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Agenda

Health and Social Care Scrutiny Board (5)

Time and Date
2.00 pm on Wednesday, 24th July, 2013

Place
Committee Room 2 and 3, Council House, Earl Street, Coventry

Public Business

1. **Apologies and Substitutions**

2. **Declarations of Interest**

3. **Minutes** (Pages 5 - 8)

   (a) To agree the minutes of the meeting held on 19th June, 2013

   (b) Matters Arising

4. **Urgent and Out of Hours Care** (Pages 9 - 48)

   Briefing Note of the Scrutiny Co-ordinator

   Presentations on **A and E Attendance and Performance; NHS 111; Walk-in Centre; and GP Out of Hours Service** by representatives from the following organisations:

   (a) University Hospital Coventry and Warwickshire

2.40 p.m.

   (b) Coventry and Rugby Clinical Commissioning Group

3.00 p.m.

   (c) The Local Area Team

3.20 p.m.

   (d) General Discussion and Findings

3.40 p.m.

5. **Briefing on a Proposed Contract Merger (Dr Jagadeshwari and Dr Ezzat and Partners)** (Pages 49 - 50)

   Briefing Note of Contracts Manager, Arden, Herefordshire and Worcestershire Area Team

3.50 p.m.

6. **Outstanding Issues Report**

   Outstanding issues have been picked up in the Work Programme

7. **Work Programme 2013-14** (Pages 51 - 56)

   Report of the Scrutiny Co-ordinator

4.00 p.m.

8. **Any other items of Public Business**

   Any other items of public business which the Chair decides to take as matters of urgency because of the special circumstances involved

9. **Meeting Evaluation**

Private Business
Nil

Bev Messinger, Director of Customer and Workforce Services, Council House Coventry

Tuesday, 16 July 2013

Notes: 1) The person to contact about the agenda and documents for this meeting is Liz Knight, Governance Services, Council House, Coventry, telephone 7683 3073, alternatively information about this meeting can be obtained from the following web link: http://moderngov.coventry.gov.uk

2) Council Members who are not able to attend the meeting should notify Liz Knight as soon as possible and no later than 1.00 p.m. on 24th July, 2013 giving their reasons for absence and the name of the Council Member (if any) who will be attending the meeting as their substitute.

3) Scrutiny Board Members who have an interest in any report to this meeting, but who are not Members of this Scrutiny Board, have been invited to notify the Chair by 12 noon on the day before the meeting that they wish to speak on a particular item. The Member must indicate to the Chair their reason for wishing to speak and the issue(s) they wish to raise.

Membership: Councillors M Ali, K Caan (By Invitation), J Clifford, C Fletcher, A Gingell (By Invitation), P Hetherton, J Mutton, H Noonan, H S Sehmi, D Spurgeon (Co-opted Member), S Thomas (Chair) and A Williams

Please note: a hearing loop is available in the committee rooms

If you require a British Sign Language interpreter for this meeting OR it you would like this information in another format or language please contact us.

Liz Knight
Telephone: (024) 7683 3073
e-mail: liz.knight@coventry.gov.uk

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Minutes of the Meeting of the Health and Social Care Scrutiny Board (5) held at 2.30 p.m. on 19th June, 2013

Present:

Board Members:	Councillor Thomas (Chair) Councillor Clifford Councillor Mrs Fletcher Councillor Hetherton Councillor J Mutton Councillor Noonan Councillor Sehmi
Co-opted Member:	Mr D Spurgeon
Cabinet Member:	Councillor Gingell
Employees (by Directorate):	
Chief Executive's:	P Barnett, J Moore (Director), Dr D Todkill
Community Services:	E Bates, S Brake, M Enderby, B Walsh (Director)
Customer & Workforce Services:	L Knight
Other representatives :	Dr A Banerjee Sarah Bank – Coventry and Warwickshire Partnership Trust (CWPT) A Hardy - University Hospital Coventry and Warwickshire (UHCW) P Masters - CWPT P Short – UHCW T Wrench - CWPT R Yeabsley – NHS England
Apology:	Councillor Ali

1. **Declarations of Interest**

There were no declarations of Interest

2. **Minutes**

The minutes of the meeting of the Health, Social Care and Welfare Reform Scrutiny Board (5) held on 1st May, 2013 were signed as a true record. There were no matters arising.

3. **Quality Accounts 2012-2013**

The Scrutiny Board considered a briefing note of the Scrutiny Co-ordinator which introduced the Board to the 2012-2013 Quality Accounts produced by local provider NHS Trusts. The Quality Accounts for University Hospitals Coventry and Warwickshire (UHCW), Coventry and Warwickshire Partnership Trust (CWPT) and West Midlands Ambulance Service (WMAS) were set out at appendices to the note. Representatives from

UHCW and CWPT attended the meeting for the consideration of this item. Councillor Gingell, Cabinet Member (Health and Adult Services) also attended the meeting for the consideration of this issue.

The Department of Health introduced the requirement for NHS trusts to issue quality accounts in 2009. The purpose was to encourage boards and leaders of healthcare organisations to assess quality across all the healthcare services they provided and to engage in the wider processes of continuous quality improvement. They were asked to consider three aspects of quality – patient experience, safety and clinical effectiveness. The Scrutiny Board had the opportunity to provide a commentary on the local Trusts Quality Accounts. Reference was made to the joint Quality Account Working Groups involving the City Council, Warwickshire County Council and the Local Involvement Networks (LINks) which had produced prepared commentaries on the Accounts. Prior to this meeting, Members had been provided with draft responses from the City Council to the UHCW and CWPT accounts. An individual response was not being made to the Quality Account for WMAS.

Andy Hardy, Chief Executive and Peter Short, Project Manager, introduced the Quality Account for UHCW. Attention was drawn to the three main priorities for the year and to performance of the hospital in these areas:

- Patient Safety - Elimination of avoidable pressure ulcers
- Clinical Effectiveness - Effective discharge from hospital
- Patient and Staff Experience - Using real time patient feedback to effect change.

Reference was made to the implications of the Francis Report and the lessons to be learnt, a review of practice had already commenced.

Members of the Board questioned the representatives on a number of issues and responses were provided, matters raised included:

i) The encouragement given to whistleblowing
ii) How to improve effective discharges from hospital including the issue of communication
iii) The importance and monitoring of 'Making Every Contact Count'
iv) Use of wipe boards on the Wards and Information Technology
v) Increasing attendances at A and E including current performance against target and the reasons behind the recent improvement in performance
vi) The level of detail in the Quality Account.

Tracey Wrench, Director of Nursing, Sarah Bank, Assistant Director of Contracting, Performance and Information and Paul Masters, Assistant Director Governance attended for the Quality Account for CWPT. The quality strategy for the Trust focused on patient safety, effectiveness of care and patient experience. The account described how the Trust had continued to develop over the previous year including reviewing quality performance and delivering quality improvements. The quality priorities for 2013-14 were outlined which had been developed following consultation with patients, staff, members of the public and stakeholders.

Members of the Board questioned the representatives on a number of issues and responses were provided, matters raised included:

i) A lack of information on outcomes and examples

ii) The development of the quality goals
iii) The support given to patients with dementia or mental health issues (including people in prison) and the help given to their families
iv) The potential for funding to provide Admiral nurses who work with family carers and people with dementia in the community and other settings
v) How the decision to defer the foundation status application by six months reflects on the Quality Account.

RESOLVED that:

(i) Authority to finalise the responses to the Quality Accounts from University Hospital Coventry and Warwickshire and Coventry and Warwickshire Partnership Trust be delegated to the Chair, Councillor Thomas, in consultation with the officers and these be submitted as a commentary to the Trusts for inclusion in the final published documents.

(ii) The Quality Account for West Midlands Ambulance Service be noted.

4. **Communicable Disease Control and Outbreak Management**

The Scrutiny Board considered two briefing notes of the Director of Public Health which provided an overview of health resilience and health protection in Coventry and informed of the background and current arrangements for the Measles, Mumps and Rubella (MMR) immunisation catch-up campaign in the city. Richard Yeabsley, NHS England and Dr Ash Banerjee and Dr D Todkill attended the meeting for the consideration of this issue. Councillor Gingell, Cabinet Member (Health and Adult Services) also attended for the consideration of this item.

Health protection and health resilience were about protecting the public from avoidable threats to their health including diseases that could be prevented through vaccination or screening programmes; man-made threats such as acts of terrorism; major incidents such as train or plane crashes; or environmental threats such as extreme weather conditions or environmental pollution. Responsibility lay was with a number of different national, regional and local organisations including different parts of the NHS and local councils. To ensure that all the parts of the system that had a responsibility worked well together, Coventry had established a Health Protection Committee, a non-statutory Committee which reported to the Health and Well-being Boards for both Coventry and Warwickshire.

In April 2013, a national catch-up programme to increase MMR vaccination uptake in children and teenagers was announced in response to a substantial national rise in the number of measles cases. The aim of the programme was for GP practices to identify and write to the parents of children aged 10 to 16 who were inadequately immunised and offer them the MMR vaccine. There was also a local communication strategy to raise awareness.

The Board were informed that Coventry had a relatively high MMR uptake compared to the rest of the region. 97.1% of two year olds were immunised compared to only 93.1% for the region as a whole and 96.4% of five year olds compared to 88.3% for the region. However, modelling suggested that there were around 5000 children aged 10 to 16 inadequately immunised and at risk. A local Measles plan had been developed. The Local Authority role included raising awareness of the campaign in schools and in some

vulnerable groups.

Members of the Board questioned the representatives on a number of issues and responses were provided, matters raised included:

i) The steps the Council had in place for getting messages out about severe weather conditions and how to react, in particular to ensure that vulnerable residents were protected
ii) The additional measures being introduced to raise awareness of the MMR immunisation catch up programme
iii) How were children of migrant families arriving in the city and children from travelling families picked up by the programme
iv) The potential for issues to arise when students arrive at Warwick University next year who have not been vaccinated and the partnership working with the university to alleviate problems
v) The potential to use the school nursing service for running campaigns/vaccinating in schools
vi) Any follow up actions if families do not respond to letters from their GP offering vaccinations
vii) Dealing with all the different communities in the city.

RESOLVED that:

(i) The Cabinet Member (Health and Adult Services) be requested to monitor the arrangements for mutual aid contacts.

(ii) Officers be requested to encourage the partnership working with Warwick University Health Centre and the GP Practices associated with the universitiy.

(iii) The results of the current Needs Assessment Survey and any subsequent recommendations concerning the needs of and contact with the different communities in the city in relation to health protection to be reported to the Cabinet Member (Health and Adult Services).

5. **Any other business**

There were no additional items of business.

(Meeting closed: 4.40 p.m.)

Briefing note

To: Health and Social Care Scrutiny Board (5) **Date: 24th July 2013.**

Subject: Urgent and Out of Hours Care

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1 Purpose of the Note

1.1 To introduce the main agenda item for this meeting of the Scrutiny Board.

2 Recommendations

2.1 The Board is recommended to note this briefing note and the attached appendices provided by NHS colleagues.

3 Information/Background

3.1 The Board has agreed that this meeting will focus on Urgent and Out of Hours care. This follows on from growing concerns about continued and sustained increases over recent years in attendance at Accident and Emergency services (A&E) provided by University Hospitals Coventry and Warwickshire (UHCW) at their University Hospital site.

3.2 Members will be aware that the A&E performance target set by the NHS nationally for NHS acute trusts (95% of patients being treated within 4 hours) has been a challenge for UHCW over recent years. This meeting will enable Member to question UHCW on their performance in meeting this target and on steps they are taking to make improvements. Over the past months performance has increased from 82% in April 2013 to 90% for G1 of 2013/14 with a high of 95.87% in June. The Board will no doubt be interested in how such an increase has been achieved and what impact if any this has had on other hospital services.

3.3 A slide presentation is attached as Appendix A. The meeting will be joined by Andy Hardy, Chief Executive, and David Eltringham, Chief Operating Officer of the Trust.

3.4 In order to provide a rounded picture of A&E services provided for Coventry patients the Coventry and Rugby Clinical Commissioning Group (CCG) has also been invited to provide its perspective as commissioners of these services. The CCG along with other Warwickshire CCGs are expected to meet the costs of A&E services therefore continued rises in attendances has a knock on effect in the wider health economy. A Briefing Note has been provided, and the meeting will be attended by Dr Steve Allen, Accountable Officer of the CCG.

3.5 Other important aspects of 'Out of Hours Care' includes services such as the Walk-In Centre (located now at the City of Coventry Health Centre in Stoney Stanton Road) and Out of Hours GP services. More recently NHS111 have been added to services available for supporting patients with care needs which may occur outside of times when services are normally open. The CCG are joint commissioners of the NHS 111 service (with other

West Midlands CCGs) and they will address their role in provision of this service in their Briefing Note.

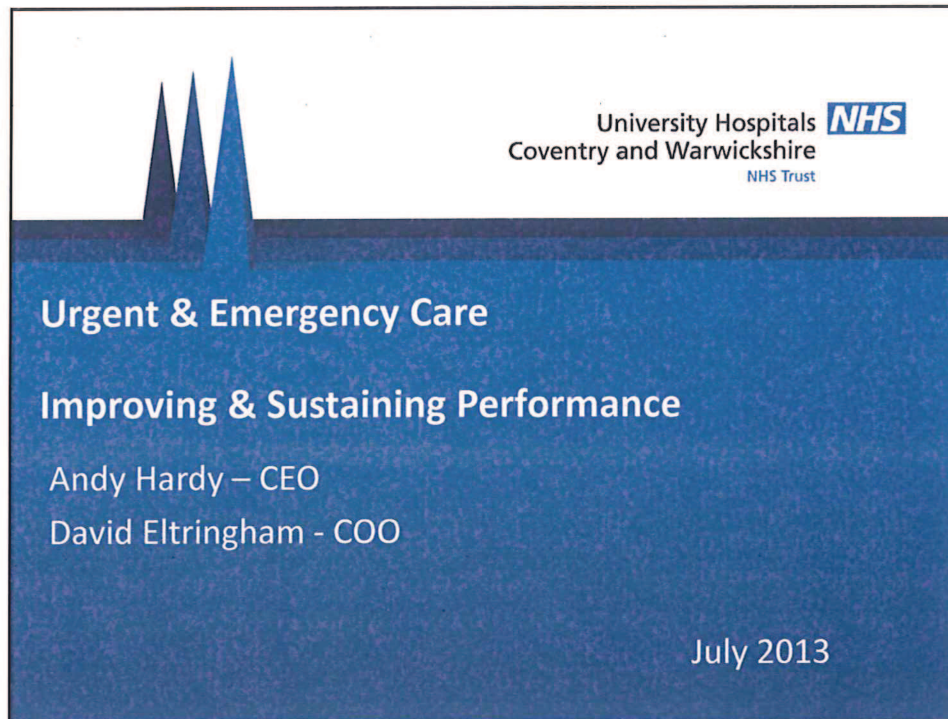
3.6 To enable Members to gain a full understanding of the services available, and how they fit together to meet the needs of Coventry patients the Board will also receive an update from NHS England and their Arden, Herefordshire and Worcestershire Team. Their role is in commissioning primary care services, as access to primary care is considered a potential factor in rising attendances at A&E. The Local Area Team also specifically commission the Walk-In Centre in Coventry as it is also a Citywide GP practice, and share responsibility with the CCG for commissioning Out of Hours GP services. Martina Ellery, Commissioning Manager for this team will attend the meeting and has provided a Briefing Note which is Appendix C.

3.7 The Board will understand that the issues under this item are complex and to an extent all of the different parts of the NHS who will be present share a role in meeting the Urgent and Out of Hours needs of Coventry patients. Attention focuses primarily on the services provided at the University Hospital site, and a lot of work has been done recently on better understanding the rise in attendances and any steps which might be potentially taken to stem this.

Briefing Note Author / Contact Details

Peter Barnett
Health Development Service Manager
Tel: 02476 831145.

16th July 2013.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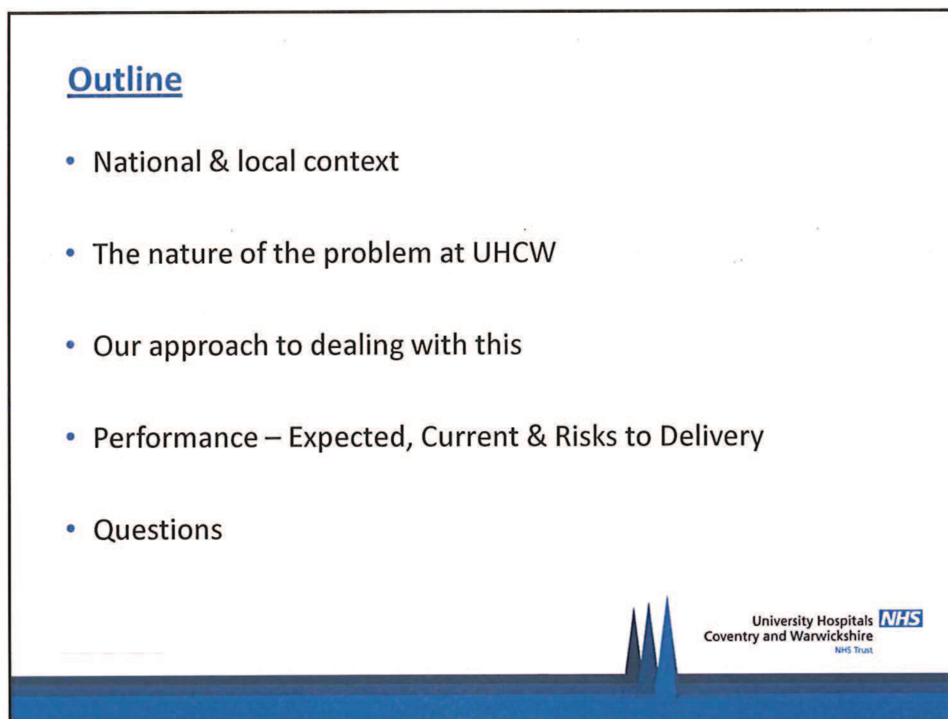
Coventry and Warwickshire
NHS Trust
Urgent & Emergency Care
Improving & Sustaining Performance
Andy Hardy – CEO
David Eltringham - COO
July 2013


Outline
National & local context
The nature of the problem at UHCW
Our approach to dealing with this
Performance – Expected, Current & Risks to Delivery
Questions
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National & Local Context

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Regulatory Standards

Two critical NHS National Contract Standards:

- 95% of patients attending the Emergency Dept (ED) are required to be seen, treated and either discharged, transferred or admitted within 4-hours
- Once a 'decision to admit' has been made no patient will wait for more than 12-hours to be admitted to an appropriate bed

In addition there are other high profile NHS National Contract Standards we should meet:

- Zero tolerance of delays more than 1-hour to release ambulances after they arrive on site (£1000 fine & DH reporting of all such breaches)

- Minimizing delays of greater than 30-mins to release ambulances after they arrive on site (£200 fine for all such breaches)

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Context....

- UHCW have struggled to deliver the A&E target for 2 years (11/12 - 93.95%)
- 4hr performance was significantly below 95% for 2012/13 (91.46%). This continued into Q1 13/14 (90.12%)
- UHCW mirrored the National A&E performance picture but was worse
- UHCW recognise & are committed to achieving & stabilising performance this year
- UHCW are committed to working with Health Economy partners to deliver sustainable improvements over the next 18-months

HSJ

NHS England area teams told to lead A&E recovery

NHS England's local area teams have been given less than a month to develop accident and emergency "recovery plans" for their patch, the organisation's interim deputy chief executive has announced.

- Exclusive: A&E performance plummets as majority of trusts miss target
- Commissioners raise concerns over Caldicott recommendations
- Addressing hearing loss services 'could save £28m'
- Exclusive: Ministers want CCG topslice to fund health and social care integration
- Savile review seeks NHS staff views on celebrity fundraisers
- St George's breached six national standards,

HSJ Live 3.5.2013: NHS England plans A&E 'recovery plan'

Coverage of today's NHS England board meeting including plans for the commissioning board to lead a national A&E "recovery plan", and the latest on the NHS 111 debacle, and the rest of today's news.

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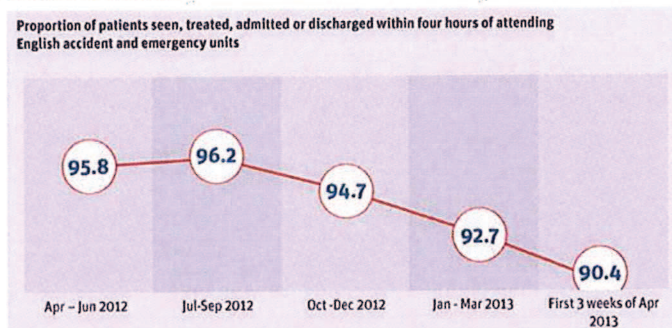
National 4hr Performance – 2010 to April 2013

(Source Health Service Journal – May 2013)

Exclusive: A&E performance plummets as majority of trusts miss target

2 MAY, 2013 | BY BEN CLOVER



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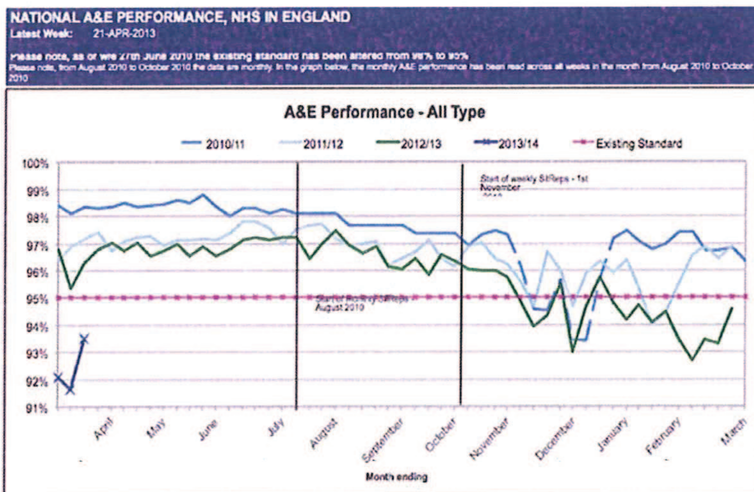
National 4hr Performance – 2010 to April 2013



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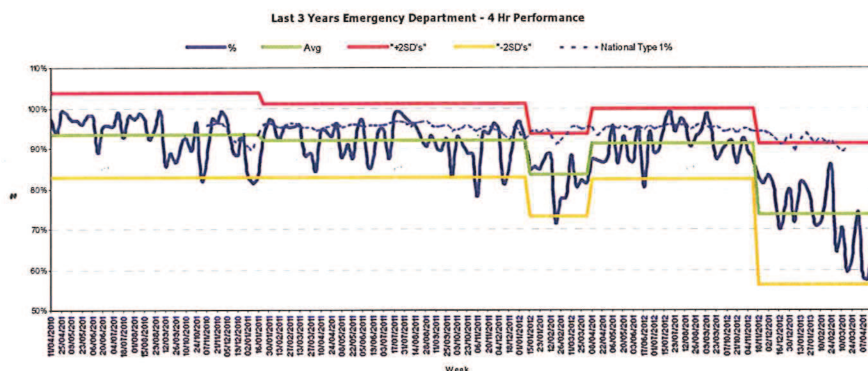
Local UHCW 4hr Performance – 2010 to April 2013



The last two years there have been winter slumps, however this year the slump began in November and was more pronounced.

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Context Summary

- UHCW has a history of performance challenge around the 4-hr Target
- Perfomance in the Coventry Urgent & Emergency Care system mirrors the National picture but is more pronounced
- The pattern of performance 'challenge' was is more acute in the Midlands e.g. those struggling to achieve the 4-hour standard include:
    - University Hospitals Leicester
    - South Warwickshire Foundation Trust
    - University Hospitals North Staffs
    - Shrewsbury & Telford Hospitals
    - Heart of England Foundation Trust

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Understanding the problem – UHCW Service Profile

Activity:

- Circa 174 000 attendances per year, comprising:
    - 91 000 ED attendances
    - 31 000 Children's ED attendances
    - 33 000 St Cross attendances
    - 14 000 Eye Casualty patients
    - 5 000 Gynecology unit direct emergencies
- Modern facilities – dedicated Children's ED & state of the art Resuscitation room
- Designated Regional Major Trauma Centre (supported by a Helipad)

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Understanding the problem

- To understand the nature of this complex problem at UHCW we have undertaken detailed analysis, specifically looking at:
  - Pressures arising from increasing or changing demand i.e. Has demand increased overall? Has it increased in specific area (e.g Ambulance Patients or the Elderly)
  - Problems arising from how we organise our services (supply side problems) i.e. do we have good Site Operations systems & processes? Do we have the correct number of beds per specialty? Are our discharge systems & processes working as well as they can?
- To test & validate our analysis we have obtained expert (National) support and advice
- To ensure we are doing all that we can we have benchmarking ourselves against best practice in the area of ED performance / Acute Care

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Demand Side Pressures?

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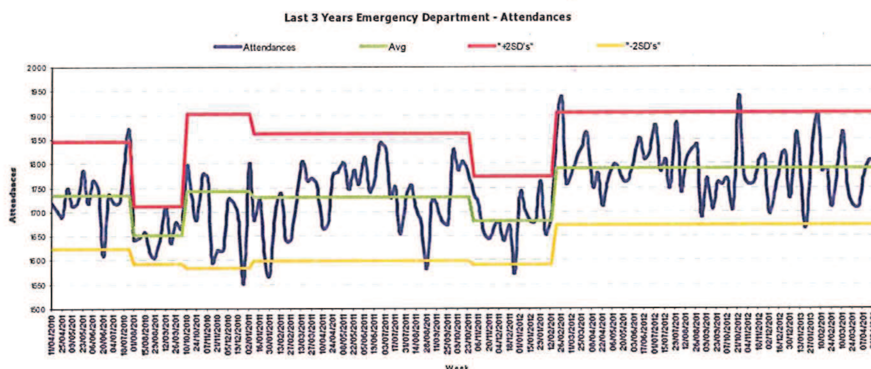
Are the number of attendances the problem?



Attendance volume changes **do not** occur at the same point as 4hr performance deterioration.

(Although it should be noted that attendance levels are trending upwards in line with National data)

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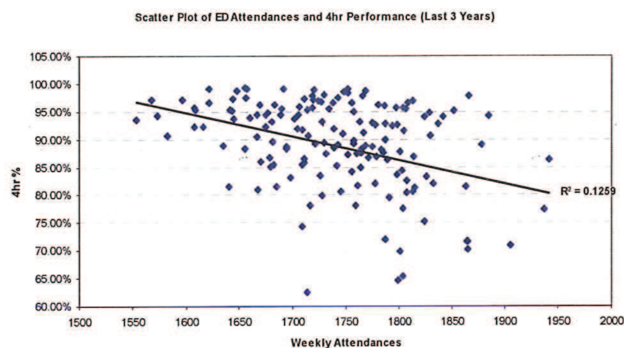
Attendances contd.



There is a **low correlation** between 4 hr performance and attendances (r = -0.35)

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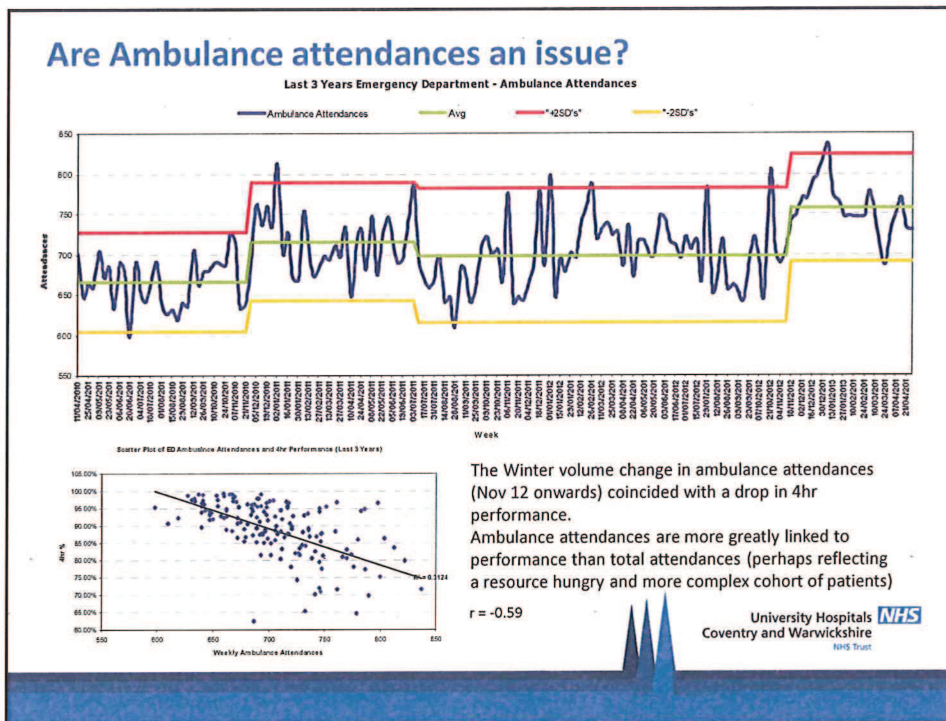
Are Ambulance attendances an issue?
Last 3 Years Emergency Department - Ambulance Attendances
Ambulance Attendances
Avg
"+2SD's"
"-2SD's"
Attendances
Week
The Winter volume change in ambulance attendances (Nov 12 onwards) coincided with a drop in 4hr performance.
Ambulance attendances are more greatly linked to performance than total attendances (perhaps reflecting a resource hungry and more complex cohort of patients)
r = -0.59
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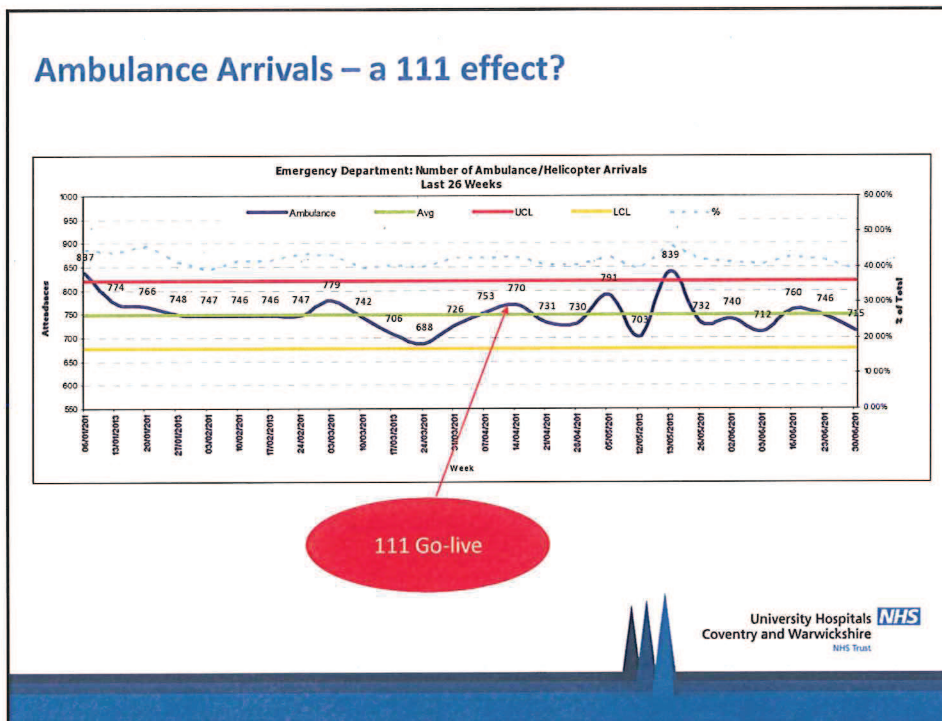
Ambulance Arrivals – a 111 effect?
Emergency Department: Number of Ambulance/Helicopter Arrivals
Last 26 Weeks
Ambulance
Avg
UCL
LCL
%
Attendances
% of Total
Week
111 Go-live
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Ambulance attendances & 111 summary

- Overall UHCW has seen a rise in the number of patients brought-in-by ambulance
- This is generally seen as an indicator of patient acuity. Ambulance patients are often more acutely unwell & use more resource in the ED when being treated
- National data suggested 111 would create further pressure (& performance issues) for the ED – especially in the volumes of patients arriving by ambulance. Significant preparations were made to deal with any rise in attendances but this has not been an issue for UHCW

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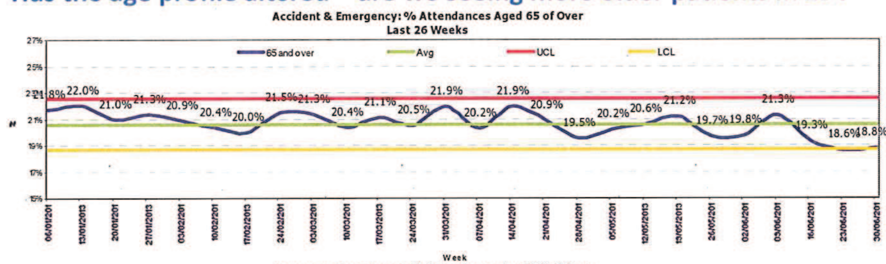
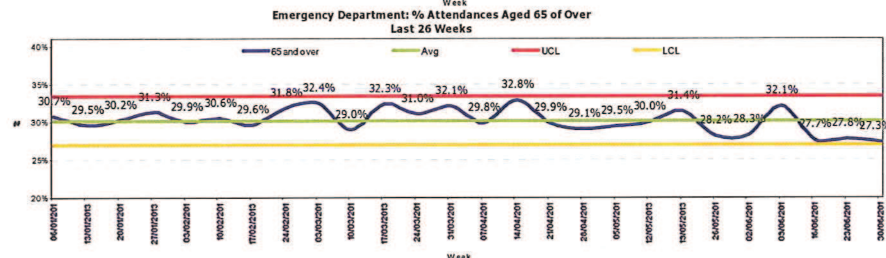
Has the age profile altered – are we seeing more older patients in ED?





- There **is not** a significant increase in age 65 & over attendances

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Age profile

- The age profile of those patients attending the ED has not changed significantly & **is not** believed to be one of the main reasons for our performance
- Whilst we do not see a shifting age profile as a root-cause we are mindful that a relatively small number of complex elderly patients can occupy many bed days. We recognise the need to make sure we match best practice in this are to prevent problems in the future

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Supply-Side Problems?

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Understanding the problem – Supply Side

- The complex nature of emergency activity requires all aspects of the hospital & local health economy to work well in order to avoid unnecessary waits & delays, specifically:
  - Flow & management of patients through ED (making sure all departments deliver support within the 4-hr timeframe e.g. x-ray, scans, blood tests etc)
  - Capacity & flow management across the hospital (ensuring the timing of patient discharge matches the demand for beds coming out of the ED / Acute Medical Unit)
  - Actively managing discharges to alleviate delays & unblock obstructions (ensuring medically fit patients waiting for discharge support are properly coordinated with partners in Social & Community Care)

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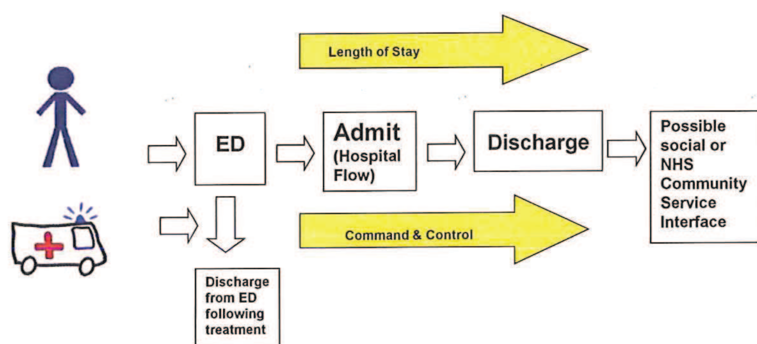
Understanding the problem



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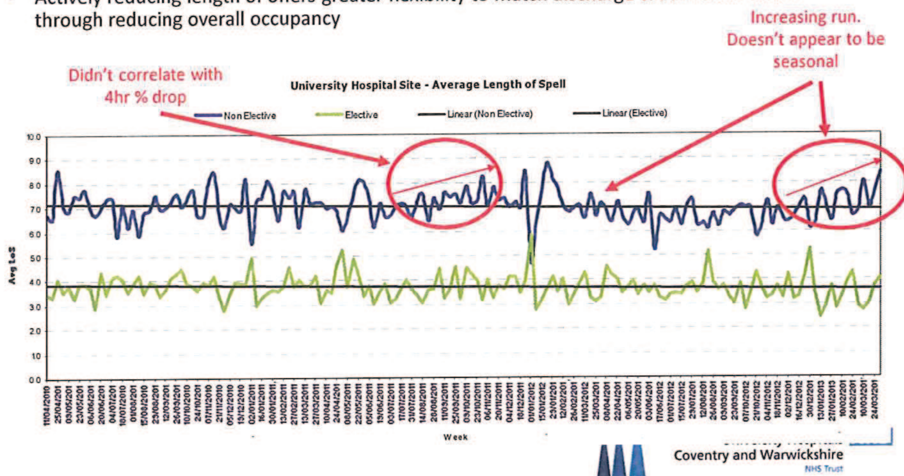
Supply side issues – length of stay

- Our in-patient length of stay is variable and relatively volatile. Whilst spikes in length of stay do not track directly to drops in ED performance, we recognise that the hospital is frequently 95%+ full of in-patients and this limits our ability to flex for peaks in activity
- Actively reducing length of offers greater flexibility to match discharge & admission times through reducing overall occupancy



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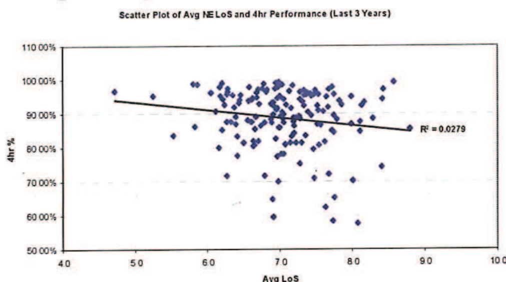
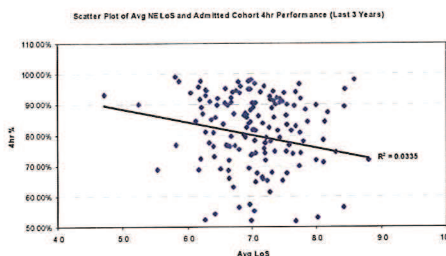
Average Length-of-Stay (LoS): Trust (UH site)



The direct weekly relationship between avg LoS of discharged patients and 4hr % is relatively low

r = -0.17



This relationship increases when you compare to the 4hr % of the admitted cohort. But still remains low.

r = -0.18

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Supply Side Problems - Medical Outliers

- 'Outliers' are patients being cared for in an inpatient bed but on a ward of the incorrect specialty e.g. medical patients being cared for on surgical wards
- Patients being looked after in the correct / designated specialty bed are know to have shorter, more appropriate lengths of stay. This usually relates to the staff on the ward (Dr's, nurses etc) being skilled in the management of the specific patient group e.g. Respiratory patients are best cared for on a respiratory ward
- UHCW has a mismatch of Surgical & Medical beds (circa 70-beds too few in medicine / too many in surgery)
- There is evidence to suggest this mismatch directly correlates to falling ED performance (a direct causative relationship is hard to prove however the issue contributes significantly to reducing patient flow / increasing length of stay)
- Outliers are created when other planned activity is reduced (at weekends / on Bank Holidays or in a deliberate way to accommodate high volumes of patients in the ED)

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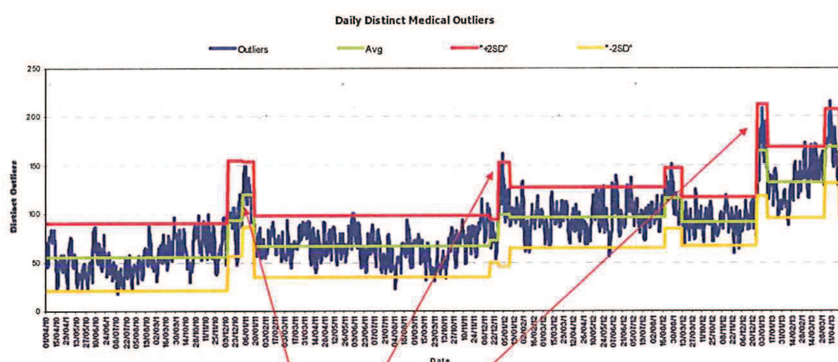
Distinct Medical Outliers



Winter 'spikes' & an upwards trend

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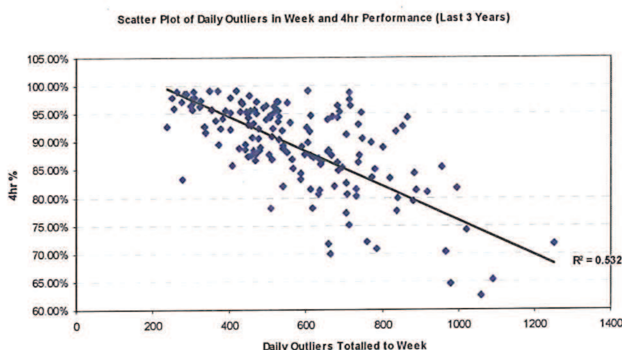
Distinct Medical Outliers



The correlation between outliers and 4hr performance is stronger than that of 4hrs and any of attendances, ambulance attendances, conversion, avg length of spell, Obs/CDU(AMU1) turnover, occupancy.

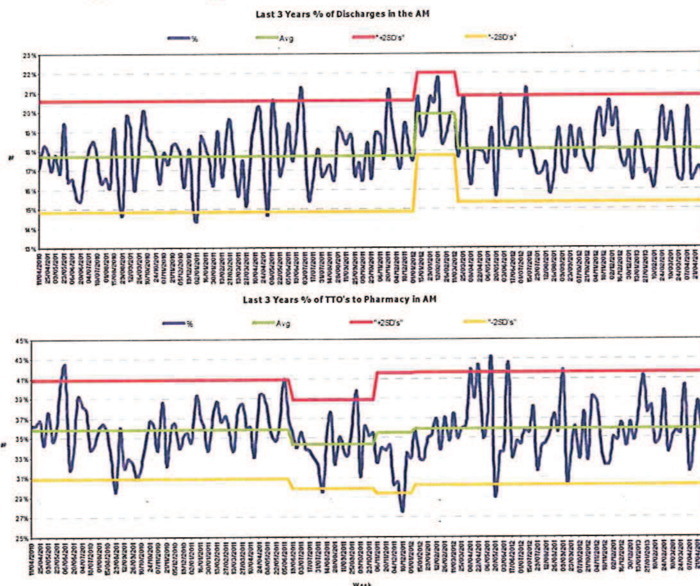
There is a -0.73 correlation coefficient and a 0.53 r^2 value.

Please note x axis shows total number of daily distinct outliers summed throughout the week. For example if there was 100 outliers per day (and that 100 could be the same 100 each day) over a 7 day week this would equal 700.

Supply Side Problems – Internal processes & timely discharge

- Best practice suggests that early / timely well managed patient discharge ensures that beds are available when they are most needed
- Usually this means a stock of beds being emptied early in the morning to accommodate the morning / early afternoon discharges & a further tranche in the late afternoon / early evening to ensure capacity for the night
- A sentinel indicator of good-practice is the early prescribing of discharge or take-home-medication (TTO's) to enable early / morning patient discharge
- Additional important indicators are weekend discharges (as a proportion of weekday discharges) – ensuring smooth 7-day discharge flow helps to prevent problems due to a lack of beds at the weekend (& helps reduce outliers by making sure sufficient 'correct' beds are available

Morning Discharges and take-home medication before mid-day



The % of discharges that occur in the morning are very stable apart form a 10 week period at the start of 2012 where a process improvement was seen

TTO's received before mid day are more variable

Whilst the lack of early discharge does not appear to have caused the ED performance problem, improving performance in this area offers an opportunity to support ED performance improvements

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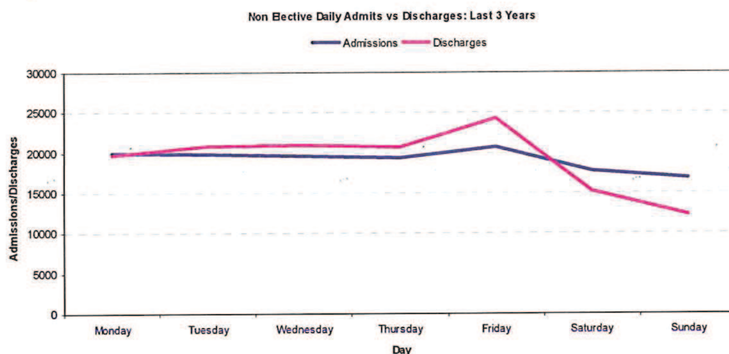
Weekday/Weekend Discharge to Admit Ratio



The above shows the profile of emergency admissions vs. discharges

This graph highlights a consistent pattern of 'filling up' at the weekends due to discharges falling (against lowered admissions) and then spending the week catching up with discharges (particularly on a Friday)

Again this is a consistent pattern over 3 years suggesting there is an opportunity to improve flow by improving 7-day working practices

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Our approach to resolving the problem

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The principles underpinning our recovery plan

Evidence
- ECIST
- Best Practice
- SHA
- Local Evidence

Actions
- Agreed Themes
- Strong Program Governance
- Focus on local ownership, support, delivery & accountability

Measurable Outcomes
- On-track & on-time
- Achieving expected improvement
- Widely shared informatics
- Board level scrutiny

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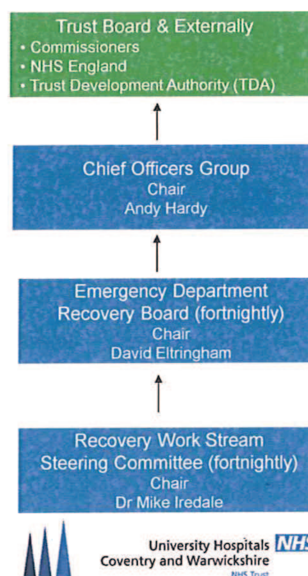
Recovery Plan Governance Structure

Strong governance framework supports the recovery programme; providing assurance that we are doing what we've committed to & that our actions are working

Plan developed with local partners through the Urgent Care Board (System Flow Board) & progress formally reported through the governance structure

Approach signed off by the NHS Emergency Care Intensive Support Team (ECIST)



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Recovery plan work-streams & rationale

1. Developing alternatives to ED

- Developing new services & pathways for patients who do not need treatment in the ED i.e. Consultant or specialist nurse led clinics for patients with urgent conditions that require expert help but can be managed on a planned basis (managing deteriorations in chronic chest conditions, managing patients with suspected DVT's etc)
- Working with commissioners to develop effective GP / Nurse led urgent care on the UHCW site for the less complex patients
- Overall working on schemes that free-up core ED capacity to enables the ED team to deal more promptly with the more complex cases (ambulance attendances etc)

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2. Improving ED Systems & Processes

- Benchmarking the way we organise our ED patient management against best-practice
- Implementing new ways of working that speed up decision making by moving the consultant workforce 'closer to the door' e.g. 'Rapid Assessment & Treatment' and 'See & Treat'
- Ensuring our Acute Medical Unit is as good as it can be. Specifically recruiting to vacant consultant posts & employing more advanced nurse practitioners to assess / treat patients as quickly as possible
- Again working on schemes that rapidly treat & move appropriate patients enables the ED team to deal more promptly with the complex cases

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3. Improving Bed & Capacity Management

- Investing in a dedicated (24/7 – 365 days/year) professional site operations team & operations centre. Ensuring a consistent approach to the day-to-day management of bed capacity & patient flow
- Re-profiling the bed base. Formally re-designating a portion of UHCW surgical capacity to medicine & recruiting the correct workforce to properly manage this patient cohort
- Re-designating surgical beds to medicine is designed to reduce or eliminate the number of outliers
- Implementing a dedicate site-operations team is a 'best-practice' measure to ensure consistent operational grip & escalation of problems at all times
- Investing in 7-day working for services critical to decision making & discharge (x-ray, scanning, pharmacy, therapies & additional weekend consultant / medical staff)

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4. Improving internal pathway management & simple discharge processes

- Providing a dedicated team, with senior clinical leadership, to develop systems that deliver daily senior reviews of all in-patients (Daily 'Board-Rounds')
- Tracking & escalating internal waits & delays for diagnostic investigations and / or therapy support
- Developing new ways of working to speed up the prescription and dispensing of TTO's (e.g. ward based carts for drug dispensing, designating doctors to focus on early TTO prescription etc)
- Schemes to improve internal pathway management have been incentivised by the commissioners. Specifically additional monies are available for achieving quality improvements in these areas
- The schemes in this section of the plan are designed to reduce length of stay (due to unnecessary waits & delays) and deliver prompt, timely discharge everyday

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5. Improving complex, supported discharge

- Whole system programme ranging from simple daily measures through to complex service redesign
- Supported by all system partners (CCC, the Community Trust, Community Trust etc) & project managed by the Arden Commissioning Support Unit
- Daily, whole system, escalation conference call (commenced in February 2013) held as an exemplar of best practice by the Trust Development Authority
- Schemes to improve complex discharge are designed to appropriately & safely reduce length of stay for patients who need support on discharge but no longer require medical treatment

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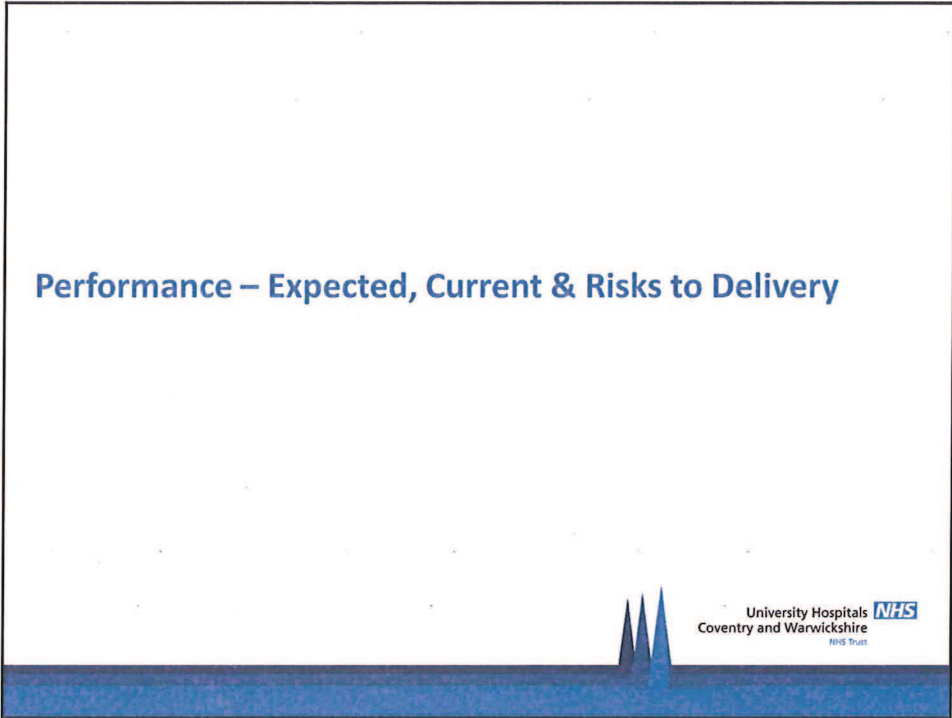
Performance – Expected, Current & Risks to Delivery
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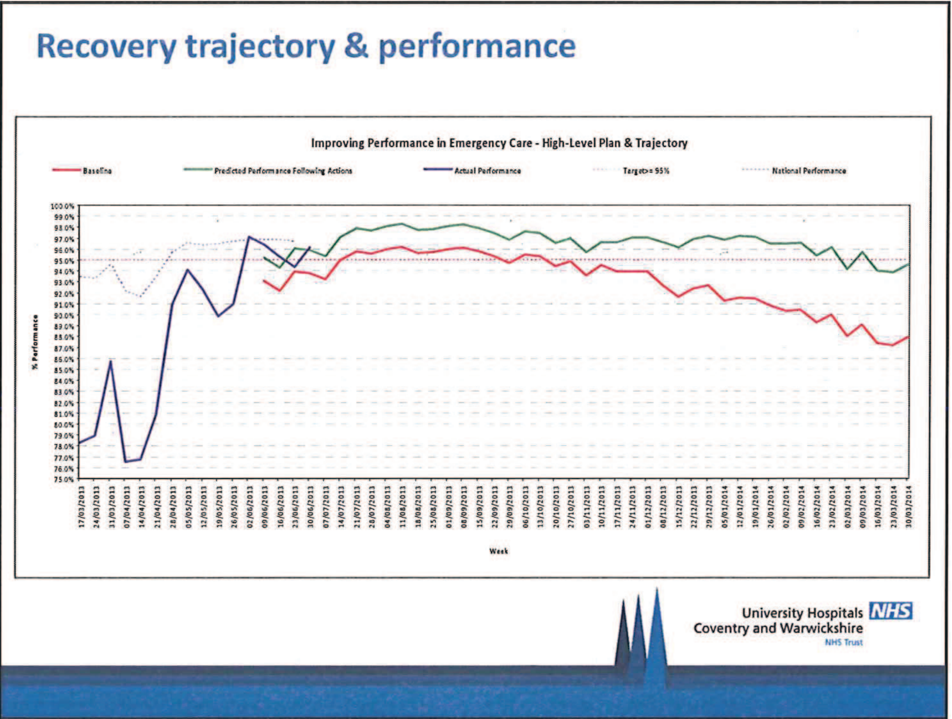
Recovery trajectory & performance
Improving Performance in Emergency Care - High-Level Plan & Trajectory
Baseline
Predicted Performance Following Actions
Actual Performance
Target>= 95%
National Performance
% Performance
Week
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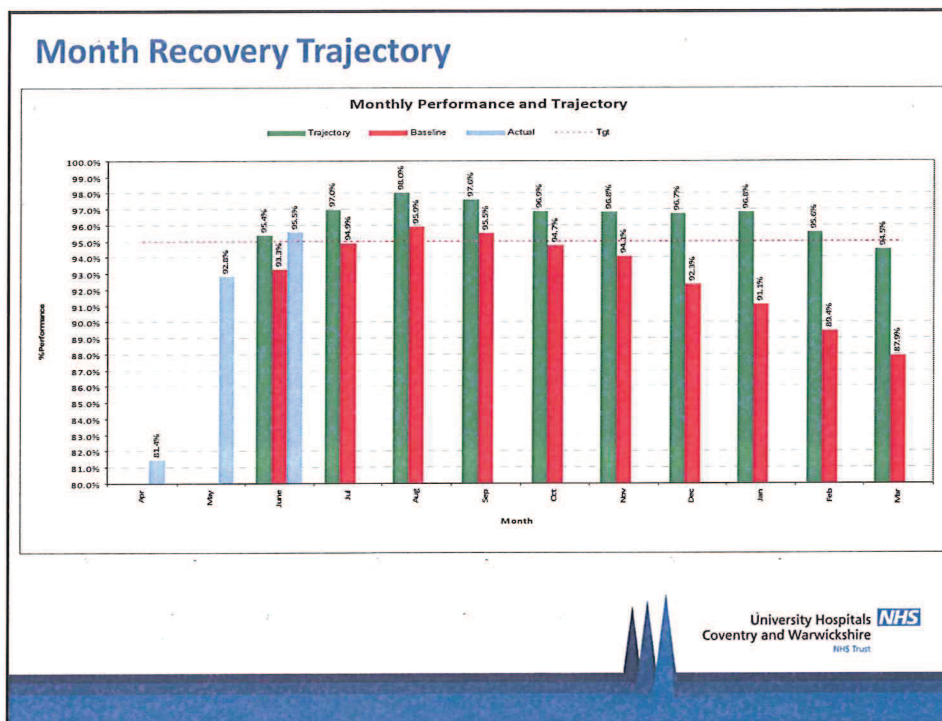
Month Recovery Trajectory



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Trajectory, overall performance & risk

- Trajectory for the year **includes** recovering lost performance in Q1 to deliver 95% for the year – this is extremely challenging
- Recovery trajectory delivered for June 2013 (95.66% vs. plan of 95.4%)
- Performance volatility remains (but is expected until all schemes are in place & working) – June delivered 95%+ for 3 weeks out of 4 (20 days out of 30)
- July remains challenging (w/c 8 July was the second busiest on record but UHCW delivered 95%+)
- Trajectory models the approximate expected impact of the various schemes on 4-hr performance
- Winter (post November) is the most challenging time
- 4% improvement is required against the baseline to delivery the trajectory

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- 2% is calculated as being delivered by bed reconfiguration. This scheme is within the Trusts gift to achieve on time & on-plan
- A further 2% improvement is required from 'extra-ordinary' Winter Plan schemes
- Winter plan schemes have been included in the Whole System Winter Plan & include:
  - Using a Homecare provider to run a virtual ward – caring for less acute patients at home & freeing up bed capacity
  - Providing additional physical bed capacity on the UHCW site
  - Using private-sector providers to ensure patients requiring planned care (surgery etc) can be treated if beds are required to support ED
  - Establishing an Urgent Care Centre to deflect appropriate patients from the ED
  - Multiple small-scale schemes to bolster staffing out of hours & at weekends
- The above schemes require investment. Traditionally the NHS has funded Winter pressures however this is usually in a bidding round in December. Commissioners & UHCW have requested decisions regarding Winter funding be considered earlier in the year to ensure the above schemes can be in place & working by December / January.
- An inability to establish all or most of the extraordinary schemes places the recovery trajectory at risk however the Trust remains fully committed, with partners, to delivering the 95%

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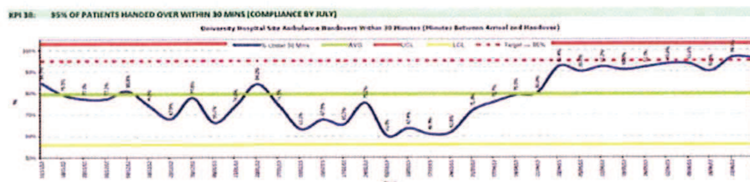
Scheme performance – examples & approach to measuring success

Ambulance Turnaround Times

- Success story with the virtual elimination of 1hr plus waits and best-ever performance against 30 min handover

Summary performance pass/fail here



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Scheme performance – examples & approach to measuring success

Improving simple discharge:

- Friday discharge volumes have remained volatile & more progress is expected in this area
- Weekend discharges have increased and at times perform above the target levels set. Again there is volatility and the schemes associated with this are under review to ensure optimal performance
- Where possible performance KPI's are 'balanced' to ensure there are no unintended consequences. For schemes to improve discharges the balancing KPI is the 30-day readmission rate – at present this is stable / unaffected by schemes to improve discharge
- Discharges before midday & the early prescription of TTO's are in their early stages and further progress is expected

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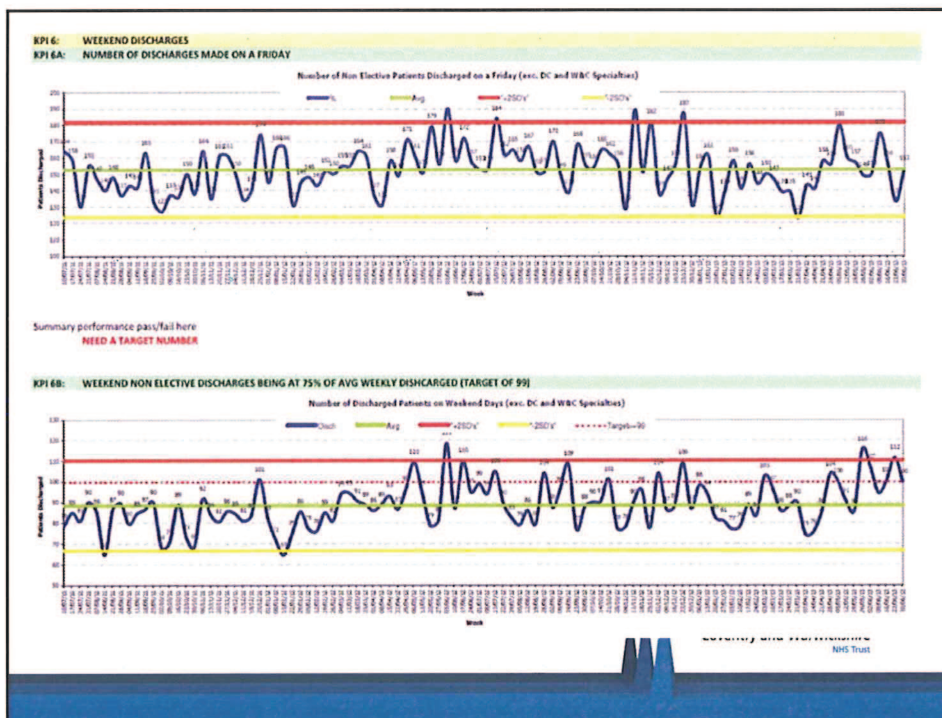

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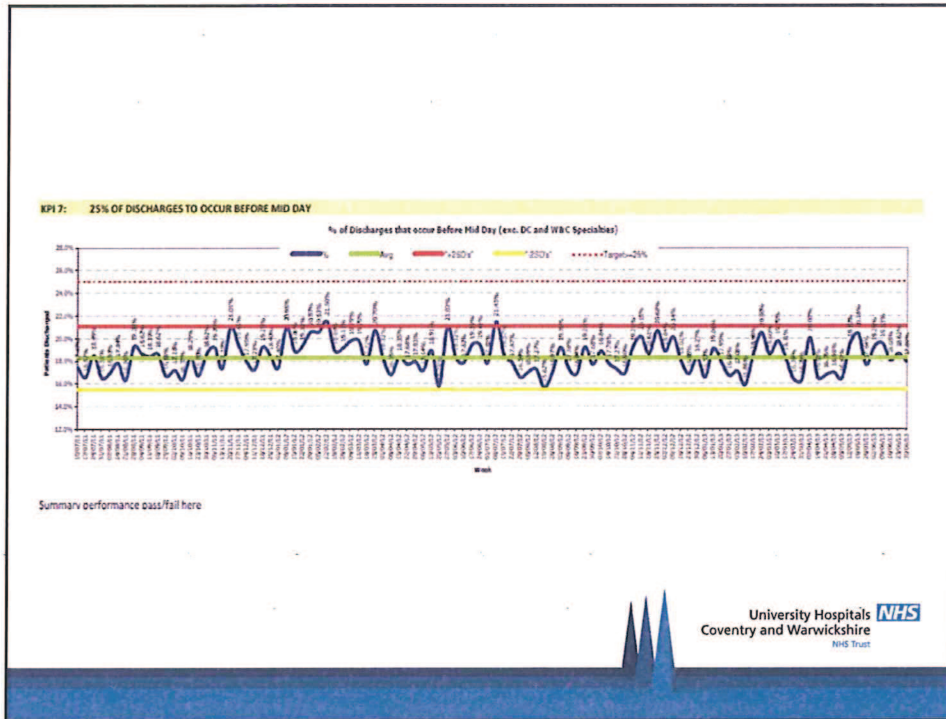
KPI 7: 25% OF DISCHARGES TO OCCUR BEFORE MID DAY
% of Discharges that occur Before Mid Day (exc. DC and W&C Specialties)
Summary performance pass/fail here
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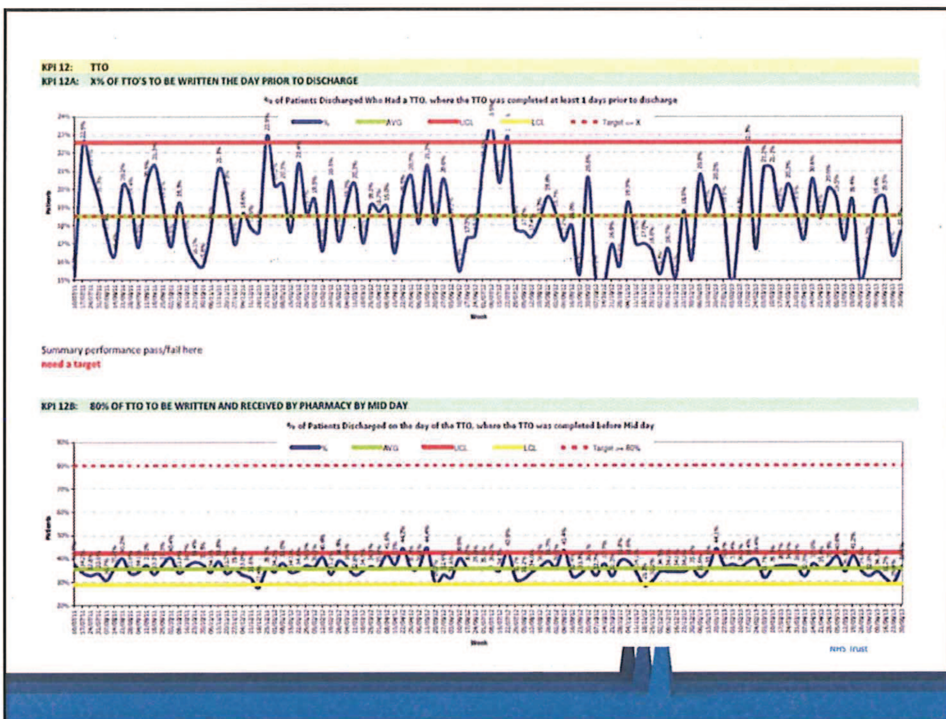
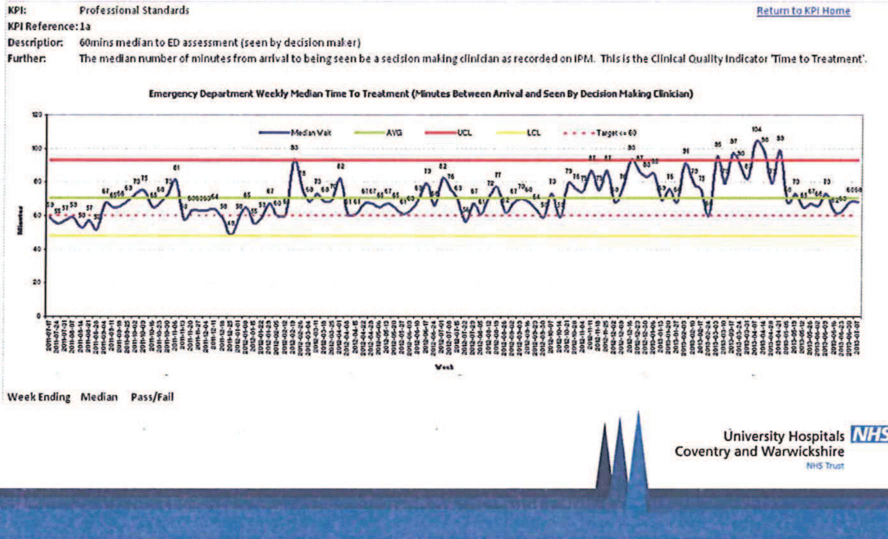

KPI 12: TTO
KPI 12A: X% OF TTO'S TO BE WRITTEN THE DAY PRIOR TO DISCHARGE
% of Patients Discharged Who Had a TTO, where the TTO was completed at least 1 days prior to discharge
Summary performance pass/fail here
need a target
KPI 12B: 80% OF TTO TO BE WRITTEN AND RECEIVED BY PHARMACY BY MID DAY
% of Patients Discharged on the day of the TTO, where the TTO was completed before Mid day

Reducing the time to be seen by a senior doctor in ED

- See & Treat appears to have help reduce the time to be seen by a senior ED doctor. RAT (scheduled for go-live on 22 July) is expected to further improve performance in this area



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Summary

- UHCW is committed to working with partners to resolve this long standing problem affecting many of it's patients
- Through a process of analysis, robust planning & a tight governance framework, we have developed a revised plan that is showing improvements in delivering against both the 95% standard and other important performance indicators (e.g. ambulance turnaround)
- There remains a risk that, without support for the early implementation of extraordinary Winter measures, delivering the full recovery trajectory will be extremely challenging

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ANY QUESTIONS?

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COVENTRY & RUGBY CCG

Report to: **Health Overview and Scrutiny Committee 24th July 2013**

Report from: **Steve Allen, Accountable Officer**

Title: **Urgent Care and GP Out of Hours**

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1. Introduction

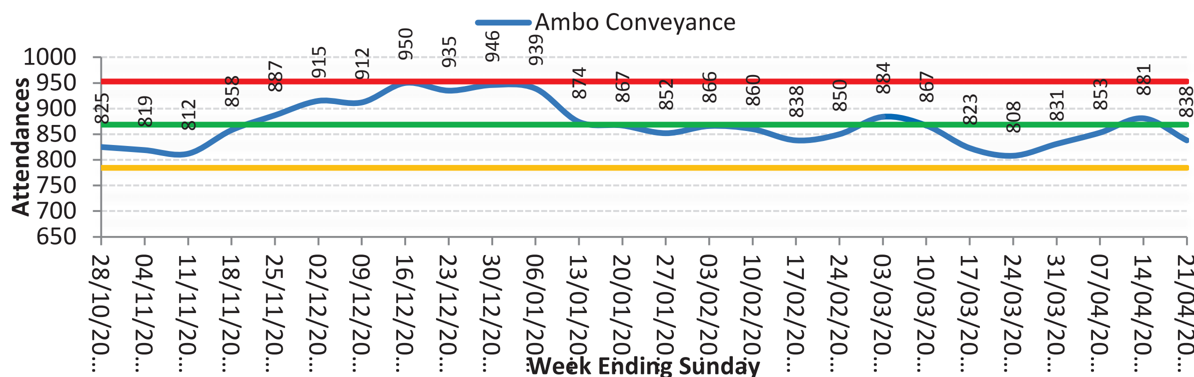
Nationally and locally there are on-going challenges with achieving the 95% A and E 4 hour wait access target. For UHCW this has not been achieved consistently since September 2012 and although performance has improved recently, the trust is not achieving the target for the financial year 2013/14 (see table 1).

There is significant commitment from health and social care partners to work together in resolving this. This report highlights the actions taken by Coventry and Rugby Clinical Commissioning group (CCG) with partners to address this issue. The report also highlights current issues in relation to urgent care including ambulance conveyance, Delayed Transfers of care (DTOC), GP Out of Hours (OOH) Services, NHS 111 and the Coventry Walk in Centre.

Table 1. UHCW A and E Performance – 4 hour wait National Target

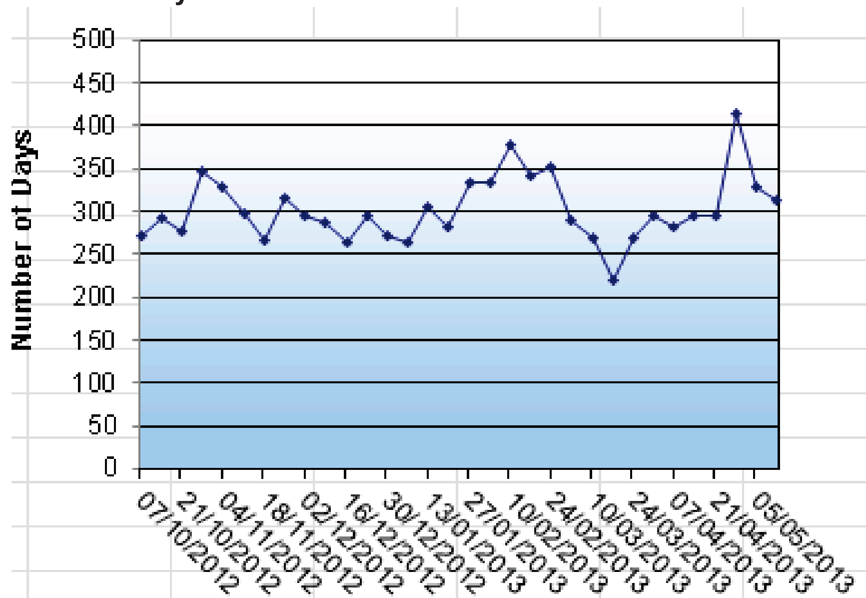
Trust	Date	Trust Total	Over 4 Hours	Trust Percentage Within 4 Hrs
UHCW	April	14,094	1049	92.56%
	May	15,432	886	94.26%
	June	15,029	808	94.62%
	Q1	**44,555**	**2743**	**93.84%**
	July	15,523	503	96.76%
	August	14,306	519	96.37%
	September	14,286	608	95.74%
	Q2	**44,115**	**1630**	**96.31%**
	October	15,100	808	94.65%
	November	14,579	1451	90.05%
	December	14,775	1876	87.30%
	Q3	**44,454**	**4135**	**90.70%**
	January	14,109	1948	86.19%
	February	13,215	1787	86.48%
	March	14,901	2748	81.56%
	Q4	**42,225**	**6483**	**84.65%**
	2012/13	**175,349**	**14991**	**91.45%**
	April	14,896	2682	82.00%
	May	14,924	1069	92.84%
	June	14,294	590	95.87%
	Q1	**44,114**	**4341**	**90.16%**
	July (to date)	3,469	205	94.09%
	Q2 (to date)	**3,469**	**205**	**94.09%**
	2013/14 (to date)	**47,583**	**4546**	**90.45%**

The level of ambulance conveyances to A and E have remained relatively static over the last 6 months as highlighted in table 2.



Delayed Transfers of Care (DTOC) at UHCW have also fallen this year following joint working with all partners across Coventry and Warwickshire. They currently stand at around 4% of occupied bed days (see table 3).

Table 3: Delayed transfers of Care



2. Contractual Issues with UHCW

In line with the national acute contract, financial penalties are being applied to UHCW for failure to meet the national access target that 95% of patients should be treated within 4 hours within A and E. This fine is nationally set at 2% of the value of the service as defined with the contract and is calculated on a monthly basis.

Performances notices have been issued in line with the contract which stipulates that recovery actions plans must be agreed between the provider and commissioner.

The CCG's Accountable Officer (GP) and lead Nurse have undertaken unannounced and announced quality review visits to UHCW A and E on three occasions in the last 6 months with the support of the Local Area team. The Local Area Team are assured that the CCG is taking all appropriate action to performance manage the trust in relation to A and E targets.

The UHCW recovery plan has been in operation for a number of months and is formally monitored by the Clinical Quality Review Group which meets on a monthly basis. The plan includes actions in a number of key areas with identified leads from the trust and CCG for each Key Performance Indicator (KPI). The key areas are: -

- **Plan Governance& Organisational Development;** robust governance of recovery arrangements in place to ensure patient safety & delivery of effective change/improvement.
- **Developing Alternative Pathways to A&E;** project plans in place for increasing number of hot clinics and Ambulatory Emergency care pathways, investment into Community Integrated Teams and risk stratification.
- **Improving ED systems & process;** includes improving systems & processes within ED and addressing interface issues resulting in current delays.
- **Improving Bed Capacity & Capacity Management**; includes reconfiguration of bed base to reduce medical outliers and remodelling of site operations to improve communication, bed management and internal flow.
- **Improving internal pathway management and simple discharge process;** improving access to diagnostics/investigations, introduction of board rounds and focus on discharge planning.
- **Improving Supported/Complex Discharge;** daily with stakeholders to manage complex discharges & community capacity effectively, a discharge transformation programme monitored by the CR System Board involving all stakeholders to reduce DTOC and reduce length of stay for individuals no longer requiring hospital.

Commissioning for Quality

The CCG has used monies available within the 2013/14 contract (CQUIN Payments) to incentivise the delivery of schemes which will support the delivery of the A and E Target.

In particular money is available to focus on improving flow through the hospital so ensuring beds are available for patients who require admission from A and E. These include: -

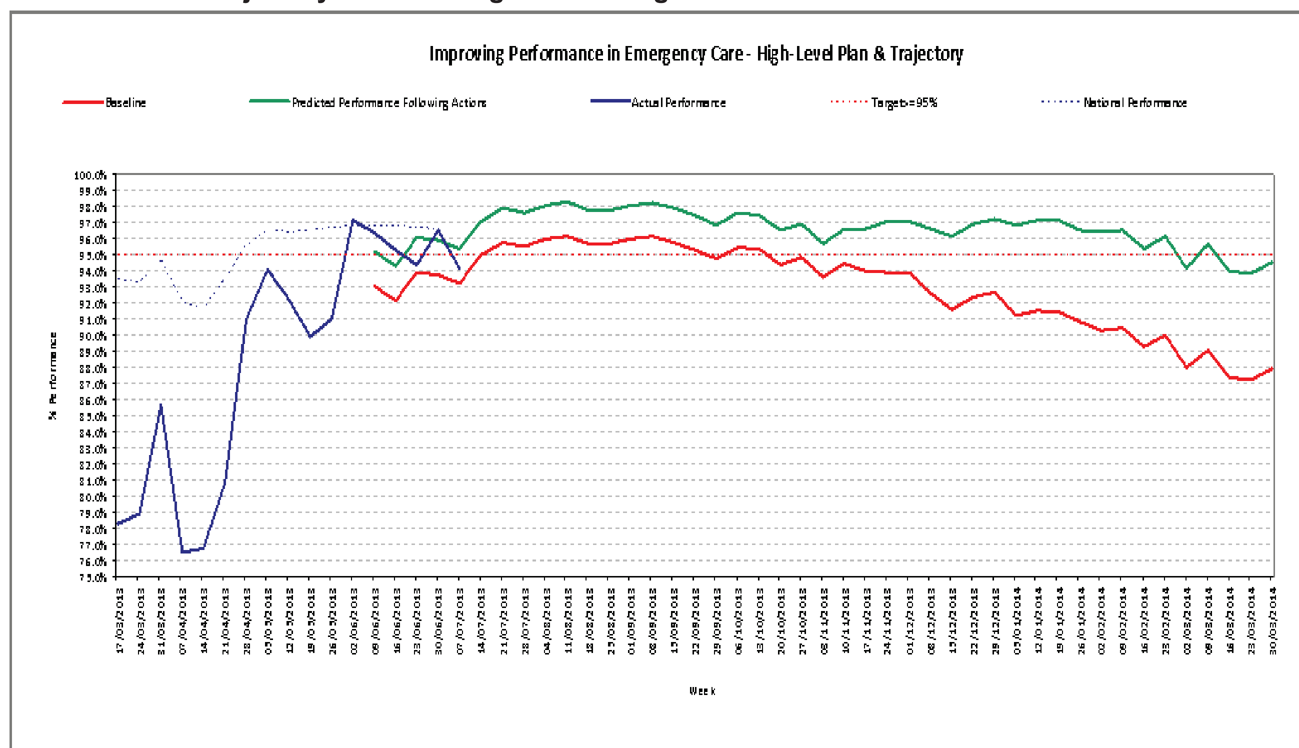
- Development of 7 day 'Board rounds', improve access to therapies and reduce the number of medical outliers.
- Improve systems to help tackle internal waits for access to diagnostic procedures, imaging and also pharmacy

Contracting for Emergency Admissions

The CCG has agreed a 'block' contract for the payment of emergency admissions for 2013/14. This will ensure that income for urgent care activity is guaranteed for the trust. The previous national PBR system meant that the trust only received 30% of the cost for any additional activity (above contract levels) and therefore the block arrangement will now mean that UHCW will be able to plan more effectively its use of emergency beds over the year.

The action plan and other initiatives outlined above appears to be having an impact on achievement of the A and E targets as can be seen below in table 4.

Table 4: UHCW Trajectory for achieving A and E target



3. Coventry and Rugby Local Health Economy Urgent Care Plan

Coventry & Rugby Local Health Economy (LHE) has established an Urgent Care Board including representatives from CRCCG, UHCW, SWFT, CWPT, Coventry City council and Warwickshire County Council. The aim of the group is to work collaboratively to manage all service aspects which contribute to system flow within Coventry and Rugby.

Work to date has concentrated on a detailed understanding of the local issues which have led to increasing waits in A and E for patients. In particular significant work has gone into a comprehensive diagnostic of patients flows through the urgent care system to understand the blockages for patients at the various points of the pathway from A and E to discharge.

From the diagnostic work, the Board is developing an Urgent Care Plan and has identified a number of key strategic aims which are now being taken forward. These are: -

1. Communication strategy:
    - Raise awareness with all clinicians, health & social care professionals on what services are available and how they can be accessed
    - Public campaign including flu vaccines (also target at risk children), "call to action", infection control/hand washing (in relation to Noro Virus).
    - Revise plans/services in light of outcomes from the A&E Friends & Family test (Sept 2013)

2. Put Primary Care at the heart of the urgent care system:
    - Explore urgent care response in-hours for primary care.
    - Improve access to speak to a GP through telephone triage in majority of practices
    - Scope and coverage of GP with the Ambulance service.
    - Explore the longer term procurement opportunities for integration of Out Of Hours, Walk-in Centres & acute and community services

3. Co-ordinated community service response:
    - Discharge Transformation Programme to establish a single integrated service to ensure timely discharge
    - Reduction in hospital attendances & admissions from Care Homes through joint contract & quality monitoring with LA's and enhanced community/primary care access
    - Re-ablement Redesign across Coventry to promote independence and prevent hospital admission that are integrated with community services
    - End of Life programme that will drive quality improvement and cost efficiency in the provision of end of life and palliative care across Coventry and Rugby.

The Board are also, in partnership with South Warwickshire CCG and Warwickshire North CCG, in the process developing an Arden Surge and Capacity Plan which includes the winter plan for 2013/14 (see appendix 1 for Coventry & Warwickshire Draft Winter plan).

4. Coventry Walk in Centre (WIC)

CCGs are responsible for commissioning walk in services for unregistered patients. The Coventry Walk-In Centre (WIC) is currently part of a single contract with Assura plc which also covers an APMS primary care practice (for unregistered patients). The APMS practice is commissioned by NHS England Local Area Team.

The Walk-in Centre element of the contract is provided from the ground floor of the Coventry Health Centre and is open from 08:00am to 22:00pm 7 days a week, 365 days a year.

The Coventry WIC has 52 pre-bookable appointments available each day which are always fully booked. It also offers 10 emergency appointments per day. The WIC has an average of 166 walk-ins each day Monday to Friday, 218 at weekends and 235 on bank holidays.

The WIC has treated an average of just over 5,000 patients per month in since April 2009. The main reason for attendance is listed in table 5 below.

Table 5: Reason for attendance at Coventry WIC (April 2012 to March 2013)

Clinical Code	Times Assigned
Upper respiratory infect	4565
Catheters, dressings, operations	4397
Viral infection NOS	3386
Cystitis	3333
Skin/subcutaneous infections	3307
Acute Tonsillitis	2588
Lower resp tract infection	2280
Pain in limb	1698
Otitis media	1475
Other reasons	1381

As part of the contract the CCG also monitors the outcome following a consultation at the WIC. Table 6 highlights this data for the period from April 2012 to March 2103.

Table 6. Informational Outcomes for Coventry WIC (April 2012 to April 2013)

Outcome	Total	%
Admission Avoided	13940	17.66%
Admitted to Hospital	543	0.69%
Advised, no treatment	32671	41.38%
Advised, and treated	27666	35.04%
Ambulance 999	400	0.51%
Referral elsewhere	3737	4.73%
Total	78957	100.00%

5. GP Out of Hours Service (OOHs)

Coventry GP OOHs service is also provided by Coventry and Warwickshire Partnership Trust (CWPT). The service provides advice and treatment to patients via home visits, telephone consultation and face to face at the treatment centre. The service sees around 3,000 patients each month and generally performs well against national and local KPIs (see table 7).

Table 7: GP OOH Performance Metrics 2012/13

Standard	Target	Jan-13	Feb-13	Mar-13		YTD
Urgent triage 20 mins	95%	93.7%	89.0%	92.2%		91.6%
Routine triage 60 mins	95%	98.0%	97.8%	97.3%		97.7%
Dental Calls 120 mins	95%	100.0%	99.0%	100.0%		99.6%
Emergency 1 hour	95%	100.0%	100.0%	100.0%		100.0%
Urgent 2 hours	95%	93.6%	96.7%	90.4%		93.5%
Routine 6 hours	95%	99.5%	99.5%	99.9%		99.6%
Routine 4 hours	95%	98.1%	98.6%	99.2%		98.4%
Emergency 1 hour	95%	100.0%	100.0%	100.0%		100.0%
Urgent 2 hours	95%	98.0%	98.5%	86.2%		97.8%
Routine 6 hours	95%	94.8%	97.9%	99.5%		97.2%

Table 8 below shows the percentage of cases which were referred to A and E from the Coventry GP OOH service. These levels benchmark as fairly average with other OOH services nationally.

Table 8: Percentage of cases referred to A&E from OOH

	Total number of patient contacts	Number of referrals to A&E	Percentage escalated
Nov-10	4072	369	**9.06%**
Dec-10	7599	424	**5.58%**
Jan-11	4307	362	**8.40%**
Feb-11	2986	314	**10.52%**
Mar-11	3370	354	**10.50%**
Apr-11	4331	381	**8.80%**

6. NHS 111

NHS 111 is being provided locally by NHS Direct and is now fully operational on an in-hours basis in the West Midlands. Short term arrangements have been put in place to cover the out of hours service following the switch on of the service and these appear to be working effectively to date.

CCGs in the West Midlands have been working closely with NHS England to ensure that the longer term arrangements for the service are robust and the service can continue to provide an effective service.

The service has been performing well across the region, and the latest data reports that there have been no significant increases in attendances at Accident & Emergency or in ambulance despatches. In addition to this, reporting statistics show that calls are being answered within the required timeframe. In June 100% of calls were answered within 60 seconds.

The CCG is aware of potential financial issues with NHS Direct for some time and have been working closely with West Midlands CCGs and NHS England to ensure alternative provider arrangements can be put in place quickly should this become necessary.

7. Future Commissioning Arrangements for Urgent Care.

Coventry and Rugby CCG are currently reviewing its contractual arrangements for Walk in Centres and GP OOHs. This will need to be viewed within the context of an urgent care strategy which is in the process of being developed by the CCG.

Walk-in-Centre

The work will need to involve other partners in the Health and social care economy. For example the Walk in Centre contract is managed on behalf of the CCG by the Local Area team. For 2013/14, it was agreed not to attempt to unbundle this contract, which is due to expire 31st March 2014. The CCG is therefore in conversation with the Area team about a co-ordinated approach to reviewing this contract to determine our requirements within the developing urgent care strategy. It is possible that the current contract will need to be extended for a period of time to enable this work to be completed in a co-ordinated manner.

Out of Hours

In relation to GP OOHs, the CCG currently have two service providers across Rugby and Coventry localities. (Harmoni provide the service in Rugby and CWPT in Coventry). The Rugby contract with Harmoni also provides services across Warwickshire and is due to expire on 31st May 2013. A joint re-tender across Arden, Hereford and Worcester is therefore being discussed.

In order to enable alignment of process across this area, it is likely that the existing contract will be extended to September 2104 at the earliest. The CCG will need to make a decision about whether to move to one provider for Out of Hours services as part of the urgent care strategy.

Appendix 1.

DRAFT Coventry & Rugby LHE – Winter 2013/14

Category/Outcome	Actions	Lead Agency/s	Costs
Communication, education and engagement to prevent the use of A&E and the dialling of 999 – showing our populations & professionals what other options are available to them	• Work with the other CCGs across Arden to develop a clear communications, education and engagement programme building on the lessons learnt to ensure the local population are fully aware of the services available to them & what services to use when. • Key messages will focus on flu vaccine (also targeting at risk children), call to action & infection control (in relation to Noro virus) • Campaign locally to raise awareness with all professionals on what services are available as an alternative to hospital & how they are accessed.	CRCCG linking with all comms departments	Existing resources
Prevention/self management – ensuring adequate capacity in primary care to manage peaks in demands, to care for those who have long term conditions and at risk groups	• Work with NHS England to ensure that patients have access to GP appointments at peak times in demand, considering additional capacity & looking at the scheduling of primary care appointments to ease the surge on both ambulance crews and A&E. • Implement a model for providing home visit response by GP or nurse (including option for GP in an ambulance) • Locality discussions with GP members to encourage practices to introduce telephone triage so improving primary care access • Review & standardisation of Infection Control and Noro Virus policies across Arden LHE to ensure that the spread of infection is limited & reducing the need & duration of hospital ward closures.	CRCCG/AT WNCCG & SWCCG	Existing resources Winter monies Existing resources Existing resources

Providing Alternatives to hospital – improved access to community services & increased capacity to prevent avoidable hospital admissions	• Care Home support strategy that includes enhance care home support from GPs, joint working with LA to improve quality of care through endorsement of contract & access to specialist advice, guidance & training • Community Integrated Teams – accelerate the implementation in Rugby to ensure established by 1st Oct 2013 • EoL Programme	CRCCG & LA's	Resource to be identified (GP) & existing resources
Improving Hospital Flow – ensuring flexibility of staffing and bedded capacity to manage increase in demand	• GP led urgent care centre on the hospital site • Increase staff capacity in the Acute Liaison Psychiatric Team within the hospital focussing on the A&E and AMU • Inpatient capacity	UHCW CWPT/ CRCCG	Winter monies
Supporting Discharge – providing adequate community, primary care & social care support to facilitate effective discharge	• Daily conference calls with UHCW, CWPT & Coventry City Council to resolve blockages to discharge • Increased reablement capacity available including care home beds and home care provision to facilitate timely discharge supported by occupational therapists and nurse co-ordinators to ensure capacity is used effectively. • Community Integrated teams – do we need to consider increasing the capacity within these teams over winter?	UHCW CRCCG & LA CWPT/SWFT	Existing resources S256 monies Winter monies
Surge Actions – ensure additional capacity is readily available when local LHE is under pressure	• Trigger system in place to access additional community capacity (beds & home care packages) that is over an above regular capacity requirements.	CRCCG & LA	Winter monies

Briefing note

To: **Date: 24th July 2013**

Subject: The role of the Area Team with regards to primary care commissioning

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1 Purpose of the Note

1.1 To brief members on the role of the Area Team with regards to Primary Care Commissioning in Coventry

2 Recommendations

For the Board to note the contents of this briefing

3 Information/Background

3.1 From 1st April 2013, the Area Teams of NHS England have taken over the responsibility for the commissioning and contract management of all Primary Care Contracts previously managed by the Primary Care Trusts (PCTs). The Arden, Herefordshire and Worcestershire Area Team are therefore responsible for Coventry General Practices.

3.2 All Primary Care contracts are managed against a nationally stipulated framework to ensure a standardised approach across the country and are underpinned by the Regulations.

Access practices provide is monitored as part of the regular contract monitoring process as in some cases, opening hours and number of appointments are stipulated in practices' contracts. There is expectation that all practices provide sufficient access for the needs of their patient population.

A number of General Practitioners are due to retire in 2013 and the area Team is working closely with all affected practices to ensure business continuity and clinical capacity is maintained and patient care is not affected by any changes.

Further, a number of practices across Arden have expressed an interest in formally merging - a robust Regulatory process if followed and the Health Overview and Scrutiny Committee are apprised of any such proposals.

3.3 The responsibility for the commissioning of all Urgent and Emergency Care as well as Out of Hours Medical Care has moved to the Clinical Commissioning Groups (CCGs) from 1st April 2013, with the exception of the Walk in Centre, which has remained with NHS England area team as it holds a registered list.

The Area Teams retained the responsibility for the commissioning of some further key elements that support the Urgent care system, such as the Extended Opening Hours Directed Enhanced Service and Influenza Vaccination programme amongst many.

The contract for the Walk in Centre contains robust key performance indicators and performance against them is monitored quarterly. Equally, the WiC submit revised and extended capacity plans for periods of particular pressure, such as Bank Holidays and special events (such as the recent Godiva festival) to ensure sufficient capacity to cope with increased demand.

3.4 NHS England Area Teams have shared responsibility with CCGs for continuous quality improvement; the Area Teams also have an important role in performance management. We are working closely with the CCGs and constituent practices to ensure that the system capacity is well prepared for periods of particular pressure.
The Area Team and the Operations Directorate in particular are heavily involved in supporting the CCGs in development of their individual and system-wide plans.
All CCGs have a monthly Urgent Care Board, which is attended by representatives of the Area Team.
Further, all CCGs have recently revised their escalation plans to ensure system preparedness and are at present reviewing and revising the Surge and Winter plans.

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Briefing note

To: Health and Social Care Scrutiny Board (5) **Date:** 24th July 2013

Subject: Briefing on a proposed contract merger (Dr Jagadeshwari and Dr Ezzat and Partners)

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1 Purpose of the Note

The Area Team has received a formal request from Dr Jagadeshwari and Dr Ezzat for a contractual merger, which was approved in principle at the Primary Care Committee.
The Board are asked to support this decision so the merger process can commence

2 Recommendations

For the Board to note the contents of this briefing and to support the decision of the Primary Care Committee to approve the proposed merger

3 Information/Background

3.1 Dr Jagadeshwari practices from Maidavale surgery in Styvechale Coventry (M86043). She holds a single handed GMS contract and the practice list is approximately 2300 patients. Dr Ezzat is a senior partner in Phoenix Family Care (M86007) based in Park Road, Coventry with two other current partners and a practice list of approximately 5800.

3.2 The contract holders are proposing a full contractual merger at earliest opportunity. Both sets of contract holders are keen to merge the contracts as soon as possible to enable robust succession planning for both practices – Dr Jagadeshwari is looking to retire from practice soon and the merger will enable continuity of care to be maintained for her list.

3.3 There are some issues with the quality of Maidavale practice premises. The medium term view, should the merger go ahead, is to designate those as a branch premises and close them down so that all services are provided from the Phoenix site. The practice has undergone some refurbishment and further improvements are planned shortly to accommodate the list. The Area Team feel assured this will have minimal impact on patient care.

3.4 Following a joint meeting with both practices, the contracting team feels reassured about the process the practices will follow to ensure all the regulatory requirements around consultation with staff and patients will be followed.
Considerable consideration has been given by both sets of contract holders to the practical aspect of the merger including service provision, staff consultation etc.

3.5 We have requested the relevant regulatory information and a service plan to enable us to commence the contract merger process and the practices have submitted both. Significant consideration has been given to access to services, clinical capacity in house and the range of services provided and the area team feels the merger will be beneficial to patients from both practices. The practice boundary will not be affected by the merger.

3.6 Once supported by the Scrutiny Committee, formal merger process will commence.

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Health and Social Care Scrutiny Board (5)
Work Programme 2013/14

Date 24th July 2013

For more details on items, please see pages 3 onwards

19 June 2013
Induction and work planning
UHCW Quality Account
CWPT Quality Account
Communicable Disease Control and Outbreak Management

24 July 2013
Attendances at A and E – University Hospital site
Amalgamation of two Coventry GP practices

25 September 2013
Francis Report
Adult Social Care Bill
Tbc Care Quality Commission (CQC)

6 November 2013
ABCS – A Bolder Community Services
NHS 111
Public and Patient Engagement

4 December 2013
Dementia diagnosis pathways
Commissioning of third sector organisations – particularly around support for LTC

15 January 2013
Commissioning landscape of the City (Jan / Feb)
What impact has the CCG had?
Has it added value? Is it cost effective?
What is the impact on GPs and their services?
Health and Wellbeing Board Work Programme – Chair to attend a Board meeting

5 February 2014
Sexual health services

5 March 2014
Physical healthcare of LD & MH patients

2 April 2014

30 April 2014

Date to be determined
Patient discharge from UHCW
Financial position at the hospital
Complaints at UHCW / wider health economy and how they are used to improve quality?
NHS England Local Area Team
Nutritional standards in inpatient care
DPH Annual Report
Private companies running GP practices

Meeting Date	Work programme item	Lead officer	Brief Summary of the issue	Source	Format
19 June 2013	Induction and work planning	Simon Brake / Peter Barnett	Short briefings on the remit of the Board and introduction to NHS organisations. First thoughts on the work programme.		Informal meeting / report
	UHCW Quality Account	Andy Hardy (Chief Exec UHCW)	NHS provider Trusts are required to produce annual statements of quality priorities and outcomes. The Board has a role in providing a short commentary on progress.	Legislation	Report / presentation
	CWPT Quality Account	Tracy Wrench (Director of Nursing CWPT)	As above	Legislation	Report / presentation
	Communicable Disease Control and Outbreak Management	Jane Moore	CCC Public Health / Public Health England / LAT – discussion on MMR / Measles – prevention of communicable disease, local resilience.	Chair's Request	Report / presentation
24 July 2013	Attendances at A and E – University Hospital site	UHCW / CCG / LAT / Local GPs	Recently hospital chief executives across the region have expressed concerns about the continued growth in A&E Attendances. The Board has been advised of significant failures in meeting the 95% target for people being seen within 4 hours. Issues to discuss: A&E Safety and Performance overall What are the numbers? 24 hour admission rate, staffing levels Breaches? What happens? What are we doing about it Trolley waits? A&E links to other problems at the hospital / quality.	Work programme	Report / presentation

	Amalgamation of two Coventry GP practices	NHS England	Two Coventry GP practices are proposed to be amalgamated into one practice and the local primary care commissioners (NHS England) are seeking the support of the Scrutiny Board for this proposal.	Statutory request	Report
25 September 2013	Francis Report	Simon Brake / Peter Barnett	- What Francis means to local Trusts - How propose to implement duty of candour - Impact on patients in Trust premises and / or at home - What are implications for the CCG - What are the implications for the City Council	HWB / Cabinet Member request	Briefing / attendance by NHS executives.
	Adult Social Care Bill	Brian Walsh / Simon Brake	The Government has published an Adult Social Care draft Bill to which it is intended that the Council will make a formal response.	Cabinet Member request	Cabinet Report
	Tbc Care Quality Commission (CQC)	Lesley Ward (CQC)	Follow up to April meeting and developing role of CQC in particular re care homes/ social care settings. Linked to above	Work programme	
6 November 2013	ABCS – A Bolder Community Services		Major programme of service re-design and change intended to reflect budget challenges for Adult Social Care services, part of wider Citywide consultation.	Cabinet Member request	Consultation document / presentation
	NHS 111		Request current position and revised plans Impact of this on UHCW A&E pressures	Work programme	

	Public and Patient Engagement		By local Trusts / CCG role / Healthwatch's role and how the public interact with and influence Health Services.	Work programme	
4 December 2013	Dementia diagnosis pathways				
	Commissioning of third sector organisations – particularly around support for LTC				
15 January 2013	Commissioning landscape of the City (Jan / Feb) What impact has the CCG had? Has it added value? Is it cost effective? What is the impact on GPs and their services?				
	Health and Wellbeing Board Work Programme – Chair to attend a Board meeting		Chair to be invited, examine Health and Wellbeing Strategy and progress		
5 February 2014	Sexual health services				
5 March 2014	Physical healthcare of LD & MH patients				
2 April 2014					
30 April 2014					

Date to be determined	Patient discharge from UHCW				
	Financial position at the hospital				
	Complaints at UHCW / wider health economy and how they are used to improve quality?				
	NHS England Local Area Team		what is their role? Role in A&E planning / primary care conversation / NHS front-door		
	Nutritional standards in inpatient care		policies / procedures for inpatient providers - Councillors visit / trial?		
	DPH Annual Report				
	Private companies running GP practices		Progress report and examination of outcomes		

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