHU and the NHS 111 Clinical Lead, Dr Christine Johnson.

Every call advisor and nurse advisor has a number of their calls audited against the criteria in the table below, the average scores achieved by staff employed by DHU are generally significantly higher than the pass mark of 86%:

Criteria	Ave. Score Oct. 14	Ave. Score Nov. 14	Ave. Score Dec. 14
1. Effective Call Control	96.5	97.1	97.5
2. Skilled Questioning	97.3	96.8	97.1
3. Active Listening	98	98.2	99.4
4. Skilled Provision of Information & Advice	98.6	97.7	98.9
5. Effective Communication	98.7	99	99.5
6. Practices According to Designated Role Requirements	94.1	94.5	93.7
7. Skilled use of Pathways Functionality	97.9	97.9	98.3
8. Delivers a Safe and effective outcome for the patient	94.7	93.8	95.6
Overall Average	**96.9**	**96.9**	**97.4**

5. Engagement in the Re-Procurement of the NHS 111 Service

As mentioned in the introduction, a competitive procurement process to provide the NHS 111 Service from April 2016 onwards is likely to be initiated in the near future. The re-procurement will be informed by the experience that has been gained over the past few years and the national pilots that are gathering evidence on how the NHS 111 Service can be improved. A programme of engagement with the local population and health community is also being planned to help inform the re-procurement exercise.

The Committee is asked to consider any issues that it would wish to see addressed via the re-procurement exercise and any recommendations it may wish to make about how the engagement with the local community around the re-procurement should take place.

Stewart Newman
Head of Urgent Care
NHS Nottingham City

Stephen Bateman
Chief Executive
Derbyshire Health United

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

DHU NHS111 Service Improvement Action Plan

As @ : 5.2.15

Category	Lead	Issue	Factors Accounted	KPI	Actions	Owner	RAG Rating	Target Date
1. Staffing	Pauline Hand (DOO)	1.1 Recruitment of additional staffing to support service delivery	Source additional call advisors	KPI 1 & 4	1.1.1 Rolling Call Advisor recruitment programme to be undertaken for NHS111 staffing in terms of preparation for Easter 2015. (See workforce plan Easter 2015)	PH/DW		Ongoing through to 31.3.15
			Source additional permanent nurse advisors	KPI 1 & 4	1.1.2 Rolling Nurse Advisor recruitment programme to be undertaken for NHS111 staffing in terms of preparation for Easter 2015. (See workforce plan Easter 2015)	PT/JDix		Ongoing through to 31.3.15
			Source Dental Nurses	KPI 1 & 5	1.1.3 Recruitment and training of 5 WTE Dental Nurses. All appointed - 3 currently in training, 1 cleared to start awaiting training date, 4 awaiting HR checks. To be trained as Call Advisors on commencement and when proficient on the system will be trained as Dental Nurses to use the clinical part of the NHS Pathways system.	PH/DW		Ongoing through to 31.3.15
			NA Agency staff to be sourced	KPI 4 & 5	1.1.4 Agreement with Hallam agency to provide 400 hours per week of Nurse Advisor staffing. Hallam not fulfilling requirement – therefore contract as preferred provider not signed 4.2.15. Re-contact alternative agencies.	JDix/PT		20.2.15
			Call forecasting to be agreed by Commissioners	KPI 1, 2, 4 & 5	1.1.6 Call forecasting for Easter to be agreed with Commissioners at Collaborative meeting on 13.2.2015	PH/SB		13.2.15
			Manpower planning review after Commissioner forecasting decision/approval	KPI 1, 2, 4, 5	1.1.7 Manpower planning to be reviewed after agreement by Commissioners about contract volumes through to Easter 2015	PH		17.2.15
			Source additional NA from alternative provider	KPI 4 & 5	1.1.8 PH/SB met with SDUC and explore option of sourcing NA/Clinician Advice as contingency/resilience support or formal sub-contract arrangement from Easter to 30.9.2015	PH		22.2.15
			Review recruitment of Paramedics into the NHS 111 Service	KPI 4 & 5	1.1.9 JD to review professional qualification requirement for NHS 111 and make recommendation for recruitment. 1.1.10 Discussions also to take place with EMAS regarding potential secondment opportunities	JD/DW PH		13.2.15 13.2.15

Category	Lead	Issue	Factors Accounted	KPI	Actions	Owner	RAG Rating	Target Date
2. **Capital Investment IT Systems**	Peter Quinn (DOF)	2.1 Red Box Integration Finding calls on the voice recorder and then matching to Adastra is a lengthy manual process adding approximately 10 minutes to each call audit	Red Box Voice recorder integrated into Adastra to enable timely location of calls	KPI 1 & 4	2.1.1 Integration of systems and testing. DHU to fund next financial year 2015/2016	PQ		31.3.15
				KPI 1 & 4	2.1.2 Communication and training with CQI auditors to deliver operational, service delivery and contractual benefits. Unable to commence until 2.1.1 commenced	PH		Q1 2015/16
3. Workforce Management system - Injixo	Pauline Hand (DOO)	3.1 NHS111 roster management is currently manually intensive	Implementation of new Workforce Management System – Injixo	KPI 1 & 4	3.1.1 Purchase undertaken. Project management of implementation underway. Duel running of systems taking place. Project risk/issues log reviewed weekly with SB/PH.	PH		31.3.15
			WFM system to integrate with HR/Payroll systems	KPI 1& 4	3.1.2 To enhance organisation efficiencies Injixo to integrate with HR and Payroll systems.	RB/PH/ DW		Commence work 1.4.15
			WFM operational processes to be defined in order to integrate with HR and Payroll systems	KPI 1 & 4	3.1.3 Processes for annual leave, starters, leavers, changes, etc… to be defined. Awaiting creation and approval from Project Sponsor and management team.	JDix/SE		18.2.15
4. UXL Programme	Pauline Hand (DOO)	4.1 Service delivery KPIs of the financial envelope to meet UXL – call lengths, productivity and transfer to NA	Ops Management Performance Team Training Team	KPI 1,3 4 & 6	4.1.1 UXL training to Nurse Advisors to use clinical validation against dispositions. Remains ongoing around current recruitment	LW		Ongoing through to 31.3.15
					4.1.2 Complete 121 reviews with all CA/NAs to recognise positive progress & role within the NHS111 service model, incorporating validation	JD/LW		Ongoing through to 31.3.15
5. Staffing Contingency	Pauline Hand (DOO)	5.1. Ensure robust contingency for staffing provision to meet service standards	Finance Ops Rota	KPI 1,2, 4 & 5	5.1.1 PH/SB met with SDUC and explore option of sourcing NA/Clinician Advice as contingency/resilience support or formal sub-contract arrangement from Easter to 30.9.2015 5.1.2 Incentives to be extended for all CA/NA staff that work over and above contracted hours to meet peak demand 5.1.3 All qualified NHS Pathways back-office staff to be mobilised to support NHS111 front line services to meet peak demand	PH PH PH		22.2.15 6.2.15 – Post Easter 6.2.15 – Post Easter

Category	Lead	Issue	Factors Accounted	KPI	Actions	Owner	RAG Rating	Target Date
6. Sickness & Absence Management	Stephen Bateman (COO)	6.1 Short term sickness is severely impacting upon service performance	HR Operations Managers Shift Managers Absence Manager	KPI 1,2, 4 & 5	6.1.1 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.	PH/DW		Completed & Ongoing
					6.1.2 Undertake staff meetings to initiate performance management / disciplinary process.	JDix		Competed & Ongoing
					6.1.3 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. update. Weekly meeting arranged with KC and HR BP to discuss actions to be undertaken with individuals.	PH/DW		Ongoing

KPI 1 – 95% calls answered in 60 seconds

KPI 2 – less than 5% abandoned calls

KP1 3 - % transfer to ED

KPI 4 - % warm transfers (26%)

KPI 5 - % call backs within 10mins

KPI 6 - % Ambulance despatches

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

10 March 2015

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.

4. Recent additions to the work programme include discussion of the dermatology contract with attendance from representatives of Rushcliffe CCG, Circle and Nottingham University Hospitals (NUH) at the 10 March meeting. In addition, service changes at Rampton Hospital will be on the agenda of the 21 April meeting.

5. The consideration of provider Trust draft priorities for Quality Accounts has been taking place during the course of late February and early March. The Chairs of the various study groups considering Quality Accounts may wish to provide a verbal update to the committee on progress.

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
7 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) • **Response to Pressures in the Urgent Care System** To consider immediate and medium-longer term planning to address pressures and demands in the urgent care system (TBC)
11 November 2014 CANCELLED	• **Out of Hours Dental Services** An initial briefing following concerns raised at the 9 September committee (Nottingham City CCG, others TBC) • **Royal College of Nursing** Further briefing on the issues faced by nurses (RCN)
9 December 2014	• **Out of Hours Dental Services** An Initial briefing following the concerns raised at the 9 September committee (NHS England) • **Daybrook Dental Practice – Apparent Breach of Infection Control Procedures** (NHS England) • **Royal College of Nursing** Further briefing on the issues faced by nurses (RCN)

13 January 2015	• **NUH Environment & Waste** Initial Briefing (Nottingham University Hospitals) • **Primary Care Access Challenge Fund Pilots** Pilot outcomes and next steps (South Nottinghamshire CCGs and Area Team) • **East Midlands Ambulance Service - New Strategies** Initial briefing (EMAS)
10 February 2015	• **Eye Casualty** (NUH) • **Third Sector Organisations briefing** (HWB3) • **Transformation Plans: Children, Young People and Families** (Notts Healthcare Trust)
10 March 2015	• **Patient Transport Service** To consider performance in delivery of Patient Transport Services (Arriva/ CCG lead) • **Healthwatch – Renal Patient Transport Review** (Healthwatch Nottingham and Nottinghamshire) • **NHS 111 Performance** To receive the latest update on workforce change implementation (Nottingham City/Nottinghamshire County CCG) • **Dermatology Contract** To receive information on issues relating to the operation of the dermatology contract (Rushcliffe CCG, Circle and NUH)

21 April 2015	• **Urgent Care Winter Pressures – Future Planning** To receive the latest update on lessons learned from winter 2014/15 (Nottingham University Hospitals) • **Rampton Hospital – Variations of Service** (NHS England) • **NUH Pharmacy Information [TBC or March]** Information received as part of ongoing review (Nottingham University Hospitals/CCG)

To schedule:

Transformation Plans for Children, Young People and Families (Nottinghamshire Healthcare Trust – Sharon Creber, Dr Lucy Allsop)
NHS 111 – to consider outcomes of GP pilot and performance following workforce changes
Nottingham University Hospital Maternity and Bereavement Unit
24 Hour Services
Outcomes of primary care access challenge fund pilots
Impact of changes to adult mental health services and mental health services for older people (early summer 2015)
Responses to Pressures in the Urgent Care System (Teresa Cope and Nikki Pownall) - April

Autumn 2015 -
East Midlands Ambulance Service – Update on New Strategies
Nottingham University Hospitals – Environment and Waste

Visits:

EMAS
Urgent and Emergency Care Services (various dates)

Study groups:

Quality Accounts
Waiting times for pharmacy at Nottingham University Hospitals NHS Trust (review now taking place as part of the committee meeting rather than via study group sessions)