Public Document Pack

NOTTINGHAM CITY COUNCIL
JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

Date: Tuesday, 15 September 2015

Time: 10.15 am

Place: LB 31-32 - Loxley House, Station Street, Nottingham, NG2 3NG

Councillors are requested to attend the above meeting to transact the following business

Acting Corporate Director for Resources

Governance Officer: Clare Routledge **Direct Dial:** 0115 8763514

AGENDA **Pages**

1	**APOLOGIES FOR ABSENCE**	
2	**DECLARATIONS OF INTEREST**	
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PLEASE NOTE THAT THERE WILL BE A PRE-MEETING FOR COUNCILLORS AT 10AM IN LB31/32 AT LOXLEY HOUSE

IF YOU NEED ANY ADVICE ON DECLARING AN INTEREST IN ANY ITEM ON THE AGENDA, PLEASE CONTACT THE GOVERNANCE OFFICER SHOWN ABOVE, IF POSSIBLE BEFORE THE DAY OF THE MEETING

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CITIZENS ARE ADVISED THAT THIS MEETING MAY BE RECORDED BY MEMBERS OF THE PUBLIC. ANY RECORDING OR REPORTING ON THIS MEETING SHOULD TAKE PLACE IN ACCORDANCE WITH THE COUNCIL'S POLICY ON RECORDING AND REPORTING ON PUBLIC MEETINGS, WHICH IS AVAILABLE AT WWW.NOTTINGHAMCITY.GOV.UK. INDIVIDUALS INTENDING TO RECORD THE MEETING ARE ASKED TO NOTIFY THE GOVERNANCE OFFICER SHOWN ABOVE IN ADVANCE.

NOTTINGHAM CITY COUNCIL

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

MINUTES of the meeting held at Ground Floor Committee Room - Loxley House, Station Street, Nottingham, NG2 3NG on 14 July 2015 from 10.16 - 12.30

Membership

Present	Absent
Councillor Pauline Allan	Councillor Eunice Campbell
Councillor John Allin	Councillor John Clarke
Councillor Ilyas Aziz	Councillor Corall Jenkins
Councillor Merlita Bryan	
Councillor Richard Butler	
Councillor Mrs Kay Cutts MBE	
Councillor John Handley	
Councillor Colleen Harwood	
Councillor Carole-Ann Jones	
Councillor Ginny Klein (Chair)	
Councillor Anne Peach	
Councillor Chris Tansley	
Councillor Parry Tsimbiridis (Vice Chair)	
Councillor Jacky Williams	

Colleagues, partners and others in attendance:

Elizabeth Allcock	-	Nottinghamshire Healthcare Trust
Dr Lucy Allsop	-	Nottinghamshire Healthcare Trust
Jonathan Bemrose	-	Nottingham East Clinical Commissioning Group
Louise Bettany	-	Arriva
Richard Brown	-	Nottinghamshire Healthcare Trust
Hazel Buchanan	-	Nottingham East Clinical Commissioning Group
Sharon Crebor	-	Nottinghamshire Healthcare Trust
Martin Gately	-	Nottinghamshire County Council
Martin Gawith	-	Healthwatch Nottingham
Claire Grainger	-	Healthwatch Nottinghamshire
Asiya Jelani	-	Arriva
Amanda Kemp	-	Nottinghamshire Healthcare Trust
Dr Bert Park	-	Nottinghamshire Healthcare Trust
Clare Routledge	-	Senior Governance Officer
James Welbourn	-	Governance Officer

11 APOLOGIES FOR ABSENCE

Councillor Eunice Campbell	-	other Council business
Councillor John Clarke	-	other Council business
Councillor Corrall Jenkins	-	personal reasons

12 DECLARATIONS OF INTEREST

None

13 MINUTES

The minutes of the meeting held on 16 June 2015 were confirmed and signed by the chair.

14 REVIEW OF ADULT MENTAL HEALTH AND MENTAL HEALTH SERVICES FOR OLDER PEOPLE TRANSFORMATION 14/15

Amanda Kemp, Deputy Director of Nottinghamshire Healthcare NHS Trust, presented the report of the Head of Democratic Services on the review of Adult Mental Health and mental health services for older people during 2014/15. The following points were highlighted:

(a) monthly meetings are held with commissioners as well as regular meetings with service users and carers regarding service delivery;

(b) feedback on the Haven House crisis house located at Mapperley has been good. Services are now running 24/7, with consultant psychiatrists working over the weekend;

(c) reinvested money has meant an increased number people being able to live independently within the community;

(d) work with the Police and other agencies to better manage crises in the community are formalised within the Crisis Care Concordat;

(e) mental health professionals working within the 111 service are helping to minimise patients with mental health issues presenting at A&E;

(f) delayed discharge and housing related issues of mental health patients are challenging, however Nottinghamshire Healthcare Trust and Nottingham University Hospitals are working together to share good practice;

(g) all staff who formerly worked on the Daybrook and Bestwood Mental Health Services Older People (MHSOP) wards at the city campus have been redeployed;

(h) since the transformation of MHSOP there has not been an increase in untoward incidents or patients length of stay and there has been a decrease in complaints;

(i) recruiting physiotherapists and occupational therapists into MHSOP is proving challenging;

(j) on occasions there have been issues relating to patient discharge from health into social care services:

Following questions from Councillors, additional points were raised:

(k) currently there is not a 24/7 mental health service available in the county; discussions are ongoing with commissioners regarding this matter;

(l) all staff who previously worked at Enright Close have been redeployed to other areas. There were no redundancies;

(m) data relating to the engagement with hard to reach communities and ethnicity will be forwarded to Committee members following the meeting;

(n) Community Psychiatric Nurses (CPNs) can now travel in police cars when called to incidents involving citizens with mental health issues as the CPNs have access to patient history, leading to a reduction in admission to police cells. This service will continue to be monitored; currently there is only a further two years of funding available from commissioners;

(o) statistics relating to patients frequently at risk of mental health issues are shared with commissioners and police colleagues;

(p) if there is not sufficient mental health inpatient beds available locally beds are purchased outside of the county, to ensure patient safety. Where possible and safe, people will be treated at home, following consultation between patients, psychiatrists and carers;

(q) nationally 75% of suicides are of individuals not known to mental health services. Inpatient suicide rates are very low;

(r) all future presentations and reports to the Committee must not only focus on the positives of the service but also report back on areas of dissatisfaction;

RESOLVED to:

(1) note the report and presentation;

(2) recommend a 24/7 mental health service be commissioned in the County to ensure adequate mental health provision is available;

(3) request that Nottinghamshire Healthcare Trust provide Committee members with data relating to the engagement with hard to reach communities and ethnicity of patients accessing adult mental health and mental health services for older people;

(4) recommend the inclusion of relevant ethnicity data in all future consultation exercises;

(5) receive an update from Nottinghamshire Healthcare Trust on the Review of Adult Mental Health and Mental Health Services for Older People Transformation in six months.

15 NOTTINGHAMSHIRE HEALTHCARE TRUST 5 YEAR STRATEGY FOR CHILDREN, YOUNG PEOPLE AND FAMILIES

Sharon Crebor, Associate Director of Transformation at Nottinghamshire Healthcare Trust introduced the 5 Year Strategy for Children, Young People and Families, highlighting the following points:

(a) a twelve week consultation commenced on 15th June 2015 regarding the following proposals:

- Community Child and Adolescent Mental Health Services (CAMHS) – new outpatient facilities for the city and south of county;
- Inpatient CAMHS – a new unit with an increase in beds from 13 to 24;
- A purpose built Education Unit for CAMHS inpatients:
- Perinatal Services – a new Mother and Baby inpatient unit, with a small increase in beds from 7 to 8 and new outpatient facility for city and south of the county;

(b) the proposal would bring the four services together onto a single site at the previously known Cedars Rehabilitation unit on Mansfield Road, Nottingham, therefore relocating services from both Thorneywood and QMC site;

(c) the Cedars site would provide the ideal therapeutic setting and a major benefit would be that younger people accessing specialist services would have them provided closer to home as well as an overall improvement in quality of care;

(d) a business case is being developed for consideration by the Nottinghamshire Healthcare Trust Board on 24 September 2015, but this is very complex due to the financial and capital investment required as well as planning consent;

(e) service users including patients and carers will be involved in the detailed design of the proposed services if approved by the Nottinghamshire Healthcare Trust Board;

Councillors were introduced to Dr Lucy Allsopp (Consultant Child and Adolescent Psychiatry), Richard Brown (Associate Director Capital Planning), and Elizabeth Allcock (Service Improvement Facilitator). Following the introduction, members asked questions and the following points were discussed:

(f) the Cedars site is within city council boundaries, so talks have been ongoing with the Nottingham City Council colleagues regarding planning, property design and education requirements. Discussions have also taken place with the integrated commissioning hub at Nottinghamshire County Council

regarding funding for the project. Details of those organisations who have been involved in proposal discussions are to be included in the consultation pack;

(g) a small number of residents attended the public consultation on 1 July. In addition to this, people have responded to an online survey and via telephone. There is a further public consultation meeting scheduled to take place on 28 July 2015;

(h) the chair of Healthwatch Nottingham welcomed proposals as the current facilities are considered antiquated;

(i) there is ongoing liaison with NHS England area commissioners regarding the proposals particularly as the psychiatric intensive care service will be East Midlands wide or wider service and the specialist eating disorder beds will be an East Midlands wide facility;

(j) every patient who has accessed the CAMHS and perinatal services has been contacted regarding the proposals and Nottinghamshire Healthcare Trust is linking in with wider user group forums to engage with hard to reach groups and patients with disabilities. Alongside this work, there have been 60 hours of one to one sessions collating patient's stories and experiences of current services;

(k) Committee members supported the use of digital technology to gauge the views of children and young people accessing services and the current proposals;

(l) if the proposals are approved Thorneywood will continue to provide adult services within the site;

RESOLVED to:

(1) give full support to the four proposals currently out for consultation as listed in point (a);

(2) consider the proposals to be a development of services rather than a substantial variation;

(3) ask Nottinghamshire Healthcare Trust to advise on the business case outcome decision of the Nottinghamshire Healthcare Trust Board;

(4) thank Nottinghamshire Healthcare Trust for the report.

16 GLUTEN FREE PRESCRIBING

Hazel Buchanan, Director of Operations, Nottingham North and East Clinical Commissioning Group (CCG), and Jonathan Bemrose, Director of Finance, Nottingham North and East Clinical Commissioning Group (CCG), introduced the report on Maximising the Use of Our NHS Resources, highlighting the following points:

(a) patients generally prefer to access services in primary care settings;

(b) pathways of care are being redesigned to ensure there is better access to GP practices, care is provided closer to home, hospital admissions are avoided and there is better sharing of information across primary and secondary care;

(c) patient and public engagement in NHS services is key to build intelligence and plan for the future;

(d) medicine management must ensure evidence based choice and patient safety;

(e) the gap between funding and the care costs will be around £140 million by 2018/19 if current trends continue;

(f) coeliac disease is a common digestive condition and triggers by intolerance to protein gluten found in bread and many processed foods;

(g) the south CCGs (Rushcliffe, North and East and North and West) spend approximately £250,000.00 providing gluten free products on prescription;

(h) gluten free products are now widely available in supermarkets and restaurants and coeliac patients can eat a wide range of foods including rice, potatoes, fruit and vegetables;

(i) the south CCGs are planning a 90 day consultation between August and October 2015 with key stakeholders, patients and public. Nottingham City CCG colleagues have been involved in dialogue regarding the consultation proposal. The three options for consultation are:

- stop all prescribing;
- restrict prescribing to bread and flour (Rushcliffe and Nottingham West);
- restrict prescribing to flour only;

Following discussions with the committee the following additional points were noted:

(j) children under 5 with multi-intolerances are to excluded from the consultation regarding gluten-free prescribing;

(k) Healthwatch Nottingham voiced concern that the report was not more explicit regarding key local public health messages, but it was confirmed that public health colleagues were involved in discussions and consultation detail;

(l) additional dietetic support would be available to support coeliac patients;

(m) pharmacists are working with GP practices to improve medicines management in this area;

(n) in order for behaviour change to take affect there needs to be better relationships between GPs and patients and application of shared decision making;

(o) it was requested that the consultation should be available online in order that anyone could contribute to the consultation exercise not just those targeted groups;

(p) as yet, there hasn't been any feedback on NHS Nottingham North and East CCG restricted prescribing of gluten free products to bread and flour in December 2014 restrictions put in place. A clinical audit following the restrictions is taking place and Committee members felt this should be included in the consultation material.

RESOLVED to:

(1) note the report;

(2) agree to a 90 day consultation between August and October 2015 regarding gluten free prescribing with key stakeholders, patients and public. The three options for consultation are:

1. **stop all prescribing**
2. **restrict prescribing to bread and flour (Rushcliffe and Nottingham West)**
3. **restrict prescribing to flour only;**

(3) the consultation should be available online for any member of the public to contribute to;

(4) be advised of the outcome from the consultation exercise at a later date.

17 HEALTHWATCH NOTTINGHAMSHIRE RENAL PATIENT TRANSPORT REVIEW

Claire Grainger, Chief Executive of Healthwatch Nottinghamshire, Asiya Jelani, Head of Communications and Engagement at Arriva, and Louise Bettany, Service Delivery Manager at Arriva presented the Healthwatch Renal Patient Transport Review, and highlighted the following points:

(a) the renal patient transport review report was presented to the Committee in March 2015, prior to publication. 45 interviews had taken place with patients who used the transport service, surveys were completed by both patients and renal staff and patient diaries were collated to contribute to the findings;

(b) findings from the report demonstrated that Arriva was providing a poor experience patients requiring renal transport;

(c) eight recommendations were developed and a meeting took place with Arriva and commissioners in April 2015 to discuss the recommendations and actions that would be taken;

(d) findings were also presented to the NUH Quality Assurance Committee; patients were sent a copy of the report and copies were placed in the renal units. There was extensive media coverage and Derbyshire and Nottinghamshire Quality Surveillance Group also received the report;

(e) next steps include updating meetings with Arriva to hear about progress, revisiting renal units in the autumn to talk to patients about their experiences after changes have been made to the services and a follow up report will be produced;

(f) A dedicated renal co-ordinator commenced employment on 14 July 2015 and a transport working group was now in place involving NUH staff, community services, commissioners and patient transport staff;

(g) Arriva have increased their “carry by’ system, with 50% of groups of patients that want to/can travel together doing so;

(h) Arriva is not a clinical organisation and cannot put in place safeguards to ensure that patients that need special transport requirements are prioritised for journeys home;

(i) Arriva has reduced its reliance on subcontracted taxi companies. Arriva has undertaken a review of governance arrangements and the service level agreement will be revised. There has also been a re-alignment of patient transport staff rotas;

(j) The Arriva renal co-ordinator will be responsible for making real time decisions as this person will have a full overview of the renal units;

(k) Arriva's standard operating procedures will help to support staff and there will be further training provided for care assistants and planners;

(l) there is now immediate notification of reduced dialysis treatment and summaries of weekly activity is submitted (including nil returns) to ensure a much clearer oversight and Arriva have absolute confidence in the this new arrangement;

(m) dialysis patients are still under the care of the unit whilst awaiting their transport, but the renal co-ordinator will support this care;

Following questions from Councillors, additional information was provided:

(n) Arriva recognises the support of the Committee, and acknowledges it is on a journey, but Arriva is confident it will provide the correct services;

(o) Arriva have a specific list of taxi providers that they work with and taxi companies must work to a minimum standard of care and service level agreements are in place. Transport providers throughout the country rely on additional resources to compliment the service they provide. This flexibility in using other services is required due to peaks in demand for transport;

(p) the renal co-ordinator is on site between the hours of 11am-7pm to ensure a robust service is in place;

(q) Arriva have organised staff forums to inform staff of the necessary changes and work is ongoing to convey changes and improvements to patients, carers and NUH staff;

(r) all volunteers involved in the Healthwatch report were trained, attended orientation sessions and asked patients a list of scripted questions. All interviews were recorded and transcribed.

RESOLVED to:

(1) thank Healthwatch Nottingham for its excellent report;

(2) thank Healthwatch Nottingham and Arriva for their presentations;

(3) recommend Arriva continue to improve service delivery to renal transport patients in accordance with Healthwatch Nottinghamshire's recommendations;

(4) monitor results from the recommendations and receive a further update at a future Committee.

18 JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE 2015/16 WORK PROGRAMME

The Committee considered the report of the Head of Democratic Services about the Committee's work programme for 2015/16.

RESOLVED to note the work currently planned.

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
15 SEPTEMBER 2015
JOINT HEALTH SCRUTINY REFERRALS – DELEGATION CHANGE
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 The 2012 Heath and Social Care Act moved responsibility for health scrutiny referrals to the Secretary of State from health scrutiny committees to Councils. Such referrals are proposed when scrutiny councillors feel that, following the consideration of evidence, proposals for substantial variation or change to a service is not in the best interests of the patient/ the public or has not been properly consulted upon.

2. Action required

The Committee is asked to:

2.1 note the delegation from Nottingham City Council to Nottingham City Council members of the Joint City and County Health Scrutiny Committee regarding urgent referrals to the Secretary of State.

3. Background information

3.1 The governance arrangements of each Council affect the power to delegate. Nottinghamshire County Council is not permitted to delegate the referral function, whilst Nottingham City Council, as a council which has adopted the strong leader and cabinet model, can.

3.2 It was agreed by Nottingham City Council in July 2015 that the Council retains responsibility for referrals to the Secretary of State on matters considered by the Joint City and County Health Scrutiny Committee, with the option of agreeing whether the City or the County should lead on taking the referral forward, where they both agree a referral should be made.

3.3 Nottingham City Council has also delegated responsibility to the City Council members of the Joint City and County Health Scrutiny Committee to make a decision to refer in urgent circumstances, given that Council only meets six times per year.

3.4 It is only the referral to the Secretary of State that can legally stop any further action on a service change taking place until he/she has made his/her decision.

4. List of attached information

4.1 None

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013)

6.2 Department of Health Guidance 2014

6.3 Nottingham City Council Full Council agenda 13 July 2015

7. Wards affected

7.1 All

8. Contact information

Clare Routledge, Health Scrutiny Project Lead
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JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
15 SEPTEMBER 2015
OUTCOMES OF PRIMARY CARE ACCESS CHALLENGE FUND PILOTS
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

1. Purpose

1.1 To consider the outcomes of the primary care access challenge fund pilots and next steps in rolling out learning across the region.

2. Action required

2.1 The Committee is asked to use the information provided to scrutinise the implications for patients in Nottingham and Nottinghamshire of the outcomes of pilots to improve access to primary care services.

3. Background information

3.1 In May 2014 the Committee heard that Derbyshire and Nottinghamshire had been awarded funding of £5.2m from a national challenge fund of £50m to pilot ways of improving access to primary care. This was to be a 12 month project supported by the NHS England Derbyshire and Nottinghamshire Area Team, working with local clinical commissioning groups to test different interventions in different practices. Across the whole area this included increasing access to and availability of appointments through 7 day a week services; new ways of communicating and flexibility in access e.g. using Skype; expanding use of telecare; and joining up services between GPs and hospitals.
The aims of an area-wide approach were to share knowledge across the area so that what works could be rolled out at pace and scale; effective achievement of training and workforce planning to support the pilots and into the future; and carrying out evaluation to secure future funding.

3.2 In January 2015 committee members requested an update on the evaluation of results at the September meeting. Fifteen individual schemes have been evaluated, of these one scheme failed and five schemes have had funding approved beyond September 2015 to complete robust evaluation prior to making further plans.

3.3 NHS England North Midlands commissioned Nottingham University's Centre for Health Innovation Leadership and Learning (CHILL) to undertake a formative evaluation of the Prime Ministers Challenge Fund primary care transformation projects (PCTPs) in their area.

Leads from NHS England and Rushcliffe Clinical Commissioning Group will be attending the committee to provide information on the outcomes so far of the pilots which have taken place across the area, how the learning is being rolled out across the area and the implications of this for patients in Nottingham and Nottinghamshire.

4. List of attached information

4.1 Prime Ministers Challenge Fund Evaluation Interim Report NHS England and North Midlands - Centre for Health Innovation Leadership and Learning (CHILL) University of Nottingham

4.2 NHS England CCG Commissioning Prime Ministers Challenge Fund Presentation

5. Background papers, other than published works or those disclosing exempt or confidential information

5.1 None

6. Published documents referred to in compiling this report

6.1 Report to and minutes of meetings of the Joint Health Scrutiny Committee held on 13 May 2014

6.2 Report to and minutes of meetings of the Joint Health Scrutiny Committee held on 13 January 2015

7. Wards affected

All

8. Contact information

Clare Routledge Health Scrutiny Project Lead
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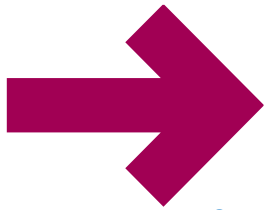
NHS England and CCG Commissioning

Health Scrutiny Committee
September 2015

Presentation overview

- Changes to Commissioning
- Challenge and opportunities facing the NHS
- The Five Year Forward View and what it means for Primary Care
- GP Access and the Challenge Fund
- Questions and Answers



Mapping the commissioners

- NHS England directly commissions community pharmacy, dentists and optometrists
- NHS England has delegated commissioning of GP contractors to Clinical Commissioning Groups (CCGs) in Derbyshire and Nottinghamshire
- CCGs also commission the majority of community and hospital care, out of hours primary care, and many enhanced primary care services
- CCGs are developing commissioning strategies for more integrated, patient centred healthcare
- CCGs also have a duty to assist NHS England improve quality in primary care
- Local authorities commission specific services from primary care (e.g. Health Checks)

Challenges and opportunities

- Rising demand and expectation in the context of constrained finances and workforce challenges
- Increasing pressure on primary care providers
- Need to improve quality, outcomes and value
- NHS England Five Year Forward View (5YFV) suggests:
  - *Radical focus on prevention and public health*
  - *More integrated health and social care*
  - *New care delivery models – e.g. primary care at scale*
  - *More streamlined urgent and emergency care*

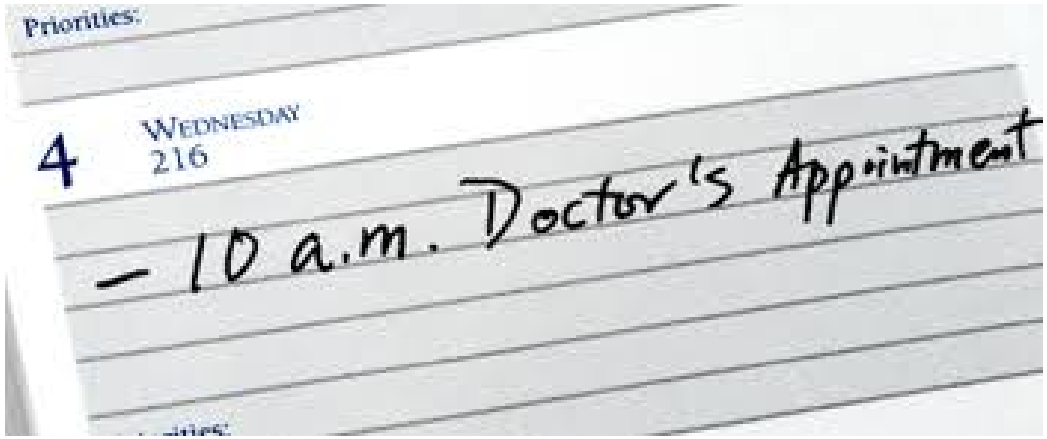
The Five Year Forward View

Taking existing primary care strengths, we will build a firm foundation for the future and deliver a new deal for primary care by:

- Stabilising core funding for general practice nationally
- Co-commissioning to shift care from acute to community
- Improving access to services and supporting new ways of working
- Expanding number of GPs: recruitment, return to work schemes and retention and investing in other new primary care roles
- Expanding funding to upgrade primary care infrastructure and scope of services offered to patients
- New initiatives to provide care in under-doctored areas
- Building public's understanding that pharmacies and online resources can help them with minor ailments without need for GP or A&E
- Identifying practical solutions to reduce bureaucracy and reshape appointment demand

Prime Ministers Challenge Fund

Improving access to General Practice including PM Challenge Fund and the Primary Care Infrastructure Fund – supporting new ways of working and new forms of access to improve patient satisfaction and convenience



Prime Ministers Challenge Fund (PMCF)

Wave 1

Transforming Primary Care in Derbyshire and Nottinghamshire

- 16 projects across 9 CCGs (Mid Notts collective term for Newark & Sherwood & Ashfield & Mansfield counted as 1)
- Project value range 245K – 1.5M
- 161 practices participating in pilot with a population of 1,4M patients
- Total value of wave one pilot £5,695,016, sustainability funding for 6 month extension: ££1,313,000

Monthly meetings of the projects (PMCF Delivery Group) Chaired by NHS England, North Midlands, to share learning and direct the local evaluation, which is being undertaken by the Centre for Health Innovation, Leadership and Learning (CHILL).

PMCF Continued

Wide breadth of projects:

- Capacity and demand modelling in general practice (Multiple CCGs)
- Weekend/evening extended access (Multiple CCGs)
- General practice staff training (Multiple CCGs)
- Alignment of OOH information systems with general practice (SystmOne) (Mid-Notts)
- Clinical triage (Multiple CCGS)
- Standardisation of general practice website (SD)
- Video link consultations (SD)
- Redesign of front in A&E (Mid-Notts)
- Urgent care hubs (Erewash, Rushcliffe)
- Self- management tools (Multiple CCGs)
- Care Home access to PC (Erewash)

PMCF Sustainability

- 15 Individual schemes being evaluated
- 1 Scheme failed (Nottingham North and East CCG Hub)

- 5 Schemes have had funding approved beyond September to complete robust evaluation before making further plans:

Pilot Name	Number of schemes	Status
Rushcliffe, urgent Care Hub	1	Funding Until Dec ember 2015
Hardwick, Weekend GP access	1	Funding until March 2016
Erewash, Primary Care Hub	1	Funding until April 2016
Notts City, Weekend Opening	1	Funding until March 2016
Nottingham West, Engaged practices	1	Funding until April 2016

Risks identified around sustainability of Hubs/Weekend access models are around future financial viability, the model has to provide value for money.

PMCF Sustainability

Remainder of schemes:

Pilot Name	Number of schemes	Status
Erewash, Primary Care access care homes	1 scheme	Incorporated in core funding with provider
Notts City, Responsiveness contract	2 scheme	Audit of systems due to conclude in September 2015 (as per plan) Staff training, decision due August 2015
Mid Notts, Improving urgent primary care	3 schemes	2 schemes non-recurrent, 1 scheme approval for extension until March 2016 pending
Southern Derbyshire, My GP 24/7	1 scheme	Decision in August 2015
Southern Derbyshire, Website/ E consultation	1 scheme	Decision in August 2015
Notts North and East, Telephone triage	1 scheme	Changes in processes will be embedded and will not require funding post September 2015
Hardwick, Improving GP access	1 scheme	Will be mainstreamed

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Prime Minister Challenge Fund Evaluation Interim Report

NHS England North Midlands

Centre for Health Innovation Leadership and Learning (CHILL), University of Nottingham

4/30/2015

Dr Paul Windrum, Dr Jane Guinery, Dr Penny Siebert, Dr Susan Brown, Robert Smith.

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1 Introduction

NHS England North Midlands has commissioned the Centre of Health Innovation, Leadership and Learning (CHILL) at the University of Nottingham to undertake a local formative evaluation of the Prime Minister Challenge Fund (PMCF) primary care transformation projects (PCTPs) in their area.

The objective of the evaluation is to examine PCTPs and the context in which they are implemented, and to establish lessons learnt to inform choices made in the adoption and implementation of these projects. The focus is on the 'proof of concept' of different types of PCTPs, and on approaches used in their implementation. Within this, it is important to identify and understand the influence of contextual factors on the types of initiative and the implementation approaches that are found to be most effective.

The NHS England North Midlands and nine local CCGs organised a combined and comprehensive PMCF bid. This Report has been prepared for NHS England and the CCGs. Its readership could be usefully extended to all those participating in the PCTPs and/or interested in selecting and implementing similar initiatives now, and in future.

1.1 Overview of report content

The following sections of this Report include information on:

- The evaluation process: describing the approaches taken to evaluate PCTPs (qualitatively and quantitatively).
- Access: describing the variety of ways access has been defined at the local level. Findings from an initial study of patient preferences are also presented.
- Types of initiative: examining and categorising different types of PCTP as described by participants.
- Emerging themes: describing some key themes that have already emerged during phase 1 of the evaluation, and which will be investigated further in phase 2.
- Next steps: an explanation of subsequent steps to be undertaken by the CHILL evaluation.

1.2 The evaluation process

The local formative evaluation conducted by CHILL comprises two streams. A qualitative stream focuses on understanding how and why initiatives are implemented by examining local contexts, assessing outcomes, and understanding what these are dependent upon. A quantitative stream seeks to quantify outcomes. This includes metrics provided by local PCTP initiatives on performance and impact, data collected on patient's perceptions of improvements in local services, their preferences regarding access in general, and the analysis of other available NHS data.

1.2.1 Overview of qualitative analysis

In phase 1 of the qualitative evaluation, work has focused on establishing profiles for the majority of the PCTPs across all CCGs in order to develop an understanding of the variety of initiatives being undertaken. Data collection has included interviews with CCG leads, service providers, and project leads on the ground where changes are being made. These have explored the rationale behind PCTPs, the implementation process, and the outcomes thus far. Approximately 25 interviews have been conducted with 33 individuals (some interviews involved multiple individuals), recorded and analysed. The profiles have been examined to identify significant issues and themes to inform phase 2 of the evaluation, where exemplar PCTPs will be analysed in relation to 'proof of concept' and implementation.

1.2.2 Overview of the quantitative analysis

In preparation for the quantitative evaluation work of the CHILL team, the NHS England North Midlands and CCG leads agreed a set of key metrics in April 2014. The intention was for data on these key metrics to be delivered to CHILL on a monthly basis by CCG leads, as part of the response and for accountability. There have been issues in obtaining this metrics data, and delivering it to the CHILL evaluation team.

To date, metrics data has been provided to CHILL by Erewash CCG and by Nottingham North & East CCG. Unfortunately, delays in delivery and/or requests for clarifications on data mean analysis could not be conducted in time for the deadline of this Report. Once clarifications have been made, the analysis will be provided in CCG overview reports (see Next Steps section).

CHILL has worked with Nottingham West CCG, Nottingham North & East CCG, Erewash CCG, and Rushcliffe CCG to develop service-specific patient questionnaires. At this point, Nottingham West CCG has deployed the questionnaire, and provided the data. We are still awaiting information on sample rates (i.e. the percentage of patients attending different surgeries that completed questionnaires during the 2 week sampling period) from Nottingham West CCG. Once this has been provided, the analysis will be provided in a Nottingham West CCG overview report (see Next Steps section).

Finally, the CHILL evaluation team has conducted a conjoint analysis survey of patient preferences on access to GP services with Stenhouse Medical Centre in Arnold (Nottingham North & East CCG). A draft report has been delivered to Nottingham North & East CCG. A summary of the findings is included in this Report.

To summarise, the quantitative stream of the CHILL evaluation is constrained by the lack of data provided to date.

2 Initial Findings

2.1 Access

Improving access has been interpreted differently across CCGs, and these differences have influenced the types of PCTPs which have been developed. In different cases 'access' has been viewed as access to:

- GPs for consultations (face-to-face, telephone, or virtual);
- overall services provided by general practices, including services delivered by other staff as well as GPs within a practice;
- a range of clinical services, with an emphasis on the most appropriate service being delivered to patients, at the right place and time (e.g. through an integrated acute care service);
- clinical information, and support, towards patient self-management (e.g. using general practice websites).

From face-to-face interviews, the practice perspective is that there are a number of different types of streamlining that can be introduced to ensure patients are allocated the most appropriate service or level of care. The findings indicate that the following factors are important in relation to patients' access:

- ensuring that patients with the most acute or urgent conditions are likely to receive swift attention;

- allocating patients to clinicians according to the level of specialism required (i.e. providing an intervention at the lowest possible skill-level to ensure efficient allocation of resources);
- allocation of appointments taking into account a trade-off between pre-bookable appointments (available for routine and/or non-urgent appointments) and urgent appointments;
- diverting patients to other sources of help, where appropriate (either as an adjunct to practice care, or as an alternative);
- encouraging and enabling patient self-management where appropriate.

2.1.1 Patient preferences in relation to access

Patient demand is an important factor determining the provision of access to primary care services. Conjoint analysis is an approach to measuring preferences (utilities) that estimates both the relative importance of different aspects of care, as well as the total satisfaction or utility that respondents derive from healthcare services (Ryan and Farrar 2000; Rubin et al 2006). Within the conjoint framework, it is assumed that if A is preferred to B then the utility or benefit derived from choosing A (with a given set of attributes and levels) will be greater than that of B (with a given set of attributes and levels).

A conjoint patient survey was conducted at Stenhouse Medical Centre in Arnold. This survey seeks to measure the relative importance of three attributes affecting patients' access to primary care that are highlighted in the PM Challenge - the availability of same day appointments at GP practices, continuity of care (i.e. being able to see the same GP or nurse), and extended opening hours at GP surgeries.

The main benefit of conjoint analysis is that one asks patients to explicitly state their preferences across a complete set of options. In this survey, this number of attributes and levels gives rise to a complete set of 8 (2x2x2) possible service combinations (or options) - Table 1 below. Patients were asked to score each combination between 100 and 1 (where 100 is the highest possible score, and 1 is the lowest possible score).

Using this information, one can identify and estimate the trade-offs which patients are happy to make between the three different aspects of GP access. The estimated contribution – known as a "partworth" – for a particular aspect (e.g. the availability of same day appointments) indicates the utility to patients of that particular aspect of access.

For GPs and Commissioners, the partworth is of direct interest because it is the benefit, as perceived by patients, in moving from one set of services to an alternative service option, given a set of trade-offs.

In addition to analysing the three main access attributes, the study takes into account individual characteristics, such as age, gender, ethnicity, socioeconomic variables, and long-term conditions that could also influence preferences for a GP access.

Patients were contacted upon entering Stenhouse Medical Centre, for a two week period, from 23/02/2015 to 06/03/2015. Questionnaires were distributed at both morning and afternoon clinics. Patients were asked to complete a questionnaire while waiting for their appointment. The effective sampling rate over the two week sampling period was 52%. The sample dataset comprises completed 388 questionnaires. For the set of 8 choices, this provides 3104 observations.

Table 1. Combinations Presented to Patients to Score

				Score
1.	Same day appointments are available	Appointment with your usual Doctor or Nurse	Surgery open 8am-8pm Mon-Fri, and opening at weekends	
2.	Same day appointments are available	Appointment with your usual Doctor or Nurse	Surgery opening hours are 9am-5pm, 5 days a week	
3.	Same day appointments are available	Appointment with any available Doctor or Nurse	Surgery open 8am-8pm Mon-Fri, and opening at weekends	
4.	Same day appointments are available	Appointment with any available Doctor or Nurse	Surgery opening hours are 9am-5pm, 5 days a week	
5.	No same day appointments are available	Appointment with your usual Doctor or Nurse	Surgery open 8am-8pm Mon-Fri, and opening at weekends	
6.	No same day appointments are available	Appointment with your usual Doctor or Nurse	Surgery opening hours are 9am-5pm, 5 days a week	
7.	No same day appointments are available	Appointment with any available Doctor or Nurse	Surgery open 8am-8pm Mon-Fri, and opening at weekends	
8.	No same day appointments are available	Appointment with any available Doctor or Nurse	Surgery opening hours are 9am-5pm, 5 days a week	

For this particular sample population, we find that, on average, patients' preferences for the availability of same day appointments are *four times* higher than indicated preferences for either continuity of care or extended GP opening hours. Respondents' preferences scores are:

- 41.8 (95% CI = 37.6 - 46.1) for options that contain same day appointments compared to those options that do not offer same day appointments.

- 9.5 (95% CI = 5.3 - 13.7) for options including the ability to see their usual GP or Nurse compared to options where the patient would be seen by any available practitioner.
- 9.2 (95% CI = 5.6 - 12.8) for those options that included extended opening hours (i.e. 8am - 8pm plus weekend availability) compared to 9am to 5pm on weekdays.

While a key focus of the Prime Minister's Challenge is on extending the hours of access to GP surgeries, these findings indicate that same day availability and continuity of care are of greater importance to patients.

Previous studies have suggested that patients may be willing to substitute continuity of care for speedier appointments. However, the patients in this survey view these as complementary and not as substitutes. Respondents' preferences score for the interaction between same day appointments and see their usual GP or practice nurse is 7.4 (95% CI = 2.7 - 12.1).

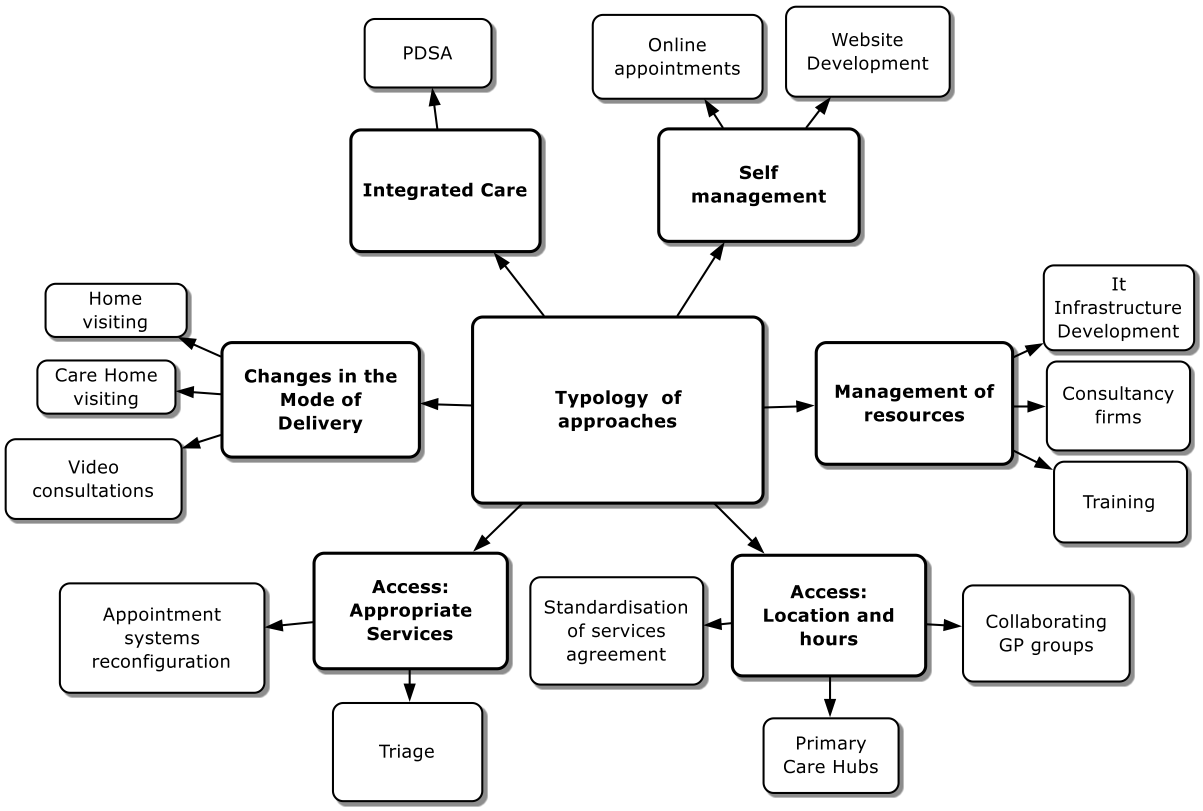
Finally, we report that the above results are consistent for men and women, and for people with and without long-term conditions. We do find a small, negative interaction between age and the offer of same day appointments, indicating that older patients have, on average, marginally lower preferences for same day appointments than younger patients.

As noted, these findings are based on a dataset collected from one Medical Centre. The CHILL evaluation is seeking to run the same survey in 3 more GP practices, and will report the collective results in the Final Evaluation Report.

2.2 Types of initiative

A revised version of a typology of PMCF projects, initially formulated at the start of the evaluation process, has been developed. This development is based on the information gained from interviews conducted in the profiling exercise. See Figure 1 below.

Figure 1 Typology of Projects: April 2015



In the typology, projects are grouped together according to the types of activities and processes that have been employed to improve access. We find that elements that were part of one project are often used, in some form, in another project. For example, most projects use some form of triage to manage access to GPs.

2.2.1 Access to appropriate services

Improving the way in which patients are routed to an appropriate health care professional or service, was judged to be an important aspect of improving access to care in the evaluated PCTPs. Key activities are the triaging and prioritising of patients according to their needs, and the reasons why patients make requests to see a GP. These often necessitate complementary changes, notably the development and use of alternative types of consultation, and changes in the appointment procedures, in order to accommodate triaging and prioritisation.

Three forms of triage have been found to be in operation across different PCTPs. The first is a form of filtering. Here a non-clinical member of staff, such as a receptionist or health care

assistant, ascertains the patient's requirements (either on the telephone or face-to-face) before offering/booking a service for them.

A second form of triage involves the patient's needs being assessed by a non-clinical operator, using a template or algorithm. This, for example, is typically used in out-of-hours 111 services. In this form of triage, the patient is directed to the appropriate level of care or service, based on the outcome of the assessment. The outcome of the assessment could be one of the following: attend the Emergency Department, set up an appointment to see a local GP at one of the local GP out-of-hours services, advise the patient to go to a walk-in centre, or pass the patient on to NEMS.

Clinical triage is a third form. It is carried out by clinically trained staff, such as advanced nurse practitioners / prescribing nurses, or GPs. Depending on the PCTP, clinical triage may be the first triage which a patient encounters, or it may follow on from one of the other two forms of triage discussed above.

We found that primary care staff and practitioners presented different views on how different forms of triage should be categorised, and on where it fits into processes that handle patient access.

A common view was that, should the member of staff talking to patients be in a position to make a clinical decision, the interaction between the staff and patient might then be redefined as a consultation, as the outcome may be a plan of care or some form of treatment, as opposed to an assessment of the level of care needed.

2.2.2 Extended access - location and hours

The projects in this category aim to directly extend the availability of appointments. The objective here is to increase GP and nurse appointments. The PCTPs that have been evaluated seek to achieve this in one of two ways. One way is to extend surgery opening hours. The other way is through the provision of a local GP-led extended hours service at a shared location, or 'hub'. GPs have formed collaborating or federated groups to implement and operate an extended 'hub' service.

Some projects in this category established an agreement that practices within a CCG would adopt a standardised way of working. For example, in one CCG, all practices were encouraged by their CCG or Clinical Cabinet to open five days a week and to no longer close at lunchtime. As part of the standardisation of services agreement, a number of CCGs developed or commissioned a set of training packages for receptionist and administrative staff.

2.2.3 Mode of delivery

This category includes those initiatives in which an alternative mode of delivering care has been introduced, such as nurse-led care home visiting services and changes in the provision of home visiting. It was thought that these activities took up a lot of GP time, and that most could be carried out effectively by Advanced Nurse Practitioners (ANPs). The rationale presented by the PCTP teams is that these changes in delivery free up GPs' time and, over time, should lead to an increase in GPs' availability for additional appointments. Other initiatives within this category include the use of technology, such as video consultations, which has been introduced as an alternative to patients going to their GP surgery for face-to-face consultation.

2.2.4 Integrated Care

This category of PCTP initiatives involves putting in place systems and procedures, at various organisational levels, that improve the patient's journey between primary and secondary care services. The objective is to improve the relationships and connections between the multiple agencies involved in providing urgent and emergency care within a locality. It is expected that this will prevent inappropriate emergency department attendance.

2.2.5 Management of resource

PCTPs in this category are focused on finding ways to manage resources more effectively in order to meet the growing volume of demand for primary care services. Core within these PCTPs is the assessment of existing practice systems, capabilities, and capacity in order to improve access. The rationale here is that a better understanding of demand and capacity will enable practices to deploy their resources more effectively, and ensure that they have in place the right skills mix to address the needs of their patients.

To achieve these changes, some PCTPs have commissioned consultancy firms to provide practice staff with the support needed to examine their systems, and audit their workload and operations. Consultants have also worked with local practices to identify what needs to be changed or improved in order to increase capacity and the availability of appointments. CCGs undertook a procurement process to identify a shortlist of providers. Practices are at liberty to choose from one of the shortlisted consultancy firms.

2.2.6 Patient self-management

This category of PCTPs covers a mixture of approaches that aim to encourage patients to be more proactive in making decisions about their own health needs. This approach makes use of different health education and technological resources, and services, as a first line of self-care. This includes investing in website development to increase the use of online appointment booking systems, website developments that signpost other primary care services (such as those offered by pharmacists), and the use of electronic communication systems to contact GPs.

3 Emerging findings

This section of the Report highlights a number of findings which have emerged during phase 1 of the evaluation, and which require further investigation in phase 2 in order to test their validity. In some instances, impacts may only be evident in the longer term.

3.1 Inherent assumptions and outstanding questions

There seem to be many inherent assumptions regarding the effect of improving access to primary care. Many of these have yet to be challenged and evidenced. The rationales can be generic, although in many instances they relate to a specific type of PCTP initiative. A number of these are described below.

In relation to extended hours;

i. Extended hours should lead to reduced ED attendance. In a number of cases, there are indications that those patients who use extended hours services are not necessarily those that would proceed to ED.

ii. Patients want to access their GPs in extended hours. There is evidence that local patient preferences appear to be for same day appointments, followed by continuity of care. Extended hours is ranked third amongst patient preferences (see the conjoint analysis described above). The lack of preference for extended hours also seems to be reflected in the number of unused appointments at weekends observed in a number of cases.

In relation to changes to appointment systems and forms of triage;

iii. Patients need same-day care. It is typically accepted that same-day appointments for urgent care are important and result in fewer DNAs. However, the use of same-day appointments may also be the result of patients having longer waits for booked appointments, as a result of changes made to the appointment system to accommodate same day appointments. That is, booking of same day appointments may be due to the patients and GP staff responding to a situation where the waiting time for alternative bookable appointments are impractically long.

Generally;

iv. GP time released through initiatives will free up appointment times for other patients. This does not seem to have been realised in many of the PCTPs. Released time is being utilised in other ways (reducing time pressures on GPs, and/or improving the quality of service to patients).

3.2 Unanticipated outcomes

A number of unintended consequences have been identified, and in many cases these raise concerns about sustainability.

Primary care services are complex systems where changes made in one area can impact on other areas, often with unanticipated outcomes. A broad range of examples of this include:

- Budgeting conflicts that may be responded to in detrimental ways. For example, ED attendance can benefit hospitals in terms of payment; NEMS is paid irrespective of number of patients attending (limiting concerns, possibly encouraging redirection of patients to extended hour services).
- Increased use of service providers with associated costs.
- Poor resource allocation occurs where extended hours contracts offered to GPs as part of the PMCF (that are relatively well paid) result in GPs reducing their input to NEMS urgent care services. This has the potential to significantly reduce the cover for urgent care over weekends and bank holidays.
- Triage and use of same day appointments may result in a deterioration of services for patients with chronic conditions who require more routine appointments.

- Skills shortages at a national level (widely reported) are also manifest as in many recent initiatives, patient demand is being re-directed to different staff such as advanced nurse practitioners (ANPs). This is leading to supply issues as demand for people with particular skills increases. Also, in some locations it is difficult to attract and recruit GPs, and this is very apparent in areas with high levels of deprivation. This may have considerable implications on PCTP feasibility and sustainability.

3.3 Heterogeneity of patient needs and behaviours

Broad assumptions regarding patient preferences, needs and behaviours to primary care access need to be avoided. It is apparent from our findings that, when making any assessment of different forms of access, the likely implications for different patient cohorts need to be carefully considered. For example:

- where IT is used as a gateway to enable patients to self-direct their care, the impact on those who are less capable of using these systems or managing their situation needs to be considered;
- the allocation of appointments to same-day or urgent cases can disadvantage patients with chronic conditions that require routine care.

Patient behaviours have been highlighted as problematic by many interviewees. When assessing the value of change, it is important to question whether:

- there may be supply-induced demand arising from changing patient expectations. Based on these concerns, some PCTPs have responded by not advertising extended services, relying on patients coming through the 111 service. This can result in the under-utilisation of services;
- patient satisfaction with access may not be well balanced with the best use of the limited resources for medical need;
- patients' expectations may be raised by changes to services (e.g. complaints are being received about delays in GP call back times, whereas previously patients access would have been less immediate);
- it is important to question whether patients have been, or can be, re-educated to change their behaviours. We note that this is difficult to gauge in the short term, and with a small number of patients experiencing the service changes.

3.4 Importance of less tangible objectives and outcomes

In selecting to undertake a specific PCTP, it is apparent that some practitioners have taken a forward view on what is required for all or some of the stakeholders within their project. For example aiming to:

- improve collaboration between individuals within general practices and the CCG, leading to an improved ability to support transformation in primary care;
- focus on service integration and the building of relationships between individuals in them, supporting future vanguards. (E.g. the integrated urgent care initiative at Newark fosters relationships between primary care and secondary care service providers);
- reduce time pressures on GPs. Though contrary to directly increasing patient access, this may have significant value in promoting GP retention and performance.

3.5 Barriers to information sharing and collaboration

Technical, commercial, and confidentiality concerns, as well as governance issues, have limited the availability of, and ability to share, data. This hampers both the internal monitoring of projects, national reporting, and the analysis that can be undertaken by CHILL as part of the evaluation.

There have been extensive discussions and duplication of effort of staff from CCGs, service providers and general practices trying to establish how to share data across practices and service providers with different systems (SystmOne, EMISweb and OHH systems).

Further barriers relate to concerns regarding data use that might impact on patient confidentiality. Although some of these issues may be addressed through the appropriate management of information, in many instances at practice, CCG and regional team levels there has been limited knowledge and consensus regarding the information that is available, the implications on its use, and what can feasibly be shared.

It is important to recognise that there is a range of technical capabilities amongst practice managers. In some instances it appears that practice managers are struggling with extracting relevant data from practice systems (e.g. appointment systems) without support. These systems were not originally intended to provide data for evaluation purposes, and (hence) steps should be taken to provide assistance.

In a number of PCTPs, service providers have been utilised to implement, manage and/or deliver the service. It is apparent that there are similar issues here, with provider organisations supplying limited, or generic and uncleansed data on services.

The feedback from practices, indicates that project leads have in many cases struggled to identify and implement meaningful metrics for their PCTP, despite in some cases recognising that outcomes need to be tested. Their perception is that there has been no clear remit to collect and analyse data, or sufficient advice on what is required, or the procedures for collection. They believe that the need was not communicated to them as part of the bid. This indicates a lack of understanding of contractual arrangements.

There also seems to be limited awareness, amongst practice managers, of the value of the analysis to them.

3.6 Preparedness and pragmatism

In an environment where funding is hard to come by and must be obtained by quick responses to calls, it is not surprising to find instances where stakeholders have identified the PMCF as a useful resource for speeding up the development of planned projects , or partially defined projects that they wished to pursue (e.g. continuing a care home and home visiting services, developing existing websites to improve use). Levels of preparedness have been observed, in both CCGs and general practices.

Experienced practitioners will also define projects in a way that enables them to retain advantage from the expenditure in the longer term. For example, by investing in tangible changes (e.g. equipment or facilities), as opposed to funding temporary additional running costs (such as additional GP payments over the time the project). Additionally, funding may be utilised to support other aspects of the business, such as improved efficiencies or increases in service provision.

3.7 Governance of PMCF projects and their implementation

The governance of projects varies considerably across CCG's and PCTPs, and in many instances is a reflection of the relationships between CCGs and service organisations, and general practices within their area. The form it takes may have significant implications for the success of a project, and this needs to be taken into account. In particular, the origin and ownership of the initiative ideas, the leadership of projects (both in relation to who leads

and how leadership is structured), the approach taken to knowledge sharing and collaboration, as well as levels of PPG participation.

Forms of governance are influenced by the situations stakeholders face in their specific primary care context, and include assumptions made about other groups' agendas and responses. It is likely that the number of general practices associated with the CCG will also have an influence on how projects can be managed, as where the number of GPs is low it is more feasible to implement a more collaborative approach. In some cases, CCG and other service provider organisation staff may take the lead role; in others incentive schemes are run that give general practices autonomy; in others practices and their CCG are working in close collaboration. Examples include Southern Derbyshire CCG, which employs a top down approach for website development; Mansfield and Ashfield where practices have the autonomy to define and manage their own projects within an incentive scheme; Rushcliffe where the CCG works closely with the clinical leads to influence GPs.

Each approach has advantages and disadvantages. These are contextual, and require further investigation in phase 2 of the evaluation. The influence of professional groups and networks, including clinical cabinets, also needs to be considered. Their influence may be significant. Interview responses from stakeholders also suggest that, in some cases, the accountability of different organisations and professional groups may be blurred, leading to inertia and miscommunication, with structures and organisational relationships not fully understood or acted through. In some cases, a specific CCG may pursue a combination of approaches. The danger here is that staff involved in PCTPs may be confused if accountabilities seem ill-defined.

Different approaches have also been taken in relation to the use of service providers (such as Greater East Midlands Commissioning Support Unit (GEM) with Southern Derbyshire CCG). This could potentially lead to issues of accountability, particularly where accountability has been given for aspects of the project not fully in the service provider's control.

Clinical accountability and legal issues around this can lead to restrictions on the form of governance which needs to be taken. For example, Rushcliffe has addressed the need for a single practice to take accountability for the extended weekend service.

Lack of recognition of the purpose of the pilots in relation to testing for proof of concept implies that accountability for monitoring of performance and impact has not been well conveyed within the original bids, and arrangements made with project leads.

Tight timescales on bids and delayed funding has had a considerable impact on PCTP implementations, though the detrimental impact of this has varied and may have been more problematic for particular forms of governance. Due to delays in the administration of the bidding and funding process at a National level, and then at the regional Team and CCG

levels, GP and CCG leads had to put together proposals at short notice, and funding intended for projects to commence in April 2014 was not made available until June 2014; in the worst case scenario, some general practices could only start up their projects in January 2015 with their deadline for completion fixed for March 2015. On a positive note, under these huge time pressures, exceedingly high levels of commitment amongst people in stakeholder organisations has been apparent.

3.8 Diffusion and adaptation

A number of observations can be made on the diffusion of ideas on PCTPs, and their adaptation over the course of the PMCF first wave.

- Diffusion: there has been significant communication on projects and their outcomes through a number of forums. Of particular note is the local PMCF Delivery Group, comprising NHS England North Midlands and local CCG leads. This has raised an awareness of the approaches being taken across the area.

- Adaptation: invariably when PCTPS are implemented, adaptations evolve in other aspects of the service. For example, triage requires adaptations to appointment systems, and decisions need to be made regarding the relative balance between urgent same-day and pre-bookable/routine appointments.

- Pragmatic adaptation: this can occur and may be problematic if it redefines the PCTP, based solely on prevailing circumstances. Examples include:
    - instead of accepting patients purely as urgent same day appointments, some appointment slots at a weekend hub are being embargoed for patients who have previously requested appointments with their own GPs. An advantage here is that a GP concerned about a specific patient can ensure that patient's condition is monitored over the weekend, potentially avoiding an admission to ED;
    - utilising Emergency Care Practitioners (ECPs) from ambulance services to support GP home visits. This was feasible because ECPs were contracted as additional support for the local hospital (in Newark), and their skills were not being fully utilised;
    - encouraging other health care providers to use an extended hours service that is currently under-utilised. An example of this is found in Rushcliffe where other providers are encouraged to make use of a hub.

The extent to which these are improvements vs. short-term work-arounds needs to be better understood.

4 Next steps

1. An 'Overview of the Evaluated PCTPs' is to be prepared for each CCG. These will be tabled for discussion and, where necessary, for validation. In cases where further information and/or data is required to establish 'proof of concept' or fully describe implementation, this will be requested (at both the CCG and practice levels).

2. Some of the evolving themes will be investigated further via a more detailed analysis of exemplar PCTPs – these evaluations are described as 'deep dives'. PCTPs will be selected for this, based on an assessment of which PCTPs can generate quantitative and qualitative findings, and are of most benefit to primary care in the area. The PCTP at Stenhouse Medical Centre (Nottingham North and East CCG) on triage has already been selected, and further exemplars are to be selected.

3. The Final Evaluation Report will include more detailed profile information on PCTPs, detailed evaluations of the deep dives, and quantitative analysis of metric data on PCTPs delivered to CHILL.

4. A dissemination event tied to the Final Evaluation report will be run in partnership with the East Midlands Academic Health Science Network (EM-AHS) to support the diffusion of knowledge gained through the CHILL evaluation across PCTPs.

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Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

15 September 2015

Agenda Item: X

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 10 March 2015 when Neil Moore, Director of Procurement and Market Development, Mansfield & Ashfield CCG and Jonathan May, UK Managing Director, Arriva, gave a presentation on Non-Emergency Patient Transport Service. The presentation showed that as of January 2015 the Key Performance Indicators (KPI's) were still not being met and some parts of the plan had not been as effective as they should have been.

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

   - Communication was made with wards if a pre-arranged time slot was not going to be met. Wards were being asked to give prior notice of patients being discharged as part of the discharge pathway.

   - All staff had been issued with a Personal Digital Assistant (PDA) to assist with the eight and a half thousand journeys planned every day in Nottingham and Nottinghamshire. Pressure was put on the system with 'same day' bookings.

   - There was assurance that patients being returned to Care Homes were not being left until later in the day for convenience reasons.

   - There were more wheelchair users than had originally been planned for.

   - There would be investment in more vehicles, staff training and an 'on line booking system'.

   - The committee, whilst acknowledging that the patient experience was important, were not happy that the KPIs were still not being met.

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

4. Senior representatives from Arriva and the commissioners will again attend the committee to provide the briefing and answer questions as necessary.

5. [Members may wish to consider what recommendations they might wish to make regarding the non-compliance with KPIs.]

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:

1) Receive the briefing and ask questions as necessary

2) Schedule further consideration

3) [Consider recommendation regarding non-compliance with KPIs].

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

June 2015

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 entering the fourth year of 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 and these initiatives are further supported by the issuing of a formal Performance Notice from Commissioners in recent weeks.

Performance Improvement

There has been some improvement to the achievement of Key Performance Indicators (KPIs) since December 2014 but the required standards are not being achieved and improvement has been modest. There has been a marked change over the last year in the acuity of patients requiring transport. There have been increases of more than 10% in requests for stretcher, bariatric and two man ambulance transport, all of which are more complicated, time consuming and require specialist vehicle resources. Arriva have recognised where service improvement is required and developed a number of new initiatives. These include:-

- **Investing in a new organisational structure & appointing new key roles to create more management capacity to invest time in staff engagement and performance improvements**. This includes focussed positions within key functions such as operations, relationships and control/planning. The investment sees 2 new senior management positions appointed to ensure better support and direction for each functional area which will create better autonomy and accountability throughout the structure to monitor and influence improvements to patient care.
- **Investing in new technologies and improvements in existing technologies, linking them where possible to create more capacity in control rooms and better utilisation of PTS crews**. This will help streamline their processes and administration to produce more opportunities to influence improvements. As well as new technologies, they are also linking their key systems to provide an effective support solution for their controllers and planners, assisting efficient planning within strict parameters set to maximise effectiveness with patient safety and experience in mind.
- **Development of 'Transport Working Groups' to enable cross provider monitoring and analysis of behaviours that impact patient experience and agree actions to improve**. By establishing Transport Working Groups particularly at the main acute sites, it is possible to identify the need for change where the practices and performance of NEPTS impact Acute & Community Hospital service delivery and vice versa. The Group, in partnership are encouraged to develop a transport monitoring dataset to help baseline areas of improvement, agree shared actions and track their impact. Often the analysis of the problems highlights the need for improved operating processes and communication pathways. The aim is to ensure optimum use of all resources and best service delivery to patients.
- **Focus on renal transport.** Including the introduction of a dedicated Renal Co-ordinator based at the renal unit at Nottingham City Hospital. The purpose of the role

is to be the main point of contact for patients and the unit staff in respect of patient transport. They would work in partnership with the unit to identify opportunities to optimise transport and dialysis resources while delivering a quality service to the patient. They would support patient flow through the unit, manage bookings; update the transport system with any unexpected changes to patient times on the day of travel. They would support the development of transport plans in partnership with all parties; manage them closely on the day ensuring a seamless service is delivered for patients. This would serve to minimise clinical staff involvement in transport and ensure the impact of changes generated from transport, the unit or the patient are considered holistically.

- **Focus on patient experience**. Continue to work closely with Healthwatch on the recommendations made in their insight report. An observation day and additional engagement has taken place with the City Dialysis unit. A patient engagement day is planned for September. Implementation of Friends & Family Test and a revised qualitative survey is out with patients currently.
- **Partner provider 'roadshows' to raise awareness.** Informal visit to wards and departments at sites across Nottinghamshire to give NHS staff the opportunity to offer feedback on Arriva's service. It also gave the opportunity for Arriva to communicate key messages and raise the level of understanding of their service with the people who use it.
- **Further diversification of third party support to create better resilience during peak demands.** As well as enabling access to a flexible resource during periods where demand exceeds the capacity of Arriva's PTS crews, this also provides a benefit to the local community and economy.
- **Further/ongoing demand profile mapping to ensure resources are dynamically available where they are needed.** As demonstrated above with the example of changed acuities, the activity is dynamic and continually evolving. Arriva have designed processes to monitor this closely and where possible revise their working practices including rotas and vehicle configuration to better meet the changing demand. The processes are designed to anticipate such changes and where necessary communicate sustained pressures for further consideration in advance with our stakeholders.
-

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 courses, infection prevention and control reports and the outcome of audits.

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 - as reported by ARRIVA			Std.	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%	95%	95%	96%	95%	95%	94%
		Patients within a 10 – 35 mile radius of the point of care will spend no longer than 90 minutes on the vehicle.	90%	94%	94%	95%	94%	95%	94%
		Patients within a 35 – 80 mile radius of the point of care will spend no longer than 120 minutes on the vehicle.	90%	90%	96%	93%	93%	88%	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 - as reported by ARRIVA			Std.	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%	76%	76%	77%	79%	79%	79%

There has been a slight improvement to this KPI since February but the performance of Arriva falls well short of the KPI target. The previous experience of heavy winter pressures followed by an easing in demand is no longer noticeable and Acute Hospital A&E units are now constantly stretched with subsequent pressures on discharges to clear beds.

3. KPI3 – Departure Times

KPI Target: 90%

KPI Summary - as reported by ARRIVA			Std.	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%	74%	75%	74%	73%	75%
		Discharge patients shall be collected within 120 minutes of request or agreed transport/or zone time.	90%	76%	78%	75%	71%	67%	68%

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. 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
KPI 1	Time on Vehicle	The patient's journey both inwards and outwards should take no longer than 30 minutes.	90%	64%	64%	62%	63%	63%	60%
		The patient's journey both inwards and outwards should take no longer than 30 minutes. (Excluding Patient over 21 miles away)	90%	67%	67%	66%	65%	65%	62%

Performance has remained static with only occasional improvements. It is still considerably below the target of 90%. Timeliness and renal transportation is a topic that has generated a number of complaints and prompted a report published by Healthwatch Nottinghamshire in March 2015 and referred to earlier in this report. 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 in previous reports, that a patient cannot be safely transported a distance of over 21 miles in 30 minutes. The table above displays from January 2015 to June 2015 the impact upon KPI performance of excluding the journeys of over 21 miles. The differences between 60% to 64% achievement and the restated KPI excluding journeys over 21 miles of 62% to 67% 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
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%	75%	72%	81%	82%	82%	82%
		Patients will arrive at the unit before their appointment time	100%	87%	89%	92%	92%	92%	91%

Performance against KPI2 – arrival no more than 30 minutes before appointment time - has seen some improvement in the Spring and early Summer after suffering due to winter pressures. In line with recommendations from Healthwatch and pressure from Commissioners, Arriva have focused on trying to ensure that more patients arrive at the renal units before their appointments. They have ensured that over 90% of patients meet their appointment but some arrive more than 30 minutes early and thus fail the first part of the KPI. 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, many patients fail to use their pre booked transport without notifying Arriva and the rate of change of patients over the course of a year can be significant.

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
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%	75%	76%	80%	83%	82%	82%

Performance against this KPI showed some improvement in in the spring and early summer but suffered in January and February due to 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.

- 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.

- 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 Patients continues to be positive and dynamic. Under the Contract Performance Notice Arriva must present a plan to Commissioners within 30 days that will demonstrate how they plan to improve their KPI performance. Arriva is keen to actively improve its reputation for reliability, collaboration and responsiveness. Over the life of the contract 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 fourth year which commenced in July 2015.

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Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

15 September 2015

Agenda Item: X

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 10 March 2015 when Mr Stewart Newman, Head of Performance at NHS Nottingham City attended the committee to present the latest performance information.

3. The committee heard that December 2014 had been a difficult month with a 35%increase in the number of calls compared to December 2013 resulting in an increase in the number of abandoned calls for that month.

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

   - The 'Triage System' used by 111 was agreed with every service provider who were also invited to attend 111 meetings. There was a form for health professionals to feedback when patients had been advised incorrectly by 111 and a 'data warehouse' was being built to monitor if 111 were sending people to the correct service/place.

   - The average call back time to patients was 30-40minutes over the past two months. All calls were monitored for an appropriate call back time; this could take up to 72 hours.

   - Staff recruitment would commence in June, with a 3 to 4 month training period to prepare them for the peak time. It was difficult to predict when the flu season would start.

   - A HR advisor was helping to tackle staff absences and deal with them appropriately.

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

5. Mr Newman 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.

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 by the end of September 2015. In order to allow CCGs to consider and respond appropriately to these revised service standards, NHS England has written to CCGs to ask that procurement activity be paused until after the service standards are released.

The current contract with DHU runs until March 2016, a competitive procurement process has been initiated by the CCGs but in light of the letter from NHS England, the CCGs are considering extending the contract with DHU.

In her role as NHS 111 Clinical Lead for Nottinghamshire, Dr Christine Johnson has been heavily involved in helping to shape the new service standards for the NHS 111 service.

2. Performance

2.1 CALL ANSWERING

The update to the Overview and Scrutiny Committee in March identified that the performance of the NHS 111 Service for Nottinghamshire on the proportion of calls answered in 60 seconds was of particular concern. Between April and December 2014, the target for 95% of calls to be answered in 60 seconds had only been met in one month and performance had fallen below 90% in 5 out of 9 months.

Performance in 2015-16 has improved although the target is still not being consistently met. In the first 4 months of the year, the target was only met in May but performance has been above 90% in every month thus far with performance at DHU in May and June being better than the national average for the first time in a year.

The other main call answering standard is that no more than 5% of calls should be abandoned. In the first four months 15-16, the percentage of abandoned calls has not been above 1% and performance has been consistently better than the national average.

2.2 DISPOSITIONS

In the first 3 months of the year, the proportion of callers being advised to attend an emergency department or been sent an emergency ambulance has been broadly in line with the national average; with fewer emergency ambulance dispositions and more emergency department dispositions.

2.3 CALL BACKS

Ideally, where patients need to speak to a nurse within the NHS 111 service they will be warm transferred to a nurse (i.e. during the same phone call). The number of people that nurses at DHU have to call back and the timeliness with which call backs are made remains a concern. The CCGs and DHU have agreed a new process around the prioritisation of callers that need to speak to a nurse to ensure that capacity is protected for those callers with the most urgent needs.

In the first 3 months of 2015-16, around 40% of callers who need to speak to a nurse have had the call warm transferred each month and a further 35% have received a call back within 10 minutes. The average wait for a call back from a nurse is around 40 minutes, although this does vary from week to week.

3. Quality and Patient Experience

A copy of the most results of the most recent patient experience survey is attached at Appendix 1 and the levels of patient satisfaction and compliance with the advice given by the NHS 111 service is very similar to that previously reported:

- 96% of callers reported that they followed some (8%) or all (88%) of the advice from NHS 111
- 86% of callers were fairly (21%) or very (65%) satisfied with the service
- 35% of callers said they would have gone to A&E or called 999 if they hadn't contacted NHS 111

Stewart Newman
Head of Urgent Care
NHS Nottingham City

Dr Christine Johnson
NHS 111 Clinical Lead
NHS Nottingham City

Private and Confidential

Mr Tom Oxley
Nottingham NHS 111
PA to Director of Nursing and Quality
Derbyshire Health United
Ashgate Manor
Ashgate Road
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NHS 111 Service Satisfaction Questionnaire Report

Nottingham NHS 111

October 2014 - March 2015

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Mr Tom Oxley
Nottingham NHS 111
PA to Director of Nursing and Quality
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S40 4AA

19 May 2015

Dear Mr Oxley

Please find enclosed your NHS 111 Service Satisfaction Questionnaire report outlining the feedback obtained from patients using this service.

This report details results obtained from 160 patients in October 2014 - March 2015.

The results have been illustrated in tables; associated benchmarks and performance bands, where applicable, will be displayed when sufficient data has been collated to make the information reliable and meaningful. Supporting documents have been provided to help you with the interpretation and understanding of your results.

In order to enable us to improve our services we would be grateful if you could complete a feedback form using the following link: http://www.cfepsurveys.co.uk/questionnaires/feedback/default.aspx?psid=178838

Please contact the office on 0845 5197493 or reports@cfepsurveys.co.uk if you require further information about your results. I hope this report gives you useful feedback about how patients rated your organisation and service, and provides a good basis for reflection.

Yours sincerely

CFEP UK Reports Team

NHS 111 Service Satisfaction Report

Number surveyed: 160

This survey was designed to give you an insight into how your NHS 111 service is viewed by your patients. The report outlines the information that has been collected and analysed from patients using your service in the form of tables. Explanation on how to interpret this information can be found in the report. Benchmarks are provided where applicable. From the report you will be able to clearly pinpoint areas where you performed well and also those areas where you feel that improvements may be needed.

Details of your survey

Data for this survey was collated in May 2015, for October 2014 - March 2015. 650 patient questionnaires were sent out and 162 questionnaires were returned giving a response rate of 25%. Of the returned questionnaires 160 were successfully completed and the data incorporated into this report (see table below).

Designation of questionnaires sent out	Number of questionnaires
Returned questionnaires	
Questionnaire blank	2
Successfully completed by patient	160
Unreturned questionnaires	
Unreturned questionnaires	488
Total number of questionnaires	650

NHS 111 Service Satisfaction Report

Number surveyed: 160

Your use of the NHS 111 service

	Number of Responses	% of Responses
Q1 Did you call the service yourself		
Yes, I called it myself	124	78%
No, someone called it on my behalf	36	23%
Blank	0	0%
Q2 How did you first hear about NHS 111		
My GP, nurse or other doctor	42	26%
Family or friend	33	21%
Leaflet through my door	3	2%
Poster	12	8%
Local TV/Radio/Newspaper	23	14%
National TV/Radio/Newspaper/Internet	34	21%
Blank	13	8%
Q3 How did you get through to the service		
Dialled 111	134	84%
Called GP surgery and diverted to 111	5	3%
Called GP surgery and message told me to call 111	12	8%
Do not remember	1	1%
Called another service and message told me to call	2	1%
Other	3	2%
Blank	3	2%
Q4 How many times did you call before you got through to the 111 call advisor		
First time	147	92%
Second time	5	3%
Over 2 calls to get through	3	2%
Don't remember	4	3%
Blank	1	1%
Q5 Did you follow all of the advice given to you by the 111 service		
Yes, all of it	141	88%
Some of it	13	8%
Did not follow any of the advice	5	3%
Blank	1	1%

Percentages may not add up to 100% due to rounding.

Satisfaction and recommendation

	Number of Responses	% of Responses
Q6 Overall, how satisfied were you with the 111 experience?		
Very satisfied	104	65%
Fairly satisfied	33	21%
Neither satisfied nor dissatisfied	7	4%
Dissatisfied	14	9%
Blank	2	1%

Percentages may not add up to 100% due to rounding.

NHS 111 Service Satisfaction Report

Number surveyed: 160

Your recommendation

Table 1: Your recommendation

	Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know	Blank
Q7 How likely is it that you would recommend the 111 service to your friends and family	99	41	5	3	9	2	1

Table 2: Scores and benchmarks

	Your score (%)	Benchmark data (%)				
		Min	Lower Quartile	Median	Upper Quartile	Max
Q7 How likely is it that you would recommend the 111 service to your friends and family	52	-	-	-	-	-

- benchmark data not available
-- score not provided
See score explanation for score calculation and quartile information.

Median or 'middle' value: the numerical value cutting the data in half – above and below this value lies the highest and lowest 50% of scores of all benchmarked doctors respectfully.

Details of score calculation for Q7

Q7 is the 'Net Promoter' question which originated in the US as a customer loyalty metric and has been widely used in industry. More recently it has been suggested for use in the NHS, to measure patient satisfaction through a simple recommendation question (Q7).

In essence, if you highly recommend then you are classified as a Promoter, if you don't, you are a Detractor. Good firms have more Promoters than Detractors.

It is scored as follows (for a 5 point Net Promoter question), please note blank responses are not included in the score calculation:

"How likely is it that you would recommend this service to friends and family?"

Question descriptors	Number of responses	Criteria category for scoring*
Extremely Likely	99	Promoters
Likely	41	Passive
Neither likely nor unlikely, Unlikely, Extremely unlikely	17	Detractors
Blank (blank, defaced or multiple option selection) and Don't know	3	

The percentage of Detractors should be then subtracted from the percentage of Promoters to obtain a Net Promoter Score. This score will fall between -100 and +100. Your score = 52%

* Original NHS guidance, which was adhered to in our reports, indicated that the 'don't know' option should be incorporated in the score calculation forming part of the percentage of detractors in the calculation, whereas in more recent NHS guidance it is indicated that this choice option should not be included in the score calculation and this is now reflected in our reports.

NHS 111 Service Satisfaction Report

Number surveyed: 160

After you used the NHS 111 service

	Number of Responses	% of Responses
Q8 During the five days AFTER your call did you get in touch with any health service about the same problem		
No	70	44%
Yes	86	54%
Blank	4	3%
Q9 What was the first service you got in touch with after calling NHS 111		
999 Ambulance Service	8	5%
A&E Department	9	6%
A Primary Care Service	58	36%
Other	13	8%
Blank	72	45%
Q10 One week after your 111 call, how was the problem		
Completely better	48	30%
Improved	76	48%
The same	25	16%
Worse	6	4%
Blank	5	3%
Q11 Who else would you have tried if the NHS 111 service had not been available		
999 Ambulance	19	12%
A&E Department	37	23%
A Primary Care Service	82	51%
Other	4	3%
Would not have contacted anyone else	10	6%
Does not apply, did not call 111 directly	1	1%
Blank	7	4%

Percentages may not add up to 100% due to rounding.

NHS 111 Service Satisfaction Report

Number surveyed: 160

Your patient demographics

	Number of Responses	% of Responses
Q13 Gender		
Female	91	57%
Male	68	43%
Blank	1	1%
Q14 How old are you in years		
0 - 15	34	21%
16 - 35	30	19%
36 - 55	38	24%
56 - 75	50	31%
76+	6	4%
Blank	2	1%
Q15 Which ethnic group do you belong to		
White	136	85%
Black or Black British	3	2%
Asian or Asian British	11	7%
Mixed	4	3%
Chinese or other ethnic group	1	1%
Prefer not to say	4	3%
Blank	1	1%
Q16 Do you have any long-term illness, health problem or disability which limites your daily activities or the work you can do		
Yes	43	27%
No	113	71%
Don't know	3	2%
Blank	1	1%
Q17 Happy to be contacted		
Yes	80	50%
Blank	80	50%

Percentages may not add up to 100% due to rounding.

Your patient comments

From the free text component of the questionnaire.

Associated patient call number has been displayed to the left of provided comment. Call numbers listed in bold refer to patients who are happy to be contacted by the out of hours provider regarding their concerns or ideas.

Comments

10240	Not really the support from all including the 111 receptionist and all who contributed to my care and well being were excellent even after care surgery etc all to a very high standard that goes for cleanliness, and the food was top notch.
10803	All I wanted was a repeat prescription for a reoccuring condition. I know what was wrong with me and needed antibiotics. Could not get any from you, had to wait 24 hours for doctor, got worse in that time.
10996	Everything.
11342	Do not repeat questions already asked. Be more flexible, not all answers are yes/no.
11664	111 is slow, should not need a second opinion and the advice given (to get a friend to take me to Kings Mill A&E) was what we were going to do anyway.
11738	My only issue was the length of time between my initial phone call and the call back to offer advice. This would not have particularly given me reason for concern if the original contact reassured me my case was not a priority as I had followed all correct procedures.
11745	Some silly questions asked.
11872	I don't think it is always sufficient to speak to a call advisor or nurse. I called once and spoke to a call advisor, then a nurse who said the problem could wait. I was worried, we called back 111 the same day. They said it couldn't wait and got us appointment with emergency service doctor - who agreed and wrote a prescription.
11949	Sometimes after talking to the 111 advisor they ask you to wait for the call back and few times it took ages for call from doctor and they call on land line number we cannot attend other important call in between. You should save an option for mobile calling as well.
12332	I found 111 very helpful as medical problems go that service was good.
12770	The operator was calm, pleasant and efficient, they arranged for a nurse to call me back who then arranged for a vehicle to collect me and take me to a treatment centre. I was quite ill and needed antibiotics so was glad that this was done quickly if I had left it I would've been in hospital.
13391	Very good service.
13626	Excellent. Easy to understand. My problem was I stuck my fingers together the night before, I couldn't prise them apart. Maybe on first contact they could have advised me who I could ask about this problem, as it was really minor, instead of wasting their time ringing back. I just made problem worse using wrong products to try to loosen glue.
13692	I liked the staff because they were so polite and friendly.
16319	I am happy to the service, it is good thanks.
16470	Questions takes too long - need to have questions that can identify urgent medical needs. I won't dial 111 again, I'll just go to walk in centre or casualty.
21525	Pleasantly surprised to speak to a doctor. I just needed advice on lower back pain.
23374	Not to wait for two hours for a call back from the doctor.
23620	Doctors should be available for telephone consultations.
24060	All worked well as a system!
29562	Really good service. I rang to request a call-out doctor as the GP would not send one - they were also unable to send one. Maybe have emergency call-out doctors for urgent issues that are not 999 but need treatment (this is more of an issue with the GP than 111).
30506	I liked how well the doctor explained everything to me and told me what I should do next.
30957	No, I think they do a very good job, very satisfied with my contact with them.
31222	Do not mislead or lie to satisfy caller with problem. Sent to walk in centre, was full and closed, was told had to be dealt with within 6 hours, 24 hours later got treatment.
31476	I got an unnecessary deep root canal filling because neither GP or dentist could identify what was causing the lump in my gum. It is still there.
31607	Waiting time is too much.

Your patient comments

From the free text component of the questionnaire.

Associated patient call number has been displayed to the left of provided comment. Call numbers listed in bold refer to patients who are happy to be contacted by the out of hours provider regarding their concerns or ideas.

Comments

31628	Nice, calm and personable manner of the adviser who answered my call. I felt reassured and thought he did a really good job.
32436	Consideration of OOH GP service. Previously when I called NHS Direct we were sent to NEMS, on contacting 111 an ambulance was called, I believe a GP could have resolved issue.
32657	I am slightly worried I "misused" 111 due to our discussions with others who felt 111 was a "last resort" after walk in/GP etc. My understanding was that 111 was to advise the best pathway (or reassure no action necessary) so perhaps an indication that I either used the service appropriately or not would be welcome.
32687	Extremely kind and full of empathy and advice with problem.
34680	Did not like the waiting for the nurse/doctor to call me back which did not happen the first time I called.
34748	Advisor was extremely friendly, clear and helpful.
34804	Very poor service at the GPs. GPs is very indifferent to online appointment bookings. Very frustrating.
35379	Was very impressed by the follow up service. Was told someone would ring back before a time and they did. Was very helpful and understanding. It's good to have someone to talk things through with when nobody seems to help.
36375	No - prompt action to answer call and speedy response with polite helpful advice - seeking professional input with quick reaction. Very satisfied with service.
42814	I would like you to improve the get back soon to the patient.
43285	Very helpful, advice helped to keep me calm etc. Arranged for doctor to call within the time they said.
43626	I did not go to the hospital like advised on the Friday night but the next morning the swelling was very bad to my eye so advised to have it checked and the doctor at Kings Mill was displeased I had been sent by 111. Said he was going to be sorting 111 out! Your service was very helpful and against your advice I did not go to the hospital Friday evening. I used an ice pack and ibuprofen advised to do to help the swelling that was getting bigger due to a blow on my head. The swelling was the size of a 50p but protruding outwards. I said if it was no better on Saturday I would go to the hospital. When I awoke I was surprised although it was my head that got the blow, my eye was all swollen, black and nearly closed. I wait til 5pm and after listening to family, friends and 111 it was best to have my head, eye checked. I went to Kings Mill, service good and fast but doctor that saw me said he was going to be sorting 111 and while I was there he then said now you're here I had better send you for an x-ray. Yes, felt I had wasted his time and yes he was displeased with your service. Today I still have bruising and the lump to my head is now the size of a garden pea. Once again thank you.
44019	The doctor I seen and staff at the walk-in centre on Station Street was brilliant.
49969	Like that it is a way to get urgent out of hours advice, without going to A&E. Took a lot of time going through all the questions at the start before being asked about your reason for calling. Some of the staff seemed to have limited knowledge of type 1 diabetes.
50722	They were extremely thorough in their questions.
50794	I contacted 111 they gave me number for two GPs to register as a temporary patient as I have recently moved to the area. I contacted both GPs to be told they do not take temporary patient. I felt lost on what to do and felt the NHS had really failed. I then contacted 111 back to told a walk in centre would call me back which they did only to be prescribed medication over the phone.
51134	The visit to the NHS GP walk in service was excellent. The conversation with 111 was scripted and the interviewee did not appear to listen, although arranged for an NHS practitioner to call me.
53709	Call back times could be shorter - it took over 2 hours for the nurse to call back.
54526	Very good.
55677	Son had temperature so respiration rate high. Phoned as concerned about temperature, advice to give temperature time to come down may have been helpful. When saw out of hours GP in morning was better. But is hard to assess over phone.
55802	Yes the waiting time. I was booked in for 12.30am and wasn't seen until 1.45am.

Your patient comments

From the free text component of the questionnaire.

Associated patient call number has been displayed to the left of provided comment. Call numbers listed in bold refer to patients who are happy to be contacted by the out of hours provider regarding their concerns or ideas.

Comments

56198	A number of the questions are not specific to my call for advice. I had mistakenly swallowed a capsule intended for inhalation via a device. I was told the drug in the capsule was not on the poison's register and this allayed my concerns.
56309	I was particularly impressed with the warm, friendly and calm professional who answered my call. Reassuring to have someone like this when you are a panicking parent. Many thanks again!
56350	The lady on the phone was so polite and sympathetic to my problem. She was so helpful and just really nice. It made the situation a lot easier. I would definitely use again/recommend it.
56351	Information requires updating on emergency dental treatment centres/surgery. Only a few from list provided would take such cases.
56377	Nothing.
56400	I think the call back time needs to be improved as I had to wait an extremely long time for the nurse to call back.
58294	Long wait but otherwise great.
58381	The waiting time from call to speak to a GP took five hours, second time four hours.
58513	The waiting room was full and very busy so we had quite a wait but this was no problem to me. All staff were vey helpful.
58788	Would have liked to have a call back sooner than they did, I was alone and had been suffering with chronic diahorrea for over two weeks and thought I was going to pass out, by the time they rang back I felt better but didn't know when I first called that it would subside. Although it was Boxing Day so I guess they were busy.
58962	After waiting 3 hours for a phone call for an appointment at the walk-in I was told they could not deal with it and to go to A&E, which I could have done a lot earlier.
59717	I know Boxing Day was very busy and with it being Christmas. It took a long time for the nurse to call me. I would have liked shorter waiting times from the first point of contact. The lady who I spoke to was lovely.
59888	Waiting times if possible but I know there's a high demand for this service. I came with back pain (spasm), after 8 days I felt I needed some strong pain relief. After diclofenac injection in my thigh I could hardly put my foot to the floor, would have preferred it in the buttocks.
60252	Sadly when we called 111, and the doctor rang me back, 11pm (ish) it was snowing so Newark OOH had been closed. I offered that maybe the best option was to just go to Newark MIU, he agreed. No appointment time was offered. When I got there the following day a nurse was kind enough to suggest we ring back to 111 to actually get an appointment time as their waiting room was full and we were looking at over 4 hour wait! Child in question is LAL! so not ideal. 6 hour call back time to then be told couldn't offer appointment time as only one doctor on. Offered Kings Mill, Mansfield. We continued on with Ibuprofen and Calpol before seeing own GP Monday am. I appreciated most people's festive time, but only one doctor on duty!!?
60728	Although I got through to 111 on my first attempt I was on hold for 20 plus minutes. I expected (was told) I would receive a call back from doctor which didn't happen until approx 3 days after. Overall happy with level of care from 111 service.
62730	They were very polite and helpful.
64149	I was in extreme pain and advised to call for an ambulance but when phoned direct told 111 should have arranged for us so had to call 111 again, go through same questions and the advisor told us the same to call ourselves we hung up and called back and advisor called one for us. First called 2pm - ambulance arrived 8am ish.
65613	Questions asked by 111 are repeated by triage nurses and doctors. Does the record transfer across?
68159	The advice was really helpful.
68768	I liked the facility very much. Staff were very good.
69490	All the questions when you are in pain.
69816	Nurse advisor very helpful and got us in to see our GP who was not as helpful. Thank you.
72033	If the person answering the call could give advice and not having to wait for a call back.

Your patient comments

From the free text component of the questionnaire.

Associated patient call number has been displayed to the left of provided comment. Call numbers listed in bold refer to patients who are happy to be contacted by the out of hours provider regarding their concerns or ideas.

Comments

72051	Instead of just looking at the computer screen they should listen more about what a patient has got to say. Was advised by 111 just to go to doctor in the morning and nothing to worry about. WAS IN HOSPITAL A WEEK WITH SEPSIS!
74714	They are good at giving advice over the phone but not good at dealing with emergencies.
75078	Not asking the list of set questions when they obviously do not apply to the caller.
76486	I rang on behalf of my daughter. It took so long for a return phone call from a nurse, roughly 2.5 hours, that my daughter had fallen asleep and I did not want to disturb her as she was exhausted. She is 9 years old! Waiting this long is not acceptable, especially for a child.
83065	I was very impressed by the friendly and calm manner of the person who answered my call and who took my problem seriously, giving me good advice and instructions as to how to proceed.
83225	Yes I was treated very well with both people that came. They thought I'd broke my ankle, did some checks then called an ambulance for me as I needed a wheel chair. Was very caring people and did all they could to help me.
84283	I got through the first time I called, however, I was on hold for about 20 minutes. Nurses who arrived were very helpful and lovely.
85547	I found the nurses very friendly and reassuring - there was a problem after an operation which I was very worried about - they were sensible and kind.
85671	Questions felt they were being read off a screen and, (as the person said) most of them were totally irrelevant/inappropriate.
86052	I was made to feel as though I was the only person they had to look after that evening. Fantastic service!
87135	I liked being given an immediate appointment to see the nurse I spoke to at Newark Hospital so she could discuss my asthma symptoms face to face.
87275	All good.
87537	The contact service is fine. It is at the walk in service that needs evaluating. The day I called I was seen by a nurse practitioner who did not diagnose me at all. I had to call back 10 hours later when my condition got worse to see a doctor. I am aware of all current day problems but nurses are not doctors.
87893	I thought it was very good, most thorough, very well presented.
87915	It took an hour for a nurse to call me back. I was at a friends and had to leave so rang and gave a new contact number to get me on, but they rang my friends number again.
88409	Very efficient. Well done.
98340	Nothing.
98353	The lady I spoke to was so reassuring as I was calling about my toddler and was feeling quite upset. She gave some really good advice.
98447	Very condescending staff on phones.

Consent to use your information or to contact you for additional information

List of patients that are happy to be contacted

10104	49508
10803	50794
10807	51134
11271	54055
11664	54526
11738	55802
11872	56198
11949	56351
12770	56377
13391	58513
13626	58788
13636	59717
13692	59888
13756	60728
14689	62705
17067	62730
21525	65613
23620	69816
29502	72033
29562	72051
30497	72143
31222	72178
31476	74714
31557	76486
31607	77913
31628	77926
31828	83065
32436	83100
32456	83225
32584	84004
32657	87135
32687	87275
34717	87351
34815	87537
34886	87893
42814	87915
43285	98353
43385	98388
43626	98457
43628	
44019	

Supporting documents

NHS111 Service Satisfaction Questionnaire

00000-00000

Example

- Please help us find out how well the NHS 111 service is working and to improve healthcare provided
- Answer the questions as honestly as you can
- If someone else called the service on your behalf, please ask then to help you fill out this questionnaire

Please mark the box like this ☒ with a blue or black ball-point pen. If you change your mind just cross out your old response and make your new choice.

1 Did you call the service yourself? **(please select one box only)**

☐ Yes, I called myself ☐ No, someone called it on my behalf

If you did not call this service yourself please discuss questions 2 – 4 with the person who called the service

2 How did you first hear about NHS 111? **(please select one box only)**

☐ My GP, nurse or other doctor ☐ Family or friend ☐ Leaflet through my door

☐ Poster ☐ Local TV/Radio/Newspaper ☐ National TV/Radio/ Newspaper/Internet

3 How did you get through to the service? **(please select one box only)**

☐ I dialed 111 ☐ I called a GP surgery and was diverted to the 111 service

☐ I called a GP surgery and a message told me to call the 111 service ☐ I do not remember how I got through

☐ I called another service and a message told me to call the 111 service ☐ Other

4 How many times did you call before you got through to the 111 call advisor? **(please select one box only)**

☐ I got through the first time I called ☐ I got through the second time I called

☐ It took over 2 calls to get through ☐ I do not remember how many times I called

5 Did you follow all of the advice given to you by the 111 service? **(please select one box only)**

☐ Yes, all of it ☐ I followed some of it ☐ No, I did not follow any of the advice

6 Overall, how satisfied were you with the 111 experience? **(please select one box only)**	Very satisfied	Fairly satisfied	Neither satisfied nor dissatisfied	Dissatisfied
	☐	☐	☐	☐

7 How likely are you to recommend this 111 service to friends and family if they needed similar care or treatment? **(please select one box only)**

Extremely likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know
☐	☐	☐	☐	☐	☐

Please turn over ⮌

1 2 3 A

cfep UK Surveys

B ☐ D ☐ M ☐ U ☐

8 During the five days AFTER your call did you get in touch with any health service about the same problem? (this includes services that the 111 service told you to contact, or contacted on your behalf)

☐ No → **Please move to Q10** ☐ Yes → **Please move to Q9**

9 What was the first service you got in touch with after calling NHS 111? **(please select one box only)**

☐ 999 Ambulance service
☐ Accident and Emergency department
☐ Minor Injuries Unit/Urgent Care Centre/Walk-in Centre/GP/Nurse/Chemist (pharmacist)
☐ Other

10 One week after your 111 call, how was the problem? **(please select one box only)**

☐ Completely better ☐ Improved ☐ The same ☐ Worse

11 Who else would you have tried if the NHS 111 service had not been available? **(please select one box only)**

☐ Dialed 999 for an Ambulance
☐ Used Accident and Emergency department
☐ Minor Injuries Unit/Urgent Care Centre/Walk-in Centre/GP/Nurse/Chemist (pharmacist)
☐ Other
☐ No, I would not have contacted anyone else
☐ This question does not apply as I did not call 111 directly

12 Is there anything you particularly liked or think could be improved about the 111 service?

The following questions about the patient provide us with general information about the range of people who have responded to this survey

13 Are you? ☐ Female ☐ Male

14 How old are you in years?

☐ 0 – 15 ☐ 16 – 35 ☐ 36 – 55 ☐ 56 – 75 ☐ 76+

15 Which ethnic group do you belong to?

☐ White
☐ Black or Black British
☐ Asian or Asian British
☐ Mixed
☐ Chinese or other ethnic group
☐ Prefer not to say

16 Do you have a long-term illness, health problem or disability which limits your daily activities or the work you can do?

☐ Yes ☐ No ☐ Don't know

☐ Please select this box if you are happy for the NHS 111 provider to contact you, should they wish to find out more about your concerns or ideas.

Thank you for your time and assistance

1 2 3 0

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Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

15 September 2015

Agenda Item: X

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

EAST MIDLANDS AMBULANCE SERVICE – NEW STRATEGIES UPDATE

Purpose of the Report

1. To provide the information the implementation of a range of new strategies by the East Midlands Ambulance Service.

Information and Advice

2. The East Midlands Ambulance Service is currently implemented various strategies to improve safety and patient experience. Updates on the implementation of the new strategies can be found as an appendix to this report.

3. Members may wish to raise the following issues: the operation of the Voluntary and Community Organisations (VCOs), how their membership will be refreshed over time and how outcomes from their activities will be reported to this committee. In addition, what issues are faced by EMAS when it comes to recruitment? Does EMAS test ambition when recruiting at emergency care assistant level? Regarding the expansion of the EMAS Fleet, what factors are taken into consideration by the NHS Trust Development Authority when considering whether or not to award a loan?

4. The committee has a longstanding interest in the rationalisation of the EMAS estate. Members will see that this briefing from EMAS does not contain an update on Estate Strategy. The committee may wish to ask when it will be possible to schedule consideration of such a briefing.

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

East Midlands Ambulance Service Trust Board Meeting Paper PB/15/171: Fleet Replacement Programme Full Business Case (28 July 2015).

Electoral Division(s) and Member(s) Affected

All

Better Patient Care – moving on in our plans

At our Trust Board meeting on 31 March they approved a number of key strategies. These will help us achieve our long term plans to give people in the East Midlands the best quality care.

Clinical and Quality Strategy

This strategy details our approach to develop our patient services ensuring that safe and effective alternatives are available when clinically appropriate. It supports our work to deliver national clinical priorities including: emergency and urgent care, mental health, the frail elderly, long-term conditions, end of life care and public health and prevention.

A Listening and Engagement Event was held on 13 April 2015 represents another stone in the laying of a strong foundation for our patient and public involvement. Activities of the day included the inaugural meeting of the EMAS Patient Voice. The meeting, chaired by our Director of Nursing and Quality also witnessed the appointment of a patient representative as Vice Chair

It is vitally important that opportunities to involve patients and public are not limited to areas in and around Nottingham, being EMAS head office. EMAS next steps are to have a good geographical spread across its 5 counties to making PPI activities fair and representative. To this end, EMAS will be setting up county-based regional arms of the Trust-wide EMAS Patient Voice. One representative, ideally the Chair of each of the county-based branches will have an automatic seat on the Trust-wide body.

EMAS will be setting up a network of voluntary and community organisations (VCOs), selected to represent 'Protected Characteristics' as defined in the Equality Act 2010. The network will include VCOs championing support for the disabled, older/younger people, BME (Black and Minority Ethnic) communities and LGBT (Lesbian, Gay, Bisexual and Transgender), among others. The aim is to have 10 groups in each of EMAS five counties, with the VCOs supporting the setting up of the county based branches of EMAS Patient Voice.

Our People

Our workforce is vital to us being able to provide the very best patient care and we plan to invest further in the recruitment and development of colleagues to support our long-term vision.

Our employment target for Nottinghamshire division is 473 wte and it is in target to achieve this by November, the agreed completion date.

Our educational programme will see us continue to provide career progression routes for new and current emergency care assistants who want to train to become

an ambulance technician or paramedic.

Workforce Recruitment and Education Plan 2015/2016: Position at the end of June 2015:
- 34 Trainee Technicians Planned v. 34 Actual
- 6 ECA Planned v. 5 Actual
- 12 ECA to Technician Planned v. 12 Actual
This is based upon numbers of new staff recruited and confirmed on courses commencing between July and August 2015

Colleagues who 'go that extra mile' will continue to be recognised and rewarded through formal Awards and Chief Executive Commendations.

To be awarded, a person/team needs to have gone above and beyond in their role(s) to ensure that our patients and/or staff feel safe, have received excellent care and are valued.

The winners of the Chief Executive Commendation award for the period 1 January to 31 March 2015 were announced April 2015 which included winners from Nottinghamshire stations and Nottingham Emergency Operations Centre.

Long service and retirement schemes continue to be key to good morale and helps the retention of colleagues at EMAS.

Fleet Services (vehicles) Strategy

We provide treatment and care at the scene of incidents and in our emergency vehicles. At the end of their shift, our crews go home and rest before their next shift; but that's not the case for our vehicles, with the majority being out on the road 24/7.

Despite the financial challenges faced by the NHS, it is vital that we invest in our fleet and this strategy includes a programme which will see us drive down the age profile of our fleet to seven years by the end of the 2018/19 financial year (some existing vehicles are more than 10 years old).

The Trust Board is currently in the process of applying for a loan from NHS Trust Development Authority to implement a major fleet replacement programme which will enable the purchase of 337 new ambulances over the next four years at a cost of £33.2m and increase the overall fleet size to 600 vehicles at the end of this strategic planning period (31 March 2019)

A copy of this document can be found on our website here.

In the meantime Nottinghamshire Division receiving their new 7 Doubled Crewed Ambulances and 1 Fast Response Vehicles.

We have extended current workshop hours.

Information Management and Technology (IM&T) Strategy

Currently no update to report

Estate Strategy

Currently no update to report

Trust Board meeting

Our Trust Board meeting begins at 9:15am on Tuesday 25 August at our HART Building Unit 1 Hamilton Place Hamilton Way Mansfield Nottinghamshire NG18 5BU. This meeting will include a Locality Plan presentation by Greg Cox, General Manager of Nottinghamshire Division.

We plan, as with previous meetings, to promote discussion and decisions made via our Twitter account @EMASNHSTrust using the hashtag #EMASLive

In the meantime, you can access the Board meeting papers and full venue address by visiting our website at http://www.emas.nhs.uk/about-us/trust-board/

EMAS Communications Keeping you and the public informed about all things 'EMAS'

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JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
15 SEPTEMBER 2015
WORK PROGRAMME
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

1. Purpose

1.1 To consider the Committee's work programme for 2015/16, based on areas of work identified by the Committee at previous meetings and any further suggestions raised at this meeting.

2. Action required

2.1 The Committee is asked to note the work that is currently planned for municipal year 2015/16 and make amendments to this plan if considered appropriate.

3. Background information

3.1 The Joint City and County Health Scrutiny Committee is responsible for setting and managing its own work programme to fulfil its role in relation to health services accessed by both City and County residents, including:

- scrutinising the commissioning and delivery of local health services
- holding local decision makers to account
- carrying out the statutory role in relation to proposals for substantial developments or variations in NHS funded services
- responding to consultations from local health service commissioners and providers.

The detailed terms of reference for the Committee can be found in the respective Council Constitutions.

3.2 In setting a programme for scrutiny activity, the Committee should aim for an outcome-focused work programme that has clear priorities and a clear link to its roles and responsibilities as outlined above. The work programme needs to be flexible so that issues which arise as the year progresses can be considered appropriately. This is likely to include consultations from health service commissioners and providers about substantial variations and developments in health services that the Committee has statutory responsibilities in relation to.

3.3 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning. Changes and/or

additions to the work programme will need to take account of the resources available to the Committee.

3.4 The work programme for the coming municipal year is attached at Appendix 1, based on areas of work identified by the Committee at previous meetings and suggestions already put forward by Councillors. Councillors are asked to put forward any other possible suggestions of issues for scrutiny.

4. List of attached information

4.1 The following information can be found in the appendix to this report:

Appendix 1 – Joint Health Scrutiny Committee 2015/16 Work Programme

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Reports to and Minutes of Joint Health Scrutiny Committee meetings held on 10 June, 15 July, 9 September, 7 October, and 9 December 2014, 13 January, 10 February, 10 March, 21 April 2015, 16 June and 14 July 2015.

7. Wards affected

All

8. Contact information

Clare Routledge, Health Scrutiny Project Lead
Tel: 0115 8763514
Email: clare.routledge@nottinghamcity.gov.uk

APPENDIX 1

Joint Health Scrutiny Committee 2015/16 Provisional Work Programme

16 June 2015	• **NUH Pharmacy Information** To receive information as part of an ongoing review (Nottingham University Hospitals) • **South Notts Transformation Partnership** To receive information relating to the establishment, remit and work plan of the Partnership (South Notts Transformation Partnership) • **Proposed Transitional Changes Within Nottinghamshire Healthcare Trust Adult Mental Health Service For 2015/16** (Nottinghamshire Healthcare Trust) • **Independent Review of Nottingham Dermatology Services 2015** To receive the report following the independent review (Nottingham Dermatology Services Independent Review Team) • **Work Programme** To consider the provisional 2015/16 Work Programme
14 July 2015	• **Transformation Plans for Children and Young People** To receive an update on the preferred site (Nottinghamshire Healthcare Trust) • **Public Consultation regarding Gluten free Prescribing** (Rushcliffe CCG)

	• **Changes in Adult Mental Health Care Provision in Nottingham City and County** To receive the latest update on the changes (Nottinghamshire Healthcare Trust) • **Healthwatch – Renal Patient Transport Review** To receive an update on addressing the findings of the Report produced in March 2015 (Healthwatch Nottinghamshire and Arriva Transport Solutions) • **Work Programme** To consider the 2015/16 Work Programme
15 September 2015	• **Nottingham City Council – JHSC Delegation Change Regarding Urgent Referrals to the Secretary of State** • **Outcomes of the Primary Care Access Challenge Fund Pilots** Evaluation of Results (South Nottinghamshire CCGs and Area Team) • **Patient Transport Service – Performance Update** (Arriva /CCG lead) • **NHS 111 Performance Update** (Nottingham City CCG) • **East Midlands Ambulance Service – New Strategies Update** Update on the implementation of new Strategies (EMAS) • **Work Programme** To consider the 2015/16 Work Programme

13 October 2015	• **Urgent Care Resilience Programme 2015/16** To receive an update on the preparation and planning for Winter 2015/16 (Nottingham City CCG and NUH) • **Rampton Secure Hospital Variations of Service** To receive an update on treatment and care of people with personality disorders (NHS England and Nottinghamshire Healthcare Trust)
10 November 2015	• **NUH Environment and Waste Update** To receive the latest update (NUH) • **Long Term NUH Strategy (5 years and beyond)** To receive a presentation (NUH) • **East Midlands Senate Briefing** • **South Notts Transformation Partnership** To receive an update on the SNTP developments (South Notts Transformation Partnership)
15 December 2015	• **Royal College of Nursing** Further briefing on the issues faced by nurses (RCN) • **Long Term Conditions (including Neurology)** • **Update on Transitional Changes Within Nottinghamshire Healthcare Trust Adult Mental Health Service For 2015/16** To receive the latest update (Nottinghamshire Healthcare Trust)

12 January 2016	• **Changes in Adult Mental Health Care Provision in Nottingham City and County** To receive the latest update on the changes (Nottinghamshire Healthcare Trust) • **Child Immunisation** To receive information relating to performance and impact of Child Immunisation (Public Health) • **NHS and Adult Social Care Workforce Challenges**
9 February 2016	
15 March 2016	
19 April 2016	

To schedule:

Dermatology Action Plan
Feedback on Gluten Free prescribing consultation
Feedback on Transformation of Children and Young People Services Business Case NHCT Trust Board decision
Healthwatch – Renal Patient Transport Review Autumn follow up
NHS England Area Team and Quality Surveillance Groups
End of Life Care
Nottingham University Hospital Maternity and Bereavement Services
NHS Out of Hours Dental Services
Daybrook Dental Services Report of findings and lessons learnt
Progress on developing 24hour services

Visits:

Urgent and Emergency Care Services
Rampton Secure Hospital

Study groups

Quality Accounts