Wiltshire Council
Where everybody matters

AGENDA

Meeting: Health Select Committee

Place: Kennet Room - County Hall, Trowbridge BA14 8JN

Date: Tuesday 11 March 2014

Time: **10.30 am**

Please direct any enquiries on this Agenda to Samuel Bath, of Democratic Services, County Hall, Bythesea Road, Trowbridge, direct line (01225) 718211 or email samuel.bath@wiltshire.gov.uk

Press enquiries to Communications on direct lines (01225) 713114/713115.

This Agenda and all the documents referred to within it are available on the Council's website at www.wiltshire.gov.uk

Membership:

Cllr Chris Caswill
Cllr Mary Champion
Cllr Christine Crisp (Chair)
Cllr Mary Douglas
Cllr Bob Jones MBE
Cllr Gordon King
Cllr Dr Helena McKeown
Cllr John Noeken (Vice Chairman)
Cllr Jeff Osborn
Cllr Sheila Parker
Cllr Nina Phillips
Cllr Pip Ridout
Cllr Ricky Rogers

Substitutes:

Cllr Pat Aves
Cllr Chuck Berry
Cllr Rosemary Brown
Cllr Terry Chivers
Cllr Dennis Drewett
Cllr Sue Evans
Cllr Russell Hawker
Cllr David Jenkins
Cllr Julian Johnson
Cllr John Knight
Cllr Ian McLennan
Cllr Helen Osborn
Cllr Mark Packard

Stakeholders:

Steve Wheeler	Healthwatch Wiltshire
Diane Goonch	Wiltshire & Swindon Users Network (WSUN)
Brian Warwick	Advisor on Social Inclusion for Older People

PART I

Items to be considered whilst the meeting is open to the public

1 **Apologies**

To note any apologies for the meeting.

2 **Minutes of the Previous Meeting** *(Pages 1 - 8)*

To approve and sign the minutes of the meeting held on 14 January 2014.

3 **Declarations of Interest**

To receive any declarations of disclosable interests or dispensations granted by the Standards Committee.

4 **Chairman's Announcements**

To note any announcements through the Chair.

5 **Public Participation**

The Council welcomes contributions from members of the public.

Statements

If you would like to make a statement at this meeting on any item on this agenda, please register to do so at least 10 minutes prior to the meeting. Up to 3 speakers are permitted to speak for up to 3 minutes each on any agenda item. Please contact the officer named above for any further clarification.

Questions

To receive any questions from members of the public or members of the Council received in accordance with the constitution. Those wishing to ask questions are required to give notice of any such questions in writing to the officer named above no later than **5pm** on **4 March 2014**. Please contact the officer named on the first page of this agenda for further advice. Questions may be asked without notice if the Chairman decides that the matter is urgent.

Details of any questions received will be circulated to Committee members prior to the meeting and made available at the meeting and on the Council's website.

6 **Royal United Hospital**

The Royal United Hospital (RUH) was one of eighteen hospitals selected to be included in the first round of inspections made under the new CQC hospital inspection regime. The inspection was carried out over 3 days, 5, 6 and 12 December 2013 and the Quality Report was published on 6 February 2014.

The Report can be accessed via the following link: http://www.cqc.org.uk/directory/RD130 or alternatively, a PDF document containing the full report can be downloaded here.

James Scott, Chief Executive, RUH will be in attendance to discuss the report. In addition Dr Tim Craft, Medical Director will also be present to update the Committee on the latest elderly care and discharge procedures at the RUH.

The Committee is asked to note the report.

7 **South Western Ambulance Service Foundation Trust Performance** *(Pages 9 - 14)*

The South Western Ambulance Service Foundation Trust (SWASFT) has provided ambulance services in Wiltshire since February 2013, when it acquired the Great Western Ambulance Service (GWAS).

Neil Le Chevalier, Deputy Director of Delivery and Paul Burkett-Wendes, Head of Operations (North) will be in attendance to report on the performance of SWASFT in Wiltshire. They will also describe the training they have implemented to reduce unnecessary admissions to hospitals. A copy of the report is attached to the agenda.

The Committee is asked to comment on the report.

8 **NHS 111 Performance** *(Pages 15 - 24)*

At its meeting in November the Committee asked that the Clinical Commissioning Group (CCG) return to its March meeting with performance figures for Harmoni, who provide the NHS 111 service in Wiltshire.

Patrick Malcahy, Interim Associate Director of Commissioning for Urgent Care, CCG will be in attendance to present the report and respond to questions. A copy of the report is attached to this agenda, alongside a leaflet on the patient transport service for the Committee's information.

The Committee is asked to comment on the report.

9 **Non-Emergency Patient Transport Service** *(Pages 25 - 50)*

The contract for non-emergency passenger transport service (NEPTS) was awarded to Arriva Transport Solutions (ATS), the contract was effective from 1 December 2013 and runs for five years. This service is for patients who have a

non-emergency medical need and require help with transport to reach their hospital appointment.

The Committee were concerned to receive reports of poor experience for some patients and flows through the acute hospitals being affected due the capacity constraints of ATS. It is understood that the acute hospitals have had to provide additional patient transport on occasion.

Andy Jennings, Commissioning Manager, CCG and Ed Potter, Arriva Head of PTS South West, will be in attendance to present the report and respond to questions. A copy of the report is attached to this agenda.

The Committee is asked to comment on the report.

10 **Sickness/absence figures for Community Maternity Service** *(Pages 51 - 52)*

In September 2013 the Great Western Hospital (GWH) presented a report in response to concerns the Committee had over the temporary closure of the Trowbridge Birthing Centre, with births previously planned for Trowbridge being transferred to Bath; this did not affect ante-natal care at the Centre. The Committee was satisfied with the response from the GWH but requested that it receive updated figures on sickness/absence and vacancy levels for the service at its March meeting.

The figures are provided in the agenda pack and are for the Wiltshire maternity service encompassing all of the Birth Centres – Chippenham, Trowbridge, Paulton, Shepton Mallet, Frome and the Princess Anne Wing in Bath. A update from Great Western Hospital is included in the Agenda Pack detailing the figures and a brief explanation of performance.

The Committee is asked to note the update.

11 **National Child Measurement Programme** *(Pages 53 - 66)*

At its meeting in January the Committee requested a report on the incidence of child obesity in Wiltshire, and the figures provided in the latest National Childhood Measurement Programme (NCMP) report.

John Goodall and Lucy James, both from Public Health will present the report and respond to questions. A copy of the NCMP report is attached for the Committees consideration. A copy of the 'Results of the National Childhood Measurement Programme for Wiltshire' will be available to view online, and will be made available in hard copy at the meeting.

The Committee is asked to comment on the report.

12 **Bristol Royal Hospital for Children** *(Pages 67 - 70)*

The Committee will be aware of the inquest held recently into the death of a Wiltshire child in March 2012 at the Children's Hospital in Bristol, following cardiac surgery. The Committee received communication from the Chief Executive of the Hospital both before and after the inquest (letters attached).

There have been a number of deaths of children at the Hospital and the Health Select Committees in Bristol and South Gloucestershire are working together to look at the cardiac services at the Hospital.

Subsequently Sir Bruce Keogh asked Sir Ian Kennedy to conduct an inquiry into the deaths of children following heart surgery at the Hospital, after a meeting with a number of families concerned about the care being given to children. A copy of the correspondence received is attached for the Committee's information.

The Committee is asked to note the report.

13 **Forward Work Programme** *(Pages 71 - 72)*

The Committee is asked to consider the attached work programme.

14 **Task Group Update**

Verbal updates on Health Select Committee Task Group activity will be given at the meeting.

15 **Urgent Items**

To consider any other items of business that the Chairman agrees to consider as a matter of urgency.

16 **Date of Next Meeting**

The Committee is asked to note the date of the next meeting.

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Wiltshire Council
Where everybody matters

HEALTH SELECT COMMITTEE

DRAFT MINUTES OF THE HEALTH SELECT COMMITTEE MEETING HELD ON 14 JANUARY 2014 AT KENNET ROOM - COUNTY HALL, TROWBRIDGE BA14 8JN.

Present:

Cllr Mary Champion, Cllr Christine Crisp (Chair), Cllr Mary Douglas, Diane Gooch, Cllr Bob Jones MBE, Cllr Gordon King, Cllr Helena McKeown, Cllr John Noeken (Vice Chairman), Cllr Jeff Osborn, Cllr Sheila Parker, Cllr Nina Phillips, Cllr Pip Ridout, Brian Warwick and Steve Wheeler

Also Present:

Cllr Peter Evans and Cllr Jon Hubbard

1 **Apologies**

The Committee noted apologies from the following:

Cllr Chris Caswill;
Cllr Nina Phillips;
Cllr Ricky Rogers;
Cllr Keith Humphries and
Nerissa Vaughan - Chief Executive, Great Western Hospital

2 **Minutes of the Previous Meeting**

The minutes of the previous meeting held 19 November 2013 were presented and subject to amendments to item 105, it was,

Resolved:
To approve the minutes of the meeting as a true and accurate record

3 **Declarations of Interest**

Standing Declarations of Interest were noted. No additional declarations were made at the meeting.

4 **Chairman's Announcements**

Positron Scanner
The Chair and Vice Chair visited Royal United Hospital (RUH), Bath on Friday 10 January 2014 to learn about the new Positron Scanner.

RUH Inspection Report

The report from the latest inspection of the RUH will be published on 4 February following the Quality Summit. The Chair and Vice Chair will be meeting James Scott, Chief Executive, on 10 February to discuss the report.

RUH Visit

At the previous HSC meeting in November 2013, James Scott extended an invitation for a number of members to visit the RUH. The invitation is open to 10 committee members to attend, and members had a choice of two possible dates, Monday, 27 January or Monday 3 February both starting at 2pm. Members were asked to express an interest in attending.

South Western Ambulance Service: Joint Scrutiny Meeting

Cllrs John Noeken and Pip Ridout will be attending a meeting of joint scrutiny committee of the South Western Ambulance Service Foundation Trust (SWASFT) on 31 January at Bristol and will report back to the Committee at the next meeting.

Arriva Patient Transport Service

The Chair drew the Committee's attention to issues regarding patient transport following the contract awarded to Arriva. Further enquiries were being made, and the Committee would be kept informed once more is known.

The Committee also welcomed a new member of the scrutiny team, Emma Dove, who joined the Council in December, and would support the Council's scrutiny function.

5 **Public Participation**

No questions had been receiived from members of the public.

6 **Care Quality Commission: New Inspection Arrangements**

Justine Button, Compliance Manager for Bath and North East Somerset (Banes) and Wiltshire Care Quality Commission was in attendance to give a presentation on the new hospital inspection regime.

The presentation detailed changes to the regime which included 5 key themes for identifying quality and safety within hospital settings. These were safe practice, effective treatment, caring attitudes, responsive care and well led teams.

The CQC aims to inspect all NHS Hospital and Foundation Trusts by December 2015 and aims to re inspect hospitals when necessary to complete focussed reviews in response to areas of particular concern. The inspection programme will also be extended to include mental health trusts, community services and ambulance trusts.

An overview of the inspection process was detailed identifying key processes for preparation, site visits and reports. Focus was also given to the construct of inspection teams which would now include a wide range of experts, service users, managers and practitioners. Focus would be given to core services of hospitals, including A&E, emergency medical and surgical services, critical care, maternity, paediatrics and end of life care. Inspections would also focus on areas of concern as a result of intelligence gathering exercises and target specific areas with both announced and unannounced inspections.

An overview of report findings and ratings will be given, and a summary of the reporting matrix given. Hospitals would be ranked across all areas inspected and also for specific key criteria as detailed above. A rating would also be given for the trust as a whole. Rating categories used were based on the OFSTED inspection model and would be graded as outstanding, good, requires Improvement or inadequate. This will allow the CQC to identify areas of good practice in addition to identifying areas of concern.

The Committee discussed the role of unannounced inspections and the importance of timing visits to assess areas of concern at periods of heightened problems. The Committee also questioned the involvement of service users and patient groups in the inspection process. It was confirmed that service users and groups would play pivotal roles in conducting inspections and providing information during the inspection process. The Committee also questioned the role of the CQC in inspecting care and nursing homes. It was confirmed that changes to the Adult Social Care inspection regime had also been planned and would be conducted in a similar fashion to the hospital inspection process. The Committee discussed powers of entry with unannounced visits and discussed how Healthwatch could support the inspection process.

Resolved:

To receive a presentation from the Care Quality Commission detailing changes to the Adult Social Care inspection regime at its meeting in May/July 2014.

7 **Great Western Hospital (GWH): Inspection Report**

Hilary Walker, Chief Nurse, and Kevin McNamara, Director of Strategy at Great Western Hospital (GWH) were in attendance to discuss the outcome of the CQC inspection and to outline the Hospital's action plan.

Hilary Walker outlined the key areas of concern highlighted by the report and presented the action plan to address the concerns indentified. This included cleanliness issues, staffing concerns, governance and monitoring problems and concerns surrounding patient record keeping practices.

Ms Walker identified changes made by the Hospital to target the findings of the CQC report and highlighted the appointment of new nursing staff and practice development nurses to support the development of the existing nursing teams.

The Committee questioned the dispute between GMB members and Carillion, and wanted to know if the dispute had directly impacted the findings in the report. Earlier in the dispute there had been reported strike action but there had not been strike action this year, although a number of ongoing tribunals were said to be having an impact on operations within GWH.

The Committee discussed the current nursing arrangements and queried the ratio of nurses to patients at GWH. Hilary Walker stated that GWH recognised that staffing levels were not where they should be to support 1:7 nursing care, but that £1.2m investment in extra staffing was going some way to address this issue. An effort had been made to recruit additional staff but there were still gaps and more work was needed to be able to reduce reliance on agency staff.

The Committee questioned the medicinal practices at GWH and asked if this had been a result of governance failings or a cultural problem within GWH. It was confirmed that governance processes were in place to monitor such practices and welcomed the suggestion that other areas of governance might be audited.

The Committee expressed concern at the findings of the CQC report and suggested that findings were a ‘wake up call’ to the leadership team. The Committee also noted that the findings identified were made under the old inspection regime, and stated that a better picture of the Hospital might be achieved following an inspection under the new regime.

The Committee discussed the appointment of overseas nurses and queried if this had an impact on some of the concerns raised in the CQC report. The Committee also questioned the role of agency nurses in the findings. It was confirmed that GWH worked with TTM Healthcare when recruiting overseas nurses. One of the requirements of the recruitment programme was an adequate understanding of the English language. However some difficulties were to be expected such as dealing with patients with strong accents or over the telephone. GWH stated that these concerns were minor issues and would not have negatively impacted the CQC findings.

The Committee discussed the use of whiteboards on wards to document patient activity. It was confirmed that GWH had applied for funding to support a digital whiteboard installation that would provide greater security to patient information due to its screen saver function.

The Committee expressed concerns over medication and the operational hours of the Pharmacy. GWH confirmed that the national review on hospital operational hours was starting to lean towards 7 day openings and that GWH was reviewing how this could be implemented in future.

The Chair then allowed Cllr John Hubbard to address the Committee. Cllr Hubbard expressed concern at the governance practices within the Hospital, and highlighted the link between culture and governance failings. It was confirmed that the failings identified in the administration of medicine was linked to a policy lapse. A policy audit was suggested and would be considered by GWH.

The Committee raised concern over possible communication issues due to language between housekeeping staff and patients, and suggested this could be a potential cause for concern. GWH stated that a response to this question would be provided in writing as the data for this was not readily available.

Resolved:
To note the GWH action plan for the CQC inspection, and to document concern at the findings of the report.

8 **Dementia Strategy**

James Cawley, Associate Director for Adult Care Commissioning and Susan Dark, Dementia and Specialist Older People Modernisation Lead, Wiltshire CCG were both in attendance to present the joint commissioning Dementia Strategy.

The Committee noted concern over the lack of information regarding funding for the initiative. It was confirmed that funding information would be made clearer following discussion of the Better Care Fund at the Wiltshire Health and Wellbeing Board. The strategy would be put out to formal consultation following its consideration by Cabinet.

The Committee noted that it would be difficult to deliver on all areas of dementia as the impact of dementia was so wide reaching, and funding could not support every instance of dementia related care. The Committee noted that the Strategy would need greater focus on areas of priority to ensure its success. It was noted that the CCG would be investing £7.5 million to support people with dementia and their carers and family. The Committee discussed the impact of other neurological conditions linked to dementia; including Parkinson's disease, and questioned whether the delivery of the strategy would be inclusive of such conditions.

The Committee also noted concern at the lack of paid carers throughout the county and stated that the strategy would need greater focus on increasing the number of paid carers across the region. The Committee also discussed housing options and the provision of sustainable care packages.

Resolved:

To make a statement to Cabinet detailing the following;

a) **The Health Select Committee was pleased with the work that had been done so far, and supported the Strategy.**
b) **Some concerns about funding were raised, but the Committee acknowledged that the formal consultation on the strategy will help identify key priorities.**

c) **The Committee will comment further following receipt of the post-consultation report**

9 **Wiltshire Council Direct Provision - CQC Registered Care Services for Adults**

The Committee received an update from James Cawley, Associate Director for Adult Care Commissioning detailing the achievements of service areas in relation to CQC ratings.

The Committee noted the achievements and queried if any key events had occurred to report back to the CQC. It was confirmed that no key events had to report.

10 **Salisbury Hospital: Mortality Rates**

The Chair outlined a meeting that had taken place at Salisbury Hospital between herself, the Vice Chair and Peter Hill, Chief Executive, and Christine Blanchard, Medical Director, Salisbury Hospital FT, relating to the mortality rates as published in the 2013 Dr Foster Hospital Guide, which showed Salisbury Hospital FT as having a mortality rate 'significantly higher than expected'.

It was explained that the way the mortality figures are calculated is complex, with the application of a number of codes, but essentially they compare the numbers of patients who have died against the number that might be expected to die. The hospital explained that the figure reported represented a blip in their performance, which they had identified and addressed themselves before the Dr Foster report was published. They have been monitoring their mortality figures on a monthly basis for a number of years. They have a multi-disciplinary mortality steering group which uses a system which allows them to drill down and audit individual records if they have concerns.

The hospital looks at trends rather than individual results but clinicians also look at the notes of patients who have died to identify any potential learning. They explained that they now send out 'lesson of the week', which can be an area for improvement or an example of good practice.

The Chair and Vice Chair were re-assured by what they heard and were satisfied with the procedures that the hospital has in place to monitor and improve mortality figures, which are usually within the expected range.

They also noted that the CQC, from their intelligence monitoring work has grouped the acute NHS Trusts into six bands based on the risk that people may not be receiving safe, effective, high quality care. Salisbury Hospital FT has been placed in band 6, the band with the lowest risk.

11 **Older Peoples Expenditure**

James Cawley, Associate Director for Adult Care Commissioning provided an update against the projected overspend on the Older People's Budget.

It was confirmed that as of Month 8, the budget was overspent by £1.8million. It was noted that the figures could fluctuate significantly throughout the year if a service user was assessed as needing a very expensive package or if a similar service user no longer needed it. It was confirmed that expenditure was continuously monitored and that for the last 3 – 4 years, the budget had been within 1% of the forecasted expenditure figure at the end of the financial year.

12 **Update on Transition of Public Health to Wiltshire Council**

Aimee Stimpson, Head of Performance and Planning, presented an update to the Committee which detailed the successful integration of Public Health into the Council. The report detailed a number of examples of Public Health's transition into the Council and the impact on service delivery as a result.

The Committee agreed that Public Health would continue to play a pivotal role in service delivery and agreed that all aspects of the Council's responsibilities were interrelated with public health and wellbeing. As a result the Committee stated its intention to support further work to integrate Public Health at all levels of the organisation.

13 **Joint Air Quality Task Group: Final Report**

The Committee received a report from Cllr Peter Evans, Chair of the Joint Air Quality Task Group, which detailed the final findings.

The Committee discussed the findings of the report and debated the closure of the task group following the completion of its work programme.

The Committee discussed the impact of Air Quality on school travel plans as detailed in the report.

Resolved:
The Committee endorsed the following recommendations of the Joint Air Quality Task Group:

a) **The 'template' created by the Calne Area Board to stage their Environment Event should be made available to other interested Area Boards.**

b) **A mechanism/process should be developed to allow Area Boards to share examples of good practice/templates for other successful activities;**

c) **Having completed its work, the Task Group is to be disbanded.**

14 **Forward Work Programme**

The Committee noted the forward work programme.

15 **Task Group Update**

The Committee noted updates from the following Task Groups;

- Transfer to Care;
- Continence Services;
- Review of AWP Services; and,
- Clinical Commissioning Group.

Following discussions on the work of the CCG Task Group and Public Health topics the Committee;

Resolved:

a) **To seek endorsement from the Overview and Scrutiny Management Committee to disband the CCG Task Group**

b) **To include Public Health and the Clinical Commissioning Group as standing agenda items for future meetings.**

16 **Urgent Items**

There were no Urgent Items.

17 **Date of Next Meeting**

The date of the next meeting was confirmed as being the 11 March 2014.

(Duration of meeting: 10.30 am - 2.10 pm)

The Officer who has produced these minutes is Samuel Bath, of Democratic Services, direct line (01225) 718211, e-mail samuel.bath@wiltshire.gov.uk

Press enquiries to Communications, direct line (01225) 713114/713115

Wiltshire Health Select Committee

Report from South Western Ambulance Service NHS Foundation Trust

Tuesday 11 March 2014

Wiltshire Performance

South Western Ambulance Service NHS Foundation Trust (SWASFT) has many performance targets relating to both the quality of clinical care and response times. In terms of response times, Red 1 performance is perhaps the most high profile target for all ambulance services. The overall performance standard for the Trust is to reach 75% of calls categorised as Red 1 or Red 2 within eight minutes.

It is important to note that these performance targets are for the whole Trust and are not recorded or commissioned at individual Clinical Commissioning Group (CCG) level.

For South Western Ambulance Service NHS Foundation Trust, the Red 1 target equates to an average of just over 3 calls per day in Wiltshire. This small number of calls, unpredictable in nature and location, mean that achieving the Red 1 performance target is a real challenge for SWASFT. The rural nature of Wiltshire makes this an even greater challenge for the Trust.

South Western Ambulance Service NHS Foundation Trust's performance figures for Wiltshire from April 2013 to January 2014 are attached to this report.

South Western Ambulance Service NHS Foundation Trust is very focused on meeting the eight-minute response target and a range of initiatives have been put in place to help improve our performance in this area. These include the recruitment of Community First Responders and the roll out of public access defibrillators, as well as a number of internal schemes to make more staff available at peak times. Whilst we are seeing some improvements in our performance across the South West, we are still struggling to meet response times in our more rural areas, including Wiltshire.

The Trust continues to review activity and demand across the region as well as the allocation of resources across the Trust. Discussions with our commissioners continue to review demand, activity and performance and we have identified that additional resources are required to meet the level of overall demand in the area. If funded, we are confident this will bring about marked improvements in our response times. However, we recognise

the competing funding priorities facing commissioners and are working to establish how we can best improve performance through the use of the schemes highlighted above.

Staff Training to Reduce Hospital Admissions

South Western Ambulance Service NHS Foundation Trust is committed to reducing the number of patients admitted to hospital. Where appropriate alternative care can be given, either over the telephone, in the patient's home or by a referral to other health or social care services, Trust staff are committed to delivering the right care in the right place at the right time.

Hospital avoidance can be defined as the ability of paramedics (and other clinicians) to treat or refer patients through a care pathway that is more appropriate to their individual needs, rather than simply conveying them to the nearest emergency department. This approach has developed over a number of years and in many ways.

As a result, South Western Ambulance Service NHS Foundation Trust has the lowest conveyance rates in the country, meaning that more patients in the South West are triaged and treated or referred to more appropriate services by one of our staff over the telephone or in their own homes. In turn this helps to reduce the pressure on our hospitals as well as offering better care and a better experience for our patients.

Most paramedics now enter their profession via a university programme at diploma or degree level. University curricula vary, but take account of guidance from the professional body (College of Paramedics) which now includes aspects such as patient assessment and examination and various facets of urgent care provision, rather than just a focus on the traditional aspects of trauma and resuscitation. All universities now teach paramedics to examine patients using the medical model and to utilise alternative care pathways, whilst also managing a much greater number of patients at home using an ever increasing range of medicines and techniques. Paramedics can now be considered as 'first contact practitioners'.

After they graduate and are recruited by SWAST, paramedics are now offered an induction and preceptorship package which allows them to get used to their new place of work. A key component of this is the ability to learn about local multi professional healthcare provision and resources so that they can start to learn about what is available to them in their locality. They are supported in doing so by a range of SWAST line management and support staff, these include Clinical Support Officers, Clinical Quality Leads and Clinical Tutors as well as personal mentors.

Every year, the Trust produces a Training Needs Analysis (TNA), which takes into account a range of elements that are essential to the continued education of staff and which contribute to clinical safety and high quality care. These include locally commissioned quality indicators (CQUINs), learning from serious incidents and feedback from staff. The

TNA informs annual core training. As an example this year we will train staff over two days (face to face) on:

- Clinical decision-making
- Conveyance decisions and identification of appropriate pathways
- Medical models of history taking
- Health records and documentation
- Domestic violence

SWAST is aiming to provide an ever increasing range of Continual Personal Professional Development (CPPD) over and above core training. CPPD takes many forms, from a career development pathway into specialist practice to short courses, sessions and study days. Subjects are extremely diverse and this year we are currently developing a 'shop window' web page: www.learnwithswast.co.uk to provide a portfolio of what is on offer.

Again, CPPD opportunities concentrate on developing clinical skills and educating our health professionals about the wide range of options for a more patient-focused approach to care.

NHS 111

The NHS 111 service in Wiltshire is provided by Harmoni. South Western Ambulance Service NHS Foundation Trust is working closely with Harmoni to ensure that collaborative working supports a high quality service for patients, particularly those patients that are transferred from NHS 111 to the Trust.

When Harmoni first launched the NHS 111 service in Wiltshire, call volumes and call transfers to South Western Ambulance Service NHS Foundation Trust were higher than expected. SWASFT worked with Harmoni to assist in the management of these calls and to reduce the number of calls transferred by providing a clinical supervisor in the NHS 111 call centre.

The number of calls transferred from NHS 111 to the ambulance service remains an issue for SWASFT, particularly since the majority of these transfers occur during periods of peak activity, such as weekends.

The Trust has recently attended a very useful meeting with Harmoni, hosted by Gloucestershire CCG, regarding NHS 111 in SWASFT's North Division. All parties are working together to review and agree arrangements for call triage and call transfers.

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Red performance – Wiltshire

		April 2013	May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	YTD Wilts	YTD SWASFT
RED1 (8-minute response) TARGET 75%	Sum	105	101	101	115	104	127	119	121	138	135	1166	11143
	Compliant	62	66	63	75	59	66	59	69	79	85	683	8030
	Performance	**59.05%**	**65.35%**	**62.38%**	**65.22%**	**56.73%**	**51.97%**	**49.58%**	**57.02%**	**57.25%**	**62.96%**	**58.6%**	**72.06%**
RED2 (8-minute response) TARGET 75%	Sum	1732	1709	1694	1754	1707	1701	1832	1830	2085	1919	17963	247674
	Compliant	1162	1128	1132	1086	1099	1083	1105	1182	1303	1266	11546	191309
	Performance	**67.09%**	**66.00%**	**66.82%**	**61.92%**	**64.38%**	**63.67%**	**60.32%**	**64.59%**	**62.49%**	**65.97%**	**64.3%**	**77.24%**
RED19 (19-minute response for transport) TARGET 95%	Sum	1836	1808	1792	1865	1810	1824	1948	1948	2219	2051	19101	257956
	Compliant	1687	1676	1643	1675	1648	1648	1735	1758	2011	1836	17317	247026
	Performance	**91.88%**	**92.70%**	**91.69%**	**89.81%**	**91.05%**	**90.35%**	**89.07%**	**90.25%**	**90.63%**	**89.52%**	**90.7%**	**95.76%**

Definitions

Red1

The Red1 category refers to those patients who are suffering an immediately life-threatening emergency; cardiac arrest, respiratory arrest, choking.

The standard for these calls is to arrive on scene within eight minutes, 75% of the time.

Red2

The Red2 category refers to those patients who are suffering a potentially life-threatening emergency; heart attack, severe breathing problems, serious bleeding.

The standard for these calls is to arrive on scene within eight minutes, 75% of the time.

Red19

The Red19 standard requires the attendance of a vehicle that is suitable to convey the patient, to arrive on scene within 19 minutes, 95% of the time.

NHS
Wiltshire
Clinical Commissioning Group

Report on NHS 111 Performance
1st November 2013 to 16th February 2014
for
Wiltshire Council Health Select Committee
11th March 2014

1 CONTEXT

The Contract for the delivery of the NHS 111 service was awarded to Harmoni by NHS Wiltshire in July 2012 following a South West procurement process; Harmoni has since been taken over by Care UK Ltd. The NHS 111 service in Wiltshire commenced "soft launch" on 19 February 2013.

As the Health Select Committee are aware, the Performance of the NHS 111 provider in our area was unacceptable during the initial period, and Full Service Commencement was not reached nor a Service Acceptance Certificate issued within the originally anticipated timeframe of March 2013. The CCG Governing Bodies for Wiltshire and Bath and North East Somerset (BaNES) met three times to consider the performance issues and clinical risks; firstly on 24 April 2013, and on 19 June 2013, and then on 17 September 2013 to agree to migrate to Full Services Commencement. The Clinical and Managerial leadership of the CCG were kept fully apprised of developments regarding this service by weekly updates from the Rectification Task Force (which was chaired by Wiltshire CCG and included the other CCGs and established 10 April 2013), and verbal updates in both Governing Body and Executive meetings.

Essentially, given the very poor start of the Service earlier in the year, the Governing Bodies decided to defer the timeline for implementation and the CCGs entered into a Rectification Plan phase with Harmoni in order to remedy the service failures and breaches to date. During this period contingency plans were enacted in order to backstop the service, and at the last meeting of the Joint Governing Body the direction was inter-alia to pursue options to preserve a dedicated Health Care Professional line within the service whilst continuing to work with Harmoni-to bring the Service up to an acceptable standard. This Health Care Professional Line has been in place ever since to provide specified services (such as paramedics, MIU, pathology and Care Homes) and pre agreed patient groups (those on palliative care registers) direct access to the Out of Hours service for clinical advice, and arrange an appointment or visit if required.

The Service reached Full Service Commencement on 28th October

2 GOVERNANCE

Wiltshire Clinical Commissioning Group and Bath and North East Somerset Clinical Commissioning Group act as co-commissioners for the contracted provision of NHS 111 services by Harmoni (Care UK Ltd). Similar co-commissioner arrangements exist between Gloucestershire Clinical Commissioning Group and Swindon Clinical Commissioning Group; and the South West Commissioning Support Unit who provide contractual support to Bristol, South Gloucestershire and North Somerset Clinical Commissioning Groups.

Collectively a contract management group has been established that meets with Harmoni to review the monthly performance report.

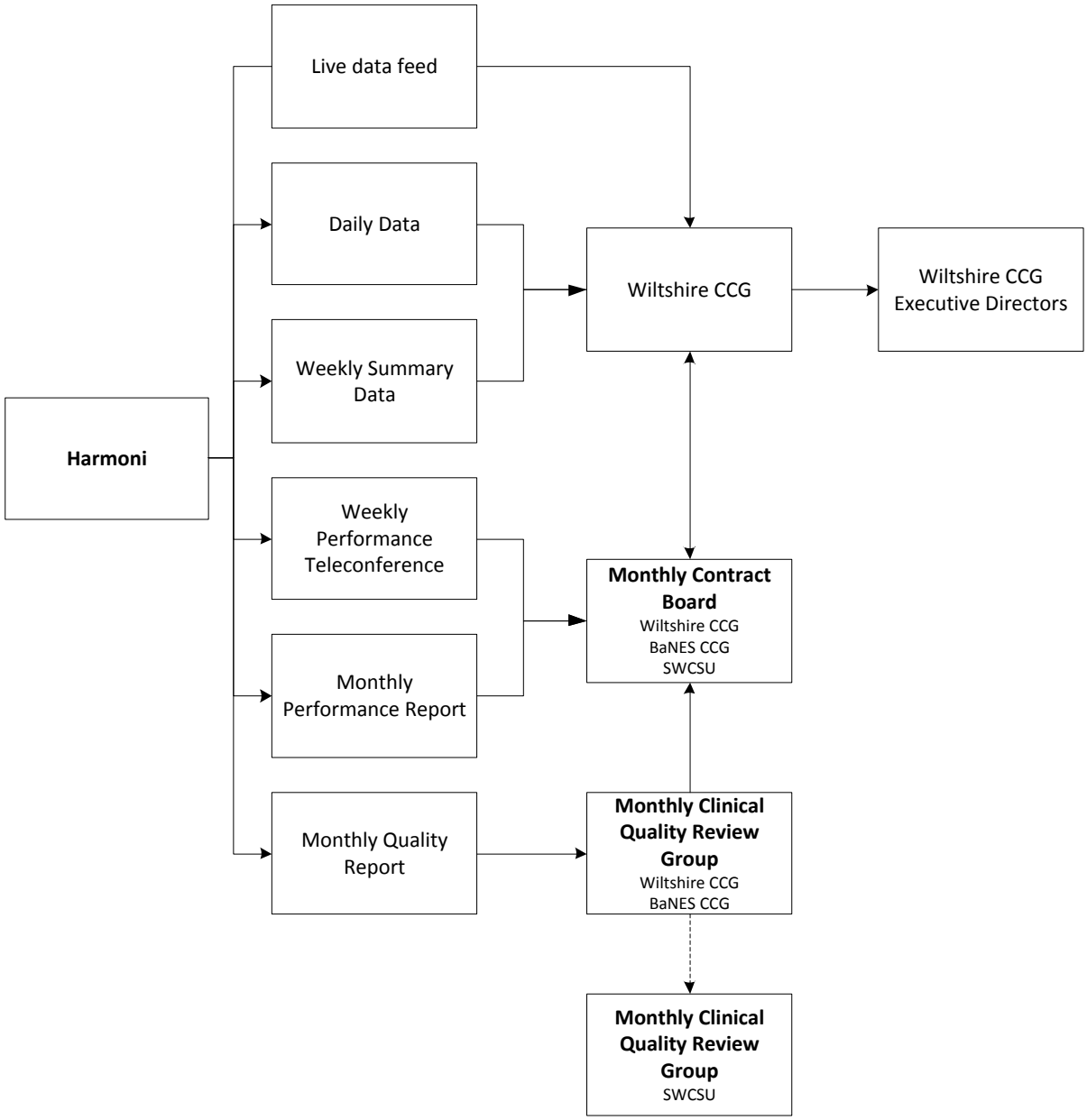
In tandem to this, a Clinical Quality Review group for Wiltshire CCG and BaNES CCG meets with Harmoni to review quality concerns that may have arisen, and also take the lead on any clinical developments. The local GP who chairs this quality group is a co-opted member to the contract board to ensure quality issue are visible to the contract and performance discussions.

In addition to monthly contract board meetings with Harmoni, performance data around a number of matrices is received daily and a weekly performance dashboard is provided prior to a weekly performance conference call.

In addition commissioners are able to access live 'real time' performance data showing the number of calls being received and or abandoned every hour. This is also linked to an automatic email alert, such that commissioners are notified if activity is indicating that performance breaches are likely.

It is expected that as we move through to 2014/15 that the management of the NHS 111 contract will fall into line with regular contract monitoring and revert to quarterly reporting, other than by exception.

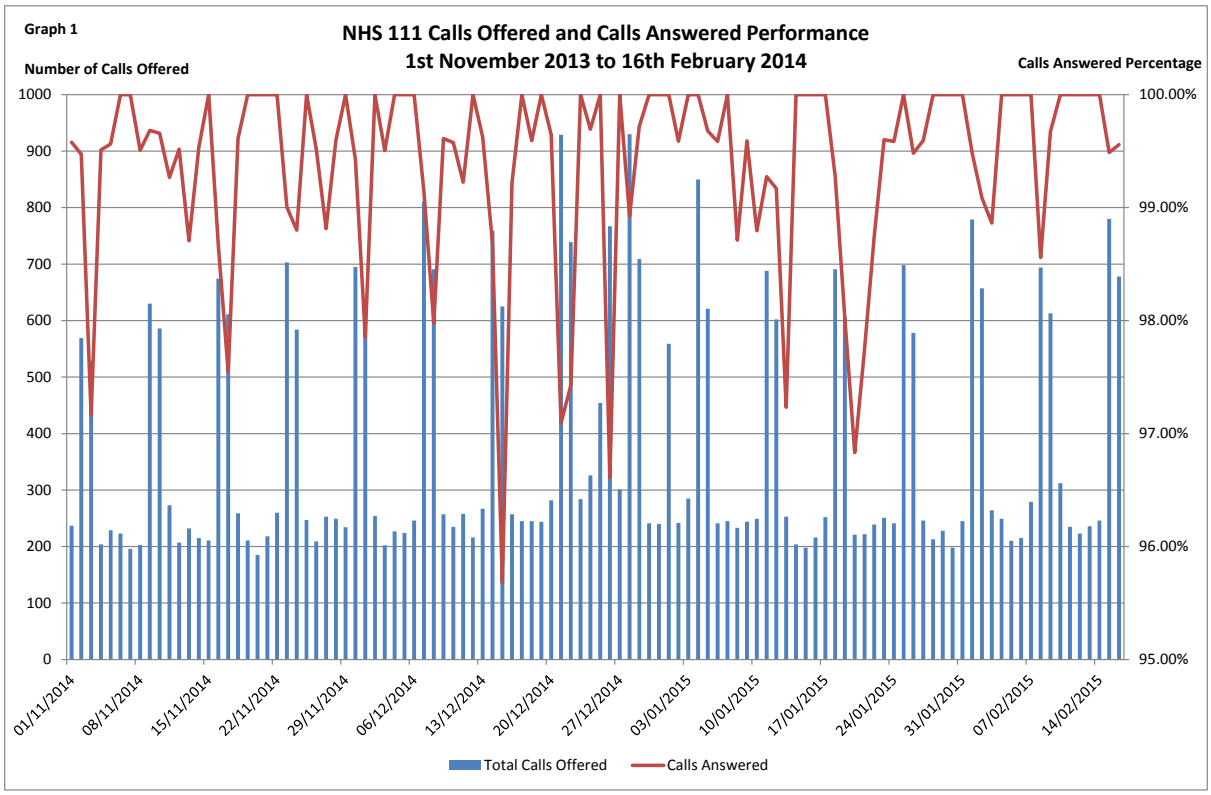
Reporting and Governance Process



3 PERFORMANCE

Following the period of rectification management and since the contract commencement in November 2013 performance by Harmoni across a number of domains has been variable. Whilst in many areas delivery has been acceptable often exceeding agreed thresholds, the CCG in conjunction with other CCG partners continue to be acutely aware that other areas of performance remain a challenge.

Call volumes for the period show a consistent pattern of around 250 calls on a weekday, increasing to around 650 calls on Saturday and Sunday, (Graph 1). It is also worth noting that calls spiked in excess of 900 for each Saturday preceding the Christmas and New Year public holidays. Whilst this call pattern has a degree of predictability, allowing Harmoni to ensure appropriate staffing volumes are in place to meet the demand, this weekend increase can impact on other NHS providers resulting in increased pressure within the overall health system. Graph 1 also shows that the percentage of calls answered is constantly high, performing often in excess of 99%, although there is a corresponding challenge in performance at times of high call volumes.

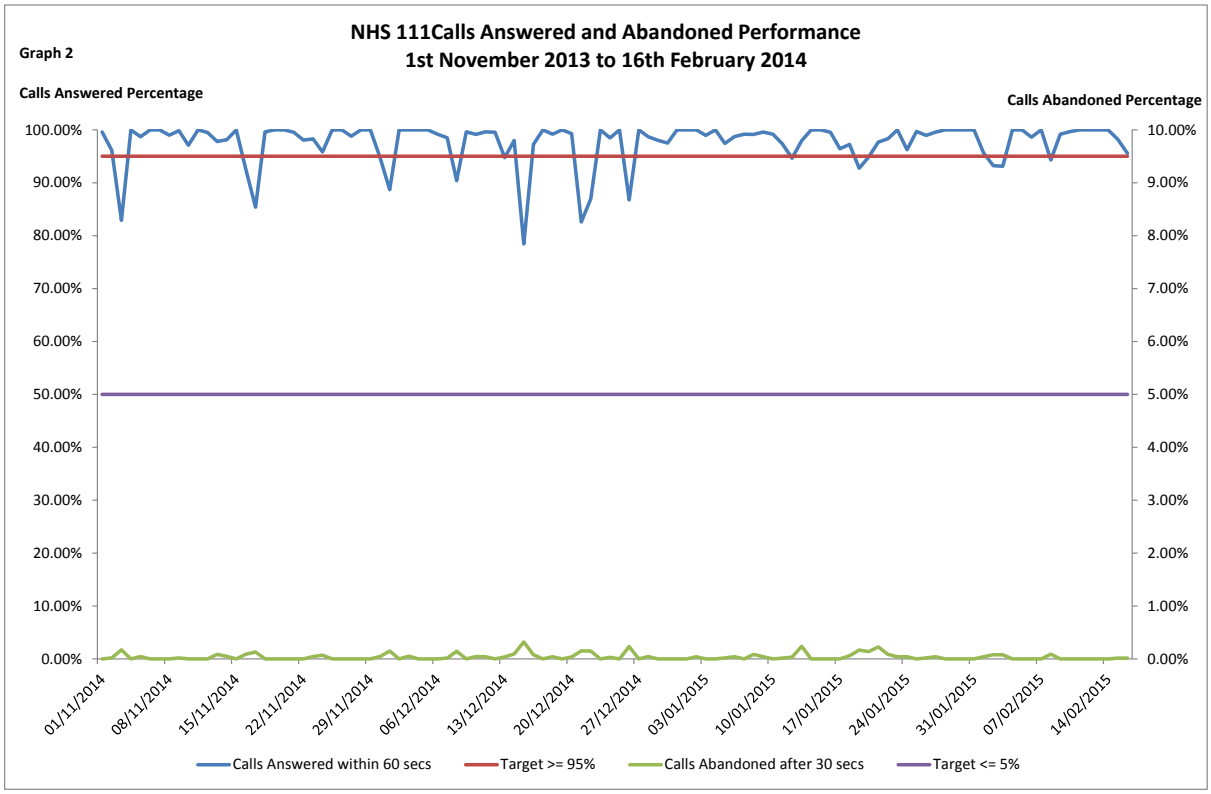


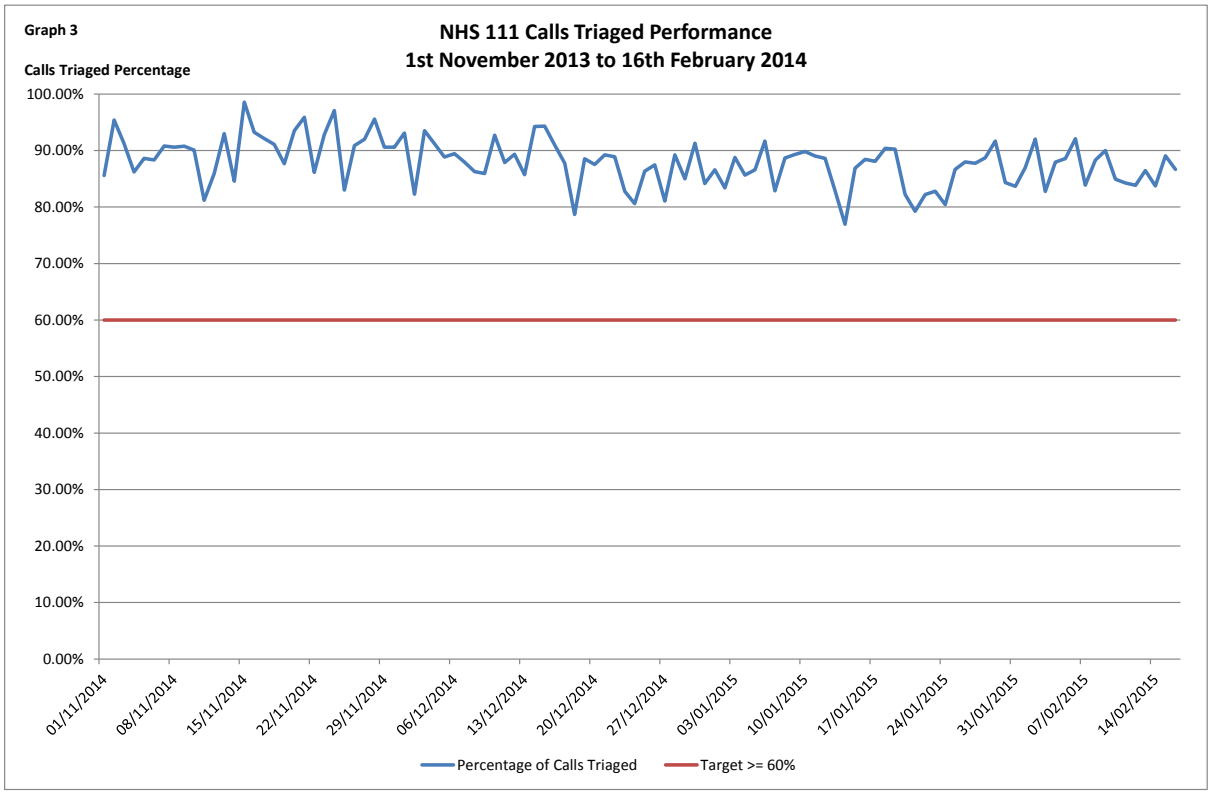
In additional to the call volumes being predictable, the call profile throughout the day follows a clear pattern, with weekday demand increasing in the early evening and weekend calls increasing in the morning to around midday.

It is recognised that performance linked to how quickly a call is answered not only links to how quickly the member of the public can received appropriate treatment or advice, but also links to the quality of the patient experience on the whole service. As such the contract has a KPI where by 95% of calls have to be answered within 60 seconds. In addition to this response measurement, there is also a requirement to ensure that the rate of calls abandoned after 30 seconds does not exceed 5% of the call volume.

Graph 2 shows that for most of the period reviewed, Harmoni have exceeded the performance threshold of 95% for calls answered and also remained below the 5% threshold for calls abandoned

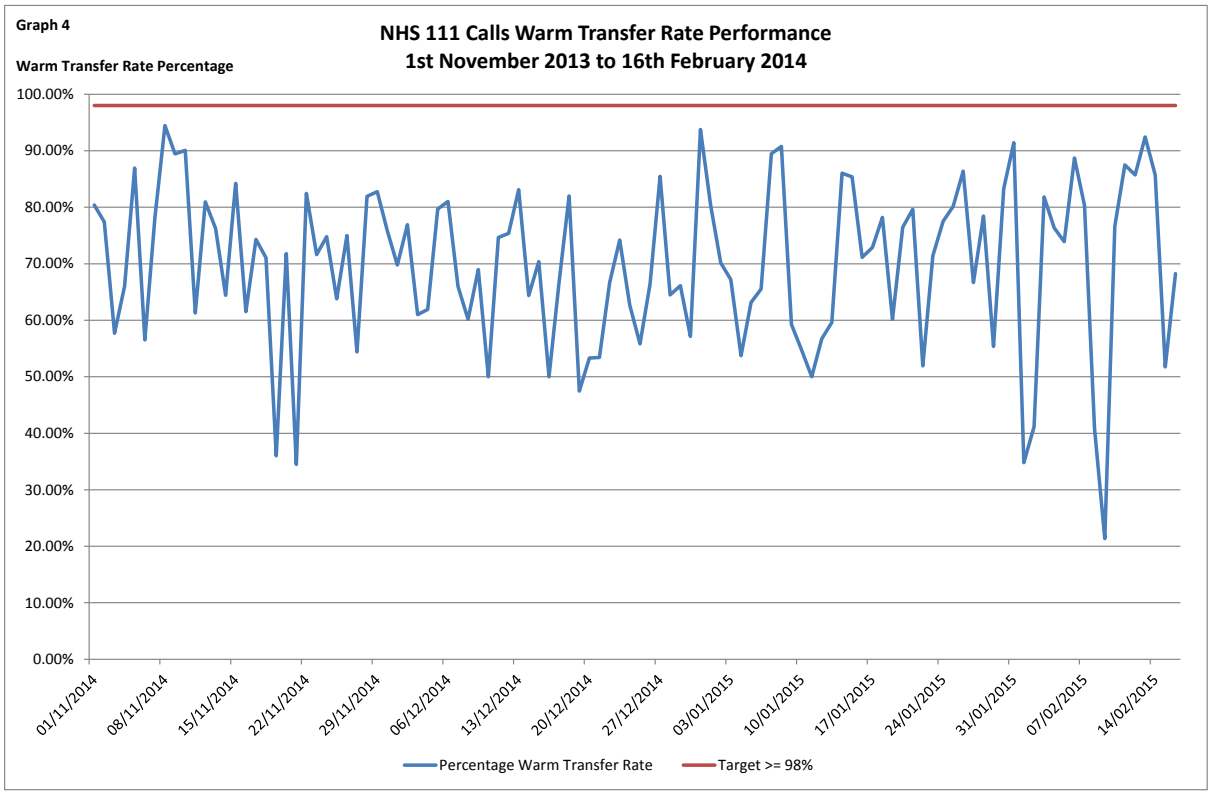
after 30 seconds. The performance breaches for call answering predominately relate to the days over the festive period.





Harmoni have a calls triaged rate[1] performance target of 60%, whereby they have to ensure that over a 24 hour period no less than 60% of calls answered are triaged to another service. To date, and for the period reviewed Harmoni have performed above the threshold required with data showing that the triage rate is consistently between 80 to 90 per cent. (Graph 3).

Although the provider is exceeding performance in this area, the CCG is working with Harmoni to address concerns around sustained performance in the warm transfer rate[2]within 30 seconds (Graph 4). The contractual target is 98%. This is an area being reviewed nationally, as the many of the providers across the country are finding this target challenging, and there may be some changes to the national specification for the NHS 111 service.



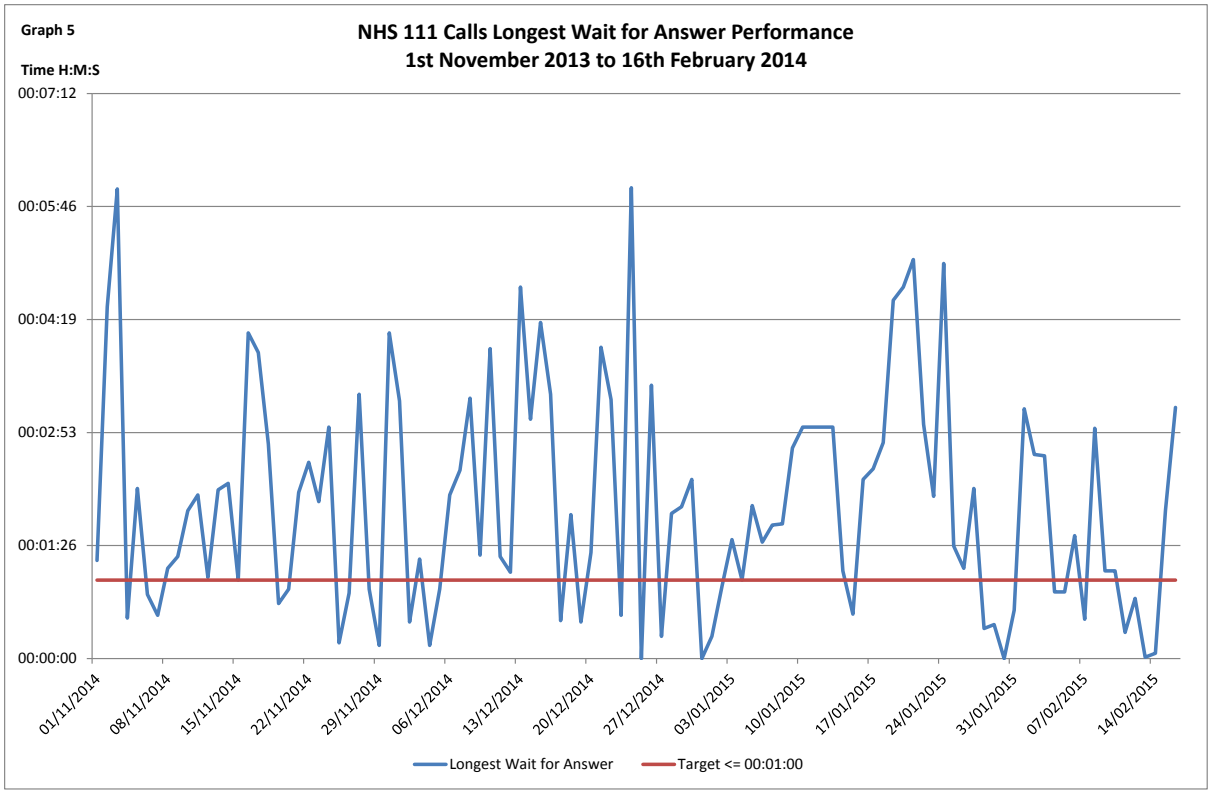
The CCG monitors the performance relating to specific transaction times. Specifically these relate to the time for a call to be answered by NHS 111, after any advisory message, and the time taken for Harmoni to return a call whereby a call advisor has requested that a clinical advisor speak to the caller.

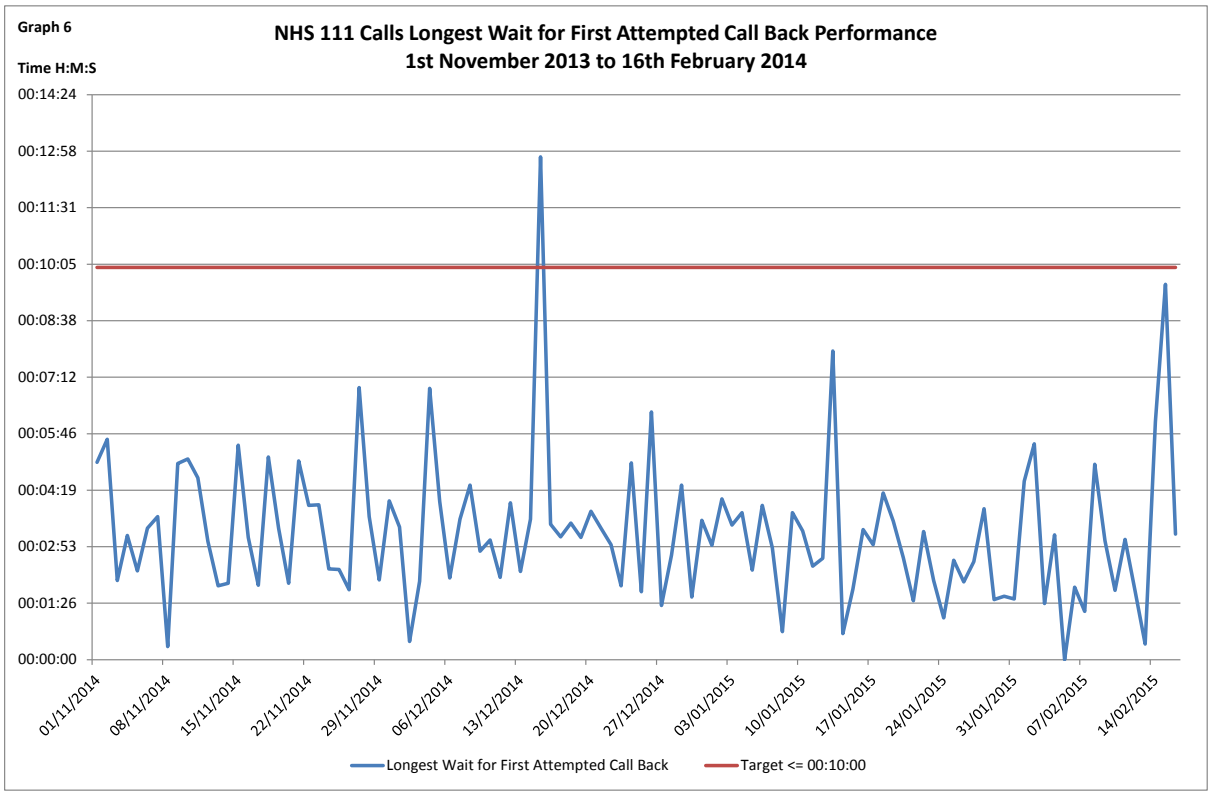
It is expected that Harmoni should answer all calls within 1 minute; the CCG has undertaken a review of these performance matrices and have noted that the inability to meet this target relates to minimal calls within 24 hour period and the majority of calls are answered within limits very close to the 1 minute target (Graph 5).

The time taken to telephone back the caller is set at 10 minutes. With one exception, this target has been delivered throughout the period reviewed (Graph 6) it is likely that the breach was due to a last minute reduction in clinical advisor resources being available on that day.

[1] Triage is the process of prioritisation. When a caller contacts the NHS 111 service and is triaged as needing to receive services from another provider

[2] A telephone call that is transferred from one individual to another (usually a call advisor to a clinical advisor) while the caller is still on the line





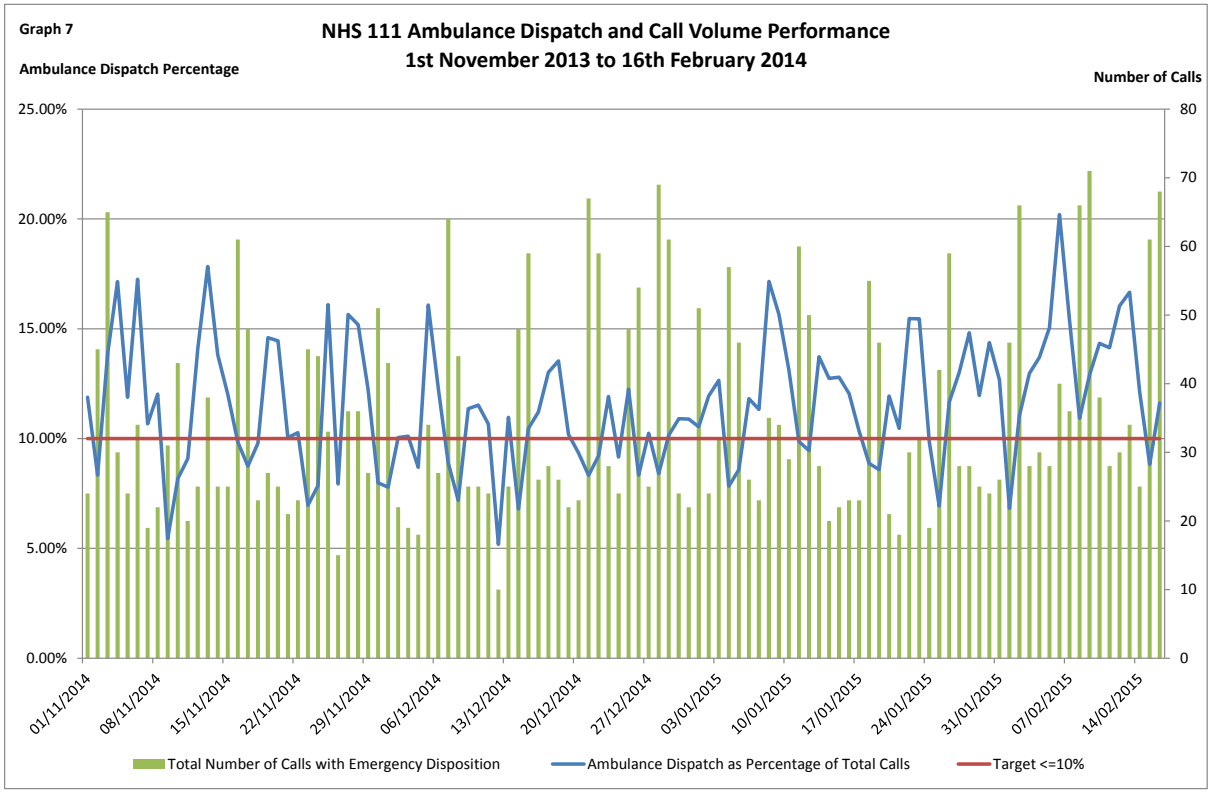
Healthcare today is very much focused on the ability of the health and social care system to respond appropriately to capacity and demand challenges, with an emphasis on collective responsibility across the whole system, rather than the historic model of a provider only being concerned around their own areas of performance. Locally, there have been commissioner and provider discussions

around the NHS 111 ambulance dispatch rate, where a call is put directly into the ambulance dispatch queue without re-triage.

The contract requires that the disposition rate of calls to the ambulance service for an emergency response is no more than 10%. The fact that this target is based on a percentage value in itself can cause the ambulance service capacity problems as the volume of calls will spike in line with calls received by the Harmoni call profile.

(Graph 7) shows the ambulance dispatch performance over the last 3 months. Whilst not being a contractual performance measure, graph 7 also shows the corresponding call volumes for the same period. Whilst the obvious correlation between under performance and increased call volume is evident, there are also periods when Harmoni are achieving performance below the 10% requirement, but call volume is still spiking. It is this scenario that can present the ambulance service with challenges in managing the high emergency disposition volumes.

The Commissioners acknowledge that Harmoni is taking steps to address its performance on the numbers of calls transferred to ambulance services and they are being supported in this by the CCGs. In order to ensure on-going patient safety and quality of service, commissioners have asked Harmoni to demonstrate that their actions will contribute to the improvement of the ambulance dispatch rate.

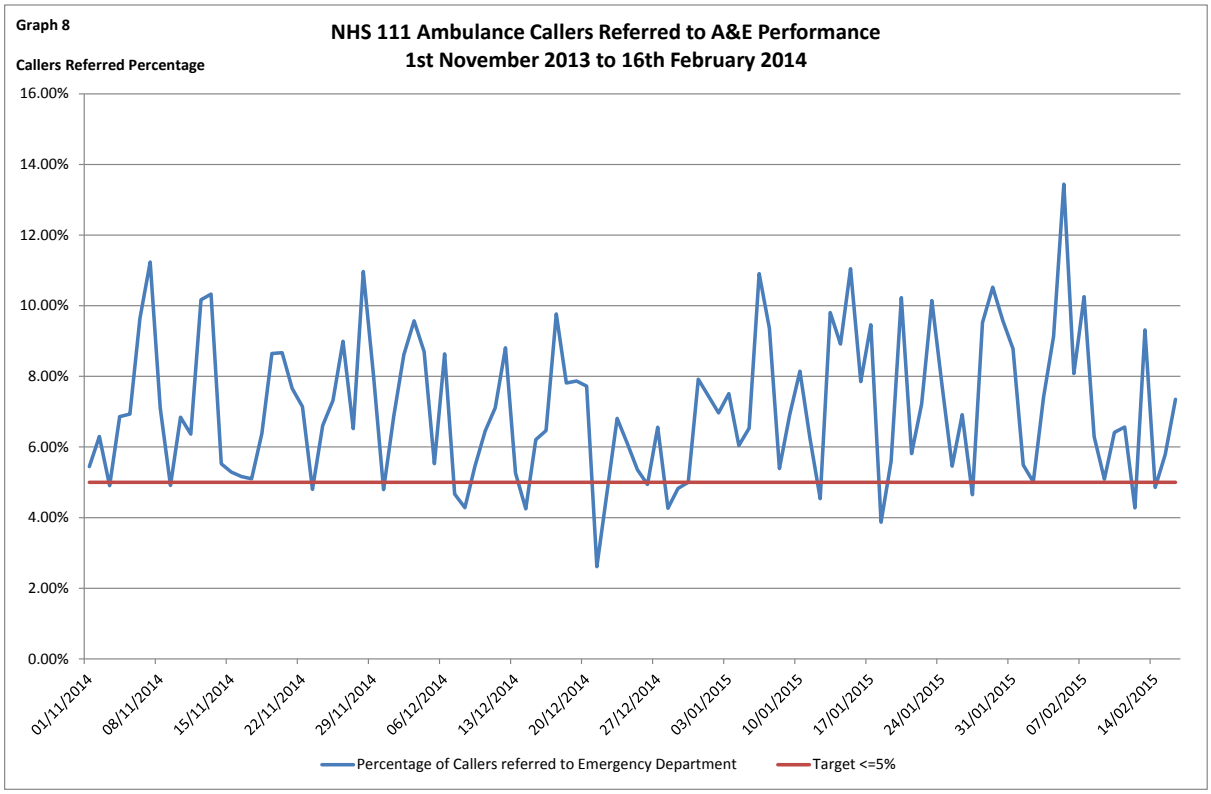


NHS 111 directs patients through algorithmic decision making software. Inherently it is risk adverse by design to ensure patient safety. There is a degree of local tailoring through a Directory of Service[3] to signpost patients to the most suitable NHS service to meet their needs.

The underperformance (over referral rate) is clearly visible and it is likely to be either as a result of an increase in patient acuity, which is a position often reiterated by acute trusts when discussing

[3] The Directory of Service is a data set within the software that details the availability of local services depending upon patient specific conditions.

their own A&E performance, or it may well be a symptom of a lack of alternative services being available.



The local Clinical Quality Review Group has undertaken a number of end to end audits, by listening to recorded NHS 111 calls to ensure that appropriate signposting is taking place and that patients are not referred to Accident and Emergency unnecessarily. The CCG in collaboration with neighbouring CCG's have invested in improved reporting so that we will be able to interrogate the Directory of Service, highlighting when a patient could have accessed an alternative service had it been available. Understanding this data will allow the CCG to be aware of levels of demand and may influence where services could be either redesigned or developed.

4 CONCLUSION

The performance of the NHS 111 service for Wiltshire has made significant progress since the launch a year ago; albeit there are a number of areas which are still challenging. Nationally the service specification is under review, and we are mindful that there may be changes which would have to be implemented. When NHS 111 services were benchmarked nationally over the Christmas and New Year period, the local service deliver stood up very well in comparison to other NHS 111 providers.

We are working closely with Harmoni in supporting a number of pilot programmes to explore ways in which performance can be improved. These include the ability for them to network calls across their other call centres during times of increased activity, as well as reviewing the number of clinical advisors / call advisors on shift. Harmoni are also looking at the possibility of developing specialist clinical advisors in areas such as mental health, who would be able to make a much more informed decision around onward care.

We believe that there is a robust performance management and clinically led quality regime in place that is sighted on ensuring that a clinically safe and effective service is delivered in Wiltshire.

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NHS
Wiltshire
Clinical Commissioning Group

Report on Arriva Non Emergency Patient Transport Service
1st December 2013 to 14th February 2014
for
Wiltshire Council Health Select Committee

1 CONTEXT

Background

In February 2012 Wiltshire and BaNES PCTs approved a review of existing non-emergency patient transport services (NEPTS) on the basis the provision across Wiltshire and BaNES was split over at least 20 different providers with very limited contractual coverage and minimal financial or clinical governance processes in place.

While some acute providers operated a central transport booking facility within their own Trust, there was no central booking facility or oversight at a PCT level, nor was there any mechanism for capturing and recording all patient journey activity. This made it extremely difficult, almost impossible, to measure NEPTS service performance, understand the volume of patient journeys, monitor standards, patient quality, safety and experience, and understand the drivers behind the costs of the service.

In Wiltshire at the time patients were receiving transport from various providers, and the provider used for any given journey depended on which hospital the patient was going to/from; where in the County they lived; and how acute their needs were. For example,

- The RUH held a direct contract with a non-NHS provider (E-zec) for RUH related journeys only (new & follow up out-patients, discharges and transfers from the RUH).

- RUH also used other non-NHS providers for ad-hoc transport requirements and used CTS taxis for the non-complex renal patients.

- The PCT had a non-contract arrangement with Great Western Ambulance Service (now South West Ambulance NHS Foundation Trust), covering part, but not all, of the County, and including the more complex renal dialysis patients attending Bristol and Bath dialysis units.

- Salisbury Foundation Trust provided an in-house patient transport service.

- Patients attending dialysis at Salisbury were transported using a Portsmouth Hospitals Trust non-NHS provider contract.

- South Central Ambulance Service moved some Wiltshire patients attending Great Western Hospital, Southampton Hospitals, and Oxford hospitals.

- Great Western Hospital had arrangements in place with a local taxi firm for patients with minor medical needs, and with Spire and AM Medical for those with greater acuity.

- For those situations where the appropriate provider for the journey was unclear, ad hoc journeys were booked by the PCT direct with taxi firms or other private providers, on behalf of GP practices, again depending where the patient was travelling from, where to, and their medical acuity.

Subsequently in May 2012, Swindon and Gloucestershire PCTs engaged with the review on the basis of the same issues and concerns. In 2011/12 it was estimated that over £8.2 million was spent on NEPTS across BaNES, Gloucestershire, Swindon and Wiltshire (BGSW). This was split over at least 30 different providers. Each of the acute hospitals across BGSW had developed booking facilities that

linked in with their current NEPTS Providers; these may have made a positive impact at a local level but all had different manual processes and systems meaning that PCTs and the region had no oversight of total activity, performance, or clinical governance. The four PCTs also faced increasing charges from the NEPTS providers and were incurring significant expenditure outside the scope of the contracts (where contracts indeed existed). The expectation was that much of this growth represented journeys for patients whose eligibility was not being assessed against the national eligibility criteria.

The NEPTS Service Review

A full service review was undertaken and several cross-cutting issues and concerns were identified. As part of this review a number of meetings with existing and potential suppliers were undertaken to understand the NEPTS market. This culminated in a NEPTS supplier day with a number of providers presenting their approaches to the commissioning teams and addressing a number of pertinent questions around operational approaches. This also identified NEPTS providers who were managing their services well and considering innovative models for the future. An options appraisal with a preferred option for the service model was then set out covering:

- a single point of contact offering patient transport advice
- assessment of eligibility for NHS funded transport based on medical need following Department of Health guidance
- a 365 day 24/7 service
- patient transport booking facilities
- signposting for non-eligible patients
- a minimum 10% of activity to be sub-contracted with third party providers to support capacity and the development of the market
- the continued use of volunteer car drivers

The Procurement Process

Following the service review, the four PCT's approved a single joint procurement process in May 2012. This included a competitive dialogue process to provide the PCTs with the opportunity to openly develop a service specification, discuss service issues and experiences in detail with providers. It was also agreed four contracts would be awarded, one per PCT, to a single accountable provider to manage the service more effectively, capturing journey information in a single database, and providing service intelligence that the PCTs had never had.

The key objectives of the procurement were to secure:

- **Quality** – patient-centred services delivered in a safe, friendly and effective manner by trained staff in clean, comfortable vehicles. This included keeping journey times low and ensuring promptness of arrival and pick-up.

- **Flexible & Responsive Service** – flexibility to respond to changing needs, e.g. new healthcare locations, on-the-day requests, flexible times for pick-up and delivery including evenings and weekends.

- **Communication & Performance Information** – routine communication with commissioners to discuss flexible and innovative approaches. Clear and complete information provided regularly on activity, finance and quality of service provision.

- **Value for Money**

- **Green** – take action to reduce the carbon footprint of patient journeys wherever possible.

- **Innovation & Use of Information Technology** – innovative service approach using best practice to respond to future needs, and making the most effective use of technology for the scheduling of journeys.

The procurement process commenced on 17th July 2012, including stakeholder engagement and consultation throughout: at all stages, bids were assessed by a panel of representatives from acute providers, commissioners and patient representatives.

The New Service

Arriva Transport Solutions Ltd (ATSL) was awarded the contract in summer 2013 and the service went live on 1st December 2013. Go-live was preceded by planning and mobilisation work between the four CCGs and Arriva, and included the transfer of 176 staff from incumbent providers, recruitment and training of new staff, procurement and equipping ambulances, establishing ambulance base stations and a control centre, establishing on-line booking systems and processes for transferring existing journeys, as well as engaging with the acute Trusts and community providers across BGSW to provide information about changes in the booking processes, etc.

The Arriva service replaced this plethora of contract and non-contract, routine and ad hoc activity with a single provider for all NEPTS. During the first 3 months of the Arriva contract, this has resulted in a number of challenges, involving as it does the provision of a NEPTS service to patients across 4 CCG areas; patients attending 4 acute trusts within the CCG boundaries and a number of significant patient flows to acute trusts outside the CCG boundaries; replacing a multitude of bespoke service arrangements that had developed over time within the different acute trusts.

The contract start date in early winter was not ideal, but was unavoidable. Data on advance bookings for December was inherited from incumbent providers, but was impossible to validate, and several tranches of bookings were being internally managed within acute trusts but not visible to either the incumbent or the new provider. Although the contract was established based on the best available activity information that the PCTs could collect, it was clear that this would only ever be at best an approximation, and only after the new service went live would an accurate picture of demand and activity begin to emerge. The start also occurred one month after the NEPTS services in some of the neighbouring CCG areas had also transferred to new providers, which heightened the level of concern with some of the acute trusts, as they would need to manage two new sets of processes.

Additional background information is provided at Appendix 1. This describes: other health-related transport that is not NEPTS; the definition of NEPTS; the contract summary; the service model; transport and mobility guidance; key performance indicators; support to acute hospitals; support to renal dialysis units.

2. GOVERNANCE

An evolving series of governance arrangements have been used, tailored to the precise needs at the time, from the initial procurement phase through to post go-live and routine contract management.

- Following contract award, a mobilisation group with representatives for the four CCGs, plus Arriva, plus South Central Commissioning Support Unit (and predecessor organisations which led and co-ordinated the procurement work on behalf of the PCTs/CCGs) met weekly, to agree the Arriva mobilisation plan and to review progress, address issues, and manage risk.

- The PTS Procurement Board transitioned into a Mobilisation Board with CCG Governing Body level representation, which met monthly. Key risks and issues were elevated as appropriate.

- Each CCG took the lead for coordination and engagement with one of the four acute trusts, to help provide focus to acute trust concerns.

- For the first month following go-live, daily conference calls were carried out between commissioners and Arriva to review progress and address issues.

- Mobilisation meetings of Arriva and commissioners continued to be held weekly until the end of January and are now held twice monthly.

- Mobilisation Boards continue monthly.

- Lead commissioners have engaged directly with respective acute trusts to help address issues.

- Arriva locality managers are based at and work closely with each hospital trust to address issues and an Arriva escalation process enables healthcare staff to escalate issues as required

- From March, routine contract performance monitoring and quality review meetings will replace the mobilisation meetings (NB majority of the existing attendees will be unchanged; CCG Quality leads will in future meet bi-monthly to review relevant issues), coordinated by South Central Commissioning Support Unit.

- Performance and activity data is provided by Arriva monthly and weekly, by CCG, and specific acute-trust level dashboards are also now in place.

3. ACTIVITY

Activity has been recorded by Arriva since the start of the contract. Having a single provider has meant that for the first time, a comprehensive view of total NEPTS activity can be achieved. This in turn helps to inform decisions about the provision of service by location, by mobility category, and by journey type and distance. It also helps to inform the position in terms of how well KPIs are achieved.

Detailed charts are provided at Appendix 2 which show the total Wilts NEPTS activity between 1st December 2013 and 14th February 2014. These are NEPTS journeys, conducted by Arriva, for patients registered to a GP practice within Wiltshire CCG. The journeys are a combination of actual journeys completed, plus aborted journeys, but excluding cancelled journeys.

Aborted journeys are billable, since they are journeys where NEPTS resource has been committed to the task, but the task was not completed. This can be for one of a multitude of reasons (e.g. patient not ready / patient too ill to travel / patient no longer requires transport / appointment cancelled but transport was not / patient too ill to travel / patient used own transport / patient had been admitted but transport not cancelled / etc.)

Cancelled journeys are those for which a booking was made but, are cancelled prior to the start of the journey, by the person/organisation that made the booking. Cancellations are not billable.

Total activity including aborted journeys, is typically slightly above the expected level, per week (excluding the bank holiday Christmas and New Year weeks). However patient mobility is also a function of activity, as is average mileage per journey.

The average mileage per journey is 15-20% above that which was identified during the tender process and on which Arriva and other providers based their contract bids. This has an impact on resourcing, since longer journeys last longer and therefore require a higher level of resource than expected in order to complete the same number of journeys.

The tender process also described the existing activity in terms of patient mobility (and therefore the numbers of each type of NEPTS resource required). The reality seen since 1 December 2013 is that the actual mix per type of NEPTS resource required, reflecting patient mobility, is in some regards significantly different:

Car, one crew: 92% of expected volume

Car, two crew: 277% of expected volume

Wheelchair, one crew: 112% of expected volume

Wheelchair, 2 crew: 45% of expected volume

Stretcher: 104% of expected volume

Arriva resourced to provide the service according to the expected mix of patient mobility. The Arriva resourcing was also established based on the expected mobility mix of all 4 CCGs who have contracted their service. Thus variances in the volume, mileage and mobility mix of other CCGs' activity, also have a bearing. These variances mean that Arriva began the contract with a level and type of resource, across the area, that did not fully match the requirement.

4. PERFORMANCE

Performance is being reported within the context of the total activity, average journey distance, and mobility mix compared to that which was expected, for Wilts CCG and other CCGs, as described above.

Detailed Key Performance Indicator (KPI) charts are shown at Appendix 3 showing performance for:

- all Wiltshire CCG patients transported by Arriva
- all Wiltshire CCG dialysis patients transported by Arriva
- all Wiltshire patients attending the three acute trusts to which majority of our patients attend, transported by Arriva.

The main Key Performance Indicator (KPI) measures shown, look at three aspects of patient experience:

- time spent on vehicle
- on-time inbound journeys
- on-time collection for outbound journeys

- Time on vehicle. Overall, performance is being achieved in line with KPIs for time on vehicle. The dips in performance for the longer distance journeys generally reflect a small or very small number of journeys in these categories.

- Inbound on time. Inbound on-time is an area where performance is improving but requires continuing improvement to get to KPI level.

- Outbound on time. Outbound on time (for on-day bookings) is generally being achieved or exceeded. The response timeframe for these journeys is four hours from the time the patient is "made ready". The area requiring greatest improvement is on-time collection for pre-booked outbound journeys. The response timeframe for these is one hour from the time the patient is "made ready".

Performance by acute trust is best at Salisbury Foundation Trust, shows continuing improvement at Salisbury Foundation Trust and Great Western Hospital, and is most variable at RUH.

Performance for dialysis patients is significantly higher than for the full patient cohort, reflecting the routine nature of these journeys and the knowledge that transport is critical for this group of patients.

There are a range of other KPI measures, and these include average and maximum telephone waiting time for booking requests made by phone. Although patients are able to make telephone bookings direct with Arriva, it is not possible to break out Wiltshire only calls, or patient-only calls, from the total, for KPI reporting purposes. Therefore telephone responsiveness figures are not included; although it is understood that in Wiltshire the volume of patient-generated telephone bookings is low. Nonetheless, average call wait time has reduced from over 3 minutes to less than 2 minutes; and the maximum daily call wait time across the areas served by Arriva has reduced from >25 minutes to <5 minutes.

KPI performance reflects some of the issues that have been found since the start of the contract, and which Arriva, Commissioners, and acute trusts, are continuing to work to address. The main issues with service delivery that have led to complaints from patients and problems for acute trusts, have been:

- Periods, particularly early in the contract, but still the case currently, when on-time pick-ups for outbound journeys was significantly below KPI, meaning many patients had long or very long waits. This arose from a combination of many factors, these include: incomplete journey data inherited from the outgoing incumbent providers; lack of familiarity in the acute trusts with the "make ready" process; inherited bookings being of an incorrect mobility, meaning on the spot reallocation of appropriate resources, which inevitably take longer to become available; wrong vehicle mix for the overall total actual activity identified, meaning insufficient resource for certain categories of patients. Although performance is improving, there is more to be done on this.

- Delays for inbound journeys, typically those later in the day where a knock-on effect from late outbound journeys earlier in the day, as described above. Again, although performance is improving, there is more to be done on this.

- Difficulty and long waits to get through when healthcare staff calling the booking centre. Initially this was a result of low levels of uptake of the online booking tool among healthcare staff; as well as an extremely high call volume due to the need to chase up "missing" or incorrect inherited journey bookings as described above; and lack of confidence in and familiarity with the new NEPTS arrangements; but is now much improved.

- Problems with incorrect mobility – with healthcare staff getting used to the mobility categories used by Arriva this is now much improved.

All of these and a range of other operational issues are being addressed, and progress is being made.

5. IMPROVEMENTS MADE SINCE SERVICE LAUNCH

Since go-live it has been clear that the issues identified in this paper would require significant investment of time and effort by Arriva, commissioners, and acute trusts, to address and resolve. A summary of many of the improvements and actions undertaken, and still being undertaken, is detailed at Appendix 4.

6. CONCLUSION

It is clear that the introduction of a new NEPTS service has been challenging, particularly given the scale of change that it represents across the healthcare community. However much work has been done, and continues to be done, to ensure the service reaches a level where it consistently achieves the required standards.

APPENDIX 1 – Additional Background Information

- other health-related transport that is not NEPTS
- NEPTS definition
- the contract summary
- the service model
- transport and mobility guidance
- key performance indicators
- support to acute hospitals
- support to renal dialysis units

Other Health Related Transport that is not NEPTS

There are a number of other health related transport arrangements that are often confused with NEPTS:

- The Healthcare Travel Costs Scheme for individuals who are on a low income
- Emergency and urgent ambulance services
- Various types of community transport such as:
    - Dial-a-ride
    - Minibus schemes
    - Voluntary care schemes

Non-Emergency Patient Transport Definition

Non-emergency patient transport services are typified by the non-urgent, planned, transportation of patients with a medical need for transport to and from premises providing NHS health care and between NHS health care providers. It encompasses a wide range of vehicle types and levels of care consistent with the patients' medical needs.

In 2007, the Department of Health published revised national eligibility criteria to ensure that NEPTS is available to those who have a genuine need for transport and whose medical condition prevents them from travelling to or from their appointment/s by any other means. Patients are eligible for transport when:

- The medical condition of the patient is such that they require the skills or support of NEPTS staff during the journey and where it would be detrimental to the patient's condition or recovery if they were to travel by other means.
- The patient's medical condition impacts on their mobility to such an extent that they would be unable to access healthcare or it would be detrimental to the patient's condition or recovery to travel by other means.

NEPTS can also be provided to a patient's escort or carer where their particular skills or support is needed during the journey. For example, this might be appropriate for those accompanying a person with physical or mental incapacity, vulnerable adults or to act as a translator during the journey. Only one escort should travel with a patient under such circumstances. Such discretionary provision would need to be agreed in advance, when transport is booked. The eligibility criteria for PTS have not been extended to include visitors. All children under the age of 18 are required to have an escort for their journey.

The distance to be travelled and frequency of travel should also be taken into account, as the medical need for NEPTS may be affected by these factors.

Financial or social grounds are not reasons for granting NEPTS. When assessing patients for NEPTS they should be routinely asked about their normal means of travel. If a patient can normally get around without support and assistance they should not be offered transport.

A patient's eligibility for NEPTS should be determined either by a healthcare professional or by non-clinically qualified staff who are both:

- Clinically supervised and/or working within locally agreed protocols or guidelines, and
- Employed by the NHS or working under contract for the NHS.

Contract Summary

Arriva's contract covers NEPTS for patients travelling to and from out-patient appointments, day case in-patient admissions, discharges, inter-hospital (including time critical), A&E/Minor Injury home returners, end of life patients, renal dialysis patients and on-site hospital transfers.

It is primarily for patients (and escorts where appropriate) who are GP-registered in the area covered by the CCG areas of BGSW. These patients must also meet the agreed eligibility criteria for PTS, as laid out by the Department of Health. It also includes some patients from other health communities/CCGs where discharge or transfers are required. There may be a requirement for transport to anywhere within England, Scotland or Wales and to specialist centres outside the specified area anywhere within the country.

Arriva are responsible for the safe, timely and comfortable transport of patients between their place of residence and the healthcare facility, between healthcare facilities and from the healthcare facility to their place of residence. They also maintain a comprehensive directory of service, detailing alternative providers of transport for those patients ineligible for NEPTS.

All Arriva staff are qualified and/or trained in accordance with NHS guidelines for national job profiles in vehicle management, health, safety, safeguarding of patients, risk and incident management, security, equality and diversity, confidentiality and complaints procedures.

An appropriately-graded crew, operating dedicated vehicles equipped with minimum internal equipment (serviced in accordance with manufacturers' specifications and fulfilling legal requirements) are used. The vehicle type and crew available are required to meet the needs of the patients including, for example, general aids, safety and specialist equipment.

The contract includes a requirement for Arriva to sub-contract a minimum of 10% of journeys with third party providers across each contract; these providers also have to meet the same quality standards. Arriva also use volunteer car drivers who are required to meet minimum standards and sign up to the volunteer car driver handbook.

Relevant data and progress reports are presented at intervals (e.g. weekly, monthly, quarterly) as specified by the CCGs, supported by quarterly user surveys and annual staff surveys. An official incidents and complaints procedure is in place within the Arriva structure and includes the CCGs within the escalation process for complaints that cannot be dealt with locally.

Service Model

The service has been commissioned to operate 24 hours a day, 7 days a week, 365 days of the year including all statutory and discretionary bank holidays. It includes a single point of contact which has a dedicated phone number for the receipt of all patient transport requests, to manage and apply the eligibility criteria and process, arrange appropriate transport and provide advice and support for patients who are ineligible for patient transport but still need help in getting to and from their relevant healthcare facilities.

Bookings for transport can also be made on-line and a key objective of the contract is to encourage health care professionals to book on-line wherever possible as the process is simple, accurate and quick. The on-line system, called CLERIC, is available 24 hours a day, as is the call centre, so that bookings can be made at any time.

Before ATSL started the service, return journeys from hospitals, etc, were booked in advance based upon the time that the patient was expected to have completed their appointment. Often this would result in the transport arriving before the patient was actually ready, and the transport would either have to continue to its next task without being able to wait (due to other patients booked or already onboard) or wait, resulting in delay to all subsequent patients. The new contract has introduced a 'book when ready' service which requires staff to book the return journey when they know the patient is ready to go home. Once a patient is 'booked ready', ATSL is expected to pick them up within an hour (where the booking has been initiated at least the day before). In this way patients do not have to wait for long periods because their appointment finished sooner than anticipated and ambulance trips are not wasted if the patient is not ready to go when the ambulance arrives. This model is proven in other contracts ATSL has across the country to enhance patient experience by reducing their wait and also reduces the number of aborted ambulance journeys.

In order to assess eligibility, health care professionals and patents will be asked four main questions:

- Pre-screening questions to assess if the patient is registered with a GP practice in the BGSW area;
- Exemption questions – exempt patients are those travelling for renal dialysis treatment, oncology patients receiving chemotherapy or radiotherapy courses of treatment and patients who must lie down for at least part of the journey – all of whom automatically are deemed eligible;
- Mobility questions to determine the type of transport required; and
- Medical questions to identify the level of care required during the journey.

For those patients who are ineligible for NEPTS, they will be signposted to other suitable transport providers within the community. They may also be able to access the Healthcare Travel Costs Scheme.

Transport and Mobility Guidance

The transport and mobility guidance is as follows:

Code Used When Booking	Description
C1	For patients who can travel in a car without the assistance of anyone
C1A	For patients who will require assistance of one person to and from the vehicle
C2	For patients who require the assistance of two crew members
W1	For patients who must travel in their own wheelchair for the journey with the assistance of one person
W2	For patients who must travel in their own wheelchair for the journey with the assistance of two people
Stretcher	For patients who must lie down for at least part of the journey
Bariatric Vehicle	For patients who are 25 stone & over
NB Oxygen Therapy	Patients requiring oxygen must travel on a vehicle with two crew members.

Key Performance Indicators

Key performance indicators are as follows:

- Patients travelling less than 10 miles should not spend more than 60 minutes on any one journey
- Patients travelling between 10 and 35 miles should not spend more than 90 minutes on any one journey
- Patients travelling between 35 and 50 miles should not spend more than 120 minutes on any one journey
- Arrival within 45 minutes before, to 15 minutes after, booked arrival time
- Where booked prior to the day of travel, patients not to wait more than 60 minutes for their (outbound) journey
- Where booked on the day of travel, patients not to wait more than 4 hours for their (outbound) journey (within two hours for end of life patients)
- Percentage of journeys cancelled by ATSL
- Percentage of journey collections missed (aborted journeys)
- Percentage of in-bound calls to ATSL call centre answered within 30 seconds
- Percentage of complaints acknowledged within one working day
- Compliance with agreed complaints procedure (full response within 25 days)
- Availability of on-line booking system
- Availability of telephone booking system

Support to Acute Hospitals

As a result of the complex issues experienced by acute trusts in coming to terms with the new transport management arrangements, ATSL have completed reviews at all the acute Trust sites in BGSW and developed joint action plans in response to the findings of these reviews. These action plans are jointly owned between ATSL and the acute Trust. Good progress is being made against the actions delivered.

Trust management has engaged in supporting staff to use the booking system effectively and the local ATSL management team have been proactive in supporting the Trust staff. A weekly acute Trust dashboard has also been developed which helps the Trusts understand its role in helping to deliver improvements in the service.

Support to Renal Dialysis Units

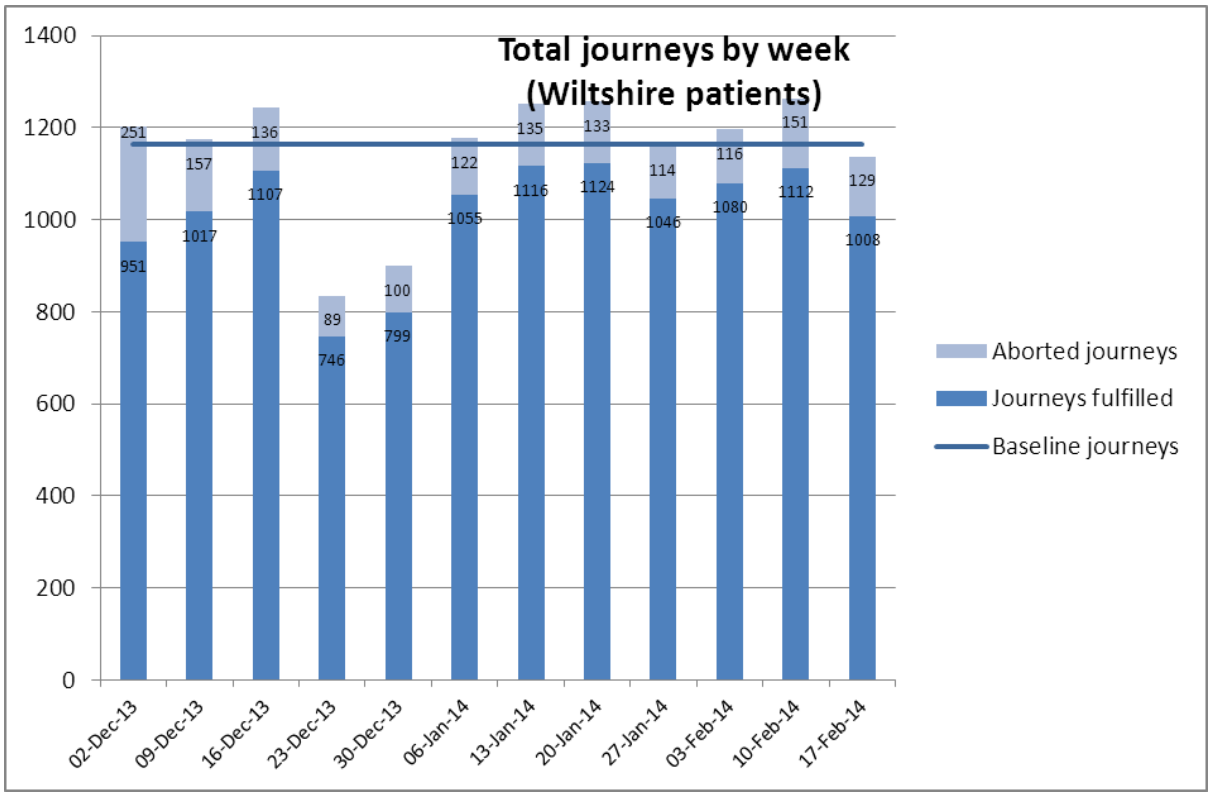
There are approximately 1,400 regular weekly dialysis patient journeys across the four CCGs. 1,200 of these are automatically planned to a combination of taxi providers and volunteer car drivers. The remainder are patients with higher mobility needs and are generally transported by ATSL vehicles.

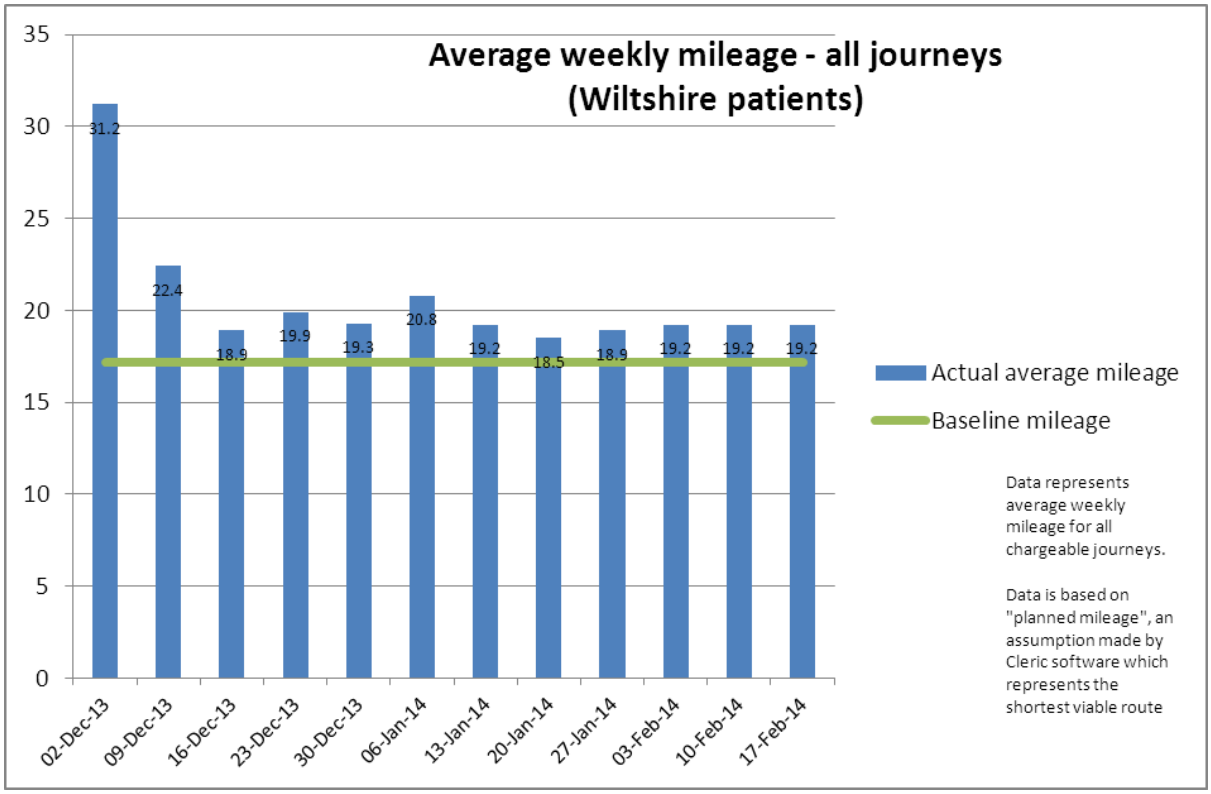
Given a number of issues experienced by renal dialysis patients and the staff of the units, particularly at the beginning of the contract, ATSL implemented two full-time planners from 3rd February 2014 to provide strong support for robust planning of dialysis journeys. A dedicated renal hotline was set up and continues to provide a direct, dedicated route to the dispatch desk for the units across the BGSW area.

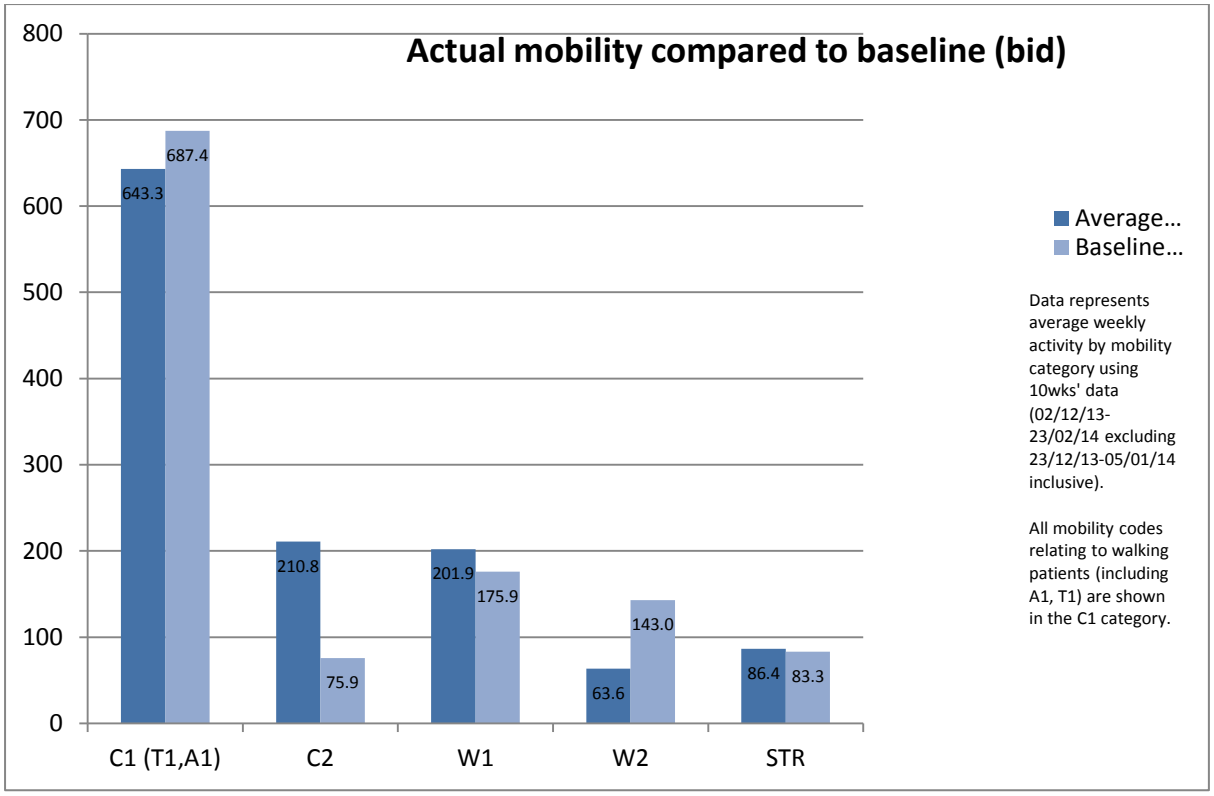
To provide further support for this group of patients, a full-time operational support manager joined the BGSW ATSL team on 17th February 2014 with a remit to provide central support for planners and the locality managers in oversight and quality assurance of renal dialysis activity. Key tasks include daily reconciliation of planned journeys against actual activity, engagement with renal unit staff, and on-going refinements of auto and manual planning arrangements in conjunction with the planners.

The CCGs and Arriva also met with NBT's service manager for the renal and transplant directorate and the clinical matron at the beginning of February to review service delivery for dialysis patients and to discuss any ongoing issues and concerns. A further meeting has been arranged in April to review progress as well as address the impending move of the Richard Bright Dialysis Unit into the new building at Southmead.

APPENDIX 2 – ACTIVITY







Mobility definitions

C1 - able to walk unaccompanied or with assistance of one person. Generally suitable for travel by taxi or car.

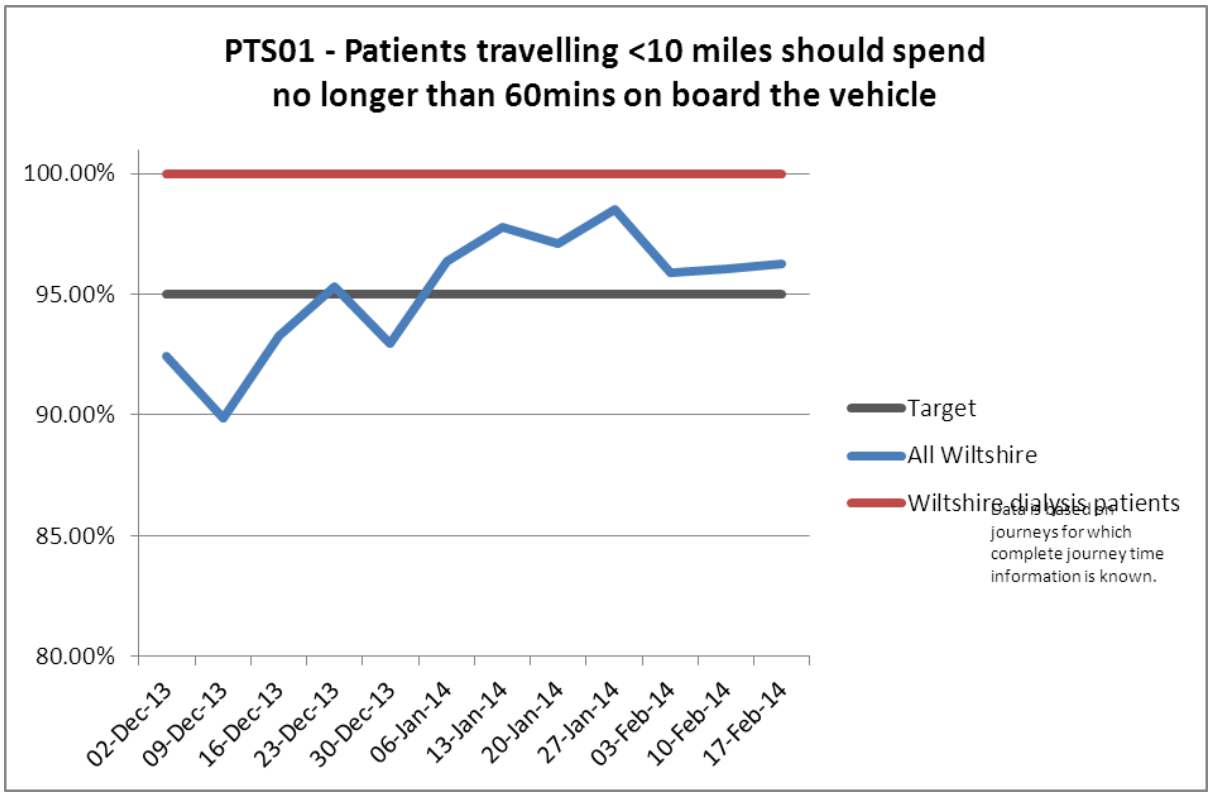
C2 - able to walk but with assistance of two people; or requires a wheelchair to be provided for transport purposes. Generally will travel by ambulance.

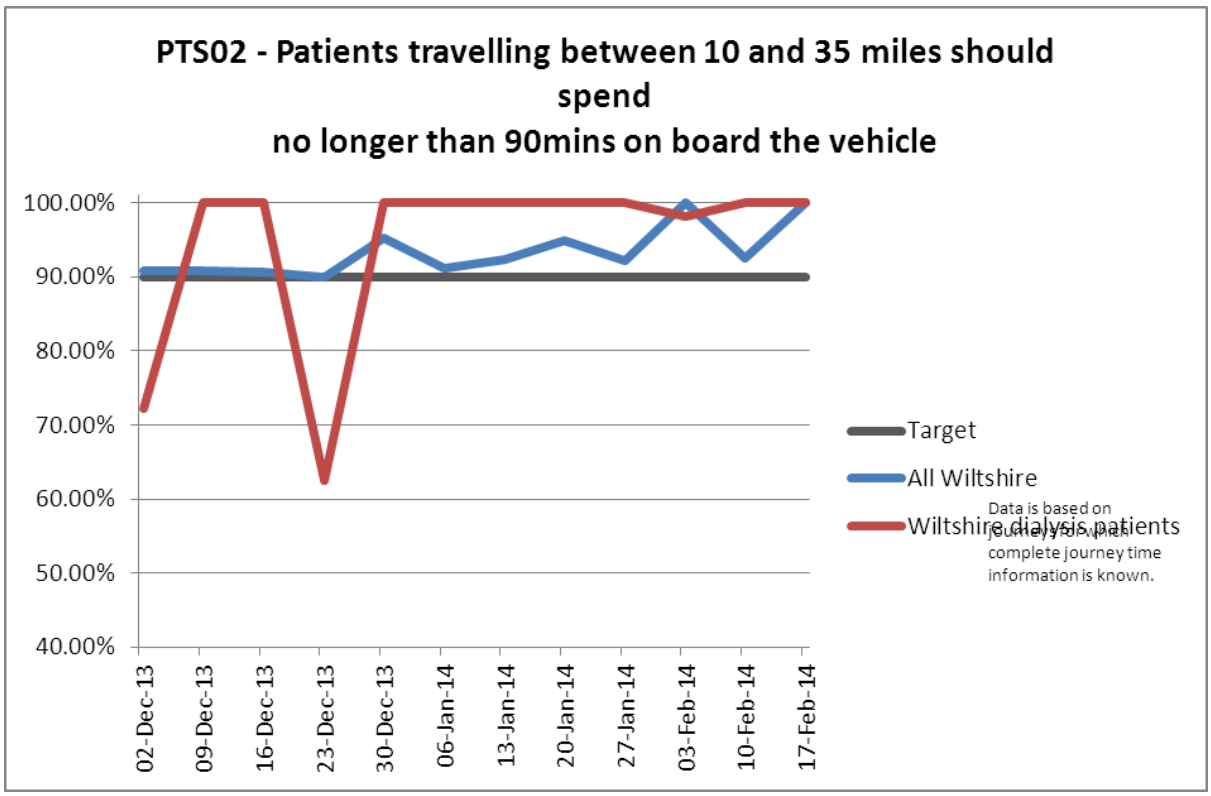
W1 - wheelchair user who is generally suitable for travel in a wheelchair-adapted car.

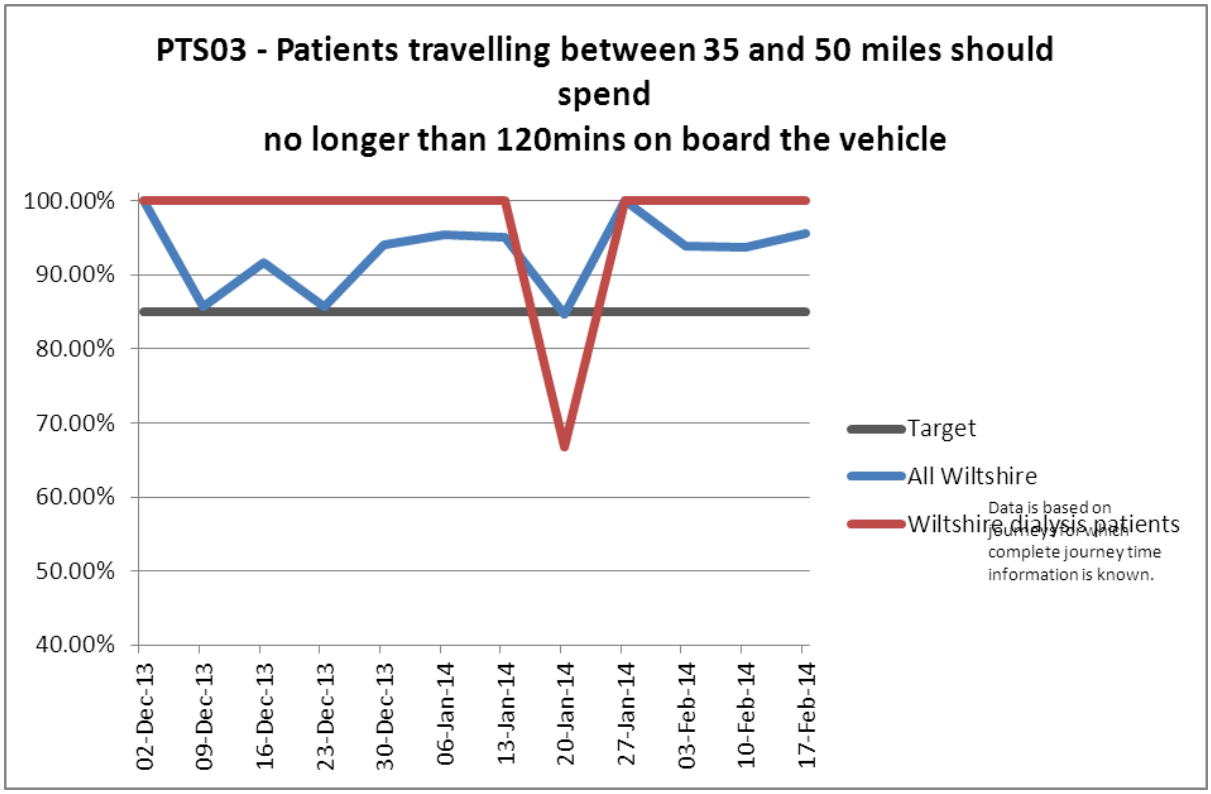
W2 - wheelchair user who is generally suitable for travel by ambulance; requires assistance of two people.

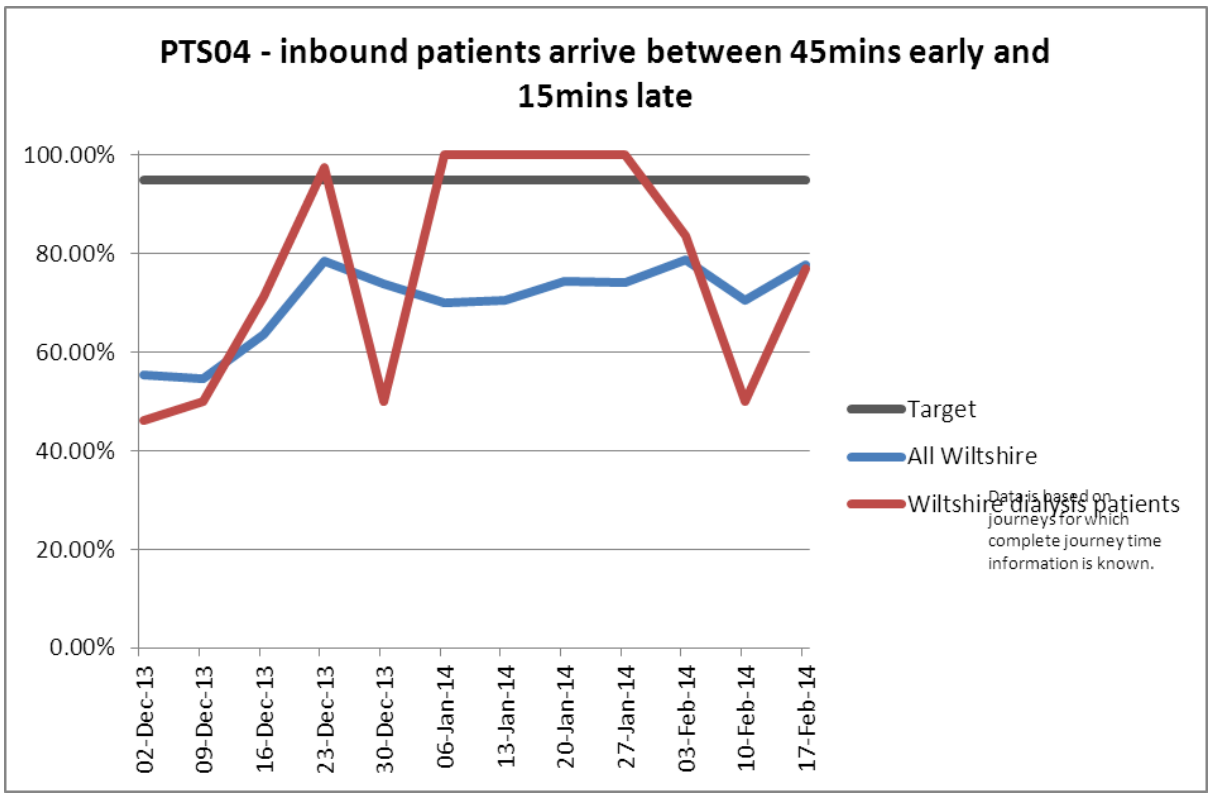
STR - only able to travel on a stretcher. Ambulance patient.

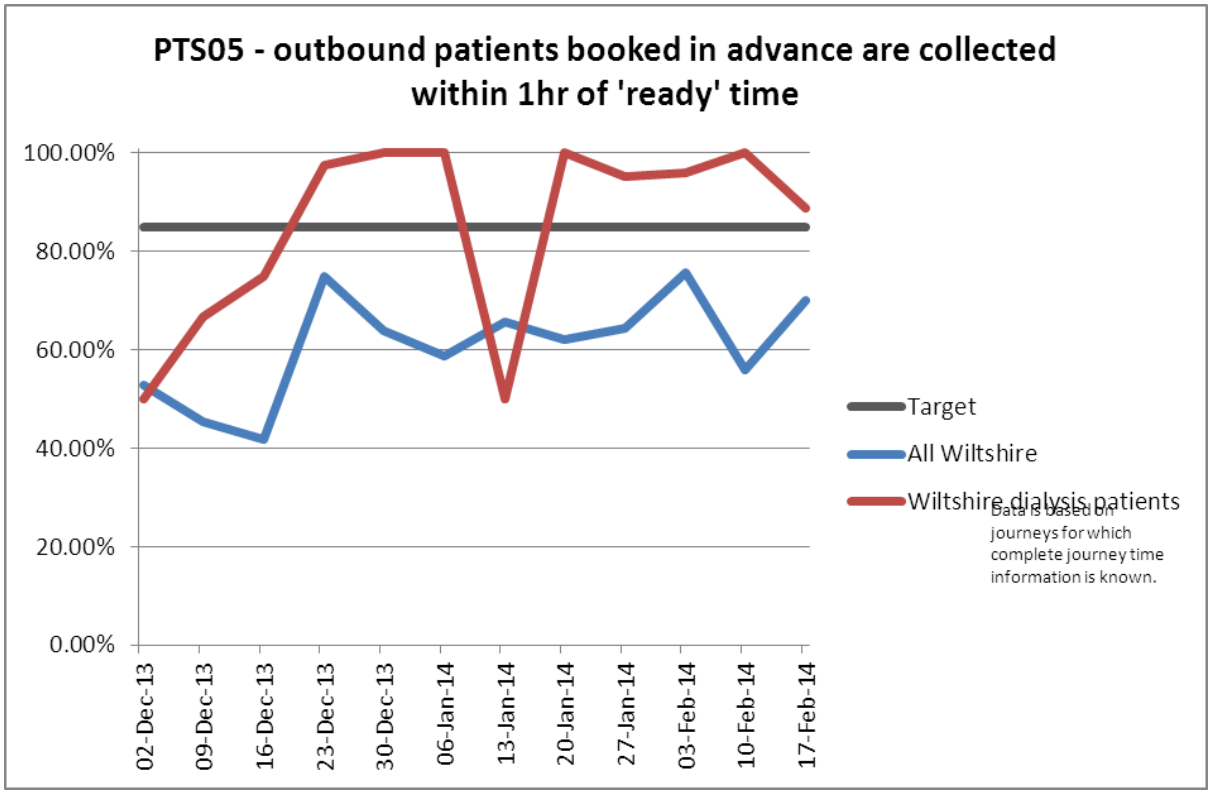
APPENDIX 3 - PERFORMANCE

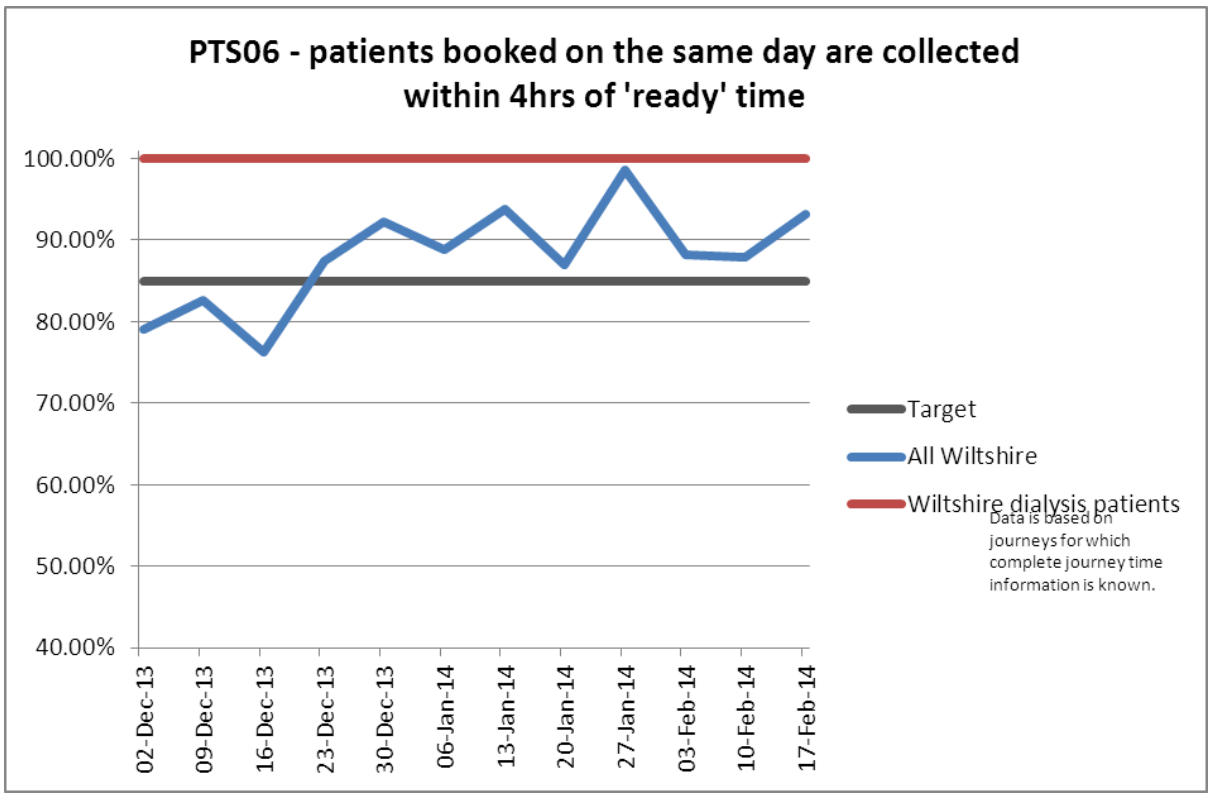


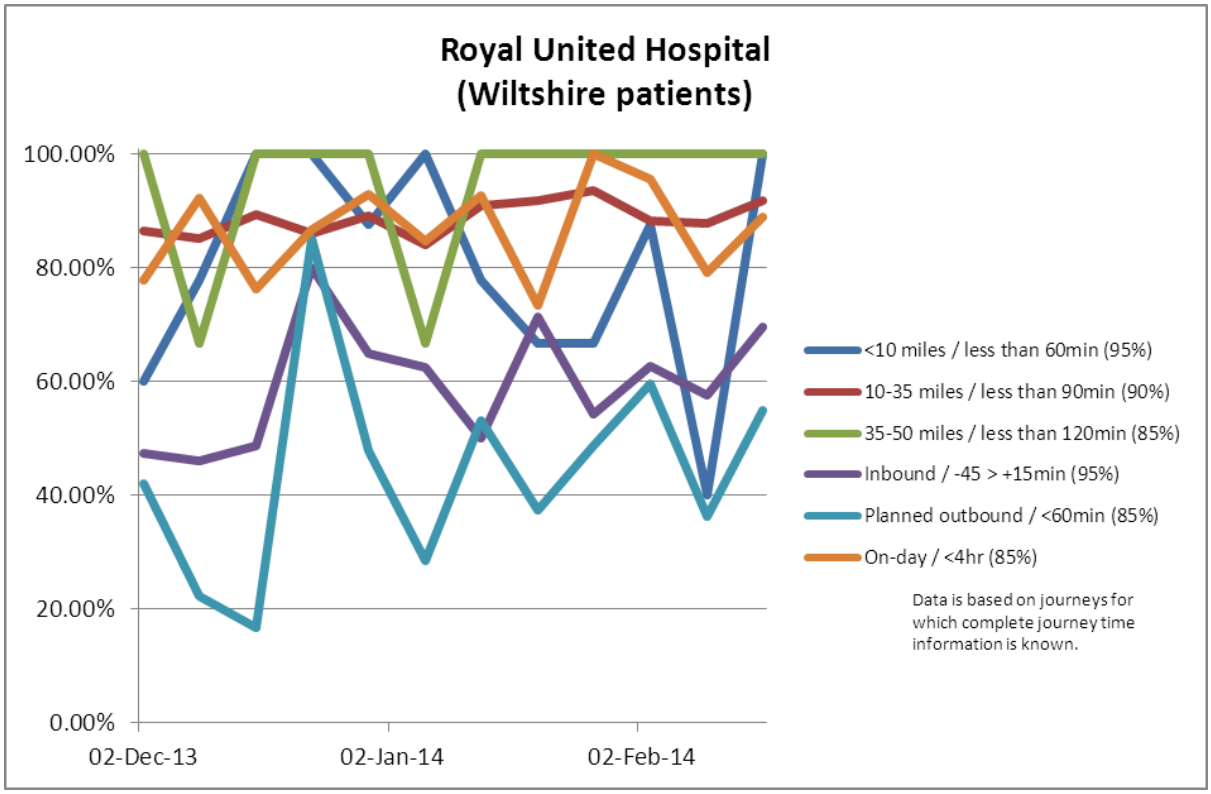


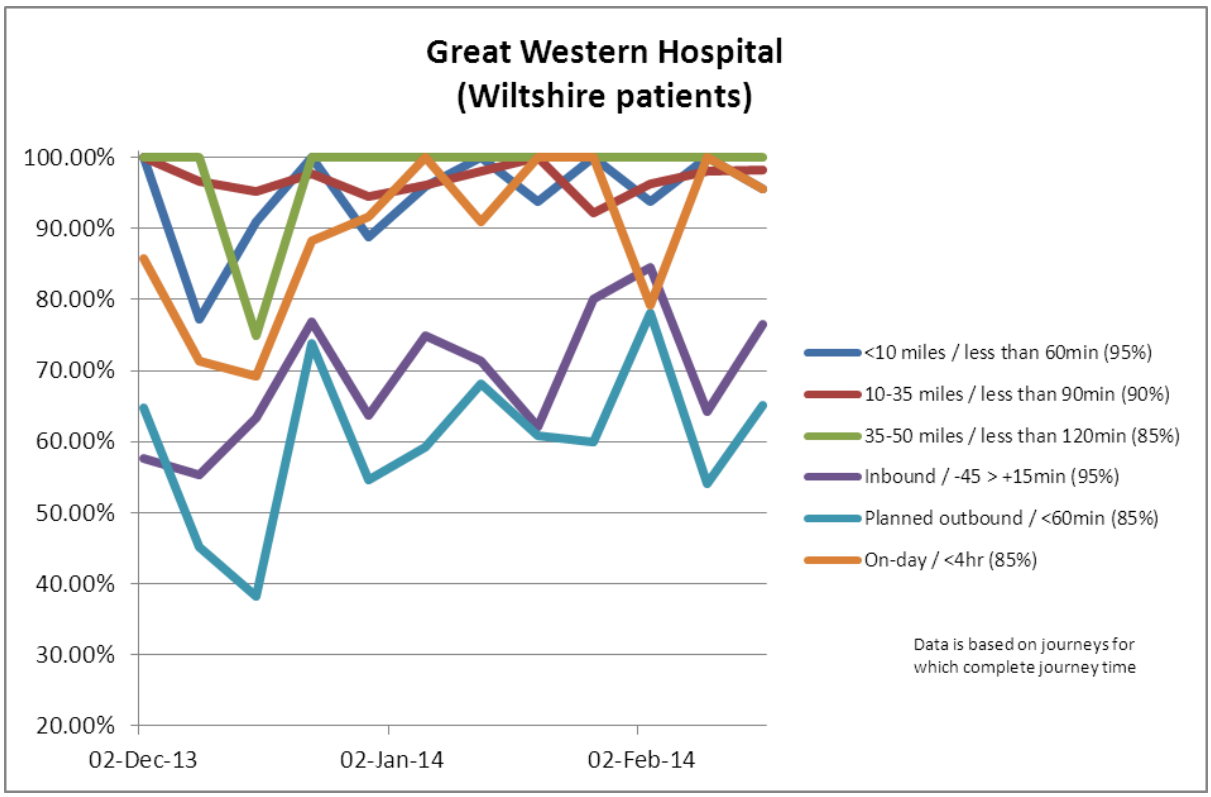

PTS03 - Patients travelling between 35 and 50 miles should spend
no longer than 120mins on board the vehicle
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
02-Dec-13
09-Dec-13
16-Dec-13
23-Dec-13
30-Dec-13
06-Jan-14
13-Jan-14
20-Jan-14
27-Jan-14
03-Feb-14
10-Feb-14
17-Feb-14
Target
All Wiltshire
Wiltshire dialysis patients
Data is based on journeys for which complete journey time information is known.

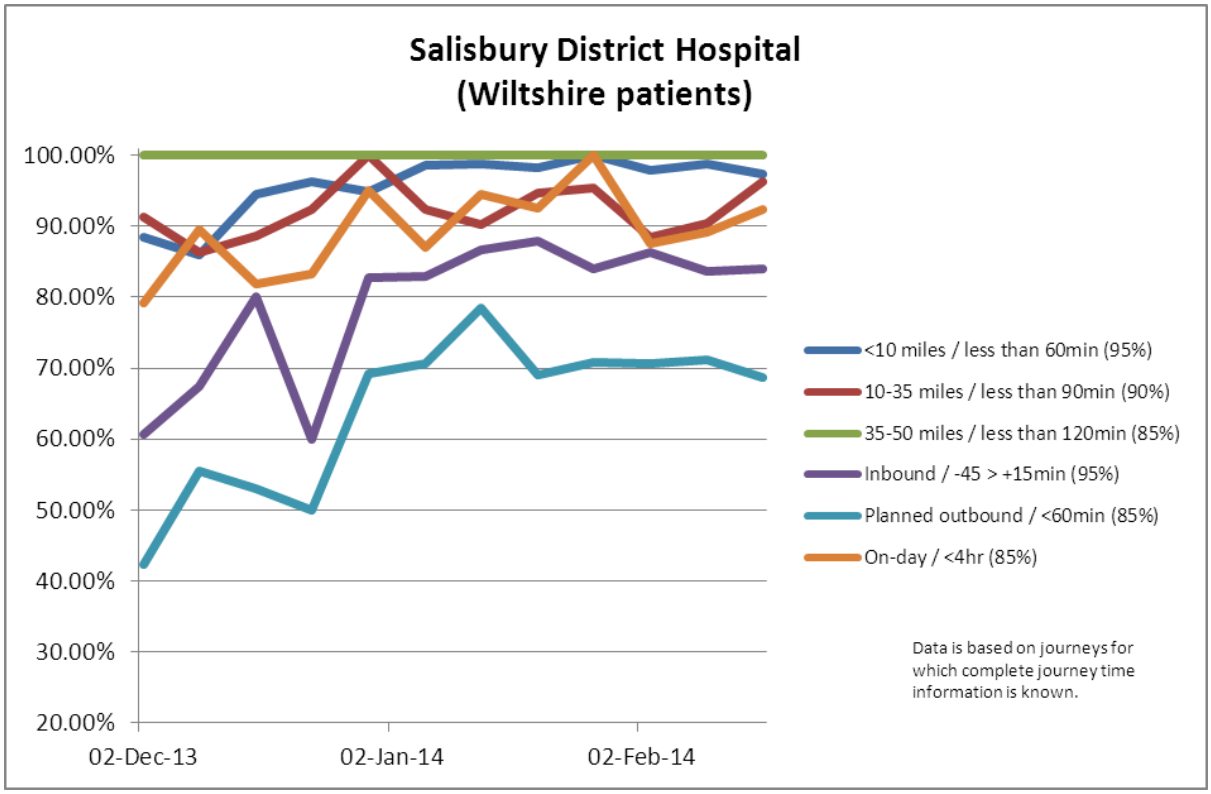

PTS04 - inbound patients arrive between 45mins early and 15mins late
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
02-Dec-13
09-Dec-13
16-Dec-13
23-Dec-13
30-Dec-13
06-Jan-14
13-Jan-14
20-Jan-14
27-Jan-14
03-Feb-14
10-Feb-14
17-Feb-14
Target
All Wiltshire
Wiltshire dialysis patients
Data is based on journeys for which complete journey time information is known.


PTS05 - outbound patients booked in advance are collected within 1hr of 'ready' time
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
02-Dec-13
09-Dec-13
16-Dec-13
23-Dec-13
30-Dec-13
06-Jan-14
13-Jan-14
20-Jan-14
27-Jan-14
03-Feb-14
10-Feb-14
17-Feb-14
Target
All Wiltshire
Wiltshire dialysis patients
Data is based on journeys for which complete journey time information is known.


PTS06 - patients booked on the same day are collected within 4hrs of 'ready' time
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
02-Dec-13
09-Dec-13
16-Dec-13
23-Dec-13
30-Dec-13
06-Jan-14
13-Jan-14
20-Jan-14
27-Jan-14
03-Feb-14
10-Feb-14
17-Feb-14
Target
All Wiltshire
Wiltshire dialysis patients
Data is based on journeys for which complete journey time information is known.


Royal United Hospital
(Wiltshire patients)
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
02-Dec-13
02-Jan-14
02-Feb-14
<10 miles / less than 60min (95%)
10-35 miles / less than 90min (90%)
35-50 miles / less than 120min (85%)
Inbound / -45 > +15min (95%)
Planned outbound / <60min (85%)
On-day / <4hr (85%)
Data is based on journeys for which complete journey time information is known.


Great Western Hospital
(Wiltshire patients)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
02-Dec-13
02-Jan-14
02-Feb-14
<10 miles / less than 60min (95%)
10-35 miles / less than 90min (90%)
35-50 miles / less than 120min (85%)
Inbound / -45 > +15min (95%)
Planned outbound / <60min (85%)
On-day / <4hr (85%)
Data is based on journeys for which complete journey time


Salisbury District Hospital
(Wiltshire patients)
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
02-Dec-13
02-Jan-14
02-Feb-14
<10 miles / less than 60min (95%)
10-35 miles / less than 90min (90%)
35-50 miles / less than 120min (85%)
Inbound / -45 > +15min (95%)
Planned outbound / <60min (85%)
On-day / <4hr (85%)
Data is based on journeys for which complete journey time information is known.

APPENDIX 4 - IMPROVEMENTS MADE SINCE SERVICE LAUNCH

- Context
- Booking centre – call taking
- Online booking
- Journey times
- Capacity and resources
- Dialysis
- Acute Trust action plans
- Comms

Context

The new NEPTS contract with Arriva went live on 1 Dec 2013, replacing a multitude of contract and ad hoc arrangements. Initial weeks were characterised by:

- an extremely high volume of calls
- problems arising from the incomplete or inaccurate nature of bookings information inherited from the previous providers
- a journey volume that exceed the expected level
- a significant variation to the expected journey mix (different patient mobility and vehicle types required)
- early winter pressures being experienced within the acute trusts
- some significant issues regarding arrangements for the movement of out-of-area patients to/from acute trusts within the contract area
- the need for acute trusts to revise their internal processes in a much more significant way than had been appreciated

Despite a comprehensive mobilisation process, the combination of these issues meant that there was considerable concern at the outset of the contract. Much of this was based on information, which though in part unsubstantiated, has been challenging to refute, given that at the same time, there have also been some examples of poor performance as a result of the impact of the factors described (typically excessively long waits, sometimes resulting in overnight re-admissions or potentially detrimental impact on patients). Within this context, the following summarises some of the improvements that have taken place during the first three months of the contract.

Booking centre - Call taking

- Initial call-taking capacity was increased by 60%, including experienced Arriva staff from other NEPTS call centres, to cope with the anticipated volume of calls, and to reduce call wait times
- Call volume has reduced from 5,500 per week to 3,500 per week (1 Dec-14 Feb)
- Call abandonment rate has reduced from >30% to <10% (1 Dec-14 Feb)
- Average call wait time has reduced from >3 minutes to <2 minutes (1 Dec-14 Feb)
- Maximum call wait time has reduced from >25 minutes to <5 minutes (1 Dec-14 Feb)
- Improved internal call handler training and individual performance management now taking place

Online booking

- Arriva trainers have attended acute trust sites to train up hospital staff and to train internal trainers
- Ad hoc issues with using online booking have been addressed and resolved
- The proportion of bookings, amendments, cancellations and "make ready" actions made online has increased steadily and is now >30% (14 Feb 2014). This reduces the burden on the call centre, meaning faster call answering; and also provides real-time visibility of bookings, for hospital staff
- The benefits of the online system are becoming progressively clearer for hospital staff, including the ability to review lists of booked journeys, and to take ad-hoc snapshots of outstanding patient journeys including those not booked ready.

Journey Timings

- Journey time and patient drop-off/collection performance has improved. Across the 4 CCGs, time on vehicle performance exceeds KPI level for all journeys over 10 miles, and is 1% below target for journeys under 10 miles (Wiltshire specific values are shown in main body of the report)
- On-time drop-off (inbound) has consistently improved but is still below KPI target
- On-day collection (within 4 hrs) outbound exceeds KPI target
- Planned outbound collection (within 60 minutes) has improved but is still below KPI target

Capacity and resources

- Total patient carrying capacity has been increased by 15% since day one
- Front-line staffing is planned to increase by 15% with five new staff already in post
- Accredited subcontractors are now receiving their work through an innovative online tool
- Significant re-profiling of Arriva vehicle shift patterns is resulting in increased capacity at critical times of the day, mainly weekday afternoons

Dialysis

- A renal hotline has been implemented to provide direct renal-dedicated assistance
- Two planners have been assigned on a dedicated basis
- Progress has been made to move to dedicated drivers for renal dialysis patients
- Ambulances fulfilling dialysis journeys now have in-built buffer (catch-up) time in their schedules to increase reliability and on-time performance
- A “renal champion” operational support manager has been appointed and is now in post to address the various issues impacting renal dialysis patients, and to manage the implementation of Arriva service for Wiltshire patients attending SFT for dialysis; and to manage the relocation of dialysis within Southmead for GBSW patients

Acute Trust Action Plans

- Diagnostic visits conducted by Arriva and joint action plans produced by Arriva, developed jointly with the acute trusts. These identify the main issues and concerns experienced within each Trust, and a series of actions that will resolve those issues. These plans are reviewed and updated weekly
- Joint performance information is now provided weekly to acute trusts, to further assist in embedding new processes and help build confidence in the new service
- Where fixed time slots are required eg for home visits, or regular reliable clinic timings, these are now booked on a throughput time, to reduce delays
- Arriva checks all open bookings daily with the acute trusts, between 3-4pm, to confirm if the journeys are still required/ ready to proceed / are to be cancelled, to reduce late afternoon/early evening delays
- Where phone numbers are provided, patients are being called in advance to ensure they are more likely to be ready when their transport arrives

Comms

- A comms pack including points of contact, FAQs, escalation arrangements, guidance on booking requirements, etc. has been distributed widely to healthcare professionals, including acute trusts, community providers, GP practices
- A monthly bulletin has begun to be distributed

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Great Western Hospital: Sickness & Absence Figures for Midwifery

Below are the figures for both sickness absence and vacancy levels across the Wiltshire maternity service encompassing all of the Birth Centres – Chippenham, Trowbridge, Paulton, Shepton Mallet, Frome and the Princess Anne Wing in Bath.

	Sickness	Vacancy
Feb-13	3.53%	4.23%
Mar-13	5.59%	4.73%
Apr-13	5.70%	7.87%
May-13	5.42%	4.90%
Jun-13	4.67%	6.00%
Jul-13	4.83%	7.20%
Aug-13	4.34%	9.05%
Sep-13	3.87%	7.35%
Oct-13	4.31%	6.48%
Nov-13	5.32%	2.50%
Dec-13	3.94%	3.12%
Jan-14	3.65%	2.70%

Key: Green = lowest level. Red = highest level.

The vacancy rate in January is almost the lowest we have seen so is evidence that that recruitment drive and the significant investment is paying off. Equally sickness absence rates are now much lower. Also in January five Midwives were recruited from Ireland so the service is in a strong position ready for the transfer to the Royal United Hospital in Bath following the recent tender exercise carried out by Wiltshire CCG.

Kevin McNamara
Director of Strategy

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The National Child Measurement Programme: Wiltshire's story

What is the National Child Measurement Programme?

The National Child Measurement programme (NCMP) is a statutory requirement of the new Public Health system, underpinned by the Health and Social Care Act 2012. Each year, our Public Health team commission a Great Western School Nursing Service to weigh and measure every child in Reception (4-5 yrs) and Year 6 (10-11 yrs).

This information is shared with schools, enabling them to benchmark themselves against others and encouraging them to think about the role of physical activity in the curriculum. It is copied to the child's GP so it can inform future medical decisions and, most importantly for us, shapes Public Health strategy, priorities and service commissioning.

Why do we do it? Because it means every state school pupil in Wiltshire is seen and counted. As a result of the NCMP, every family is offered support and advice to protect and improve their child's health and our Public Health Team are equipped with the evidence we need to make strategic, focussed and effective decisions.

Wiltshire's Results

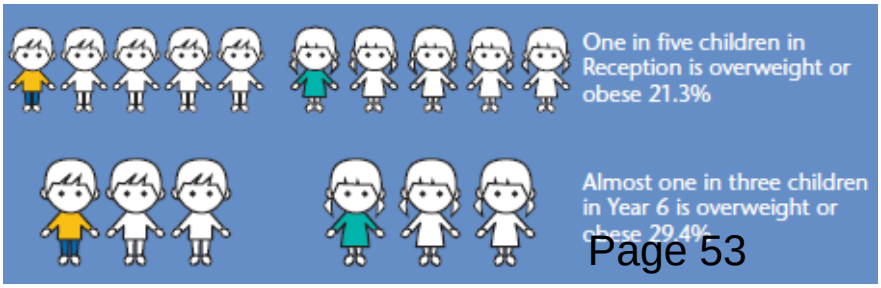
Results from the 2012 school year have confirmed that, once again, obesity in Wiltshire is lower than both the South West and England averages. However, due to the many health issues associated with being overweight, obesity continues to pose a significant challenge to the health and wellbeing of Wiltshire's young people.

2012 school year	Reception year		Year 6	
	Number	%	Number	%
Underweight	20	0.4	33	0.8
Healthy weight	3881	78.3	2966	69.9
Overweight	678	13.7	604	14.2
Obese	375	7.6	643	15.1
Overweight and obese combined	1053	21.3	1247	29.4
Coverage	4954	95.4	4246	93.5

- In Reception Year, 23.6% of boys compared to 18.8% of girls were overweight or obese.
- In Year 6, 29.5% of boys compared to 29.2% of girls were overweight or obese.

- Calne, Amebsury, Melksham, Tidworth and Wilton have the highest percentages of Reception Year children identified as overweight or obese by this year's NCMP.
- Trowbridge, Warminster, Wilton and Mere have the highest percentages of Year 6 children identified as overweight or obese by this year's NCMP

- Some areas within Wiltshire experience notably higher percentages of childhood overweight and obesity than the Wiltshire average. More deprived areas of the county tend to have higher rates of overweight and obesity than the more affluent areas.
- There have been significant improvements in delivery of the NCMP programme. Between the 2006 and 2012 school years the percentage of eligible children weighed and measured has increased from 85% to 94% in Reception Year and from 68% to 94% in Year 6. This means we are measuring more children and can be more confident of the accuracy of our results.



- This is the equivalent of 2,300 children in Wiltshire.

...Complete the picture

The prevalence of obesity in England has trebled since the 1980s. Obesity contributes to the onset of cardiovascular disease, strokes, diabetes, high blood pressure and cancer. Other more immediate risks include early puberty, developing eating disorders, teasing and discrimination by peers, low self-esteem, anxiety and depression. The issue is particularly important locally and nationally because it affects a large proportion of the population.

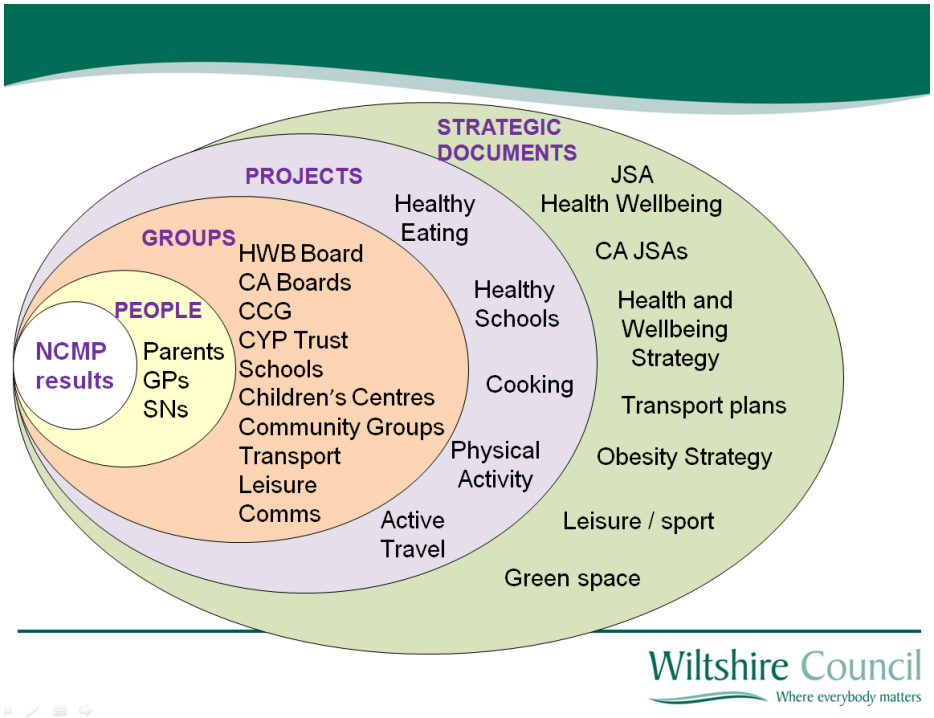
In this context, the National Child Measurement Programme becomes a powerful resource for our Public Health Team, because it allows us to identify families and Community Areas at greatest risk and intervene early to improve health outcomes for these groups. As part of the NCMP follow up process, every family receives a letter detailing the results of their child's participation in the programme. When a child is deemed to be overweight or obese, they are offered advice on healthy eating and free swimming sessions for 3 months. Between April and September 2012, more than 150 families in Wiltshire took up this membership. This opportunity is also offered to participants of the ABC Cook workshop and MEND 7-13 programme, detailed later in this report.

Programmes like this one mean the Public Health team can take full advantage of our new home at the heart of the Council. With Leisure now integrated into our Public Health and Public Protection team, we can connect policies and strategies that encourage healthy lifestyles to the delivery of health and exercise services.

Now housed in County Hall, we are also able to build stronger, more effective links with Children's Services and their School Effectiveness Team. As a result of the Healthy Schools programmes outlined later in this report, Wiltshire is seeing an increasing number of children making healthy, sustainable and safe journeys to school through School Travel Plans. While travel plans are not a direct Public Health responsibility, we can now influence decision makers more effectively, working with a wider range of partners than ever to improve health outcomes for Wiltshire's young people.

How do we use the NCMP data?

The National Child Measurement Picture provides a comprehensive and accurate picture of obesity levels among Wiltshire's young people. For comprehensive results, please see the full NCMP report.



We use this evidence to identify and analyse trends in obesity levels and co-ordinate our messages and strategies. This greatly strengthens our capacity for prevention and early intervention.

Understanding our current position facilitates focussed, evidence-based decisions on how to target our resources. NCMP data informs, shapes and underpins:

- Our Childhood Obesity Strategy (3 yearly)
- Our interactive NCMP spreadsheet (available on the Wiltshire Intelligence Network)
- Adolescent Health profiles
- The Wiltshire Joint Strategic Assessment (JSA)
- The Wiltshire Health and Wellbeing Joint Strategic Assessment (HWB JSA)
- The Wiltshire Community Area Joint Strategic Assessments (CJSAs)
- The Wiltshire Clinical Commissioning Group Joint Strategic Assessments (CCG JSAs)
- Children and Young People's Needs Assessment
- Corporate performance score card
- Corporate Public Facing indicator basket (in development)

Comparison of this data to earlier years of the NCMP indicates that rates of overweight and obesity in Reception Year children appear to be starting to stabilise. It is too early to say if this is a sustained improvement, but it demonstrates that with access to relevant and frequent data, we are able to take positive steps to improve health outcomes.

Moreover, as almost every child is weighed and measured, this programme offers an unparalleled opportunity to map and reduce inequalities in health outcomes *within* Wiltshire, because we can identify the community areas with the highest levels of obesity.

We are not alone in this effort. Sharing the results of the NCMP not only encourages evidence-based decision making from partner organisations – such as schools and the CCGs – it ensures we are working from the *same* information and therefore, that we are working together towards shared goals. Most importantly, we can use this data to tell the stories of real people and support real families in Wiltshire. How we are doing this is explored below.

How are our Public Health Team improving this picture?

When children are identified as overweight or obese, we support them to adopt healthier lifestyles; providing advice and information on the small changes that can make a big difference.

Leisure Services

Free swimming for U16s is offered across Wiltshire during school holidays. This has been a popular programme across Wiltshire and as Leisure Services takes root within the Public Health Team, joint initiatives like this will make us more effective at tackling obesity in Wiltshire.

Breastfeeding promotion

Evidence shows breastfeeding lowers the risk of childhood obesity. This simple, natural tool to tackle obesity in Wiltshire is supported by The Wiltshire Breastfeeding Strategy 2011-14, which resulted in the implementation of a range of initiatives:

UNICEF's Baby Friendly Initiative - This comprehensive, evidence based initiative is currently implemented in all hospital settings and in communities in Wiltshire. It ensures appropriate policies, training and practice are in place to support women who choose to breastfeed to do so successfully.

Mum2Mum – is Wiltshire's multi-agency Breastfeeding Peer Support programme, connecting mums who have experienced breastfeeding with those who value support through our children's centres.

The Breastfeeding Welcome Scheme – In 2012 Wiltshire joined this national scheme designed to make it easier for mothers to breastfeed comfortably when they're out and about. In 2013 Wiltshire Council further demonstrated its commitment to the scheme by making all front facing buildings 'Breastfeeding Welcome'.

A comprehensive Breastfeeding data set now enables us to monitor progress and target resources appropriately.

ABC Cook is a targeted programme equipping parents and carers with cooking and healthy eating skills. Delivered as 6 weekly sessions in Children's Centres, we supported around 200 participants (including 117 children) in 2012-13, with 62% of participants drawn from the areas of highest deprivation in Wiltshire.

Hey! (Healthy Eating for Young Children) is an Early Years community health improvement project led by Danone. Delivered through Children's Centres, Danone's ambition for HEY! is to improve the health outcomes and life-chances of local children aged 1-3, by engaging their parents in healthy eating and Skills for Life learning.

Healthy Lifestyles

MEND is a 10 week programme offering exercise, nutrition and psychological support to the families of overweight children. MEND is currently running in Trowbridge Castle Place. We are developing our own in-house programme to replace MEND, called the SHINE programme.

SHINE (Self Help Independence Nutrition and Exercise) was developed at the University of Sheffield and reports promising outcomes. Seeking to encourage those at risk to take positive action to control weight, the SHINE approach can be tailored to different age groups and settings and will be adopted in Wiltshire in September 2014.

Change4Life (C4L) is a Public Health England initiative to encourage physical activity and healthy eating. Registration with C4L is recommended to parents and schools in their NCMP results letters, enabling them to access to free change4life resources including recipes and ideas for easy 'small changes'. Between Jan 2009 and Oct 2013, 11,555 Wiltshire residents registered on the Change4Life website. Data analysis shows that the most registrations were received from areas of deprivation in Wiltshire. More than 100 schools in Wiltshire have registered as *change4life supporters*, giving them access to free resources including lesson plans to support students and their families.

School Travel Plans were originally introduced to reduce congestion, but now encourage schools to think more widely about the environmental, health and educational benefits of sustainable travel (walking, cycling, scooting, bus travel, car share and park-and-stride). The funding scheme "Taking Action on School Journeys" supports schools in installing on-site infrastructure or investigating ways to improve walking / cycling journeys. They encourage schools to promote healthy travel choices and improve access to and safety of sustainable school travel options. Across Wiltshire more than 140 schools currently have an approved travel plan.

Healthy School Status is programme that encourages schools to promote the health and wellbeing of young people, by bringing together good practice on all health related issues and providing consistent messages, encouraging and supporting schools to focus on approaches that are particularly effective. Over recent years, 97% of Wiltshire Schools have achieved Healthy Schools Status and benefit from a framework to audit their provision and implement new work.

Healthy Schools

Change4Life Clubs in Primary schools is a government funded initiative to promote more sport and physical activity in schools. Devizes School has been given the contract to implement this C4L initiative in Wiltshire.

Bike it Plus was launched in 2011 to encourage more cycling, walking and scooting or skating to school. Active travel themed events for pupils, staff and parents are delivered in selected primary schools. There are 15 schools supported at present in Trowbridge, Chippenham, Devizes and Warminster - all areas of high obesity. The initiatives are delivered in partnership with Wiltshire Council staff working on Road Safety, Bikeability training and School Travel Planning. The Bike It Plus second year report (December 2013) highlighted significant increases in levels of cycling, walking, scooting and skating to school.

Where next?

Our Public Health team are working closely with the Wiltshire Clinical Commissioning Group (CCG) to develop a refreshed strategic plan to tackle obesity in Wiltshire. As such, targeting obesity will remain an investment priority in 2014/15.

Reducing obesity levels in Wiltshire is a Public Health action priority, underpinning our service plan and forward work plan.

Service Plan priority areas
Reducing smoking
Combating risky behaviour
Enabling people to live healthy lifestyles
Improving mental health and wellbeing
Workplace health
Improving older people's health
Early diagnosis
Supporting local businesses through Public Protection activities
Supporting the best start in life 0-2
Reducing Antisocial Behaviour and perception of Antisocial Behaviour
Community involvement in air quality
Reducing the impact of infectious and zoonotic diseases

Indicator number	**Public Health Outcomes Framework Priority Indicators** (provisional)
2.22	Take up of NHS Health Check Programme by those eligible
2.6	Excess weight in 4-5 and 10-11 year olds
2.12	Excess weight in adults
2.14	Smoking prevalence - adults
2.13	Percentage of physically active and inactive adults
4.5	Under 75 mortality rate from cancer
4.4	Under 75 mortality rate from all cardiovascular diseases

How can you support our work?

Obesity is not always an easy topic to talk about, but few issues are as important to tackle in safeguarding the future of young people in Wiltshire.

By remaining informed about the wider implications of obesity and the work our Public Health team are undertaking, in conjunction with our partners, you can help us to improve public awareness of, and interest in this important issue.

As elected members, it is also helpful for you to remain aware of inequalities within Wiltshire. The NCMP results report highlights the differences between Community Areas, with Melksham, Westbury, Trowbridge, Warminster, Chippenham, Devizes and Salisbury Community Areas highlighted as having statistically significantly higher than average percentages of obese or overweight children.

Armed with this knowledge, you can support the Public Health Team in signposting your constituents to council services:

The Change for life website - http://www.nhs.uk/Change4Life/Pages/change-for-life.aspx

The NHS Healthy Choices site - http://www.nhs.uk/LiveWell/Pages/Livewellhub.aspx

Our council website resource hub - http://www.wiltshire.gov.uk/healthyweight4life

Contact information:

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Results of the National Childhood Measurement Programme for Wiltshire

2012 School Year

NHS

Wiltshire Council
Where everybody matters

Welcome

Maggie Rae, Corporate Director, Wiltshire Council

Keith Humphries, Cabinet Member Public Health, Public Protection, Adult Social Care and Housing

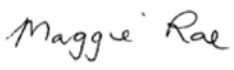
We are delighted to be presenting this report on the latest National Child Measurement Programme (NCMP) results for Wiltshire.

Each year the programme measures the height and weight of more than 9,000 children in Reception Year and Year 6 within state-maintained schools with pupils categorised as underweight, healthy weight, overweight or obese. As one of the new statutory public health functions of the council the NCMP provides vital information on current levels of childhood obesity in Wiltshire to inform commissioning of services to meet these needs and monitor progress in tackling obesity.

Results for the 2012 school year have confirmed that levels of overweight and obesity in Wiltshire continue to be lower than both the South West and England averages. However, because of the number of children it affects, childhood obesity remains a significant public health challenge to our children's health and wellbeing.

The NCMP has been running for seven years in Wiltshire and over this time we have seen notable improvements in participation in the programme with the programme now outperforming the England average.

We would like to take this opportunity to thank everyone involved in making this important programme a success, including the Great Western Hospital Trust Public Health Nursing teams who carry out the measurement process; our local schools which continue to support delivery of the programme on their sites; and also the council's public health and education and learning teams who ensure the programme runs smoothly and that results are acted on each year.



Maggie Rae, Corporate Director

Keith Humphries, Cabinet Member
Public Health, Public Protection,
Adult Social Care and Housing

Introduction

The National Child Measurement Programme is a statutory public health function of the Local Authority (LA) which provides vital information on rates of childhood obesity locally and nationally. This annual programme measures the height and weight of over 9,000 children in Reception Year and Year 6 within state-maintained schools with pupils categorised as underweight, healthy weight, overweight or obese.

Key findings from the 2012 School Year

- One in five pupils in Reception Year (aged 4-5 years) and one in three pupils in Year 6 (aged 10-11 years) in Wiltshire were found to be overweight or obese in the 2012 school year. This is equivalent to 1,282 children identified as overweight and 1,018 identified as obese.
- Levels of overweight and obesity in Wiltshire continue to be lower than both the South West and England averages for Reception Year and Year 6.
- Some areas within Wiltshire experience notably higher percentages of childhood overweight and obesity than the Wiltshire average. More deprived areas of the county tend to have higher rates of overweight and obesity than the more affluent areas.
- There have been significant improvements in delivery of the NCMP programme. Between the 2006 and 2012 school years the percentage of eligible children weighed and measured has increased from 85% to 95% in Reception Year and from 68% to 94% in Year 6. This means we are measuring more children and can be more confident of the accuracy of our results.

Why is the NCMP so important?

Childhood obesity presents a significant public health challenge, putting children at greater risk of developing cancer, Type-2 diabetes and heart disease in later life.

Information collected through the NCMP allows us to offer support directly to children and families where weight problems are identified. The parents of every child identified as overweight or obese through the NCMP receives a letter outlining the support available locally to help the family adopt healthier lifestyles.

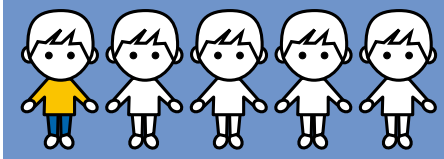
Equally importantly, the results of the NCMP allow us to plan and target prevention activities to ensure they are reaching areas of greatest need. School level results are also shared with head teachers encouraging more emphasis on healthy eating and physical activity in the curriculum in schools where levels of overweight and obesity are highest.

What does the NCMP tell us about childhood obesity in Wiltshire?

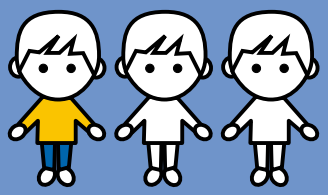
Wiltshire's percentage of overweight or obese children in Reception Year (21.3%) is lower than the England (22.2%) and South West percentages (22.9%).

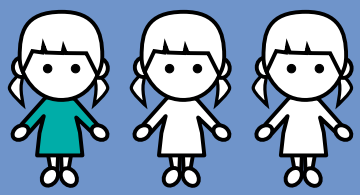
Wiltshire's percentage of overweight or obese children in Year 6 (29.4%) is also lower than the England (33.3%) and South West percentages (30.9%).

However, this is still equivalent to one in five pupils in Reception Year and one in three pupils in Year 6 in Wiltshire being overweight or obese in the 2012 school year. This is equal to 1,282 children identified as overweight and 1,018 identified as obese. Therefore, athough levels of overweight and obesity are lower than national and regional averages, childhood obesity still presents a significant public health challenge to our children's health and wellbeing because of the number of children it affects.



One in five children in Reception is overweight or obese 21.3%





Almost one in three children in Year 6 is overweight or obese 29.4%

Overview of results from the NCMP for the 2012 school year

2012 school year	Reception year		Year 6	
	Number	%	Number	%
Underweight	20	0.4	33	0.8
Healthy weight	3881	78.3	2966	69.9
Overweight	678	13.7	604	14.2
Obese	375	7.6	643	15.1
Overweight and obese combined	1053	21.3	1247	29.4
Coverage	4954	95.4	4246	93.5

It is important to understand variations in overweight and obesity amongst our population so that we can understand and tackle inequalities in health outcomes. This is why NCMP results are looked at for differences between genders, levels of deprivation and community areas.

Gender

Both locally and nationally, levels of overweight and obesity are slightly higher in boys than girls.

- In Reception Year, 23.6% of boys compared to 18.8% of girls were overweight or obese
- In Year 6, 29.5% of boys compared to 29.2% of girls were overweight or obese.

Health inequalities

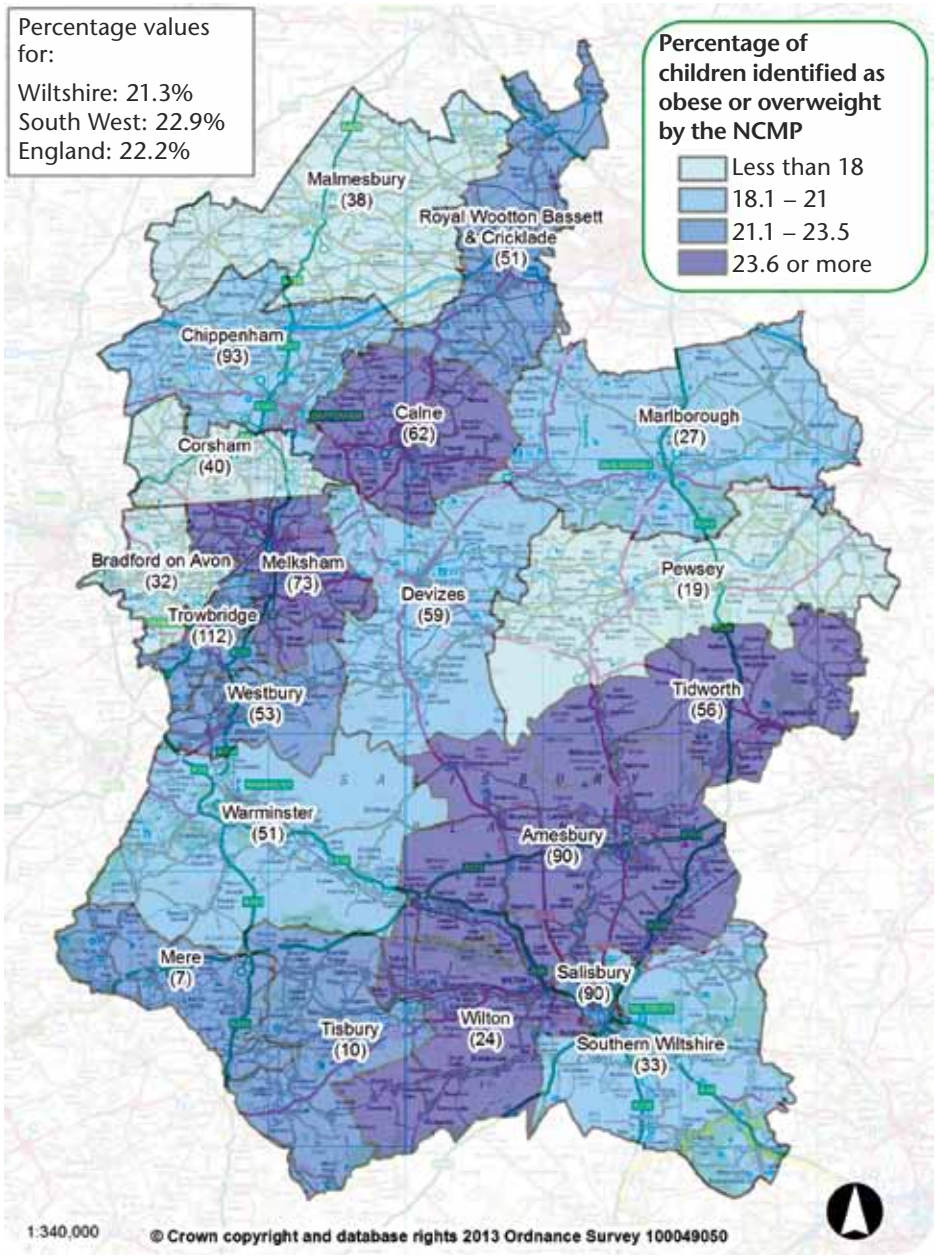
More children with unhealthy weights live in areas of higher deprivation and this is an example of how people's experiences of health inequalities can be seen from an early age.

- In the most deprived areas 24.3% of Reception age children were identified as overweight or obese by this year's NCMP compared to 21.3% for Wiltshire as a whole.
- In the most deprived areas 33.3% of Year 6 children were identified as overweight or obese by this year's NCMP compared to 29.4% for Wiltshire as a whole.

Wiltshire community area results

The map below shows the percentage and number of overweight and obese children in Reception Year by community area in the 2012 school year. This ranges from 13.6% in Pewsey to 26.6% in Calne.

Calne, Amebsury, Melksham, Tidworth and Wilton have the highest percentages of Reception Year children identified as overweight or obese by this year's NCMP. The numbers in brackets located under the name of each community area on the map indicate the number of Reception Year children identified as overweight or obese in that area. For example Malmesbury (38) had 38 Reception Year children identified as overweight or obese.



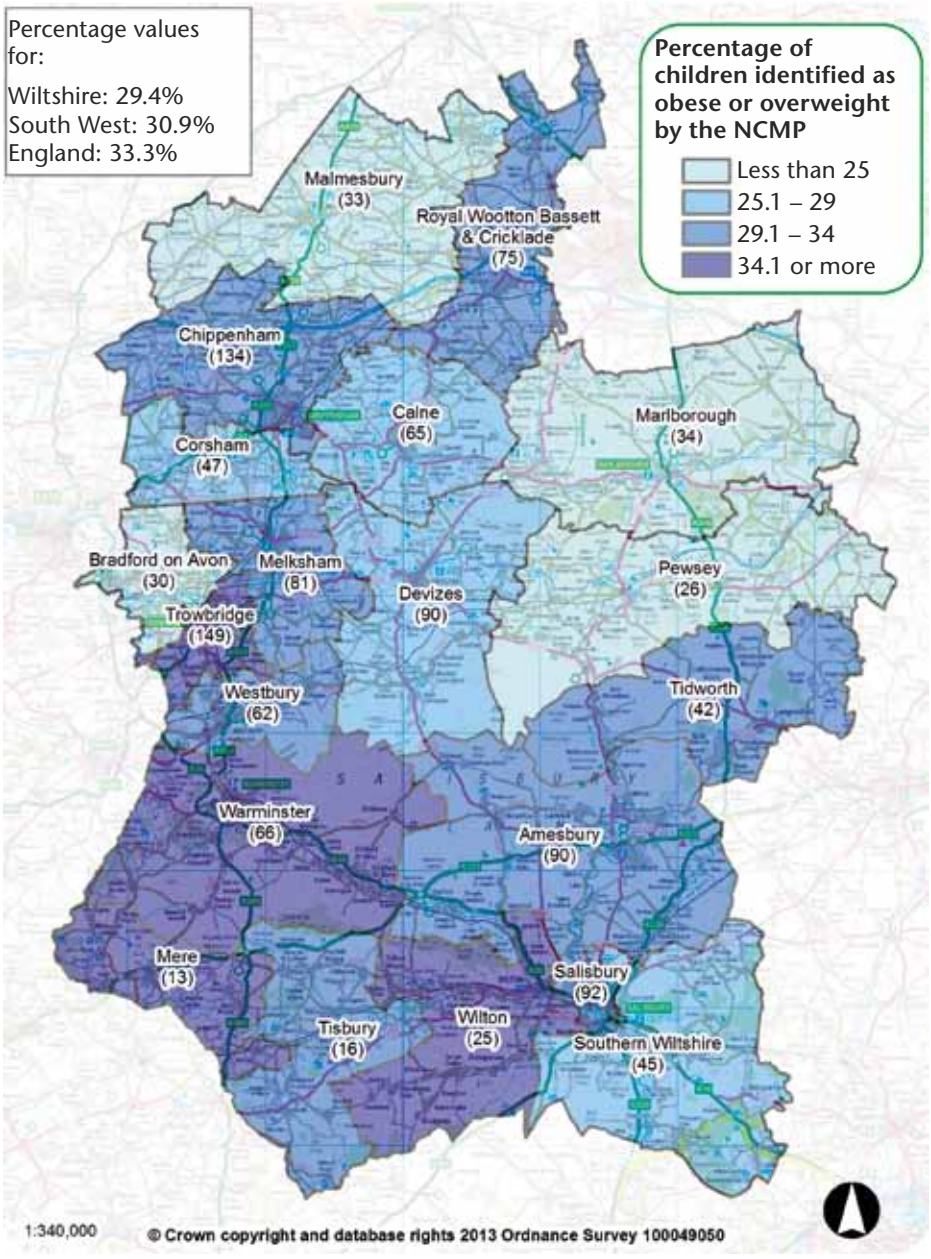
The table below provides data on the number of children identified as overweight or obese in Reception Year through the NCMP in 2011 and 2012 by community area.

Community Area	Number of Children Identified as Overweight or Obese	
	Reception Year	
	2011 School Year	2012 School Year
Amesbury	52	90
Bradford-on-Avon	33	32
Calne	52	62
Chippenham	89	93
Corsham	44	40
Devizes	66	59
Malmesbury	35	38
Marlborough	34	27
Melksham	58	73
Mere	10	7
Pewsey	19	19
Salisbury	84	90
Southern Wiltshire	45	33
Tidworth	44	56
Tisbury	*	10
Trowbridge	116	112
Warminster	58	51
Westbury	56	53
Wilton	18	24
RWB and Cricklade	53	51

* Numbers lower than 5 have been suppressed to prevent disclosure of identifiable information

The map below shows the percentage and number of obese or overweight children in Year 6 by community area in the 2012 school year. This ranges from 19.2% in Malmesbury to 37.2% in Trowbridge.

Trowbridge, Warminster, Wilton and Mere have the highest percentages of Year 6 children identified as overweight or obese by this year's NCMP. The numbers in brackets located under the name of each community area on the map indicate the number of Year 6 children identified as overweight or obese in that area. For example Malmesbury (33) had 33 Year 6 children identified as overweight or obese.



The table below provides data on the number of children identified as overweight or obese in Year 6 through the NCMP in 2011 and 2012 by community area.

Community Area	Number of Children Identified as Overweight or Obese	
	Year 6	
	2011 School Year	2012 School Year
Amesbury	86	90
Bradford-on-Avon	35	30
Calne	62	65
Chippenham	153	134
Corsham	54	47
Devizes	100	90
Malmesbury	48	33
Marlborough	48	34
Melksham	77	81
Mere	14	13
Pewsey	34	26
Salisbury	110	92
Southern Wiltshire	38	45
Tidworth	53	42
Tisbury	8	16
Trowbridge	143	149
Warminster	52	66
Westbury	51	62
Wilton	21	25
RWB and Cricklade	68	75

Public health action to address the obesity challenge in Wiltshire

There are many complex behavioural and societal factors that combine to contribute to the causes of obesity. This means everyone has a role to play in reducing childhood obesity locally and is why public health is working closely with partners both within the council and beyond, including the NHS, voluntary sector and with private business, to tackle this challenge. Examples of some of the evidence-based activities already in place to support communities, schools, families and GPs are outlined below.

When children are identified as overweight or obese through the NCMP, public health supports families to adopt healthier lifestyles; providing advice and information on small changes families can make to their eating and exercise habits; offering three months of free family swimming and signposting families to speak to their school nurse or GP for extra support.

Support services for children who are overweight or obese are also available for families to sign up to either via their GP or directly with the service. These include the MEND and BOOT UP programmes offering healthy living programmes for overweight children and their parents and free access to Slimming World groups by GP referral for children aged 11 and over with parents or carers also attending free.

Public health commissions and delivers a range of preventative programmes to support families to learn the skills to adopt healthier lifestyles early and before weight problems arise. These include running programmes to increase active travel to school, delivering healthy lifestyle and cooking courses for families in areas with the highest levels of obesity and using the national Change4Life brand to promote free resources on healthy eating and physical activity.

Useful links

If you would like to find out more about childhood obesity in Wiltshire or find advice and information on adopting healthier lifestyles, the websites below may be of interest to you:

Healthy Weight 4 Life: **www.wiltshire.gov.uk/healthyweight4life**

Change4 Life: **www.nhs.uk/Change4Life**

The Wiltshire Intelligence Network: **www.intelligencenetwork.org.uk**

If you have a specific question about the National Childhood Measurement Programme, you can contact Wiltshire Council's Public Health Team on **0300 0034566** or via **publichealth@wiltshire.gov.uk**

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10 January 2014

Dear Colleague

I am writing to provide you with information ahead of an inquest into the death of a child who died following cardiac surgery at the Bristol Royal Hospital for Children in spring 2012. The inquest into the death of Sean Turner will commence on Monday 13 January and is currently scheduled to take place over a period of two weeks. The Trust has been working closely with the Coroner to provide all the information required for the inquest to establish the factors which caused Sean's death.

I anticipate that the inquests may attract local and regional media coverage and, as such, I wanted to provide you with up to date assurances regarding the safety and quality of paediatric cardiac surgery services in the Bristol Children's Hospital.

Like all paediatric cardiac units in England, the service's outcomes have and continue to be exposed to considerable review and scrutiny both from within and, importantly, independently through external bodies including the National Institute for Cardiovascular Outcomes Research (NICOR). All of these reviews indicate that Bristol's services are safe and delivering good outcomes for children.

NHS England recently commissioned a review of mortality rates at the ten children's heart centres operating in England and found UH Bristol to be providing a safe service with good outcomes. The review did recommended further investigation into three units based on their outcomes but Bristol Children's Hospital was not one of them.

The most recent national monitoring of quality and safety in NHS Trusts and Foundation Trusts, the CQC's Intelligent Monitoring Report, also confirms UH Bristol to have the lowest possible risk profile (band 6), which is independent confirmation of the strong safety profile of the Trust across both adult and children's services – UH Bristol was one of just 37 Trusts nationally to be afforded this rating.

We are aware that the experience of children and families during their time with us is as important as the excellent clinical results we strive for. The Trust continually seeks feedback from families of their experiences of care at the Bristol Children's Hospital in order to continually improve the service we offer; in a recent survey of parents of children cared for on our specialist paediatric cardiac ward (Ward 32), 99% described their experience as good, very good or excellent.

We are proud that our service continues to develop and the Trust has learnt much from recent events, including the Care Quality Commission's views on the areas where they considered further improvement was warranted. We have worked hard to ensure that all staff understand the importance of truly excellent communication with families, and work together at all times for the benefit of the families they are caring for.

With the support of our commissioners we have now established a dedicated High Dependency Unit (HDU) within Ward 32 which ensures there is additional staff available to support children and their families when they are at their most vulnerable.

As mentioned, I anticipate media interest in the inquest and we are preparing for this; our priority will be to ensure that we maintain the confidence of the families who rely upon us and we will be providing additional support and information to them throughout this period. This will include a telephone contact point for them to access at any time during the inquest alongside enhanced support from our cardiac liaison nurses for those parents who have children in the hospital through this period.

As you would expect, the Trust will not be offering public comment on the inquest proceedings, although media coverage is likely to continue throughout; if you have any questions arising from the inquest coverage or this letter, then please email paediatriccardiacservices@uhbristol.nhs.uk and we ensure a prompt response.

Yours faithfully,

Robert Woolley
Chief Executive

University Hospitals Bristol NHS
NHS Foundation Trust

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5 February 2014

Dear Colleague,

I am writing further to my letter of 10 January, regarding the inquest into the death of Sean Turner in spring 2012, following congenital heart surgery at the Bristol Royal Hospital for Children, which concluded on 23 January.

The Coroner heard that Sean was born with a rare and complex heart condition and had undergone a procedure which carries recognised risk. In a narrative judgment, however, she said that there were lost opportunities to render medical care or treatment to Sean in the post-operative period and she identified two specific aspects of his medical care. I therefore made a public apology to Mr and Mrs Turner and their family.

The Coroner said that there was no evidence of a failure to provide basic care to Sean. She said that was aware of the actions taken by the Trust following his death and she therefore did not make any recommendations for further action. We will nonetheless ensure that we have learned all possible lessons for the future care of children like Sean.

Congenital heart surgery is a high risk service. We are able to treat children today who in the past would simply not have survived the conditions they were born with. There will unfortunately always be adverse outcomes for some of these children. Independent analysis nonetheless shows that our results are comparable to other national centres for this type of surgery.

Further inquests for children with heart conditions are listed in the coming months and, although the circumstances in each case are different, they will doubtless attract media attention. We seek always to balance our duty to maintain the confidence of families under our care and the wider public, to support our staff in the difficult work they do and to be open and honest with families when things go wrong.

I hope you find this letter helpful. If you have any questions, please do contact me.

Yours faithfully,

Robert Woolley
Chief Executive

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Overview and Scrutiny Work Plan

Committee	Review / Task Group	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Scrutiny Officer	STATUS (incl. date)
		Cabinet 21st Nov	Cabinet 17th Dec	Cabinet 21st Jan	Cabinet 11th Feb	Cabinet 18th Mar	Cabinet 22nd April	Cabinet 20th May	Cabinet 17th Jun	Cabinet 22nd Jul		
		Council 12th Nov			Council 4th and 25th Feb			Council 13th May		Council 29th Jul		
HEALTH	Clinical Commissioing Group (CCG) Task Group										MM	Task Group to be dissolved pending endorsement by O & S Management Committee in March
	Continence Services Task Group	Review in progress						Health May 2014			MM	Task Group reviewing provision of continence products. Report to HSC May 2014
	Review of AWP/Dementia Services	Review in progress									MM	Task Group reviewing provision of revised dementia services. Awaiting completion on consultation on Dementias Strategy.
	Help to Live at Home										MM	Task Group to commence in Spring 2014, members appointed
	Urgent Care/Winter Pressures										MM	Task Group to commence in Spring 2014, members appointed
	Local Safeguarding Adults Board Annual Report										MM	Annual Report Next due Sept 2014
	Public Health Annual Report										MM	Annual Report Next due Sept 2014

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