Adult Social Care & Health Overview & Scrutiny Committee

Date: Monday, 13 January 2020
Time: 2.00 pm
Venue: Committee Room 2, Shire Hall

Membership
Councillor Christopher Kettle
Councillor Pamela Redford
Councillor Tracy Sheppard
Councillor Sally Bragg
Councillor Wallace Redford (Chair)
Councillor Clare Golby (Vice-Chair)
Councillor Helen Adkins
Councillor Jo Barker
Councillor Mike Brain
Councillor John Cooke
Councillor John Holland
Councillor Andy Jenns
Councillor Jerry Roodhouse
Councillor Andy Sargeant
Councillor Margaret Bell

Items on the agenda: -

1. General

(1) Apologies

(2) Disclosures of Pecuniary and Non-Pecuniary Interests

Members are required to register their disclosable pecuniary interests within 28 days of their election of appointment to the Council. A member attending a meeting where a matter arises in which s/he has a disclosable pecuniary interest must (unless s/he has a dispensation):

- Declare the interest if s/he has not already registered it
- Not participate in any discussion or vote
- Must leave the meeting room until the matter has been dealt with

- Give written notice of any unregistered interest to the Monitoring Officer within 28 days of the meeting Non-pecuniary interests must still be declared in accordance with the Code of Conduct. These should be declared at the commencement of the meeting.

(3) Chair's Announcements

2. Public Speaking

Any member of the public who is resident or working in Warwickshire, or who is in receipt of services from the Council, may speak at the meeting for up to three minutes on any matter within the remit of the Committee. This can be in the form of a statement or a question. If you wish to speak please notify Paul Spencer in writing at least two working days before the meeting. You should give your name and address and the subject upon which you wish to speak. Full details of the public speaking scheme are set out in the Council's Standing Orders.

3. Questions to the Portfolio Holder

Up to 30 minutes of the meeting is available for members of the Committee to put questions to the Portfolio Holder: Councillor Les Caborn (Adult Social Care and Health) on any matters relevant to the remit of this Committee.

4. Developing Stroke Services in Coventry and Warwickshire - Public Consultation

5 - 138

At its meeting on 14 October 2019, the Joint Coventry and Warwickshire Health OSC (JHOSC) gave initial consideration to this review. This Committee is asked to comment on the stroke review proposals, in order that members' views are submitted to the next JHOSC meeting on 22 January 2020.

5. Performance Monitoring - Clinical Commissioning Groups (CCGs)

The Committee agreed in September to hold a special meeting to monitor CCG performance.

(1) Warwickshire North and Coventry & Rugby CCG 139 - 220

(2) South Warwickshire CCG 221 - 246

6. Any Urgent Items

Agreed by the Chair.

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Disclaimers

Webcasting and permission to be filmed

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The public reports referred to are available on the Warwickshire Web
https://democracy.warwickshire.gov.uk/uuCoverPage.aspx?bcr=1

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Agenda Item 4

Adult Social Care & Health
Overview and Scrutiny Committee
13 January 2020

Developing stroke services in Coventry and Warwickshire Public Consultation

Recommendation(s)

1. For the Warwickshire Adult Social Care & Health Overview & Scrutiny Committee to review the attached Pre Consultation Business Case and Consultation Documentation

2. For the Warwickshire Adult Social Care & Health Overview & Scrutiny Committee to note the changes to the dates of the consultation due to pre-election guidance.

3. Adult Social Care & Health Overview & Scrutiny Committee are recommended to identify their response to the consultation as relevant to Warwickshire to be referred to the Coventry and Warwickshire Joint Health Overview and Scrutiny Committee on 22nd January 2020.

1.0 Key Issues

1.1 The aim of our proposals are to improve stroke services, which are part of both CCG plans and the health and care system improvements identified by the Coventry and Warwickshire Health and Care partnership.

1.2 Comparisons of the performance and outcomes of current local stroke services against best practice standards and the achievements of other health systems in England, show we could achieve better health outcomes for patients and more effective and efficient services. It is clear from the analysis of current service provision that there is also considerable unwarranted variation and inequity in the range of services available for patients across the system.

2.0 Options and Proposal

2.1 Options for the future delivery of stroke care have been co-produced and appraised through a process involving extensive professional, patient and public engagement.

2.2 The resultant Pre-Consultation Business Case (PCBC) describes the process and outputs in detail, proposing the implementation of a new service configuration that would see:

- Removal of the current inequities in service provision across Coventry and Warwickshire
- Prevention of c.230 strokes in 3 years by bringing anticoagulation prescribing to best practice levels
- Centralisation of hyper-acute and acute care at University Hospitals Coventry and Warwickshire (UHCW)
- The provision of 2 sites for bedded rehabilitation at George Eliot Hospital and Leamington Rehabilitation Hospital for the 30% of the population experiencing a stroke who cannot go home with Early Supported Discharge or Community Stroke Rehabilitation
- The provision of new community services to deliver consistent Early Supported Discharge and Community Stroke Rehabilitation services at home for 70% of stroke patients, enabling them to return directly home after hyper acute and/or acute care.

2.3 The preferred future stroke pathway and delivery model will create services that meet the NHS Midlands and East Stroke Service Specification and will enable providers to deliver an “A” rating on The Sentinel Stroke National Audit Programme (SSNAP) performance targets for stroke care.

2.4 Extensive public and patient engagement and co-production to help inform and shape the proposed pathway has taken place over the last 4 years (details included within the PCBC). Further public engagement is being gathered via a public consultation process on the proposed future stroke pathway.

2.5 Clinical engagement with acute and community stroke clinicians has taken place in developing the pathway options to ensure that any proposals are deliverable and achieve the best practice clinical outcomes

2.6 The preferred future stroke pathway considerably improves the quality of outcomes and clinical care and removes the current significant unwarranted variation in access to care provision across Coventry and Warwickshire.

2.7 It is unusual for us to develop a PCBC that only proposes one option to achieve the improvements, however this is a proposal for a whole stroke pathway improvement and not just a business case for as single service improvement. The complexity and interdependencies of handover of care, and need for an integrated workforce approach across the pathway, has led to the proposed option and pathway.

2.8 The PCBC was submitted to NHS England for a Strategic Service Change Regional Panel review and assessment of the readiness to proceed to public consultation. The NHS England Panel review meeting took place on 15 August 2019. The Panel granted provisional assurance against the five assurance tests in the NHS England Planning, Assuring and Delivering Service Change for Patients, subject to minor amendments.

2.9 These amendments have been completed, and the resulting consultation document has been signed off by NHS Coventry and Rugby Clinical Commissioning Group, NHS South Warwickshire Clinical Commissioning Group Governing Body and NHS Warwickshire North Governing Body in preparation for consultation.

2.10 The full Consultation Document is attached to this paper for your response.

2.11 The consultation went live on 9 October 2019. Following the announcement of the General Election, the Clinical Commissioning Groups became subject to pre-election guidance. The consultation has remained open, and respondents have continued to feed back on the proposals via the website and postal responses.

2.12 The public events which were due to be held in November and December have been postponed until January. These dates have been rescheduled to the following calendar

Date	**Time**	**Venue**
Monday 6 January 2020	10am-12noon	Townsend Hall, 52 Sheep Street, Shipston-on-Stour, CV36 4AE
Monday 6 January 2020	3pm-5pm	Benn Partnership Trust, Railway Terrace, Rugby, CV21 3HR
Monday 6 January 2020	6pm-8pm	Benn Partnership Trust, Railway Terrace, Rugby, CV21 3HR
Wednesday 8 January 2020	10am-12noon	The SYDNI Centre, Cottage Square, Leamington Spa, CV31 1PT
Thursday 9 January 2020	6pm-8pm	Foundation House, Masons Road, Stratford-upon-Avon, CV37 9NF
Monday 13 January 2020	10am-12 noon	Chess Centre, 460 Cedar Road, Nuneaton, CV10 9DN
Tuesday 14 January 2020	6pm-8pm	Atherstone Memorial Hall, Long Street, Atherstone, CV9 1AX
Monday 20 January 2020	3pm-5pm	Queens Road Baptist Church, Queens Road, Coventry, CV1 3EG
Monday 20 January 2020	6pm-8pm	Queens Road Baptist Church, Queens Road, Coventry, CV1 3EG

2.13 These dates have been publicised via press release, social media and through our voluntary and community channels. All those who had registered to attend the postponed events have also been contacted with the new event dates.

3.0 Financial Implications

3.1 Detailed modelling and remodelling has been undertaken throughout the development of the PCBC to quantify the projected demand for stroke services; this has taken full account of forecast population and housing growth.

3.2 The activity projects have then been used to derive costs of the proposed new model. The table below summarises the current and future additional cost of the proposed stroke pathway/service. It must be noted that the increase in acute/bedded costs to CCGs identified is due to national tariff changes that are already within contractual baselines.

3.3 All commissioner and provider organisations have signed up to delivering the proposed model within the financial envelope identified and have included this within their financial plans, with this forming a part of the developing five year plan. Whilst financial risks have been identified, all commissioning and provider organisations involved have signed up to jointly mitigating these risks.

3.4 This proposal represents an investment of nearly £3.1 million into the Coventry and Warwickshire Health System.

	Current Investment by CCG	**Cost of Proposed Model**
	£000s	**£000s**
Community Early Supported Discharge and Rehabilitation	1,663	4,775
Ambulance additional journeys		171
Atrial Fibrillation Community Investment		128
Community elements	**1,663**	**5,074**

Additional cost of community model	3,411
Additional cost of Acute model	374
Less savings on Continuing HealthCare packages	-700
Net additional CCG investment	**3,085**

4.0 Environmental Implications

4.1 An Integrated Impact Assessment has been produced for the proposals, which can be found at https://www.strokecovwarks.nhs.uk/mf.ashx?ID=41245f6d-f5c1-4025-97d7-b90a4e8637d2

5.0 Timescales associated with the decision and next steps

5.1 The initial timescale for public consultation: Wednesday 9 October 2019 to Tuesday 21 January 2020

5.2 Although the consultation remained open and we were able to gather feedback during the pre-election period, we needed to postpone the events to January. In light of this, we have added an additional two weeks to the consultation timeframe. This allows people additional time to attend the events, reflect on the information they have gathered and feedback to the consultation.

5.3 The public consultation will now run from Wednesday 9 October 2019 to Sunday 2 February 2020, for a total of 16 weeks.

Background papers

1. Developing stroke services in Coventry and Warwickshire Public Consultation - Full Document.
2. Improving Stroke Outcomes for Coventry and Warwickshire Pre-Consultation Business Case
3. The appendices to the Pre-Consultation Business Case - https://www.coventryrugbyccg.nhs.uk/mf.ashx?ID=fe0bcbe5-5231-4999-a51b-40c08b72991d
4. Transport Modelling for Stroke Changes in Coventry and Warwickshire – West Midlands Ambulance Services https://www.strokecovwarks.nhs.uk/mf.ashx?ID=012d567a-8bfe-481f-aa31-305b43a64cb6

	Name	**Contact Information**
Report Author	Rose Uwins, Senior Communications and Engagement Manager, NHS Coventry and Rugby Clinical Commissioning Group and NHS Warwickshire North Clinical Commissioning Group	rose.uwins@coventryrugbyccg.nhs.uk Tel: 07979232001
Accountable Officer	Adrian Stokes, Interim Accountable Officer, NHS Coventry and	

	Rugby Clinical Commissioning Group and NHS Warwickshire North Clinical Commissioning Group	

Developing stroke services
in Coventry and Warwickshire
Public Consultation - Full Document
9 October 2019 - 2 February 2020

NHS Coventry and Rugby CCG, NHS South Warwickshire CCG
and NHS Warwickshire North CCG

Contents

Foreword

Welcome to our public consultation on developing stroke services in Coventry and Warwickshire.

The consultation document explains why we need to change the way stroke services in Coventry and Warwickshire are delivered, how the proposals for change have been developed and our preferred proposals for an improved stroke service.

We started by considering changes to hospital services, but it became clear that we needed to review the whole patient pathway, including rehabilitation services (such as physiotherapy) and stroke prevention, in order to make the biggest difference to the health outcomes of stroke patients.

From the work we have done it is evident that services across our area differed from place to place and also did not meet some of the principles of good care set out in national guidance.

It was also clear from public feedback that high quality specialist stroke services were valued by people, but there was also a desire for localised rehabilitation services where possible.

We have listened to all feedback from the extensive public engagement over the last four years and taken it into account in the final proposals we are bringing to you for public consultation.

We are clear from what people have said through the engagement so far, that should the proposals be approved, the home-based rehabilitation services must be in place before any changes to hospital services are made.

We are now looking for your views as we need your assistance to help us gain feedback on our final proposals. Our objectives are about developing a pathway of excellence for stroke care which results in real improvements in health outcomes for local people.

Our proposals would need more investment in specialist rehabilitation services (such as physiotherapy), medicines and more ambulance transfers than the services available now. But we feel that it is important to make this £3.1 million investment in order to reduce the chances of having a stroke and the disability resulting from a stroke.

Thank you for taking the time to read this document. Please complete the questionnaire at the end of this document, attend one of our consultation events or complete the online survey at www.strokecovwarks.nhs.uk. Your contributions and opinions really do count and will help in making the decisions about future stroke services in the area.

About us

We are three NHS Clinical Commissioning Groups (CCGs): NHS Coventry and Rugby, NHS South Warwickshire and NHS Warwickshire North. The CCGs plan and buy the majority of NHS healthcare services across the area and are overseen by NHS England.

The key partners in this consultation are:

- **University Hospitals Coventry and Warwickshire NHS Trust (UHCW)**
- **South Warwickshire NHS Foundation Trust (SWFT)**
- **George Eliot Hospital NHS Trust (GEH)**
- **Coventry and Warwickshire Partnership NHS Trust (CWPT)**
- **Warwickshire County Council**
- **Coventry City Council**
- **West Midlands Ambulance NHS Foundation Trust**

UHCW, SWFT and GEH currently provide acute stroke services. Rehabilitation services are currently provided by Leamington Spa Hospital, Hospital of St Cross in Rugby, CWPT and GEH. Rehabilitation services provided from a hospital bed or at home are to support stroke survivors to regain their health following a stroke. Rehabilitation may include a package of care such as physiotherapy, speech therapy and emotional support at home.

Acknowledgements:

This public consultation is the culmination of a long journey to develop a pathway of excellence for stroke services in Coventry and Warwickshire. We have been through a process of co-production of proposals that includes pre-consultation engagement and planning work with the help of our local patients, carers, clinicians, community groups and our dedicated Stroke Patient and Public Advisory Group. This work has led to the proposed options for the future of this important service. The input we have received has made a real difference in the production of our plans and we would like to thank everyone that has contributed.

About stroke

Stroke, a preventable disease, is the fourth single leading cause of death in the UK and the single largest cause of complex disability.
(Source: Stroke Association (2018) State of the nation: Stroke statistics).

A stroke is a rapid loss of brain function that occurs when the blood supply to part of the brain is cut off, leading to brain cells either being damaged or destroyed. Whilst largely preventable, stroke is one of the main causes of deaths in the UK and is also the leading cause of adult disability.
Strokes are medical emergencies and urgent treatment in the first 72 hours is essential because the sooner a person receives an effective diagnosis and treatment for a stroke, the less damage is likely to occur.

There are two types of stroke:

- An **ischaemic stroke** resulting from a blockage in one of the blood vessels leading to the brain.
- A **haemorrhagic stroke** resulting from a bleed in the brain.

In addition, a **transient ischaemic attack (TIA)** or 'mini-stroke' is a sign that a person is at risk of going on to have a full stroke.

Although people often assume that only older people have strokes, in fact young and middle-aged people also experience strokes. A stroke can have a huge impact on the quality of someone's life, irrespective of age.

Why we are developing proposals to change stroke services

There is strong and growing evidence, that quick specialist assessment and treatment significantly improves a person's chance of surviving with the least complications and disabilities following a stroke. When we reviewed our services we discovered that we have some gaps against these specifications. We want to change these services so that all patients get the best outcomes.

The CCGs are clear on the improved outcomes they want to see delivered through this change. By ensuring a consistent, high quality service offer, improvement will be made against the following three key clinical outcomes:

1. Reduced levels of mortality for people who have suffered a stroke
2. Reduced levels of dependency for those who have suffered a stroke
3. An improvement in cognitive function for people after suffering a stroke

We also want to ensure that we are in the best position to develop the Integrated Stroke Delivery Networks described in the new NHS Long Term Plan published in January 2019. These networks would, over the next five years ensure our services meet the NHS seven-day standards, National Clinical Guidelines for Stroke and higher intensity models of stroke rehabilitation. We would also be prepared for adoption of the latest medical advances such as mechanical removal of a blood clot in the brain (this is called a thrombectomy). The increased use of this process (from 1% to 10% in the future) is predicted to mean that 1,600 more people a year in England, would be able to live an independent life after their stroke.

(Source: NHS Long Term Plan - stroke care).

We have used this important clinical evidence to help develop our plans:

1. The National Stroke Strategy
Key changes were identified in stroke care and has contributed to a reduction in the numbers of patients dying within 10 years of having a stroke.
www.strokecovwarks.nhs.uk

2. Evidence that hyperacute interventions such as brain scanning and thrombolysis are best delivered as part of a networked 24/7 service.
https://doi.org/10.1371/journal.pone.0070420

3. Areas that have centralised hyperacute stroke care into a smaller number of well-equipped and staffed hospitals have seen the greatest improvements in patient care (**https://doi.org/10.1136/bmj.g4757**)

4. The NHS Long Term Plan, **https://www.longtermplan.nhs.uk**

5. The Midlands and East Regional Stroke Services Specification sets out expected standards to achieve the best outcomes for patients, in particular in relation to:

   - **Pre-hospital care**
   - **All patients suffering from a stroke receive appropriate hyperacute care within the first 72 hours**
   - **Full access to Early Supported Discharge services and specialist community stroke rehabilitation**
   - **Greater focus on prevention**
   - **Long term care.**

To view the complete Midlands and East Stroke Service Specification, please go to **www.strokecovwarks.nhs.uk/Documents/Documents**

Current stroke services

Current stroke services in Coventry and Warwickshire are providing a good standard of care but they are not meeting the latest national and regional guidance and evidence. They could be better. There are also different services available in different areas and we want to address this through our proposed improvements.

The main gaps we have identified from working with the professionals and patients, carers and the Stroke Association are:

- Not everyone who could benefit (ie within the first 72 hours of having a stroke) is being taken to the hyperacute unit at University Hospital Coventry and Warwickshire.
- Although we have tested out a model of the best practice specialist rehabilitation services in one area, we don't have these available for everyone after their stroke.
- We struggle to recruit specialist stroke doctors and there is growing evidence that there are not enough specialist stroke nurses. Our stroke doctors, nurses and therapists are not organised in a way to deliver a joined-up, seamless service for patients. Introducing a better integrated and networked stroke service will help us to recruit, develop and retain the right number of stroke specialists.
- Although we are already preventing stroke by identifying patients with AF in primary care and increasing anticoagulation rates for diagnosed patients, we know we aren't identifying everyone. We could reduce stroke risk by optimising drug therapy and early intervention could save around 100 local people a year from having strokes.
- People want more local co-ordinated action and information on how to prevent strokes, so that they can easily find out how to help themselves and loved ones.
- Having looked at our services, we are also clear that we are not in the best place to develop services in line with the ambitions in The NHS Long Term Plan which are nationally set.

By 2020 we would begin improved post-hospital stroke rehabilitation models with full roll out over the period of the Long Term Plan.

By 2022 we would deliver a ten-fold increase in the proportion of patients who receive thrombectomy after a stroke, so that each year 1,600 more people will be independent after their stroke.

By 2025 we would be amongst the best performers in Europe for delivering thrombolysis to all patients who could benefit.

In summary we have considered the evidence, what local people and professionals have told us and taken advice from experts, to come to a conclusion that we need to make improvements that would require change now.

How we have developed our proposals

Clinical involvement in developing proposals for the future

We have looked at national and regional evidence and best practice for delivering stroke services and have taken advice from a range of experts at different stages of the development. This included Professor Tony Rudd, National Clinical Director for Stroke.

We have worked with local doctors, specialist nurses and therapists - including GPs and stroke consultants, nursing and therapy specialists and tested our proposals with a panel of national experts in stroke care, as part of the review led by the NHS West Midlands Clinical Senate. This work led us to understand what the best clinical model is for stroke patients in Coventry and Warwickshire.

Dr Gavin Farrell, Consultant Clinical Neuropsychologist, Head of Neuropsychology Services Central England Rehabilitation Unit, and Chair of the Stroke Clinical and Operations Group explains:

"The whole redesign of the stroke pathway came about when NHS East and Midlands published the new stroke specification, and we have been working over the last few years as a senior group of people, senior doctors, nurses, therapists and commissioners across Coventry and Warwickshire to implement the recommendations of the specification.

Really, the specification was designed to increase the level of provision for stroke and increase the ability for people with stroke to get to the acute hospitals as quickly as possible and to get the specialised interventions they need in order to help survival. The level of rehabilitation people should receive after leaving hospital was also specified so that they could have the care they need when they're back at home."

Claire Quarterman Clinical Lead for the Early Supported Discharge Team and Community Rehabilitation Team, and a member of the clinical and operations group says:

"I have been part of a clinical and operational working party discussing the stroke services we currently offer to patients and trying to think about how we can improve services to make them equitable and accessible. We want everybody who has had a stroke, no matter where they live in the region, to get access to the best possible acute stroke care and following on from that, the rehabilitation they need to live the best life they can."

Throughout the development of the proposals clinical involvement has been continuous. The clinical and operations group of local stroke service providers has provided clinical expertise into the development and evaluation advising on:

- Potential scenarios for improved service delivery.
- Staffing models of each aspect of the proposed options.
- Ability to implement scenarios and more latterly proposals.

Patient and public involvement in developing proposals for the future

At the same time as getting information from clinical experts over the last five years, we have held an extensive programme of pre-consultation engagement with the public including stroke survivors and carers. Just as we created a local group of clinical experts, we also created a group of stroke patient and carer experts. This group, known as the Patient and Public Advisory Group (PPAG), is chaired by a representative from the Stroke Association. It includes people who have experienced a stroke, carers and family members of those who have experienced a stroke and Healthwatch representation.

Initially, we asked local stroke survivors and carers about how we could improve hospital stroke services and through this work tested out some scenarios. A clear outcome of this work was a message that they wanted us to plan improvements in hospital services, but also to look at preventing more strokes and rehabilitation after the stroke.

It was at this stage that we established the Patient and Public Advisory Group to act as a critical friend to guide and feedback on the engagement process. We also went back with the patient and public feedback, to look at how we might design an overarching stroke service that included preventing more strokes, providing the right type of hospital care and then more specialist rehabilitation for those who have had a stroke.

How we developed possible ideas for hospital care when people first have a stroke

In 2014/15 we began talking with local stroke survivors and carer groups, as well as other members of the public who could be affected by a change to gather their views on how we could improve stroke services sharing with them reasons why change was necessary - such as the national shortage of expert stroke doctors and the new evidence about timeliness and organisation of care that improves the chances of recovery.

After the discussions we asked people whether:

- We should do nothing and leave services as they are.
- We should centralise the hyperacute and acute service at University Hospitals Coventry and Warwickshire. All patients across the city and county would go to the Hyperacute and Acute unit rather than as currently, some go to their local hospital – George Eliot Hospital or South Warwickshire Foundation Trust.
- All patients go to University Hospitals Coventry and Warwickshire Hyperacute unit for 2-3 days. After this, people from the Warwickshire North area transfer to George Eliot Hospital and people from South Warwickshire area transfer to South Warwickshire Foundation Trust.
- All patients go to University Hospitals Coventry and Warwickshire Hyperacute unit for 2-3 days. Then Warwickshire North and South Warwickshire patients transfer to one other hospital, either George Eliot Hospital or South Warwickshire Foundation Trust, with the closure of stroke facilities at the other hospital.

At that time, we were only looking at the hospital services and we collated the feedback from engagement we did with them on this. However, the groups asked that we also look at stroke rehabilitation and how people can prevent a stroke. Along with other views, they were clear that travelling to a specialist centre when you first have a stroke was acceptable if your rehabilitation could be closer to home.

Areas of concern included:

- Transport and travel
- Travel time by ambulance
- Having enough staff and beds at University Hospitals Coventry and Warwickshire
- Parking at University Hospitals Coventry and Warwickshire

Commissioners in Coventry and Warwickshire considered all feedback and worked with clinicians, senior managers and local authority colleagues to address the concerns.

At the same time, the commissioners who buy health and care services reviewed the available evidence and guidance, and developed some principles for the potential scenarios for hospital services which included:

- All scenarios must meet the requirements of the NHS Midlands and East Regional Stroke Service Specification, and therefore provide:

  A Hyperacute Stroke Unit (HASU) – should remain at University Hospitals Coventry and Warwickshire as the specialist hospital and trauma centre;

  Acute Stroke Unit (ASU) care: one to be next to the Hyperacute Stroke Unit at University Hospitals Coventry and Warwickshire as a minimum;

  An Early Supported Discharge (ESD) service should be available for everyone who needs it after their stroke.

- Stroke rehabilitation beds would be provided locally for the post-acute phase of care: for those patients who no longer require acute stroke care, but have ongoing care and rehabilitation needs that prevent them from returning home. All high risk TIAs (mini stroke) would be seen at UHCW as a location near to the HASU is critical.

Based on these principles, a list of scenarios for the provision of hyperacute and acute services was developed by the clinical leads as follows:

- **Scenario 1 -** Hyperacute Stroke Unit at University Hospitals Coventry and Warwickshire / 1 Acute Stroke Unit at University Hospitals Coventry and Warwickshire

- **Scenario 2 -** Hyperacute Stroke Unit at University Hospitals Coventry and Warwickshire / 3 Acute Stroke Units at University Hospitals Coventry and Warwickshire, South Warwickshire Foundation Trust & George Eliot Hospital

- **Scenario 3 -** Hyperacute Stroke Unit at University Hospitals Coventry and Warwickshire / 2 Acute Stroke Units at University Hospitals Coventry and Warwickshire and South Warwickshire Foundation Trust

- **Scenario 4 -** Hyperacute Stroke Unit at University Hospitals Coventry and Warwickshire / 2 Acute Stroke Units at University Hospitals Coventry and Warwickshire & George Eliot Hospital

These scenarios were then assessed to see if they met various clinicial conditions including:

1. Scenarios are capable of meeting the NHS Midlands and East Stroke Service Specification.
2. Scenarios must be clinically viable in terms of both workforce and number of patients treated; the latter is critical for staff to maintain their stroke specialist knowledge and skills.
3. Scenarios must be no less than 10 bedded units, as the findings from the visits to stroke units already identified as providing the best practice was that this was the minimum for the service to be clinically sustainable.

It was agreed that the only clinically viable option for the acute phase of the stroke pathway would be to centralise hyperacute and acute services at University Hospitals Coventry and Warwickshire. There is clear evidence that hyperacute stroke/acute stroke units need to treat a minimum number of cases to be able to recruit specialist staff and maintain their skills. There isn't enough stroke activity in Coventry and Warwickshire to sustain more than one hyperacute service.

Outcome of the engagement work to look at the different ideas for hyperacute and acute stroke services

Feedback from public engagement in 2014/15 led to the extension of the stroke patient pathway to include stroke community rehabilitation and proposals to improve stroke prevention. During 2016 the clinical group developed specialist stroke home based community rehabilitation and a proposal for how to prevent more strokes. A second stage of formal engagement was undertaken to understand the views of the proposals:

- 5000 questionnaires were circulated across Coventry and Warwickshire
- 23 public meetings took place
- 27 newspaper articles were published
- 3 radio interviews were undertaken
- Social media reached 800,000 people
- Over 300 people completed questionnaires to feedback their views.

People were asked if they agreed with the proposal to prevent more strokes by:

- Making the most effective use of the treatments available
- Centralising the service for everyone who suffers a TIA and is at high risk of a stroke.

173 respondents agreed with the proposals to prevent more strokes, 70 disagreed.
People were also asked what they thought about the proposal for a stroke rehabilitation service. The proposal includes Early Supported Discharge where people would receive rehabilitation at home. For those not well enough for Early Supported Discharge, community based beds would be available in hospital at South Warwickshire Foundation Trust (SWFT) in Leamington Spa and the George Eliot Hospital (GEH) in Nuneaton.

- 160 people agreed with the developed proposal for stroke rehabilitation
- 133 people disagreed with the developed proposal for stroke rehabilitation.

Key concerns were raised during the engagement relating to travel and the requirement for Coventry and Rugby residents to travel to the George Eliot Hospital in Nuneaton or South Warwickshire Foundation Trust to receive bedded stroke rehabilitation.

In response, the Clinical and Operational Group considered alternative scenarios for delivering bedded rehabilitation for the population of Coventry and Warwickshire (for more information please see the business case at): **www.strokecovwarks.nhs.uk/Documents/Documents**

Review of ideas for inpatient rehabilitation services

This further work identified that there were a number of potential scenarios for providing bedded rehabilitation. A long list of potential scenarios was developed by the Clinical and Operational Group. These scenarios were assessed against their ability to:

- Meet national guidance and the requirements of the NHS Midlands and East Regional Stroke Service Specification
- Demonstrate at least the minimum levels of delivery of: quality; being safe; being sustainable and better outcomes for patients.

Following these clinical assessments two viable stroke rehabilitation options remained:

Option 1

Early Supported Discharge Service (ESD) and community rehabilitation in all areas of Coventry and Warwickshire. Bedded rehabilitation at South Warwickshire Foundation Trust (SWFT) in Leamington and George Eliot Hospital (GEH) in Nuneaton

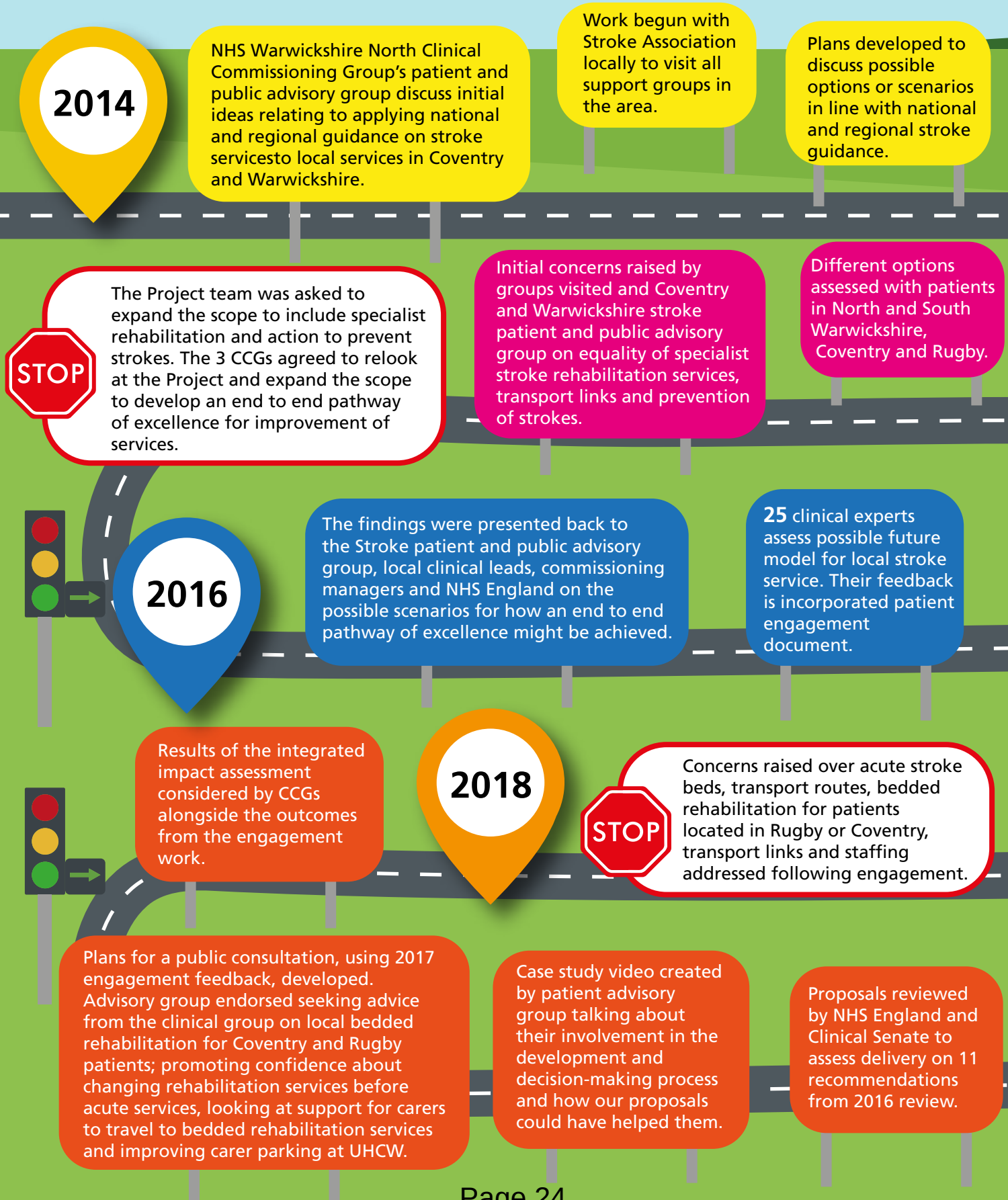
Option 2

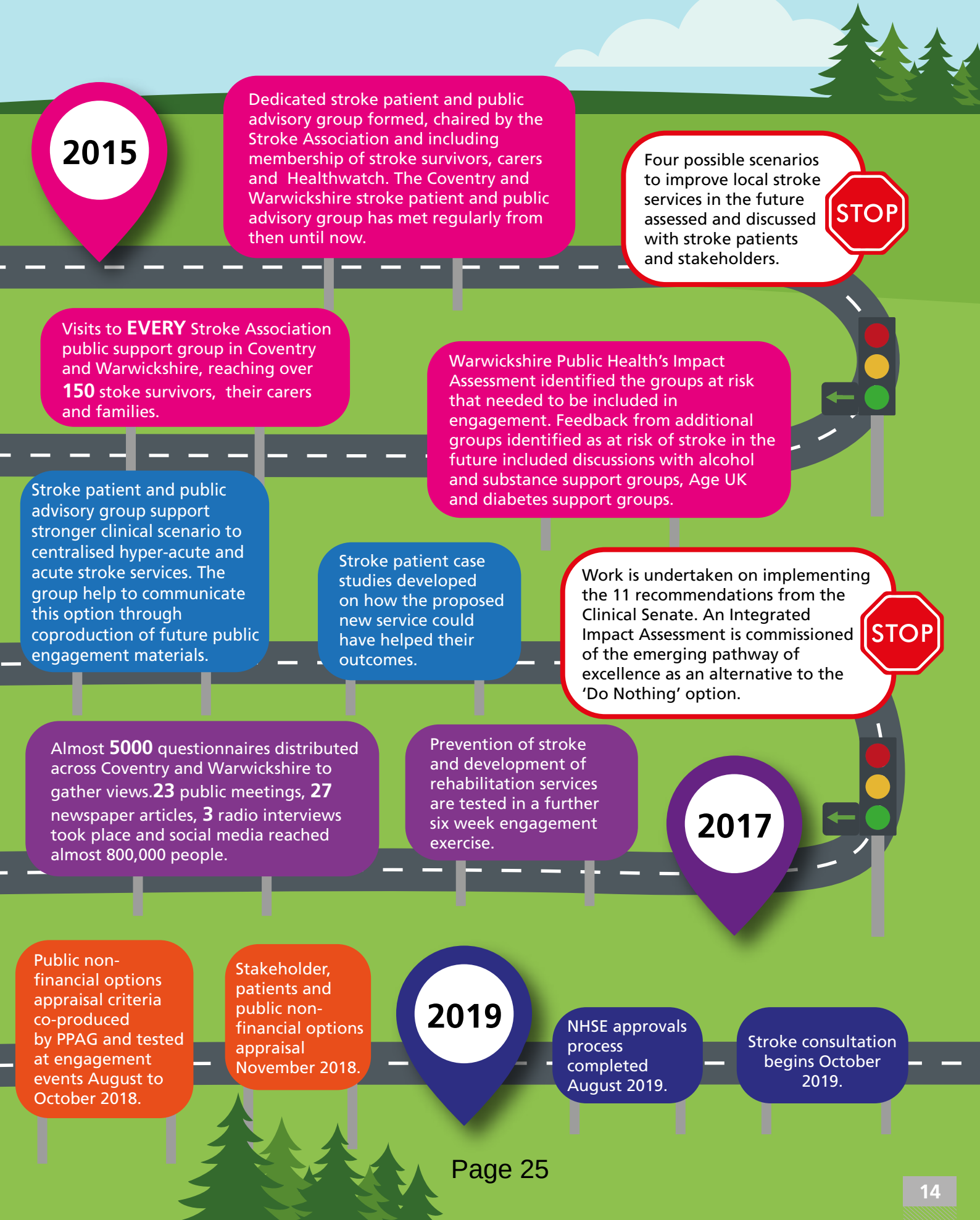
ESD and community rehabilitation in all areas. Community bedded rehabilitation provision in Coventry with specialist therapy in-reach. Bedded rehabilitation at SWFT in Leamington and GEH in Nuneaton

These options were then taken forward for full non-financial appraisal by all key stakeholder groups.

Details of the options appraisal are provided in the Redesigning Stroke Services in Coventry and Warwickshire Engagement Report August to November 2018 and in the business case at: **www.strokecovwarks.nhs.uk/Documents/Documents** and under the heading non-financial options appraisal later in this document.

Patient and public engagement has informed the development of proposals for an improved stroke service since 2014 to the present (please see the infographic below).




2015
Dedicated stroke patient and public advisory group formed, chaired by the Stroke Association and including membership of stroke survivors, carers and Healthwatch. The Coventry and Warwickshire stroke patient and public advisory group has met regularly from then until now.
Four possible scenarios to improve local stroke services in the future assessed and discussed with stroke patients and stakeholders.
STOP
Visits to EVERY Stroke Association public support group in Coventry and Warwickshire, reaching over 150 stoke survivors, their carers and families.
Warwickshire Public Health's Impact Assessment identified the groups at risk that needed to be included in engagement. Feedback from additional groups identified as at risk of stroke in the future included discussions with alcohol and substance support groups, Age UK and diabetes support groups.
Stroke patient and public advisory group support stronger clinical scenario to centralised hyper-acute and acute stroke services. The group help to communicate this option through coproduction of future public engagement materials.
Stroke patient case studies developed on how the proposed new service could have helped their outcomes.
Work is undertaken on implementing the 11 recommendations from the Clinical Senate. An Integrated Impact Assessment is commissioned of the emerging pathway of excellence as an alternative to the 'Do Nothing' option.
STOP
Almost 5000 questionnaires distributed across Coventry and Warwickshire to gather views.23 public meetings, 27 newspaper articles, 3 radio interviews took place and social media reached almost 800,000 people.
Prevention of stroke and development of rehabilitation services are tested in a further six week engagement exercise.
2017
Public non-financial options appraisal criteria co-produced by PPAG and tested at engagement events August to October 2018.
Stakeholder, patients and public non-financial options appraisal November 2018.
2019
NHSE approvals process completed August 2019.
Stroke consultation begins October 2019.

Concerns expressed during patient and public engagement and how we have addressed them

Consistent areas of concern included:

- Transport and travel including travel time by ambulance
- Capacity at University Hospitals Coventry and Warwickshire
- Parking

Commissioners considered all feedback and worked with clinicians, senior managers and local authority colleagues to address the concerns.

We have constantly considered patient and public feedback in the development of proposals for an improved stroke service. Commissioners throughout the development of the new model have listened and responded to concerns expressed by patients and the public, these have included the following:

Travel

People are worried that there won't be enough ambulances to take additional patients if the hyperacute unit and acute unit are centralised at University Hospitals Coventry and Warwickshire.

The detailed modelling we have done means that we know that we would need more investment into ambulance services. Extra funding has been identified to commission adequate ambulance service provision.

People are concerned about how they would travel to visit family and friends.

It is important that patients and relatives have the right information at the right time and we have reviewed and refreshed the information pack, currently being piloted, to provide stroke patients with information on public transport, patient and voluntary transport and private transport. This includes useful information from bus timetables to the local area, how stroke survivors aged 50 plus and/or their carers can attend NHS related appointments all the way through to social and wellbeing activities for low cost.

We're changing bus routes - the number 65 hourly bus service, operated by Arriva, is now extended to service Tamworth Hospital to George Eliot Hospital, Nuneaton. This gives a new direct service from several North Warwickshire communities.

Keeping information accurate - transport planners regularly send the latest public transport timetables to named representatives on stroke wards to make sure information is up to date.

Getting more from bus transport - bus operators have agreed the principles of a bus pass plus across Coventry and Warwickshire, costs are to be agreed.

Posters detailing voluntary car schemes in Warwickshire advertise in local hospitals and are available on stroke units.

For information on travel and transport please visit: **warwickshire.gov.uk/activetravel**

Capacity at University Hospitals Coventry and Warwickshire

People are concerned about beds, they worry that moving the acute stroke services at George Eliot Hospital and Warwick Hospital would mean there would not be enough beds for stroke patients in hospitals.

Faster discharge where appropriate - the new model offers Early Supported Discharge and community rehabilitation. This means that patients can continue their recovery at home and in the community. The new model has taken into account population growth and busiest times.

Our review of established services show that because of shorter stays in hospital for the majority of stroke patients (70%), fewer acute beds will be needed. Community stroke rehabilitation beds have been allocated for patients who are not fit enough for Early Supported Discharge and community rehabilitation. Please see 'staffing tables by Provider' detailed in the business case at: **www.strokecovwarks.nhs.uk/Documents/Documents**

People are aware and concerned about national shortages in specialist stroke consultants and difficulties in recruitment

Bringing the workforce together - a more centralised model for the acute stroke service would optimise the specialist workforce available and improve recruitment, retention, education and training and workforce sustainability (for further detailed information please visit the business case at): **www.strokecovwarks.nhs.uk/Documents/Documents**

People are concerned about busy times at A & E and delay in reaching the Hyperacute Stroke Unit or the Acute Stroke Unit.

Getting you to where you need to be - clinicians have developed a protocol to ensure patients are handed over quickly to the hyperacute stroke unit and do not get delayed in the Emergency Department. To inform the protocol, clinicians looked at peak and surge demand times (busiest times) and developed plans to make sure patients would reach the right service even at these times.

People are worried about the difficulty in parking at UHCW

A new car park would provide an additional 1,600 car parking spaces (awaiting planning decision).

Review of ideas for community rehabilitation beds

At a meeting in August 2018, the Stroke Patient and Public Advisory Group worked to co-produce a set of desirable criteria and the process to be used to assess the options for bedded rehabilitation. The group also confirmed their support for the preferred option for acute and hyperacute stroke services to be centralised at University Hospital, Coventry.

The assessment criteria co-produced by the Patient and Public Advisory Group and subsequently tested at further public engagement events in Autumn 2018 were:

- Services should be equitable, consistent and always available
- Services should focus on the best possible outcomes and recovery
- Services should be personalised with a package of care that is right for each individual patient
- We should create an environment where experiences, knowledge and information can be shared to benefit stroke survivors and their carers
- Professional who are delivering services should understand the stroke patients' feelings and the consequences of having a stroke
- All stroke services should work together with a smooth transition at all points in the stroke patients' care.

At the patient and public engagement events in autumn 2018 the preferred option for stroke hyperacute and acute services was also revisited, as well as discussing the options for stroke rehabilitation. The findings from these engagement events then fed into a formal public and stakeholder non-financial options appraisal event for bedded stroke rehabilitation services.

To ensure a mix of people offering a range of perspectives attended the meeting, invitations were sent to people of different ages, religions, ethnicity, gender etc. More than 40 people attended, including staff members who would be involved in delivering a future improved service. They were asked to consider the relative importance of each of the criteria and score each option out of 10 for how well they met (or did not meet) each of the desirable criteria. There was overwhelming support for the option of one bedded rehabilitation unit at Leamington Spa Hospital and one at George Eliot Hospital (to view the full report on the non-financial options appraisal please visit: **www.strokecovwarks.nhs.uk/Documents/Documents**)

The Clinical and Operational Group then completed a financial option appraisal (for more detail please see the business case at: **www.strokecovwarks.nhs.uk/Documents/Documents**)

Our proposal for local stroke services

Over the last four years we have worked with clinicians, stakeholders, patients and the public collaboratively which has led to a proposed new clinical model for stroke services. The new model will provide a pathway of excellence for stroke services, removing the current differences in services and access for the population of Coventry and Warwickshire (for more detail please see the business case at **www.strokecovwarks.nhs.uk/Documents/Documents**.)

Acute or emergency stroke services

- Acute stroke services would be located at University Hospitals Coventry and Warwickshire with stroke rehabilitation provided closer to people's homes.
- All patients across the city and county would go to the hyperacute and acute stroke unit at University Hospitals Coventry and Warwickshire
- Patients would be diagnosed and treated there until they are ready for rehabilitation closer to home, either in a bedded rehabilitation unit or in their own home with clinical support.
- The acute stroke units at Warwick Hospital and the George Eliot Hospital in Nuneaton would no longer operate because all patients would be treated in one specialist centre.

Rehabilitation stroke services

- There would be an Early Supported Discharge Service (ESD) (where patients are given support to leave hospital as soon as they are able to) and community rehabilitation in all areas of Coventry and Warwickshire for patients after they leave the acute stroke unit.
- Patients who need rehabilitation in hospital would receive care and treatment at Leamington Spa Hospital and the George Eliot Hospital in Nuneaton.

Tell us your views

Your views are important to us and you can feed back to us in the following ways:

1. Complete the questionnaire on the next pages and post it back to us to. You can post the questionnaire free to: Freepost **NHS QUESTIONNAIRE RESPONSES**. Please ensure you use capital letters as shown in the address, so the Post Office machines can scan the address.

2. Complete the online survey at: **http://www.strokecovwarks.nhs.uk**

3. Attend one of our events at the times and in the locations below:

Date	Time	Venue
Monday 6 January 2020	10am-12 noon	Townsend Hall, 52 Sheep Street, Shipston-on-Stour. CV36 4AE
Monday 6 January 2020	3pm-5pm	Benn Partnership Trust, Railway Terrace, Rugby. CV21 3HR
Monday 6 January 2020	6pm-8pm	Benn Partnership Trust, Railway Terrace, Rugby. CV21 3HR
Wednesday 8 January 2020	10am-12 noon	The SYDNI Centre, Cottage Square, Leamington Spa. CV31 1PT
Thursday 9 January 2020	6pm-8pm	Foundation House, Masons Road, Stratford-upon-Avon. CV37 9NF
Monday 13 January 2020	10am-12 noon	Chess Centre, 460 Cedar Road, Nuneaton. CV10 9DN
Tuesday 14 January 2020	6pm-8pm	Atherstone Memorial Hall, Long Street, Atherstone. CV9 1AX
Monday 20 January 2020	3pm-5pm	Queens Road Baptist Church, Queens Road, Coventry. CV1 3EG
Monday 20 January 2020	6pm-8pm	Queens Road Baptist Church, Queens Road, Coventry. CV1 3EG

Consultation survey

Q1: Have you experienced a stroke or transient ischaemic attack (TIA)?

- ☐ Yes, I have experienced a stroke or TIA
- ☐ No, I haven't had a stroke or a TIA
- ☐ Prefer not to say

Q2: Are you a carer, friend or relative of someone who has had a stroke or TIA?

- ☐ Yes, I am a carer, friend or relative of someone who has had a stroke or TIA
- ☐ No, I am not a carer, friend or relative of someone who has had a stroke or TIA
- ☐ Prefer not to say

Q3: To what extent do you agree or disagree with our proposal to locate all acute or emergency stroke services in Coventry?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree / disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q4: Please tell us about the impact our proposal to locate all acute or emergency stroke services in Coventry would have on you:

- ☐ No impact
- ☐ Postive impact
- ☐ Negative impact
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q5: Please tell us about the impact our proposal to locate all acute or emergency stroke services in Coventry would have on your family/ friends/carer:

- ☐ No impact
- ☐ Postive impact
- ☐ Negative impact
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q6: To what extent do you agree with patients who have had a stroke being given support to leave hospital as soon as they are able to (early supported discharge?)

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree / disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q7: Please tell us about the impact that early supported discharge services would have on you:

- ☐ No impact
- ☐ Postive impact
- ☐ Negative impact
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q8: Please tell us about the impact that early supported discharge services would have on your friends/family/carer:

- ☐ No impact
- ☐ Postive impact
- ☐ Negative impact
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q9: To what extent do you agree or disagree with rehabilitation being available in hospital at Leamington Spa Hospital and the George Eliot Hospital in Nuneaton?

- ☐ Strongly Agree
- ☐ Agree
- ☐ Neither agree / disagree
- ☐ Disagree
- ☐ Strongly disagree
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q10: Please tell us about the impact that having hospital rehabilitation at Leamington Spa Hospital and the George Eliot Hospital in Nuneaton would have on you:

- ☐ No impact
- ☐ Postive impact
- ☐ Negative impact
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q11: Please tell us about the impact that hospital rehabilitation at Leamington Spa Hospital and the George Eliot Hospital in Nuneaton would have on your family/friends/carers:

- ☐ No impact
- ☐ Postive impact
- ☐ Negative impact
- ☐ Prefer not to say

Please tell us the reason for your answer

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Q12: Is there anything you would like to add regarding stroke services in Coventry and Warwickshire which has not been covered by earlier questions (for example, can you suggest another option?)

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Equalities monitoring - optional

We recognise and actively promote the benefits of diversity and we are committed to treating everyone with dignity and respect regardless of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. To ensure that our services are designed for the population we serve, we would like you to complete the short monitoring section below. This is optional and the information provided will only be used for the purpose it has been collected for and will not be passed on to any third parties.

Q13: Please tell us which area of Coventry or Warwickshire you live in.

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Q14: Please tell us your postcode below

Please use all capital letters eg CV34 4DE

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Q15: What is your gender?

- ☐ Male
- ☐ Female
- ☐ Prefer to self-define .....
- ☐ Prefer not to state

Q16: If female, are you currently pregnant or have you given birth within the last 12 months?

- ☐ Yes
- ☐ No
- ☐ Prefer not to state

Q17: What is your age?

- ☐ Under 16
- ☐ 16-24
- ☐ 25-34
- ☐ 35-59
- ☐ 60-74
- ☐ 75+
- ☐ Prefer not to say

Q18: What is your ethnic group?

- ☐ English/Welsh/Scottish/Northern
- ☐ Irish / British Irish
- ☐ Gypsy or Irish Traveller
- ☐ Any other White background, please describe

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Mixed/Multiple ethnic groups

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed/Multiple ethnic background, please describe

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Asian/Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladesh
- ☐ Chinese
- ☐ Any other Asian background, please describe

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Black/African/Caribbean/Black British

- ☐ African
- ☐ Caribbean
- ☐ Any other Black/African/Caribbean background, please describe

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Other ethnic group

- ☐ Arab
- ☐ Any other ethnic group, please describe:

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Q19: Do you look after, or give any help or support to family members, friends, neighbours or others because of either:

- ☐ Long-term physical or mental health problems/disability
- ☐ Problems related to old age
- ☐ No
- ☐ Prefer not to say
- ☐ Other, please describe

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Q20: Are your day-to-day activities limited because of a health condition or illness which has lasted, or is expected to last, at least 12 months? (Please select all that apply)

- ☐ Vision (such as due to blindness or partial sight)
- ☐ Hearing (such as due to deafness or partial hearing)
- ☐ Mobility (such as difficulty walking short distances, climbing stairs)
- ☐ Dexterity (such as lifting and carrying objects, using a keyboard)
- ☐ Ability to concentrate, learn or understand (Learning Disability/Difficulty)
- ☐ Memory
- ☐ Mental ill-health
- ☐ Stamina or breathing difficulty or fatigue
- ☐ Social or behavioural issues (for example, due to neuro diverse conditions such as Autism, Attention Deficit Disorder or Aspergers' Syndrome)
- ☐ No
- ☐ Prefer not to say
- ☐ Any other conditions or illness, please describe

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Q21: What is your sexual orientation?

- ☐ Bisexual
- ☐ Heterosexual / straight
- ☐ Gay or Lesbian
- ☐ Prefer to self-define
- ☐ Prefer not to state
- ☐ Don't know / not sure

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Q22: Are you?

- ☐ Single - never married or partnered
- ☐ Married/civil partnership
- ☐ Co-habiting
- ☐ Married (but not living with husband/wife/civil partner)
- ☐ Separated (still married or in a civil partnership)
- ☐ Divorced/dissolved civil partnership
- ☐ Widowed/surviving partner/civil partner
- ☐ Prefer not to say
- ☐ Other, please describe:

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Q23: What is your religion and belief

- ☐ No religion
- ☐ Baha'i
- ☐ Buddhist
- ☐ Christian (including Church of England, Catholic, Protestant and all other Christian denominations)
- ☐ Hindu
- ☐ Jain
- ☐ Jewish
- ☐ Muslim
- ☐ Sikh
- ☐ Prefer not to say
- ☐ Other, please describe

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You can post the questionnaire free to: Freepost **NHS QUESTIONNAIRE RESPONSES**. Please ensure you use capital letters as shown in the address, so the Post Office machines can scan the address.

Engagement team
c/o NHS Arden&GEM
Westgate House
Market Street
Warwick
CV34 4DE

For more information about this consultation and our proposals, please go to **http://www.strokecovwarks.nhs.uk/**

This consultation document is available in different formats and languages on request. Please contact us for further information on:
Tel: 0121 611 0611
Email: agem.communications@nhs.net

Coventry and Rugby CCG
South Warwickshire CCG
Warwickshire North CCG

Improving Stroke Outcomes for Coventry and Warwickshire

Pre-Consultation Business Case

Contents

APPENDICES

1.0 EXECUTIVE SUMMARY

1.1 Purpose of this Document

This document aims to describe the process through which we have worked with all key stakeholders since the outset of the programme in 2014, to develop a proposed new clinically and operationally sustainable model for stroke services across Coventry and Warwickshire that:

- meets nationally and locally defined requirements and guidance for the provision of stroke services
- has considered the growing bank of evidence for the most effective treatment and care services/pathways and lessons from other systems developing best practice care models
- has been shaped by substantial stakeholder engagement throughout the journey
- has had clear and consistent multi-agency governance and assurance
- has undergone open and transparent appraisal both financially and non-financially to ensure the long-term viability of the model
- is aligned with local and national strategy

This document also describes how stroke services are currently provided across Coventry and Warwickshire, sets out the issues and inadequacies with the current services and our proposal for change.

We recognise that stroke services across Coventry and Warwickshire can achieve better health outcomes for patients by being set up in line with established best practice guidance. In so doing, they can also be more effective and efficient.

As system leaders it is our role to present the community with a clear service pathway and proposal for change. This will require us to make changes to the structure of the existing services, including enhancing some services and reducing or stopping others when they are no longer appropriate. We believe that through delivery of this business case we will create services that contribute to a more effective health and social care system.

1.2 Stroke and TIA Definition

Stroke is the leading cause of disability and fourth largest cause of death in the UK. Just over 1,200 people a year in Coventry and Warwickshire have a stroke and are taken to one of our three local hospitals. In 2016/17 there were over 15,000 stroke survivors on local GPs stroke registers and over 320 people were diagnosed with a Transient Ischaemic Attack (TIA).

A stroke occurs when the blood supply to part of the brain is cut off and is therefore unable to carry essential nutrients and oxygen to the brain, causing brain cells to become damaged or to die. The damage caused can have different effects on the body and how people think, feel and communicate, depending on where the damage occurs.

There are two types of stroke:

- Ischaemic stroke – most strokes are an ischaemic stroke, caused by a blockage that cuts off the blood supply to the brain; and
- Haemorrhagic stroke – these are caused by bleeding in or around the brain.

A Transient Ischaemic Attack (TIA) is also known as a mini-stroke; whilst the same as a stroke, the symptoms last for a short amount of time and no longer than 24 hours, as the blockage that stops the blood getting to the brain is temporary.

As people age their arteries become harder and narrower and are at more risk of becoming blocked, causing ischaemic strokes. Certain medical conditions and lifestyle factors however – including high blood pressure and obesity - are known to speed up this process and increase the risk of a stroke.

1.3 Governance Arrangements

The development of the Pre-Consultation Business Case has been a Commissioner-led process overseen initially by the Warwickshire and Coventry CCG Federation and now by the Strategic Commissioning Joint Committee (comprising CCG Clinical Chairs, Accountable Officers, Chief Financial Officers and other key members of all three local CCGs). However, it has extensively involved key stakeholders through a multi-agency project governance structure. This structure was established at the beginning of the programme in 2014 and has been in place throughout.

Local acute and community service providers, as well as ambulance, Local Authority and patient representatives, have been represented at various levels, including via:

- Stakeholder Board – comprising provider strategy and medical leads;
- Clinical Review Group – comprising Medical Leads to support the development of the clinical model; and
- Activity and Finance Workstream.
- Clinical and Operations Group – comprised of Clinical and Operational Leaders

A full description of the governance and assurance structure and arrangements can be found in section 5.1.

1.4 The Case for Change

There is a strong and growing evidence base, that the organisation and timeliness of stroke specialist assessment and treatment significantly affects outcomes. The following key issues have been identified with the current service organisation and provision which results in locally increased mortality and morbidity following a stroke:

- The current service provision across Coventry and Warwickshire does not meet the requirements of the NHS Midlands and East regional Stroke Services Specification, particularly in ensuring that all patients suffering a stroke receive appropriate hyper acute care within the first 72 hours. Currently, on average 4 patients per day do not receive hyper acute assessment;

- The HASU/ASU beds and rehabilitation services for Coventry and Warwickshire patients do not universally meet all of the national performance standards for best practice care. Indeed, the latest published data in the NHS Atlas of Variation (2015) showed that the number of patients in Coventry and Warwickshire directly admitted to an Acute Stroke Unit within 4 hours of onset of a stroke was amongst the lowest in the country;
- There is variable service provision and inequality of access to key services for Coventry and Warwickshire patients which must be corrected; particularly to HASU beds, inpatient rehabilitation, specialist community rehabilitation and Early Supported Discharge (ESD). Cohorts of patients in Warwickshire North and South Warwickshire currently have no access to some of these services;
- Inadequate provision exists in primary prevention, in the form of gaps in anticoagulation therapy for those with atrial fibrillation to reduce the risk of stroke, with evidence that we could avoid c230 strokes over 3 years by bridging this gap;
- The Sentinel Stroke National Audit Programme (SSNAP) results between Dec 2017-Mar 2018 show that Coventry and Warwickshire services are poor when compared to national average performance in delivering rapid access to appropriate services. The most significant issues arising from the SSNAP audits in support of the case for improvement are:
    - The proportion of patients scanned within 1 hour – in one of the local units 13% of patients are scanned within an hour, in comparison to a national average of 52.4%;
    - The median time taken for patients to be scanned – most recent results show it takes just over 2 hours and 43 minutes at one of our hospitals for patients to be scanned, against a national average of just under an hour;
    - The time taken for patients to be admitted to a Stroke Unit – whilst the national average time for patients to be admitted to a Stroke Unit is 3 hours and 52 minutes, it takes between 6 and 11 hours for patients in Coventry and Warwickshire; and
    - The proportion of patients assessed by a Stroke Specialist Consultant Physician within 24 hours is below the national average for two of the three acute providers in Coventry and Warwickshire.
- There is considerable variation in the acute care provided across the three sites, particularly in relation to lengths of stay. It is clear from review work undertaken that, due to a lack of specialist stroke ESD and community stroke rehabilitation services, patients are currently staying longer in the available acute stroke beds than is in their best interest;
- Critically, there are insufficient Stroke Specialist Consultants to operate an improved and effective service within the current configuration of services, given the requirement to staff services on each of the three acute sites. At the outset of this work, there were only four permanent Stroke Specialist Consultants working across the three acute providers. Five years later this is still the case. There are known

national shortages of these specialists and recruitment to vacant posts has been challenging for all providers.

Given these issues, work is clearly required to improve local stroke care across Coventry and Warwickshire so that more patients can survive their stroke and achieve their optimum level of recovery and independence.

1.4.1 Clinical Best Practice

The assessment of current services and design of the future clinical model and pathway has taken into consideration published evidence, guidance and observations of best clinical practice at other organisations in England.

The NHS Midlands and East Stroke Specification sets out the criteria, as recommended by the External Expert Advisory Group, that different parts of the stroke pathway need to meet to deliver high quality care to patients. These are the expected standards that commissioners should adopt when commissioning stroke care services. The proposed clinical model has been developed with the NHS Midlands and East Regional Stroke Services Specification at the forefront of thinking.

Learning from other stroke service models in England

Members of the Coventry and Warwickshire Stroke Clinical Review Group have learned from a number of other stroke units in the country which had been identified as demonstrating clinical best practice and from published evaluation findings. These included the London Stroke Model, Nottingham stroke service, Stoke on Trent stroke service and North Essex ESD service. The evidence is clear that centralising stroke treatment at a much smaller number of hospitals with specialist stroke care has considerable benefits.

The Coventry and Warwickshire model proposed has been designed taking into account learning from the operation of each of these sites as well as wider documented evidence. This has included testing the capacity planning for the proposed new service provision; the capacity we have planned is broadly in line with the findings from research into stroke services at other best practice regions with similar demographics.

Early Supported Discharge (ESD) and Community Stroke Rehabilitation

There is strong evidence nationally that a new and comprehensive ESD service will be able to reduce patient's length of stay in hospital. Within Coventry, ESD services were piloted from December 2014 to May 2015 and following the success of the pilot, standard ESD has been substantively commissioned in Coventry only since September 2015.

Data from the pilot and the current service provide strong evidence of the success and reach of the proposed model. Full details of this evidence can be found in section 4.3.

The success of an ESD service rests on the provision of high quality, sustainable community stroke rehabilitation services. The community stroke rehabilitation element of the proposed model provides flow through the system that enables ESD to sustain high quality, high

intensity, and timely discharges for those most likely to gain full or near to full recovery post stroke. It also provides interdisciplinary rehabilitation to support flow from bedded rehabilitation for those who have had a moderate to severe stroke, to enable appropriately supported discharge from hospital.

Atrial Fibrillation (AF)

There is evidence that optimally treating high risk AF patients has the potential to avert 230 strokes over three years in Coventry and Warwickshire ('The Size of the Prize on CVD prevention', Public Health England and NHS England).

This evidence indicates that there is significant clinical and financial benefit potentially from this intervention and it has been factored into the activity and financial modelling for the proposed new service.

1.4.2 Local and National Strategy

The proposed new service model is in line with the following local and national strategy documents:

- The National Stroke Strategy (2007), which advocated provision of specialist stroke units, rapid access for TIA patients, immediate access to diagnostic scans and thrombolysis (for those who need it) and Early Supported Discharge.
- The NHS England Five Year Forward View (2014), which cited the centralisation of 32 stroke units in London to 8 units and the reduction in mortality rates and lengths of stay in hospital that resulted from this service change.
- The NHS Long Term Plan (2019) which includes commitment to improved post-hospital stroke rehabilitation models by 2020
- Coventry and Rugby CCG's Commissioning Intentions (2017 – 2019)
- South Warwickshire CCG's Strategic Plan (2016 – 2020)
- Warwickshire North CCG's Vision for Quality Clinical Vision
- The Coventry and Warwickshire Sustainability and Transformation Plan

1.5 Summary of Current Stroke Service Provision

The current services in Coventry and Warwickshire for patients who suffer a stroke or have a Transient Ischemic Attack (TIA) are provided locally by three acute hospital trusts and a local provider of community physical and mental health services, as listed below:

- University Hospitals Coventry & Warwickshire NHS Trust (UHCW)
- South Warwickshire NHS Foundation Trust (SWFT),
- George Eliot Hospital NHS Trust (GEH)
- Coventry and Warwickshire Partnership NHS Trust (CWPT).

The services currently provided are described in the table below.

Services	UHCW	SWFT	GEH	CWPT
HASU beds	6	0	0	Not Available
ASU beds	30	12	18 (+1 assessment bed)	Not Available
Inpatient stroke Rehabilitation beds	6	20	Not Available	Not Available
Total beds	42	32	19	Not Available
TIA service	7-day consultant-led	5-day service	7-day nurse-led	Not Available
Thrombolysis	Yes	Treated at UHCW	Treated at UHCW	Not Available
Carotid imaging	Yes	Yes	2 sessions	Not Available
Carotid endarterectomies	Yes	Treated at UHCW	Treated at UHCW	Not Available
Stroke outreach team	Not Available	Yes	Yes	Not Available
Early Supported Discharge (ESD) service	Not Available	Rugby residents only	Not Available	Coventry residents only
Community Stroke Rehabilitation	Not Available	Not Available	Not Available	Yes

A more detailed description of the key services in the current system is provided below.

1.5.1 Hyper Acute Stroke Units

There is a Hyper Acute Stroke unit (HASU) at University Hospitals Coventry & Warwickshire NHS Trust (UHCW). This offers 24-hour, 7-day cover with rapid assessment for patients on arrival to the Emergency Department. It includes rapid access to imaging and thrombolysis as appropriate and wider access to other specialist skills and diagnostics.

The HASU sees all Coventry and Rugby patients who are suspected of having a stroke, and also patients from north and south Warwickshire who are assessed by a paramedic to be FAST-positive within 4 hours of onset of symptoms.

As soon as patients are assessed as having a stroke (this can sometimes be in the ambulance or in the Emergency Department in UHCW), all patients are seen by the Stroke Consultant-led Team for a multi-disciplinary assessment. This assessment determines likely diagnosis and if confirmed as a stroke, they are admitted to the HASU.

However, not all Coventry and Warwickshire patients suspected of having had a stroke are immediately taken or directed to the HASU. Therefore, not all patients have an immediate specialist assessment, where they will also have access to the full range of specialist skills and diagnostics. This is a significant gap in the current service provision when it is compared to the NHS Midlands and East regional Stroke Services Specification, which identifies that any patient within 72 hours of onset of stroke symptoms can benefit from assessment and treatment in a hyper-acute centre.

There is a cohort of patients from north and south Warwickshire who are either:

- Taken to, directed to or who self-present at their local general hospital; or
- Assessed by a paramedic to be FAST-positive after 5 hours of onset of symptoms and are then taken to their local general hospital Emergency Department i.e. George Eliot Hospital NHS Trust (GEH), or South Warwickshire NHS Foundation Trust (SWFT).

After the hyper acute element of care at UHCW:

- Patients are discharged home if medically appropriate;
- Where further acute care is needed, Coventry and Rugby patients are transferred to the Acute Stroke Unit (ASU) at UHCW;
- Patients from south and north Warwickshire needing further acute care are repatriated to the local ASUs at SWFT or GEH respectively, within 72 hours if possible, subject to bed availability. If there is no ASU bed available in their local hospital, they are admitted to UHCW ASU until a local bed becomes available.

1.5.2 Acute Stroke Units

All three local acute providers deliver Consultant-led Acute Stroke Care on a 24 hour, 7 day basis and have brain imaging available on all sites.

1.5.3 Rehabilitation, Outreach and Early Support Discharge

There is considerable variation in the stroke specialist rehabilitation services available across the area, as described in the table below.

Rehabilitation service	Coventry & Rugby CCG	South Warwickshire CCG	Warwickshire North CCG
Inpatient rehabilitation	6 beds at the Hospital of St Cross for patients from Rugby aged 65 years and over	20 beds in Leamington Spa	No specifically designated beds
ESD	Available to all patients	Not available	Not available
Community rehabilitation	Community Stroke rehabilitation services for Coventry residents provided by CWPT. Community general rehabilitation services for Rugby residents provided by SWFT	Stroke Outreach therapy service provided by SWFT	Stroke Outreach therapy service provided by GEH. Community general rehabilitation services provided by SWFT

The lack of comprehensive access to specialist stroke rehabilitation services is a gap when comparing the current services to the requirements of the NHS Midlands and East regional Stroke Services Specification.

1.5.4 TIA

For those patients experiencing a TIA, carotid imaging is available on site at both UHCW and SWFT; it is available for two sessions each week at GEH. Patients presenting at GEH who require carotid imaging when carotid imaging is not available are transferred to UHCW. All patients from across Coventry and Warwickshire requiring a carotid endarterectomy undergo surgery at UHCW.

Both UHCW and GEH provide onsite TIA clinics on a daily basis, 365 days a year. UHCW's clinics are Consultant-led, whilst GEH clinics are nurse-delivered with Consultant leadership.

Since January 2016, all high-risk TIA patients in the south Warwickshire region, who previously would have been seen at SWFT, are now seen at UHCW.

1.6 Proposed Future Clinical Model

A significant amount of work has been undertaken by clinicians from across the health economy to design a new model for stroke services that meets the clinical best practice outlined in the NHS Midlands and East Stroke Services Specification.

1.6.1 Stakeholder engagement.

Over the last five years, the model of care has been co-designed through public and patient representative engagement. The rationale behind the proposed model has been shared extensively, including with:

- Local commissioners;
- Health, social care and other key partners including the Stroke Association;
- The Warwickshire and Coventry Adult Social Care and Health Overview and Scrutiny Committees and District and Borough Council Scrutiny Committees
- The Public and Patient Advisory Group specifically established to advise on the development of proposals since the project started in 2014;
- Stroke survivors in stroke clubs and
- Health professionals and other key stakeholder groups (i.e. Local Authorities, Councillors).

All of these parties have helped to shape and inform the development of the proposed stroke service model. During the engagement in 2017 they have been supportive of this proposed model assuming that a number of key access factors, particularly for carers and relatives, can be mitigated. We have taken this feedback on board and reshaped the proposals during 2018 to reach this final case. Further, engagement in 2018 helped to shape the process for appraising the options for bedded rehabilitation; coproducing the desirable criteria to be used for the non-financial appraisal and culminating in stakeholder participation in the non-financial option appraisal.

1.6.2 Options development and analysis

Development of the Options

To develop the proposed model a range of options have been considered; initial development work focused on the acute stroke pathway only. A long list of scenarios was developed and explored for the provision of an acute pathway. The long list is as follows:

- Scenario 1 - Do Nothing
- Scenario 2 - HASU at UHCW / 1 ASU at UHCW
- Scenario 3- HASU and ASU for Coventry and Rugby patients up to discharge at UHCW, and for North and South Warwickshire patients up to day 7, with repatriation to ASU and SWFT or GEH at day 8 as required. (discounted as clinically not viable)
- Scenario 4 - HASU at UHCW / 3 ASUs at UHCW, SWFT & GEH
- Scenario 5A - HASU at UHCW / 2 ASUs at UHCW & SWFT
- Scenario 5B - HASU at UHCW / 2 ASUs at UHCW & GEH

An assessment based on clinical viability using the following criteria was undertaken:

1. Be capable of meeting the Midlands and East Stroke Service Specification;
2. Be clinically viable in terms of both activity and workforce. Local clinicians agreed that to be clinically sustainable, a Stroke Unit would require a minimum of 10 stroke beds being operational.

Assessment of each of the long list options found that option 2 is the only option that would be capable of sustaining the expert workforce required to drive improvements to outcomes. As such all other options were clinically unsustainable. The details of the assessment are described in sections 5.3 and 5.4.

A single preferred acute pathway clinical option was at this stage selected. This was discussed with local Councillors who are the Health portfolio holders and members of the Public and Patient Advisory Group during 14th to 17th September 2015. It was also considered at the Health Overview and Scrutiny Committees in Warwickshire and Coventry in September 2015. All groups were generally supportive of the model but asked that it be expanded to include comprehensive stroke rehabilitation services and interventions to prevent strokes. The model of care was therefore extended to include these.

During June and July 2017, a further comprehensive public engagement process was undertaken on a proposal for a centralised hyper acute and acute service, bedded rehabilitation on two sites, ESD, community stroke rehabilitation at home and improvements in AF anticoagulation therapy. This resulted in some specific concerns being raised regarding access and travel, most of which are addressed through an action plan working with Council colleagues. Alongside this the stroke expert Clinical and Operations Group leading the clinical design of the future stroke service model was asked to revisit the work completed to date and to consider if there was another method of delivering bedded rehabilitation for the Coventry and Rugby population, to address the travel for carers concerns raised.

This further work identified that there were a number of potential scenarios for providing the bedded rehabilitation aspect of the pathway. A long list of potential scenarios was developed by the Clinical and Operations Group. These scenarios were assessed against their ability to:

- meet national guidance and the requirements of the NHS Midlands and East Regional Stroke Service Specification
- demonstrate at least the minimum levels of delivery of: quality; being safe; being sustainable and better outcomes for patients

Following these clinical assessments two viable stroke rehabilitation options remained:

Rehab Option 1: Early Supported Discharge Service (ESD) and community rehabilitation in all areas. Bedded rehabilitation at South Warwickshire Foundation Trust (SWFT) in Leamington and George Eliot Hospital (GEH) in Nuneaton

Rehab Option 2: ESD and community rehabilitation in all areas. Community bedded rehabilitation provision in Coventry with specialist therapy in-reach. Bedded rehabilitation at SWFT in Leamington and GEH in Nuneaton

These options were then taken forward for full non-financial appraisal by all key stakeholder groups. Details of the options appraisal are provided within section 5.7

On the basis of this work, an options appraisal of the two viable options for providing bedded rehabilitation was carried out. The appraisal involved representatives from all key stakeholder groups, examples include; patients and carers, local councillors, voluntary sector and community support NHS clinicians, social care commissioner and managers.

The outcome of the options appraisal identified Rehab Option 1 as the preferred option:

Early Supported Discharge Service (ESD) and community rehabilitation in all areas. Bedded rehabilitation at South Warwickshire Foundation Trust (SWFT) in Leamington and George Eliot Hospital (GEH) in Nuneaton.

Integrated Impact Assessment (IIA)

Two Integrated Impact Assessments have been undertaken in 2015 and 2017/18 as proposals have developed. They were completed to estimate the possible implications of re-designing stroke services on patients and their carers and how these effects may be distributed amongst different groups and geographies. The impact assessment focused on three main areas; travel and access; health and determinants of health and equality. The IIA made recommendations to enhance potential positive outcomes and minimise negative impacts of the proposals.

The assessment and scoring from the IIA suggest that proposals for the centralisation of all acute care and proposed models for rehabilitation would have an overall positive impact on patients and carers compared to the do-nothing scenario. Whilst the centralisation and community bedded rehabilitation options will invariably negatively impact on travel and access for some patients and carers, particularly from the North and South of Warwickshire, the expected health benefits, greater proportion of time recovering at home and a greater

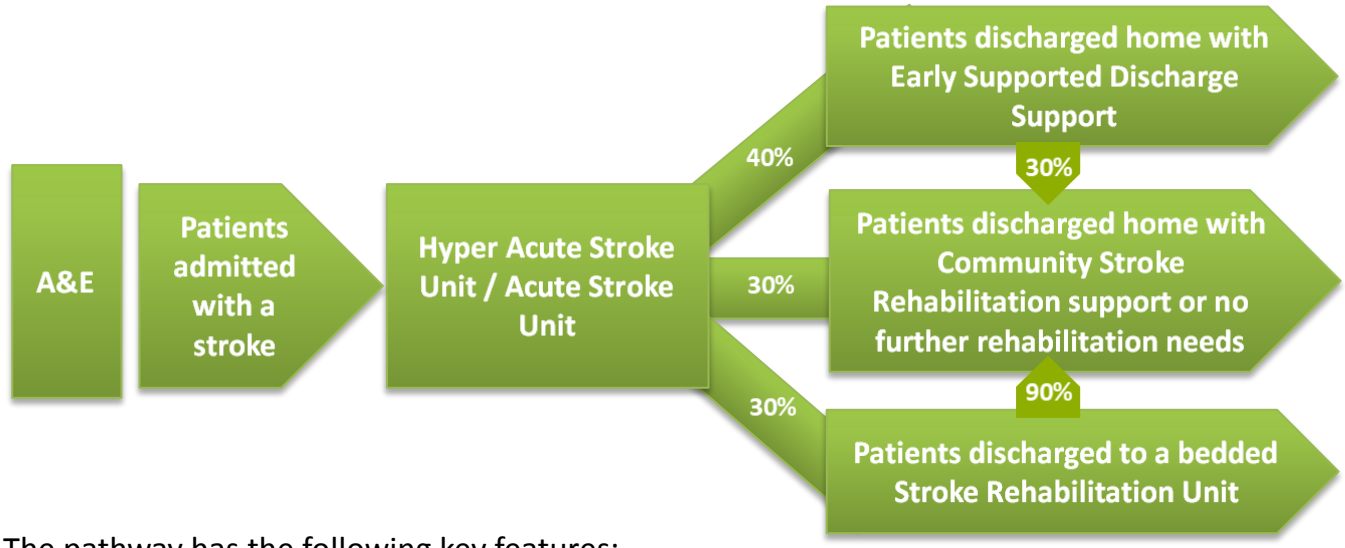
equity of exemplar service provision across the area, in the proposals would more than offset any negative impacts.

1.6.3 The proposed future model for stroke services

We believe that the resulting proposed new pathway of excellence will be the best possible clinical model for stroke services in Coventry and Warwickshire for the following reasons:

- It has been designed taking into account the requirements of the NHS Midlands and East Stroke Services Specification and the latest clinical best practice evidence;
- It improves equity of access to stroke services across Coventry and Warwickshire;
- It fits with local and national strategy;
- It will create workforce development opportunities and improve recruitment and retention of stroke specialist staff;
- It has been tested through a range of clinical quality assurance processes, including the West Midlands Clinical Senate and West Midlands Cardiovascular Network;
- Significant stakeholder engagement and co-production of the proposals through the engagement activities undertaken has provided support to proceed with this option.

At a high level, the proposed future pathway is as follows:



The pathway has the following key features:

- Provision of a single centralised Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at UHCW, with the necessary infrastructure, support and workforce to assess and diagnose all patients suspected of having had a stroke from across Coventry and Warwickshire, within 72 hours of onset;
- Home-based stroke specialist ESD service across all of Coventry and Warwickshire;
- Home-based community stroke rehabilitation across all of Coventry and Warwickshire;
- Bedded stroke rehabilitation services for those patients that require more intensive support after discharge from the ASU and
- A systematic focus on preventing stroke in the form of an integrated anticoagulation pathway that acts to reduce the risk of stroke.

The CCGs are clear on the improved outcomes they wish to see delivered through this change. By ensuring a consistent, high quality service offer, improvement will be made against the following three key clinical outcomes:

1. Reduced levels of mortality for people who have suffered a stroke: case adjusted mortality rates for Coventry and Warwickshire will meet those of comparable population areas;
2. Reduced levels of dependency for those who have suffered a stroke: outcomes will be at least comparable with similar populations by improving and increasing access to the specialist stroke ESD and community rehabilitation services at home, and specialist bedded stroke rehabilitation, and
3. An improvement in cognitive function for people after suffering a stroke: outcomes will be at least comparable with similar population areas.

1.6.4 Equity of access to services

Put simply, under the new model, all patients across Coventry and Warwickshire will be seen more promptly and in the right place by specialist skilled professionals, where they will receive the highest quality care.

There will be no inequality of access to the appropriate specialist care. A consistent stroke service will be in place across all of Coventry and Warwickshire, removing the current inequity of access to services. This applies to all elements of the pathway, including HASU and ASU beds and stroke specialist rehabilitation services.

Centralisation of acute care and standardised bedded rehabilitation will ensure a body of suitably qualified and experienced staff is available to see and treat all patients. The home-based rehabilitation will provide an extra 620 packages of care and the anticoagulation therapy will prevent 230 strokes over three years.

1.6.5 Quality assurance

In order to ensure that the new model is appropriate clinically, the following quality assurance reviews and processes have been undertaken:

Health Gateway Review 0;

National Clinical Advisory Team Review;

West Midlands Strategic Clinical Network Assurance;

West Midlands Clinical Senate Review;

Assessment of the fit against the “Five Tests” for Reconfiguration;

Two Integrated Impact Assessments (IIA); and

A Privacy Impact Assessment (PIA).

The outcome from all of these tests has been supportive of the new model. In particular, external clinical advice has agreed that our preferred model is appropriate and based on best practice.

1.7 Financial and Activity Impact

The preferred option for the proposed future clinical model for Coventry and Warwickshire has been agreed by all stakeholders to provide the best possible quality of care for stroke patients. However, given the finite resources within the health economy, it is also important to demonstrate that the proposed new model is affordable. Finance and activity modelling work has therefore been undertaken to estimate the likely impact on patient flows, costs and potential savings from the potential new models and is described in section 7.

1.7.1 Bed capacity modelling

Modelling has been undertaken to establish the number of beds required to manage demand through the current service model (do nothing state) and to manage the flow of patients through each of the options under consideration for the proposed future state.

Activity for 2017/18 was used to form the baseline for modelling, with growth of 1.07% assumed annually. In establishing the future bed base, the following assumptions were made:

- HASU length of stay would continue to be up to 3 days;
- ASU length of stay is expected to reduce from the current 18 days (spell average) to 11 days at day 1 of introduction of the full pathway;
- the HASU will operate at 85% bed occupancy, the ASU and bedded rehabilitation will operate at 90% bed occupancy, to allow the future service to manage peaks in activity to deliver the necessary patient flow through the system;
- 40% of patients on the Acute Stroke Unit will require a standard ESD package, with a further 30% of patients suitable for bedded rehabilitation provision and 30% discharged with community rehabilitation;
- 30% of the patients discharged with ESD will go on to receive community stroke rehabilitation support.
- 90% of the patients discharged from bedded rehabilitation will go on to receive community stroke rehabilitation support.
- There will be no bed base reduction at any of the acute providers. Beds that are identified as not required for stroke care will be used to support the delivery of other acute hospital activity.

The results of this work on bed modelling are shown in the table that follows:

Bed/Service provision	Current	Future	Difference (Beds)
Hyper Acute Stroke beds	6 beds at UHCW	12 beds at UHCW	+ 6 beds
Acute Stroke beds	30 ASU beds at UHCW 12 ASU beds at SWFT 18 ASU beds plus 1 assessment bed at GEH (Total 61 beds)	31 ASU beds at UHCW	- 30 beds
Community Stroke Rehabilitation beds	6 inpatient rehabilitation beds at Rugby site, UHCW for Rugby patients aged 65+ 20 inpatient rehabilitation beds at Leamington site, SWFT for SW patients only (Total 26 beds)	17 for C&R CCG (preferred option 9 in SWFT/8 in GEH) 12 beds in SW (SWFT) 10 beds in NW (GEH) (Total 39 beds)	+ 13 beds (N.B. different specification of beds)
Total bed numbers	**93 beds**	**82 beds**	**- 11 beds**

1.7.2 Financial modelling

The financial implications of the proposed model have been assessed. This assessment has been discussed at STP level and the following principles agreed by both Commissioners and Providers:

- The bedded part of the stroke pathway will continue to be covered by tariff under the current tariff cost envelope.
- The three CCGs will invest the required amounts in the additional ambulance transfers, elements of prevention and the community stroke rehabilitation pathway

In line with these assumptions, estimates have been produced by Commissioners and Providers of income, activity and costs under the current model and the future model options. These estimates have been based on 2017/18 planned activity and prices to enable a consistent approach to be taken.

Assumptions have been made for future demand driven by changes in population demographics and expected growth rates for Coventry and Warwickshire. It is important to note that there will be no savings to Commissioners from the planned bed base realignment outlined in the previous section.

The table that follows provides the results of the financial analysis of the investment required by CCGs in the community elements of the pathway.

Community pathway elements	£000s
Historic Investment by CCGs	1,663
Revised Investment by CCGs	5,074
Additional Investment by CCGs	**3,411**

Additional cost of Acute model	374
Less savings on CHC packages	-700
Net additional CCG investment required	**3,085**

This analysis indicates that the CCGs will be required to invest a further £3.1m in the community pathway. It has been agreed how this investment will be split between the CCGs:

- Proposed investment levels are within CCG financial plans for 2019/20 (on a part year basis) and will be in 2020/21 (on a full year basis). The five-year financial plan being developed will include the impact of this service provision.
- The source of funding for stroke prevention (Atrial Fibrillation anticoagulation therapy) is savings delivered from elsewhere within CCG budgets.

Section 7.3 provides full details of the financial modelling that has been undertaken.

1.7.3 Financial risks

A number of financial risks have been identified whilst undertaking the modelling and are described in full in section 7.4.4. Of those risks identified, all have in place mitigation plans and only two of the risks are identified as high.

The first, is the risk of failing to achieve an acute length of stay of 11 days. It is expected, based on clinical evidence nationally and locally, that the introduction of bedded rehabilitation, ESD and Community Stroke Rehabilitation across all geographical areas will achieve this reduction in the acute length of stay.

The second, is the risk that the realignment of use of the beds no longer required for stroke as part of the proposed model, will result in a reduction in provider income for those beds. A period of transitional activity and associated cost has been agreed to mitigate the potential impact should this risk materialise.

1.7.4 Conclusions

The financial analysis indicates that the CCGs would be required to invest £3.1m in the proposed model of care, to fund the delivery of the community elements of the pathway.

Some modest financial savings will accrue to the CCGs as a result of the new model: £0.7m from a combination of the impact of improved anticoagulation therapy for AF and reduction in long term NHS funded packages of care through the improved rehabilitation offer.

This is considered an appropriate investment to make to remove the current system inequality, increase the quality of services, improve outcomes and access, addressing the key issues outlined above.

After the consultation process, and as part of mobilisation, further work will be undertaken on the timing of the required investments.

1.8 Implementation

Implementation will be overseen by the formation of an Implementation Board, chaired by a Chief Executive of one of the provider organisations (to be nominated), with membership comprising at least one Executive from each of the provider and commissioner organisations. The Implementation Board will have responsibility and accountability for signing off progression through the implementation gateways defined.

It is proposed that the already established Stroke Clinical and Operations Group will reconfigure to become the Implementation Team, with day to day responsibility and accountability for managing the delivery of the new networked clinical model.

1.8.1 Timescales

Implementing the proposed new clinical model represents a significant change to current services and as such will be a complex process.

We are currently in the early stages of implementation planning as the focus to date has been on comprehensively engaging with all key stakeholders to design the most appropriate service delivery model.

Acknowledging that greater detail will be provided during and following consultation, the present outline implementation timeline is provided overleaf. A high-level project plan Gantt chart illustrating the key tasks and project gateway decision points that will be used by the Implementation Board to determine whether implementation can progress has been developed.

Business Case	
Business case complete	June 2019
NHS England Assurance process commences	June 2019
Consultation period	October 2019 –January 2020
Governing Bodies consider consultation results and decision made (BC updated with consultation outcomes)	January 2020 - February 2020
Contract signed	March 2020
Proposed Mobilisation and Implementation should pathway be agreed	
Community pathway mobilisation/ implementation	
Recruitment commences to ESD and CSR posts	March 2020
Mobilisation of ESD and CSR	May 2020
ESD and CSR fully implemented	Jan 2021
Acute pathway mobilisation/ implementation	
Recruitment commences to acute posts	March 2020
Adequate acute staffing in post. Go/No Go gateway decision	Jan 2021
UHCW: additional HASU/ASU beds implemented	April 2021
SWFT: ASU beds closed / SWFT CSRB implemented	
GEH: ASU beds closed / GEH CSRB implemented	
Complete pathway implemented	**April 2021**

A significant amount of work has been undertaken with regard to the future workforce requirements, identifying a proposed future workforce model and the potential actions required to implement such a model. This work is described in sections 6.2 and 8.1.4.

1.8.2 Risks

This is a complex service reconfiguration and as such work has already taken place to identify the potential risks to delivery of the proposed new clinical model and to develop appropriate mitigation plans. The key risks include, workforce planning, capacity planning and maintaining affordability given these two risks. Full details of the risk analysis and mitigation plans are described in detail in section 8.1.5

2.0 BACKGROUND AND CONTEXT

This document describes how stroke services are currently provided across Coventry and Warwickshire, sets out the issues with the current services and our proposal for change.

Just over 1,200 people a year in Coventry and Warwickshire have a stroke and are taken to one of our three local hospitals. In 2016/17 there were over 15,000 stroke survivors on local GPs stroke registers and over 320 people were diagnosed with a Transient Ischaemic Attack (TIA). Current stroke services in Coventry and Warwickshire have improved over time and are providing a good standard of care but, they are not meeting the latest national and regional guidance and evidence.

Comparisons of the performance and outcomes of current stroke services across Coventry and Warwickshire with best practice standards and the achievements of other health systems in England, show we can achieve better health outcomes for patients, more effective and efficient services. The range of services currently available to our patients also varies considerably based on where people live.

The Coventry and Warwickshire Sustainability & Transformation Plan (STP) defines the re-configuration of stroke services as outlined in this Business Case as a key priority as part of its Emergency and Urgent Care Workstream. It is important to note that each of the leaders within the STP has agreed that the model outlined in this business case is the right one and should be implemented.

As system leaders it is our role to present the community with a clear service pathway that is easy to navigate. This will require us to make changes to the structure of existing services; enhancing some and reducing or stopping others when they are no longer appropriate. We believe that through delivery of this business case we will create services that contribute to a more effective health and social care system.

We begin by outlining the current way in which stroke services are delivered.

2.1 Current services

The current services in Coventry and Warwickshire for patients who suffer a stroke or have a Transient Ischemic Attack (TIA) are described in the table below. These services are provided locally by three acute hospital trusts: University Hospitals Coventry & Warwickshire NHS Trust (UHCW), South Warwickshire NHS Foundation Trust (SWFT), George Eliot Hospital NHS Trust (GEH) and a local provider of community physical and mental health services, Coventry and Warwickshire Partnership NHS Trust (CWPT).

Providers of Stroke, TIA & Related Services

Provider	Stroke / TIA Services
University Hospitals Coventry & Warwickshire NHS Trust (UHCW) – covering Coventry, Rugby and parts of Warwickshire	• Hyper Acute Stroke Unit (6 beds); • Acute Stroke Unit (30 beds); • Only site that undertakes thrombolysis; • Inpatient Stroke Rehabilitation Beds (6 beds in Rugby); • TIA Service (7-day Consultant-led service); • Carotid imaging available; • Only site to undertake carotid endarterectomies.

Provider	Stroke / TIA Services
South Warwickshire NHS Foundation Trust (SWFT) – covering south Warwickshire population for acute care and Warwickshire population for general community services	• Acute Stroke Unit (12 beds); • TIA (5-day service); • Carotid imaging available; • Stroke patients requiring thrombolysis treated at UHCW; temporary transfer of high risk TIA patients (in place from January 2016); • Inpatient Stroke Rehabilitation Beds (20 beds in Leamington Spa); • Stroke Outreach team; • ESD service for Rugby residents.
George Eliot Hospital NHS Trust (GEH) – covering north Warwickshire, south west Leicestershire and parts of north Coventry	• Acute Stroke Unit (18 + 1 assessment bed); • TIA (7-day nurse-led service); • Patients requiring thrombolysis, or carotid endarterectomies transferred to UHCW; • carotid imaging, 2 sessions a week at GEH otherwise UHCW; • Stroke Outreach team.
Coventry and Warwickshire Partnership NHS Trust (CWPT) – covering Coventry for Community and Mental Health services (and Warwickshire for Mental Health)	• Community Stroke Rehabilitation and ESD service for Coventry residents.

2.2 Hyper Acute Stroke Unit

A hyper acute stroke unit (HASU) offers 24-hour, 7 day cover with rapid assessment for patients on arrival to an Emergency Department. This includes rapid access to imaging and thrombolysis as appropriate and wider access to other specialist skills and diagnostics.

At UHCW, a single 6-bedded HASU has been in operation since 2008 providing a Consultant-led service, with immediate on-site access to vascular and cardiac imaging, radiology and neuro-interventional and neuro-radiology imaging.

The HASU sees all Coventry and Rugby patients who are suspected of having a stroke and all patients from north and south Warwickshire for whom an ambulance has been called and they are assessed by a paramedic to be FAST-positive, within approximately 4 hours of the onset of symptoms.

However, not all Coventry and Warwickshire patients suspected of having had a stroke are immediately taken or directed to the HASU. Therefore, not all patients have an immediate specialist assessment, where they will also have access to the full range of specialist skills and diagnostics.

There is a cohort of patients from north and south Warwickshire who are either:

- Taken to, directed to or self-present at their local general hospital; or
- Assessed by a paramedic to be FAST-positive after 4-6 hours of onset of symptoms and then taken to their local general hospital Emergency Department i.e. GEH or SWFT.

Patients who are taken to UHCW are seen by the Stroke Consultant-led Team for a multi-disciplinary assessment to determine likely diagnosis. If a stroke is confirmed, the patient is admitted to the HASU, as well as being assessed for their suitability for thrombolysis and their ongoing care needs.

After the hyper acute element of care at UHCW:

- Patients are discharged home if medically appropriate;
- Where further acute care is needed, Coventry and Rugby patients are transferred to the Acute Stroke Unit (ASU) at UHCW;
- Patients from south and north Warwickshire needing further acute care are repatriated to the local ASUs at SWFT or GEH respectively, within 72 hours if possible and subject to bed availability. If there is no ASU bed available, they are admitted to the UHCW ASU until a local bed becomes available.

2.3 Local Acute Stroke Units

All three local acute providers deliver Consultant-led Acute Stroke Care on a 24 hour, 7 day basis and have brain imaging available on all sites. Their bed allocation is as follows:

Number of Acute Stroke & Related Beds

Provider	ASU	Assessment	Total Beds
UHCW	30	0	30
GEH	18	1	19
SWFT	12	0	12
Total			61

2.4 Rehabilitation, Outreach and Early Supported Discharge

There is considerable variation in the range of stroke specialist rehabilitation services that are available across Coventry and Warwickshire.

The table below details the current service availability for CCG resident populations:

Rehabilitation service	Coventry & Rugby CCG	South Warwickshire CCG	Warwickshire North CCG
Inpatient rehabilitation	6 beds at the Hospital of St Cross for patients from Rugby aged 65 years and over	20 beds in Leamington Spa	No specifically designated beds
ESD	Available to all patients	Not available	Not available
Community rehabilitation	Community Stroke rehabilitation services for Coventry residents provided by CWPT. Community general rehabilitation services for Rugby residents provided by SWFT	Stroke Outreach therapy service provided by SWFT	Stroke Outreach therapy service provided by GEH. Community general rehabilitation services provided by SWFT

2.5 TIAs

For patients experiencing a TIA, carotid imaging is available on site at UHCW and SWFT and for two sessions each week at GEH. Patients presenting at GEH who require carotid imaging when carotid imaging is not available, are transferred to UHCW. All patients from across Coventry and Warwickshire requiring a carotid endarterectomy undergo their surgery at UHCW.

Both UHCW and GEH provide onsite TIA clinics on a daily basis, 365 days a year. UHCW's clinics are Consultant-led, whilst GEH clinics are nurse-delivered with Consultant leadership.

Since January 2016, all high-risk patients in the south Warwickshire region, who previously would have been treated at SWFT, are now treated at UHCW.

2.6 Conclusion

Stroke is the fourth commonest cause of death in the UK each year. In Coventry and Warwickshire just over 1,200 people each year experience a stroke.

Current stroke services in Coventry and Warwickshire have improved over time and are providing a good standard of care but, they are not meeting the latest national and regional guidance and evidence.

It is clear from the analysis of current service provision that there is considerable unwarranted variation and inequity in the range of service provision for patients across each CCG footprint in Coventry and Warwickshire. For example, access differs to inpatient rehabilitation beds, specialist community rehabilitation and ESD.

3.0 THE CASE FOR CHANGE

There is strong and growing evidence, that prompt specialist assessment and treatment significantly improve a person's chance of surviving with the least complications and disabilities following a stroke. The evidence shows that patients are 25% more likely to survive or recover from a stroke if treated in a specialist centre. Patients need fast access to high quality scanning facilities and some need fast thrombolytic treatment. Being within 30 minutes (by ambulance) from a hyper-acute unit will permit a more expert assessment, quicker treatment and far higher chances of a full rehabilitation. The most recent clinical guidelines from the RCP Stroke Working Party in 2016, state that 'patients with acute stroke should be admitted directly to a hyper-acute unit….'.

There are several issues with the current service provision in Coventry and Warwickshire. To investigate the current state of Stroke and TIA services we have undertaken reviews of our service provision, performance and outcomes. We have also reviewed and identified best practice to understand how local services compare and can be improved. This work has been undertaken by a Clinical Review Group comprising of local medical leads and a Clinical and Operations Group comprising of local clinical and operational leaders, supported by external clinical review and challenge from the National Clinical Director for Stroke and the West Midlands Cardiovascular Network. Their work is summarised through this section, the outputs of which have told us that a number of key improvements are needed. We have used these insights to develop our proposed future clinical model and priorities for action.

3.1 NHS Midlands and East Stroke Services Specification

The Midlands and East Stroke Services Specification (Appendix 1) was developed by NHS Midlands and East in October 2012 and updated in 2015. The specification was developed by an External Expert Advisory Group in consultation with stakeholders, including Stroke Networks, clinical staff working in the field, commissioners, patients and carers who have experienced NHS services. It built on clinical best practice to describe the standards commissioners should adopt, setting out the criteria that pathways need to meet to deliver high quality care and outcomes.

The specification states that a "whole pathway approach" to the provision of stroke services is crucial to maximising clinical outcomes for patients, to achieve the resultant quality of life and improve their experience of stroke services. In particular, the first 72 hours of care is vital. The specification defines components of the pathway with recommended timescales for each phase.

The three CCGs that cover Coventry and Warwickshire need to commission stroke services in line with the Midlands and East Stroke Services Specification. However, the current Stroke and TIA service provision across Coventry and Warwickshire does not meet the requirements of this specification. In particular, not all patients suffering a stroke receive appropriate hyper acute care within the first 72 hours and there is a lack of comprehensive access to ESD services and specialist community stroke rehabilitation.

3.2 Primary Prevention

There is inadequate provision in primary prevention of stroke in Coventry and Warwickshire. Local data suggests patients with atrial fibrillation are going unidentified and improvements can be made to better manage atrial fibrillation, hypertension and diabetes locally.

The clinical evidence shows that:

- Reducing blood pressure in all adults with diagnosed and undiagnosed hypertension by 5 mmHg reduces risk of cardiovascular disease (CVD) events by 10%
- Statin therapy to reduce cholesterol by 1 mmol in people with a 10 year risk of CVD risk greater than 10% reduces the risk of CVD events by 20-24%
- Anti-coagulation of high risk AF patients averts one stroke in every 25 treated

NHS Commissioning for Value and Public Health England analysis identified that there are significant opportunities in Coventry and Warwickshire to prevent the occurrence of strokes through ensuring that Atrial Fibrillation is identified (to the right prevalence rate), anticoagulation treatment is optimised and patients at high risk of having a stroke are managed appropriately (see data below).

The Size of the Prize in Cardiovascular Disease Prevention – Coventry and Warwickshire

1. The diagnosis and treatment gap, 2015/16

Hypertension	Estimated adult population with hypertension	230,500
	Estimated adult population with undiagnosed hypertension	92,800
	GP registered hypertensives not treated to 150/90 mmHg target	25,700
Atrial Fibrillation (AF)	GP registered population with Atrial Fibrillation (AF)	15,900
	Estimated GP registered population with undiagnosed AF	8,000
	GP registered high risk AF patients (CHA2DS2VASc >=2) not anticoagulated	3,200
CVD risk	Estimated adult population 30 to 85 years with 10 year CVD risk >20%	63,500
	Estimated percentage of people with CVD risk ≥20% treated with statins	49%

2. The burden: first ever CVD events, 2015/16

Coronary Heart Disease	1,650
Stroke	1,000
Heart Failure	900

3. The opportunity: potential events averted and savings over 3 years by optimising treatment in AF and hypertension, 2015/16

Optimal anti-hypertensive treatment of diagnosed hypertensives averts within 3 years:	150 heart attacks	Up to £1.10 million saved[2]
	230 strokes	Up to £3.40 million saved[1]
Optimally treating high risk AF patients averts within 3 years:	260 strokes	Up to £4.60 million saved[1]

3.3 Access

There is significant inequality of access to HASU/ASU beds and rehabilitation services for Coventry and Warwickshire patients.

3.3.1 HASU / ASU beds

Not all patients suspected of having had a stroke from across Coventry and Warwickshire are immediately taken or directed to the HASU for an immediate specialist assessment, where they will have access to the full range of specialist skills and diagnostics. All Coventry and

Rugby patients suspected of having had a stroke are treated in the HASU, whilst patients from the rest of Warwickshire will only be taken to the HASU if they are assessed by a paramedic to be FAST-positive within 4 hours of the onset of symptoms.

There remains a cohort of patients from north and south Warwickshire who are either:

- Taken to, directed to or self-present at their local general hospital; or
- Assessed by a paramedic to be FAST-positive after 5 hours of onset of symptoms and are then taken to their local general hospital Emergency Department i.e. GEH or SWFT. Once at their local general hospital, if they are assessed to be in the hyper acute phase of a stroke and will benefit from thrombolysis, they will be transferred to UHCW as an emergency patient. Otherwise, once confirmed as a stroke patient, their care will remain at their ASU.

Thrombolysis is only delivered from one site as Coventry and Warwickshire only has sufficient numbers of patients having a stroke for one unit to operate safely. UHCW has the required staff and infrastructure to deliver this.

3.3.2 Rehabilitation

Access to rehabilitation services is inequitable.

- Stroke inpatient rehabilitation beds are currently only available to south Warwickshire patients and a small cohort of patients from Coventry and Rugby.
- ESD services are only available to Coventry patients.
- Community stroke rehabilitative services are available to residents of Coventry and Rugby, with Outreach teams providing more limited post-hospital support to patients in north and south Warwickshire.

3.4 Performance and Outcomes

The Sentinel Stroke National Audit Programme (SSNAP) measures stroke service performance against a range of key areas critical to delivering optimal outcomes for patients. The results for the period October 2018 to December 2018 (Appendix 2) show that Coventry and Warwickshire services need to improve. The most significant issues arising from the SSNAP audits in support of a case for improvement are the:

- proportion of patients scanned within 1 hour – two of the local units are more than 20% below the national average of 52.4%;
- median time taken for patients to be scanned – across the system it varies from 26 minutes to just over 1 hour and 52 minutes for patients to be scanned, against a national average of just under an hour;
- time taken for patients to be admitted to a Stroke Unit – whilst the national average time for patients to be admitted to a Stroke Unit is just over 3.5 hours, it takes between 3 hours 20 mins and over 11 hours for patients in Coventry and Warwickshire; and
- proportion of patients assessed by a Stroke Specialist Consultant Physician within 24 hours - two of the three acute providers are significantly below the national average.

The most recent results against these four metrics can be found in the table below:

Key SNNAP Metrics - October 2018 to December 2018

Domain Metric	Time Period	England Average	GEH	SWFT	UHCW
Proportion of patients scanned within 1 hour of clock start[1]	Oct 2018 – Dec 2018	54.5%	31.9%	34.1%	67.4%
Median time between clock start and scan	Oct 2018 – Dec 2018	0h 52m	1h 40m	1h 52m	0h 26m
Median time between clock start and arrival on Stroke Unit	Oct 2018 – Dec 2018	3h 37m	11h 34m	3h 58m	3h 20m
Proportion of patients assessed by a Stroke Specialist Consultant Physician within 24hours	Oct 2018 – Dec 2018	84.4%	88.4%	63.6%	75.2%

3.5 Length of Stay

The Clinical Review Group completed two separate point prevalence audits in October and December 2014, to ascertain the appropriateness of patients in acute hospital beds at the time of the audits. These audits found that of the 93 beds available across Coventry and Warwickshire, all were occupied in the first audit, with 77% (72 beds) occupied in the second audit.

The audit was repeated by the clinicians in 2017, to test whether these findings were still relevant, the results confirmed the findings remain relevant.

The audits identified a number of patients who were in acute stroke inpatient beds that could have been benefitting from rehabilitation support outside hospital, had those services been available. These included patients that could have been:

- discharged with support from either a standard or enhanced ESD service
- discharged to a residential or nursing care home
- discharged with a package of care including further community stroke rehabilitative care, or
- receiving onward support in a specialist stroke rehabilitation unit, this latter being the largest cohort of the patients.

Analysis of current activity data still supports these conclusions. Average lengths of hospital stay for patients that have experienced a stroke vary between 17 and 25 days (average length of stay for the system is 18 days). This is significantly longer than the length of stay in areas where they have optimised the configuration of services such as London, who achieve an average length of stay of 11 days.

[1] The term 'Clock Start' is used throughout SSNAP reporting to refer to the date and time of arrival at first hospital for newly arrived patients, or to the date and time of symptom onset if patient already in hospital at the time of their stroke. https://www.strokeaudit.org/results/Clinical-audit/Regional-Results.aspx

3.6 Best Practice Standards of Care

3.6.1 HASU / ASU beds

Whilst there have been improvements made in stroke care locally, there remains inequity of access to services for patients suspected of having had a stroke. In particular there is inequity of access to both hyper acute stroke care (for those outside of the 4 hour window) and adequate rehabilitation services, to meet the national best practice care standards.

The latest published NHS Atlas of Variation data (published in September 2015 using 2013/14 data) showed the number of patients in Coventry and Warwickshire directly admitted to an acute stroke unit within 4 hours of onset of a stroke was amongst the lowest in the country.

Extract from Map 40, NHS Atlas of Variation

Percentage of people with acute stroke who were directly admitted to a stroke unit within four hours of arrival at hospital by CCG, 2013/14			
CCG Name	**Rate**	**95% Lower Limit**	**95% Upper Limit**
NHS Coventry and Rugby	43.00	38.20	47.94
NHS Warwickshire North	38.10	32.32	44.23
NHS South Warwickshire	34.20	29.64	39.06

This data highlights local variance from best practice standards and national performance in accessing the right care at the right time to help improve patients' chances of survival, optimising their independence and in minimising the level of disability resulting from a stroke.

3.6.2 Rehabilitation

As has been highlighted above, there is considerable unwarranted variation in the range of stroke rehabilitation services provided across Coventry and Warwickshire. In the north of Warwickshire and in Rugby, there is limited or no access to local stroke specialist rehabilitative care and there are varying levels of rehabilitative care in hospitals. This results in significant inequity in service provision for our population.

3.7 Findings from Local Stroke Review

A significant work programme was undertaken by the Clinical Review Group (CRG), which was led by the nominated lead clinical representative for all three CCGs, with the clinical leads of stroke and rehabilitative care for all local providers involved.

This work included a review of local stroke services, which concluded that:

- **HASU:** Not all patients with a suspected stroke are being seen in a specialist hyper acute stroke unit and therefore some may be missing the opportunity provided by a hyper acute assessment and/or unit;
- **Service configuration:** Local services are not configured in the best way to achieve the improved standards that other best practice areas have achieved, as demonstrated in the NHS Atlas of Variation;

- **Workforce:** There are insufficient Stroke Specialist Consultants to operate an improved stroke service as currently configured and a national shortage of Stroke Specialist Consultants;
- **Equity of service provision:** There is a need to address the inequity of access to services, particularly stroke specialist rehabilitation;
- **Length of Stay:** Due to a lack of specialist stroke ESD and community stroke rehabilitation services, patients are currently staying longer in the available acute hospital stroke beds than is ideal; and
- **Community services:** Many patients are currently in stroke acute hospital beds whilst they are waiting for other community-based services, such as care packages.

Appendix 3 contains the complete review document.

3.8 Workforce Challenges

A workforce review undertaken by the Clinical and Operational Group has identified existing gaps and a high probability of long-term workforce challenges and constraints, which make continuing with the current configuration of services a risk. There is a particular issue with respect to the Stroke Specialist Consultant workforce where there is an acknowledged national shortage of Stroke Consultants. The BASP 2011 report Meeting the Future Challenge of Stroke indicated a deficit of circa 163 posts.

At the outset of this work, there were only four permanent Stroke Specialist Consultants working across the three acute providers and recruitment to vacant posts has been challenging for all providers. Five years later this remains the case. To respond to this challenge, the Clinical Review Group signed up to developing a new, networked clinical workforce model as part of the future service model to ensure sufficient medical cover across all three acute sites.

There is also a potential challenge relating to stroke nurse staffing as there may be a change in nursing skills mix required, with an increase in the ratio of qualified nursing staff needed and a decrease in the numbers of unqualified nursing staff.

Optimising the limited specialist workforce across the area will improve recruitment, retention, education and training and help to mitigate the workforce sustainability risk.

3.9 Benefits

The key benefits being sought from these proposals mostly relate to access to services and clinical outcomes. A Benefits Realisation Plan has been developed (Appendix 4) identifying the key indicators that will be measured to monitor the improvements resulting from the new pathway.

At a summary level, these are:

- More timely access to stroke-related services, including a specialist assessment at the outset of a stroke;

- Improved mortality rates overall;
- Reduced level of long-term disability;
- Increased number of patients admitted to a centralised Stroke Unit within 4 hours;
- Increased number of patients given a brain scan in a timely manner;
- The financial cost of the new proposals assumes financial savings resulting from reducing the incidence of strokes as a result of better prevention (i.e. improved diagnosis and treatment of AF) and from reductions in long term care costs as a result of the increased access to better rehabilitation services and access to the HASU for all. Whilst it can be assumed that there is likely to be financial savings resulting from reduced social care requirements (as a result of improved health outcomes/reduced disability following the onset of stroke) these benefits have not been included or quantified within either the benefits or financial analysis.

3.10 Conclusion

The comprehensive review of local services has identified a range of significant issues with current service performance, access and outcomes against expected best practice and published guidance. Significant scope for improving the quality of services and delivering consequent benefits in patient outcomes and experience has been identified across the stroke pathway, from prevention to acute care.

Given this range of access, quality and significant workforce issues, work is clearly required to improve local stroke care across Coventry and Warwickshire so that more patients can survive their stroke and achieve their optimum level of recovery.

4.0 SUPPORTING EVIDENCE AND BEST PRACTICE

This section further explains the work that has been done to ensure that we are proposing the best possible clinical model for Coventry and Warwickshire.

We believe that the new service model proposed in this Business Case is the best possible clinical model for stroke services in Coventry and Warwickshire for the following reasons:

- It has been designed taking into account the NHS Midlands and East Stroke Services Specification and the latest available clinical best practice evidence;
- It ensures equity of access to services across Coventry and Warwickshire;
- It fits with local and national strategy;
- It has been tested through a range of quality assurance processes that have been undertaken and
- The range of engagement activities that have been undertaken have in general agreed that it is the best option, with some concerns from the public about travel for carers and relatives.

4.1 The Midlands and East Stroke Services Specification

In 2011, following the benefits realised by the London Stroke Model, the then NHS Midlands and East Strategic Health Authority (SHA) set out its ambitions for regional improvements in Stroke and TIA healthcare, underpinned by a vision to provide fast access to the best standards of service possible.

This resulted in the Midlands and East SHA commencing a review of stroke services in 2012, to help drive an improvement in the way that patients have access to high quality stroke, TIA and rehabilitation services. The underpinning aim of this was to deliver:

- Centralisation of Stroke Units;
- Reduced unwarranted variations in clinical outcomes and services and
- Services based on evidence and best practice.

In response to the latter, the NHS Midlands and East developed the Stroke Services Specification, which used a comprehensive and current evidence base to agree best practice. The NHS Midlands and East Stroke Services Specification evidence base includes:

- National Stroke Strategy (2007) Department of Health;
- National Clinical Guidelines for Stroke (2016) Royal College of Physicians;
- Quality Standards Programme: Stroke (2010) National Institute for Clinical Excellence;
- Stroke Service Standards (2010) British Association of Stroke Physicians Quality and Outcomes Framework for 2012/13 (2011) NHS Employers;
- The NHS Outcomes Framework 2012/13 (2011) Department of Health;
- A Public Health Outcomes Framework for England 2013-2016 (2012) Department of Health;

- The 2012/13 Adult Social Care Outcomes Framework (2012) Department of Health and
- Supporting Life after stroke (2011) Care Quality Commission.

The specification identified 7 phases of the stroke care pathway, as follows:

The specification defines components of the pathway with recommended timescales for each phase, as follows:

Regional Specification Pathway and Lengths of Stay

The proposed future clinical model for Coventry and Warwickshire has been developed with the Midlands and East Stroke Services Specification at the forefront of thinking. In particular:

- All patients suffering from a stroke will receive appropriate hyper acute care within the first 72 hours,
- There will be comprehensive access to ESD services and specialist community stroke rehab, and
- There will be greater focus on primary prevention in the form of improvements in identifying atrial fibrillation and using anticoagulation to reduce the risk of stroke.

4.2 Equity of access

Achieving the best outcomes for patients experiencing a stroke requires access to the full range of specialist stroke rehabilitation services for the whole population. Equity of access is therefore a core requirement for high quality stroke services, with access to services being based on patients' needs and not their home address.

Under the new model, all patients across Coventry and Warwickshire will be seen more promptly and in the right place by specialist skilled professionals, where they will receive the highest quality care.

There will be no inequality of access to the appropriate specialist care. Centralisation of acute care and standardised bedded rehabilitation will ensure a body of suitably qualified and experienced staff is available to see and treat all patients. The home-based rehabilitation with provide an extra 620 packages of care and the anticoagulation therapy will prevent 230 strokes over three years.

A consistent stroke service will be in place across all of Coventry and Warwickshire, removing the current inequity of access to services. This applies to all elements of the pathway, including HASU and ASU beds and stroke specialist rehabilitation services.

4.3 Clinical best practice evidence

The Midlands and East Stroke Service Specification is based on a comprehensive evidence base and agreed best practice. However, given the time that has elapsed since its publication, in developing the future clinical model and pathway for Coventry and Warwickshire, we have also observed best practice in other organisations/health systems.

London Stroke Model

Evidence is clear that centralising acute stroke treatment at a much smaller number of hospitals has considerable benefits. The London Stroke Model was implemented in July 2010 and in their November 2010 stroke newsletter from the stroke clinical director Dr Tony Rudd, the London Cardiac and Stroke Networks reported that:

- The average length of stay for Stroke patients decreased from 15 days in 2009/10 to 11.5 days year-to-date at August 2010;
- The 2010 National Sentinel Stroke Audit evidenced that 84% of London patients were spending 90% of their time on a dedicated stroke unit against a national average of 68% for periods Q1 2009/10 – Q1 2010/11; and
- The 2010 National Sentinel Stroke Audit evidenced that 85% of high-risk TIA patients were being treated within 24 hours, against a national average of 56% for periods Q1 2009/10 – Q1 2010/11.

The reconfiguration has been shown to have delivered an absolute reduction in mortality of 3% and enabled an additional 6% of people to achieve independent life at home after a stroke. More than 95 extra lives are saved every year in London alone as a result of concentrating specialist stroke care in eight HASUs.

The London HASU model, which operates 24 hours a day, seven days a week, avoids £5.2 million each year.

National Institute for Health Research Published Evaluation Findings

On 28 May 2019, the National Institute for Health Research published "Evaluation of reconfigurations of acute stroke services in different regions of England and lessons for implementation: a mixed-methods study". Earlier NIHR evidence published in 2014 showed that the London model appears to perform better on key indicators such as mortality. This study adds to the earlier published evaluations by evaluating the longer-term results of the London model as well as the subsequent reconfiguration of Manchester services.

The 2019 evaluation was a mixed-methods study comparing the effectiveness of the different models of stroke service centralisation implemented in London, Manchester and the Midlands and East region with the rest of England. The paper concludes that:

- Centralised service models where all stroke patients are eligible for treatment in a hyperacute stroke unit seem to perform better than those with more selective admission criteria. If all patients went to a specialist unit for stroke, there were fewer deaths than if some patients went to units that were not specialist.
- Centralising stroke services led to fewer patient deaths, less time spent in hospital, provision of better care and overall good patient experiences and value for money.
- This should guide other urban regions looking to reconfigure their stroke care so that the changes can be made as effectively as possible.

Other models

Members of the Clinical Review Group made contact with and/or visited a number of other stroke units in the country, which had been identified as demonstrating clinical best practice, or were in areas of similar demographics to Coventry and Warwickshire. These included the following services and key findings:

Nottingham stroke service

- There are two general hospitals, Nottingham City Hospital (NCH) and Kings Mills Hospital (KMH), which treat 2500 strokes per year, including 600 mimics;
- There are 16 HASU beds at NCH and four at KMH with an average length of stay of 2 days;
- There are 20 ASU beds at NCH and 16 at KMH with an average length of stay of 7 days;
- There is standard ESD capacity for c.30 patients in the south (NCH area) and a community Stroke team. ESD for the KMH team is unknown; and
- There are 40 rehab ward beds at NCH, of which 21 are for standard rehab and for which there is daily consultant input. The other 19 beds are for complex slower rehab with twice a week input from consultants, due to aiming for more therapist led care. There are 20 rehab beds at KMH.

Stoke stroke service

- There is a Hub and Spoke model for the city and county. There is 1 HASU and 1 ASU at University Hospitals of North Midlands (UHNM), 1 ASU at Stafford Hospital, 1 ASU at Macclesfield Hospital and 1 ASU at Leighton/Crewe. 1,200 patients are treated per year;
- There are six HASU beds at UHNM;
- There are 26 ASU beds at UHNM, 10 at Stafford Hospital, 12 at Macclesfield Hospital and 10 beds at Leyton/Crewe. This is a total of 58 ASU beds and the average length of stay across HASU and ASU is 5-7 days.

North Essex ESD service

- The service is spread over four sites and is led by a stroke service lead that actively in-reaches every morning to the stroke ward to identify ESD candidates. The stroke co-ordinator then meets with the patient on the ward, introduces the service and arranges an initial visit for within 24 hours of discharge;
- On average 75% of acute strokes are discharged through the ESD service (349 patients in 2013-14);
- Approximately 50% of patients are referred for further rehabilitation with the community stroke team; and
- The ESD team has access to a community stroke team for longer-term rehabilitation and refers 50% of patients.

The capacity proposed for Coventry and Warwickshire, for each aspect of Stroke and TIA service provision is broadly in line with that expected from the results of the primary research into stroke services at other best practice regions with similar demographics. These included the Nottingham, Stoke and North Essex services outlined above.

Coventry ESD and Community Stroke Rehabilitation Pilot

There is clear evidence nationally that an ESD service can reduce length of stay in hospital. The experience in Coventry from the development of an ESD service has supported this.

In Coventry in December 2014 a pilot ESD service was established to support the discharge of appropriate patients over the winter period. Analysis of the impact of the service was undertaken, including consideration of the numbers of individuals who were supported to leave the Stroke Unit; the level of ESD support offered and what impact this had on the length of stay on the Stroke Unit.

In the first 3 months of the ESD provision, the provider was able to evidence a reduction in the average length of stay by 9 days compared to the same time period in the previous year. However, this also included facilitating an earlier discharge of 12 patients from the Stroke Unit who were suffering from other neurological conditions or having had a recent TIA, as part of the team's approach to free up capacity on the Stroke Unit.

As a result of the positive outcomes of the pilot, the service was substantively commissioned for Coventry in September 2015. The service model in place in Coventry is a standard ESD service, matching the model proposed for the whole of Coventry and Warwickshire in this Business Case. The clinical performance and results of this service therefore offer strong evidence supporting the success of the proposed model.

The length of stay for Coventry patients has reduced overall on average by 11 days. Analysis of the percentage of patients suitable for ESD from SSNAP has shown that on average 53% of patients were found to be suitable over the last year. The results are shown below:

- Dec – Mar 2017 = 62.8%
- Apr – Jul 2017 = 61.9%
- Aug – Nov 2017 = 47.5%
- Dec – March 2018 = 42%

The numbers of patients during the last two financial years who have been discharged out of hospital supported by the Coventry ESD service are as follows:

- Apr 2016 - Mar 2017 = 281
- Apr 2017 – Mar 2018 = 274
- Apr 2018 – Mar 2019 = 267

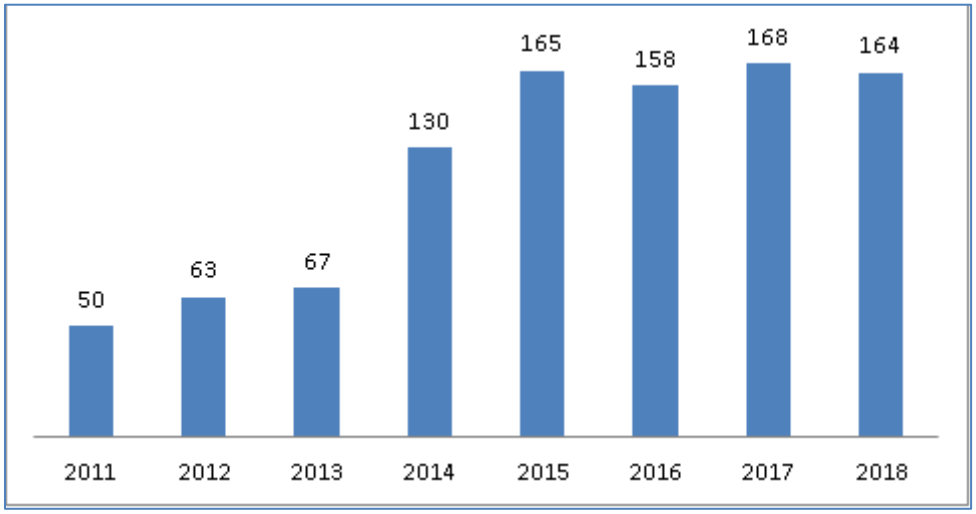
The existing Coventry Community Stroke Therapy Team (CST) provides community stroke rehabilitation support to ESD patients needing ongoing therapy beyond the 6 weeks of ESD support (approximately 30% of all ESD patients) to enable them to achieve their potential and maximise gains and independence post stroke. The team also supports the 30% of stroke patients with moderate to severe stroke who are discharged from the HASU/ASU directly home. This team supports those with the highest levels of impairment and complexity; the majority of the patients will require 2 therapists for each and every therapy session.

The success of the ESD service is dependent on the existence of sustainable, high quality community stroke rehabilitation. Community stroke rehabilitation supports:

- Patient flow from ESD to enable response times within 24-48 hours and intensity of treatment for this cohort with the most potential for change to remove long term disability. The flow to community stroke rehabilitation enables ESD to sustain high quality, high intensity, timely discharges for those most likely to gain full, or near to full, recovery post stroke;
- Patient flow from bedded rehabilitation for those who have had a moderate to severe stroke and who are now medically stable and able to return to the community. Community stroke rehabilitation provides: interdisciplinary rehabilitation to support discharge from hospital and meet a person's maximal level of independence; carer and social care support for long term decisions regarding care and environment needs; goal setting based on participation in the community despite levels of disability, including consideration of return to work and meaningful roles for those affected by stroke.
- Access to and availability of beds in the HASU/ASU by maintaining the flow of patients through the system

The Coventry community stroke rehabilitation team sits alongside the ESD team as a sister service, facilitating timely handover from the ESD team to maintain patient flow into this early intervention team. The proposed model therefore includes plans to ensure equivalent provision across Coventry and Warwickshire. Existing service activity and outcomes have been used as the evidence base for our modelling.

The chart below shows the annual volumes of patients supported to leave hospital by the existing Coventry CST team. A significant step change in activity can be noted from the point at which in-reaching to hospital and the ESD service began in 2014.



The figures below show the CST service reported outcomes, taken from their latest Key Performance Indicator report (October to Dec 2018), which demonstrate on average:

- 8% reduction in disability (using the Modified Rankin Score[2]);
- Of the patients suitable for scoring there was on average a 25-point improvement per patient in increased functional independence on discharge from the service using FIM/FAM[3] (Functional Independence Measure and Functional Assessment Measure).
- 10% improvement in independence in Activities of Daily Living (using the Modified Barthel Score[4]) and;
- 88% of patients achieved all of the agreed rehabilitation goals; a further 8% of patients partially achieved the agreed goals.

Atrial Fibrillation (AF)

There is evidence that optimally treating high risk AF patients has the potential to avert 230 strokes over three years in Coventry and Warwickshire ('The Size of the Prize on Cardiovascular Disease prevention', Public Health England and NHS England referenced in Section 3.2 above). This evidence indicates that there is significant clinical and financial benefit potentially from this kind of intervention.

[2] The Modified Rankin Score (mRS) is a **6 point** disability scale with possible scores ranging from **0 to 5**. A separate category of 6 is usually added for patients who expire. The Modified Rankin Score (mRS) is the most widely used outcome measure in stroke clinical trials

[3] **FIM+FAM** is designed for measuring disability in the brain-injured population. FIM is an 18 item global measure of disability, FAM specifically addresses cognitive and psychosocial function, which are often the major limiting factors for outcome in brain injury.

[4] The **Barthel scale** or **Barthel** ADL **index** is an ordinal **scale** used to **measure** performance in activities of daily living (ADL). Each performance item is rated on this **scale** with a given number of points assigned to each level or ranking

4.4 Local strategy

4.4.1 CCG Commissioning intentions and work priorities

Improving stroke care in the way proposed in this Business Case fits with the strategies of each of the CCGs in Coventry and Warwickshire as follows:

Coventry and Rugby CCG's Commissioning Intentions (2017 – 2019)

Coventry and Rugby CCG's Commissioning Intentions document for 2017/18 – 2018/19 sets out its seven key priorities. Stroke forms part of its Urgent & Emergency Care priority, with the CCG setting out its plan to work with partners to commission a single integrated stroke pathway that secures consistent specialist care, including rehabilitation.

South Warwickshire CCG's Strategic Plan (2016 – 2020)

South Warwickshire CCG's 2016 – 2020 Strategic Plan, translating our 2020 Vision into Reality, acknowledges that for some services where there is a strong relationship between the numbers of patients and the quality of care – including stroke – there is evidence to suggest improvements in outcomes and patient experience that are derived from having expertise, facilities and equipment in one place. As such, it sets out the vision to centralise stroke services to work towards the delivery of the NHS Midlands and East stroke pathway, given the evidence this will deliver better clinical outcomes.

Warwickshire North CCG's Vision for Quality Clinical Vision

One of the four clinical priority areas for the CCG comprises urgent and emergency care, including emergency general surgery, stroke services and cardiovascular disease. The CCG's plan for improved stroke care centres on:

- Improving identification of patients at risk of cardiovascular disease through primary and secondary care prevention and developing a pathway for heart failure, including cardiac rehabilitation services;
- Commissioning TIA services from a provider of specialist stroke care; and
- Commissioning additional stroke rehabilitation services in the local area.

4.4.2 Coventry & Warwickshire Sustainability & Transformation Plan

The Coventry and Warwickshire Sustainability & Transformation Plan (STP) defines the re-configuration of stroke services as outlined in this Business Case as a key priority as part of its Emergency and Urgent Care Workstream.

It is important to note that each of the leaders within the STP has agreed that the model outlined in this business case is the right one and should be implemented. The STP Board discussed and approved this Business Case at its meeting on 20 May 2019.

4.5 National strategy

Every year over 100,000 people in the UK have a stroke. Stroke is the leading cause of disability and fourth largest cause of death in the UK, with costs to the NHS and economy of circa £7 billion a year. Whilst there has been a gradual decline in mortality rates, due to public campaigns such as FAST, stroke remains the single largest cause of severe acquired disability,

driving the need for continued investment in delivering appropriate quality and timely services.

The National Stroke Strategy (2007) previously set out a clear direction for the development of stroke services in England over a 10-year period, with recommendations for the entirety of the patient pathway from prevention to end of life. The evidence-based strategy advocated provision of specialist stroke units, rapid access for TIA patients, immediate access to diagnostic scans and thrombolysis and early supported discharge.

The NHS England Five Year Forward View (2014) also advocated new models of care, including specialist care, citing examples of the centralisation of 32 stroke units in London to 8 units and the resulting reduction in mortality rates and lengths of stay in hospital.

The NHS Long Term Plan set out a series of ambitions for improving stroke care, with key milestones for improved post-hospital stroke rehabilitation models.

The National Stroke Programme, developed jointly by NHS England and the Stroke Association, seeks to support local organisations to deliver better prevention, treatment and care and meet the ambitions for stroke set out in the Long-Term Plan. The national programme aims to:

- Improve post-hospital stroke rehabilitation models for stroke survivors
- Deliver a ten-fold increase in the proportion of patients who receive a thrombectomy after stroke so that each year 1,600 more people will be independent after their stroke
- Train more hospital consultants to offer mechanical thrombectomy
- Deliver clot-busting thrombolysis to twice as many patients, ensuring 20% of stroke patients receive it by 2025 – the best performance in Europe
- Enhance the Sentinel Stroke National Audit Programme (SSNAP) to identify further need and drive improvements
- Ensure three times as many patients are receiving 6 month reviews of their recovery and needs – from 29% today to 90%

The Sentinel Stroke National Audit Programme (SSNAP) June 2017 recognised overall continued improvement in the management of strokes within acute stroke units and discharge, but there are still notable variances across the country:

- Some organisations are still not providing 24 hour hyper-acute stroke care;
- Nearly 10% of applicable patients do not receive swallow assessments within 72 hours of admission;
- In-hospital stroke patients tend to be identified and managed slowly
- Approximately one 5th of stroke admissions are not seen by a specialist stroke physician within 24 hours of admission;
- At least 50% of stroke patients will suffer from depression or cognitive impairments in the weeks following their stroke and will require psychological support.

The proposed new model set out in this Business Case aligns to the ambitions and commitments set out in the Long Term Plan and National Stroke Programme. It has been developed recognising the local variations from accepted clinical best practice set out within SSNAP and the national direction of travel. This includes the centralisation of HASU services.

The model also has the values, principles and pledges within the NHS Constitution at its core, ensuring that the population of Coventry and Warwickshire receive improved access, equity and quality of care to further improve the quality of their lives.

4.6 Conclusion

There is an established and increasing evidence base establishing best practice in stroke care. NHS England has set out key ambitions and commitments for the improvement of stroke services nationally, which are reflected in local commissioning strategies and priorities.

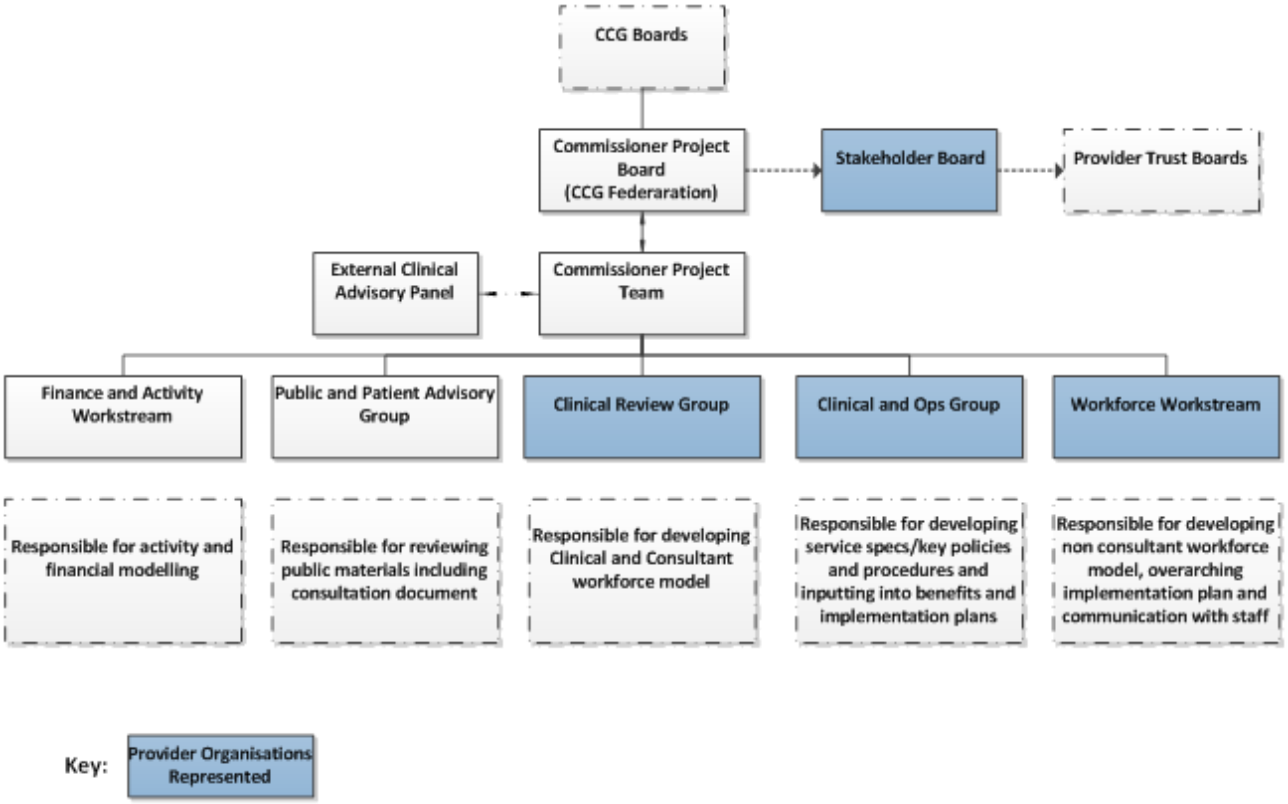
Evaluations of centralised HASU/ASU service models have been completed, demonstrating that centralised stroke services have led to fewer patient deaths, less time spent in hospital, the provision of better care and overall good patient experiences and value for money.

This section has summarised the strong evidence base and the national policy direction and priorities that support the proposed new clinical model set out in this Business Case.

5.0 OPTIONS DEVELOPMENT AND APPRAISAL

5.1 Assurance & Governance Arrangements

Whilst the development of the Pre-Consultation Business Case has been a Commissioner-led process overseen initially by the local Warwickshire and Coventry CCG Federation and now by the Strategic Commissioning Joint Committee (comprising CCG Clinical Chairs, Accountable Officers, Chief Financial Officers and other key members of all three local CCGs), it has extensively involved key stakeholders through a multi-agency project governance structure as shown below:



The Senior Responsible Officer for the project is Andrea Green, Chief Officer for Warwickshire North CCG, who is responsible to the Warwickshire & Coventry CCG Federation and now to the Strategic Commissioning Joint Committee, which acts as the Project Board.

Local acute and community service providers, as well as ambulance, Local Authority and patient representatives, have been represented at various levels, including via:

- Stakeholder Board – comprising provider strategy and medical leads;
- Clinical Review Group – comprising Medical Leads to support the development of the clinical model;
- Activity and Finance Workstream.
- Clinical and Operations Group – comprised of Clinical and Operational Leaders

The Clinical Review Group has been a primary group in expanding the clinical model beyond the hyper-acute and acute stroke phases to include the community and rehabilitative phases of care; helping to build the evidence and model for this.

The Clinical and Operations Group has provided clinical and operational management expertise, oversight and challenge into the development and evaluation of;

- potential scenarios for service delivery
- staffing models of each aspect of the proposed service options
- implementation plans

There has been an extensive programme of pre-consultation engagement with the public including, stroke survivors and carers. The project also established a Public & Patient Advisory Group which is chaired by a Stroke Association representative. A member of this group attends the Stroke Stakeholder Project Board. This group has overseen the pre-consultation engagement to date and has helped to broaden the voice of the patient/public, feeding into the Chair who sits on the Stakeholder Board. The pre–consultation engagement is further described in section 5.2 and in detail in appendices 5-7.

5.2 Stakeholder Engagement

The CCGs have undertaken an array of stakeholder engagement activities and co-production with regards to improving the Stroke and TIA service provision across Coventry and Warwickshire. Throughout the engagement programme, the focus has been on ensuring that there is good visibility, clarity and understanding of the services currently being delivered and the evidence base for the proposed changes in the stroke pathway and services. The engagement process provides the platform through which patients, carers, the public, health professionals and other key stakeholder groups (i.e. Local Authorities, Councillors etc.) are able to voice their thoughts, observations and concerns.

The feedback from the pre-consultation activities has resulted in two phases of development of potential scenarios, the first to identify and build the scenarios for the provision of Hyper Acute and Acute services (sections 5.3 and 5.4) and the second phase to facilitate the inclusion of rehabilitation services and primary prevention of stroke (sections 5.5 and 5.6). Crucially the pre-consultation engagement has supported the co-production of the options under consideration and the non-financial appraisal of those options.

The summarised findings from the engagement processes are noted in section 5.2.2. Appendices 5 and 6 contain full details of the engagement processes.

5.2.1 Pre-consultation engagement approach and objectives

A programme of pre-consultation engagement has been undertaken in two phases:

- **Phase 1** was undertaken in 2014/15 to build up the possible scenarios for the Hyper Acute and Acute pathway; and
- **Phase 2** followed on from the outcome of Phase 1, in which it was identified there was the need for the inclusion of rehabilitation and prevention of stroke in patients with Atrial Fibrillation. Phase 2 focused on the option of UHCW providing the centralised specialist HASU/ASU units with localised rehabilitation at home via ESD, bedded and community rehabilitation.

The engagement builds on significant work that has been undertaken in recent years to help improve stroke and stroke-related services across the local health economy.

5.2.2 Summary of Engagement, Themes and Responses

The responses from stakeholders throughout the engagement process were varied, mainly depending on the location of those being engaged, with issues and queries being raised in relation to each scenario. It is important to note that most respondents acknowledged that 'something' needed to change. Depending on their personal circumstances, how that change would affect them varied across the county.

The overriding theme however, appears to be an acknowledgement of the need for intensive hyper acute care at the onset of a crisis. This is offset by concerns around the longer and costlier travel journeys some patients and families will experience during the acute phase of care.

The consultation material will address the key concerns and queries raised through the pre-engagement process. It is acknowledged that the issue of travel, transport and parking is the predominant theme and this has not only been included in an extended Integrated Impact Assessment in 2017/18, but the Coventry and Warwickshire CCGs are already engaged with the West Midlands Combined Authority to establish a long-term transport plan for vulnerable people which includes patients and carers. Work is in train with local Councils to see if local policies might better support transport for carers and relatives not just for those who have a stroke, but others who are deemed vulnerable.

Other areas of concern raised that the consultation document has addressed include:

- Travel, transport and parking: including costs of travel and difficulty in parking at UHCW, the impact on both patients and family/carers/visitors and ambulance travel times;
- The loss of rehabilitation beds in Rugby;
- Concerns about capacity in UHCW;
- Concerns about recruitment to serve the new model;
- Whether the longer distance to UHCW for those patients who live further afield, negates the benefit of being taken to the HASU for assessment;
- Whether the closure of acute stroke services at GEH and SWFT will result in the closure of other services;
- Risk of over-crowding on the UHCW site, and potential negative impact on beds for those that most need them; and
- The need for good communication between the hospital units and Consultants and other staff. There is a perception that teams across sites do not currently communicate when patients are being transferred.

5.2.3 Health Overview and Scrutiny Committees

The programme has undertaken extensive stakeholder engagement and co-production with regards to developing and appraising the options for improving stroke service provision across Coventry and Warwickshire. A key aspect of this process has been regular engagement with Council Overview and Scrutiny Committees. Senior members of the programme have attended committee meetings to provide updates on progress and receive feedback and comments.

Below is a summary of meetings attended:

September 2015 Health Overview and Scrutiny Committees in Warwickshire and Coventry

2nd June 2016 Nuneaton and Bedworth Health Overview and Scrutiny Panel

13th October 2016 Brooke Overview and Scrutiny Committee (Rugby Borough Council)

6th July 2017 Nuneaton and Bedworth Health Overview and Scrutiny Panel

10th July 2017 Coventry Health and Wellbeing Board

13th July 2017 Brooke Overview and Scrutiny Committee meeting

22nd February 2018 Nuneaton and Bedworth Health Overview and Scrutiny Panel

27th February 2018 Warwickshire and Coventry Council Joint HOSC Members briefing session

8th October 2018 Coventry Health and Wellbeing Board

20th March 2019 Coventry and Warwickshire Joint Health Overview and Scrutiny Committee

18th April 2019 Nuneaton and Bedworth Health Overview and Scrutiny Panel

The feedback from each meeting attended has been considered and any requirements for further engagement/consultation that came out of those meetings have been detailed below with reference to the specific meeting the request came from.

Rugby Borough Council's Brooke Overview and Scrutiny Committee

Andrea Green, Senior Responsible Officer for the project on behalf of the Coventry and Warwickshire CCGs and Chief Officer NHS Warwickshire North and NHS Coventry and Rugby CCGs and Dr Adrian Canale-Parola, Chairman of Coventry and Rugby CCG attended Rugby Borough Council's Brooke Overview and Scrutiny Committee meeting on 13 July 2017 to present the Improving Stroke Services In Coventry and Warwickshire engagement document and respond to questions. Key points discussed included:

- the methods by which consultation materials would be publicised and stakeholder groups would be engaged
- the expected impact of ESD and community stroke rehabilitation on outcomes and the number of Social Care packages required following implementation and
- the rationale for the 6 beds at St Cross Hospital not being included.

It was agreed that a full list of consultees would be shared with the Scrutiny Committee and explained that minimum clinical standards based on bed numbers needed to be considered in assessing the viability of units. 6 beds had been identified as too small a number to sustain a viable unit.

Members were informed that outcomes of the engagement period will be considered in August/September 2017.

Further bed modelling has been considered since the engagement report and more information will be available during the consultation period.

Summary of Nuneaton and Bedworth Health Overview and Scrutiny Committee

Members considered the stroke engagement document at their meeting on 6 July 2017, below is a summary of the key points raised and responses to those points:

- Transport: councillors were clear that this was a very real issue for local residents both in terms of getting to UHCW and parking capacity and costs whilst there. The recent Integrated Impact Assessment completed since the engagement phase will be available to provide information at the consultation stage.
- Rehabilitation: the importance of getting this right and ensuring patients are cared for close to home. Further bed modelling has taken place since the engagement phase and more information will be available at the consultation stage.
- Workforce: a need to understand concerns about workforce capacity and skills. Further workforce assessment has taken place and more information will be available at the consultation stage.
- Carers: the importance of supporting and listening to carers during the process and ensuring there is a sufficient community service offering to support them. Carers have been listened to during the engagement phase they will continue to be engaged during and after the consultation phase.
- Nuneaton: ensure more engagement in Nuneaton during the consultation phase. Every effort will be made to engage widely and comprehensively with the people of Nuneaton.

Warwickshire and Coventry Council Joint HOSC Members briefing session

Warwickshire and Coventry Council worked together to form a joint HOSC Members briefing session on 27 February 2018, to hear about the proposals after taking account of the public engagement during June and July 2017.

The final proposals and actions to address the outcomes of the engagement in June and July 2017 and the latest Integrated Impact Assessment were presented.

Coventry and Warwickshire Joint Health Overview and Scrutiny Committee

At its meeting on 20 March 2019, the Committee considered a report presented by Andrea Green, Senior Responsible Officer, which provided an update on the process and timescale to complete the Pre-Consultation Business Case and the NHS England assurance process. Members raised a number of issues in response to the report and responses were provided. Particular areas of questioning included the reason for the delays in the project progress and additional work that had been required.

The Committee resolved that the public consultation should take place over a twelve week period and requested that arrangements be put in place for an informal briefing for members on the proposals when appropriate.

5.3 Long-List of Scenarios - Hyper Acute and Acute Services

At the onset of the project a set of underpinning principles were agreed by Commissioners for the potential scenarios for the delivery of stroke services. These were:

- All scenarios must meet the requirements of the NHS Midlands and East regional Stroke Service Specification and therefore provide for:
    - A Hyper-Acute Stroke Unit – to remain at UHCW;
    - Acute Stroke Unit(s) with one aligned to the HASU at UHCW at a minimum;
    - A standard Early Supported Discharge service;
- Stroke rehabilitation beds will be provided locally for the post-acute phase of care: for those patients who no longer require acute stroke care, but have ongoing care and rehabilitation needs that prevent them from returning home;
- All high risk TIAs would be seen at UHCW.

Based on the above principles, a longlist of scenarios for the provision of Hyper Acute/Acute services was developed by the Clinical and Operations Group as follows:

Scenario 1 - Do Nothing

Scenario 2 - HASU at UHCW / 1 ASU at UHCW Centralisation

Scenario 4 - HASU at UHCW / 3 ASUs at UHCW, SWFT & GEH

Scenario 5A - HASU at UHCW / 2 ASUs at UHCW & SWFT

Scenario 5B - HASU at UHCW / 2 ASUs at UHCW & GEH

During the work to develop the above scenarios, two additional scenarios were considered:

- Scenario 3 - a scenario was introduced which sought to have a HASU and an ASU for Coventry and Rugby patients up to the point of discharge, and north and south Warwickshire patients at UHCW up to day 7. The latter cohort of patients would be repatriated to a local ASU at SWFT or GEH as appropriate, if a longer acute hospital stay was needed. This scenario was later discounted following external advice sought from a senior External Clinical Advisory Panel member who cautioned against splitting a patient's acute length of stay in an ASU;
- Scenario 5 – a 2-ASU scenario was considered, with one ASU being specified at UHCW and the other at either SWFT or GEH. It was later agreed that this scenario would be sub-divided into Scenarios 5A –and Scenario 5B, with specific locations at SWFT and GEH identified for each.

5.4 Short-List of Scenarios - Hyper Acute and Acute Services

5.4.1 Clinical and Operational Viability Assessment of Scenarios

Having developed the long-list of scenarios, an initial assessment based on clinical viability was undertaken. The criteria against which the scenarios were assessed were developed by the Clinical Review Group. These were that each scenario must:

1. Be capable of meeting the NHS Midlands and East Stroke Service Specification;
2. Be clinically viable in terms of both activity and workforce. Using the findings of the visits to Stroke services that were demonstrating best practice, members of the Group agreed that to be clinically sustainable, a Stroke Unit would require a minimum of 10 stroke beds being operational.

To support the assessment of the scenarios against criteria 2 above, capacity modelling was completed, the results of which are shown in the table overleaf.

Shortlisting Exercise Based on Clinical Viability – Modelling Results for Total No of Beds

	Scenario 1	Scenario 2	Scenario 4	Scenario 5A	Scenario 5B
UHCW	**42 beds** (6 HASU / 30 ASU / 6 Stroke Rehab)	**43 beds** (12 HASU / 31 ASU)	**40 beds** (10 HASU / 30 ASU)	**40 beds** (12 HASU / 28 ASU)	**39 beds** (13 HASU / 26 ASU)
SWFT	**32 beds** (12 ASU / 20 Stroke Rehab)	**0 beds** (All ASU)	**3 beds** (All ASU)	**2 beds** (All ASU)	**0 beds** (All ASU)
GEH	**19 beds** (All ASU)	**0 beds** (All ASU)	**2 beds** (All ASU)	**0 beds** (All ASU)	**3 beds** (All ASU)

It can be seen that in Scenarios 4, 5A and 5B, the Acute Stroke Units at both SWFT and GEH are projected to require considerably fewer than 10 beds, which was determined as the minimum threshold for sustaining an acute stroke service. This is predominantly due to:

- A shift of suspected stroke activity from SWFT and GEH to UHCW;
- Reduction in overall lengths of acute hospital stay by the introduction of an ESD service and additional support in the community.

On the basis that Scenarios 4, 5A and 5B result in the Acute Stroke Units at SWFT and GEH being clinically unsustainable, these scenarios were discounted. This left two scenarios under consideration i.e. **Scenario 1** – Do Nothing; and **Scenario 2** – Centralisation.

Given that Scenario 1 – Do Nothing does not meet the Midlands and East Stroke Service Specification requirements and was included for comparative purposes only, the Coventry & Warwickshire Stroke project identified only one clinically viable scenario for the acute phase of the pathway: Scenario 2 - Centralisation. As only one clinical viable scenario remained for the provision of hyper acute and acute services, financial modelling was not undertaken on the non-viable options.

5.4.2 Patient and Public Engagement and Feedback

In parallel, in 2014/15 the pre-engagement phase of the project with the public was handled informally through meetings with stroke groups and groups representing the 'nine protected characteristics' equality strands and identified in the initial Integrated Impact Assessment. The purpose was to ascertain their thoughts and wishes for an acute stroke service.

The 2015 engagement exercise then engaged on the following 4 scenarios:

1. Do nothing;
2. Maximise centralisation at UHCW (hyper acute and acute unit for ALL patients);
3. All patients go to UHCW Hyper-Acute unit for 2 – 3 days then patients who are from the Warwickshire North area transfer to GEH and patients from South Warwickshire transfer to Warwickshire Hospital; and
4. All patients go to UHCW Hyper-Acute unit for 2 – 3 days then North and South Warwickshire patients transfer to one other hospital, either the George Eliot Hospital or Warwick Hospital with closure of stroke facilities at the other unit.

The feedback captured in the Engagement Report was considered by the Project Board who, in response to the feedback, decided to expand the scope of the project to include specialist stroke community rehabilitation services and action to prevent more strokes for patients with Atrial Fibrillation.

5.5 Long list of Scenarios – Rehabilitation Services

The original principles for the stroke service improvements described in section 5.3 had only included the ESD aspects of out of hospital care. Following the feedback received in 2015 from the first engagement phase, a decision was made by Commissioners to expand the scope of the business case to include specialist stroke community rehabilitation and action to prevent more strokes; namely increased anticoagulation rates for those with Atrial Fibrillation.

There is clear clinical best practice evidence in the Midlands and East Specification and also described from other health systems and the Coventry pilot, that improved outcomes and shorter lengths of stay are achieved by services that enable those patients suitable for ESD to receive ESD and community rehabilitation. This evidence is detailed in section 4.3.

This evidence strongly suggests that ESD and an expansion of community rehabilitation in patients own homes are a prerequisite in whichever new pathway is introduced for Coventry and Warwickshire.

A proposed model of care that included the expanded scope above was developed. At this stage there appeared to be only one way to secure a clinically viable, future end to end pathway. So, from 15th June to 28th July 2017 a further, comprehensive, 6 week public engagement process was undertaken on a proposal for a centralised hyper acute and acute service, bedded rehabilitation on 2 sites, ESD, community stroke rehabilitation at home and improvements in AF anticoagulation therapy.

This engagement included the following activities:

- More than 500 stakeholders received electronic engagement and a questionnaire via NHS and Local authority partners, Healthwatch and the voluntary sector;
- Five public meetings were held;
- There were nine community engagement events and meetings;
- Local media advertisements, including two items on local radio throughout July 2017 and 27 articles in local newspapers.

The key concerns identified by the public from this engagement related to concern for carers of those living in Coventry and Rugby, who would need to travel to access the bedded stroke rehabilitation proposed for them at George Eliot Hospital and Leamington Rehabilitation Hospital i.e. not a local provision for this cohort of individuals. This feedback was considered in the updated Integrated Impact Assessment and most of these addressed through an action plan working with Council colleagues. Alongside this, the stroke expert Clinical and Operations Group leading the clinical design of the future stroke service model, was asked to revisit the work completed to date and consider if there was another method of delivering bedded rehabilitation for the Coventry and Rugby population, that might mitigate this.

The following longlist of scenarios was identified by the Clinical and Operations Group for the provision of rehabilitation services:

Scenario 1 ESD and community rehabilitation in all areas. Bedded rehabilitation at South Warwickshire Foundation Trust (SWFT) in Leamington and George Eliot Hospital (GEH) in Nuneaton

Scenario 2a ESD and community rehabilitation in all areas. Community bedded rehabilitation provision in Coventry with specialist therapy in-reach and bedded rehabilitation at SWFT in Leamington only.

Scenario 2b ESD and community rehabilitation in all areas. Community bedded rehabilitation provision in Coventry with specialist therapy in-reach. Bedded rehabilitation at SWFT in Leamington and GEH in Nuneaton

Scenario 3a ESD in all areas (no community rehabilitation). Discharge to Assess in Coventry with in-reach. Bedded rehabilitation at SWFT in Leamington only

Scenario 3b ESD in all areas (no community rehabilitation). Community bedded rehabilitation provided in Coventry with specialist in-reach. Bedded rehabilitation at SWFT in Leamington and GEH in Nuneaton

Use of rehabilitation beds at the Hospital of St Cross, Rugby was not considered clinically feasible for inclusion in the long list. Splitting the specialist rehabilitation model over three hospital bedded units would demand a workforce model that clinicians agreed could not be recruited to and sustained. The key drivers for this were:

- the reduced size and patient volumes that each rehabilitation unit would be managing would present viability challenges for the size of clinical teams and retention of clinical skills in each of the units;

- operating over three units would increase the additional workforce needed and the national workforce shortage in specific skill sets led to concerns regarding the ability to recruit sufficient staff to operate the services.

5.6 Short list of Scenarios – Rehabilitation Services

5.6.1 Clinical and Operational Viability Assessment of Scenarios

Having developed the long-list of scenarios, the Clinical and Operations Group reviewed each option to assess their ability to meet the following minimum essential criteria:

- meet national guidance and the NHS Midlands and East Regional Stroke Service Specification
- must demonstrate at least the minimum standards of quality; be safe; be sustainable and deliver better outcomes for patients

In addition, the Clinical and Operations Group assessed the long-list options against nine standard, health service best practice criteria:

1. *Better access to services – equality; travel; car parking*
2. *Improved clinical quality – better health outcomes; better configuration; enabling new methods of delivering care*
3. *Improved environmental quality – conditions conducive to effective care; meeting patient and staff expectations; functional suitability*
4. *Development of services – increasing quantity*
5. *Improved strategic fit – meeting strategic needs of the locality or region*
6. *Meeting training, teaching, research needs – easier to recruit, train, retain staff; protecting accreditation standards; improve productivity*
7. *More effective use of resources – human; service; facilities; better value for money*
8. *Ease of delivery – practical delivery and implementation*
9. *Meeting national, regional policy initiatives*

Against these nine criteria each option was scored by the Clinical and Operations Group, to facilitate a robust discussion about the relative risks, benefits and issues with each. The agreed scoring criteria used a scale of 0 to 4, with the following descriptors:

Score	Description
4	Excellent degree of confidence in delivery model. High certainty of delivery of model and associated outcomes
3	Comprehensive and able to fully meet requirements. High level of confidence in delivery model and associated outcomes
2	Acceptable level of confidence in delivery model. Reasonable level of confidence in delivery model and associated outcomes
1	Limited degree of confidence in delivery model. Fails to meet requirements of delivery model and associated outcomes
0	Deficient model that offers no confidence in ability to deliver the model and associated outcomes

As a result of this assessment process, 3 scenarios were rejected due to not meeting the essential criteria. Two viable options remained:

Option 1 Early Supported Discharge Service (ESD) and community rehabilitation in all areas. Bedded rehabilitation at South Warwickshire Foundation Trust (SWFT) in Leamington and George Eliot Hospital (GEH) in Nuneaton

Option 2b Early Supported Discharge Service (ESD) and community rehabilitation in all areas. Community bedded rehabilitation provision in Coventry with specialist therapy in-reach. Bedded rehabilitation at SWFT in Leamington and GEH in Nuneaton.

These options were to be taken forward (as Option 1 and Option 2) for full non-financial appraisal by all key stakeholder groups. Details of the non-financial appraisal process are provided in section 5.7.

5.6.2 Patient and Public Engagement and Feedback

The Clinical and Operations Group shortlisting process had identified two viable options for the provision of bedded rehabilitation; both assume that ESD and community stroke rehabilitation at home will be delivered in all areas.

Further engagement sessions were carried out with the Patient and Public Advisory Group and wider stakeholder groups to recap on the journey so far, gather feedback and agree the process for appraising the viable options.

One of the key activities undertaken was the co-production of the list of desirable non-financial criteria against which the options would be appraised. An initial meeting with the Patient and Public Advisory Group in August 2018 resulted in the development of a set of patient and public focussed criteria with which to assess the options for future stroke bedded rehabilitation services. These were shared with wider members of the public via 4 public engagement sessions in September 2018. These sessions tested and further developed the detail of the desirable criteria.

Key themes already captured from previous engagement in 2017 and the Integrated Impact Assessment were also incorporated into the desirable criteria.

5.7 Options Appraisal

The results of the option development work had found that there was only one option for the provision of HASU/ASU services and the establishment of ESD and community rehabilitation across Coventry and Warwickshire. The only aspect of the stroke pathway with options for consideration was therefore the bedded rehabilitation provision.

A wide and representative group of stakeholders were invited to a non-financial options appraisal event, to appraise the two viable options for the provision of bedded stroke rehabilitation. The stakeholder group included patients and carers, local councillors, voluntary sector and community support groups, community pharmacists, NHS clinical staff, NHS commissioners, social care commissioner and managers. The process of inviting stakeholders to this event involved mapping our comprehensive stakeholder lists against the nine protected characteristics within equality law and cross-referencing these to the 2017/18 Integrated Impact Assessment to ensure appropriate representation was achieved.

The options appraised were:

1. One bedded rehabilitation unit at South Warwickshire Foundation Trust (SWFT) in Leamington Spa and one bedded rehabilitation Unit at George Eliot Hospital (GEH) in Nuneaton.
2. One bedded rehabilitation unit in the Coventry area, not on an NHS hospital site, with specialist therapists coming into the site to provide rehabilitation into the unit; one bedded rehabilitation unit at South Warwickshire Foundation Trust (SWFT) in Leamington Spa and one bedded rehabilitation Unit at George Eliot Hospital (GEH) in Nuneaton.

Both options assumed that HASU/ASU care would be provided at UHCW and ESD and Community rehabilitation at home would be delivered in all areas.

As described in section 5.6.2 above, through extensive patient and public engagement a list of non-financial desirable criteria was co-produced and used to appraise each of the clinically viable service delivery options. These criteria are shown in the table below.

Stakeholder coproduced desirable criteria for the non-financial options appraisal

Equality, accessibility and consistency of services	Services should be equitable, consistent and always available Availability of car parking / accessibility of public transport Equality of access no matter where you live, who you are and what your personal circumstances are Staff development, training, skills and information should be consistent – from ambulance teams to rehab therapists No patient or carer should feel disadvantaged by the new service
Improved clinical quality of services	Service should focus on the best quality and the best possible outcomes and recovery Providing better long term health outcomes for patients Addressing existing clinical problems that not all clinical services are available on all sites There needs to be the right balance of staff, in the right places with the right skills and knowledge Providing the opportunity to ensure that we have the best clinical outcomes for every stroke patient
Improved delivery of services	Professionals who are delivering the services should understand the stroke patients' feelings and the consequences of having a stroke We should create an environment where experiences, knowledge and information can be shared to benefit stroke survivors and their carers All stroke services should work together with a smooth transition at all points in the stroke patients care Patients should feel that staff are working in one team for their patient, even if they work for different organisations. Holistic services need to be considered as they help people to not fall through the cracks Services should integrate and include community and voluntary

Development of personalised services	Services should be personalised with care that is right for each individual patient Loved ones and carers need to be supported, informed and consulted at all stages Services should be modelled on the best outcome and care for patients not what can be done with the current staff or finances Patients and loved ones should receive timely, awareness raising communications and signposting All or other health considerations should be taken into consideration when planning the patients care

The options appraisal event used the following process:

- The co-produced desirable criteria were reviewed as a group and weightings agreed for their relative importance
- Smaller table top groups were then asked to consider each of the two viable options against the desirable criteria to enable each individual present to score these
- Each table then fed back their scores which were entered into a single spreadsheet.
- The result was a consensus view from those attending the options appraisal event on the options for bedded rehabilitation.

The agreed weightings and resulting scores for each option are shown below:

The non-financial options appraisal desirable criteria	Weight (decimal)	Option 1 Table Score (from 0 to 10) as decimal	Option 2 Table Score (from 0 to 10) as decimal	Score for Option 1	Score for Option 2
Equality, accessibility and consistency of services	0.27	0.70	0.51	18.78	13.76
Improved clinical quality of services	0.32	0.86	0.39	27.03	12.30
Improved delivery of services	0.24	0.85	0.45	20.09	10.69
Development of personalised services	0.18	0.77	0.57	14.06	10.37
			TOTAL	**79.97**	**47.12**

Options were scored on a scale of 0 to 10, where 0 indicated an option completely failed to meet the criteria and 10 indicated that an option completely met the criteria. As the results above show, the **preferred option from the non-financial options appraisal was option 1**.

One bedded rehabilitation unit at South Warwickshire Foundation Trust (SWFT) in Leamington Spa and one bedded rehabilitation Unit at George Eliot Hospital (GEH) in Nuneaton.

Full details of the options appraisal can be seen in Appendix 8.

5.8 Risk Assessment of Options

To support Commissioners in assessing the clinical and operational delivery feasibility of each of the bedded rehabilitation options and further support the decision-making as to the preferred option, a risk assessment was undertaken by the Clinical and Operations Group.

At the non-financial options appraisal event stakeholders had challenged the Clinical and Operations Group assessment that it would not be possible to sustainably staff 3 hospital sites for rehabilitation. The option of providing bedded rehabilitation at the Hospital of St Cross, Rugby was therefore included in the risk assessment to enable a robust re-assessment of this position.

The options risk assessed were:

Option 1	*ESD and community rehabilitation in all areas. Bedded rehabilitation at SWFT in Leamington Spa and GEH in Nuneaton*
Option 2	*ESD and community rehabilitation in all areas. Community bedded rehabilitation provision in Coventry, not on an NHS hospital site, with specialist therapy in-reach. Bedded rehabilitation at SWFT in Leamington Spa and GEH in Nuneaton*
Option 2 using Rugby	*ESD and community rehabilitation at home available in all areas. One bedded rehabilitation unit at South Warwickshire Foundation Trust (SWFT) in Leamington Spa, one bedded rehabilitation Unit at George Eliot Hospital (GEH) in Nuneaton and one bedded rehabilitation unit at the Hospital of St Cross, Rugby.*

The Clinical and Operations Group agreed a set of criteria to reflect the range of clinical, operational delivery and healthcare system risks that any model could present. The agreed risk assessment criteria are shown in the table that follows.

	Risk Assessment Criteria
1	Patients are transferred to the bedded rehabilitation provider that are ready for rehabilitation but have medical needs outside the capability of the rehabilitation provider
2	Patients developing complications and/or deteriorating cannot be appropriately supported in the bedded rehabilitation provider, leading to transfers to A&E
3a	Difficulty in recruiting and retaining sufficiently skilled clinical staff to cover the rotas – Consultants
3b	Difficulty in recruiting and retaining sufficiently skilled clinical staff to cover the rotas – Nurses
3c	Difficulty in recruiting and retaining sufficiently skilled clinical staff to cover the rotas - other clinical staff
4	Difficulty in securing a high quality, sustainable provider with on-site facilities conducive to rehabilitation
5	Limitations on the capabilities of the bedded rehabilitation reduce capacity, impacting on patient flow out of UHCW
6	Lack of consistent clinical governance arrangements across the providers reduces the system ability to manage the quality of care
7	Adverse impact on wider NHS provider sustainability in the health system, that could impact on the need for changes in other local services
8	Fragmented care and unnecessary delays in the management of patients journeys due to lack of access to social workers and/or other community-based infrastructure to support patient needs assessment
9	An inability to sustain staff skill levels and competence in stroke rehabilitation

Each of the options was assessed against the risk criteria, using a NHS standard likelihood and consequence assessment matrix.

Consequences	Likelihood				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Negligible (1)	1	2	3	4	5
Minor (2)	2	4	6	8	10
Moderate (3)	3	6	9	12	15
Major (4)	4	8	12	16	20
Catastrophic (5)	5	10	15	20	25

To ensure consistency in the scoring of each option the following assumptions were agreed and applied when considering each option against the risks.

1. Beds provided at the Hospital of St Cross in Rugby would be providing the same level of service as those provided by SWFT and GEH
2. The number of beds provided at the Hospital of St Cross in Rugby would be based upon the geographically identified number of patients closest to the location
3. For all options risk assessed ESD and community stroke rehabilitation would be provided as per the Business Case
4. For all options, clear service specifications would be in place for the services commissioned
5. The beds provided for community bedded rehabilitation with in-reach (Option 2) would all be provided from one location

The results of the risk assessment are shown below.

	Option 1		Risk
	L	C	Score
1	3	2	6
2	1	1	1
3a	3	2	6
3b	3	4	12
3c	3	4	12
4	1	5	5
5	2	4	8
6	1	2	2
7	2	2	4
8	2	2	4
9	2	3	6
			66

	Option 2		Risk
	L	C	Score
1	4	3	12
2	4	3	12
3a	3	2	6
3b	4	4	16
3c	4	4	16
4	4	5	20
5	3	4	12
6	2	2	4
7	3	3	9
8	3	2	6
9	4	3	12
			125

	Option 2 using Rugby		Risk
	L	C	Score
1	3	2	6
2	1	1	1
3a	3	2	6
3b	4	4	16
3c	4	4	16
4	1	5	5
5	2	4	8
6	1	2	2
7	4	4	16
8	3	2	6
9	4	3	12
			94

As is shown in the results above, Option 1 has a lower level of risk than Option 2, having a total risk score of 66 compared to 125. The risk assessment also supported the original assessment that developing a third rehabilitation unit in Rugby poses higher risks of an inability to recruit the required nursing and therapy staff and critically, presents a significant, red risk of having an adverse impact on wider NHS provider sustainability in the health system, that could impact on the need for changes in other local services.

The risk assessment therefore supports the results of the non-financial options appraisal in determining that **the option with the least clinical and operational service delivery risks is Option 1**.

One bedded rehabilitation unit at South Warwickshire Foundation Trust (SWFT) in Leamington Spa and one bedded rehabilitation Unit at George Eliot Hospital (GEH) in Nuneaton.

The full risk assessment document can be found in appendix 9.

5.9 Integrated Impact Assessment and Equalities

Integrated Impact Assessments have been carried out in 2015 and 2017/18 as proposals have developed, the purpose of these was to identify the groups most likely to be affected by stroke and provide a full analysis of the impacts of the potential scenarios on travel and access, determinants of health and equality.

The scenarios considered within the 2017/18 assessment reflect the short-list of options identified through the process described in sections 5.3, 5.4, 5.5 and 5.6:

Scenario 1: Do nothing

Scenario 2a: all stroke patients in Warwickshire will be treated at UHCW throughout both the hyper-acute and acute phases. When appropriate for discharge, patients will be sent home for supported rehabilitation or, in the case of bedded rehabilitation requirements (around 30% of patients), will have the choice of either GEH or Leamington Spa Hospital (LSH) dependent on proximity to usual residence and/or bed availability.

Scenario 2b: all stroke patients in Warwickshire will be treated at UHCW throughout both the hyper-acute and acute phases. When appropriate for discharge, patients will be sent home for supported rehabilitation or, in the case of inpatient bedded rehabilitation requirements (around 30% of patients), will be transferred to either GEH or Leamington Spa Hospital (20%) with the remainder of patients in Coventry and Rugby (10%) being commissioned a suitable care home bed in Coventry, with access to a specialist in-reach stroke rehabilitation team.

The Integrated Impact Assessment (IIA) documents are appended (appendices 10 and 11).

The following table summarises the potential scale of the impact for each of the elements of service changes on patient numbers and estimated numbers of those by district and in the quantifiable equality population groups. These are considered a broad estimate of the scale of impacts for consideration alongside the following impact assessments. The impact on carers and visitors can be assumed to follow a similar distribution in the absence of additional information to the contrary.

IIA estimates of impacts for the proposed changes by district and assorted equality groups, based on 2015/16 data.

Element of the Service Change	Description	Estimated numbers impacted	By Area	By Equality group
Centralisation Stroke	All Stroke patients **not currently** treated at UHCW for hyperacute and acute stage	726	Coventry – 19	Age (over 65s) - 582
			North Warwickshire – 84	BAME - 89
			Nuneaton & Bedworth – 86	Males - 346
			Rugby – 32	Female - 380
			Stratford – 133	Deprived areas - 58
			Warwick – 191	Pregnant/maternity - 13
			Out-of-Area – 81	
Centralisation (TIA)	All TIA patients not currently treated at UHCW.	165	Coventry – 1	Age (over 65s) - 135
			North Warwickshire – 23	BAME - 24
			Nuneaton & Bedworth – 44	Males - 79
			Rugby – 3	Female - 86
			Stratford – 25	Deprived areas - 9
			Warwick – 41	Pregnant/maternity - 3
			Out-of-Area – 28	
ESD and community rehabilitation	All stroke patients **suitable for ESD and community recovery and rehabilitation** post-acute stage (70%) including those currently receiving ESD and community rehab	952	Coventry – 245	Age (over 65s) – 683
			North Warwickshire – 76	BAME - 137
			Nuneaton & Bedworth – 199	Males - 510
			Rugby – 86	Female - 442
			Stratford – 99	Deprived areas - 131
			Warwick – 123	Pregnant/maternity – 21
			Out-of-Area – 123	
Complex and bedded rehabilitation	All stroke patients requiring inpatient rehabilitation post-acute stage (30%) including those currently receiving inpatient rehab	408	Coventry – 105	Age (over 65s) - 323
			North Warwickshire - 33	BAME - 65
			Nuneaton & Bedworth - 85	Males - 190
			Rugby - 37	Female - 218
			Stratford - 42	Deprived areas - 45
			Warwick – 53	Pregnant/maternity - 5
			Out-of-Area – 53	

Source: The Strategy Unit.

Summary of the impacts and potential mitigations identified in the IIA

The proposed changes are designed to improve outcomes for all stroke patients regardless of their area of residence: thereby increasing the likelihood of survival, decreasing recovery time with lower risk of complications and permanent disability, enabling shorter lengths of stay in hospital with more time at home, receiving appropriate support and rehabilitation.

The total number of stroke patients likely to be affected by the changes is estimated, using 2017/18 activity data, to be an additional 699 patients in the hyper and acute phase, an estimated total of 1,268 patients for the ESD and community rehabilitation and 349 patients for bedded rehabilitation. It is important to note that because many patients will receive input and care from a combination of all of these stroke services, individual patients will appear multiple times in these numbers.

Three principle areas of impact were identified in the IIA:

- Travel and access
- Health
- Equality

It is recognised that there will be negative short-term impacts felt by some of the carers of, and regular visitors to stroke patients during the inpatient stays in both the hyper/acute and rehabilitation phases, particularly those reliant on public transport.

Carers and visitors in North Warwickshire, Warwick and Stratford-upon- Avon district will be disadvantaged most in terms of longer and further journeys in relation to acute care in Coventry. Carers and visitors from Coventry and Rugby will be impacted most during the rehabilitation phase, should their relatives need rehabilitation in a bedded setting prior to discharge home, as the rehabilitation beds will located in Nuneaton and Leamington only.

On balance the negative impacts of increased travel time and distance for some visitors and carers is offset by improved availability of specialist stroke treatment throughout the pathway, reduced lengths of stay (during both the acute and rehabilitation phases) and the potential improvement in health outcomes and reduction in disability for all stroke survivors.

Nevertheless, the CCGs have established a Health and Transport planning group with the Local Authorities to develop plans to address the transport and travel challenges faced. Membership includes voluntary and community providers, Public Health and Local Council representation. Responsibilities of the group include:

- developing a fuller understanding of the criteria/eligibility arrangements around current access to various transport schemes
- developing a consistent message around health services in Warwickshire and Coventry regarding parking costs and information provided by healthcare providers about travel costs and who is entitled to concessionary parking schemes.
- supporting the development of cross border acceptance of public transport travel passes between different bus providers in Warwickshire and Coventry.

To support those visitors and carers who will be using public transport, information regarding existing direct and non-direct public transport services will be made available, as will information about voluntary and subsidised transport schemes. Consideration will also be

given to inpatient visiting hours, especially during winter, to reduce the amount of time visitors and carers spend traveling in the dark.

UHCW is currently working with partners to creating additional car parking on site of circa 1600 spaces, which are anticipated to be in place by March 2021.

Summary of overall impacts and conclusions

The technical documents included at appendix 11 of this business case provide a full account of the scores for each element of the IIA. For example, the EIA scores can be found in section 5.3 and appendix 7.10 of the technical documents and the health scores are in section 5.2 and appendix 7.9 of the technical documents. The summary scores are shown below:

Scenario	Travel & Access	Health			Equalities
		Health Impact	Health Inequalities	Determinants of Health	
1	0	0	0	0	0
2a	-6.5	+20	+15	-1	+18
2b	-5.5	+3	-7	+1	+22

The assessment and scoring suggest that both proposals for centralisation of all acute care and rehabilitation would have an overall positive impact on the population compared to the do-nothing scenario, reducing the inequalities in the current/do nothing scenario. Scenario 2a offers the greatest gain in terms of the direct health benefits to patients and the most positive impact on reducing health inequalities.

If the scoring is considered alongside information on the scale of the impact in terms of the volume of patients affected by the proposed changes, the impacts would be magnified further, as the clinical model for 2a is considered more effective and viable than in option 2b. Scenario 2b offers the most flexible rehabilitation pathway and appears to provide the greatest extent of positive impacts in terms of equality of access, particularly in respect of those in the population with protected characteristics. However, it should be noted that some of the equality groups would constitute a relatively small volume/scale of stroke patients (e.g. pregnant/maternal women and those from BAME groups), thus additionally their carers and visitors. Similarly, the number of strokes from areas that might be affected more by changes to travel are lower than in some of the more urban areas.

Overall, the IIA demonstrates both quantitative and qualitative evidence that the proposed scenarios could have major benefits for the Warwickshire and Coventry populations including vulnerable groups. The key benefits relate to the ability of the changes to achieve:

- Everyone within 72 hours of the onset of stroke to have the benefit of assessment in a Hyper Acute Stroke Unit ('HASU');
- Increased timeliness and equitable access to hyper acute, acute and rehabilitative care for all Coventry and Warwickshire residents, removing inequalities in the current provision;
- Improved workforce development opportunities, and recruitment and retention of Stroke specialist staff;
- Reduced levels of mortality and morbidity for people who have suffered a Stroke;

- Reduce levels of dependency for people after suffering a stroke;
- Improved cognitive function for people after suffering a stroke;
- Improvements in stroke prevention for all patients reducing the current inequalities.

Whilst the centralisation will invariably negatively impact on patients and visitors travel and access, particularly from the North and South of Warwickshire, the expected health benefits, greater proportion of time recovering at home and a reduction in inequalities from the exemplar service provision across the area in the proposals should more than offset them.

Headlines from the feedback from the groups identified as most affected by stroke echoed the feedback by the Stroke group engagement meetings and were as follows:

Transport	Location	Services
Transport is a problem if people have to travel further;	Quality of care more important than location;	Things cannot stay as they are;
Concern about increased travel time to UHCW in an ambulance;	All services should be at UHCW where best care is delivered;	There is the need for consistency in service provision;
Extra travel wouldn't be too much of a problem;	GEH provides better care;	Concerns around capacity as UHCW is already busy;
Concern about cost of transport and car parking;	Centralisation is a good idea; better if they come back to their local hospital afterwards;	Better training for carers needed;
Parking is difficult at UHCW;	Specialist unit first and then to a local hospital is a good idea;	Best treatment and facilities are the most important;
Concern about increased travel for visitors;	Access to specialist first and then to a local hospital;	Community care needs consideration;
Public transport from Nuneaton to Coventry is difficult, particularly for the elderly;	Access to specialist stroke unit in their local area, which are better for people especially the elderly;	Sharing of patient notes between hospitals do not work;
Voluntary transport is variable, particularly at weekends;	Specialist stroke unit in Nuneaton needed;	Poor communication between hospitals, with the need to repeat yourself; and
Long-term outcomes are more important than travel;	Do not change the existing services;	Patients need to be discharged only with sufficient support.
Car parking is difficult and expensive at UHCW and Warwick;	It doesn't make sense to bypass the local hospital if time is critical;	
Concern about poorer outcomes for patients if they have to travel further;	Care closer to home is best, to help local carers and relatives;	
Need to think about how patients travel home.	Centralisation at UHCW may not be best for everyone.	

5.10 Quality Assurance

In line with best practice the Coventry & Warwickshire Stroke project has undertaken the following quality assurance reviews and processes:

- Health Gateway Review 0;
- National Clinical Advisory Team Review;
- West Midlands Strategic Clinical Network Assurance;
- West Midlands Clinical Senate Review;
- Achievement of the five tests for service change will be tested in the final assurance meeting with NHS England;
- Two Integrated Impact Assessments (IIA) as the model has evolved; and
- Privacy Impact Assessment (PIA).

Each of the quality assurance reviews and processes are detailed below.

5.10.1 Health Gateway Review 0

In October 2014 the project commissioned an OGC Health Gateway 0 Review to help assure the process being undertaken. This review resulted in a rating of 'amber' (i.e. successful delivery appears feasible but issues that appear resolvable require management attention). Each of the 4 actions recommended by the OGC Health Gateway Team were subsequently addressed as follows:

- Critical path to be clearly identified – a clearly defined critical path document was produced and monitored;
- Project governance structure to be reviewed and strengthened – this resulted in clearer delineation between Commissioner and Provider roles;
- Robust risk management strategy and plan to be developed – this task was completed, and a detailed risk register maintained and shared with all parties; and
- Necessary resources required for successful delivery of the Business Case to be secured – the necessary support and resources were secured.

5.10.2 National Clinical Advisory Team Review

The project has been supported by an External Clinical Advisory Group (ECAG) comprising the following members:

- Dawn Good, Head of Stroke Services, Nottingham University Hospitals NHST;
- Dr Christine Roffe, Consultant Stroke Physician, North Staffordshire Combined HCT;
- Professor Tony Rudd, Consultant Stroke Physician, Guy's & Thomas' NHSFT and National Clinical Director for Stroke;
- Matthew Ward, Head of Clinical Practice, West Midlands Ambulance Service; and
- Rob Wilson, Cardiovascular Manager, West Midlands Strategic Clinical Network.

The ECAG was specifically invited to review the longlist of scenarios in 2014 which resulted in a more detailed exploration and development of the post-acute element of the care pathway. In addition to this, Professor Tony Rudd has visited each of the three local acute

provider sites to see the Stroke wards and meet with key staff and in doing so, provide support and guidance in the development of the clinical model.

5.10.3 West Midlands Strategic Clinical Network Assurance

From the outset of the project, the Associate Director for the West Midlands Strategic Clinical Network has been represented on the Stakeholder Board and as such, has had oversight of the development of local plans. Additionally, the regional Stroke lead for the Strategic Clinical Network has provided his support and input on request.

5.10.4 West Midlands Clinical Senate Review

A review of the clinical model was undertaken by the West Midlands Clinical Senate in line with NHS England's stage 2 assurance process. As a result, the Senate convened an Independent Clinical Review Panel chaired by Dr Nick Harding, Chair of Sandwell & West Birmingham CCG and comprised of a further 22 panel members including the national Clinical Director for Stroke, Professor Tony Rudd.

Following a review of submitted information, the Panel convened a 3-day review in January and February 2016, of which the first two days were spent with members of the Coventry and Warwickshire Stroke programme. Members of the programme met with the Panel on day 2 and included the Senior Responsible Officer; the Clinical, Finance and Project Management leads; and Stroke medical/clinical leads from the current four provider organisations.

Following the review and the updated clinical case for change document, the Clinical Senate submitted their report in May 2016 which concluded that the case for change "contains strong and compelling national and international evidence for improved stroke care and that its final iteration should result in an enhanced patient care pathway and is likely to improve patient outcomes". The Senate approved the clinical model and case for change, whilst identifying 11 recommendations to be addressed.

Project leaders met with the Senate to review completion of the 11 recommendations in July 2018. The Senate concluded that adequate work had been done to meet the recommendations. A copy of the letter from the Clinical Senate Chair is attached (Appendix 12).

5.10.5 "Five Tests" for Reconfiguration

Support from GP Commissioners

Through the governance of the project, GP clinical commissioners have been engaged with and provided support to the Clinical Review Group. The CCG Federation convened as the stroke Project Board acting as the oversight and decision-making body for the project. The CCG Federation is chaired by the clinical chair of one of the CCGs and attended by the other two clinical chairs. The CCGs evolved the Federation into a Joint Strategic Commissioning Committee in 2017. The CCG federation reviewed and approved the Pre-Consultation Business Case and proposed model on 13th February 2019.

Strengthened Public and Patient Engagement

As evidenced in section 5.2, there has been wide and deep engagement across the whole community with stroke survivors and their carers. A Patient and Public Advisory Group chaired by the Stroke Association has met regularly as part of our assurance process and advised on the process for our engagement and the appraisal of options. On-going engagement will be carried out to support the implementation of the commissioned pathway and public views will be fed into these plans.

Clarity on the Clinical Evidence Base

The clinical model which the CCGs seek to commission is based on national evidence used in developing the Midlands and East Stroke Services Specification, is in line with stroke service developments nationally and is supported by Professor Tony Rudd – the National stroke lead. Local services have been audited and assessed against best practice and local clinical engagement has supported the shaping of the model. Evidence from other areas stroke service improvements have also been used to test the design of the proposed clinical model. Sections 3.6, 3.7, 4.1, 4.3 and 4.5 of this document draw together clinical evidence base that underpinned the development of the proposed model.

Consistency with Current and Prospective Customer Choice

The CCGs as commissioners are committed to the provision of patient choice and to ensuring that patients service options are of both adequate quality and accessible.

Overall, the proposed future pathway increases patient choice of the right quality and volume of services although it is acknowledged that there will also be some changes to the locations for the provision of some services that will result in a reduction in choice:

- The provision of HASU services remains unchanged in terms of location of the service but, offers expansion in the level of cover that enables patients in North and South Warwickshire to have greater access to a HASU within 72 hours of onset of symptoms. An additional 699 patients per year are anticipated to have access to HASU/ASU as a result, which clinical evidence suggests will significantly improve individual outcomes.
- There will be increased provision and choice of ESD and CSR; currently patients within North and South Warwickshire do not have access to the right range of specialist rehabilitation services. The expansion of these community services is expected to give an additional circa 860 patients access to ESD and CSR, improving the quality of the outcome of their care through increasing access to services.
- The proposed future pathway limits the locations for provision of ASU from 3 sites (GEH, SWFT and UHCW) to one site (UHCW). The CCGs acknowledge that this reduces choice for this service but, on balance the expected improvement in service quality and outcomes through both the increased access to and quality of specialist care is considered to outweigh the reduction in choice.

Alongside this the outcomes of the engagement with patients and the public, has shaped the model to ensure that all patients will get access to specialist services when they need

them, but are returned to their own home, or into a facility close to home where they require further medical or nursing care, as soon as they are medically able.

The 5th Test

From 1 April 2017 NHS England introduced a new test for proposed service changes. This test requires that in any proposal that includes plans to significantly reduce hospital bed numbers, commissioners are expected to be able to evidence that they can meet one of the following three conditions:

i. Demonstrate that sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it; and/or

ii. Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions; or

iii. Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme).

The proposed service model does not reduce the overall number of hospital beds; it realigns the use of some beds based on robust modelling of the proposed improvements in patient pathways and a significant expansion of community services.

5.10.6 Data Protection Impact Assessment

A Data Projection Impact Assessment (Appendix 13) has been undertaken based on the services being delivered by existing providers and the proposed new model. All providers are currently subject to an existing Information Sharing Agreement. The assessment has been reviewed by the CCG Information Governance Advisory Group. The Group concluded that no immediate further actions are needed and that once the model has been agreed and as implementation arrangements develop, the assessment should be revisited.

5.11 Conclusion

Whilst the development of the Pre-Consultation Business Case has been a Commissioner-led process, it has extensively involved key stakeholders through a multi-agency project governance structure.

There is an existing, well-established evidence base for the most effective clinical models for providing stroke care, which the programme has drawn on in establishing the elements of the pathway that need to be in place for Coventry and Warwickshire.

Clinical and operational leaders alongside members of the public, including stroke survivors and carers, have played a key role in the development and evaluation of the potential scenarios for service delivery. Crucially, public engagement has also supported the co-production of the process for the non-financial appraisal of the options.

To develop the proposed model a range of options have been considered. Initial development work focused on the acute stroke pathway only (HASU/ASU, supported by ESD). Following an assessment of the clinical viability of the options on the long-list, it is evident that there is only one clinically viable scenario for acute care: centralisation of HASU/ASU services at UHCW.

ESD and community stroke rehabilitation are key services required for a high quality stroke pathway. Both need to be provided in patients homes and community settings across Coventry and Warwickshire and require some investment and development; they are not optional parts of the care model. Development work for these services has focussed on modelling the workforce implications to develop the optimal service delivery model affordable within Commissioners planned investments in stroke care.

There were a number of potential ways in which bedded rehabilitation could be provided. A long list of potential scenarios was developed and clinically assessed for viability, with two viable options remaining. A full non-financial appraisal of these options by all key stakeholder groups, identified the preferred option as the provision of bedded rehabilitation at two sites, Leamington and Nuneaton.

A clinical and operational risk assessment of the different models and a financial appraisal of indicative costs supported the outcome of the non-financial appraisal.

Our work to identify and evaluate the options for provision of the future clinical model for stroke care has therefore identified the preferred option for Coventry and Warwickshire as:

- *Centralised HASU/ASU at UHCW*
- *ESD and community rehabilitation in all areas.*
- *Bedded rehabilitation at SWFT in Leamington and GEH in Nuneaton.*

6.0 FUTURE CLINICAL MODEL

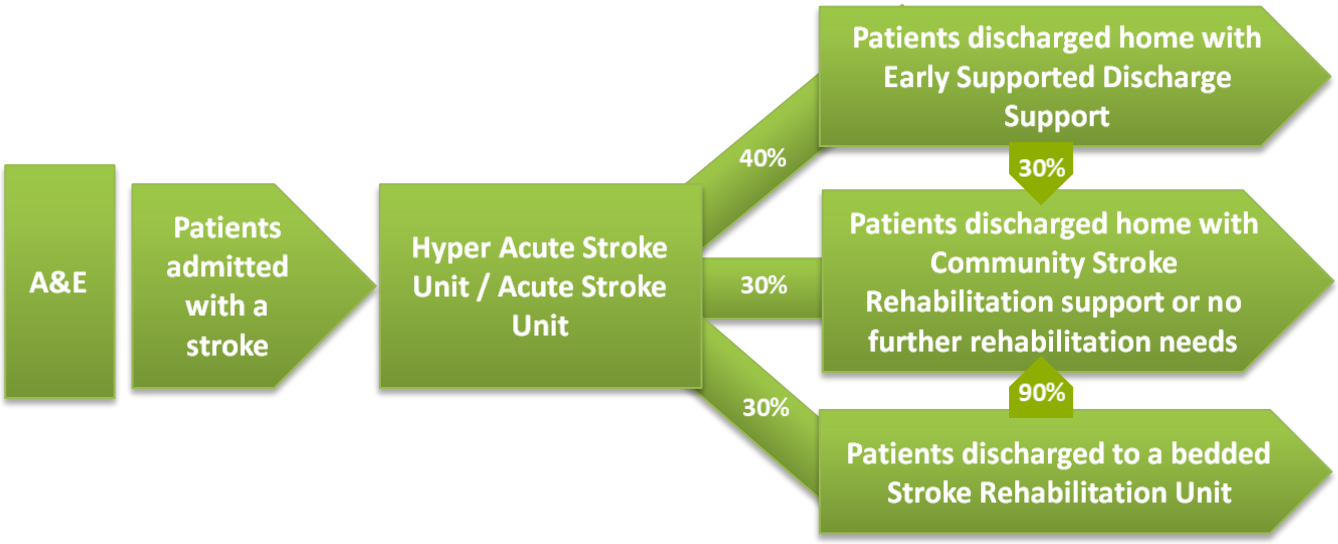
A significant amount of work has been undertaken by clinicians from across the health economy to design a new model for stroke services in Coventry and Warwickshire that will meet the clinical best practice outlined in the Stroke Services Specification developed by NHS Midlands and East and more recent updates to national clinical guidelines.

This section sets out the future clinical model and vision.

6.1 Future Clinical Model & Pathway

Patients will be seen more promptly and in the right place by specialist, skilled professionals, where they will receive the highest quality care. Once the acute episode is complete, patients will either transfer to an inpatient community rehabilitation bed or return home or to their usual place of residence with the appropriate level of community support from both health and social care services. The three CCGs are working in partnership with their partners in local authorities and the third sector to develop seamless services that support people to be as independent as possible and receive appropriate support when they need this.

At a high level, the future pathway will be as follows:



The future pathway has the following key features:

- Provision of a single centralised hyper acute stroke unit (HASU) and an acute stroke unit (ASU) at UHCW, with the necessary infrastructure, support and workforce to assess and diagnose all patients suspected of having had a stroke from across Coventry and Warwickshire, within 72 hours of onset;
- An Early Supported Discharge service;
- Community stroke rehabilitation services, and
- Bedded stroke rehabilitation services for those patients that require more intensive support after discharge from the ASU.

- All patients suspected as having a stroke will be admitted to the HASU/ASU for assessment and treatment, patients will then follow one of 3 routes depending on their clinically assessed need:
    - Discharged home with community stroke rehabilitation support, or potentially requiring no further support. Analysis of historic activity identifies this route applies to 30% of patients
    - Discharged home with Early Supported Discharge. Analysis of historic activity identifies this route applies to 40% of patients; 30% of these patients will need further rehabilitation and therapy input to reach their goals and increase their independence and will go on to receive community stroke rehabilitation support
    - Discharged to a bedded Stroke Rehabilitation Unit. Analysis of historic activity identifies this route applies to 30% of patients. 90% of patients within this cohort will, on discharge from bedded rehabilitation, go on to receive community stroke rehabilitation to achieve their optimal rehabilitation.

It is proposed that the HASU length of stay will be up to 72 hours in line with the NHS Midlands and East Stroke Services Specification. ASU length of stay will be eight days, after which patients will transfer to a bedded rehabilitation facility if they are not ready to return home.

Components of the new pathway are outlined through the rest of this section, all of which are explicitly in line with the NHS Midlands and East Stroke Services Specification.

6.1.1 Early prevention and Atrial Fibrillation

Each CCG has plans in place to improve primary and secondary prevention of stroke, including:

- Identification of patients with Atrial Fibrillation (AF) in primary care; and
- Increased anticoagulation rates for those diagnosed with Atrial Fibrillation.

During August and September 2017, primary and secondary care professionals involved with the AF and anticoagulation pathway started regular meetings to discuss, plan and agree collaborative working practices to deliver an integrated anticoagulation pathway.

The CCGs are already commissioning primary prevention improvements where there are opportunities for the better management of AF, hypertension and diabetes. Opportunistic screening for AF is underway to increase the identification of patients to bring prevalence up to the expected 2%. Work is progressing across Coventry and Warwickshire to put contracts in place with General Practice. It anticipated that contracts will be in place across the region by 31st March 2020.

In addition, a full programme of work across the diabetes pathway is underway, with an emphasis on stroke. From April 2018 the national programme for prevention of diabetes has been rolled out.

6.1.2 Pre-Hospital Care

All patients identified as having a stroke within the first 72 hours of onset will be transferred by emergency ambulance for a hyper acute assessment at UHCW. Ambulances will need to collect patients from wherever they have their stroke, as well as from Warwick and George Eliot Hospitals as some patients may self-present at their local A&E Department.

6.1.3 Hyper Acute Stroke Unit

For all patients suspected of having a stroke, the HASU will provide expert specialist clinical assessment, clinical imaging and the ability to offer intravenous thrombolysis for those who need it 24 hours a day, 7 days a week, typically for no longer than 72 hours after admission. At least 600 cases per year are typically required to provide sufficient patient volumes to make a hyper acute stroke service clinically sustainable, to maintain staff expertise and to ensure good clinical outcomes. As is shown in the activity modelling in section 7, the proposed HASU patient flow will easily meet this target.

6.1.4 Acute Stroke Unit

Acute stroke care will immediately follow the hyper acute phase, mostly after the first 72 hours of admission. The ASU will provide:

- Continuing specialist day and night care;
- Daily multi-disciplinary care;
- Continued access to Stroke Specialist Consultant care;
- Access to physiological monitoring; and
- Access to urgent imaging as required.

In-hospital rehabilitation should be assessed immediately after the person has had a stroke and commence as soon as possible.

6.1.5 Early Supported Discharge

ESD will enable appropriate stroke survivors to leave hospital ‘early’ through the provision of intense rehabilitation in the community at a similar level to the therapy care provided in hospital. The ESD service will operate 7 days a week, able to deliver immediate response to all hospital discharges and patients at risk. The service is therapy led, with medical support provided by the Stroke Consultant where required.

The team will provide intense rehabilitation at home for up to six weeks, thereby reducing the risk of re-admission for stroke related problems, increasing independence and quality of life, with support to the carer(s) and their family. Based on analysis of 3 years of activity data and the Coventry ESD service outcomes it is assumed that 40% of patients will be appropriate to receive ESD services.

Local CCGs will commission ESD using a standard ESD specification across Coventry and Warwickshire, thus ensuring equity of access, service quality and performance standards.

6.1.6 Community Bedded Stroke Rehabilitation

Community bedded stroke rehabilitation is recommended for stroke patients who are medically stable enough to not require daily medical care from stroke physicians, but have ongoing care and rehabilitation needs that prevent them from returning home. The point prevalence audits, bed audits on the UHCW stroke unit and clinical discussions have concluded that this cohort equates to 30% of the patients in an acute stroke unit at any point in time.

Local CCGs will commission community bedded stroke rehabilitation using a standard specification across Coventry and Warwickshire, thus ensuring equity of access, service quality and performance standards.

The provision of this service will be predicated on 'pulling' appropriate patients from the acute stroke unit, providing goal focused rehabilitation and facilitating an onward discharge either home or into an onward residential or care setting, should that be required. Based on local activity analysis, 90% of the patients admitted to bedded stroke rehabilitation will be discharged with community stroke rehabilitation to achieve their optimal rehabilitation.

The facility will require the wider health and care system to support onward flow and thus ensure capacity to continuously improve patient flow from the acute stroke service.

The criterion for the bedded rehabilitation facility has been determined as follows:

- Nurse led care provision, with multidisciplinary therapy interventions;
- Initial admission for up to six weeks of care and stroke rehabilitation;
- Maximum extension of a further four weeks reviewed on an individual case basis;
- Minimum of a weekly review of progress and identification of onward care and therapy needs;
- In-reach support from the ESD service to identify and facilitate the onward pathway of care, including access to the ESD/Community Neuro-Rehabilitation service; and
- Support from Social Care to support onward discharge to home, residential/nursing home placement, ensuring that the maximum period of a 10 week admission is not breached.

6.1.7 Community Stroke Rehabilitation

Stroke survivors' rehabilitation will continue out in the community after time spent in a bedded rehabilitation unit, or after their acute inpatient stay on an ASU. These services enable stroke survivors to develop a greater quality of life and independence following a stroke. Patients will access community stroke rehabilitation services following standard discharge from a stroke unit or following ESD.

The service will ensure regular review of rehabilitation goals with stroke patients, their carer(s) and families and regular review of whether the full rehabilitation potential has been achieved, so that patients can be suitably discharged from the service.

Local CCGs will commission community stroke rehabilitation using a standard specification across Coventry and Warwickshire, thus ensuring equity of access, service quality and performance standards.

6.1.8 Long-term Recovery

Stroke survivors and their carer(s) should be enabled to live a full life in the community in the medium and long-term (i.e. greater than three months). The ESD and community stroke rehabilitation teams will review all stroke patients at 6 months post stroke and offer long term access to rehabilitation for patients with a stroke-based need for multi-disciplinary team intervention. Support will be required from local services to ensure that stroke survivors receive tailored support to assist in their re-integration into the community and maximise the quality of life experienced by stroke survivors, their carer(s) and families.

6.2 Workforce

An important part of mobilising and implementing the proposed model is creating the workforce that will be required by providers to deliver the pathway.

Workforce modelling has been completed with providers as part of the development of the options for service delivery and the subsequent financial appraisal of those options. Staffing levels and skill mix have been based on the NHS Midlands and East Stroke Service Specification, which gives clear guidance on the minimum staffing levels for the various core specialist skills required for high quality stroke care. For those staff groups not prescribed in the Midlands and East Stroke Service Specification, workforce requirements were agreed based on published national guidelines for stroke services and local clinical experience. With regard to ESD and community stroke rehabilitation, local clinical experience of patient complexity, the impact of rurality and recruitment challenges have been used to adapt the proposed skill mix. The workforce model was reviewed with West Midlands CVD Network and their recommendations were used to further shape the proposed model.

The rehabilitation services (community and bedded) have been modelled to provide a 7 day service, in particular it should be noted that therapy services will operate 7 days a week, including providing immediate response to all hospital discharges and patients at risk. The capacity for specific elements of rehabilitation services will vary across the 7 days and has been modelled to match the known profile of demand. This will facilitate the flow from acute and rehabilitation beds over the weekend into the community whilst offering priority visits and intervention to these groups of patients at weekends.

It is acknowledged that as a result of local tailoring, the proposed skill mix for ESD and community stroke rehabilitation includes some deviations from the NHS Midlands and East Stroke Specification. Where the proposed workforce model is not fully aligned to the Specification the adjustments are based on responding to the clinical expertise and experience of the local clinicians.

There are strong rationales underpinning the decisions to change the skill mix profile which include:

- The proposed model has been designed to mirror that of the successful Coventry pilot described in section 4.3; a key factor in this decision is the successful outcomes the team is delivering. The most recent SNNAP results (July-Dec 18) measuring modified Rankin scores, shows that the team delivers input to a much higher percentage of moderate and severely impaired patients as compared to national levels.
- The ESD and CSR teams do not currently include nursing posts as nursing vacancies are currently high in the acute pathway, rehabilitation and community nursing both locally and nationally. Band 4 Assistant Practitioner and Band 3 Rehabilitation Technician Posts have been created within the model and their roles will include traditional nursing activities such as tissue viability and continence management.
- The model includes senior therapist posts; reasons for this include:
    - Having experienced clinical specialists on the ground and available to risk assess, manage arising daily concerns and support less experienced and unregistered staff is an essential foundation for any future plans to develop services further to provide enhanced ESD
    - Providing banding progression through all therapy disciplines was felt to be a clear and sure way of attracting, recruiting and retaining the high numbers of therapy disciplines required.
    - Band 8b psychology posts have been sustained in the model to provide governance and guidance to Band 8as as this support is not available within the existing structures outside of the stroke teams.

The tables that follow show the current stroke workforce in place in each of the providers and the proposed workforce developed to meet the needs of the future service model.

The current stroke workforce is as follows:

Role	Band	UHCW	SWFT	GEH	CWPT
Consultant		4	1	1	0
SpR		2	2.34	1	0
Stroke Specialty doctor (Fast Bleep/TIA clinics)		2	0	0	0
SHO		4	0	1	0
Dietetics	*7*	0	0.65	0.9	0
Dietetics	*6*	1	0	0	0.37
Speech & Language Therapist	*7*	0.8	0.6	0.5	1.45
Speech & Language Therapist	*6*	1	1.3	0.5	0.67
Speech & Language Therapist	*5*	0.6	0.6	0	0
Speech & Language Therapist	*4*	1	0	0.4	0
Physiotherapy	*7*	0.8	2	0	0.8
Physiotherapy	*6*	3	2	1	2.88
Physiotherapy	*5*	3	2	1	1
Physiotherapy	*2*	0	1.5	0	0
Occupational Therapy	*7*	1	1.28	0	1.64
Occupational Therapy	*6*	2.8	1.4	0	1.81
Occupational Therapy	*5*	2	1.5	0	1
Occupational Therapy	*2*	0	1.3	0	0
Therapy assistants/MTO	*4*	0	0	0	2.9
TIA support worker	*3*	1.02	0	0	0
Therapy assistants	*3*	2.79	2.3	1	4
Therapy assistants	*2*	2	0	0	0
Psychology	*8b*	0.5	0.5	0.5	0.84
Psychologist	*8a*	0	0	0	0.8
Psychology assistant	*5*	0.5	0	0	0
Pharmacy	*8a*	0.5	0	0	0
Stroke co-ordinator/Clinical Lead	*8a*	1	0	0	0.83
Stroke CNS/TIA CNS	*7*	0	1	2.6	0
Stroke CNS	*6*	1.4	2	1	0
Stroke secretary	*4*	2	0	0	0
Stroke data officer	*3*	1	0	0	1
Stroke data officer	*2*	1	2.02	0	0
Nursing	*7*	1	2	1	0
Nursing	*6*	2.8	4	4.8	0
Nursing	*5*	28.42	25.81	11.11	0
HCA	*3*	3.18	2.6	1.93	0
HCA	*2*	16.33	23.2	10.49	0
Ancillary	*2*	0	1.46	0	0
Total number of staff					**244.52**

The proposed workforce model is as follows:

Role	Band	HASU/ ASU	Bedded Rehab	ESD	Community Rehab
Consultant Physician (thrombolysis trained)		8			
SpR		3	2	0	0
Stroke Specialty doctor (Fast Bleep/TIA clinics)		2	0	0	0
SHO		4	0	0	0
Dietician	*6*	1	1	0.4	0.5
Dietician	*5*	0.5	1.63	0	0
Dietician	*3*	0	0.5	0	0
Speech & Language Therapist	*7*	0.8	2	1.6	1.05
Speech & Language Therapist	*6*	2	2	1	1.87
Speech & Language Therapist	*5*	1	2	0	0
Speech & Language Therapist	*4*	1	0	0	0
Speech & Language Therapist	*3*	0	0.5	0	0
Physiotherapist	*7*	1.8	2	2.3	2
Physiotherapist	*6*	4	4	1.8	7.1
Physiotherapist	*5*	3	2	4	3
Occupational Therapy	*7*	1	2	1.8	1.84
Occupational Therapy	*6*	3.8	4	2.3	5.8
Occupational Therapy	*5*	2	2	3.8	3
Assistant Practitioner	*4*	0	0	0	6.85
TIA support worker	3	1.6	0	0	0
Rehab Assistant	*3*	4.2	6	10.8	6
Rehab Assistant	*2*	2	0	0	0
Psychologist	*8b*	0	0	0	1.84
Psychologist	*8a*	1	1.2	1.4	1.2
Psychology Asst	*5*	0.5	0	0	0
Pharmacist	*8a*	1	0	0	0
*Stroke Services Team Leader**	*8a*	1	0	0.9	0.9
*Stroke Clinical Nurse Specialist**	*7*	1	0	0	0
Stroke Fast Bleep Holders	*6*	6	0	0	0
Medical Sec	*4*	2	0	0	0
Data Clerk/Admin	*3*	1	2	2.5	0
Admin	*2*	1	1	0	0
Ward Sister	*7*	1.2	2	0	0
Ward nurse	*6*	5	2	0	0
Ward nurse	*5*	38	29.5	0	0
HCA – ward	*3*	8.2	3.2	0	0
HCA - ward	*2*	21	19.2	0	0
Orthotics		0	0.24	0	0
Total number of staff					**306.12**

*These roles will be working on opposite shifts to provide 7-day specialist cover to HASU/ASU

6.3 Conclusion

To deliver the NHS Midlands and East Stroke pathway and to achieve the step change improvement that has been achieved by other health economies in areas of best performance, we need to change the way that stroke services are collectively provided across Coventry and Warwickshire.

The new networked stroke pathway proposed has been designed based on the best practice evidence available, incorporating HASU, ASU, bedded rehabilitation, ESD and community rehabilitation support services. It will ensure that all stroke survivors can access the right standard of stroke specialist ESD and community stroke rehabilitation, providing evidenced based care to reduce the level of disability of those who survive a stroke.

The proposed future service model for stroke care described in this Business Case will meet the projected population demands and support providers to achieve the best practice standards for anyone on the stroke pathway.

The new networked workforce model and pathway when commissioned will place the local providers in the best position to overcome the current recruitment challenge and gap between the number of stroke specialist staff we need and those employed.

The NHS Long Term Plan and National Stroke Programme set out national ambitions for improvements and new developments in stroke services such as mechanical thrombectomy, to further increase stroke survival and rehabilitation outcomes. Crucially, the proposed new clinical model for stroke in Coventry and Warwickshire will establish a service structure and pathway that gives the foundations for these improvements in stroke care to be delivered.

7.0 FINANCIAL AND ACTIVITY IMPACT

Finance and activity modelling have been undertaken to estimate the likely impact on patient flows, costs and potential savings from the potential new models. The results of this work provide evidence to demonstrate that the proposed new model is affordable.

7.1 Financial Appraisal of Remaining Options

Following an assessment of the clinical viability of the potential options for a new model of stroke services, it was evident that:

- there is only one clinically viable scenario for acute care: centralisation of HASU/ASU services at UHCW
- ESD and community stroke rehabilitation are key services required for a high quality stroke pathway. Both require some investment and development across Coventry and Warwickshire; they are not optional parts of the care model.
- There is more than one possible way to provide bedded stroke rehabilitation.

Based on the options development and appraisal the financial case has been prepared on the basis of a do-nothing comparison to a centralised model for HASU/ASU. Modelling for ESD and community stroke rehabilitation has been based on a clinical assessment of the workforce needed to provide these services. A smaller financial options appraisal was undertaken to develop indicative costs for the following options for bedded rehabilitation:

Option 1 - Bedded rehabilitation at SWFT in Leamington Spa and GEH in Nuneaton.

Option 2a - Bedded rehabilitation provision in the Coventry area, not on an NHS hospital site, with specialist therapy in-reach; one bedded rehabilitation unit at SWFT in Leamington Spa and one bedded rehabilitation unit at GEH in Nuneaton.

A lack of clarity on how clinical and operational risks could be mitigated and market availability of beds have made this option difficult to quantify. Pathway costs are subject to significant variation dependent on the location, spread of patients and the exact service support put in. Best estimates of the costs range from this option saving £135k on Option 1 to incurring an additional £200k per annum, assuming that therapy support needs doubling and with medical support going into the facilities. Given the risks identified in section 5.8, the actual pathway required to deliver this option could be beyond this cost base.

Option 2b - One bedded rehabilitation unit at SWFT in Leamington Spa, one bedded rehabilitation unit at GEH in Nuneaton and one bedded rehabilitation unit at the Hospital of St Cross in Rugby.

This pathway when costed was £788k per annum more than Option 1.

The results of the risk assessment (section 5.8) provide a strong steer from the clinical and operational leaders of stroke services that:

- Option 2a has significantly higher levels of clinical and operational risk than Option 1.
- Option 2b poses higher risks of an inability to recruit and a significant risk of having an adverse impact on wider NHS provider sustainability in the health system, than both Option 1 and Option 2a

The above financial appraisal provides a high level, indicative financial test only. Option 1, as the clinically most viable option and preferred option from the non-financial options appraisal, has been used as the basis for the financial case that follows.

7.2 Bed Modelling

Bed capacity modelling has been undertaken to establish the number of beds that should be required to manage demand through the current service model (do nothing state) and for the proposed future clinical model. Modelling for the proposed new clinical model has also been tested to ensure achievement of SSNAP measures.

Activity for 2017/18 was used to form the baseline for modelling, with growth of 1.07% assumed annually. Appendix 14 details the assumptions applied to the activity to complete the modelling and their source/evidence base. Cross boundary activity involving Coventry and Warwickshire's bordering providers (University Hospitals of Leicester, Worcestershire Acute Hospital and Birmingham Heartlands Hospitals) was also analysed to identify any potential impacts. The resulting cross-boundary flow of activity was found to be minimal.

The results of the activity modelling on the required bed numbers are shown in the table below:

Bed and Service Provision: Current vs Future State

Bed/Service provision	Current	Future	Difference (Beds)
Hyper Acute Stroke beds	6 beds at UHCW	12 beds at UHCW	+ 6 beds
Acute Stroke beds	30 ASU beds at UHCW 12 ASU beds at SWFT 18 ASU beds plus 1 assessment bed at GEH (Total 61 beds)	31 ASU beds at UHCW	- 30 beds
Community Stroke Rehabilitation beds	6 inpatient rehabilitation beds at Rugby site, UHCW for Rugby patients aged 65+ 20 inpatient rehabilitation beds at Leamington site, SWFT for SW patients only (Total 26 beds)	17 for C&R CCG (preferred option 9 in SWFT/8 in GEH) 12 beds in SW (SWFT) 10 beds in NW (GEH) (Total 39 beds)	+ 13 beds (N.B. different specification of beds)
Total bed numbers	**93 beds**	**82 beds**	**- 11 beds**

In establishing the future bed base, the following assumptions about the patient flow through the proposed future clinical model were made:

- HASU length of stay would continue to be up to 3 days;
- Acute length of stay is expected to reduce from the current 18 days (spell average) to 11 days at day 1 of introduction of the full pathway, reducing further to 7 days from

year 2 of the new pathway being implemented. The implementation plan for the proposed new model introduces and embeds the new community rehabilitation services in phase 1, to make the necessary changes to patient flow to reduce length of acute stay in advance of centralising the HASU and ASU services.

- Following their stay on the ASU, patients will be discharged as follows:
    - 40% of patients will be discharged with a standard ESD package
    - 30% of patients will transfer to bedded rehabilitation provision
    - 30% of patients will be discharged with community stroke rehabilitation.
- Community stroke rehabilitation will also support 30% of the patients completing ESD and 90% of the patients discharged from bedded rehabilitation.
- Bed occupancy rates have been agreed with clinical input from providers to enable the pathway to manage peaks in demand and to deliver the patient flow necessary to sustain the existing HASU/ASU bed ringfencing policy. The occupancy rates applied are as follows:
    - HASU – modelled assuming 85% occupancy
    - All other Stroke related beds – modelled assuming 90% occupancy

The proposed new clinical model results in a redistribution of the current stroke bed capacity and an overall reduction of 11 beds in the total number of stroke beds required. These beds will be reallocated to other hospital specialisms, recognising the demand pressures for other acute hospital beds in the system from demand growth and given the need to ensure that patient flow is maintained.

7.3 Activity Impact

A detailed model of patient flow through the system was constructed with clinical engagement and using points prevalence audits to test and refine assumptions (Appendices 14-16). The tables below show a comparison of activity flows through the Coventry and Warwickshire acute hospitals through the current versus the proposed future pathway, for each of the acute provider organisations. This illustrates the potential impact that the centralisation of HASU/ASU is likely to have on both patients and providers.

Activity Impact

	UHCW		GEH		SWFT	
	Current	Future	Current	Future	Current	Future
Suspected stroke patients – arriving by ambulance	2,077	3,091	437	-	577	-
No of patients assessed in A&E	2,336	3,345	659	224	820	246
Patients transferred to UHCW HASU	-	-	-	120	-	109
No of patients Treated in HASU/ASU	1,053	1,752	281	-	418	-
No of patients to receive bedded rehab			-	170	-	179

Early supported discharge and Community Stroke Rehabilitation	Coventry and Warwickshire
No of patients to receive ESD	465
No of patients to receive CSR	803

Due to the likely increase in patient journeys identified within the proposed new model we have directly engaged with NHS West Midlands Ambulance Service (WMAS) to enable them to model patient journeys under the proposed future model. This modelling completed by WMAS has identified that implementation of the proposed new model will result in an additional 2.78 ambulance journeys per day. WMAS have confirmed that this increase could be planned into their annual workload. The WMAS modelling report can be found in Appendix 15.

Specific review and agreement of the proposed model was sought from NHS England Specialised Commissioning to ensure that the changes proposed would not impact on the services commissioned by them. A letter of support in principle from Specialised Commissioning has been received.

7.4 Financial Modelling

The financial implications of the proposed new model have been assessed through joint work between commissioners and providers. The results have been discussed at STP level and the following principles have been agreed by both commissioners and providers:

- The bedded part of the stroke pathway (i.e. HASU/ASU and bedded rehabilitation) will continue to be covered by tariff under the current tariff cost envelope.
- The three CCGs will invest the required amounts in the additional ambulance transfers, elements of prevention and the community stroke rehabilitation pathway.

The agreement that tariff will cover the bedded elements of the proposed new pathway has been used to set an overall financial envelope. This will be recast for the latest tariff at the time of implementation. The three local acute providers have agreed to operate the model within this envelope and to jointly mitigate and manage any risks associated with this element of the pathway, having assessed the costs of delivery and scope for efficiencies.

It is important to note that there will be no savings to Commissioners from the planned stroke bed base realignment outlined above. Tariff will continue to be paid on the nationally set basis.

The level of investment required from CCGs into the community elements of the pathway has been calculated based on the activity modelling and costing of the proposed workforce models and associated service delivery costs. Further details on the commissioner investments are provided in section 7.4.2

In line with the agreements and assumptions identified above, estimates have been produced by Commissioners and Providers of the impact on income, activity and costs under the current model and the future model options, both at system and individual provider level. These estimates have been based on 2017/18 planned activity and prices to enable a consistent approach to be taken.

The table that follows compares the costs for both CCGs and providers of the current and preferred option.

	Current Investment by CCGs	Proposed Model	Change from Current Investment	UHCW	GEH	SWFT	CWPT	Other
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Acute HRGs	10,440	9,312	-1,128	9,312				
Rehabilitation	2,478	3,980	1,502		1,990	1,990		
Bedded facilities			0					
Acute Outpatients	642	642	0	642				
Acute elements	**13,560**	**13,934**	**374**	**9,954**	**1,990**	**1,990**	**0**	**0**
Community - ESD and Rehab	1,663	4,775	3,112			2,669	2,106	
Ambulance extra journeys		171	171					171
AF Net investment		128	128					128
Community elements	**1,663**	**5,074**	**3,411**	**0**	**0**	**2,669**	**2,106**	**299**
Total cost of pathway/model	**15,223**	**19,008**	**3,785**	**9,954**	**1,990**	**4,659**	**2,106**	**299**

Notes:

- The original investment envelope was £13.1m (2017) but this has been revised upwards due to changes in the national tariff.
- Current Acute HRG spend based on 19/20 plan and as such within Provider and CCG baselines
- Community costings – taken from Provider costings

7.4.1 Inpatient Bedded Care Costs

The cost of hospital bedded care will remain the same for CCGs with the three acute providers agreeing to deliver within the current funding. All three acute provider Boards have confirmed in writing their sign up to this agreement and to jointly managing and mitigating any risks arising.

The financial impact of the proposed model was assessed through joint work with providers to agree the likely impact. The table that follows shows the position from the acute provider perspective:

	Cost of Proposed Model
	£000s
Acute Inpatient	9,312
Rehabilitation	3,980
Acute Outpatients	642
Acute elements	**13,934**

	Funding Envelope
	£000s
HRG Tariff	10,440
Rehabilitation	2,478
Acute Outpatients	642
Funding by CCGs	**13,560**

Difference	**374**

Please note that the following assumptions have been made in this analysis:

- Total acute costs for UHCW, GEH and SWFT are paid on a cost and volume basis at national tariff.

- Staffing has been costed on updated pay levels.
- A risk share arrangement is in place for under/over activity based on length of stay.
- The Trust income changes (and therefore the CCG costs) have been calculated based on the effects of the change to Atrial Fibrillation anticoagulation therapy only. Evidence indicates that there is the potential to avert 230 strokes over three years across the three CCGs (NHS England Atrial Fibrillation QIPP Report 2012/13). NICE estimates the average cost of acute and community care for one stroke at between £12,228 and £40,000 per year. However, there are additional costs associated with delivering this part of the pathway in terms of prescribing and patient identification, which make this a small net cost overall.

Further assumptions have been included relating to length of stay as described in the following section.

Length of Stay Assumptions

The centralised service model improves Commissioner and Provider financial sustainability.

The baseline activity data used for modelling reflects a current average length of stay per spell of 18 days. Given the current limitations on availability of stroke rehabilitation beds, the current acute spell length is believed to include some rehabilitation level bed days, which is therefore inflating the reported average acute stay.

The proposed new model of care sets a target of 11 days for the average acute length of stay (i.e. HASU/ASU total stay). This is based on a prudent expectation of the acute length of stay reduction that will be achieved through establishing comprehensive ESD and community stroke rehabilitation. The reduction in length of stay helps to lower the bed requirement for acute stroke from the existing bedded quantum at the three sites to the equivalent of 12 additional beds at UHCW.

For Commissioners, the provision of alternative rehabilitation options will reduce the average length of stay needed within an acute setting by creating services which actively ‘pull’ patients who are medically stable and in need of rehabilitation into non-acute settings which are more appropriate and closer to home.

The 11 day average acute length of stay is noted as being a prudent estimate when compared with other similar models in England evidencing a 7 day average length of stay. As discussed in section 4.3, evidence from the evaluation of other systems in England that have already centralised stroke admissions supports the assumption that investment in community services will deliver a reduction in length of stay. Further, local evidence from the implementation of the ESD and community stroke rehabilitation in Coventry has already demonstrated a significant reduction in acute length of stay for Coventry patients. The three local acute providers report current average acute stroke lengths of stay of between 12 and 14 days. It is therefore recognised that a proportion of the overall reduction in length of stay required has already occurred and gives credence to the deliverability of the business case.

The development of this Business Case coincides with the release of 11 decant beds at UHCW, which were created to enable fire stopping works at the Trust. These beds will accommodate the bed requirement transfer to UHCW. The prudent assumptions on the

expected length of stay further mitigate the capacity risk at UHCW. To transact this, commissioners have agreed an unbundling methodology with UHCW.

It is important to note that there will not be any overall bed closures for the system; beds not required for stroke care will be transferred to other specialties as required by demand.

7.4.2 Commissioner Costs

As stated above, it has been agreed by all three Commissioners that they will fund the additional costs required in the community elements of the pathway.

As with the acute costs, joint work with providers has been undertaken to calculate the cost of these changes, based on activity modelling and costing of the consequent workforce model and associated service delivery costs. The resultant total investment and split between each of the three CCGs has been agreed and signed off by CCG Governing Boards as follows:

- NHS Warwickshire North CCG 17th July 2019
- NHS Coventry and Rugby CCG 17th July 2019
- NHS South Warwickshire CCG 17thJuly 2019

The table below compares the costs for both CCGs and community providers of the current and proposed model.

	Current Investment by CCGs	Cost of Proposed Model
	£000s	£000s
Community - ESD and Rehab	1663	4,775
Ambulance additional journeys		171
AF Community investment		128
Community elements	**1,663**	**5,074**

Additional cost of community model	3,411
Additional cost of Acute model	374
Less savings on CHC packages	-700
Net additional CCG investment required	**3,085**

Agreed split by CCG:

CRCCG	300	1,283
SWCCG	440	547
WNCCG	1,008	1,254
	1,748	**3,085**

This analysis indicates that the CCGs will be required to invest a further £3.1m in the community pathway. The agreed split of investment between the CCGs is as shown in the table above. Proposed investment levels are within CCG financial plans for 2019/20 (on a part year basis) and 2020/21 (on a full year basis). The five-year financial plan being developed will also include the impact of this service provision.

The proposed new stroke pathway is expected to improve patient outcomes, leading to a reduction in the costs of long term packages of care. Savings of £700k have been assumed

across Coventry and Warwickshire. These savings have been assumed as a source of funding for the additional community-based costs (including Atrial Fibrillation anticoagulation therapy) of the proposed pathway, reducing the additional CCG investment requirement.

The estimate of costs has been based on the following assumptions:

- It is based on a current cost breakdown received from providers. Current staffing levels will be altered in line with business case assumptions. It has been assumed that income will cover costs under the proposed model.
- ESD: up to 40% of all Coventry and Warwickshire patients would receive this service. This is consistent with what is known about the numbers of patients receiving the current Coventry service and take-up rates. Further details of the modelling used to predict ESD demand can be found in Appendix 16.
- Community stroke rehabilitation: costs have been included for the provision of a service throughout Coventry and Warwickshire which meets the Midlands and East Service Specification.
- Ambulance service: additional funding will be required as a centralised model will increase the number of emergency transports into the specialist centre following a 999 call and also the number of non-emergency journeys as a result of repatriation for rehabilitation. The estimated activity impact of this and associated costs have been worked up by WMAS.

In line with the Implementation Plan for the proposed new model, the cost of the community pathway has been assumed to start at an earlier stage than the bedded pathway, to enable the pull of patients through the system to be created and embedded before implementation of the acute centralisation.

7.4.3 Impact on Social Care Costs

The financial impact of improved stroke management on Social Care costs has not been included in the costings due to there being:

- no increase in the number of stroke patients that social care will be supporting; the new model will change the flow of patients through the system, not the volume and should reduce patients' level of dependency through the enhanced rehabilitation. Therefore, there are not expected to be any additional costs incurred by the Local Authorities
- there being net anticipated savings to the Council from improved patient outcomes that are not necessarily attributable to the CCGs.

It should be noted that similar stroke models piloted in other parts of the country have observed significant reductions in post-stroke Social Care packages. In Essex, a shift took place from 8.9% of strokes requiring a Social Care package before implementation of the new stroke pathway to 2.7% after implementation. It is estimated that this could save around £2m across all 3 CCGs if this percentage reduction is applied to the projected strokes in this business case.

7.4.4 Financial Risks and Sensitivity Analysis

A number of financial risks have been identified which are described in the table below.

Risk Number	Risk	Description	Value estimate (£m)	Provider (£m)	Commissioner (£m)	Recurrent?	Level of Risk	Basis	Mitigating actions
1	Risk Share	The proposal is that tariff is risk shared for acute length of stay at under 11 days.	1.4	1.2	0.3	R	High	Currently above 11 days as a system	Agreement has been reached that Providers will take the risk on the bedded part of the Stroke pathway. Work with Clinical leads undertaken with expectation that pathway can deliver better than 11 day length of stay. Contract approach and clauses should mitigate. Acute Length of stay will reduce with introduction of bedded rehab, which accounts for a substantial part of current Acute length of stay.
3	Bed Opportunity Cost	The movement of bed usage may not result in an income neutral equivalent service being re-provided within the Trusts.	0.4	0.4		NR	High	Trust Estimate on possible income loss	ESD already in place for CRCCG, 6-9 months implementation is anticipated at most. Clear communication of issues during implementation phase with recovery actions. Contract approach will be to pay for reasonable levels of transition with limits on reasonable adjustment set. Delay on implementation of the next phase would be the ultimate mitigation.
5	Provider Efficiency	Sensitivity analysis shows that there is a risk of additional beds in both HASU/ASU needed for peak times	1.2	1.2		R	Medium	Assumption based on additional 5 days LOS, 6 beds at £200k per bed.	Peak times will be managed through overflow and through occupancy being allowed to be greater than 85%. Sustained period of peak flow unlikely.
9	CCG Community Savings	CHC Community package investment and AF Prevalence assumptions	0.7		0.7	R	Medium	Based on NICE guidance, but without certainty as to where savings occur.	Prudent assessment of impact of AF already in place. Community package impact will be taken out of budgets as part of investment plan, but prudent assessment of valuation taken.
11	Tariff Changes	Tariff has been based on 2019/20 tariff levels and these will change impacting on commissioners/providers. As an STP this should only move the deficit.	0.0			R	Medium	Tariff changes each year. Could change as contract basis may change. Not financially valued.	Zero impact confirmed for Health Economy
TOTAL			3.7	2.8	1.0				

As described in section 7.2 above, bed capacity has been modelled on the basis of running the proposed new model with bed occupancy of 85% in HASU and 90% in all other beds, in line with accepted best practice. Sensitivity analysis has been undertaken to test the resilience of the resultant bed numbers, modelling the impact of an increase in acute length of stay and variations in the total volume of strokes through the model. In terms of acute length of stay it has already been shown that the creation of dedicated rehabilitation beds alone should reduce the required number of beds to the level for 11.5 length of stay. An increase in the overall total number of strokes is a more likely risk to the model. Planning bed capacity based on the occupancy rates used means that occupancy should be low enough to offset the sensitivity around this in the short to medium term. Increased numbers should only be needed for very high peak times as outlined within the risk table. The health economy will need further conversation if this does peak in a sustained way above this level.

The results of the sensitivity modelling are shown in Appendix 17. This has been included within the risks.

7.5 Conclusion

The financial analysis indicates that the CCGs would be required to invest £3.1m to deliver the proposed model of care. The three CCG Governing Boards have agreed to invest this level of funding and included their respective proposed investments in financial plans for 2019/20 (on a part year basis) and 2020/21 (on a full year basis).

Working together, the three acute providers have agreed to deliver the hospital bedded elements of the pathway within the national tariff and a joint risk share arrangement is in place for under/over activity based on length of stay. Some modest financial savings will accrue to the CCGs as a result of the new model (£0.7m from the impact of improved anticoagulation therapy for AF and reduction in long term NHS funded packages of care through the improved rehabilitation offer).

This is considered an appropriate investment to make to increase quality, improve outcomes and access and address the key issues outlined in this business case.

After the consultation process and as part of mobilisation, further work will be undertaken on the timing of the required investments.

8.0 IMPLEMENTATION

This section outlines the next steps for the CCGs to proceed to implementation of the proposed future clinical model for Stroke services.

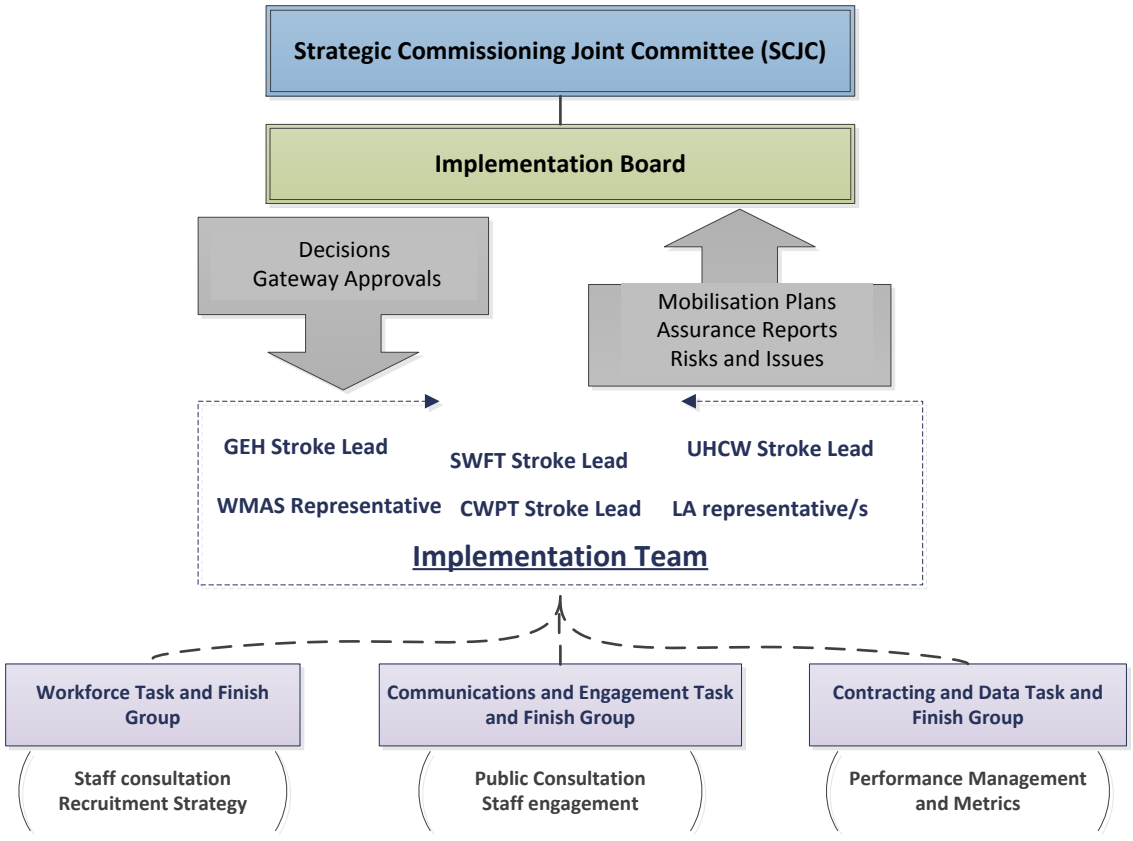
8.1.1 The Process Following Consultation

Once the final pathway has been identified following public consultation, the project will move into the contracting and implementation phase. As Commissioners commence the contract process, they will focus on the governance arrangements with accountability routed through the Strategic Commissioning Joint Committee (SCJC) formed from the three CCGs of Coventry and Warwickshire.

Implementation will be overseen by the formation of an Implementation Board, chaired by a Chief Executive of one of the provider organisations (to be nominated), with membership comprising at least one Executive from each of the provider and commissioner organisations.

It is expected that the governance structure for the implementation process will be as set out in the diagram below.

Governance Structure – Implementation Phase



The Implementation Board will meet every two months. Providers will agree arrangements for project management support and leadership at the start of the implementation phase. The Implementation Board will have responsibility and accountability for signing off progression through the implementation gateways defined. The governance responsibilities associated with implementation are in addition to the existing and ongoing duties commissioners and providers have for monitoring and performance managing the delivery of patient services.

It is proposed that the already established Stroke Clinical and Operations Group will reconfigure to become the Implementation Team, with day to day responsibility and accountability for managing the delivery of the new networked clinical model. The C&W Stroke Implementation Team membership will comprise a minimum of a Stroke project lead from each provider organisation and representation from West Midlands Ambulance Service, both Coventry and Warwickshire Local Authorities and any other key stakeholders identified as critical to the delivery of the future pathway.

In line with best practice project management, the Implementation Team will be responsible for ensuring that mobilisation plans (including timelines) are provided and adhered to, providing formal assurance reports and escalating any risks and issues to the Implementation Board and SCJC as appropriate. They will also be responsible for monitoring achievements against the benefits plan which will include; the regular performance review of patient flow through the system, outcome data, staffing skill mix effectiveness and ensuring that defined gateways are achieved before transitioning to the next phase of implementation. This is a complex programme of implementation, delivered in phases with defined "go/no go" gateways. On the basis of the performance and progress review, the Implementation Team will make recommendations to the Implementation Board for approval regarding progress and/or suggested amendments to the implementation plans.

Individual providers will be responsible for establishing their own internal governance structure and mobilisation plans for their specific elements of the model.

8.1.2 Commissioning of Future Stroke Pathway

The Commissioners have undertaken an options appraisal of the available contractual mechanisms and procurement routes in order to recommend the most effective way of commissioning the integrated stroke pathway. In assessing the contract mechanisms and procurement routes the commissioners considered the following factors:

- Local needs and profiles;
- Sustainability;
- Continuity;
- Value for money
- Affordability;
- Stability
- Deliverability, and
- Procurement Law and Guidance.

After assessing the options, the Commissioners intention is to move to a Lead Provider arrangement with mandated sub-contractors as this should give the best opportunity for an integrated model of care and an integrated workforce across the future pathway

CCG Commissioners recognise that there is further work required to underpin the future contracts with robust outcome measures, performance indicators and clinical protocols in order to support the principle of integrated care, continuous improvement and ensure

patients flow seamlessly through the pathway. These will be developed in collaboration with providers.

8.1.3 Implementation

Implementing the proposed new clinical model represents a significant change to current services and as such will be a complex process.

We are currently in the early stages of implementation planning as the focus to date has been on comprehensively engaging with all key stakeholders to design the most appropriate service delivery model. Therefore, and, acknowledging that greater detail will be provided during and following consultation, the present outline implementation timeline is provided below. A high-level project plan Gantt chart illustrating the key tasks and project gateway decision points is attached at Appendix 18.

Business Case	
Business case complete	June 2019
NHS England Assurance process commences	June 2019
Consultation period	October 2019 –January 2020
Governing Bodies consider consultation results and decision made (BC updated with consultation outcomes)	January 2020 - February 2020
Contract signed	March 2020
Proposed Mobilisation and Implementation should pathway be agreed	
Community pathway mobilisation/ implementation	
Recruitment commences to ESD and CSR posts	March 2020
Mobilisation of ESD and CSR	May 2020
ESD and CSR fully implemented	Jan 2021
Acute pathway mobilisation/ implementation	
Recruitment commences to acute posts	March 2020
Adequate acute staffing in post. Go/No Go gateway decision	Jan 2021
UHCW: additional HASU/ASU beds implemented	April 2021
SWFT: ASU beds closed / SWFT CSRB implemented	
GEH: ASU beds closed / GEH CSRB implemented	
Complete pathway implemented	**April 2021**

8.1.4 Workforce

The workforce model for the proposed new clinical model is based on ensuring that the system has the right skills to manage patients complex and varying needs, in the right setting. It has also been developed based on understanding the current local and national recruitment pressures, to seek to optimise where we are targeting workforce expansion. For example, recognising that we currently have high levels of nursing vacancies in the acute stroke pathway, Band 4 Assistant Practitioner and Band 3 Rehabilitation Technician posts in the ESD and community stroke rehabilitation services will include traditional nursing activities such as tissue viability and continence management, so that our nursing recruitment can be focussed on enhancing the acute team.

The workforce required for the future clinical model represents a significant increase in the numbers of staff in the stroke services workforce in Coventry and Warwickshire. It is recognised that this will present a significant challenge given the current difficulties faced in recruitment and is therefore identified as a key implementation risk, with mitigation plans

agreed. Critically, the implementation plan has been designed to include key clear gateway criteria for progression with the implementation of aspects of the proposed new clinical model, many of which are based on levels of recruitment to new posts achieved.

A Workforce Group has already been established as part of the STP-wide Workforce action to manage recruitment. The group will work closely with colleagues in the Cardio Vascular Disease Network and Health Education England in recruiting to and shaping the workforce. This group will take the following actions to manage the recruitment process and deliver our workforce plans:

1. Assess the **current skill mix and competencies** of the workforce against the recognised national competency frameworks, to give a clear indication of where new skills should be recruited and which new posts should be prioritised. Further to this the effectiveness of the workforce skill mix will be regularly reviewed as part of the routine review of the achievement of expected outcomes and benefits and responding to any staff turnover.

2. With regard to **nursing recruitment challenges**, we will recruit more experienced nurses from within the existing workforce. We will use targeted recruitment processes and work closely with local universities to highlight opportunities within stroke services. We will give opportunities for the development of existing staff who would like to progress into more specialist band 6 and 7 roles within the nursing team. We will put a development plan in place to offer newly qualified and less experienced nursing staff opportunities to gain experience within the specialist wards as part of a rotational training process. We will offer targeted training to ensure that the necessary competencies are readily available in both the acute and community nursing workforce. We will rotate band 5 nurses through ASU, bedded rehabilitation and community services to give them a broad understanding of the pathway and develop the skills required to deliver care in a seamless way. We will offer rotational opportunities at band 6 and 7 for nurses to enhance the ability to retain this important workforce.

3. Within **therapy services**, nationally there is no current shortage of staff at band 5, there are however challenges in retaining staff at this level and a consequential high turnover, due to limited progression opportunities, particularly noted in some fixed community posts. The presence of clinical specialism within the therapy offer can act as a draw and a clear range of skills and specialists to learn and develop from. Consideration will be given to providing rotational opportunities between services once the model is embedded and this should increase competency, neuro skill and retention at a band 5 level, at least in some posts. We will need local specific actions to recruit experienced band 6 and higher posts. We will run an internal STP wide development programme around the stroke pathway to attract and retain experienced workforce. The band 6/7 physiotherapy and occupational therapy posts in the new structure will be clearly differentiated, to allow current post holders to be clearly slotted into the roles and to attract new employees. We anticipate a shift of band 6/7 experience and clinical experts from acute services into community services as the rehabilitation offer increases in the community, this will allow flow through for

lower banded staff to move into their first Band 6 or 7 position in an environment of increased governance and support in bedded units and we would expect this trend to continue and allow a sustainable workforce from OT and PT perspective.

4. For **medical recruitment**, the role of Consultant Stroke Physician is recognised nationally as being a shortage specialty and recruitment to the proposed establishment will be a challenge. Promoting a new "stroke pathway of excellence" for the area with a minimum 1:6 on-call rotation should make the posts more attractive to new consultants in particular. The opportunity to have varied input across the whole pathway will also be attractive. Recognising the challenge in recruiting, despite our attractive service model, this has been identified as a key risk to implementation. We have designed our implementation plans to mitigate the risks to delays in implementing the future clinical model, through phased implementation of the model. We will work with HEE and the local Deanery to agree additional training placements locally at F1, STR and SPR level.

5. We will include **new and extended roles** in the pathway in the medium term. We will seek to develop extended scope practitioners, including extended scope nursing roles, therapy roles, physician's associates and extended scope pharmacists. Having the HASU/ASU on a single site will make the mentoring and support of these roles less complicated and will offer opportunities to develop skills based, rather than qualification-based job roles. This approach could also be applied to more junior roles with the introduction of nursing associates and assistant practitioners, both within nursing and therapies, to extend the scope of skills delivery. Additionally, we will use apprenticeships to develop HCA and therapy assistant roles.

6. We will put in place **retention and reward strategies** across the health economy to help retain the workforce. This approach will help to secure additional short-term staffing, whilst the new pathways are established, and staff gain confidence in the delivery model.

Timescales for recruitment

Subject to the consideration of the outcome of public consultation and assuming that CCG Boards approve the implementation of the proposed model in February 2020, recruitment to the new workforce model would start in March 2020. The high-level project Gantt chart attached at Appendix 18 sets out the timescale for recruitment for the key workforce groups.

It is important to note that whilst the implementation of the proposed new model will be phased, with ESD and community stroke rehabilitation introduced first and centralisation of HASU/ASU occurring after these rehabilitation services are fully mobilised, recruitment to key posts within the new HASU/ASU model will start immediately after CCG Board approval, i.e. in March 2020. This is a key requirement for mitigating the risk of delays in recruitment given the national shortages of specialist staff in specific key areas such as Stroke Consultants. Recruitment to the ESD and community stroke rehabilitation teams would also start in March 2020.

A whole health economy wide induction process for those people joining the pathway, both for existing staff and for those new to the team, will be required. This will have the dual benefits of enabling everyone to have a common understanding of the pathway and where they fit within the services and support the development of an integrated networked approach across the team that is not dependent on the employing organisation, but on the delivery of the pathway.

8.1.5 Risk Analysis

This is a complex service reconfiguration and as such work has already taken place to identify the potential risks to delivery of the proposed new clinical model and to develop appropriate mitigation plans. The key risks identified are as follows:

Workforce: The inability to recruit the necessary staff and reconfigure existing staff as required by the new clinical model.

In mitigation implementation will be phased with clear thresholds for gateway progression to ensure that the service is safely mobilised and embedded. The establishment of a clinical network workforce model is seen as a key benefit for recruitment as well as quality of care and whilst initially being applied to Consultants, the principle will be reviewed with respect to its value for other major staff groups such as nurses and AHP staff. Mobilisation of the rehabilitation services will be front-loaded enabling extra time to complete Consultant recruitment before the centralisation of the HASU/ASU services. Whilst the intention is to recruit to a networked model of Stroke Consultants, recognising the recruitment challenge, alternative mitigating workforce strategies have been outlined by the providers to enable progression to centralisation should only 50% of the new consultants required be recruited. Core to these is the separation of the rehabilitation beds Consultant cover from the HASU/ASU. Establishment of a Workforce Workstream is underway to oversee the workforce challenges and proposals, also acting as the link with the West Midlands Deanery and West Midlands Health Education. The specific situation at the time of each gateway review will be considered by the Implementation Board and the relevant mitigation plan will be enacted should recruitment not be progressing as planned.

Capacity: Whether sufficient capacity at UHCW can be developed and sustained to be able to manage any peaks in demand for the HASU and ASU services and any delays in patient flow.

In mitigation, capacity planning has been completed using the latest available data and clinically agreed assumptions on the impact of the new model on patient flow. Bed occupancy of 85% for the HASU and 90% for the ASU has been assumed and sensitivity analysis completed which demonstrate that the system is resilient to expected peaks in activity. In addition, implementation will see rehabilitation services implemented first to enable the impacts on acute length of stay to embed prior to the centralisation of the HASU/ASU service. Review and oversight of the implementation of the new service model will be managed by an Implementation Board that includes all providers within the networked model, to ensure alignment and joint ownership of any issues and actions.

9.0 CONCLUSION

This document has described how stroke services are currently provided across Coventry and Warwickshire, the current gaps and inadequacies with these and our proposal for change.

It is clear from the analysis of current services that there is considerable unwarranted variation in the range and quality of service provision for patients across each CCG footprint in Coventry and Warwickshire. For example, access significantly differs to inpatient rehabilitation beds, specialist community rehabilitation and ESD dependent on where patients live within the STP footprint. Current services do not meet the Midlands and East Stroke Specification and fail to deliver against a range of key service performance indicators. National and local skill shortages have a significant impact on workforce availability and the ability to recruit and retain sufficient staff to operate high quality services across three sites.

Given this range of current, significant access, quality and workforce issues, work is clearly required to improve local stroke care across Coventry and Warwickshire so that more patients can survive their stroke and achieve their optimum level of recovery.

Considerable collaborative work has been undertaken over the last 4 years with all stakeholders to design, develop and appraise new clinical models for future stroke services. We recognise that stroke services across Coventry and Warwickshire can be better delivered to provide improved health outcomes for patients, by being set up in line with established best practice guidance.

The Business Case has identified the preferred option which is:

- A centralised HASU/ASU at UHCW which will receive all stroke patient presentations
- One bedded rehabilitation unit at South Warwickshire Foundation Trust (SWFT) in Leamington Spa;
- One bedded rehabilitation Unit at George Eliot Hospital (GEH) in Nuneaton;
- ESD and community stroke rehabilitation at home areas available across all of Coventry and Warwickshire;

In addition, actions have been agreed to improve the identification of people with Atrial Fibrillation and further improve their anticoagulation therapy for people to reduce the occurrence of stroke.

The proposed new clinical model will create a pathway of excellence for stroke services, improving the quality of services and removing the current inequities in service provision and access for our population. We believe that through delivery of this business case we will create services that contribute to a higher quality, more effective health and care system, and allow the further development of the NHS long term plan Integrated Stroke Delivery Network and mechanical thrombectomy.

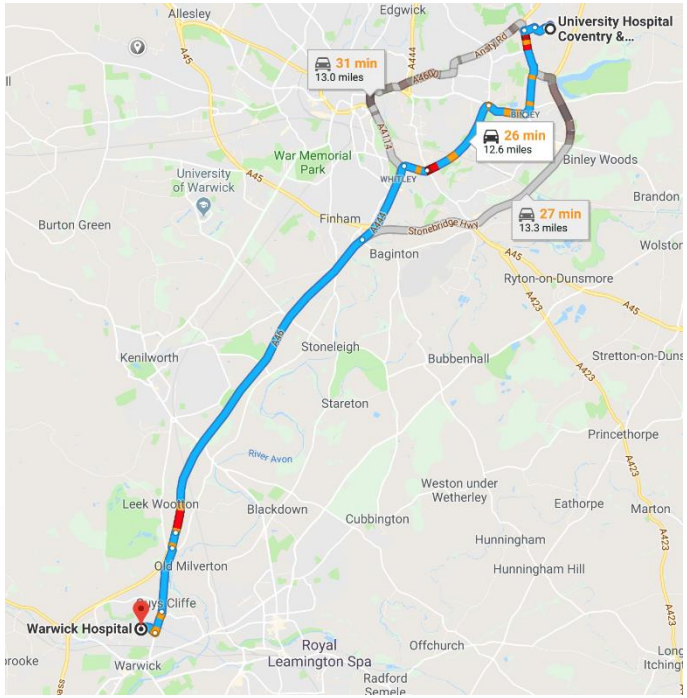
Modelling for Stroke Changes
Coventry & Warwickshire

Activity Impact via Day of Week

George Elliot, UHCW & Warwick

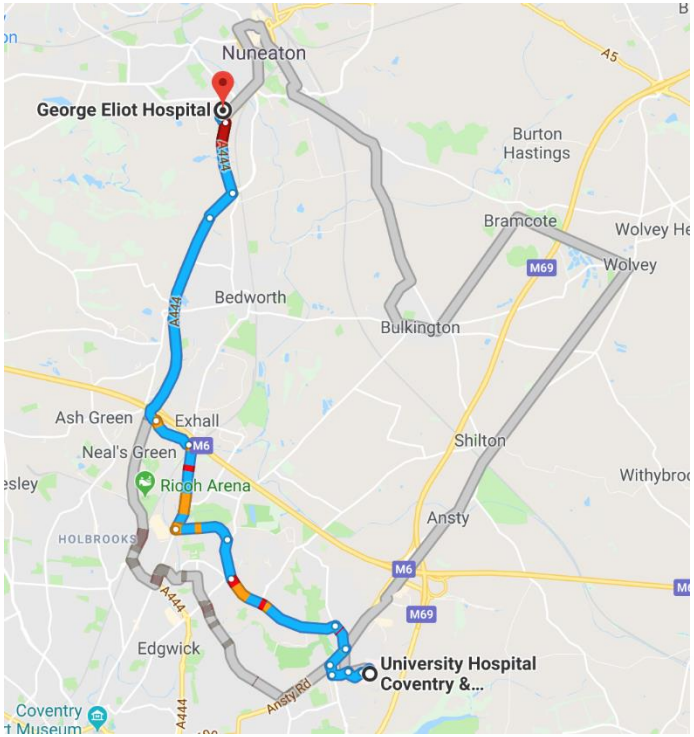
Day Of Week	WMAS Transports into:			Grand Total
	George Elliot	UHCW	Warwick	
Monday	71	285	81	437
Tuesday	54	311	66	431
Wednesday	61	304	84	449
Thursday	70	304	96	470
Friday	65	283	89	437
Saturday	61	295	83	439
Sunday	55	295	78	428
Grand Total	**437**	**2,077**	**577**	**3,091**

Additional Time Impact per Journey – South Warwickshire



Additional journey distance is no more than 12.6 miles taking no more than 26 mins

Additional Time Impact per Journey – South Warwickshire



Additional journey distance is no more than 8.8 miles taking no more than 27 mins

WMAS Resource Impact

Metric	Value	notes
Transports over the 12 month period	1,014	Number of transports over the 12 month period
Transports per day (calculated)	2.78	Transports per day
Extra travel time to new location	0.40	Duration as part of an hour for extra travel time there
Extra travel time from new location to next	0.40	Duration as part of an hour to get the ambulance back to the responding area
Extra time needed per transport	0.80	Total extra time per patient
Extra time needed per day	2.22	Extra time (hours) per day
Divisional UHU	0.40	UHU in division (actual)
DCA incidents per shift	4.80	12 hour shift for DCA x UHU is what can be done in one shift
TOTAL Impact on WMAS	0.40	Extra 12 hour DCAs needed to be rostered

WMAS Resource Cost

0.40 x (12 / 7) Ambulance Costing

Pay					£
1.6 Paramedic	Band 6	57,587	57,587	1.6	92,139
1 Technicians	Band 4	36,307	36,307	1.2	43,568
				2.8	135,708
Non Pay					
0.5 DCA's			25,225	0.5	12,613
Fuel cost per mile			0.289	22,231	6,425
Maintenance			9,665	1	9,665
Consumables			0	0	0
Insurance			1,100	1	550
					29,252
Total Annual Cost					**164,960**

Pay rates - Top of scale, includes unsociable hours. 70:30 split para/tech. Also includes 30% relief for training, sickness, annual leave

Based on average milage 22,231 p.a. and 4.84 miles per litre and fuel cost £1.40 per litre

Monthly additional cost to WMAS £13,747 – based on 0.4 total additional 12 hour ambulances, with WMAS ensuring sufficient resource rostered 24/7

Adult Social Care and Health
Overview & Scrutiny Committee - 13 January 2020

Performance Monitoring Warwickshire North and Coventry & Rugby Clinical Commissioning Groups

Recommendation

That the Overview and Scrutiny Committee receives and considers this report and notes:

- The CCGs performance management approach
- The CCGs assurance and governance processes in place
- The current CCG performance report

1. Introduction

This committee last received an update on performance across the three CCGs at its September meeting; the Committee was not assured by the report presented and that the Committee required a further meeting with a more detailed report on performance at which appropriate executives of the CCG would attend to present and take questions from the Committee.

A meeting was due to be held on the 11th November 2019, but due to the recent election this meeting was then moved to the 13th January 2020.

This report provides information on the performance monitoring by Coventry & Rugby and Warwickshire North Clinical Commissioning Groups (CCGs) that deliver NHS services to Rugby and North Warwickshire residents. The information consists of three sections:

- Overview of governance, key performance summary, priorities for action across the three CCGs, and how as joint working further develops ensuring the role of 'Place' maintains local visibility of performance;
- Copies of the latest performance report taken to the CCGs most recent public governing body meeting, and which can be found on each CCGs own website;
- A glossary containing descriptions of the key performance targets that are routinely monitored, how they are calculated and what targets CCGs are expected to deliver.

2. CCG Performance Reporting

Governance on performance is assured in various ways across the NHS:

- Monthly contractual meetings between CCGs and host NHS providers, where performance in year is discussed, performance notices issued, and remedial action plans developed as necessary.
- Monthly Clinical Quality Review meetings between the CCG and NHS providers, where the quality aspect of care is discussed, and the need for recovery actions identified and action plans developed as necessary, this also feeds into the contractual meetings between CCGs and providers.

- Monthly Finance & Performance Committees, as part of internal organisation assurance, where performance report is considered by nominated CCG or Trust members and Executive Team, actions discussed, assurance sought and need for further actions agreed.
- Monthly Clinical Quality Committees, as part of internal assurance quality report is considered by nominated CCG or Trust members and Executive team, actions discussed, assurances sought and need for further actions agreed.
- Public Governing Body Meetings, where a joint report on Quality and Performance is taken to the whole CCG or NHS Trust Board, and publically available on the CCGs own website. This includes Annual General Meetings, and Annual Report publication.
- Local Authority Health Oversight Committee.
- NHS Regulator Meetings – System Review Meetings Monthly. System locality based i.e. Warwickshire North/GEH, Coventry & Rugby / UHCW/CWPT, South Warwickshire/SWFT, as well as whole system review (STP – CW HPB).
- Quality Assurance Framework, annual assessment of performance against key delivery targets by NHS E/I of the CCGs performance.

Retaining accountability at 'Place'

The committee expressed a desire at the meeting in September that any future reorganisation of CCGs should retain the ability to keep accountability as local as possible.

Coventry and Warwickshire Health and Social Care System has previously agreed that as joint working and greater integration in the planning and delivery of health and care services further develops, that this should be under the planning unit of 'Place'.

The four 'Place's across Coventry & Warwickshire are; Coventry, Rugby, Warwickshire North and South Warwickshire, this allows for all partners to be able to coordinate the development of joint working, coordination and delivery of services around each 'Place', based on an assessment of local need and local priorities, and only looking to coordinate services at a more strategic level when it makes sense to do so, such as specialist and tertiary services.

'Place' in the context of governance around performance becomes a mechanism by which we can ensure local accountability, and local delivery of services against defined standards. It helps to ensure regardless of any future strategic alignment of organisations that a majority of service delivery can still be monitored at a local level.

3. Performance Monitoring – Some Context

The NHS has for many years had targets for health improvement currently these include the 'NHS Constitutional standards' which are reported nationally by NHS England, together with other priority targets as identified in national planning guidance each year.

CCGs overall performance as a commissioner is assessed against the 'Oversight Framework' from which a summary of measures are used to grade CCGs as to whether their performance is in one of four categories: outstanding, good, requires improvement, or is inadequate.

Full details of an individual CCG's performance against the framework's indicators are available on the MyNHS website (at https://www.nhs.uk/mynhs).

Table 1: Clinical Commissioning Group Key Facts

	Warwickshire North	Coventry & Rugby	South Warwickshire
Population	193,000	467,000 Coventy 360k Rugby 106k	291,000
Budgets 2019/20	£266m	£744m	£401m
Number of GP practices	26 (4 PCNs)	66 (8 PCNs)	33 (5 PCNs)
Host Trusts	George Eliot Hospital NHS Trust (GEH)	University Hospitals Coventry and Warwickshire NHS Trust (UHCW) Coventry Partnership NHS Trust (CWPT)	South Warwickshire Foundation NHS Trust (SWFT)

PCN – Primary Care Network – these are networks of GP practices typically covering 30 to 50,000 patients.

The overall national figures of 195 CCGs in 2018/19 were:

- Outstanding 24
- Good 102
- Requires Improvement 58
- Inadequate 11

Performance reports that are then presented to each CCG Board across Coventry & Warwickshire focus on the NHS Constitutional Standards, and local CCG key priorities, together with additional reports that show how CCGs are performing against the IAF, as well as individual targets that we hold NHS providers to account for.

Where a key target has not been met, there is an exception report against that target explaining the reason for being away from target, and the actions being taken to recover this target. The performance committee will request specific reports against specific key priorities that provide detailed analysis of the issues and actions being taken, against which the committee gives assurance ultimately to each CCG's Governing Body.

Typically the performance for each key measure includes 12 months information, so that it can be seen as to whether the target has simply missed one reporting period, or whether there is an ongoing issue.

4. Key NHS Constitutional Areas where the CCGs are seeking to Improve Performance

A copy of Warwickshire North and Coventry & Rugby CCGs performance report is provided for Members. This report identifies the key areas to improve performance, existing and new actions to improve performance and any associated risks.

This report was discussed in detail at our CCG Finance and Performance committees in December 2019 prior to being submitted to our CCG Governing Body meeting in January 2020.

The full range of performance standards we are measured against are all published on the CCGs websites.

5. Background papers

Appendix A – CR & WN CCG Governing Body Performance report September 2019
Appendix B – CR & WN CCG Finance & Performance – Performance report December 2019
Appendix C – Glossary of Operational Standards

Report Author:
Andrew Harkness
Chief Transformation Officer
Warwickshire North and Coventry & Rugby CCGs
Andrew.harkness@warwickshirenorthccg.nhs.uk

NHS Coventry and Rugby Clinical Commissioning Group
NHS Warwickshire North Clinical Commissioning Group | Enc I

Report To:	Governing Body
Report Title:	Quality, Safety and Performance Report
Report From:	Steve Jarman-Davies, Jo Galloway
Date:	12th Sept 2018
Previously Considered by:	Commissioning, Finance and Performance Committee, 23rd August 2018 Clinical Quality and Governance Committee 22nd August 2018

Action Required							
Decision:		**Assurance:**	✓	**Information:**		**Confidential**	

Purpose of the Report:

To provide assurance to the Governing Body of the performance of services commissioned by Coventry and Warwickshire and Warwickshire North CCGs for the month of June (unless otherwise specified). The report also provides an update on quality concerns within commissioned services that are either being investigated or are being monitored against improvement plans.

Key Points:

Performance

Referral to Treatment Times (RTT)
85.9% of CRCCG patients had been waiting less than 18 weeks from their GP referral date to be seen or treated by a hospital specialist against a target of 92%. The figure for WNCCG was 83.5%.
There were 28 CRCCG patients waiting over 52 weeks. 21 were waiting at UHCW, one at Royal Free London NHS Foundation Trust (General Surgery), four at the Royal Orthopaedic Hospital NHS Trust (Specialist Orthopaedic), one at Oxford University Hospitals NHS Trust (Orthopaedic) and one at the London North West University Healthcare Trust (ENT). There was one WNCCG over 52 week breach, who was waiting at UHCW.
Both CCGs achieved against the diagnostic test waiting times target with 99.6% of CRCCG and 99.4% of WNCCG patients receiving diagnostic tests within 6 weeks of referral.

A & E 4 hour waits
A & E 4 hour waits performance was 89.3% at UHCW, remaining below the 95% target, but a significant improvement on the April position. GEH also underachieved, with 91.6% of patients seen within 4 hours.

Cancer waiting times
CRCCG underachieved in quarter 1 against the cancer two week wait for outpatient appointment for patients referred urgently with breast symptoms at 83.5% and WNCCG underachieved against the 62 day wait target for screening at 85.7%. Other targets were achieved. Two patients at UHCW had waited more than 104 days from referral to treatment. There were no 104 day breaches at GEH.

Mixed Sex Accommodation
There were no Mixed Sex Accommodation breaches for CRCCG or for WNCCG patients.

Cancelled Operations
There were 39 patients in quarter one who had operations cancelled at UHCW, on or after the day of admission for non-clinical reasons and weren't offered another binding date within 28 days, a reduction on the quarter 4 position. Five cancellations at GEH were not offered another binding date within 28 days.

Dementia Diagnosis
Both CCGs continue to underachieve against the 67% dementia diagnosis target, with 59.2% of the estimated dementia cases diagnosed for CRCCG and 59.0% for WNCCG.

Early Intervention in Psychosis (EIP)
CRCCG underachieved at 25% and WNCCG marginally underachieved at 50% against the 53% EIP target.

IAPT
CRCCG underachieved against the 2018/19 19% annual IAPT access target in April at 18.1%. However this is an improvement on the Q4 position at 15.7%. WNCCG also underachieved at 17% The IAPT recovery rate targets were met in April by both CCGs.

Quality

University Hospitals Coventry and Warwickshire (UHCW)
There are three areas on Level 2 and four areas on Level 3 of the CCG Quality Assurance Framework:

- Level 2 – A CQC inspection took place from 23 April to 1 June 2018 and the final report was published on 31 August 2018. The overall CQC rating of the Trust was requires improvement. The trust is developing an action plan in response to the CQC findings and the report will be discussed at the next Clinical Quality Review Meeting (CQRM).
- Level 2 – There is a risk relating to Dermatology and delays for first clinic appointments; it is positive to note that waiting times have now significantly improved and the target was met for June 2018.
- Level 2 – The midwife to birth ratios is reported as 1:34 for June 2018. The Trust has made some positive progress with recruitment and the ratio will be monitored as part of the midwifery dashboard at CQRM.
- Level 3 – The CCG continues to monitor implications associated with delays in urgent clinic letters that should be sent within 7 days. The CCG and Trust have completed a joint investigation and the final report and remedial action plan were presented to the August CQRM.
- Level 3 – The CCG has formally raised concerns with the Trust in relation to its internal management systems used to manage patient follow up appointments. The CCG is utilising formal contractual mechanisms to gain assurance and confirmation of the management plan to resolve this issue.
- Level 3 – The Trust is not currently meeting the 4 hour Accident and Emergency target. Following a request from the CCG, the Trust has presented a review of serious incidents to CQRM. No themes or trends were identified and a follow up quality assurance visit will be undertaken. Urgent and emergency services at University Hospital continue to be rated as requires improvement by CQC.
- Level 3 (system-wide issue) – The Trust is experiencing increased risk and capacity issues on Ward 14 due to issues relating to children and young people in crisis being cared for on the paediatric ward. A multi-agency group is working to develop alternative solutions to alleviate system pressures on Ward 14. A business case for a CAMHS tier 3.5 service has been developed.

Coventry and Warwickshire Partnership Trust (CWPT)
There are four areas on Level 2 of the CCG Quality Assurance Framework:

- Level 2 - The Trust has reported that there is an eleven month waiting time for the Adult ASD diagnosis service. The Trust is undertaking work to review patient pathways, referrals and eligibility criteria. The CCG is working with the Trust to re-scope the pathway and activity in order to manage demand.
- Level 2 – Following the June 2017 inspection, the CQC rated the Trust as requires improvement. The Trust has an action plan in place which is monitored at CQRM. CQC will be undertaking a well led inspection between 2 and 4 October 2018.
- Level 2 - The Care Quality Commission (CQC) inspection identified long waiting times for access to child and adolescent mental health services (CAMHS). The CCG has issued a contract performance notice and also conducted follow up quality assurance visit in July 2018. The visit provided assurance that processes are in place to support patients in crisis, the waiting list is better managed and the wait to follow up for core interventions is reducing.
- Level 2 - In response to a serious incident, the Trust has developed an action plan and initiated a review of wound care across Integrated Community Services. CWPT provided an update at the July 2018 CQRM.

George Eliot Hospital (GEH)
There are three areas on level 2 of the CCG Quality Assurance Framework:

- Level 2 – Following the October 2017 inspection, the CQC rated the Trust as requires improvement. A Quality Oversight and Assurance Group has been set up to provide assurance to system stakeholders that associated clinical and quality risks are appropriately assessed and addressed.
- Level 2 – End of life care was rated as inadequate by CQC in January 2018 and there have been recruitment challenges experienced within this service. The Trust has been successful in its recruitment of an End of Life Consultant and a Lead Nurse and both are expected to be in post within the next couple of months. Recruitment of a second End of Life Consultant is underway. Actions in relation to End of Life Care form part of Trust's Overall Improvement Plan in response to the CQC inspection.
- Level 2 –The Trust did not achieve the required 85% compliance of the total workforce to complete Workshop to Raise Awareness of Prevent (WRAP) training by March 2018. The Trust has a plan and trajectory in place which sets out to achieve compliance by the end of September 2018.

Cygnet, Coventry
A CQC re- inspection at Cygnet took place in June 2018 and CQC has rated the service as overall good.

The Pears, RNIB
The Pears is a care and education facility for children and adolescents with complex health needs, provided by the Royal National Institute for the Blind. The Pears was rated as Inadequate following a review from OFSTED. The CCG is working with stakeholders to provide support to the provider.

Recommendation:

Members are asked to note the contents of the attached report.

Implications							
Objective(s) / Plans supported by this report:	1,2,3 & 4						
Conflicts of Interest:	N/A						
Financial:	**Non-Recurrent Expenditure:**	Not applicable					
	Recurrent Expenditure:	[Detail recurrent financial implications including time period. If not relevant state 'not applicable']					
	Is this expenditure included within the CCG's Financial Plan? *(Delete as appropriate)*	**Yes**	✓	**No**		**N/A**	
Performance:	The CCG is required to meet the national NHS Constitution targets						
Quality and Safety:	The report outlines quality and safety issues in relation to commissioned services against the Clinical Governance Framework						
Equality and Diversity:	The report provides information relating to patients with protected characteristics where care is provided by commissioned services						
	Has an equality impact assessment been undertaken? *(Delete as appropriate)*	**Yes** (attached)		**No**		**N/A**	✓
Patient and Public Engagement:	Not applicable						
Clinical Engagement:	Not applicable						

Risk and Assurance:	The following areas are identified on the CCG risk register: • A&E performance UHCW • RTT Performance • CHC Complaints • Lack of Assurance regarding CHC Service Performance • Timely CHC assessments • CHC Transition

NHS
Warwickshire North
Clinical Commissioning Group

September 2018

Quality, Safety and Performance Report

NHS
Coventry and Rugby
Clinical Commissioning Group

Quality & Equality First

Contents

1 - CCG Performance Overview

Introduction

This report focuses on the month of June unless stated otherwise.

Exception reporting, mitigating actions and, where required, Remedial Action Plans, are presented and reviewed through the Commissioning, Finance and Performance Committee and Clinical Quality and Governance Committee as formal committees to the Governing Body. These are therefore not included in this report.

Separate Provider Dashboards are included in section 3.

Referral to Treatment Times (RTT)

85.9% of CRCCG patients had been waiting less than 18 weeks from their GP referral date to be seen or treated by a hospital specialist against a target of 92%. The figure for WNCCG was 83.5%.

There were 28 CRCCG patients waiting over 52 weeks. 21 were waiting at UHCW, one at Royal Free London NHS Foundation Trust (General Surgery), four at the Royal Orthopaedic Hospital NHS Trust (Specialist Orthopaedic), one at Oxford University Hospitals NHS Trust (Orthopaedic) and one at the London North West University Healthcare Trust (ENT). There was one WNCCG over 52 week breach, who was waiting at UHCW.

Both CCGs achieved against the diagnostic test waiting times target with 99.6% of CRCCG and 99.4% of WNCCG patients receiving diagnostic tests within 6 weeks of referral.

Actions to Improve RTT Performance

Contract performance notices are in place with UHCW for the RTT and 52 weeks wait target. UHCW and GEH have undertaken extensive work with an intensive support team on demand and capacity for elective and outpatient activity. Three specialty clinically led review workshops have taken place already for UHCW for Ophthalmology, MSK and Dermatology, with Urology planned in the next reporting period.

The STF recovery profile for GEH only delivers 87% by the end of 2018/19, and 92% is only delivered from June 2019.GEH performance dipped considerably in June 2018 and a contract performance notice will be issued as this is below the STF trajectory.

CRCCG continues to work with UHCW to confirm the exact timescale for recovery against the 52 weeks wait target. A revised remedial action plan and trajectory has been received from the Trust and this will be monitored via regular monthly meetings**.**

A & E 4 hour waits

A & E 4 hour waits performance was 89.3% at UHCW, remaining below the 95% target, but a significant improvement on the April position. GEH also underachieved, with 91.6% of patients seen within 4 hours.

Actions to Improve A & E 4 hour waits performance

The system is under NHSE / NHSI escalation in 2017/18. The Action plan relating to these meetings is monitored via the local A&E delivery board, and through the Coventry and Warwickshire A&E Delivery Board.

UHCW

Key deliverables to achieve the improvement trajectory include:

- Implementation of actions from walk around by Glen Burley (SWFT)
- Achieving 98% in the Minors stream
- New Rapid assessment and treatment area
- Increasing use of Ambulatory Care
- Increased Medical workforce, especially at weekends
- Focus remains on monitoring adherence to the ED timed pathways, continued ring fencing of assessment beds.
- Local A&E Board have an escalation remedial plan managed at Director level through Contracting process, but also reporting to the Coventry & Warwickshire A&E Board about progress of actions. QIPPs are set up for 2018/19 in relation to HIUs, NHS 111 clinical assessment.

GEH

Key deliverables and enablers from the Trusts RAP to achieve the improvement trajectory include:

- Achieving 95% in the Minors stream
- Ring-fencing of CDU
- Increasing use of Ambulatory Care
- Revised SoP for Surgical assessment unit
- Revised DoP for Acute medical unit (AMU) and footprint to enable GP admissions directly to AMU
- Revised Medical workforce to include: medics, PAs, ENPs, Physiotherapists, Pharmacists, GPs, ANPs
- Review surgical review pathways – ensuring timely access to specialty level reviews.
- Implementation of revised rapid assessment and treatment model (RAT)

Cancer waiting times

CRCCG underachieved in quarter 1 against the cancer two week wait for outpatient appointment for patients referred urgently with breast symptoms at 83.5% and WNCCG underachieved against the 62 day wait target for screening at 85.7%. Other targets were achieved.

Two patients at UHCW had waited more than 104 days from referral to treatment. There were no 104 day breaches at GEH.

Actions to Improve Cancer waits performance

Two week capacity at UHCW is being proactively managed by UHCW with daily monitoring of referrals. The trust achieved against the cancer two week wait target for outpatient appointment for patients referred urgently with breast symptoms in May and June for its patients. One delay in June was as a result of patient choice. The two breaches against the 62 day wait target for screening related to complex diagnostic pathways (many, or complex, diagnostic tests).

Mixed Sex Accommodation

There were no Mixed Sex Accommodation breaches for CRCCG or for WNCCG patients.

Cancelled Operations

There were 39 patients in quarter one who had operations cancelled at UHCW, on or after the day of admission for non-clinical reasons and weren't offered another binding date within 28 days, a reduction on the quarter 4 position. Five cancellations at GEH were not offered another binding date within 28 days.

Actions to Improve Cancelled Operations performance

The CCG will be enacting the sanctions relevant to the Trust failing to achieve this indicator and have requested the information required from the Trust finance team to enable this to take place.

The sanction is "Non-payment of costs associated with cancellation and non- payment or reimbursement (as applicable) of re- scheduled episode of care"

Care Programme Approach

In Quarter one 117 out of 124 CRCCG patients on CPA were followed up within 7 days after discharge from psychiatric inpatient care. This equates to 94.4% of the total, leading to the CCG marginally underachieving against the 95% target. WNCCG achieved against the target at 98.0 %.

Dementia Diagnosis

Both CCGs continue to underachieve against the 67% dementia diagnosis target, with 59.2% of the estimated dementia cases diagnosed for CRCCG and 59.0% for WNCCG.

Actions to Improve Dementia Diagnosis performance

As part of refreshing CRCCGs Dementia Action Plan, a range of recovery actions are ongoing and/or actively being considered, including:

- Systematic data cleanse working with practices across Coventry and Rugby to ensure that all GP practices are submitting complete and accurate data by the end of 2018/2019.
- Ensuring those people referred back to GP's from MAS where a diagnosis is recorded at "Possible" or "Probable" are being recorded correctly.
- Ensuring people being discharge from hospital with "Query Dementia" are being followed up by their GP practice.
- Consideration of a new invesment proposal to support and engage with targeted GP practices to train GPs on how to diagnose dementia wher cases are uncomplex.

- Consideration of a new investment proposal to encourage GP practices to identify and undertake cognitive functional assessments of people aged 65+ living within the communities including Care Homes.
- Review the dementia pathway, to harness primary care involvement through early concerns to diagnosis and post diagnosis and increase referrals to MCI (Mild Cognitive Impairment)
- Establish a working group to establish 5 poorest areas (at practice level), Identify 5 best performing areas and get demographic information on each area
- Find the best performing comparator authorities/CCGs and Trusts, research and share best practice
- Produce an action plan to work with the poorest performing practices – initially working with the poorest five before expanding.
- Continue to increase awareness amongst all key stakeholders of the post diagnostic support available across the CCG such as Dementia Navigators (Alzheimer's Society), Admiral Nurses (Dementia UK & the GP Alliance) and Dementia Assessment and Community Services (CWPT) offering a range of evidence based interventions
    - Dementia Pop-up Clinics are being set up across up to 5 GP Practices. The Pop-up Clinics will be run by the Dementia Navigators (Alzheimer's Society) once a month and will be an opportunity for GPs and patients to get some support / guidance around memory concerns.
    - Dementia Navgiators service across WNCCG is currently bing reviewed with contract expiring March 19 - this service will be re-commissioned
    - Ensure CWPT informs practices when patients have been identified with dementia at the memory clinic, (ongoing).

Early Intervention in Psychosis (EIP)

CRCCG underachieved at 25% and WNCCG marginally underachieved at 50% against the 53% EIP target.

Actions to Improve EIP performance

A business case for additional funding has been agreed by the CRCCG Governing Body, as follows:

Recurrent investment of 5 Care Coordinators at an annual cost of £187,141 (including overheads). This recognises that performance against key metrics is comparatively poorer for Coventry than for Warwickshire and that the demographics of a University city would suggest greater demand for EIP services.

For WNCCG, a decision was deferred until later in the year but if investment was approved the recommendation is that this would provide recurrent investment of 3 Care Coordinators at a cost of £111,544 (inc OHs).

It is anticipated that through this recurrent investment, quality and clinical outcomes for Coventry and Rugby patients will improve in three key areas:
1. Strengthening and improve consistency in meeting the access and waiting time standards
2. Reducing the caseload per Care Coordinator; and
3. Lengthening the treatment pathway for patients.

IAPT

CRCCG underachieved against the 2018/19 19% annual IAPT access target in April at 18.1%. However this is an improvement on the Q4 position at 15.7%. WNCCG also underachieved at 17% The IAPT recovery rate targets were met in April by both CCGs.

Actions to Improve IAPT performance

CRCCG are undertaking a review of counselling services provided by third sector, with a view to rationalising all related activity to ensure that patients are receiving the correct support and access to IAPT is appropriately maximised. The purpose of the review is to support provision of the IAPT service reaching the access and recovery rate with strong interfaces with other local counselling/therapy provision. The review will:

• Review capacity and skill mix of the core IAPT service provided by CWPT and MIND to maximise the impact of meeting key performance indicators and increase levels of innovation

• Explore with partners across the system such as CWPT, primary care, local employers and the third sector, that robust marketing and promotional strategies are in place to aid the trust in meeting the following national targets

• Map and understand provision of local counselling services

• Explore opportunities for innovation, collaboration and partnership working between providers and referring agencies

Activity Tracker

CRCCG
General and Acute Referrals were 10.6% above plan. The CCG was 15.8% above plan for GP referrals and 3.9% above plan for 'other' referrals. There has been a significant increase in General Medicine new attendances for patients referred from A & E which is being addressed with the trust to ensure that these are being recorded correctly.

On the basis of SUS data, non-elective activity was 4.5% below target.

WNCCG
General and Acute Referrals were 2.7% above plan. The CCG was 5.4% above plan for GP referrals and 0.77% below plan for 'other' referrals.

On the basis of SUS data, non-elective activity was 5.1% above target.

Delayed Transfers of Care for both CCGs continue to run below the 3.5% target level.

Coventry & Rugby Clinical Commissioning Group NHS Constitution Measures

Measure	Annual Target	Jan-18	Feb-18	Mar-18	Q1	Q2	Q3	Q4	17-18	Apr-18	May-18	Jun-18	Q1	18-19 YTD
Referral to treatment times (RTT)														
Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral	92%	84.2%	84.8%	84.4%	86.9%	85.4%	84.3%	84.5%	85.3%	84.8%	86.2%	85.9%	85.6%	85.6%
RTT > 52 weeks breaches - Incomplete Pathways	0	19	12	13	41	35	78	44	198	16	23	28	67	67
Patients waiting less than 6 weeks from referral for a diagnostic test	99%	99.7%	99.8%	99.8%	99.5%	99.2%	99.9%	99.8%	99.6%	99.5%	99.8%	99.6%	99.6%	99.6%
A&E Waits														
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (UHCW)	95%	81.4%	78.1%	79.2%	82.6%	81.7%	84.1%	79.6%	82.0%	84.8%	90.4%	89.3%	88.2%	88.2%
12 Hour Trolley Waits (UHCW)	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cancer Waits														
Cancer two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	97.9%	97.8%	93.5%	92.7%	96.2%	97.2%	96.3%	95.5%	92.0%	93.2%	94.8%	93.4%	93.4%
Cancer two-week wait for first outpatient appointment for patients referred urgently with breast symptoms	93%	98.9%	98.9%	84.5%	98.4%	97.8%	97.8%	97.8%	97.4%	68.2%	94.5%	92.0%	83.5%	83.5%
Cancer one month (31-DAY) wait from diagnosis to first definitive treatment for all cancers	96%	100%	99.3%	98.9%	99.6%	98.7%	98.7%	99.2%	99.1%	100%	99%	98.6%	99.2%	99.2%
Cancer 31-day wait for subsequent treatment where that treatment is surgery	94%	100%	100%	100%	98.2%	97.2%	96.6%	100%	98.0%	94.1%	100%	98.6%	98.4%	98.4%
Cancer 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97.3%	99.1%	99%
Cancer 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	91.9%	100%	100%	96.9%	95.3%	95.4%	97.4%	96.2%	100%	95.8%	96%	96.4%	96.4%
Cancer two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	89.8%	87.4%	89.6%	84.6%	87.6%	89.9%	88.7%	87.8%	85.4%	90.3%	89.4%	88.4%	88.4%
Cancer 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	100%	90.9%	100%	100%	94.6%	94.4%	97.0%	96.5%	100%	88.9%	100%	95.8%	95.8%
Cancer 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient	85%	83.3%	87.5%	92.9%	95.7%	96.4%	90.6%	87.1%	92.1%	100%	78.9%	78.6%	81.6%	81.6%

Coventry & Rugby Clinical Commissioning Group NHS Constitution Supporting Measures

Measure	Annual Target	Jan-18	Feb-18	Mar-18	Q1	Q2	Q3	Q4	17-18	Apr-18	May-18	Jun-18	Q1	18-19 YTD
Mixed Sex Accommodation														
Mixed Sex Accommodation Breaches	0	0	4	0	2	1	6	4	13	2	1	0	3	3
Cancelled Operations														
All patients who have operations cancelled, on or after the day of admission for non-clinical reasons to be **offered another binding date** within 28 days(UHCW). (Breach no.)	0	Reported Quarterly Only			54	39	46	55	194	Reported Quarterly Only			39	39
Operations Cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health														
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.	95%	Reported Quarterly Only			95.7%	99.2%	97.6%	98%	97.6%	Reported Quarterly Only			94.4%	94.4%

Coventry & Rugby Clinical Commissioning Group NHS Mental Health Measures

Mental Health														
Dementia Diagnosis	67%	60.2%	59.9%	59.4%	59.7%	59.1%	59.6%	59.4%	59.4%	59.5%	59.3%	59.2%	59.2%	59.2%
Early Intervention in Psychosis: Percentage of people experiencing First Episode Psychosis (FEP) treated with a NICE-recommended package of care within two weeks of referral.	53% for 1819	78%	79%	75%	78%	43%	50%	77%	54.4% #	11.1%	42%	25%	29%	15.4%
IAPT 6 Weeks - First Treatment	75%	99.3%	100%	99.1%	99.1%	99.4%	99.7%	99.3%	99.4%	99.3%				99.3%
IAPT 18 Weeks - First Treatment	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%
IAPT Access (Annnualized)	19% for 18/19	18.2%	16.3%	14.9%	14.6%	14.7%	16.9%	16.5%	15.7%	18.1%				18.1%
IAPT Recovery Rate	50%	51.4%	51.5%	51.3%	48.4%	53.1%	49.2%	51.4%	50.6%	57.9%				57.9%

Indicators achieved by CRCCG in the latest period

NHS Constitution Measures (Monthly)	Annual Target	Jun-18
Patients waiting less than 6 weeks from referral for a diagnostic test	99%	99.6%
12 Hour Trolley Waits (UHCW)	0	0

NHS Constitution Measures (Quarterly)	Annual Target	Q1
Cancer two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	93.4%
Cancer one month (31-DAY) wait from diagnosis to first definitive treatment for all cancers	96%	99.2%
Cancer 31-day wait for subsequent treatment where that treatment is surgery	94%	98.4%
Cancer 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	99.1%
Cancer 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	96.4%
Cancer two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	88.4%
Cancer 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	95.8%

NHS Constitution Supporting Measures (Monthly)	Annual Target	Jun-18
Operations Cancelled for a second time	0	0
Mixed Sex Accommodation breaches	0	0

Mental Health Measures (Monthly)	Annual Target	Apr-18
IAPT 6 Weeks - First Treatment	75%	99.3%
IAPT 18 Weeks - First Treatment	95%	100.0%
IAPT Recovery Rate	50%	57.9%

Indicators not acieved by CRCCG in the latest period

NHS Constitution Measures (Monthly)	Annual Target	Jun-18	Compared with previous month
Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral	99%	85.9%	↓
RTT > 52 weeks breaches - Incomplete Pathways	0	28	↑
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (UHCW)	95%	89.3%	↓

NHS Constitution Supporting Measures (Quarterly)	Annual Target	Q1	Compared with previous quarter
Cancer two week wait for first outpatient appointment for patients referred urgently with breast symptoms	93%	83.5%	↓
Cancer 62 day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient	85%	81.6%	↓

NHS Constitution Supporting Measures (Quarterly)	Annual Target	Q1	Compared with previous quarter
All patients who have operations cancelled, on or after the day of admission for non-clinical reasons to be offered another binding date within 28 days(UHCW). (Breach no.)	0	39	↓
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric inpatient care during the period.	95%	94.4%	↓

Mental Health Measures (Monthly)	Annual Target	Jun-18	Compared with previous month
Dementia Diagnosis	67%	89.2%	↔
Early Intervention in Psychosis	53%	25.0%	↓

Mental Health Measures (Monthly)	Annual Target	Apr-18	Compared with previous month
IAPT Access (Annualized)	19%	18.1%	↑

Warwickshire North Clinical Commissioning Group NHS Constitution Measures

Measure	Annual Target	Jan-18	Feb-18	Mar-18	Q1	Q2	Q3	Q4	17-18	Apr-18	May-18	Jun-18	Q1	18-19 YTD
Referral to treatment times (RTT)														
Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral	92%	84.6%	84.1%	82.1%	84.0%	83.0%	84.4%	83.6%	83.7%	83.6%	84.9%	83.5%	84.0%	84.0%
RTT > 52 weeks breaches - Incomplete Pathways	0	11	5	7	41	14	27	23	105	6	6	1	13	13
Patients waiting less than 6 weeks from referral for a diagnostic test	99%	99.5%	99.8%	99.7%	99.6%	98.8%	99.6%	99.6%	99.4%	99.5%	99.5%	99.4%	99.4%	99.4%
A&E Waits														
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (GEH)	95%	78.8%	77.7%	76.6%	94.7%	92.0%	86.3%	77.7%	87.7%	82.8%	92.6%	91.6%	89.1%	89.1%
12 Hour Trolley Waits (GEH)	0	2	10	48	0	0	0	60	60	51	0	0	51	51
Cancer Waits														
Cancer two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	98.5%	98.7%	98.5%	94.5%	97.0%	97.2%	98.6%	96.8%	95.3%	97.6%	96.5%	96.5%	96.5%
Cancer two-week wait for first outpatient appointment for patients referred urgently with breast symptoms	93%	100%	100%	99.1%	94.3%	97.2%	96.9%	99.7%	96.9%	92.8%	97.1%	94.9%	94.9%	94.9%
Cancer one month (31-DAY) wait from diagnosis to first definitive treatment for all cancers	96%	95.7%	100%	98.4%	98.2%	94.6%	96.7%	98.1%	96.9%	96.3%	98.8%	100%	98.3%	98.3%
Cancer 31-day wait for subsequent treatment where that treatment is surgery	94%	100%	100%	85.7%	100%	100%	97.3%	97.0%	98.5%	100%	100%	100%	100%	100.0%
Cancer 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Cancer 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	91.9%	97.8%	97.0%	96.0%	96.0%	96.0%	95.7%	95.9%	100%	100%	97.4%	98.9%	98.9%
Cancer two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	81.6%	84.4%	82.9%	86.5%	76.7%	81.4%	83.2%	82.0%	93.0%	89.4%	92.5%	91.5%	91.5%
Cancer 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	92.3%	100%	100%	100%	94%	97.4%	94.7%	96.2%	66.7%	100%	83.3%	85.7%	85.7%
Cancer 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient	85%	100%	85.7%	83.3%	100%	75%	90.9%	87.5%	88.9%	75.0%	87.5%	100%	86%	85.7%

Warwickshire North Clinical Commissioning Group NHS Constitution Supporting Measures

Measure	Annual Target	Jan-18	Feb-18	Mar-18	Q1	Q2	Q3	Q4	17-18	Apr-18	May-18	Jun-18	Q1	18-19 YTD
Mixed Sex Accommodation														
Mixed Sex Accommodation Breaches	0	0	2	1	0	5	0	3	8	0	0	0	0	0
Cancelled Operations														
All patients who have operations cancelled, on or after the day of admission for non-clinical reasons to be **offered another binding date** within 28 days (GEH). (Breach no.)	0	Reported Quarterly Only			0	0	0	3	3	Reported Quarterly Only			5	5
Operations Cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health														
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.	95%	Reported Quarterly Only			95.0%	97.7%	100%	95%	97.1%	Reported Quarterly Only			98.0%	98.0%

Warwickshire North Clinical Commissioning Group NHS Mental Health Measures

Mental Health														
Dementia Diagnosis	67%	59.7%	58.7%	58.7%	59.7%	61.3%	60.1%	58.7%	58.7%	59%	58.9%	59%	59%	59%
Early Intervention in Psychosis: Percentage of people experiencing First Episode Psychosis (FEP) treated with a NICE-recommended package of care within two weeks of referral.	53% for 1819	0%	No Data	50%	75%	100%	75%	25%	68.4%	50%	100%	50%	75%	50.0%
IAPT 6 Weeks - First Treatment	75%	98.0%	100%	100%	99.3%	99.3%	100%	99.3%	99.5%	97.8%				97.8%
IAPT 18 Weeks - First Treatment	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%
IAPT Access (Annnualized)	19% for 18/19	18.9%	15.9%	15.9%	17.3%	17.2%	17.9%	16.9%	17.3%	17.0%				17.0%
IAPT Recovery Rate	50%	51.6%	51.7%	56.5%	60.0%	60.6%	56.0%	53.0%	57.1%	58.3%				58.3%

Indicators achieved by WNCCG in the latest period

NHS Constitution Measures (Monthly)	Annual Target	Jun-18
Patients waiting less than 6 weeks from referral for a diagnostic test	99%	99.4%

NHS Constitution Measures (Quarterly)	Annual Target	Q1
Cancer two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	96.5%
Cancer two-week wait for first outpatient appointment for patients referred urgently with breast symptoms	93%	94.9%
Cancer one month (31-DAY) wait from diagnosis to first definitive treatment for all cancers	96%	98.3%
Cancer 31-day wait for subsequent treatment where that treatment is surgery	94%	100.0%
Cancer 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100.0%
Cancer 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	98.9%
Cancer 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	91.5%
Cancer 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient	85%	85.7%

NHS Constitution Supporting Measures (Monthly)	Annual Target	Jun-18
Operations Cancelled for a second time	0	0

Mental Health Measures (Quarterly)	Annual Target	Q4
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.	95%	98.0%

Mental Health Measures (Monthly)	Annual Target	Jun-18
IAPT 6 Weeks - First Treatment	75%	98%
IAPT 18 Weeks - First Treatment	95%	100%
IAPT Recovery Rate	50%	58.3%

Indicators not achieved by WNCCG in the latest period

NHS Constitution Measures (Monthly)	Annual Target	Jun-18	Compared with previous month
Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral	99%	84.0%	↑
RTT > 52 weeks breaches - Incomplete Pathways	0	1	↓
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (UHCW)	95%	91.6%	↓

NHS Constitution Measures (Quarterly)	Annual Target	Q1	Compared with previous quarter
Cancer two month (62-day) wait from referral from an NHS screening service to first definitive treatment for all cancers.	90%	85.7%	↓

NHS Constitution Supporting Measures (Quarterly)	Annual Target	Q1	Compared with previous quarter
All patients who have operations cancelled, on or after the day of admission for non-clinical reasons offered another binding date within 28 days(UHCW). (Breach no.)	0	5	↑

Mental Health Measures (Monthly)	Annual Target	Jun-18	Compared with previous month
Dementia Diagnosis	67%	59.0%	↔
Early Intervention in Psychosis	53%	50.0%	↔

Mental Health Measures (Monthly)	Annual Target	Apr-18	Compared with previous month
IAPT Access (Annualized)	19%	17.0%	↓

2 - CCG Quality Overview

1. Introduction

The Clinical Quality and Governance Committee in Common for Warwickshire North CCG and Coventry and Rugby CCG routinely receives comprehensive reports on the quality and safety of commissioned services based on a wide range of data and soft intelligence including contractual quality indicators, patient experience reports and learning and the impact on practice. This includes acute and community services, small providers both NHS and independent, nursing, residential homes and primary care. The committee also receives updates on safeguarding, infection prevention and control and transforming care issues.

This report provides a summary of escalated quality issues for the attention of the Governing Body together with an overview of quality in relation to performance issues. The following are also provided for information to Governing Body in the Provider Dashboard section of the main report:

- Quality Indicators Dashboards for Coventry and Warwickshire Partnership Trust (CWPT)
- Quality Indicators Dashboards for University Hospitals Coventry and Warwickshire NHS Trust (UHCW)
- Quality Indicators Dashboards for George Eliot Hospitals NHS Trust (GEH)

2. Items on Escalation

An overview of the Quality Assurance Framework and escalation levels is included as Appendix 2.

University Hospitals Coventry and Warwickshire NHS Trust

Items on Level 2 of the Clinical Quality Framework:

CQC Inspection and Rating
A CQC inspection took place from 23 April to 1 June 2018 and the final report was published on 31 August 2018. The overall CQC rating of the Trust was requires improvement. The Trust received ‘good’ for three domains (are services effective; are services caring; and are services well-led) and ‘requires improvement’ for two domains (are services safe; and are services responsive). University Hospital Coventry was rated as requires improvement overall and Hospital of St Cross was rated as good overall. It is positive to note that the caring domain for end of life services at University Hospital Coventry was rated as outstanding.

Overall CQC’s rating of the trust remained the same and it was rated as requires improvement because:

- Whilst improvements had been seen in many services, overall, safe and responsive were rated as requires improvement. University Hospital Coventry was requires improvement overall. Hospital of St Cross was rated as good.
- Effective, caring and well led were rated as good. Improvements were noted in trust wide leadership with a clear overarching vision and strategy, underpinned by the drive for innovation.
- Four core services at University Hospital improved their overall rating to good overall: medical care, surgery, services for children and young people and end of life care. Medical care services at Hospital of St Cross overall improved their rating to good.
- Three services at University Hospital were rated as requires improvement: urgent and emergency services, critical care and neurosurgery.

The trust is developing an action plan in response to the CQC findings and the report will be discussed at the next CQRM.

Dermatology
Patients experiencing delays receiving their first Dermatology clinic appointments has significantly improved. The most recent available data for June 2018 demonstrates that the Trust is now meeting the target with performance of 93.4% against a target of 92%.

Maternity

The Trust has reported the number of stillbirths as 2.14 per 1000 for April, 7.83 per 1000 for May 2018 and 0 per 1000 for June 2018. The Trust has also reported that the midwife to birth ratio is classified as red with a ratio of 1:34 in June 2018. To address this UHCW has developed and implemented a new Perinatal Review Team Tool for stillbirths, this includes a Multi- Disciplinary Team review of all stillbirths; enabling the Trust to identify themes since January 2018. Redefining the skill mix has facilitated recruitment of midwifes and 43 WTE posts have been offered to commence in September and October 2018. In addition, the organisation has recruited 3.5 WTE staff into a new Clinical Preceptor Support Midwife posts to work alongside and support the newly recruited midwifes. The CCG will continue to monitor the maternity dashboard at CQRM.

Items on Level 3 of the Clinical Governance Framework:

Urgent Clinic Letters sent within 7 days
The CCG and Trust have undertaken a joint investigation and the final audit report was noted at the August CQRM. The Remedial Action Plan that has been received by the CCG will be monitored through CQRM, until the CCG is assured that actions have been completed and that the data associated with this performance indicator is accurate and the Trust is meeting the national standard.

Partial Booking System (in relation to timely follow up appointments)
The CCG formally raised concerns with the Trust in relation to its internal management systems used to manage patient follow up appointments as a result of a serious incident. The CCG is utilising formal contractual mechanisms to gain assurance and confirmation of the management plan to resolve this issue. The concern was formally raised with the Trust at the July CQR meeting and detailed updates will continue to be provided at all future CQRMs until the issue is resolved.

Accident and Emergency Department (A&E)
The Trust is not currently meeting the 4 hour target and the CCG formally requested the Trust to conduct a review of Serious Incidents reported over the past twelve months. The review was presented to the CCG at the August CQRM, where it was agreed that no themes or trends were identified and it was confirmed that an ongoing report for ED and Acute Medicine would be developed and shared with the CCG. The CCG's also plans to conduct an announced quality assurance visit to validate the assurance provided by the Trust. Urgent and emergency services at University Hospital continue to be rated as requires improvement by CQC.

System Wide Issue - Children and Young People in Crisis
Increasing numbers of children and young people presenting in crisis are being admitted to UHCW. The trust has assessed the risk consequence as major due to the nature of admissions in relation to self-harm and self-harming behaviour. The trust has mitigating actions in place and there has

been one serious incident (Moderate harm) reported to date. A business case has been developed for a Tier 3.5 service and this is due to be presented to the Governing Body meeting for decision in September 2018. Funding has also been agreed by the CCGs to increase the Assessment and Liaison Team Service to a 7 day service. A task and finish group has been set up and weekly meetings are currently being held. Membership includes the CCGs, UHCW, CWPT, NHSE Specialised Commissioning, both local authorities and NHSI. A system-wide action plan has been developed and the West Midlands Clinical Network is supporting the system by undertaking a Children and Young People Admission Process Review. A Clinical Risk Review Meeting, chaired by the CCG Accountable Officer, took place on 10 August 2018. This meeting reviewed the current challenges and assessed level of risk; reviewed the actions in place to mitigate the risk; and agreed oversight and governance. A further meeting has been scheduled for 14 September.

Coventry and Warwickshire Partnership Trust

Items on Level 2 of the Clinical Governance Framework:

Adult Autistic Spectrum Disorder (Diagnostic Service) Waits
The Trust has reported that there is an eleven month waiting time for the Adult ASD diagnosis service. The Trust is undertaking work to review patient pathways, referrals and eligibility criteria. The CCG is working with the Trust to rescope the pathway and activity in order to manage demand.

CQC Inspection and Rating
A CQC inspection took place from 26 to 30 June 2017 and the final report was published on 8 November 2017. The overall rating is requires improvement.

The CQC action plan forms a standing agenda item at the CQRM and the CCG is assured that CWPT has robust governance arrangements in place to monitor the action plan. CQC will be undertaking a formal Well Led inspection between 2 October and 4 October 2018 and this will be preceded by a number of unannounced inspection visits to core services during August and early September.

CAMHS Waits
A CQC inspection took place from 26 to 30 June 2017 and the final report was published on 8 November 2017. The overall rating was requires improvement.

The CCG issued a contract performance notice in relation to CAMHS waiting times. The CCG has been assured that children and families are offered a range of alternative support options whilst waiting and patients are regularly reviewed to assess their risk and prioritise patients by clinical need. The CAMHS element of the CQC action plan is included as a standing item for CQRM. A quality assurance visit was conducted by the CCG in January 2018 with a follow up visit undertaken in July 2018 to review progress with actions.

A team of six staff with representation from the three CCGs, NHS Improvement and the two local authorities visited three different trust venues, including the navigation hub and two locality teams. A further visit is also scheduled for locality hubs in the near future.

Commissioners were welcomed at each site by enthusiastic, passionate staff and were overall assured that the service is working hard to deliver a more efficient and effective service. Processes are in place to support patients in crisis; the waiting list is better managed and the wait to follow up for core interventions is reducing. The service is working hard to embed new ways of working and is able to demonstrate better outcomes. The issues raised in the CQC inspection are being addressed. Whilst it was not possible to engage face to face with service

users as the service is reduced over the summer period, patients have indicated on Experience of Service Questionnaires that the service they have received has met their needs.

Tissue Viability
In response to a serious incident, the Trust developed an action plan and initiated a review of wound care across Integrated Community Services. CWPT provided an update on progress with actions at the July CQRM. The Trust has a tissue viability/wound review group in place, the teams' competency framework has been made role specific, care records have been reconfigured, team leadership has been strengthened, there is senior clinical oversight in all clinics and all patients on the caseload have been reviewed. The CCG is planning to undertake an assurance visit.

George Eliot Hospital

Items on Level 2 of the Clinical Governance Framework:

CQC Inspection
A CQC inspection took place in October 2017, with the final report published on 25 January 2018. The overall rating was 'Requires Improvement' and three Requirement Notices were also issued by CQC. A Quality Oversight and Assurance Group has been set up to provide assurance to system stakeholders that associated clinical and quality risks are appropriately assessed and addressed. The CCG has membership of this group and also monitors the Trust's improvement plan at CQRM. The CCG undertook an assurance visit to A&E in July 2018. The visit provided assurance that the Trust has addressed the improvement actions highlighted during the CQC visit.

Fragile Services - End of Life Care (EoLC)
The Trust, CQC and the CCG have identified that the End of Life Care service faces particular challenges with recruitment. End of life care was rated as inadequate by CQC in January 2018. The Trust has provided assurance regarding the immediate actions in place to manage this service, together with processes in place to monitor and review the agreed actions. The Trust has been successful in its recruitment of an End of Life Consultant and a Lead Nurse and both have commenced in post. Recruitment of a second End of Life Consultant is underway. Actions in relation to End of Life Care form part of Trust's Overall Improvement Plan in response to the CQC inspection. NHSI has undertaken a themed review of end of life care with positive verbal feedback provided to the Quality Oversight and Assurance Group meeting.

PREVENT WRAP Training
GEH did not achieve the 85% target for compliance with the total workforce to complete WRAP training by March 2018. Performance has risen to 60.1% at the end of July 2018, a significant improvement on the March figure of 46%. GEH has until the end of September 2018 to reach the national compliance target of 85%. The Trust has a PREVENT training plan and training road map with projected targets for compliance. The CCG continues to monitor the Trust's improvement against trajectory through attendance at the GEH Adult and Children Safeguarding Meeting. The trust is on target to achieve compliance by the end of Q2.

3. Quality in Relation to Performance Issues

University Hospitals Coventry & Warwickshire (UHCW)

The Trust currently has no issues on level 2 or 3 of the Quality Assurance Framework that are performance issues with associated quality concerns.

Coventry and Warwickshire Partnership Trust

Items on Level 2 of the Clinical Quality Framework:

Capacity within Integrated Practice Units (IPU) 18-21
Community mental health services are organised into three integrated practice units. IPU Cluster 18 to 21 provides assessment and treatment services for those referred with suspected dementia. The Trust has identified some capacity issues that could impact on patients' access to assessment and treatment. The Trust has provided assurance that there is a mechanism in place for reviewing and prioritising patients. Assurance has also been provided that no patient harm has been identified. The CQC inspection rated this service as inadequate. The CCG received the Trust's action plan at the January 2018 CQRM, which included improvement actions in relation to this service. The Trust has provided the CCG with assurance that actions related to this issue are on track. The CCG continues to monitor through monthly Key Performance Indicator (KPIs) reporting.

George Eliot Hospital

The Trust currently has no issues on level 2 or 3 of the Clinical Quality Framework that are performance issues with associated quality concerns.

4. Other Providers

BMI Meriden
The CQC inspected BMI Meriden in April 2018 and the inspection report was published in June. The CQC rated BMI Meriden overall as 'good' which is an improvement on the previous rating of requires improvement.

Cygnet
Cygnet is a private provider of bedded specialist mental health services based in Coventry. A previous CQC inspection in 2017 rated the service as overall requires improvement. The quality team visited in May 2018 and gained assurance regarding the actions the provider was taking in response to the CQC report. The CQC revisited Cygnet in June 2018 and has now rated Cygnet as being overall good. The quality team continues to liaise with the provider and is seeking further clarification regarding mandatory training.

5. Primary Care Update

Coventry and Rugby CCG
CQC has inspected the majority of Coventry and Rugby CCG practices, with two out of sixty- nine practices yet to be inspected. CQC inspections have identified three practices that have been provided with a rating of overall requires improvement. The CCG is working with CQC and the

three practices to ensure that there are robust improvement plans in place. There have been concerns raised regarding one GP practice; the concerns are being addressed and reported via Primary Care Committee.

Warwickshire North CCG
CQC has inspected all of the twenty-seven Warwickshire North practices all of which have achieved an overall rating of good. There have been concerns raised regarding two GP practices; the concerns are being addressed and reported via Primary Care Committee.

6. Care Homes

Coventry
There are 72 nursing and residential homes across Coventry with a total of 2017 beds. Currently there are three Nursing Homes and one Residential Home that are on escalation.

Warwickshire North and Rugby
There are 96 nursing and residential homes across Warwickshire North and Rugby with a total of 2,229 beds. Two residential homes, both owned by Chasewood Care Ltd, have recently closed in Warwickshire North; one has been deregistered by CQC whilst the other is awaiting the outcome of a CQC Notice of Decision. There are no care homes currently on Service Escalation Panel.

Name	Beds	Themes	CQC Status	Location
Nursing Homes				
Coundon Manor	72	Governance and Leadership	**Requires Improvement** Report: April 2018	CRCCG
Evedale	64	Governance and Staffing	**Requires Improvement** Report: Jan 2018	CRCCG
Keresley Wood	47	Governance and Staffing	**Requires Improvement** Report: April 2018	CRCCG
Residential Homes				
Chasewood Lodge	107	Safeguarding and Well Led	**Inadequate** Report: June 2018 Closed July 2018	WNCCG
The Langleys	15	Health and Safety, Governance and Leadership	**Inadequate** Report: May 2018	CRCCG

Pears Royal National Institute of Blind (RNIB)
The Pears, a registered home with the Royal National Institute for the Blind (RNIB) was rated as Inadequate following a review from OFSTED. An OFSTED monitoring inspection visit took place on the 10th and 11th July 2018 which resulted in OFSTED issuing an 'intent to cancel registration' notification.

An urgent strategic meeting involving all commissioners, inspectors and providers took place on 10th August, and a subsequent meeting was chaired by the CCG Director of Nursing and Quality. CCG clinical leads are working collaboratively with all stakeholders to review, support and monitor improvements. Communication has been shared with commissioning CCG's informing them of the Ofsted inspection and actions in place to provide support.

3 - Provider Level Performance and Quality

UHCW Performance Dashboard

Measure	Threshold	1718	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	1819 YTD
18 weeks referral to treatment									
Incomplete pathways within 18 weeks	92%	83.4%	83.0%	84.4%	84.2%				83.8%
RTT 52 Week Waits	0	391	27	28	27				82
Diagnostic test waiting times									
Diagnostic waiting times	99%	99.6%	99.5%	99.8%	99.8%				99.7%
Accident & Emergency									
A&E 4 hour wait	95%	82.0%	84.8%	90.4%	89.3%				88.2%
12 hour Trolley waits	0	0	0	0	0				0
Access									
Cancelled operation breaches	0	194							0
Operations cancelled for a second time	0	0	0	0	0				0
Cancer									
Cancer Two Week Wait Standard	93%	95.6%	92.4%	93.5%	95.0%				93.6%
Cancer Breast Symptom Two Week Wait Standard	93%	97.6%	66.7%	95.8%	94.4%				83.2%
Cancer 31 Day Standard	96%	98.8%	99.5%	98.0%	99.0%				98.8%
Cancer 31 Day Subsequent Surgery Standard	94%	98.3%	96.8%	100.0%	97.1%				97.9%
Cancer 31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	97.6%				99.2%
Cancer 31 Day Subsequent Radiotherapy Standard	94%	96.7%	100.0%	97.0%	96.0%				96.8%
Cancer 62 Day Standard	85%	85.1%	85.9%	88.0%	84.5%				86.2%
Cancer 62 Day Screening Standard	90%	94.9%	90.5%	90.6%	94.4%				92.1%
Cancer 62 Day Consultant Upgrade Standard	85%	91.1%	86.7%	85.5%	85.7%				85.8%
Cancer 104+ day waits	0	41.5	1	3	2				6
Patient Experience									
Mixed sex accommodation breaches	0	5	0	0	0				0

CCG Quality Dashboard - University Hospitals Coventry & Warwickshire (UHCW)

Indicator	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Patient Experience																
Complaints responded to within timescale (%) (25 days)	90%	95%	92%	92%	84%	90%	79%	71%	93%	85%	93%	N/A	N/A	52%	72%	83%
PALs contacts responded to within 5 working days	N/a	94%			95%	98%	95%	95%	91%	93%	N/A	N/A	N/A	N/A	N/A	N/A
Patient Experience and Friends and Family Test																
A&E Friends and Family Test - percentage recommended	88%	81.00%	81.00%	82.00%	81.00%	92.00%	77.00%	80.50%	80.40%	84.50%	82.00%	77.10%	81.00%	83.00%	84.00%	84.00%
A&E Friends and Family Test - response rate	13.0%	15.70%	13.50%	15.00%	13.80%	13.80%	9.90%	11.30%	11.00%	11.00%	12.10%	11.90%	12.90%	13.60%	12.20%	10.50%
Inpatient Services Friends and Family Test - percentage recommended	96%	91.00%	91.00%	91.00%	92.00%	92.00%	90.00%	91.10%	91.70%	92.00%	92.00%	92.30%	92.00%	92.00%	93.00%	92.00%
Inpatient Services Friends and Family Test - response rate	26.0%	28.20%	25.50%	28.10%	27.00%	24.70%	20.90%	24.50%	23.20%	18.90%	21.10%	21.90%	21.30%	22.30%	20.50%	20.80%
Outpatient Services Friends and Family Test - percentage recommended	94%	87.00%	90.00%	89.00%	89.00%	91.00%	89.00%	90.20%	88.85%	92.07%	92.00%	91.91%	90.00%	94.00%	96.00%	90.00%
Maternity Friends and Family Test Antenatal Care Setting - percentage recommended	96%	96.00%	99.00%	100.00%	96.00%	98.00%	98.00%	94.80%	92.31%	95.30%	94.00%	97.96%	95.00%	94.00%	92.00%	97.00%
Maternity Friends and Family Test Birth Setting - response rate	24.0%	13.40%	15.00%	16.90%	20.00%	16.00%	18.00%	17.00%	N/A	10.00%	16.00%	16.00%	19.00%	16.00%	21.00%	11.00%
Maternity Friends and Family Test Birth Setting - percentage recommended	97%	98.00%	99.00%	98.00%	98.00%	98.00%	97.00%	95.60%	98.51%	98.00%	96.00%	98.57%	100.00%	97.00%	94.00%	100.00%
Maternity Friends and Family Test Post Natal Ward Setting - percentage recommended	95%	99.00%	95.00%	96.00%	96.00%	100.00%	97.00%	94.90%	98.55%	98.10%	96.00%	92.37%	99.00%	97.00%	88.00%	92.00%
Maternity Friends and Family Test Post natal Community Setting - percentage recommended	98%	98.00%	100.00%	97.00%	99.00%	96.00%	98.00%	99.00%	96.63%	95.65%	100.00%	97.85%	99.00%	97.00%	98.00%	97.00%
Hospital-Acquired Infections																
MRSA bacteraemia (post 48 hrs)	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
C.diff	42	2	2	3	3	2	4	2	4	3	4	3	2	4	5	8
Numbers of unjustified breaches	0	0	0	0	0	0	0	5	0	0	0	0	0	0	0	0
Hospital Mortality																
SHMI	1.1	1.0972 (Apr 16 - Mar 17)			1.0950 (Jul 16 - Jun 17)			1.0928 (Oct 16 - Sep 17)			N/A			109.28		
HSMR	100	92.3	91.9	84.8	104.6	86.6	87.7	91.6	98.72	110.77	102.88	101.63	105.36	100.72	106.69	88.63%

Indicator	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Safeguarding Children's Training																
Staff training compliance Level 2 (combines Level 1 and Level 2)	90%	86.90%	86.40%	86.60%	87.00%	85.90%	85.60%	86.80%	86.20%	86.50%	85.40%	85.70%	86.00%	86.90%	88.30%	N/A
Staff training compliance Level 3	90%	88.80%	89.00%	89.10%	88.90%	90.00%	87.20%	87.70%	86.90%	87.40%	86.20%	87.90%	87.00%	86.80%	88.90%	N/A
N/A																
Staff training compliance Level 1	90%	88.00%	86.90%	87.20%	87.20%	85.40%	84.50%	84.90%	84.40%	83.90%	84.30%	85.20%	85.90%	86.90%	88.20%	
Staff training compliance Level 2	90%	92.30%	92.20%	92.60%	86.00%	88.00%	86.40%	85.50%	86.70%	83.30%	83.60%	85.80%	85.90%	87.10%	87.70%	
PREVENT																
% of staff trained - PREVENT awareness	85%		85.10%			89.30%			91.80%			91.10%		N/A	N/A	N/A
% of staff trained - PREVENT WRAP	85%		86.50%			96.80%			96.20%			92.30%		N/A	N/A	N/A
N/																
Compliance with use of the WHO Safer Surgery Checklist	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Patient Safety																
Number of Serious Incidents reported	N/a	19	9	11	12	6	8	12	7	12	9	13	13	7	14	12
Number of overdue Serious Incidents	0	12	14	12	14	15	9	8	6	7	1	1	2	4	3	6
Number of Never Events	0	0	0	0	1	1	0	1	0	2	0	0	0	0	0	0
Duty of Candour failures	100%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Patient Safety Thermometer																
Falls with harm	0.51%	0.19%	0.00%	0.47%	0.09%	0.29%	0.09%	0.18%	0.09%	0.28%	0.29%	0.54%	0.29%	0.18%	0.12%	0.18%
Pressure Ulcers (All)	4.23%	4.47%	2.43%	3.63%	2.61%	2.96%	2.43%	2.83%	3.11%	2.51%	3.89%	4.51%	1.05%	4.32%	4.35%	4.12%
Pressure Ulcers (New)	0.88%	1.05%	0.19%	0.47%	0.65%	0.38%	0.53%	0.37%	0.73%	0.85%	0.72%	1.35%	4.28%	0.92%	0.78%	0.27%
Catheter-Acquired UTI (New)	0.25%	0.00%	0.00%	0.00%	0.09%	0.00%	0.00%	0.06%	0.09%	0.00%	0.00%	0.09%	0.10%	0.28%	0.24%	0.00%
VTE risk assessment	85%	95.25%	93.84%	94.88%	95.99%	94.75%	96.07%	94.52%	93.69%	94.70%	92.65%	90.52%	94.67%	93.11%	92.84%	92.13%
Workforce																
Statutory/Mandatory training	95%	86.04%	85.96%	86.39%	86.63%	85.04%	85.01%	85.55%	85.58%	85.10%	84.29%	84.55%	84.45%	85.89%	86.92%	86.36%
Agency spend as a % of Trust Paybill	7%	6.10%	6.21%	6.69%	6.14%	5.07%	4.82%	6.10%	6.37%	5.86%	6.25%	6.00%	6.47%	6.99%	7.57%	7.00%
PDP Appraisal Compliance	90%	81.94%	83.45%	85.00%	85.98%	86.25%	89.49%	89.55%	88.67%	86.85%	87.59%	88.39%	87.82%	85.78%	85.07%	83.87%
Sickness Absence Rate	4%	3.71%	3.71%	3.89%	4.00%	3.80%	3.77%	4.02%	4.35%	4.50%	4.85%	4.45%	4.09%	4.13%	4.08%	4.06%
Cancer Waiting Times																
100 day cancer waits	0	1.0	4.5	7.0	6.0	2.0	7.5	4.5	1.0	4.5	4.5	3.0	4.0	0.5	3.0	N/A

GEH Performance Dashboard

Measure	Threshold	1718	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	1819 YTD
18 weeks referral to treatment									
Incomplete pathways within 18 weeks	92%	84.0%	83.1%	84.7%	82.5%				84.0%
RTT 52 Week Waits	0	26	1	2	1				26
Diagnostic test waiting times									
Diagnostic waiting times	99%	100.0%	100.0%	99.7%	99.4%				100.0%
Accident & Emergency									
A&E 4 hour wait	95%	87.7%	82.8%	92.6%	91.6%				87.7%
12 hour Trolley waits	0	60	51	0	0				51
Access									
Cancelled operation breaches	0	3	5						5
Operations cancelled for a second time	0	0	0	0	0				0
Cancer									
Cancer Two Week Wait Standard	93%	97.2%	95.9%	98.1%	96.9%				97.2%
Cancer Breast Symptom Two Week Wait Standard	93%	97.0%	93.7%	96.3%	94.0%				97.0%
Cancer 31 Day Standard	96%	97.4%	95.7%	98.4%	100.0%				97.4%
Cancer 31 Day Subsequent Surgery Standard	94%	98.1%	100.0%	100.0%	100.0%				98.1%
Cancer 31 Day Subsequent Drug Standard	98%	100.0%	100.0%	100.0%	No Data				100.0%
Cancer 31 Day Subsequent Radiotherapy Standard	94%	50.0%	No Data	No Data	No Data				50.0%
Cancer 62 Day Standard	85%	84.8%	91.2%	89.7%	85.5%				84.8%
Cancer 62 Day Screening Standard	90%	93.4%	50.0%	100.0%	85.7%				93.4%
Cancer 62 Day Consultant Upgrade Standard	85%	100.0%	100.0%	100.0%	0.0%				100.0%
Cancer 104+ day waits	0	17	0	0.5	0				0.5
Patient Experience									
Mixed sex accommodation breaches	0	2	0	0	0				0

CCG Quality Dashboard - George Eliot Hospital NHS Trust (GEH)

Indicator	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Patient Experience																
Complaints responded to within timescale (%) (25 days)	90%	100%	89%	87%	93%	88%	100%	82%	100%	100%	100%	75%	100%	92%	N/A	N/A
Patient Experience Friends and Family Test																
A&E Friends and Family Test - percentage recommended	87%	85.50%	86.42%	86.27%	87.38%	87.00%	83.00%	85.00%	84.00%	85.00%	85.00%	84.00%	82.00%	83.00%	87.00%	86.00%
A&E Friends and Family Test - response rate	12.5%	25.67%	28.07%	24.12%	20.43%	27.20%	24.70%	25.40%	27.00%	25.70%	27.70%	26.70%	29.40%	31.10%	26.30%	24.00%
Inpatient Services Friends and Family Test - percentage recommended	96%	96.94%	98.40%	98.16%	98.08%	98.96%	97.87%	98.19%	99.00%	97.00%	98.00%	96.00%	89.00%	90.00%	95.00%	98.00%
Inpatient Services Friends and Family Test - response rate	25.9%	22.05%	36.56%	30.52%	32.10%	28.10%	32.90%	26.63%	31.60%	21.70%	20.40%	20.50%	36.90%	35.10%	43.70%	22.60%
Maternity Friends and Family Test Antenatal Care Setting - percentage recommended	97%	96.97%	96.77%	96.55%	90.48%	100.00%	97.67%	96.55%	N/A	85.00%	96.00%	96.00%	95.00%	88.00%	96.00%	95.00%
Maternity Friends and Family Test Birth Setting - response rate	23.9%	47.20%	52.20%	42.20%	46.77%	48.63%	53.55%	51.91%	N/A	48.00%	59.00%	37.00%	62.00%	49.00%	57.00%	49.00%
Maternity Friends and Family Test Birth Setting - percentage recommended	98%	97.37%	96.39%	95.89%	98.85%	93.26%	98.97%	98.94%	N/A	95.00%	97.00%	93.00%	92.00%	94.00%	93.00%	95.00%
Maternity Friends and Family Test Post Natal Ward Setting - percentage recommended	98%	94.87%	96.49%	96.40%	98.85%	96.69%	86.40%	93.75%	N/A	92.00%	98.00%	94.00%	93.00%	87.00%	92.00%	89.00%
Maternity Friends and Family Test Post natal Community Setting - percentage recommended	98%	81.08%	100.00%	83.30%	97.50%	98.30%	95.16%	94.82%	N/A	98.00%	100.00%	100.00%	95.00%	90.00%	94.00%	96.00%
Hospital-Acquired Infections																
MRSA bacteraemia (post 48 hrs)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	N/A
C.diff	13	0	0	3	0	1	0	0	0	2	0	2	0	0	1	N/A
3																
Numbers of unjustified breaches	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	
Hospital Mortality																
SHMI	1.0			110 Jan 16 - Dec 16			108 Apr 16 - Mar 17			106 Jul 16 - Jun 17			107 Oct 16 - Sep 17	N/A	N/A	N/A
HSMR	100	93.68 Mar 16 - Feb 17	N/A	96.50 Apr 16 - Mar 17	96.50 Apr 16 - Mar 17	98.76 Jun 16 - May 17	101.94 Aug 16 - Jul 17	106.11 Sep 16 - Aug 17	108.93 Oct 16 - Sept 17	112.27 Nov 16 - Oct 17	113.99 Nov 16 - Oct 17	115.14 Dec 16 - Nov 17	119.09 Jan 17 - Dec 17	120.23 Feb 17 - Jan 18	120.86 Mar 17 - Feb 18	N/A

Indicator	Threshold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Safeguarding Children's Training																
Staff training compliance Level 2 (combines Level 1 and Level 2)	90%	70%	71%	73%	72.00%	73.00%	69.00%	86.00%	94.00%	93.00%	93.00%	N/A	N/A			
Staff training compliance Level 3	90%	60%	63%	67%	68.00%	68.00%	70.00%	75.00%	94.00%	75.00%	76.00%	N/A	N/A			
Safeguarding Adults Training																
Adults Vulnerable Training	90%	67%	65%	66%	63.00%	63.00%	62.00%	63.00%	67.00%	87.00%	93.00%	N/A	N/A			
Safer Surgery Checklist																
Compliance with use of the WHO Safer Surgery Checklist	100%	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	N/A	
Patient Safety																
Number of Serious Incidents reported	N/a	7	11	6	2	11	2	11	4	3	15	16	7	4	7	5
Number of Never Events	0	0	1	0	2	0	0	0	0	0	0	0	0	0	0	0
Patient Safety Thermometer																
Falls with harm		0.37	0.39	0.40	0.37	0.37	1.55	0.00	0.75	0.00	1.05	0.34	0.35	0.71	0.38	0.00
Pressure Ulcers (All)		10.45%	6.61%	8.06%	11.40%	9.67%	8.53%	6.87%	9.02%	9.47%	9.47%	7.51%	7.34%	10.60%	8.33%	5.61%
Pressure Ulcers (New)		3.36	3.50	2.42	2.94	2.33	1.94	1.53	2.26	2.26	2.11	3.07	2.80	4.59	1.89	2.11
Catheter-Acquired UTI (New)		0.75	0.00	1.21	0.00	0.00	0.00	1.15	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
VTE risk assessment	95%	95.90	96.11	94.35	98.53	97.40	96.12	97.71	96.99	96.24	95.06%	95.56%	96.50%	93.29%	95.45%	93.33%
Workforce																
Statutory/Mandatory training	85%	94%	95%	95%	95%	95%	94%	94%	94%	94%	94%	94%	94%	93%	93%	
PDP Appraisal Compliance	85%	87%	88%	88%	87%	80%	93%	83%	81%	80%	83%	83%	84%	86%	87%	
Sickness Absence Rate	3.39%	3.21%	2.75%	3.72%	4.25%	3.94%	3.68%	3.80%	4.00%	4.31%	5.3%	4.6%	4.5%	4.3%	4.1%	
Cancer Waiting Times																
100 day cancer waits	0	4	9	6	9	5	4	14	12	10	3					

WMAS – Ambulance Response Programme

Category 1 Mean 7:00 90th 15:00	Dec '17			Jan '18			Feb '18			Mar '18			Apr '18			May '18			Jun '18		
	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th
Cov & Rug CCG	444	07:19	13:20	412	06:50	11:49	399	06:56	11:59	358	06:58	11:41	331	06:21	10:51	302	06:36	10:56	387	06:52	11:41
Warks North CCG	194	06:53	11:51	183	07:30	12:35	157	07:32	12:33	158	08:21	14:46	153	07:27	13:22	140	07:19	11:42	157	07:07	11:15
South Warks CCG	198	08:27	15:54	183	08:26	15:12	172	09:04	14:53	162	09:06	16:53	155	07:53	13:36	177	08:45	16:06	151	09:20	16:06
West Mids	6,040	07:04	12:11	5,548	06:48	11:44	4,968	07:03	12:06	5,209	07:10	12:31	4,731	06:50	12:04	4,952	06:51	11:50	4,983	06:59	12:03

Category 2 Mean 18:00 90th 40:00	Dec '17			Jan '18			Feb '18			Mar '18			Apr '18			May '18			Jun '18		
	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th
Cov & Rug CCG	2,986	13:35	26:10	3,049	12:43	23:51	2,718	14:28	27:40	2,970	14:33	28:29	2,602	10:22	19:06	2,728	12:04	22:12	2,762	13:00	23:21
Warks North CCG	1,264	15:37	30:27	1,323	14:06	02:14	1,232	14:48	27:49	1,272	15:22	29:54	1,070	11:52	22:02	1,200	13:03	23:18	1,209	14:00	24:46
South Warks CCG	1,471	15:36	29:18	1,457	15:06	02:52	1,412	16:43	30:44	1,478	16:31	30:57	1,249	13:20	23:38	1,274	15:10	26:39	1,412	15:06	26:21
West Mids	41,688	13:13	24:16	42,458	12:22	22:26	37,719	13:14	24:22	40,958	14:17	26:48	36,659	11:24	20:24	39,132	12:00	21:30	38,309	12:28	22:22

Category 3 90th 120:00	Dec '17			Jan '18			Feb '18			Mar '18			Apr '18			May '18			Jun '18		
	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th	Inc Total	Mean	90th
Cov & Rug CCG	2,773	38:34	91:12	2,538	36:09	86:57	2,313	42:48	98:33	2,452	40:27	99:35	2,374	21:21	48:01	2,598	31:01	70:13	2,618	36:08	79:50
Warks North CCG	1,170	36:58	86:36	1,187	34:13	80:22	1,056	40:22	90:03	1,157	38:13	89:23	1,080	22:37	49:13	1,197	29:18	66:31	1,163	33:14	73:20
South Warks CCG	1,689	35:05	78:24	1,530	30:26	68:20	1,374	34:14	75:40	1,448	31:28	66:45	1,446	22:48	48:25	1,571	27:59	60:53	1,481	33:31	72:21
West Mids	36,405	39:51	92:57	34,914	35:19	82:49	30,876	41:35	96:47	33,150	42:53	102:21	33,298	25:37	55:17	35,666	30:57	68:13	34,041	34:58	77:02

CCG Performance Dashboard - Coventry & Warwickshire Partnership Trust (CWPT)
Mental Health & Learning Disabilities 2018/19

Indicator	Threshold	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Care Programme Approach (CPA)										
Care Programme Approach (CPA) 7 Day Follow Up	95%	97.10%	100.00%	97.00%	97.6%	98.3%	96.55%	98.25%	97.22%	97.30%
Care Programme Approach (CPA) having formal review within 12 months	95%	95.08%	95.20%	95.41%	95.16%	95.7%	95.19%	To be reported in M4	95.46%	To be reported in M4
Inpatients										
Average Length of Ward Stay in Days (age independent services) - excluding rehabilitation	<44	38	37	41	33	33	39	33	40	28
Admissions to Inpatients Services that had access to Crisis Resolution Home Treatment Teams	95%	97.47%	95.89%	95.45%	97.5%	97.0%	98.55%	Data Not Available		98.85%
Minimising Delayed Transfer of Care (MH & LD Services)	<= 7.5%	0.66%	0.92%	0.66%	0.3%	0.3%	2.25%	2.32%	1.74%	1.65%
Emergency Re-admission Rates within 30 Days (age independent services)	<10.80%	8.42%	2.20%	5.32%	7.3%	6.0%	5.95%	4.49%	1.98%	8.62%
Early Intervention Service										
% of service users experiencing a first episode of psychosis or ARMS (at risk mental state) who waits less than two weeks to start a NICE recommended package of care	50% (2017/18) from 1st April 2018 increase to 53%	CRCCG 63% WNCCG 100%	CRCCG 43% WNCCG No pathways	CRCCG 36% WNCCG 0%	CRCCG 78% WNCCG 0%*	CRCCG 79% WNCCG 0 pathways	CRCCG 75% WNCCG 50%	CRCCG 11.1% WNCCG 50%	CRCCG 41.7 WNCCG 100%	CRCCG 25%* WNCCG 50%
Memory Assessment Service										
Referral to Assessment within 12 weeks - C&R CCG only	95% (if referrals increase by more than 5% this threshold will not apply)	95.28%			100%			245/252 97.2%		
Referral to Assessment within 52 weeks (WNCCG)		100%			100%			260/261 99.6%		
Referral to Assessment within 52 weeks (SWCCG)		100%			100%					
Referral to treatment within 18 weeks		284/284 100%			317/317 100%			340/340 100%		
% of patients diagnosed with dementia that are offered a PDS package within 4 weeks of diagnosis. The offer will be valid for 6 months with a reminder to service users and carers of the offer of a PDS package in month 3	100%	300/300 100%			209/209 100%			197/197 100%		
CAMHS										
Referral to Treatment: Emergency (48 hours)	100% except Routine (18 weeks) which is 95%	24/24 100%	24/24 100%	24/24 100%	33/33 100%	41/41 100%	49/49 100%	42/42 100%	25/25 100%	24/24 100%
Referral to Treatment: Urgent (5 working Days)		No Referral to treatment within 5 days this month			2/2 100%	4/4 100%	6/6 100%	5/5 100%	No Referral to treatment within 5 days this month	1/1 100%
Referral to Treatment: Routine (18 weeks)		**104/110 94.5%**	**104/110 94.5%**	**104/110 94.5%**	223/228 97.8%	150/154 97.4%	162/162 97.6%	116/116 100%	45/45 100%	44/44 100%
Referral to Treatment: Routine within 26 weeks		110/110 100%	110/110 100%	110/110 100%	226/228 99.1%	153/154 99.4%	164/166** 98.8%	116/116 100%	45/45 100%	44/44 100%

CCG Performance Dashboard - Coventry & Warwickshire Partnership Trust (CWPT)
Mental Health & Learning Disabilities 2018/19

Indicator	Threshold	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
LD Adults										
All clients in service for over 12 months to have had an annual health check (inpatient services)	100%		1/1 100%			4/4 100%			6/6 100%	
LD Children										
Referral to intervention waiting time - community only broken down into group and individual interventions	<18 weeks 95%		0/0 100%			0/0 100%			0/0 100%	
POS										
% seen, physically reviewed and examined by CWPT POS clinician (Junior Doctor) within 3 hrs of admission to the unit from time of arrival at POS	90% (Q1 and Q2) and 95% from Q3 onwards		148/155 95.1%			107/108 99.07%			173/175 98.9%	
Crisis										
% of patients contacted within 4 hours of referral (exclude those service users where an attempt to make contact has happened but the patient is either not contactable by phone or DNA a home visit)	95%	215/217 99.1%	176/177 99.4%	159/162 98.1%	157159 98.7%	176/176 100%	166/171 97.1%	216/218 99.1%	247/248 99.6%	268/274 99.6%
% of service users who have a crisis plan agreed which has been developed in consultation with community IPU, CRHT, patient and carer	Q1 25% Q2 50% Q3 75% Q4 95%		**43.44%**			**46.82%**			**48.60%**	
AMHAT										
90% of all appropriate referrals received from A&E (clock starts on receipt of appropriate referral during the team's normal hours of operation) have had their assessment commenced within 90 minutes from AMHAT receiving the referral Proposed sites to be excluded:- Observation (ward 12) and AMU at UHCW AMU and CDU at GEH Fairfax/Oaken at SWFT	90%		593/640 92.7%			729/813 97%			**728/838 86.9%**	
Response to emergency assessment bed areas will be within 12 hours* from receipt of appropriate referrals during the service hours of operation * 12 hours applies to CDU at GEH and observation areas at all sites except SWFT (which has a 90 min response time) * AMU at GEH and UHCW are classified as generic ward referrals and come within the 36 hours however the team invariably respond far sooner	95%		212/217 98.5%			206/212 97%			227/238 95.4%	
90% of all appropriate referrals received from wards have had their assessment commenced within 36 hours from AMHAT receiving the referral. This will be subject to clinical availability and existing clinical priorities	90%		212/212 100%			369/373 99%			325/366 88.8%	
There will be agreed weekly admissions avoidance targets for each acute site which will be signed off by the AMHAT clinical lead and a nominated lead from each acute site (where possible)	UHCW - 10 admissions per week GEH - 6 admissions per week SWFT - 6 admissions per week (including Fairfax)		**UHCW = 145 GEH = 82 SWFT = 74**			**UHCW = 145 GEH = 118 SWFT = 74**			UHCW = 147 GEH = 100 SWFT = 65****	
CAMHS LAC										
Referral to treatment (4 weeks)	95%		Data collection processes under review			Data collection processes are currenlty being reviewed by CWPT, no information has been submitted for Q4.			20/24 83%*****	
CAMHS ASD										
Waiting time (average) from referral to assessment broken down by CCG	Threshold to be agreed once proposals are signed off by each CCG		CRCCG 71 weeks SWCCG 89 weeks WNCCG 62 weeks			CRCCG 65 weeks SWCCG 88 weeks WNCCG 62 weeks			CRCCG 87.5 wks SWCCG 114 wks WNCCG 65 wks	

CCG Quality Dashboard - Coventry & Warwickshire Partnership Trust (CWPT)

Area	Indicator	Thres-hold	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Patient Experience																	
Patient Experience	Number of complaints	N/a	5	6	13	5	8	6	1	9	5	5	7	7	7	5	11
	Number of PALS Contacts	N/a	56	74	76	57	79	79	76	67	39	63	43	56	55	57	50
	Community Friends and Family Test - percentage recommended	96%	94%	95%	95%	98%	98%	98%	95%	96%	96%	96%	95%	93%	96%	93%	96%
	Mental Health Friends and Family Test - percentage recommended	88%	89%	94%	88%	96%	96%	95%	89%	87%	95%	90%	94%	92%	83%	86%	91%
Hospital-Acquired Infections																	
Hospital-Acquired Infections	MRSA bacteraemia (post 48 hrs)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	C-Difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Mixed Sex Accommodation																	
Mixed Sex Accommodation	Numbers of unjustified breaches (Unify)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Safeguarding Children Training																	
Safeguarding Children Training	Staff training compliance Level 1	90%	97.14%	97.29%	97.13%	96.99%	96.87%	95.99%	96.42%	96.61%	97.03%	96.80%	N/A	96.54%	96.57%	96.67%	
	Staff training compliance Level 2	90%	90.78%	90.32%	90.29%	90.55%	90.27%	90.27%	85.68%	86.58%	86.69%	85.01%	83.99%	84.67%	84.60%	84.75%	84.24%
	Staff training compliance Level 3	90%	88.59%	87.36%	85.56%	86.74%	85.51%	83.33%	82.96%	81.49%	82.22%	79.25%	80.12%	80.52%	79.25%	78.59%	80.49%
Safeguarding Adults Training																	
Safeguarding Adults Training	Staff training compliance Level 1	90%	97.11%	97.29%	97.13%	96.99%	96.90%	95.96%	96.45%	96.61%	97.00%	96.72%	N/A	96.49%	96.59%	96.54%	
	Staff training compliance Level 2	90%	90.53%	90.10%	90.15%	90.48%	90.24%	90.24%	85.69%	86.68%	87.80%	84.93%	83.93%	83.46%	83.16%	83.31%	82.83%
	Staff training compliance Level 3	90%	88.51%	85.37%	86.08%	86.08%	85.71%	92.65%	92.75%	91.30%	89.86%	70.42%	61.54%	70.77%	73.33%	67.74%	62.90%
PREVENT																	
PREVENT	% of staff trained - PREVENT awareness	85%	42.3%			55.30%			66.50%			91.50%			N/A		
	% of staff trained - PREVENT WRAP	85%	39.4%			52.50%			66.70%			96.60%			N/A		
Patient Safety																	
Patient Safety	Number of Serious Incidents reported	N/a	11	10	11	23	10	11	12	10	11	20	12	6	9	9	9
	Number of overdue Serious Incidents	0		1	1	0	1	0	1	5	5	5	5	7	9	6	6
	Number of Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Duty of Candour failures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety Thermometer																	
Patient Safety Thermometer	Falls with harm	0.8%	0.94%	2.82%	1.51%	2.18%	1.93%	1.13%	0.49%	1.09%	0.28%	1.69%	2.20%	1.41%	0.88%	1.43%	0.59%
	Pressure Ulcers (New)	1.16%	1.65%	3.04%	3.04%	1.31%	0.96%	1.58%	0.49%	0.65%	2.48%	1.13%	1.98%	0.94%	0.22%	0.57%	1.47%
	Pressure Ulcers (All)	5.13%	4.47%	5.64%	4.90%	3.49%	3.54%	7.01%	1.95%	4.36%	4.68%	3.38%	4.18%	3.29%	3.94%	2.29%	5.60%
	Catheter-Acquired UTI (New)	0.51%	1.18%	0.22%	0.22%	0.00%	0.00%	0.23%	0.24%	0.00%	0.00%	0.28%	0.00%	0.00%	0.00%	0.00%	0.29%
	VTE risk assessment	11%	6.35%	9.11%	5.08%	9.17%	12.22%	6.33%	9.49%	5.88%	6.61%	7.32%	8.37%	5.88%	5.69%	7.14%	7.37%
Workforce																	
Workforce	Statutory/Mandatory training	95%	4.30%	11.60%	16.90%	24.90%	31.90%	39.70%	48.30%	57.00%	61.90%	70.60%	78.10%	83.50%	7.10%	14.20%	20.50%
	Percentage of Agency Usage	3.6%	4.56%	4.72%	4.63%	4.78%	4.82%	4.94%	4.99%	4.88%	4.89%	4.84%	4.86%	5.03%	6.20%	5.69%	8.45%
	PDP Appraisal Compliance	95%	88.60%	87.70%	88.40%	88.40%	87.90%	85.90%	84.90%	84.80%	84.10%	86.10%	85.80%	86.50%	86.10%	86.30%	85.20%
	Sickness Absence Rate	4.65%	4.08%	4.53%	4.88%	5.13%	5.30%	5.60%	5.28%	5.64%	5.69%	5.51%	5.30%	4.76%	5.00%	5.38%	5.91%

South Warwickshire Foundation Trust: Divisional Dashboard KPIs

Community Dashboard
South Warwickshire NHS Foundation Trust

Measure		Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Community Hospital Average Length of Stay (days)	Nicol Ward - GP Led Respite & Intermediate Care	28	19.5	15.5	17.0	16.5	24.5	22.7	23.1	19.5	20.3	18.2	9.6	28.1	24.5	24.5	17.03
	Ellen Badger - GP Led Rehabilitation Ward	28	31.4	33.7	34.3	16.9	24.0	24.3	31.6	23.7	27.8	22.3	23.3	27.3	19.8	32.09	27.82
	Feldon Ward - Stroke Unit	42	44.3	47.1	48.2	45.9	42.5	28.1	36.9	27.3	46.1	31.1	33.4	63.1	55.6	45.67	38.69
RTT - Open Pathways (Incomplete) by therapy	Physiotherapy - Adult	92%	99.9%	99.9%	99.8%	99.7%	100.0%	99.7%	99.4%	99.5%	99.7%	99.5%	99.5%	99.1%	99.2%	99.8%	99.8%
	Occupational Therapy - Adult	92%	98.4%	100.0%	100.0%	100.0%	100.0%	97.1%	99.1%	98.6%	95.3%	100.0%	98.4%	100.0%	100.0%	100.0%	100.0%
	Occupational Therapy - Paediatric (Non-admitted)*	95%	82.5%	89.7%	88.1%	76.9%	82.1%	91.8%	87.9%	86.3%	96.7%	95.2%	96.9%	100.0%	74.3%	93.9%	96.8%
	Podiatry	92%	95.6%	99.0%	95.1%	94.2%	96.3%	96.3%	97.7%	99.3%	98.0%	98.8%	98.0%	97.4%	95.0%	93.5%	95.3%
	Dietetics	92%	99.3%	99.7%	100.0%	96.4%	99.1%	98.8%	99.3%	99.7%	99.6%	100.0%	99.7%	100.0%	100.0%	100.0%	100%
	Wheelchair Services	92%	100.0%	98.9%	100.0%	100.0%	100.0%	100.0%	98.9%	97.7%	92.5%	80.2%	79.8%	95.2%	78.5%	89.8%	87.1%
Wheelchairs	% of children receiving a wheelchair in 18 weeks (SWCCG)	92%	54.6%			71.4%			90.0%			70.0%			61.5%		
	% of adults receiving a wheelchair in 18 weeks (SWCCG)	92%	32.8%			50.5%			43.9%			48.4%			38.0%		
	% of children receiving a wheelchair in 18 weeks (CRCCG)	92%	33.3%			75.0%			75.0%			40.0%			66.7%		
	% of adults receiving a wheelchair in 18 weeks (CRCCG)	92%	27.8%			38.9%			55.8%			55.9%			44.4%		
	% of children receiving a wheelchair in 18 weeks (WNCCG)	92%	10.0%			50.0%			53.9%			70.0%			53.8%		
	% of adults receiving a wheelchair in 18 weeks (WNCCG)	92%	28.0%			47.6%			40.4%			52.9%			29.4%		

Section 4 – Activity Tracker

Year to Date - Activity Vs Plan Performance for WNCCG & CRCCG

Month 3 2018-2019

Actuals reported from the Monthly Activity Report

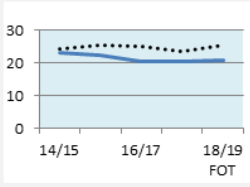
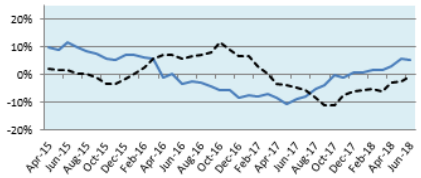
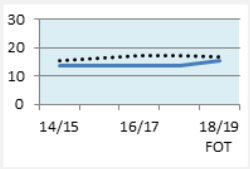
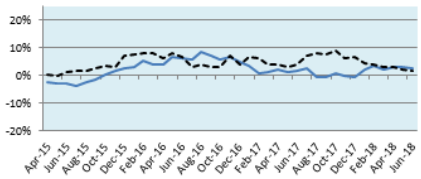
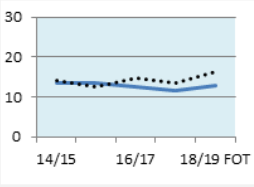
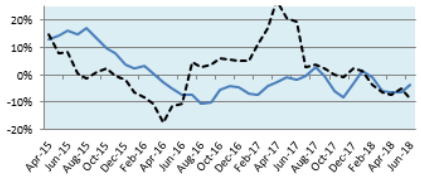
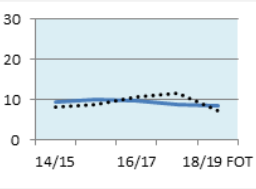
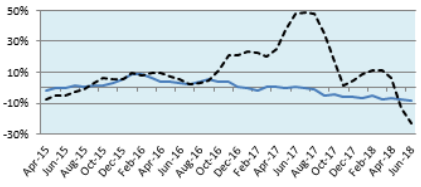
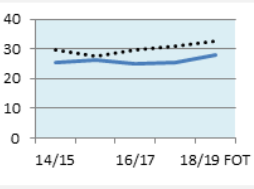
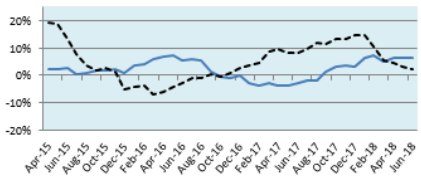
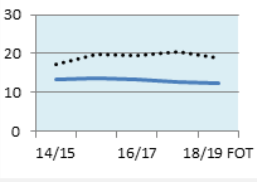
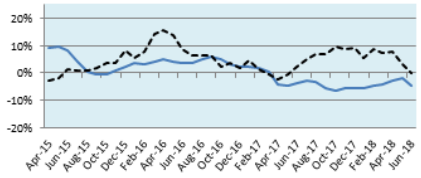
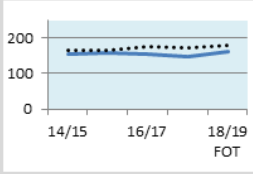
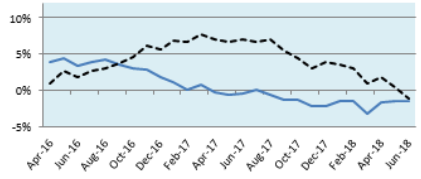
	Warwickshire North CCG							Coventry & Rugby CCG						
	Plan	MAR Actual	Variance	% Variance	SUS Actual	Variance	% Variance	Plan	MAR Actual	Variance	% Variance	SUS Actual	Variance	% Variance
MAR All Referrals (G&A)*	**18080**	**18563**	**483**	**2.7%**				**42689**	**47210**	**4521**	**10.59%**			
MAR GP Referrals (G&A)	10038	10581	543	**5.4%**				24024	27822	3798	**15.81%**			
MAR OTHER Referrals (G&A)	8042	7982	-60	-0.7%				18665	19388	723	**3.87%**			
MAR 1st OP Atts	18338	15314	-3024	-16.5%	17839	-499	-2.7%	48398	37445	-10953	-22.63%	52855	4457	**9.2%**
MAR Total Elective Inpatients**	**6453**	**6528**	**75**	**1.2%**	**6343**	**-110**	-1.7%	**15716**	**16278**	**562**	**3.58%**	**16105**	**389**	**2.5%**
MAR Non Electives	4586	4772	186	**4.1%**	4821	235	**5.1%**	13408	12688	-720	-5.37%	12810	-598	-4.5%
A&E Attendances (Excl Planned Fups)	20205				19958	-247	-1.2%	53208				51292	-1916	-3.6%

* formulated by adding a "All referrals (G&A)" and "Other Referrals (G&A)"

** formulated by adding all elective daycase (G&A) and elective inpatients (G&A)

Please note that GP and Other referrals information is taken from MAR

GP Referrals Tracker: GP-initiated New Outpatient Attendance trends for key specialties

Specialty	Rate per 1000 per annum**	18/19 Forecast year-on-year growth				12 month rolling year-on-year growth in attendances
		CRCCG		WNCCG		
Orthopaedics (Including paediatric orthopaedics)		↑	2.8%	↑	8.4%	
Gynaecology		↑	11.7%	↓	-3.0%	
ENT		↑	11.0%	↑	19.2%	
Cardiology		↓	-2.8%	↓	-36.9%	
General Surgery		↑	9.7%	↑	5.4%	
Ophthalmology		↓	-1.2%	↓	-7.6%	
All Specialties*		↑	9.8%	↑	3.5%	

Source: SUS

CRCCG ------ WNCCG

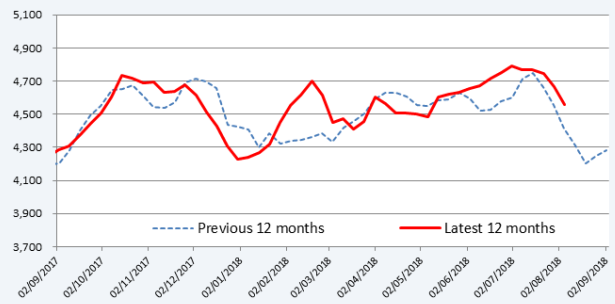
*Excluding non General & Acute specialties ,therapies, pathology, radiology, general medicine and dermatology

Dermatology has been excluded as community clinic activity from Warwickshire North, which has moved to GEH in 17-18 , was not included in the 16-17 baseline and inflates the growth figure.

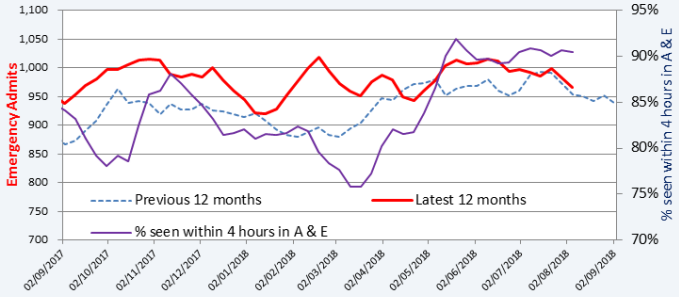
** Adjusted for population growth.

UHCW Weekly Urgent Care Tracker - 4 week rolling average

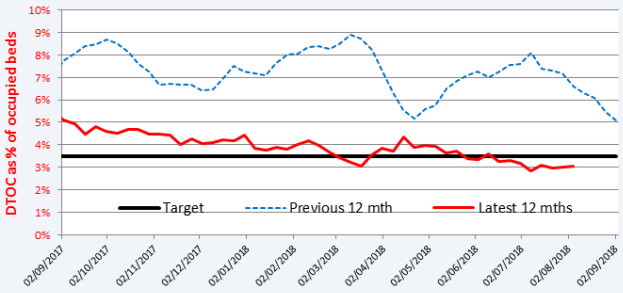
A & E Attendances (Including WIC)



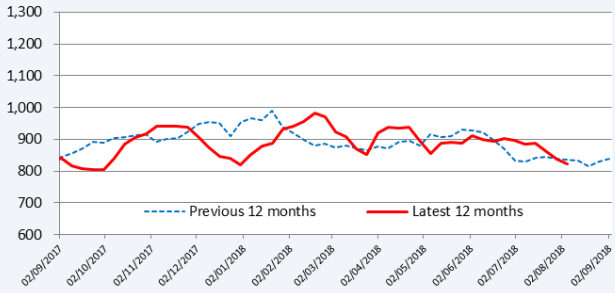
Emergency Admissions via A & E



Delayed Transfers of Care

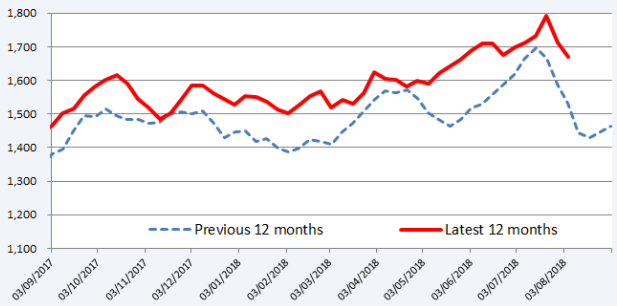


Walk-In Centre Attendances

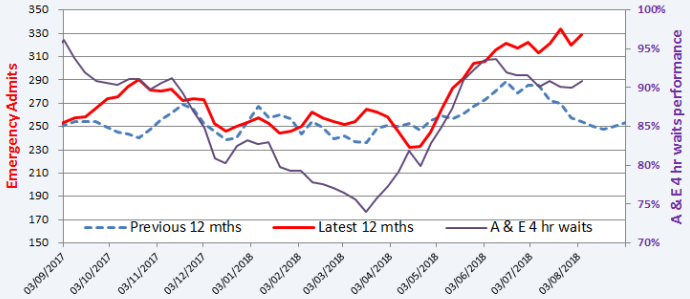


GEH Weekly Urgent Care Tracker

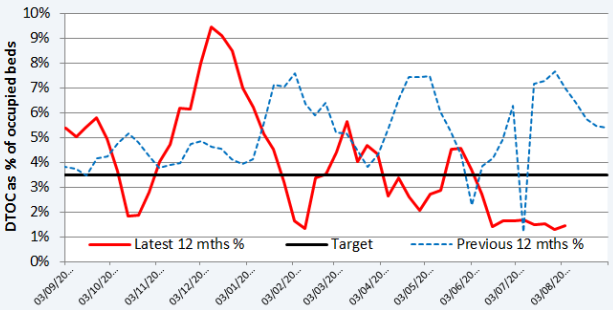
A & E Attendances



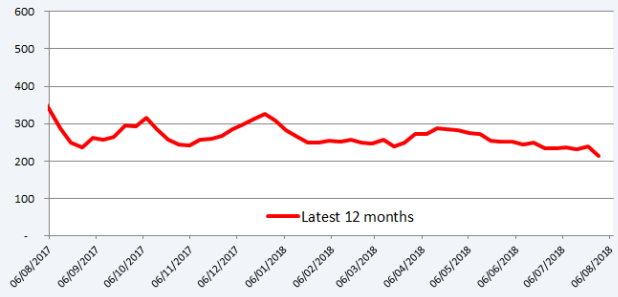
Emergency Admissions



Delayed Transfers of Care



GP Urgent Care Centre Attends



** Rolling 4 week average*

Data Source: SRG Daily Scorecard

Appendices

Appendix 1 – Providers contract performance notices and sanctions applied

Contract Performance Notice	Date Issued	Milestones	Expected Recovery Date
George Eliot Hospital NHS Trust (GEH)			
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A & E department.	12th December 2017	Remedial Action Plan has been received and is being monitored via regular monthly meetings.	March 2019

Contract Performance Notice	Date Issued	Milestones	Expected Recovery Date
Coventry and Warwickshire Partnership NHS Trust			
CAMHS waiting time from initial appointment to follow up appointments 12 weeks (Coventry patients)	31st October 2017	Performance Notice Issued. Commissioners received a revised trajectory in July 2018 and are awaiting an updated Remedial Action Plan outlining the actions being taken to achieve the trajectory and deliver improvement of the target at a CCG level, which it will review. Achievement of the trajectory has been recalculated as follows: North Warks – end August 2018 Coventry – end September 2018 Rugby – tbc (this has not been split off from Coventry and is the subject of further work); Performance against the RAP and trajectory is being closely monitored through the contractual process. A representative from CRCCG and SWCCG attends the fortnightly waiting times meetings held by the Trust. The CCG review an update on the trajectory on a monthly basis at the Contract Technical Meeting. CRCCG are working closely with WCC regarding the Warwickshire CAMHS contract (including Rugby) to monitor performance and the issuing of any Performance Notices	End of July 2018

Contract Performance Notice	Date Issued	Milestones	Expected Recovery Date
University Hospital Coventry and Warwickshire NHS Trust			
Accident and Emergency 4 hour wait	30th June 2017	Contract Management Meeting took place on 11th July 2017; the trust should provide a Remedial Action Plan within 5 working days.	To be confirmed
Referral to Treatment within 18 weeks - Incomplete Pathways	30th June 2017	Contract Management Meeting took place on 11th July 2017; a Remedial Action Plan has been received and is being monitored via regular monthly meetings.	2018/19. The CCG continues to work with the Trust to confirm the exact timescale for recovery and sustainability of the target. March 2018: A revised remedial action plan and trajectory has been received from the Trust and this will be monitored via regular monthly meetings
Zero tolerance RTT waits over 52 weeks for incomplete pathways	30th June 2017	Contract Management Meeting took place on 11th July 2017, Remedial Action Plan received and being monitored via regular monthly meetings.	2018/19. The CCG continues to work with the Trust to confirm the exact timescale for recovery and sustainability of the target. March 2018: A revised remedial action plan and trajectory has been received from the Trust and this will be monitored via regular monthly meetings.
All Outpatient clinic letters (where the Service User's ongoing care and treatment would necessitate the Service User's GP taking prompt action) to be sent within 10 calendar days (7 days from 1st April 2018) following the Service User's outpatient attendance.	19th April 2018	Contract Management Meeting took place on 1st May 2018, draft improvement plans received 4th May 2018 to inform the key lines of enquiry for a Joint Investigation. Updated improvement plans to be shared with CCG for discussion at CQRG on 31st May 2018	Further to the Joint Investigation a Remedial Action Plan has been received from UHCW with actions to be completed by the end of October 2018 and a further audit to be undertaken in February 2019 to provide assurance on the use of the Urgent Flag to a reduction in errors.

Appendix 2

Quality Escalation Matrix

Escalation level	Criteria	Level of risk	Actions for consideration	Reports to
Level Zero	All KPIs are being achieved/within trajectory	Negligible	• Monitor KPIs	CCG Quality meeting
Level One	Minor concern/s	Minor	**Level Zero, plus:** • Risk assess • Share at informal CQRM	Quality meeting Informal CQRM
Level Two	Moderate concern/s	Moderate	**Level One, plus:** • Consider quality assurance visit/deep dive • Request action plan • Agree trajectory for improvement • Escalate to CQRM • Exception report to CPPM	CQRM CQGC Governing Body Risk Register
Level Three	Major concern/s	High	**Level Two, plus:** • Undertake quality assurance visit / deep dive • Raise contract query • Escalate to joint quality contracting meeting • Consider performance notice • Consider inviting executive team to CQGC to provide assurance	CQRM CQGC Governing Body QSG Risk Register
Level Four	Extreme concern/s	Catastrophic	**Level Three, plus:** • Independent review/Appreciative enquiry • Consider Risk Summit • Inform CQC and other regulatory bodies • Invite provider executive team to CQGC to provide assurance	CQRM CQGC Governing Body QSG Risk Register

Appendix 3 – Abbreviations used in this report – alphabetical list

A&E	Accident and Emergency Department
AMHs	Adult Mental Health Services
AMU	Acute Medical Unit
BCF	Better Care Fund
CAMHs	Children and Adolescents Mental Health Services
CCG	Clinical Commissioning Group
Cf & P	Commissioning, Finance & Performance Committee
CPA	Care Programme Approach
CQGC	Clinical Quality and Governance Committee
CQSG	Clinical Quality, Safety and Governance Committee
CT	Computed Tomography scan
C&RCCG	Coventry and Rugby Clinical Commissioning Group
CWPTC	Coventry and Warwickshire Partnership NHS Trust
ED	Emergency Department
EMAS	East Midlands Ambulance Service NHS Trust
ENT	Ear Nose and Throat
F & P	Finance & Performance Committee
GEH	George Eliot Hospital NHS Trust
GP	General Practitioner
HEFT	Heart of England NHS Foundation Trust
HSMR	Hospital Standardized Mortality Ratio
IAPT	Improving Access to Psychological Therapies
KPI	Key Performance Indicator

NHS	National Health Service
POD	Point of Delivery
PSA	Prostate-specific antigen
RAP	Remedial Action Plan
RCA	Root Cause Analysis
ROH	The Royal Orthopaedic Hospital NHS Foundation Trust
RTT	Referral to Treatment
SDIP	Service Development and Improvement Plan
SHMI	Summary Hospital-Level Mortality Indicator
STF	Sustainability and Transformation Fund
SWCCG	South Warwickshire Clinical Commissioning Group
SWFT	South Warwickshire NHS Foundation Trust
TRUS	Transrectal ultrasound guided biopsy
UHCW	University Hospitals Coventry and Warwickshire NHS Trust
WHO	World Health Organization
WIC	Walk-In-Centre
WMAS	West Midlands Ambulance Service NHS Foundation Trust
WNCCG	Warwickshire North Clinical Commissioning Group

NHS Coventry and Rugby Clinical Commissioning Group
NHS Warwickshire North Clinical Commissioning Group | Enc x

Report To:	Finance and Performance Committee
Report Title:	Month 6 2019/20 Performance Report
Report From:	Andrew Harkness
Date:	5th December 2019
Previously Considered by:	N/A

Action Required							
Decision:		**Assurance:**	✓	**Information:**		**Confidential**	

Purpose of the Report:

To provide assurance to the Committee of the performance in Sept 2019 of services commissioned by Coventry and Rugby CCG and Warwickshire North CCG.

Key Points:

Following on from discussions at the last F&P Committee and Governing Body, focus is being given to the priorities identified as key performance issues for both CCGs by NHS England / Improvement, as well as the wider performance areas identified locally as issues important to raise with F&P Committee from across the total portfolio of the two CCGs:

This report therefore focuses on the following areas, and gives a summary of the actions being taken to address delivery:

- A&E 4 hours
- Cancer 62 days
- Out of Area Mental Health Placements
- Transforming Care

Other areas are covered where there are ongoing issues .These include the following:

- RTT 18 weeks
- Dementia Diagnosis
- IAPT Access
- Delayed Transfers of Care
- Care Programme Approach

A & E 4 hours
A & E 4 hour waits performance worsened in October falling to 80.6% at UHCW and 75.7% at GEH, with 2 reported over 12 hour trolley breaches within the published national dataset for September. However there were no 12 hour trolley wait breaches in October.

Cancer 62 days
CRCCG performance fell slightly below the 85% target to 82.9% in September. WNCCG performance deteriorated significantly to 67.5%. At UHCW there was significant underperformance in Gynaecology as a result of the lack of outpatient capacity to meet the 14 day target in August.

WNCCG performance deteriorated significantly to 67.5% in September. At GEH factors driving down underperformance include histopathology delays, capacity issues (diagnostics), reliance on Tertiary provision, oncology capacity.

Out of Area Mental Health Placements
Out of Area Placements increased in August to above trajectory. The trajectory submitted in June 2019 has now been reviewed and through a robust process of alignment against the revised action plan.

Transforming Care
The TCP has seen significant success in relation to children's admissions over the last 10 months, moving from having the highest number of inpatient children in the region to our current position, which is below the end of year trajectory with further discharges anticipated. However it is anticipated that by March 2020 there will be 16 adults in NHSE funded beds against a trajectory expectation of 13. The cohort of people who have been admitted to CCG funded adult beds is also significantly above trajectory levels at 31 compared with a March 2020 target of 13 due to a significant spike in July when there were 11 admissions .

RTT 18 weeks
84.2% of CRCCG patients had been waiting less than 18 weeks from their GP referral against a target of 92%. However long waits have fallen and the number waiting over 40 weeks has fallen considerably. UHCW is part of the national pilot for average waiting times, and as such currently has an average waiting time of 10.3 weeks, but is working to reduce this to 9.5 weeks by the end of March 2020

83.1% of WNCCG patients had been waiting less than 18 weeks from their GP referral date. Trust capacity at GEH has been constrained by emergency pressures on inpatient electives, and capacity issues arising from the impact of the HMRC tightening on pensions and consultants resisting doing additional sessions.

Dementia Diagnosis
Performance remains flat at 63.1% for CRCCG and 61.7% for WNCCG and despite positive activities to promote early diagnosis in Dementia, there are a number of reasons why performance is off track:

- Within primary care more work can be done to overcome cultural/organisational challenges preventing a greater uptake of early dementia assessments.
- There is a recognition that no 'magic bullet' exists and no single model or approach has been championed and promoted by NHSE and therefore the challenge is multi-faceted.

IAPT Access

There was a steady month-on-month improvement in performance against the IAPT access target for both CCGs between April and July. However performance dipped in August to 21.2% for WNCCG and 17.7% for CRCCG. This is expected to have been due to seasonal factors. A Performance Notice was issued to CWPT on the 8th July and the CCG is assured all efforts are being undertaken to reach and sustain the target level of 22% by the end of the financial year.

Delayed Transfers of Care
Delayed transfers of care at GEH remained at below the target level of 3.5% of occupied beds. However UHCW breached again in September with DTOC at 4.4%.There have been a number of very complex patients who are with court of protection and high cost placements. The stranded patient numbers have also increased due to the complexities of the conditions they are presenting with.

Care Programme Approach
This indicator was off track in August 2019 and back above the 95% target in September causing the CCG to underperform in Q2. In August there were 6 local exclusions which have all been counted as not followed up for the purposes of this indicator, all other patients were followed up within 7 days. The Trust continues to adhere to national exclusions where possible.

Recommendation:
Members are asked to note the contents of the attached report.

Implications							
Objective(s) / Plans supported by this report:	1,2,3 & 4						
Conflicts of Interest:	N/A						
Financial:	**Non-Recurrent Expenditure:**	Not applicable					
	Recurrent Expenditure:	[Detail recurrent financial implications including time period. If not relevant state 'not applicable']					
	Is this expenditure included within the CCG's Financial Plan? *(Delete as appropriate)*	**Yes**	✓	**No**		**N/A**	
Performance:	The CCG is required to meet the national NHS Constitution targets						
Quality and Safety:	The report outlines quality and safety issues in relation to commissioned services against the Clinical Governance Framework						
Equality and Diversity:	The report provides information relating to patients with protected characteristics where care is provided by commissioned services						
	Has an equality impact assessment been undertaken? *(Delete as appropriate)*	**Yes** (attached)		**No**		**N/A**	✓
Patient and Public Engagement:	Not applicable						
Clinical Engagement:	Not applicable						
Risk and Assurance:	The following areas are identified on the CCG risk register: • A&E performance UHCW • RTT Performance • CHC Complaints • Lack of Assurance regarding CHC Service Performance • Timely CHC assessments • CHC Transition						

Month 6 19/20
Performance Report Dec 2019

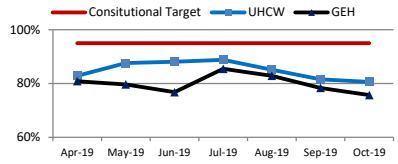
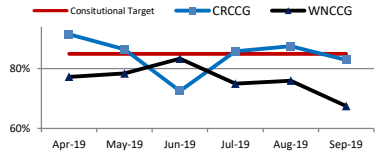
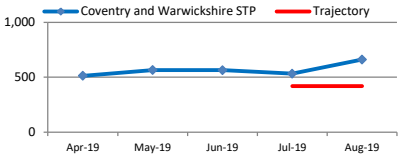
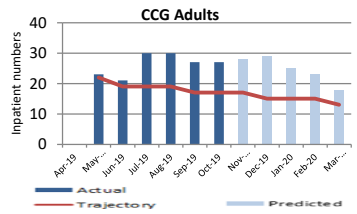
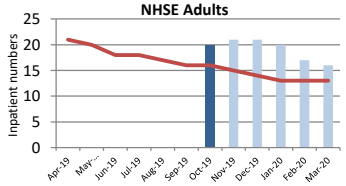
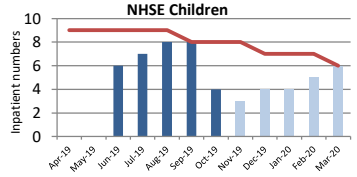
NHS
Warwickshire North
Clinical Commissioning Group

NHS
Coventry and Rugby
Clinical Commissioning Group

Contents

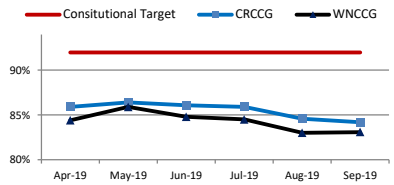
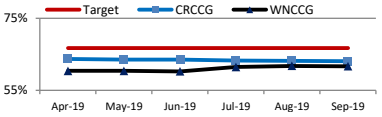
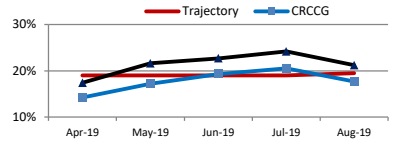
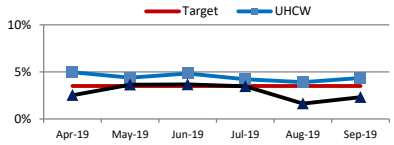
Coventry and Rugby CCG/ Warwickshire North CCG Exception Report Summary

Priority KPIs

Indicator	Trend	Comments	Expected Recovery
A & E 4 hour waits		A & E 4 hour waits performance worsened in October falling to 80.6% at UHCW and 75.7% at GEH, with 2 reported over 12 hour trolley breaches within the published national dataset for September. However there were no 12 hour trolley wait breaches in October. A revised action plan is being developed for UHCW to detail how performance will be impacted through measures around improvements to management of frailty patients, from the new frailty pathways, increasing SDEC pathways, and the impacts of transformation schemes through Coventry Place. GEH is moving its ambulatory care area, to free space in ED, and to increase overall capacity for ambulatory care this is underway and should be complete in December 2019.	TBC
Cancer 62 Days Waits		CRCCG performance fell slightly below the 85% target to 82.9% in September .At UHCW there was significant underperformance in Gynaecology as a result of the lack of outpatient capacity to meet the 14 day target in August. The trust has put in additional clinics to address this but the 62 day wait performance may be impacted for a couple of months. WNCCG performance deteriorated significantly to 67.5% in September. At GEH factors driving down underperformance include Histopathology delays , Capacity issues (diagnostics) ,Reliance on Tertiary provision ,Oncology capacity (SLA with UHCW), GEH in various specialties not following EAG/best practice pathways.	Jan-20
Out of Area Placements (Beddays)		Out of Area Placements increased in August to above trajectory. The trajectory submitted in June 2019 has now been reviewed and through a robust process of alignment against the revised action plan. There is a clear agreement of the stakeholders in the system that whilst the trajectory projection originally sought to be very ambitious, it was appropriate that it was revised to show reductions in OAP's against initiatives towards the latter end of the transformation period to allow a more realistic and maximum period for activities and transformation to embed and yield the required benefits.	Mar-20
Transforming Care for people with Learning Disabilities	  	The TCP has seen significant success in relation to children's admissions over the last 10 months, moving from having the highest number of inpatient children in the region to our current position, which is below the end of year trajectory with further discharges anticipated. However it is anticipated that by March 2020 there will be 16 adults in NHSE funded beds against a trajectory expectation of 13. The cohort of people who have been admitted to CCG funded adult beds is also significantly above trajectory levels at 31 compared with a March 2020 target of 13 due to a significant spike in July when there were 11 admissions . A review of admissions and discharges over the course of 19/20 has identified 3 key reasons for the current position: • The absence of an Autism pathway and limited service provision for those experiencing Autism only has both delayed the discharge process increasing the length of stay and also has limited the admission avoidance interventions available. • A number of admissions have been for people who are either rated as green or not on the Transforming Care register at all. This lack of escalation has prevented admission avoidance interventions that otherwise have proven to be effective in supporting people through a crisis and maintaining them in the community. • A number of discharges have been delayed due to challenges with securing appropriate specialist accommodation, delays in obtaining Ministry of Justice support and the absence of a legal framework to support discharge for those with capacity The current position places the TCP as an outlier, and as a result we have been escalated within the region and identified as a challenged TCP. This has brought with it increased support from NHSE, both financial support and oversight e.g. attendance at SRO weekly assurance calls and monthly meetings with TCP operational leads, in addition to attending the monthly LD and Autism Transformation Board meetings. In response to the sustained position, the TCP has developed a Recovery Plan to progress improved service delivery, organisational co-ordination and overall leadership of the programme. In addition to the Recovery Plan, the TCP has some targeted work in progress to reduce the average length of stay and improve the effectiveness of our discharge planning processes to ensure successful transition to the community.	See TCP update 1

Coventry and Rugby CCG/ Warwickshire North CCG Exception Report Summary

Ongoing Issues

Indicator	Trend	Comments	Expected Recovery
Referral To Treatment 18 weeks		84.2% of CRCCG patients had been waiting less than 18 weeks from their GP referral against a target of 92%. However long waits have fallen and the number waiting over 40 weeks has fallen considerably. UHCW is part of the national pilot for average waiting times, and as such currently has an average waiting time of 10.3 weeks, but is working to reduce this to 9.5 weeks by the end of March 2020 - this is consistent with maintaining RTT as it was, but the Trust is no longer required to publish its RTT performance nationally. 83.1% of WNCCG patients had been waiting less than 18 weeks from their GP referral date. Trust capacity at GEH has been constrained by emergency pressures on inpatient electives, and capacity issues arising from the impact of the HMRC tightening on pensions and consultants resisting doing additional sessions.	TBC
Dementia Diagnosis		Despite positive activities to promote early diagnosis in Dementia, there are a number of reasons why performance is off track: 1. Within primary care more work can be done to overcome cultural/organisational challenges preventing a greater uptake of early dementia assessments. Simultaneously, we need to ensure GPs have access to specialist support or training to make a positive impact upon the early diagnosis standard. 2. Recognition that no 'magic bullet' exists and no single model or approach has been championed and promoted by NHSE and therefore the challenge is multi-faceted.	Mar-20
IAPT access		There was a steady month-on-month improvement in performance against the IAPT access target for both CCGs between April and July. The dip in August is expected to be due to seasonal factors. A Performance Notice was issued to CWPT on the 8th July and the CCG is assured all efforts are being undertaken to reach and sustain the target level of 22% by the end of the financial year.	Mar-20
Delayed Transfers of Care		Delayed transfers of care at GEH remained at below the target level of 3.5% of occupied beds. However UHCW breached again in September with DTOC at 4.4%. •There have been a number of very complex patients who are with court of protection and high cost placements. The stranded patient numbers have also increased due to the complexities of the conditions they are presenting with. •IDT have had sickness and patients are not picked up quickly this has been flagged to the operational team. •There has also been an issue around the PW3 beds and capacity. •Homes are also taking more days than usual to assess patients this has created delays in discharges but has been flagged through commissioning both by health and social services.	Mar-20

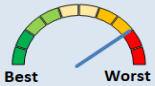
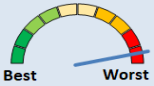
New issues

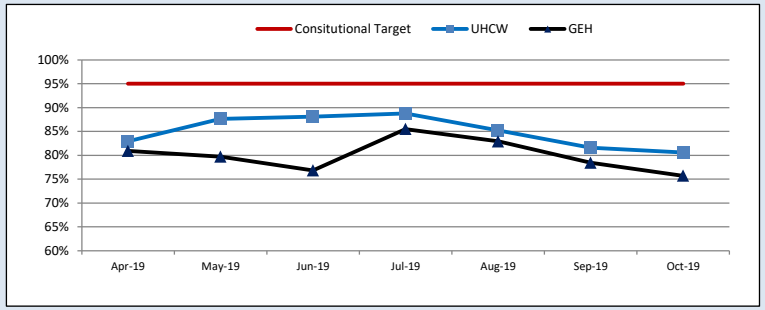
Care Programme Approach (CRCCG)	This indicator was off track in August 2019 and back above the 95% target in September causing the CCG to underperform in Q2. In August there were 6 local exclusions which have all been counted as not followed up for the purposes of this indicator, all other patients were followed up within 7 days. The Trust continues to adhere to national exclusions where possible, however they cannot be applied in all cases.	Q3 19/20

Contract Performance Notices

Trust	Contract Performance Notice	Date Issued	Milestones	Expected Recovery Date
George Eliot Hospital NHS Trust	**Reference Number 1 2019-20 GEH Contract Failed Ophthalmology Pathway**	24th April 2019	Identification of capacity to treat patients First outpatient appointment dates at treating providers Clinical summit with STP acute providers Formalisation of agreed patient treatment pathways	Mar-20
Coventry and Warwickshire Partnership NHS Trust	**Looked After Children – Health Assessments**	21st Dec 2018	The Provider has issued an update against the recovery action plan and trajectory which is being closely monitored through the contractual process. Recovery trajectory on plan for August 2019.	TBC
	EIP - % of service users experiencing a first episode of psychosis or ARMS who waits less than two weeks to start a NICE recommended package of care	20th June 2019	The Contract Performance Notice has been issued on the basis that the Trust has not consistently met the required performance against the KPI for periods exceeding three months throughout 2018/19 for CRCCG and SWCCG. The CCG and Trust are using the forum of an existing EIP Steering Group meeting to develop a joint understanding of the reasons for the underperformance and to co-produce a recovery action plan and measurable trajectory for achievement of the target.	TBC
	IAPT - % of those with depression and or anxiety who enter IAPT	8th July 2019	The Contract Performance Notice has been issued on the basis that the Trust has not met the required performance against the KPI for the 2018/19 year-end target for CRCCG and SWCCG. The CCG and Trust are using the forum of an existing IAPT Steering Group meeting to develop a joint understanding of the reasons for the underperformance and to co-produce a recovery action plan and measureable trajectory for achievement of the target.	TBC

Patients Admitted, Transferred Or Discharged 4 Hours Of Their Arrival At An A&E Department

	Latest Performance	Benchmarked Nationally	Trend	Performance History			
				Month	Prev Month	Quarter 2 19/20	YTD
UHCW			↓	80.6%	81.6%	85.2%	85.5%
GEH			↓	75.7%	78.4%	82.4%	79.6%



Reasons for being off track

UHCW performance is still below the NHS constitutional target, and the STF recovery profile for this year a position which at present the Trust is unable to meet. A&E attendances and corresponding admissions are above last year. A&E attendances are 2.4% above last year and admissions are 6.7% above last year as at the end of September. Pressures are not in themselves attendances, as these have risen less than the national position and less than other local Trusts, but admissions have increased more than the national position, especially around elderly patients with signs of frailty.

GEH A&E attendances and corresponding admissions are still very high above last year. A&E attendances are 7.9% above last year and admissions are relatively level. The STF trajectory expected A&E delivery to be around 80% at this point of the year, to fall to mid 70s in December and to increase to 80% by the end of March. The Trust is currently performing well below this trajectory. NHS E/I and the CCG have asked for a revised recovery plan, due to be with us in the next two weeks.

Existing Recovery Actions

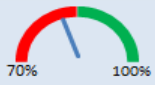
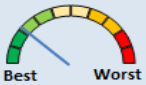
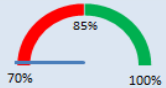
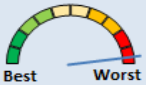
A revised action plan is being developed for UHCW to detail how performance will be impacted through measures around improvements to management of frailty patients, from the new frailty pathways, increasing SDEC pathways, and the impacts of transformation schemes through Coventry Place. Focus remains on normal Trust activities on managing flow, focus on LLOS (superstranded), RED to Green, discharge before 11:00, TTOs being ready earlier in the day, and flow out of the hospital to free up beds for new patients. DTOC figures have remained around 4%, but the number of superstranded patients has not yet seen any reduction. In part this is because of the Hospital at home programme, which is being reviewed. The Trust STF trajectory had it performing above 85% at present reaching 90% by the end of March 2020, the Trust is currently well below this profile. A revised action plan has been requested by NHS E/I and the CCG in response to a new performance notice. There are a range of actions underway but there is a lack of clarity as to the level of impact of each part of the recovery plan.

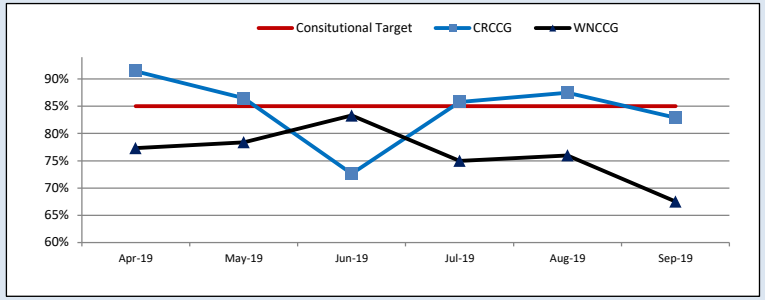
GEH is moving its ambulatory care area, to free space in ED, and to increase overall capacity for ambulatory care this is underway and should be complete in December 2019. There are a suite of actions focusing of PDSA cycles for improvement, such as Frailty, Ambulatory Care, MADE events undertaken to improve flow, renewed focus on Red to Green, avoiding delays for access to specialists, testing to avoid the need to keep people in ED and avoid admissions, focus on patient flow through the Trust, i.e. Red to Green, discharge before 11:00, TTOs in place, and extra capacity is in place to support these. Rotas for staff have been changed to get more senior decision makers dealing with patients earlier in the pathway. All of these will be detailed in the recovery plan, with expectation of the level of impact of each measure on performance. To be reported next time.

CCG Specific Actions

Focus for the system remains on mobilisation of demand management transformation schemes, in particular CHES2, flow through D2A working with the LA to free capacity, the clinical triage of patients in 111, avoidance of ambulance conveyance by WMAS, and focus on reducing levels of HIUs attending A&E. Development of frailty and SDEC pathways, and development of PCNs to support urgent care. There is also focus on the impact of GP case management, extension of GP appointments,. Data from the WMAS SCC indicates a lower level of transfer to hospital and a significant increase in patients being treated at home.

62 Days Waits From Urgent GP Referral To First Defined Treatment For Cancer

	Latest Performance	Benchmarked Nationally	Trend	Performance History			
				Month	Prev Month	Quarter 2 19/20	YTD
CRCCG			↓	82.9%	87.5%	85.6%	84.7%
WNCCG			↓	67.5%	76.0%	71.1%	75.6%



Reasons for being off track

UHCW:

CANCER TYPE	AFTER 62 DAYS	TREATED WITHIN 62 DAYS
Breast	1	93%
Lower Gastrointestinal	0	100%
Lung	2	82%
Other	7.5	73%
Skin	0.5	97%
Urological (Excluding Testicular)	10	55%

At UHCW there was significant underperformance in Gynaecology as a result of the lack of outpatient capacity to meet the 14 day target in August. The trust has put in additional clinics to address this but the 62 day wait performance may be impacted for a

GEH:

CANCER TYPE	AFTER 62 DAYS	TREATED WITHIN 62 DAYS
Breast	0	100%
Lower Gastrointestinal	1	83%
Lung	1	50%
Other	6	40%
Skin	0	100%
Urological (Excluding Testicular)	4	50%

At GEH the following factors are driving down underperformance: Histopathology delays , Capacity issues (diagnostics) ,Reliance on Tertiary provision ,Oncology capacity (SLA with UHCW) GEH in various specialties not following EAG/best practice pathways.

Existing Recovery Actions

- Additional 2WW capacity been actioned for Breast and Gynaecology.
- New separate weekly review meeting with Director of Operations for long waiters.
- Radiology task and finish group commenced to work through mitigations to improve radiology turnaround times for test and reporting.
- Tracker posts recruitment completed, awaiting staff to work through current notice periods.
- Gynaecology workshop held in September to look at mitigations to improve performance across the Coventry & Warwickshire

Achievements since last report

UHCW: There has ben an improvement in the following cancer types: Lower GI, Lung, Skin
GEH: There has ben an improvement in the following cancer types: Lower GI.

New and Proposed Actions

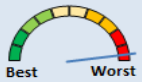
- At last month's Cancer Board meeting the Operational and Performance Group escalated Pathology turnaround times as system issue; this issue and actions will be discussed specifically at the next CWHCP cancer board.
- Through the joint working approach of the Cancer Operational and Performance Group there agreement to clear operating standards from UHCW as a tertiary centre.

CCG Specific Actions

- Urology - a system wide Urology group has already been established through planned care, the system lead for cancer is meeting with the project lead to ensure actions from the two groups dovetail.
- In addition the Cancer Board has set up a system wide workshop on implementation of the prostate 28 day pathway to formulate a system wide action plan going forward.

Total number of inappropriate Out of Area placement (OAP) bed days for adults requiring non-specialist acute mental health inpatient care

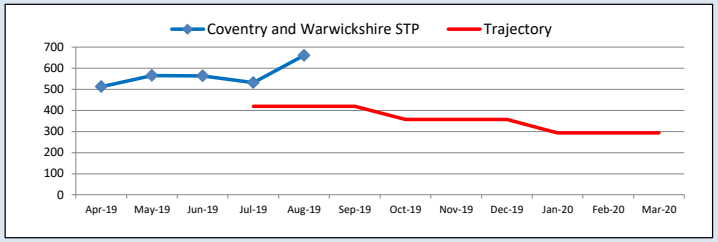
Benchmarked Nationally



Trend

Performance History

Month	Prev Month	Average Quarter 1 19/20	YTD
661	532	548	567



The Five Year Forward View for Mental Health objective is that by 2020/21 Out of Area Placements (OAPs) will essentially be eliminated for acute mental health care for adults.

Reasons for being off track

- Lack of consistent ownership of the OoA numbers and issues, subsequent actions are ad hoc and ineffective in the medium/long term.
- No centrally owned management system from point of admission and discharge, governance and oversight - people spending too long phoning round to expedite admission and discharge
- Reduced bed capacity due to anti-ligature works on x wards
- Lack of community based services for people in crisis outside of CRHT provision - leading to increased admissions and readmissions.
- There is no dedicated acute service pathway for patients with Personality Disorders resulting in a disproportionate use of inpatient services for patients with PD, characterised by frequent stays, longer admissions and occasional specialised PD placements. It is estimated that behaviours associated with behavioral difficulties account for a significant number of all adult admissions.

Existing Recovery Actions

- Governance: Refreshed governance structure and arrangements, updated policies & standard operating Procedures for Bed Management, Monitor and understand impact of initiatives and interventions to implement intelligence led decision making Transfer of the Acute OAP budget.
- Inpatients: Implementation of Patient Flow Team, Flow Co-ordinator in post, CWPT formally approved funding for Flow Team, Recruitment of team completed.
- "Cambio Bed Management System: Implementation of Patient Flow Team
- Focus on current top 50 long stayers.
- Crisis Resolution and Home Treatment: Implementation of revised CRHT Model ,
- Safe Haven Pilot Warwickshire.
- Enhanced Liaison: Implementation of AMHAT CORE 24
- Psychiatric Clinical Decisions Unit (PCDU
- Street Triage
- Strengthen Community MH Services: New locality based triage for non-urgent referrals, Development of a new cluster 3 pathway with 3rd sector partners, Development of a cluster 4/5 complex mood pathway, Development of Complex Trauma and PD Pathway.
- Step Down : Supportive step down arrangements; Crisis Response In reach, 6 week intensive rehab for patients with longer term needs - 3rd sector pilot, Redesign of the Intensive Day Treatment wards .

Achievements since last report

The Out of Area Action plan from July 2019 details the existing and most recent actions and includes the anticipated impact on bed days and an action risk overview.

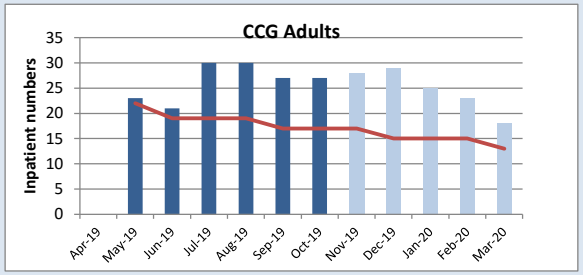
New and Proposed Actions

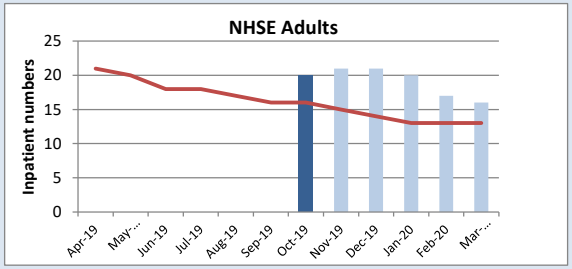
The Out of Area Action plan from July 2019 details the existing and most recent actions.

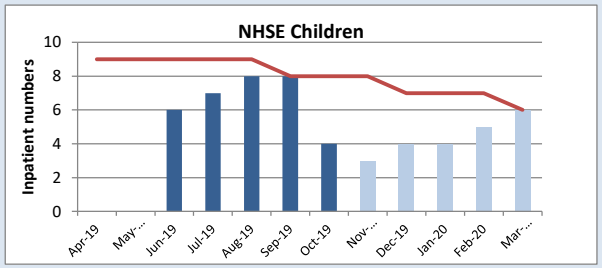
CCG / CWPT Specific Actions

The trajectory submitted in June 2019 has now been reviewed and through a robust process of alignment against the revised action plan. There is a clear agreement of the stakeholders in the system that whilst the trajectory projection originally sought to be very ambitious, it was appropriate that it was revised to show reductions in OAP's against initiatives towards the latter end of the transformation period to allow a more realistic and maximum period for activities and transformation to embed and yield the required benefits.

Transforming Care Partnership - Inpatient admissions for those with a Learning Disability and/or Autism







Reasons for being off track

A review of our admissions and discharges over the course of 19/20 has identified 3 key reasons for the current position:
• The absence of an Autism pathway and limited service provision for those experiencing Autism only has both delayed the discharge process increasing the length of stay and also has limited the admission avoidance interventions available.
• A number of admissions have been for people who are either rated as green or not on the Transforming Care register at all. This lack of escalation has prevented admission avoidance interventions that otherwise have proven to be effective in supporting people through a crisis and maintaining them in the community.
• A number of discharges have been delayed due to challenges with securing appropriate specialist accommodation, delays in obtaining Ministry of Justice support and the absence of a legal framework to support discharge for those with capacity
The current position places the TCP as an outlier, and as a result we have been escalated within the region and identified as a challenged TCP. This has brought with it increased support from NHSE, both financial support and oversight e.g. attendance at SRO weekly assurance calls and monthly meetings with TCP operational leads, in addition to attending the monthly LD and Autism Transformation Board meetings.

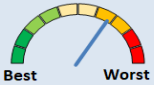
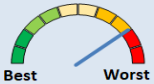
Recovery Actions

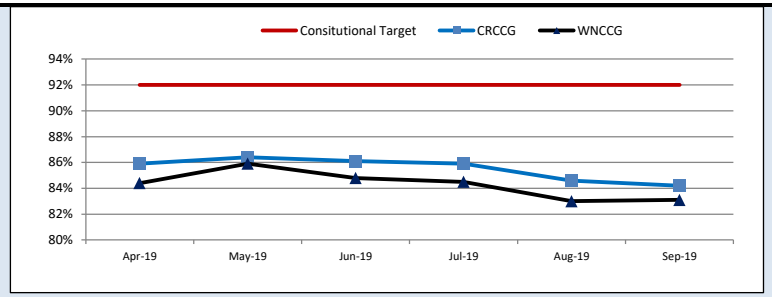
In response to the sustained position, the TCP has developed a Recovery Plan , to progress improved service delivery, organisational co-ordination and overall leadership of the programme. The key elements of this plan are:
• Instigation of an Autism Outreach Service, for those who do not meet the criteria for core Mental Health or LD services, but who require proactive additional support to avoid them moving into crisis.
• Initiating a pilot to provide additional resource into the Adult Intensive Support Team focusing specifically on those with Autism only, and who are at high risk of admission to hospital.

• Increased resources within CWPT to co-ordinate and focus the use of existing services to better support those who fall within the TCP cohort.
• Increased resources to deliver Care and Treatment Reviews and provide improved programme coordination and leadership.
• TCP workshop with colleagues from Worcestershire CCGs to share best practice with a focus on Autism only
• Establishing the multi-agency Admission Avoidance Subgroup to the Learning Disability and Autism Transformation Board to oversee and drive the delivery of the Recovery Plan.

In addition to the Recovery Plan, the TCP has some targeted work in progress to reduce the average length of stay and improve the effectiveness of our discharge planning processes to ensure successful transition to the community. Some specific actions are:
• All planned discharges are overseen by a Discharge Coordinator, reviewed weekly by the SRO with NHSE to escalate any barriers. For those within CWPT, each inpatient is reviewed monthly by the newly established inpatient review panel chaired by the Director of Nursing and Clinical Transformation.
• Stratification of discharges into: long term (those in high/medium secure services or without an appropriate legal frame work), complex (needs bespoke commissioned package) and routine (needs can be met through existing commissioned services).
• Development of a discharge pipeline aligned to wider accommodation developments, linking with the regional housing lead for support.
• Learning from the operational factors that delay discharges which are fed in to monthly meetings to enable system wide change to processes to be implemented to prevent further delays. For example, joint review of funding process for people who do not meet current eligibility for funding for S117, Continuing Healthcare or Care Act.

Patients On Incomplete Non-Emergency Pathways Waiting No More Than 18 Weeks From Referral

	Latest Performance	Benchmarked Nationally	Trend	Performance History			
				Month	Prev Month	Quarter 2 19/20	YTD
CRCCG			↓	84.2%	84.6%	84.9%	85.5%
WNCCG			↑	83.1%	83.0%	83.5%	84.2%



Reasons for being off track

The CCG in agreeing plans for RTT in 2019/20 agreed that RTT would not be expected to be maintained in year at the outturn position, but that total number of waiters should be at the March 2019 position by the end of March 2020. In this respect RTT on track, however total incompletes (total waiters) did see a large rise in April to August, not due to an increase in new clock starts these fell by 1%, but from less clocks being closed. Long waits have fallen and the number waiting over 40 weeks has fallen considerably. UHCW is part of the national Pilot for average waiting times, and as such currently has an average waiting time of 10.3 weeks, but is working to reduce this to 9.5 weeks by the end of March 2020 - this is consistent with maintaining RTT as it was, but the Trust is no longer required to publish its RTT performance nationally. It it working internally to have no over 40 week waiters across all specialties by the end of March 2020 as part of its work on reducing average waiting times. There is a 26 week pilot in place across the STP moving Outpatients currently waiting, and to have no 52 week waiters reported, and is working to move ophthalmology patients to SWFT, this is expected by April to cover all other specialties, with plans being developed in the next months. UHCW expects to deliver 9.5 weeks as an average wait for current waiters, and to deliver no 52 week waits working internally to get to zero over 40 week waits by the end of March 2020.

GEH performance for RTT has fallen, and total waiters have increased. Trust capacity has been constrained by emergency pressures on inpatient electives, and capacity issues arising from the impact of the HMRC tightening on pensions and consultants resisting doing additional sessions. The Trust are looking at ways to get around the NHS pensions issue, but have several consultants who have reduced already their contracted sessions. This is also affecting activity by visiting consultants i.e. UHCW (Oral Surgery/ENT). The Trust is looking to recruit extra capacity where they can, have ringfenced elective capacity in terms of beds for T&O, and are part of a pilot to move patients at 26 weeks to other Trusts i.e. SWFT for Ophthalmology, as part of the STP choice at 26 weeks pilot, which is expected to cover all specialties by the start of April (although implementation plans are being worked through), they already utilise IS capacity for some long wait patients. There are then transformation board activities looking to reduce referrals though Advice and Guidance, MSK FCPs, and reductions in Follow Up activity to free capacity for new patients (Patient initiated follow Up). This will have a limited impact and the expectation is that RTT will remain at its current position, the Trusts expects to deliver no 52 week waiters, but that maintaining the list at March 2019 position will be difficult.

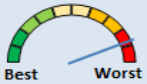
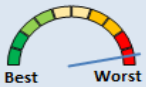
Existing Recovery Actions

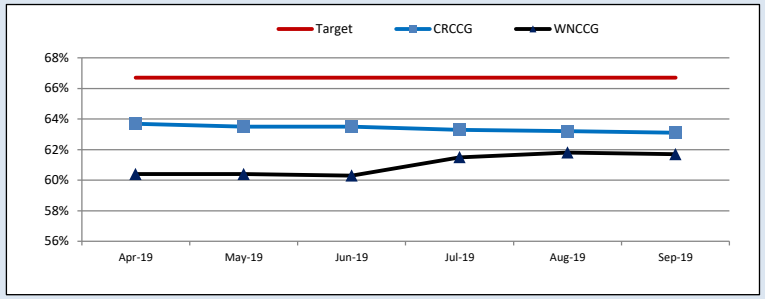
UHCW expects to maintain RTT a through the year at UHCW, any improvement would arise from patients moving to other providers and being seen more quickly than at UHCW, there is a 26 week pilot in place across the STP moving Optients currently waiitng, and to have no 52 week waiters reported, and is working to move ophthalmology patients to SWFT, this is expected by April to cover all other specialties, with plans being developed in the next months. UHCW expects to deliver 9.5 weeks as an average wait for current waiters, and to deliver no 52 week waits working internally to get to zero over 40 week waits by the end of March 2020.The STF recovery profile for GEH of 87%is not being delivered by the Trust, due to continued emergency pressures constraining elective activity. The CCG continues to see a significant movement of referrals away from GEH as a result of patients choosing to be seen where waiting times are shorter. Total patients on the waiting list have grown as a result and is well above the March 2019 position which was expected to be maintained.

CCG Specific Actions

Focus is on demand management activities to restrict GP referrals in line with GP referral guidance especially for LPPs/PLCV, Single point of access for MSK, rollout of consultant connect, all coordinated through the Rugby Place Forum which has oversight of these actions across Coventry and Rugby and the the Warwickshire North Transformation Board. The pilot for 26 weeks has commneced, and work in the next few months will detail how it might be expanded to cover all specialties by April 2020. Considerable focus on long waiters to ensure that there are no over 52 week waiters in year, and the number of over 26 week waiters is managed to avoid negative patient outcomes, with patients continuing to be treated on the basis of their cinical urgency.

Estimated diagnosis rate for people with dementia - GP Practice Registers

	Latest Performance	Benchmarked Nationally	Trend	Performance History			
				Month	Prev Month	Quarter 2 19/20	YTD
CRCCG			↓	63.1%	63.2%	63.1%	63.1%
WNCCG			↓	61.7%	61.8%	61.7%	61.7%



Reasons for being off track

Despite positive activities to promote early diagnosis in Dementia, there are a number of reasons why performance is off track: 1. Within primary care more work can be done to overcome cultural/organisational challenges preventing a greater uptake of early dementia assessments. Simultaneously, we need to ensure GPs have access to specialist support or training to make a positive impact upon the early diagnosis standard. 2. Recognition that no 'magic bullet' exists and no single model or approach has been championed and promoted by NHSE and therefore the challenge is multi-faceted.

Existing Recovery Actions

1. Cross referencing dementia diagnosis data to ensure diagnoses made by the secondary care Memory Assessment Service (MAS) are correctly recorded on GP systems. It has now been agreed that MAS will send lists of patients active on their caseloads to practices every six months. This was carried out for the first time in April and was repeated in October.

2. Ensuring and monitoring that those patients referred back to GPs from MAS with a dementia diagnosis phrased as "Possible" or "Probable" are coded correctly on GP systems. MAS are now recording the ICD10 codes on all diagnostic letters, providing primary care with the relevant READ code to ensure patient records are correct. Reminders have been sent to MAS Clinicians to ensure this continues.

3. Ensuring practices are assured that the necessary high-quality post-diagnostic support is available to back-up increased diagnosis rates, including Dementia Navigators, Admiral Nurses (Coventry) and MAS Community Services. An Admiral Nurse has now been recruited for Warwickshire North, so this is being communicated to practices. Warwickshire County Council's Dementia Navigator service is being reviewed with a view to recommissioning in 2020 (for Coventry the Dementia Navigator service is grant funded until 2023). The Dementia Navigator service will be relaunched as Dementia Connect from April 2020.

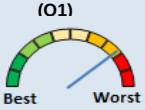
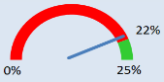
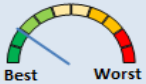
Achievements since last report

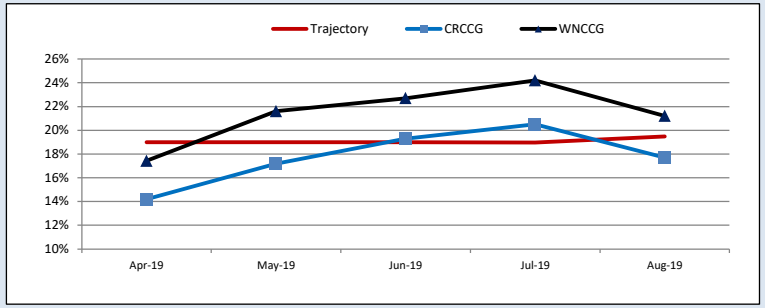
The Cognitive Assessment in Primary Care scheme, which is currently funded until November 2019 has included:
a. Closely monitoring the performance of practices involved and offering individual support and challenge where required.
b. The GP Lead and a Commissioning Manager have been carrying out individual visits to practices to gain feedback, understand challenges and success and support them in trouble-shooting. Practices have fed back that these visits have been beneficial in targeting concerns, and they have enabled us to identify and resolve issues affecting performance.

New and Proposed Actions

1. Considering the future of the Cognitive Assessment in Primary Care Scheme post-November 2019 when current funding ends. Following a review in October 2019, we anticipate recommending that funding is extended for the remainder of the year, then following some adaptations based on learning so far. The CCG's are likely to propose the creation of a Mental Health Enhanced Services offer which would include the Cognitive Assessment Scheme within the scope of this wider service offer. It is anticipated that coverage and sign up to the scheme would be vastly increased across both C&R & WN CCG's as a result.
2. Targeting practices with unexpectedly low dementia registers to support with data cleansing when the CWPT MAS active caseload data is released to practices in October 2019.
3. Developing "Dementia on a Page" support leaflets ensuring GPs, patients and other stakeholders understand the range of support available. These are being developed via the STP.
4. Making use of PLT and CCG lunchtime talks to promote dementia diagnosis and support amongst primary care colleagues.
5. Arranging webinar for GPs with the national support team at NHSE for early 2020.
6. Ensure we are maximising the impact of all patient-facing staff.
7. Investigating the role of CWPT in increasing DDR.
8. Considering whether a care homes dementia assessment programme would be feasible and beneficial.

Improving Access to Psychological Therapy- Access Rate (Annualised)

	Latest Performance	Benchmarked Nationally (Q1)	Trend	Performance History			
				Month	Prev Month	Quarter 1 19/20	YTD
CRCCG			↓	17.7%	20.5%	16.9%	17.8%
WNCCG			↓	21.2%	24.2%	20.6%	21.4%



Reasons for being off track

The IAPT service have flagged that there is a decline in the amount of space available within GP practices, which is impacting on their ability to offer sessions to patients, adversely impacting the access rate. This has been supported by CCG analysis that demonstrates a trend of decreasing referrals in practices that have withdrawn space availability for IAPT therapists. There are a number of emerging third-sector services offering provision similar to IAPT, it is felt that this is also impacting on the number of referrals.

Existing Recovery Actions

An IAPT system steering group with representation from commissioners, IAPT service leads and contracting colleagues meets on a monthly basis and a trajectory and recovery plan has been developed based on the following high impact actions:

- Alignment of therapists with PCNs and creative use of community space
- Expansion of further LTCs i.e. Cardiac (CRCCG) and pain management (SWCCG)
- Increase use of digital therapies i.e. Silvercloud which is linked to IAPTUS
- Develop an offer of group based therapies to employers of blue light services and vets focusing on (stress, anxiety, mindfulness, sleep hygiene etc.)
- Increase the interface with CYP and their carers
- Sharing assessments slots across localities
- Implementation of online referrals

Achievements since last report

Performance has improved for both CCGs beween Apriland July. The dip in August is expected to be due to seasonal factors.

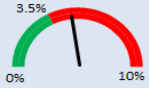
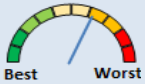
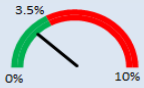
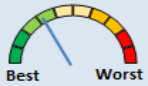
New and Proposed Actions

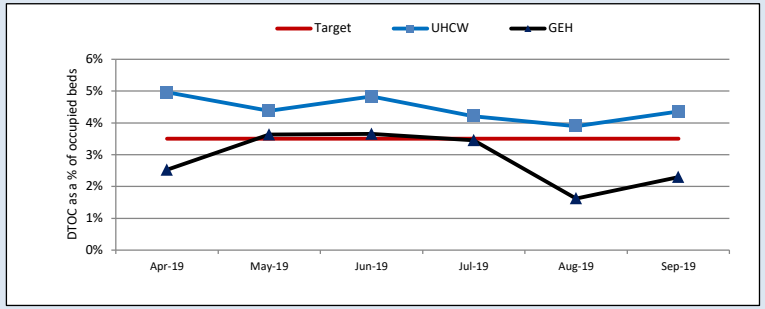
As a result of the Performance notice, performance is improving and we are assured all efforts are being undertaken to meet the access rate, with an expected recovery date in Q4 of 2019/20.

CCG Specific Actions

A performance Notice was issued on the 8th July against the performance of this KPI.

Delayed transfers of Care (As a percentage of occupied beds)

	Latest Performance	Benchmarked Nationally	Trend	Performance History			
				Month	Prev Month	Quarter 2 19/20	YTD
UHCW			↑	4.4%	3.9%	4.2%	4.4%
GEH			↑	2.3%	1.6%	2.5%	2.9%



Reasons for being off track

•There have been a number of very complex patients who are with court of protection and high cost placements. The stranded patient numbers have also increased due to the complexities of the conditions they are presenting with.

•IDT have had sickness and patients are not picked up quickly this has been flagged to the operational team.

•There has also been an issue around the PW3 beds and capacity.

•Homes are also taking more days than usual to assess patients this has created delays in discharges but has been flagged through commissioning both by health and social services.

Existing Recovery Actions

There has been a push on discharges in recent weeks.
The CCG is continuing with daily DTOC meetings and the MADE event which is taking place from the 9th to 13th of December will help with getting back on track.

NHS Oversight Framework Dashboard October 2019

Domain	Area	Measure	Period	Target	Description	CRCCG Data	CRCCG Benchmarked against England	CRCCG Worst/ Best Eng quartile	CRCCG History	CRCCG Trend	WNCCG Data	WNCCG Benchmarked against England	WNCCG Worst/ Best Eng quartile	WNCCG History	WNCCG Trend
New Service Models	Acute Emergency Care and Transfers of Care	127c	2019 Oct	95%	A&E admit, transfer, discharge in 4 hrs	80.6%					75.7%				
		127e	2019 Aug		Delayed transfers of care per 100,000	11.4					7.9				
		127f	18-19 Q2		Hospital bed use following emerg admit	550					501				
	Integrated Primary Care and Community Health Services	127b	19-20 Q2		Emergency admits for UCS conditions	2591					2261				
		131a	19-20 Q1		% NHS CHC assesments taking place in acute hospital setting	1%					0%				
	Personalisation & Choice	105b	19-20 Q1		Personal health budgets (Per 100,000)	26.7					17.6				
		144a	2019 July		Utilisation of the NHS e-referral service to enable choice at first referral	99.94%					99.98%				
Preventing Ill Health and Reducing Inequalities	Antimicrobial Resistance	107a	2019 June	0.965	AMR: appropriate prescribing	0.884					0.997				
		107b	2019 June	10%	AMR: Broad spectrum prescribing	8.3%					9.3%				
	Falls	104a	Q2 19-20		Injuries from falls in people 65yrs +	2321					2091				
	Health Inequalities	106a	18-19 Q2		Inequality in unplanned hospitalisation for chronic ACS and UCS conditions	2183					2098				
Quality of Care and Outcomes	Cancer Services	122b	18-19 Q4	85%	Cancer 62 days of referral to treatment	81.0%					75.9%				
	General	121a	19-20 Q1		High quality care - acute score	61					61				
		121b	19-20 Q1		High quality care - primary care score	67					66				
		134a	19-20 Q1		Evidence based interventions										

Domain	Area	Measure	Period	Target	Description	CRCCG Data	CRCCG Benchmarked against England	CRCCG Worst/ Best Eng quartile	CRCCG History	CRCCG Trend	WNCCG Data	WNCCG Benchmarked against England	WNCCG Worst/ Best Eng quartile	WNCCG History	WNCCG Trend
Quality of Care and Outcomes	Mental Health	123a	19-20 Q1	50%	IAPT recovery rate	52%					56%				
		123b	19-20 Q1	5.5%	IAPT Access	4.2%					5.1%				
		123c	2019 July	53%	EIP 2 week referral	61%					76%				
		123f	2019 June		MH - Out of Area Placements	483					294				
		123g	19-20 Q1		% of people on GP SMI registers receiving physical health checks	18.4%					20.6%				
		123j	2019 May		Ensuring quality of MH data submited to NHS is robust (DQMI)	68.70					86.80				
	People with long term conditions and complex needs	126a	2019 June	67%	Dementia diagnosis rate	63.2%					60.3%				
	Planned Care	129a	2019 March	92%	18 week RTT (% of pts waiting 18 weeks or less)	85.9%					84.4%				
		129b	2019 Aug		Overall Size of Waiting List	29,580					14,837				
		129c	2019 Aug	0	Patients waiting over 52 weeks for treatment	0					0				
		133a	2019 Aug	1%	Pts waiting >6 weeks for diagnostics	0.3%					0.7%				
	Smoking	125d	19-20 Q1	6%	Maternal smoking at delivery	10.4%					15.0%				
Finance and Use of Resources	Finance and Use of Resources	109a	19-20 Q1		Reducing the rate of low priority prescribing										
		141b	19-20 Q1		In-year financial performance										
		145a	19-20 Q1		Expenditure in areas with identified scope for improvement										
Leadership and Workforce	Leadership and Workforce	165a	19-20 Q1		Quality of CCG leadership										

Coventry & Rugby Clinical Commissioning Group NHS Constitution Measures

Measure	Annual Target	Q1	Q2	Q3	Q4	18-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Q1	Q2	19-20 YTD
Referral to treatment times (RTT)																		
Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral	92%	85.6%	85.6%	86.2%	85.7%	85.8%	85.9%	86.4%	86.1%	85.9%	84.6%	84.2%				86.0%	84.9%	85.8%
RTT > 52 weeks breaches - Incomplete Pathways	0	67	34	6	0	107	0	0	0	0	0	0				0	0	0
Patients waiting less than 6 weeks from referral for a diagnostic test	99%	99.6%	99.6%	99.9%	99.7%	99.7%	99.7%	99.2%	99.7%	99.8%	99.7%	99.6%				99.5%	99.7%	99.6%
A&E Waits																		
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (UHCW)	95%	88.2%	89.3%	88.7%	81.6%	86.9%	82.9%	87.6%	88.1%	88.8%	85.2%	81.6%	80.6%			86.2%	85.2%	84.3%
12 Hour Trolley Waits (UHCW)	0	0	0	0	0	0	0	0	0	0	0	0	0			0	0	0
Cancer Waits																		
Cancer two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	93.4%	90.6%	95.7%	96.0%	93.89%	94.8%	97.6%	97.8%	93.7%	90.2%	96.1%				96.7%	93.3%	95.0%
Cancer two-week wait for first outpatient appointment for patients referred urgently with breast symptoms	93%	83.5%	91.8%	97.7%	97.5%	94.12%	93.4%	98.1%	97.3%	99.3%	97.2%	96.3%				96.1%	97.8%	96.9%
Cancer one month (31-DAY) wait from diagnosis to first definitive treatment for all cancers	96%	99.2%	96.3%	97.3%	97.5%	97.51%	97.2%	96.9%	99.4%	100.0%	98.9%	95.8%				97.8%	98.4%	98.2%
Cancer 31-day wait for subsequent treatment where that treatment is surgery	94%	98.4%	96.3%	95.1%	99%	96.74%	96.3%	95.7%	95.2%	92.9%	100.0%	96.6%				95.8%	97.1%	96.4%
Cancer 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	99.1%	100%	100%	100%	99.81%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%	100.0%	100.0%
Cancer 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	96.4%	98.6%	98.7%	96.9%	97.86%	100.0%	94.4%	97.6%	100.0%	100.0%	97.2%				97.6%	98.7%	98.2%
Cancer two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	88.4%	83.8%	85.4%	81.0%	84.81%	91.5%	86.5%	72.6%	85.8%	87.5%	82.9%				83.7%	85.6%	84.7%
Cancer 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	95.8%	94.1%	95.8%	96.8%	95.51%	100.0%	80.0%	88.9%	87.5%	100.0%	100.0%				88.5%	96.3%	92.5%
Cancer 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient	85%	81.6%	87.5%	83.3%	92.6%	85.71%	87.5%	100.0%	84.2%	81.0%	86.4%	94.4%				88.6%	86.9%	85.0%

Coventry & Rugby Clinical Commissioning Group NHS Constitution Supporting Measures

Measure	Annual Target	Q1	Q2	Q3	Q4	18-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Q1	Q2	19-20 YTD
Mixed Sex Accommodation																		
Mixed Sex Accommodation Breaches	0	3	0	2	4	9	1	0	0	1	0	0				1	1	2
Cancelled Operations																		
All patients who have operations cancelled, on or after the day of admission for non-clinical reasons to be **offered another binding date** within 28 days(UHCW). (Breach no.)	0	39	22	18	21	100	27			6						27	6	33
Operations Cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0
Mental Health																		
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.	95%	94.4%	97.4%	98.4%	100%	97.5%	95.4%			94.1%						95.4%	94.1%	94.8%

Coventry & Rugby Clinical Commissioning Group NHS Mental Health Measures

Measure	Annual Target	Q1	Q2	Q3	Q4	18-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Q1	Q2	19-20 YTD
Dementia Diagnosis	67%	59.2%	59.8%	61.1%	63.5%	63.5%	63.7%	63.5%	63.2%	63.3%	63.2%	63.1%				63.5%	63.1%	63.1%
Early Intervention in Psychosis: Percentage of people experiencing First Episode Psychosis (FEP) treated with a NICE-recommended package of care within two weeks of referral.	56%	29%	35%	49%	29%	37%	50%	40%	44%	36%	77%	56%				44%	56%	50%
IAPT 6 Weeks - First Treatment	75%	99.2%	99.2%	99.5%	99.3%	99.4%	98.7%	100.0%	100.0%	98.7%	99.3%					97.2%		99.3%
IAPT 18 Weeks - First Treatment	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%		100%
IAPT Access (Annnualized)	22% for Q4 19/20	17.4%	17.2%	16.9%	18.6%	17.5%	14.2%	17.2%	19.3%	20.5%	17.7%					16.9%		17.8%
IAPT Recovery Rate	50%	54.8%	50.8%	52.1%	51.9%	53.7%	54.4%	52.3%	50.0%	52.0%	53.0%					52.3%		52.2%

Warwickshire North Clinical Commissioning Group NHS Constitution Measures

Measure	Annual Target	Q1	Q2	Q3	Q4	18-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Q1	Q2	19-20 YTD
Referral to treatment times (RTT)																		
Patients on incomplete non-emergency pathways waiting no more than 18 weeks from referral	92%	84.0%	81.5%	84.5%	84.9%	83.7%	84.4%	85.9%	84.8%	84.5%	83.0%	83.1%				83.5%	83.9%	84.2%
RTT > 52 weeks breaches - Incomplete Pathways	0	13	12	13	2	40	0	0	0	0	0	0				0	0	0
Patients waiting less than 6 weeks from referral for a diagnostic test	99%	99.4%	98.9%	99.8%	99.7%	99.5%	99.5%	98.6%	99.6%	99.3%	99.3%	98.9%				99.2%	99.2%	99.2%
A&E Waits																		
Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department (GEH)	95%	89.1%	88.3%	79.9%	80.8%	84.5%	80.9%	78.5%	76.8%	85.5%	82.9%	78.4%	75.7%			78.8%	82.4%	80.6%
12 Hour Trolley Waits (GEH)	0	51	0	12	16	79	19	15	6	0	1	1	0			40	2	42
Cancer Waits																		
Cancer two week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	96.5%	96.2%	97.2%	94.4%	96.06%	96.3%	97.2%	95.0%	96.3%	94.7%	95.3%				96.5%	95.5%	95.9%
Cancer two-week wait for first outpatient appointment for patients referred urgently with breast symptoms	93%	94.9%	94.8%	93.5%	90.5%	93.38%	94.0%	93.1%	60.0%	94.1%	96.0%	97.9%				93.6%	96.1%	94.3%
Cancer one month (31-DAY) wait from diagnosis to first definitive treatment for all cancers	96%	98.3%	98.6%	98.7%	98.2%	98.44%	95.7%	97.6%	97.4%	100.0%	98.8%	96.2%				96.9%	98.4%	97.7%
Cancer 31-day wait for subsequent treatment where that treatment is surgery	94%	100%	94.7%	97.1%	92.1%	96.1%	100.0%	83.3%	100.0%	91.7%	100.0%	92.3%				92.3%	93.3%	93.0%
Cancer 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100%	94.1%	100%	100%	98.68%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%	100.0%	100.0%
Cancer 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	98.9%	99.0%	94.6%	97.3%	97.29%	97.8%	91.4%	100.0%	97.8%	93.9%	96.4%				96.4%	96.3%	96.3%
Cancer two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	91.5%	76.1%	77.0%	75.9%	79.92%	77.3%	78.4%	83.3%	75.0%	76.0%	67.5%				79.9%	71.1%	75.6%
Cancer 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	85.7%	92.9%	94.1%	94.4%	92.19%	50.0%	100.0%	100.0%	100.0%	100.0%	80.0%				90.0%	90.0%	90.0%
Cancer 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient	85%	86%	90.0%	92.9%	76.5%	86.3%	100.0%	75.0%	100.0%	90.9%	100.0%	62.5%				92.3%	84.0%	86.8%

Warwickshire North Clinical Commissioning Group NHS Constitution Supporting Measures

Measure	Annual Target	Q1	Q2	Q3	Q4	18-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Q1	Q2	19-20 YTD
Mixed Sex Accommodation																		
Mixed Sex Accommodation Breaches	0	0	1	1	3	5	0	1	0	1	0	0				1	1	2
Cancelled Operations																		
All patients who have operations cancelled, on or after the day of admission for non-clinical reasons to be **offered another binding date** within 28 days (GEH). (Breach no.)	0	5	5	3	19	32	9			22						9	22	31
Operations Cancelled for a second time	0	0	0	0	0	0	0	0	0	0	0	0				0	0	0
Mental Health																		
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period.	95%	98.0%	92.9%	97.7%	100%	96.3%	95.5%			97.6%						95.5%	97.6%	97.7%

Warwickshire North Clinical Commissioning Group NHS Mental Health Measures

Measure	Annual Target	Q1	Q2	Q3	Q4	18-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Q1	Q2	19-20 YTD
Dementia Diagnosis	67%	59%	58.7%	59%	60.2%	60.2%	60.4%	60.4%	60.3%	61.5%	61.8%	61.7%				60.3%	61.7%	61.7%
Early Intervention in Psychosis: Percentage of people experiencing First Episode Psychosis (FEP) treated with a NICE-recommended package of care within two weeks of referral.	56%	75%	0%	80.0%	60.0%	64.7%	No Data	100%	50.0%	100%	50.0%	100.0%				67%	66.6%	77.7%
IAPT 6 Weeks - First Treatment	75%	98.7%	99.3%	100%	98.3%	99.3%	100%	100%	96.9%	98.4%	100.0%					98.9%		98.8%
IAPT 18 Weeks - First Treatment	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					100%		100%
IAPT Access (Annnualized)	22% for Q4 19/20	17.7%	18.9%	18.1%	21.6%	19.1%	17.4%	21.6%	22.7%	24.2%	21.2%					20.6%		21.4%
IAPT Recovery Rate	50%	57.9%	54.1%	51.3%	52.8%	55.2%	52.0%	62.5%	53.1%	50.0%	57.0%					57.9%		54.7%

Glossary of some key performance targets, monitored by CCGs and NHS England/ Improvement

A&E 4 Hour Target

The operational standard for A&E waiting times is that 95% of patients should be admitted, transferred or discharged hours of their arrival at an A&E department.

Trolley-waits of over 12 hours

The waiting time for an emergency admission via A&E is measured from the time when the decision is made to admit, or when treatment in A&E is completed (whichever is later) to the time when the patient is admitted.

** Note this time is not calculated from the time of arrival at the department, it is from the time a decision is made to admit a patient. By definition therefore any 12 hour breach, excludes time spent in A&E waiting to be seen, assessed and before a decision to admit had been made.

A&E Department Type

1. Emergency departments are a Consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients

2. Consultant led single specialty accident and emergency service (e.g. ophthalmology, dental) with designated accommodation for the reception of patients

3. Other type of A&E/minor injury activity with designated accommodation for the reception of accident and emergency patients.

   The department may be doctor led or nurse led and treats at least minor injuries and illnesses and can be routinely accessed without appointment. A service mainly or entirely appointment based (for example a GP Practice or Out-Patient Clinic) is excluded even though it may treat a number of patients with minor illness or injury. Excludes NHS walk-in centres

4. NHS walk in centres

Cancelled Operation on the Day

A last-minute cancellation is one that occurs on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation.

For example, you are to be admitted to hospital on a Monday for an operation scheduled for the following day (Tuesday). If the hospital cancels your operation for non-clinical reasons on the Monday then this would count as a last-minute cancellation. This includes patients who have not actually arrived in hospital and have been telephoned at home prior to their arrival.

It excludes cancellations which are initiated by the patient, i.e. patient not turning up.

The elective cancelled operations standard is a pledge in the Handbook to the NHS Constitution which states “all patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another

binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.

Cancer Targets

**Note there are 9 operational targets relating to cancer treatment times, 8 of which has an expected operational standard – this standard is below 100% as there is an acceptance that there will be understandable clinical exceptions that would be expected to fall outside this operational target. It is also useful to note that this target is 'of the patients seen' the performance is, patients not seen are not counted in this measure – there are separate targets for this.

In additional nationally performance is formally assessed on a quarterly basis, although each month performance is nationally reported as well by CCG and by NHS provider. The monthly figures are therefore earlier indicators of performance, but it is the quarterly figure that is used to judge an organisations performance actually in year.

This is to avoid issues in regard of low patient volumes in a month, if a Trust only see's five patients in a month if it fails to treat one patient in the month, the operating performance is 80%, remembering that some clinical exceptions are expected and accounted for in the quarterly performance figures.

- A **maximum two-week wait** to see a specialist for all patients referred with suspected cancer symptoms, standard is that **93%** should be seen within the standard;
- A **maximum two-week wait to see a specialist for all patients referred for investigation of breast symptoms**, even if cancer is not initially suspected, standard is that **93%** should be seen within the standard;
- A **maximum one month (31-day) wait from the date a decision to treat (DTT)** is made to the first definitive treatment for all cancers, standard is that **96%** should be seen within the standard;
- A **maximum 31-day wait for subsequent treatment where the treatment is surgery**, standard is that **94%** should be seen within the standard;
- A **maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy**, standard is that **94%** should be seen within the standard;
- A **maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen**, standard is that **98%** should be seen within the standard; ;
- A **maximum two month (62-day) wait from urgent referral for suspected cancer to the first definitive treatment for all cancers**, standard is that **85%** should be seen within the standard;
- A **maximum 62-day wait from referral from an NHS cancer screening service** to the first definitive treatment for cancer, standard is that **90%** should be seen within the standard; ;
- A **maximum 62-day wait for the first definitive treatment following a consultant's decision to upgrade** the priority of the patient (all cancers), **no operational standard in place**;

Issues with low numbers an example:

Using the earlier example, 80% performance against an 85% target could be as simple as 4

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full Year
Met	4	4	5	4	4	4	5	4	4	4	5	4	51
Total	5	5	5	5	5	5	5	5	5	5	5	5	60
Actual %	80%	80%	100%	80%	80%	80%	100%	80%	80%	80%	100%	80%	85%
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Q1	Q2	Q3	Q4
13	12	13	13
15	15	15	15
87%	80%	87%	87%

from 5 patients, the fact that the target is 85% signifies that it is not expected that 100% would ever be expected to be delivered, but the fact that 1 from 5 failed to meet the standard, means mathematically the organisation trips against the standard numerically.

Taking this example further (see below) over 12 months if 5 patients were treated each month, then this gives a total of 60 patients in total, if 85% is the standard – in the year we might then expect 15% of 60 patients to have not met the target, or 9 patients.

If 1 patient failed each month this would give 9 months from 12 not meeting the standard, but over the full year 51 from 60 patients will have met the standard, which equates to 85% so over the year the standard was met.

It also means the organisation met the target in 3 quarters of the year, this is important as often some targets are officially measured for performance on a quarterly basis, such as many of the cancer targets, but performance is reported on a monthly basis.

So for this example, only 25% of monthly data met the target, 75% of quarterly data met the target but 100% of yearly data met the target. Context in this example is clearly very important in judging overall performance.

Cancer Waits over 104 days

The Going Further on Cancer Waiting Times operational standards have been designed to take in to account the practicalities of managing very complex diagnostic pathways, patients who are temporarily clinically unfit for cancer treatment, and those who choose to defer their diagnosis or treatment for personal reasons.

For these reasons, some patients may have a recorded waiting time in excess of 62 days, which is both accurately reported and is clinically directed in the best interests of the patient concerned.

It is also recognised that a small proportion of patients will have a recorded waiting time of more than 104 days for this reason i.e. 6 weeks beyond a breach of the 62 day standard.

The exact approaches to managing patients with a long waiting time, both proactively and retrospectively, require clarification so that avoidable non-clinical factors can be identified and separated from clinically appropriate management, and patient choice.

Equally, providers should have effective processes in place to review such patient pathways and escalation approaches for delays which may have direct clinical significance and/or have resulted in a harm event for the delayed patient concerned.

This ‘backstop’ standard aims to ensure that the cancer operational standards, performance management and reporting arrangements act as a tool to improving access times for all cancer patients.

NHS Provider Boards should receive routine reports on cancer waiting times performance. These reports must show performance against each of the cancer operational standards and the actions being taken to improve and sustain cancer performance.

These reports should be presented in a way which allows the Trust Board to see the number and proportion of patients with a long waiting time.

Where required , the Trust Board should see outcomes of the root cause analysis (RCA) in relation to the cancer pathway/s concerned, and may request further forms of exception reporting as required by local circumstances.

Clinical Commissioning Groups (CCGs or equivalent) may request further exception reporting and ensure that themes identified within the RCAs are embedded in the Trust’s Cancer Improvement Plan.

Diagnostic Waiting Times

The monthly diagnostics collection is used to measure performance against the diagnostic operational standard (less than 1% of patients should wait 6 weeks or more for a diagnostic test).

The monthly diagnostics collection collects data on waiting times and activity for 15 key diagnostic tests and procedures, by provider organisation level, from NHS Trusts, NHS Foundation Trusts and Independent Sector Providers. Data is also reported by Commissioning organisation, i.e. Clinical Commissioning Groups, but in addition, NHS England also nationally commissions some specialised services.

The 15 key diagnostic tests reported within the overall summary measure generally reported in performance reports are:

- Magnetic Resonance Imaging
- Computed Tomography
- Non-obstetric Ultrasound
- Barium Enema
- DEXA Scan
- Audiology - Audiology Assessments
- Cardiology - Echocardiography
- Cardiology - Electrophysiology
- Neurophysiology - Peripheral Neurophysiology
- Respiratory Physiology - Sleep Studies
- Urodynamics - Pressures & Flows
- Colonoscopy
- Flexi Sigmoidoscopy
- Cystoscopy
- Gastroscopy

These waiting times are reported separately to Referral to Treatment Times (RTT) to ensure access to diagnostic tests are managed for all patient pathways, not just GP referrals.

However, the RTT waiting time includes any diagnostic wait. The RTT waiting time is time from referral by a GP to the start of treatment, or discharge back to a GP.

The diagnostic waiting time is exactly that a current aged waiting list profile of current waiters for a diagnostic test, it is not the actual time it took for patients to receive their diagnostic test.

Referral to Treatment (RTT) Waiting Times

92% of patients on an RTT Pathway must have waited less than 18 weeks, from the point of referral by a GP.

A patient's waiting time starts from the point the hospital or service receives a referral letter, or when a patient books their first appointment through the NHS e-Referral Service.

During this time period, the patient may:

- undergo tests, scans or other procedures to help ensure that their treatment is tailored appropriately to their condition
- have medication or therapy to manage their symptoms until they start treatment
- be referred to another consultant or department
- the waiting time ends if a clinician decides no treatment is necessary, you decide you don't want to be treated, or when your treatment begins.

This could include:

- being admitted to hospital for an operation or treatment
- starting treatment that doesn't require the patient to stay in hospital, such as taking medication
- beginning fitting for a medical device, such as leg braces
- agreeing to the patients' condition being monitored for a time to see whether they need further treatment
- Receiving advice from hospital staff to manage their condition.

The 92% standard is the current operating standard used to monitor performance of CCGs and Trusts, and is again of the current patients on an existing RTT pathways, 92% of them have been waiting less than 18 weeks.

The target of actual experienced waiting times by patients ceased to be operationally monitored several years ago.

Constitutional Standard 18 weeks RTT

The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible.

This patient right exists separately to the operational management standard of 92% of current waiter having waited less than 18 weeks.

The maximum waiting time for non-urgent consultant-led treatments is 18 weeks from the day your appointment is booked through the NHS e-Referral Service, or when the hospital or service receives your referral letter.

However, the patient's right to an 18-week waiting time does not apply if:

- They choose to wait longer
- delaying the start of their treatment is in their best clinical interests – for example, where stopping smoking or losing weight is likely to improve the outcome of the treatment
- it is clinically appropriate for their condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage
- the patient fails to attend appointments that the patient had chosen from a set of reasonable options
- the treatment is no longer necessary

Management of Long Waits over 18 weeks

The NHS Long Term Plan has committed the NHS to a zero-tolerance approach to people waiting over a year for planned care and introduced a 52-week maximum wait with fines on commissioners and providers for any breaches.

Operationally this means that there should be no over 52 week waits reported by any CCG or any Trust, from April 2019 onwards.

It also strengthens the right of patients to select an alternative provider where their current one cannot provide them with the elective care they need within six months. This choice of alternative provider at 26 weeks has to be in place across all systems by 1 April 2020.

Delayed Transfers of Care (DTOC)

A delayed transfer of care (DTOC) from NHS-funded acute or non-acute care occurs when an adult (18+ years) patient is ready to go home and is still occupying a bed.

A patient is ready to go home when all of the following three conditions are met:

- a clinical decision has been made that the patient is ready for transfer home
- a multidisciplinary team (MDT) decision has been made that the patient is ready for transfer home
- the patient is considered to be safe to discharge/transfer home.

The monthly return captures delays for patients awaiting lower levels of care, either a discharge home or a transfer to a non-acute bed for intermediate or interim care, irrespective of whether these beds are within the same or a different care provider.

Patients may spend longer in NHS-funded care than is necessary because of delays caused by internal systems within the reporting trust. Although good practice means these delays should be addressed as part of normal internal business improvement practices, internal delays do NOT equate to a delayed transfer of care (DTOC) and must NOT be reported in the monthly return.

Delays caused by external systems, which are outside of the control of the care provider, DO equate to a DTOC and must be reported in the monthly return.

Operationally Trusts are monitored against a target of reducing DTOCs to being less than **3.5%** of total occupied beds. So if a Trust has 100 beds, of which 80 are occupied, and of which 5 of these are reported as DTOCs, this equates to 6.3% DTOCs (5 from 80 beds), note it is not 5 from 100 i.e. total available beds.

Dementia Diagnosis (CCGs)

The NHS publish data about people with dementia for each GP practice. So that the NHS (GPs and commissioners) can make informed choices about how to plan their services around their patients' needs.

These publications include a dementia diagnosis rate indicator, as not everyone with dementia has or is expected to have a formal diagnosis. This statistic compares the number of people thought to have dementia with the number of people diagnosed with dementia, aged 65 and over.

The expectation is that each CCG achieves a **66.7% identification rate** on GP practice lists compared to their estimated prevalence of dementia (calculated nationally). This data is published every month.

Early Intervention in Psychosis

The Early Intervention in Psychosis Waiting Times data contains information on the number of people with first episode of psychosis who have accessed or are waiting for treatment.

From 1st April 2016 at least 50% of people experiencing a first episode of psychosis will commence treatment with a NICE-approved care package, with a specialist early intervention in psychosis (EIP) service within a maximum of two weeks from referral to start of treatment. The standard will be extended to reach at least 60% of people experiencing first episode psychosis, by 2020/21.

Improving Access to Psychological Therapies (IAPT)

This programme began in 2008 and has transformed the treatment of adult anxiety disorders and depression in England. IAPT is widely-recognised as the most ambitious programme of talking therapies in the world and in the past year alone more than one million people accessed IAPT services for help to overcome their depression and anxiety, and better manage their mental health.

Plans set out in the NHS Long Term Plan build on the ambitions of the Five Year Forward View for Mental Health, and will see the number of people with anxiety disorders or depression who can access talking therapies through IAPT increase by an additional 380,000 per year to reach 1.9 million by 2023/24.

For the duration of the Five Year Forward View , prevalence estimates are based on the Adult Psychiatric Morbidity Survey (APMS; 2000).

For the 2023/24 long term plan LTP ambition, the NHS are adopting updated prevalence estimates (APMS; 2014) which include over 75s for the first time, take account of population growth since 2000 and reflect updated CCG boundaries.

This updated prevalence estimate was used to calculate the overall activity ambition set out in the Long Term Plan but are being used to set STP trajectories for the first time in this tool, which means estimates for some STPs have changed. In order to support STPs to transition to the updated prevalence estimates we have developed a phased activity trajectory which apportions the national ambition each year as follows:

- 2019/20 uses access target of 22% - this is the last year of using 2000 APMS prevalence estimates.

- 2020/21 uses national access target of 25% of the total national prevalence taken from CCG plans for 2019/20, this is apportioned using a phased approach to close the gap between the prevalence estimates from 2000 and 2014.
- 2021/22 apportions the LTP 1.6 million national ambition using a phased approach to close the gap between the prevalence estimates from 2000 and 2014
- 2022/23 apportions the LTP 1.8 million national ambition using a phased approach to close the gap between the prevalence estimates from 2000 and 2014
- 2023/24 apportions the LTP 1.9 million national ambition using the 2014 APMS prevalence estimates.

Progress is monitored each month firstly as a yearly coverage rate i.e. the access target of 22% for 2019/20, this is translated into a monthly rate one twelfth of this 1.8% each month, or as a rolling quarterly rate of 5.4%.

The second target is a recovery rate where 50% of patients who complete an IAPTs intervention, are expected to report as having recovered.

Adult Social Care and Health Overview and Scrutiny Committee 13 January 2020

NHS South Warwickshire Clinical Commissioning Group Performance Monitoring

Recommendation(s)

The Adult Social Care and Health Overview and Scrutiny Committee receives and considers this report and notes:

- the CCG Performance Management approach;
- the CCG assurance and governance processes in place;
- the current CCG performance and quality reports.

1. Introduction

1.1. The CCG have a duty to meet the NHS Constitution indicators; to ensure the CCG delivers these requirements the CCG undertakes an annual planning process to set activity, finance and performance plans with its key providers. These plans ensure that sufficient activity is commissioned to meet the health needs of the population of south Warwickshire and to deliver the Constitutional indicators and other national and local key performance and standards. These activity plans and performance requirements are included in the relevant provider contracts.

1.2. The CCG manages performance against these targets through its performance framework by monitoring daily, weekly and monthly performance data to assess provider's performance against the agreed targets and standards.

1.3. The CCG holds its providers to account for delivery of performance through its contract framework which includes monthly Contract Review Group (CRG) meetings and monthly Clinical Quality Review Group (CQRG). Where under performance or failure to deliver the standard is identified, the CCG works collaboratively with the provider's managers and clinicians to understand the reason for the underperformance and to develop and agree recovery action plans and delivery trajectories for the relevant standard or indicator.

1.4. The provider contracts support this process formally and the relevant contract mechanisms and levers are applied as required, including application of contract performance notices and contractual sanctions.

1.5. The CCG and main provider performance is reported monthly through the CCG's governance process. For those indicators that are failing to meet the relevant standard the monthly performance report details the cause of the underperformance, what actions are being completed to improve the performance and the expected date the indicator will be delivered.

1.6. The performance report is scrutinised monthly by the Executive Team and Performance Committee, which includes the clinical lead GPs, and any further actions required are identified.

1.7. The performance report is then discussed in public in the Governing Body meetings. The reports are published on the CCG website 7 days prior to the Governing Body meeting and the public can ask any questions prior to, or at the meeting.

1.8. Separate quality reports are also monitored and reported in the same way.

1.9. The CCG is held to account for its performance by NHS England through the Improvement and Assessment Framework and also through south Warwickshire place based quarterly meetings between NHS England and Improvement, the CCG and South Warwickshire Foundation Trust where finance, quality and performance are reviewed.

2. Current Performance

2.1. In September 2019, the CCG achieved 16 of the 32 NHS Constitution and Acute priority indicators with the main areas of concern remaining:

- A&E 4 hour waits
- Referral to Treatment (RTT) pathway (incomplete aggregate target)
- Diagnostics
- Cancer – Two week wait
- Cancer – 31 day standard
- Cancer – 31 day surgery
- Cancer – 62 day standard

2.2. The CCG achieved 9 of the 18 Mental Health indicators with Dementia and IAPT remaining a priority area.

2.3. Where applicable Contract Performance Notices have been served to the relevant providers for these indicators and Remedial Actions Plans and recovery trajectories have been agreed. Progress against these plans is detailed in the report.

2.4. The CCG report, attached at Appendix 1, details the reasons for the underperformance and actions being taken to address any areas of non-achievement in detail for each indicator failing the required standard.

3. Background Papers

Appendix 1: South Warwickshire CCG Performance Report M6
Appendix 2: South Warwickshire CCG Quality Report

	Name	Contact Information
Report Author	Alison Cartwright Chief Delivery Officer South Warwickshire CCG	Alison.cartwright@southwarwickshireccg.nhs.uk

NHS South Warwickshire Clinical Commissioning Group

Report To:	Performance Committee	**For decision**	
Report Title:	Performance Report, 2019/20, Month 6	**For discussion**	√
Report From:	Alison Cartwright Chief Delivery Officer	**For information**	
Date:	11 December 2019	**Confidential**	

Purpose of the Report:

To update Performance Committee Members on the September 2019 position regarding performance against national targets and priority indicators for NHS South Warwickshire CCG (the CCG).

Key Points:

- The CCG achieved 16 out of the 32 Constitutional and Acute priority indicators in September 2019 with good progress has been sustained/improved for the following indicators:
  - RTT over 52 week waits (Incomplete pathway)
  - Cancer – Two week wait (Breast Symptoms)
  - Cancer – 31 day radiotherapy
  - Ambulance Handover Local Threshold
  - Delayed Transfer of Care (Acute)
  - RTT – Children's wheelchairs

- Areas of concern remain:
  - A&E 4 hour waits
  - Referral to Treatment (RTT) pathway (incomplete aggregate target)
  - Diagnostics
  - Cancer – Two week wait
  - Cancer – 31 day standard
  - Cancer – 31 day surgery
  - Cancer – 62 day standard
  - Cancer – 104 day waits
- The CCG achieved 9 out of the 18 Mental Health indicators with Dementia and IAPT remaining an issue.
- Where applicable Contract Performance Notices have been served to the relevant providers for these indicators and Remedial Actions Plans and recovery trajectories have been agreed. Progress against these plans is detailed in the report.

Recommendation (s):

Performance Committee members note the areas of performance improvement and deterioration and the actions being taken to address these.

Previously Considered By:	**Date:**
Executive Team	4 December 2019

NHS South Warwickshire Clinical Commissioning Group

CCG Strategic Objective(s) this report relates to:	
Out of Hospital	n/a
Personalisation	n/a
Specialist Provision	n/a
Delivering Today	√

Management of Conflicts of Interest:	Not applicable.
Financial Implications:	Financial penalties and with-holds utilised as per the national contract to lever improvements in performance.
Performance Implications:	See detail within the report.
Quality Implications:	See detail within the report.
Equality and Diversity Considerations:	Not applicable.
Patient, Public and Stakeholder Engagement:	Not applicable.
Risk Assessment:	High risk area given current performance challenges.

NHS South Warwickshire Clinical Commissioning Group

Executive Summary

1.1 The report details September 2019 performance for the NHS Constitution Rights & Pledges and priority indicators for both the CCG and its main providers of services. Actions being taken to address any areas of non-achievement are detailed in section 5.

1.2 There were 11 separate NHS Constitution CCG indicators breaching during the month.

Acute Performance at a glance

Performance Summary	Indicators achieved	Indicators breaching	Total Indicators
NHS Constitution – CCG	6	11	17
Priority Indicators not in the NHS Constitution	10	5	15

Good Progress	Basis	Target	Sept-19
A&E: 12 hour trolley waits	SWFT	0	**0**
RTT – 52 week breach	CCG	0	**0**
Cancer 2 week wait – Breast Symptoms	CCG	93%	**94.9%**
Cancer 31 day – subsequent treatment radiotherapy	CCG	94%	**96.3%**
Number of operations cancelled for a second time	SWFT	0	**0**
Operations cancelled for non-clinical reasons not rebooked within 28 days (Quarter 2)	SWFT	0	**0**
DTOC % of delayed bed days as percentage of occupied beds –Acute	SWFT	3.5%	**2.5%**
Ambulance Handover Local Threshold	SWFT	98%	**99%**
CHC: 12+ week cases open at month end (Oct 2019)	CCG	0	**0**
CHC: % eligibility decisions made within 28 days from receipt of Checklist (Oct 2019)	CCG	80%	**100%**
RTT – Children's Wheelchairs (Quarter 2)	SWFT	100%	**100%**
Paediatric – Occupational Therapy *(Non-Admitted)*	SWFT	95%	**98.7%**
Cancer – 31 day standard	CCG	96%	**95.9%**
E-Referrals - Utilisation	SWFT	100%	**99.9%**

NHS South Warwickshire Clinical Commissioning Group

Areas of Concern - NHS Constitution	Basis	Target	Sept-19	Trend from Aug 2019
A&E: Patients should be admitted, transferred or discharged within 4 hours	SWFT	95%	**86.6%**	↓
Diagnostic Tests – Patients shouldn't more than 6 wks	CCG	99%	**98.9%**	↑
RTT – Incomplete Pathway	CCG	92.0%	**91.4%**	↑
Cancer 2 week wait – GP Referrals	CCG	93%	**79.8%**	↓
Cancer 31 day – subsequent treatment surgery	CCG	94%	**90%**	↓
Cancer 31 day – subsequent treatment anti drug regimen	CCG	98%	**96.7%**	↓
Cancer – 62 day standard	CCG	85.0%	**71.2%**	↓
Cancer – 62 day upgrade	CCG	85%	**81%**	↓
Breaches of Mixed Sex Accommodation	CCG	0	**1**	↑

Areas of Concern - National Priority Areas	Basis	Target	Sept-19	Trend from Aug 2019
DTOC % of delayed bed days as percentage of occupied beds -Non-Acute	SWFT	3.5%	**10.6%**	↑
Transforming Care: CCG Cohort	TCP	19	**27**	↑
CHC: % DSTs completed in acute setting (Oct 2019)	CCG	<15%	**22.7%**	↓
Cancer – 104 Day breaches *(patients)*	CCG	0	**3**	↑
Ambulance Handovers 60 minutes +	SWFT	0	**4**	↓
NHS 111: % calls answered in 60 seconds	Local CCGs	95%	**73.7%**	↓

NHS South Warwickshire Clinical Commissioning Group

Mental Health Performance at a glance

Performance Summary	Indicators achieved	Indicators breaching	Total Indicators
NHS Constitution – CCG	1	0	1
Priority Indicators not in the NHS Constitution	8	7	15

Good Progress	Basis	Target	Sept -19
Care Programme Approach: Proportion of patients followed up within 7 days of discharge from psychiatric inpatient care (Quarter 2)	CCG	95%	**100%**
% of patients physically reviewed by Place of Safety clinician within 3 hours of admission (Quarter 2)	CCG	90%	**98%**
% of patients contacted within (4hs) of referral to Crisis	CCG	95%	**99%**
CAMHS - Referral to Treatment (Emergency - 48 hrs)	CWPT	100%	**100%**
CAMHS - Referral to Treatment (Urgent - 5 days)	CWPT	100%	**100%**
CAMHS - Referral to Treatment (Routine - 18 weeks)	CWPT	95%	**100%**
Mental Health: Early Intervention in Psychosis (EIP) – complete patients	CCG	56%	**100%**
Improving Access to Psychological Therapies (IAPT): Recovery Rate (July 2019)	CCG	50%	**59%**
Referrals for ED with treatment started within 1 week (Quarter 2)	CCG	90%	**100%**

Areas of Concern - National Priority Areas	Basis	Target	Sept-19	Trend from Aug 2019
Improving Access to Psychological Therapies (IAPT): Access Rate (Jul 2019)	CCG	4.75% Q3	**3.9%**	↓
Dementia diagnosis percentage (65 + years)	CCG	66.7%	**61%**	↑
SMI Physical Health Checks (Quarter 2)	CCG	34%	**27.5%**	↓

Areas of Concern- Local Priority Areas	Basis	Target	Sept-19	Trend from Aug 2019
Children and Young People's Emotional Well-Being and Mental Health Follow-ups (over 12 weeks) – M5	CCG	12 weeks	**21**	-
Children and Young People's Autism Spectrum Disorder Assessment Waits (CYP ASD) (*over 12 weeks - proxy*) – M5	CCG	12 weeks	**486**	-
% AMHAT referrals received from A&E commencing assessment within 90 mins (Quarter 2)	CWPT	90%	**79%**	↓
% AMHAT referrals received from wards commencing assessment within 36 hours from AMHAT (Quarter 2)	CWPT	90%	**77%**	↓

NHS Constitution Rights and Pledges

3.1 September 2019 performance for the CCG and its main providers is shown below:

NHS Constitution Measures
NHS South Warwickshire CCG

	Measure	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
A&E	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department - **SWFT**	95%	97.7%	95.4%	**92.0%**	**90.2%**	**90.6%**	96.1%	**93.8%**	**93.1%**	**93.2%**	**93.8%**	**91.3%**	**86.6%**
	A&E Trolley Waits of greater than 12 hours (from DTA to admission) **- SWFT**	0	0	0	0	0	0	0	0	0	0	0	0	0
RTT	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral	92%	**89.5%**	**90.4%**	**90.7%**	**91.3%**	**91.1%**	**91.0%**	**90.8%**	**91.3%**	**91.5%**	**90.9%**	**91.1%**	**91.4%**
	Incomplete pathways of greater than 52 weeks	0	**3**	**2**	**1**	0	**1**	**1**	**1**	**1**	**1**	**1**	**2**	0
Diagnostics	Patients waiting for a diagnostic test should have been waiting no more than 6 weeks from referral	99%	99.2%	**98.8%**	**98.4%**	**97.9%**	**98.6%**	99.2%	**98.9%**	**97.7%**	**98.0%**	**97.2%**	**98.0%**	**98.9%**
Cancer - 2WW	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	96.2%	97.7%	98.2%	97.1%	97.1%	97.1%	**88.0%**	**92.5%**	93.7%	96.3%	**89.9%**	**79.8%**
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (cancer not initially suspected)	93%	99.4%	95.9%	97.0%	96.8%	96.5%	96.2%	**72.8%**	94.9%	**92.3%**	93.6%	94.5%	94.9%
Cancer - 31 day	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	**94.5%**	96.2%	99.2%	**95.5%**	97.2%	96.3%	**94.9%**	98.4%	**95.5%**	97.0%	96.2%	95.9%
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	95.7%	95.7%	100.0%	95.5%	100.0%	100.0%	100.0%	100.0%	**93.3%**	**89.3%**	100.0%	**90.0%**
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100.0%	100.0%	100.0%	**93.1%**	100.0%	100.0%	100.0%	100.0%	**97.0%**	100.0%	100.0%	**96.7%**
	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	100.0%	100.0%	96.1%	96.3%	97.4%	97.5%	98.0%	95.7%	98.1%	95.9%	**92.9%**	96.3%
Cancer - 62 days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	**73.1%**	**71.1%**	**80.0%**	**72.1%**	**81.1%**	**79.5%**	**78.4%**	**80.0%**	**59.3%**	**69.8%**	**81.1%**	**71.2%**
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	**85.7%**	**87.5%**	**50.0%**	**80.0%**	0 patients	100.0%	**89.5%**	**87.5%**	100.0%	100.0%	**80.0%**	100.0%
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	85%	89.5%	**81.3%**	85.0%	**72.7%**	**76.9%**	100.0%	92.3%	**72.2%**	100.0%	91.3%	88.2%	**81.0%**
MSA	Breaches of Mixed Sex Accommodation guidelines - Instances	0	**4**	**2**	**4**	**3**	**2**	**2**	**9**	**2**	**1**	**2**	**2**	**1**
Cancelled Operations	All patients who have operations cancelled, on or after the day of admission for non-clinical reasons to be offered binding date within 28 days, or the treatment to be funded at the time and hospital of the patient's choice - **SWFT**	0	**1**			**2**			**1**			0		
	Number of operations cancelled for a second time **- SWFT**	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health	Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period	95%	100.0%			98.2%			95.4%			100%		

NHS Local Mental Health Priorities

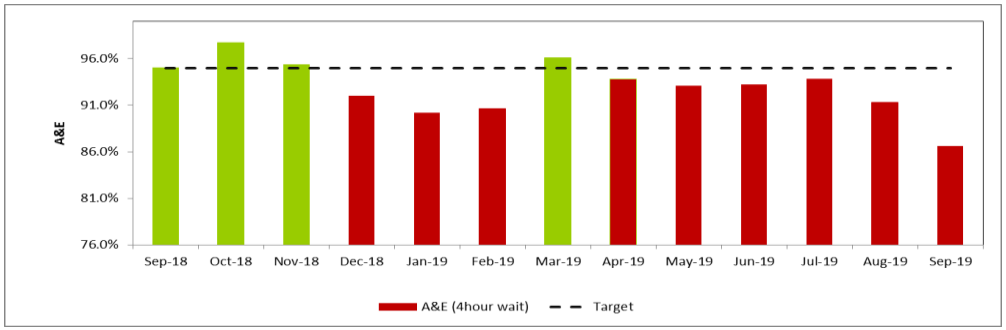
3.2 September 2019 performance for the CCG at CWPT is shown below. Exception reports for non-compliant standards are detailed further on in the report.

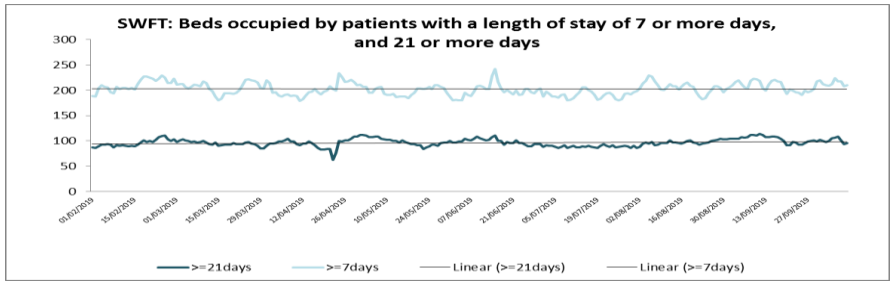
Mental Health Dashboard

Ref	Indicator	Target	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
C10	Adult - % of service users experiencing a first episode of psychosis or ARMS (at risk mental state) who waits less than two weeks to start a NICE recommended package of care - Completed Pathways	50%	N/A	0.0%	N/A	N/A	0.0%	33.3%	0.0%	30.8%	100.0%	100.0%	100.0%	100.0%
CON29	% of patients contacted within (4 hours) of referral to the Crisis Team	95%	93.2%	96.2%	99.4%	100.0%	100.0%	98.7%	99.4%	96.6%	97.1%	97.5%	99.0%	99.0%
CON36	Adult - % seen, physically reviewed and examined by CWPT POS clinician (Junior Doctor) within 3 hrs of admission to the unit from time of arrival at POS	Q4 - 95%	100.0%			100.0%			100.0%			98.0%		
SQ92a	Adult - 90% of all appropriate referrals received from A&E which have had their assessment commenced within 90 minutes from AMHAT receiving the referral.	90%	94.1%			92.8%			85.0%			79.0%		
SQ94	Adult - 90% of all appropriate referrals received from wards have had their assessment commenced within 36 hours from AMHAT receiving the referral. This will be subject to clinical availability and existing clinical priorities.	90%	96.2%			97.6%			92.0%			77.0%		
From NHSE	Adult - Dementia diagnosis percentage (65 + years)	66.7%	58.6%	59.0%	59.4%	59.0%	59.3%	60.5%	60.2%	60.2%	60.0%	60.7%	60.6%	61.0%
	Adult - Improving Access to Psychological Therapies (IAPT): Access Rate	4.75%	4.6%	4.4%	4.0%	3.9%	4.0%	4.6%	4.4%	4.8%	5.0%	3.9%	*Not available*	
	Adult - Improving Access to Psychological Therapies (IAPT): Recovery Rate	50%	53.6%	55.9%	58.3%	58.1%	56.0%	58.6%	47.6%	48.1%	51.9%	59.0%	*Not available*	
CON10	CAMHS - Referral to Treatment (Emergency - 48 hours)	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	CAMHS - Referral to Treatment (Urgent - 5 working days)	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	CAMHS - Referral to Treatment (Routine - 18 weeks)	95%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	CAMHS - Referrals Received by Navigation Hub (All CAMHS)		184	127	123	128	132	165	137	147	118	159	77	*Not available*
CON149	CAMHS - Waiting time from initial appointment to follow up appointment (12 weeks)	95%	41.0%	32.7%	43.3%	68.0%	66.7%	57.5%	57.0%	70.0%	62.0%	73.0%	56.3%	48.0%
CON63	CAMHS - ASD Waiting time from referral to assessment (Average wait)	TBC	59	51	52	53	55	54	54	58	60	61	64	*Not available*
CON64	CAMHS - Number of ASD assessments undertaken each month	20	10	16	13	12	10	16	6	9	7	9	9	*Not available*
CYP ED from NHS E	CAMHS - referrals for an assessment or treatment of any eating disorder will access NICE concordant treatment within 1 week for urgent cases	90% for 18/19	100.0%			100.0%			100.0%			100.0%		
CYP ED from NHS E	CAMHS - referrals for an assessment or treatment of any eating disorder will access NICE concordant treatment within 4 weeks for routine cases	90% for 18/19	81.1%			45.5%			80.0%			100.0%		
(CON10)	CAMHS - patients will have an assessment within 48 hours of referral to ALT where medically fit	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	CAMHS - Looked After Children referred within 9 weeks			83%		77%			65%			*Not available*		
	SMI Physical Health Checks	34%	27.4%			29.5%			28.0%			27.5%		

NHS South Warwickshire Clinical Commissioning Group

EMERGENCY CARE TARGETS: 4 Hour Wait





Issues:

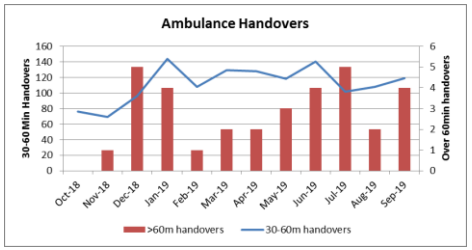
- 8.7% (+545) rise in Type 1 attendances in Sept '18 vs Sept '19.
- Patient flow issues caused by;
  - Bed occupancy
  - Increasing numbers of out of area patients due to WMAS Strategic Cell diverting ambulances
  - Ambulance diverts in place for Worcester during November increasing conveyances

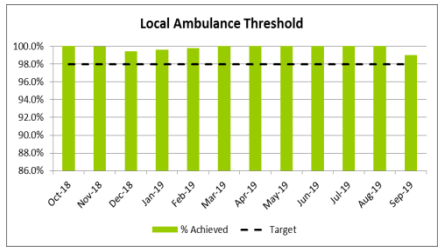
Ongoing Actions:

- A joint CCG and Trust Demand Management group is in place, which is reviewing all Urgent Care services within south Warwickshire to identify opportunities for joint working and improvements to patient access and pathways.
- Pilot between SWFT Frailty Unit and WMAS continues, with paramedics about to contact the frailty teams upon attendance on scene.
- Work is ongoing at reviewing the requirements and capabilities for Stratford MIU to adopt the national UTC criteria.
- GP remains in place in A&E at weekends.
- Ward reconfiguration planned to support better patient flow through the hospital and improve A&E performance, by ensuring beds are available for patients who require admission.
- Criteria led discharge now rolled out to seven wards, meaning patients can be discharged over the weekend in line with defined clinical criteria.

Ambulance Handovers

There were 4 over 60 minute handovers in September. The CCG continues to achieve the local ambulance threshold indictor, reporting 99% in Month 6.





Data received from WMAS.

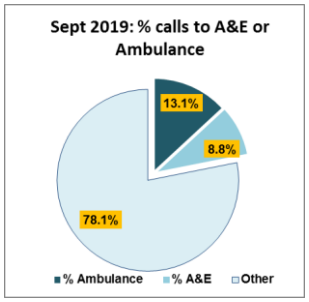
Recovery Date: Q4 2019/20

NHS South Warwickshire Clinical Commissioning Group

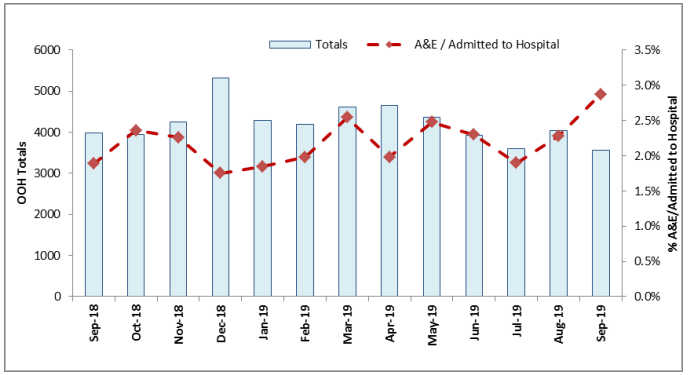
EMERGENCY CARE TARGETS: 111 and OOH

111 Outcomes Performance

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Sept-19 England
Total Calls answered		5,804	5,553	5,482	5,160	5,669	4,979	1,310,829
Calls per 1000 people		21.9	21.2	20.6	19.4	21.4	18.8	23.3
% of total calls answered	% Ambulance dispatches	10.9%	10.5%	12.7%	13.1%	12.1%	12.4%	13.8%
	% Recommended to attend A&E	7.2%	9.0%	8.8%	8.8%	7.7%	8.2%	9.6%
Of total cases triaged…	% Recommended to attend primary and community care	13.0%	13.1%	12.8%	14.0%	13.4%	14.8%	55.7%
	% referred to OOH	43.8%	43.0%	38.4%	36.4%	38.4%	36.7%	
	% Not recommended to attend other service	10.1%	11.7%	10.6%	11.3%	11.2%	10.6%	13.8%



Out of Hours Performance: % A&E/Admission Referrals



111 Update

- There has been a 13.9% decrease in call volumes when comparing September with August.
- Although call volumes were lower, there was a slight increase in the number of ambulance dispatches and those recommended to attend primary care.

111 Service Improvement Actions:

- Successful transfer of the NHS 111 service from Care UK took place on 5th November. Transition was smooth with no disruption to service. Successful first overnight with call handling performance at 94.9% (KPI 95% within 60s). Daily sitrep calls are in place to monitor mobilisation.
- WMAS reporting they are managing the NHS 111 clinical queue well.
- Performance continues to improve steadily as WMAS embed the service. Some staffing issues have been noted which impacted performance for the first weekend, but WMAS are working to resolve this.

OOH Update

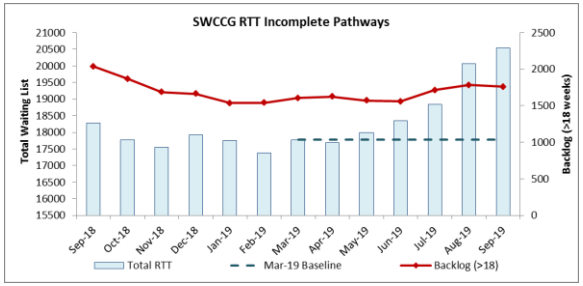
- There has been a 13.4% decrease in calls when comparing September 2019 against September 2018.

OOH Service Improvement Actions:

- 3 Contract Performance Notices now remain in place for;
  - Time taken to call back a healthcare professional
  - Urgents consulted within 2 hours
  - Urgents visited within 2 hours
- CPN relating to Calls triaged within 60 minutes KPI has now been closed as performance has been reached for 3 months.
- Monthly report against improvement actions is still being received.
- Performance has been much improved and actions are in place to support delivery. Performance is green for two of the remaining CPNs and Commissioners are confident this will continue ensuring the other CPNs will be closed shortly.

NHS South Warwickshire Clinical Commissioning Group

REFERRAL TO TREATMENT: Overview



Main Positions

	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
SWCCG	88.8%	89.5%	90.4%	90.7%	91.3%	91.1%	91.0%	90.8%	91.3%	91.5%	90.9%	91.1%	91.4%
SWFT	90.2%	91.0%	92.4%	92.7%	93.5%	92.8%	92.8%	92.2%	93.1%	93.0%	92.2%	92.1%	92.2%

SWCCG patients at out of area Trusts

	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
UHCW	83.0%	84.8%	84.2%	84.0%	82.8%	83.8%	83.8%	83.5%	84.0%	83.3%	83.3%	83.9%	84.4%
Worcester	83.1%	83.8%	82.4%	82.4%	84.1%	86.1%	85.5%	86.2%	84.4%	83.2%	85.0%	83.7%	87.2%
HEFT/UHB	90.4%	91.5%	91.2%	89.0%	89.1%	88.3%	88.7%	86.3%	84.9%	85.4%	85.6%	85.3%	84.7%
Oxford	83.1%	81.1%	81.0%	80.7%	85.1%	83.3%	83.8%	83.4%	79.8%	81.5%	81.7%	80.9%	82.1%

CCG Issue:

- Underachievement at out of area Trusts, including University Hospitals Coventry and Warwickshire, Worcestershire Acute Hospitals, University Hospitals Birmingham and Oxfordshire University Hospitals.

SWFT Issues:

- Specialties failing target are Gynaecology, Ophthalmology, Plastic Surgery and Urology.
- The aggregate standard continues to be achieved through over-performance in other specialties, including 98.1% in Orthopaedics.
- The total waiting list at SWFT has grown by 18% since March, from 12,369 in March to 14,640 in September.

SWFT Actions:

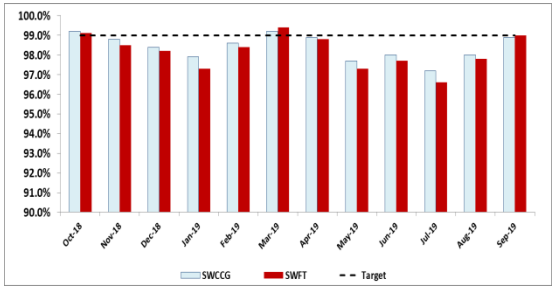
- Specialty level recovery plans are in place for each of the challenged specialties.
- The community ophthalmology contract went live on 2nd September 2019 and is expected to reduce demand for routine eye conditions.
- Consultant availability is limited across all specialties, therefore fewer additional sessions to provide capacity are being run.
- Work progressing with providers and NHS England to offer Ophthalmology patients choice of provider if they have been waiting 26 weeks and a decision to treat has been made.

Out of Area Trusts Recovery Actions:

- University Hospitals Coventry and Warwickshire:
  - A seasonality tool to aid RTT planning and improve patient waits has been developed
- Worcestershire Acute Hospitals:
  - Plan in place to achieve zero 40+ week waiters by Q4.
- University Hospitals Birmingham (HGS Sites):
  - Focus on reducing 40+ week waits, RCAs completed as standard for 52 week breaches to ensure learning taken.
- Oxford University Hospitals:
  - The Trust are completing the refresh of the John Radcliffe Hospital theatres, following the enforcement notice from the CQC in 2018, and should therefore have increased capacity for the remainder of 2019/20.

Recovery Date: Quarter 4 2019/20

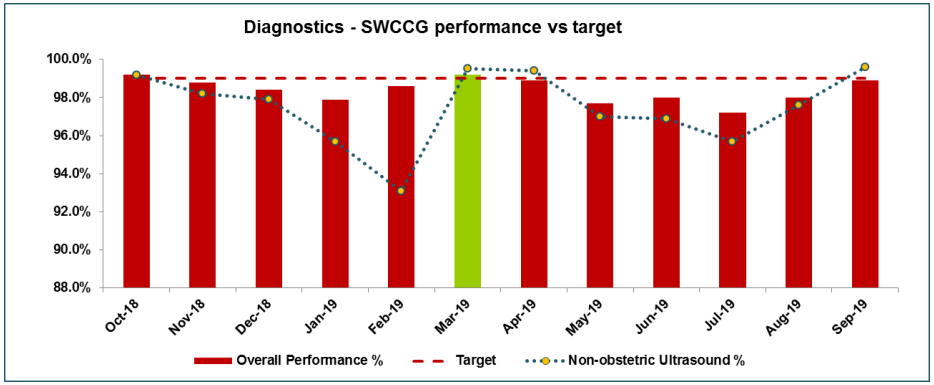
DIAGNOSTICS



SWFT	Breach	Total	% within 6 weeks
Urodynamics - pressures & flows	2	44	95.5%
Colonoscopy	4	138	97.1%
Flexi sigmoidoscopy	2	65	96.9%
Cystoscopy	28	164	82.9%

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
SWCCG	99.2%	98.8%	98.4%	97.9%	98.6%	99.2%	98.9%	97.7%	98.0%	97.2%	98.0%	98.9%
SWFT	99.1%	98.5%	98.2%	97.3%	98.4%	99.4%	98.8%	97.3%	97.7%	96.6%	97.8%	99.0%

Non-Obstetric Ultrasound



Issues:

- The main issue to sustainable delivery of the standard is Endoscopy, due to;
  - Increased demand within individual modalities
  - Consultant capacity
  - Endoscopy suite capacity

Ongoing actions:

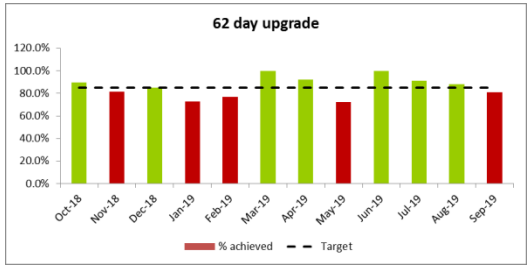
- IST deep dive of into Radiology has commenced, which will be supported by capacity and demand modelling.
- The IST review is expected to provide;
  - Better understanding of capacity issues
  - Suggested actions to improve performance
  - Support to implement change
- The Diagnostics Recovery Board is still monitoring the Radiology and Endoscopy recovery plans, ensuring all actions are on track.
- Recruitment has been focussed on areas where there is a single specialist to increase capacity and workforce resilience.
- IST review of Endoscopy has now commenced.

Recovery Date: End of Q3 2019/20

CANCER

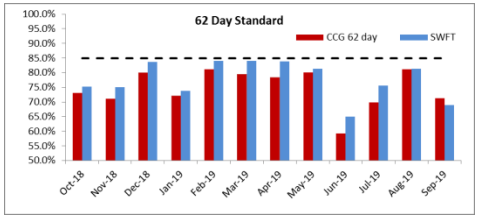
62 day Cancer – consultant upgrade

- 4 breaches (out of 21). All reasons are still being investigated.
- 3 patients were first seen at SWFT and treated at UHCW
- 1 patient was seen at ROH and treated at UHCW



62 day Cancer

There were 19 breaches, out of 66 patients seen.



Seen	Treated	Delay Reason	Breaches
SWFT	SWFT	Admin Delay	1
		Diagnostic Delay	4
		Patient choice	5
		Patient DNA'd	1
		Medical Reasons	2
	UHCW	Capacity Issues	1
		Unknown	3
		Patient choice	1
	ROH	Could not contact patient	1

Of the 62 day breaches, 3 patients waited longer than 104 days.

Seen	Treated	Tumour Type	Wait Days	Delay Reason Description
SWFT	SWFT	Skin	112	Patient choice
		Urological	111	Patient DNA
	UHCW	Urological	118	Elective capacity inadequate

Issues:

- Delays at diagnostic stage due to a lack of diagnostic capacity.
- Complex pathways for some specialties with onward referral to tertiary centres, leading to late referrals.
- Issues with the process for internal escalation of breached patients.
- Difficulties with running Waiting List Initiatives, due to pension implications for clinical workforce.

Recovery Actions:

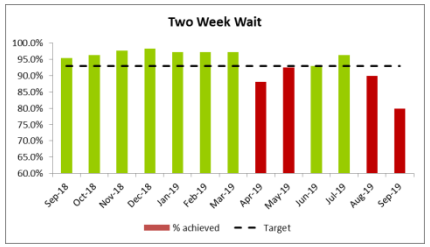
- Recovery actions identified by the NHS Intensive Support Team are in place, and progress against these is still being monitored through the SWFT Cancer Board.
- The Coventry and Warwickshire performance and operational group meeting is continuing to meet and has agreed to set up a system wide workshop to be held during Q3. This will focus on implementation of the prostate 28 FD pathway, to;
  - Map patients against the 28 day FD target
  - Identify waste
  - Review current MDT configuration
  - Formulate a system wide action plan
- The West Midlands Cancer Alliance is still looking to support providers to implement the best practice pathways for the four transformational national optimal pathways across the West Midlands; lung, colorectal, upper gastrointestinal and prostate

Recovery Date: End of Quarter 4 2019/20

NHS South Warwickshire Clinical Commissioning Group

CANCER (continued…)

Two Week Wait



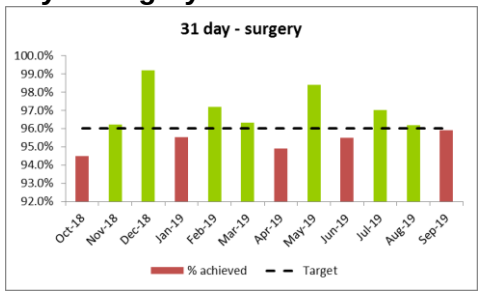
- 185 patients (out of 916) waited longer than two weeks.
- Capacity continues to be impacted by the lack of availability of clinicians to provide additional capacity.
- Issues in Upper GI and Lower GI, due to an increase in referrals.

Provider	Breach Reason	No of breaches
SWFT	Clinic Cancelled	3
	Reason being investigated	1
	Capacity issues	148
	Patient Choice	26
Worcester	Clinic Cancelled	1
	Reason being investigated	1
	Capacity issues	4
	Patient Choice	1

Recovery Date:

Q3 2019/20

31 day – Surgery

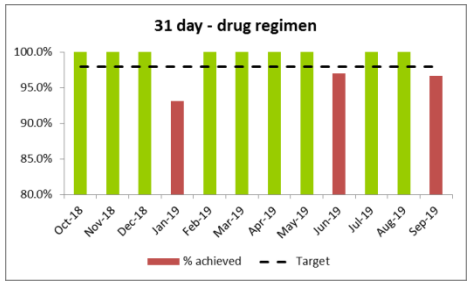


- Two breaches were reported; one at SWFT and another at Worcester
- The SWFT breach has been confirmed as an elective capacity delay.
- The breach at Worcester is being investigated with the provider.

Recovery Date:

Q3 2019/20

31 day – drug regimen



- There was one breach reported in September.
- This was reported at SWFT and was due to an administrative delay.
- The patient waited a total of 41 days.
- Small numbers impact this metric, therefore no recovery actions are currently in place, but is being monitored to ensure no trends emerge.

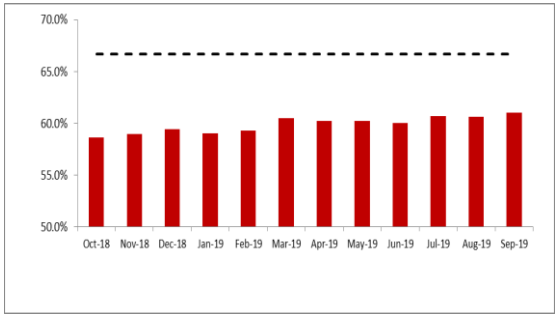
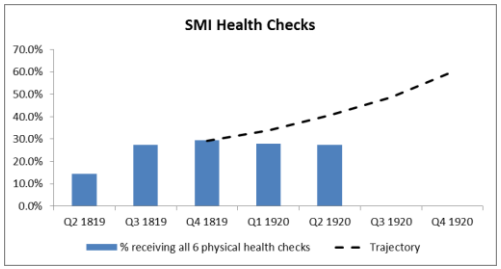
Recovery Date:

Q3 2019/20

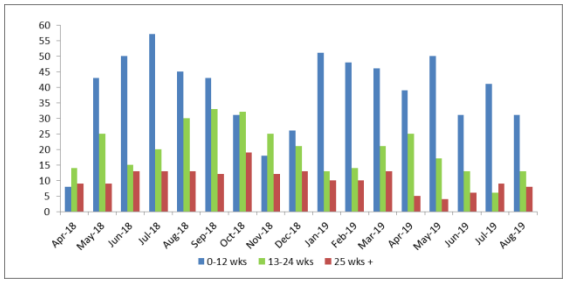
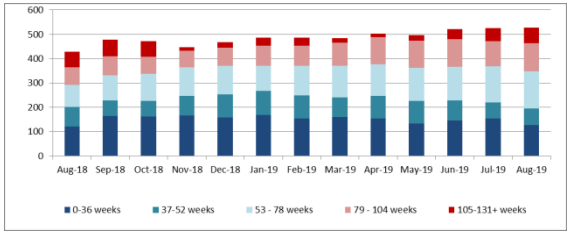
NHS South Warwickshire Clinical Commissioning Group

Contract Performance Reported by Exception

PRIORITY AREA/CONTRACT EXCEPTION REPORT

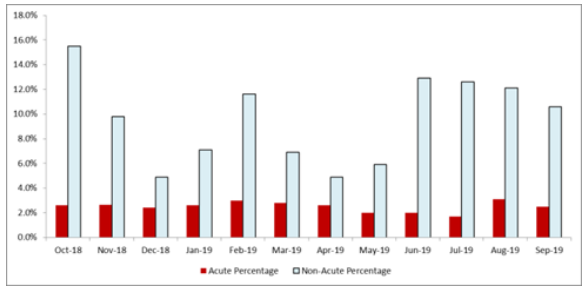
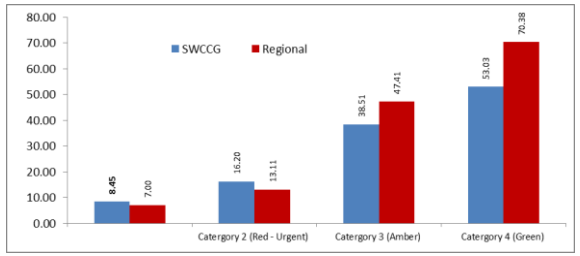
Indicator	Issue	Action	Recovery Date
Dementia Diagnosis Rates 	• Referral and diagnosis conversion rates. • Follow-up and shared care issues are affecting capacity within the CWPT Memory Assessment Service • Patient and family concerns of impact of diagnosis lead to late presentation within primary care. • Issues within post diagnosis support.	• Actions following the GP refresher event are in progress; • EMIS template undergoing revision, once complete, this will be communicated to all trained GPs. • Care home diagnosis work is being planned by rolling out on a network basis utilising trained GPs. Mapping of care homes is underway to understand the number of homes per network and to identify networks/GPs for the first roll out. • The MAS has sent out to each GP an up to date list of dementia patients in their area.	Q4 2019/20
SMI Physical Health Checks 	• Capacity to deliver comprehensive checks • A further 6 indicators are being added to the checks to monitor to follow up actions • Data sharing between CWPT and GP Practices	• A stretch QOF approach is currently being developed, with a paper to be presented to Primary Care Committee in December for approval. • Development of support for people with SMI in the wider system is continuing with Healthy Living Pharmacies and "Get Set to Go initiative.	To achieve 60% by Q4 2019/20

PRIORITY AREA/CONTRACT EXCEPTION REPORT

Indicator	Issue	Action	Recovery Date
Children and Young People's Emotional Well-Being and Mental Health (CYP) 	• 52 patients are on the waiting list, of which 21 have waited 12+ weeks. • There is significant, ongoing pressure on clinical capacity, which is being outstripped by demand. • Increased utilisation of the navigation hub impacting on workforce and triage timeframes. • Workforce issues due to maternity leave across CAMHS services. • Maximum wait time is now 36 weeks, which has reduced from 49+.	• Work on the enhanced triage system pilot is ongoing, to ensure patients undergo a 20 minute triage, and are then streamed to assessment. • It was felt that for patients with less need, a shorter clinician assessment would be suitable, and free consultant time. The pilot has found that the process was better for patients, as they had an improved pathway. • The pilot has been extended to provide a larger cohort of patients by which outcomes can be assessed.	Q4 2019/20
Children and Young People's Autism Spectrum Disorder Waits (CYP ASD) 	• 528 patients are on the waiting list, of which 491 have waited 12+ weeks. • There has been an increase in referrals from education, with an associated requirement for commissioned capacity from WCC. • Due to the multi-professional and multi-agency nature of assessments, developing remedial plans is complex. • The assessment team includes; ○ Children's Neurodevelopmental Team (CWPT) ○ Paediatrician (SWFT) ○ SALT (0-11, SWFT) ○ Educational Psychologist (11+,WCC) • Shortage of qualified children's neurodevelopmental staff to undertake assessments nationally.	• A new WCC ASD group has been established, and it is anticipated that the workstreams will be informed by the ASD JSNA, which is due to be published before the end of Q3. • Communications Team are working to send out messages about the service and the challenges experienced, to help manage parent expectations. • To help manage this, a prioritisation criteria is being communicated, and a fact sheet for every referral will be produced.	TBC

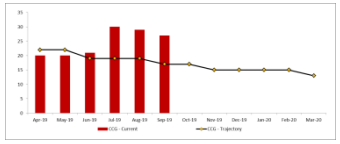
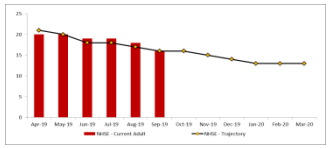
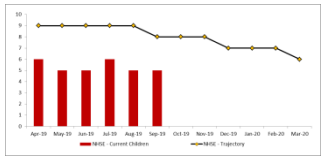
NHS South Warwickshire Clinical Commissioning Group

PRIORITY AREA/CONTRACT EXCEPTION REPORT

Indicator	Issue	Action	Recovery Date
Delayed Transfers of Care 	• Delay in access to Nursing and Residential home placements and packages of care. • High number of out of area delays. • Large number of regional community beds at SWFT. • Delays at Out of Area Trusts, where local influence is limited. Reason for Delay / Days Delayed / Patients Delayed Completion of assessment: 37 / 0 Public funding: 54 / 4 Further non-acute NHS care: 170 / 4 Residential home placement: 109 / 0 Nursing home placement: 70 / 2 Care package in own home: 59 / 2 Community / Equipment adaptations: 5 / 0 Patient or family choice: 5 / 0 Disputes: 8 / 0 Housing Act: 0 / 0	• Assessment of Reduced Mobility Pathway for upper limb taken to DToC Board for review, funding in place until January 2020, now looking at alternatives for patients inappropriately referred to service, such as family support. • Restricted Mobility Pathway for lower limb patients now in place until March 2020, with three nursing-home based beds. • The Board discussed appropriate use of both pathways, and how to use the services to best effect for patients, including reviewing clinical criteria. • 3 additional Moving on Beds ('Enhanced' service) are available countywide for individuals who require support of 2 carers for hoisting and personal care.	Q2 2019/20
WMAS: 999 ARP Performance 	• South Warwickshire patients waited longer than the regional average for Category 1 (8.45 mins compared to 7.00 mins) and Category 2 (16.20 mins compared to 13.11) – based on mean reporting. • WMAS overall performance compares favourably with other Trusts nationally.	• Work to embed the new terms of the 2019 contract is ongoing. WMAS are keen for continued collaboration with Commissioners for delivery of the contract. • WMAS have now taken over the NHS 111 service, which will support a more integrated way of working across 111 and 999. The development of a CAS (clinical advice service) within 999 to further clinically validate appropriate cat 3 and 4 calls is also planned.	Not applicable

NHS South Warwickshire Clinical Commissioning Group

PRIORITY AREA/CONTRACT EXCEPTION REPORT

Indicator	Issue	Action	Recovery Date
Transforming Care: CCG Cohort (Overall TCP) Of 27 adult CCG patients, 8 are SWCCG patients.  **Transforming Care: NHSE Adult Cohort (Overall TCP)** Of 16 people in NHSE commissioned beds, 3 is a SWCCG patients.  **Transforming Care: NHSE Children and Young People Cohort (Overall TCP)** Of 5 children in NHSE commissioned beds, 2 are SWCCG patients. 	The TCP has been escalated by NHSE as 18/19 year end was above trajectory for the number of people in hospital. Concern about the recent number of admissions for people with autism into CCG commissioned MH wards has raised the escalation level to Red. Trajectories for 2019/20 have been agreed with NHSE. • The NHSE cohort is above trajectory for September, including 2 admissions of individuals placed by the justice system into these beds in September. These types of admissions and discharge can only happen on order of the court. • The CCG September cohort remains significantly above the planned trajectory. However, no admissions in-month and 3 discharges, improved the position. • Modelling indicates the TCP will be over the CCG and NHSE adults trajectories in March 2020. • The CYP cohort is well below trajectory and if the current reduced admission rate continues the TCP would be on track to meet CAMHS trajectory in March 2020.	High Impact Actions for 2019/20 are focussed on: • Admission prevention and improving the accuracy of discharge planning; • Ensuring operational focus on this becomes embedded as business as usual; • Development of emotional wellbeing and crisis offer for children and young people; • Development of ASD/ADHD needs assessment and statement of intent and associated commissioning activity; • Development of the Coventry and Warwickshire Autism Strategy; • Working with local partnership trust to develop and deliver improvements in reasonable adjustments in mental health services for people with LD or ASD. The TCP are working with STP leads and joint commissioning boards to develop governance arrangements to ensure continued focus on delivery of inpatient reduction as part of a wider focus on delivery of long term plan priorities from April 2019 onwards.	End of Quarter 4 2019/20

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End of Report

NHS South Warwickshire Clinical Commissioning Group

Report To:	Governing Body	**For decision**	
Report Title:	Nursing, Quality and Governance Report	**For discussion**	√
Report From:	Alison Walshe Chief Nurse	**For information**	
Date:	20 November 2019	**Confidential**	

Purpose of the Report:	
To update Governing Body members regarding nursing, quality and governance matters.	
Key Points:	
This report provides an overview of current nursing, quality and governance matters, as discussed in detail at Clinical Quality and Governance Committee and Performance Committee.	
Recommendation (s):	
That Governing Body members note the content of this report.	
Previously Considered By:	**Date:**
-	-

CCG Strategic Objective(s) this report relates to:	
Out of Hospital	
Personalisation	√
Specialist Provision	
Delivering Today	√

Management of Conflicts of Interest:	Not applicable.
Financial Implications:	Not applicable
Performance Implications:	The CCG is performance managed on its CHC and Transforming Care targets.
Quality Implications:	Report focused on nursing, quality and governance.
Equality and Diversity Considerations:	Not applicable.
Patient, Public and Stakeholder Engagement:	Not applicable.
Risk Assessment:	Quality and Governance are areas of high priority for the CCG.

Introduction

1.1 This report provides an update to Governing Body on nursing, quality and governance matters.

Nursing and Quality

Contractual Quality - SWFT

2.1 The latest unannounced CQC inspection of SWFT commenced on 20 August 2019 with visits to A&E and the Medical wards at Warwick Hospital. Shortly after, a different inspection team visited the Trust's community Children's and Adults' services in a number of locations across Warwickshire, Coventry and Solihull. This completed the main patient-facing element of the process. A 'Well Led' component followed these visits, including a 'Use of Resources' review. Formal letters from the Inspection Team are attached in Appendices 1 and 2. These letters reference many positive findings, particularly relating to staff and culture and demonstrate progress made since the last inspection in January 2018. The final report is awaited.

2.2 From the perspective of contractual quality indicators (KPIs) I am pleased to report that SWFT is giving consideration to alternative methods of achieving improved response rates for the Friends and Family test. Whilst satisfaction with services is generally very good, the CCG has been concerned for a significant period of time regarding the statistical validity of the results because response rates in some areas, particularly A&E, are poor and well below the national average. Other KPIs that are below threshold include:

- Stroke service KPIs remain below the threshold however the CCG are currently out to consultation on a revised service model across Coventry and Warwickshire.
- Caesarean section rates have exceeded the threshold of 28% and have been on an increasing trend over the past few months with July at 35.14%. This has been noted nationally and the Trust hopes that the national programme 'Saving Babies Two' (an updated care bundle) may result in a reduction in C-section rates.
- Dementia and Delirium screening and investigation remains below thresholds of 90%. The compliance for screening has improved and is now slightly below threshold (86.9%). The two new Care of the Elderly consultants and a new Admiral Nurse will help drive this work to support compliance with this indicator.
- The percentage of patients seen in the Chest Pain clinic (2 week wait for rapid access) continues to be below the required threshold. With the cessation of a national requirement for a 2-week rapid access chest pain clinic, we have agreed with the trust to undertake a joint deep dive service review to identify areas for change in outpatient scheduling that will ensure priority cases (which previously would have met 2-week wait criteria) are seen and treated in a timely manner.

Patient Safety

2.3 SWFT have reported a fourth 'Never Event' during 2018/19; this time in gynaecology theatres. A Duty of Candour letter has been sent by the Trust and a further procedure under local anaesthetic has been scheduled. This run of never events this year is, however, of significant concern. The CCG has agreed to undertake joint visits with the Trust to review the embedding of Trust pre-op/pre-procedure policies across directorates and departments.

Infection Prevention and Control

2.4 The CCG continues to perform strongly on infection prevention and control. To date this year, there have been zero MRSA bacteraemias at SWFT and, in relation to C difficile, the CCG has acquired 36 infections against the target of 33 for the first 2 quarters. We expected higher

numbers during the summer months and are still working to achieve the overall annual target of 68 infections.

2.5 Significant work has been undertaken across Coventry and Warwickshire during the past year to progress the development of an Anti-microbial Resistance (AMR) Policy. This is a separate item on the agend for formal approval.

Mortality

2.6 Please see below the table below that demonstrates mortality figures (SHMI) at the CCG's major acute providers.

TRUST	SHMI Value published 18/07/19 (Mar 18 - Feb 19)	SHMI Value published 22/08/19 (Apr 18 - Mar 19)	SHMI Value published 19/09/19 (May 18 - Apr 19)	SHMI Value published 10/10/19 (June 18 - May 19)
OUH (Oxford University Hospitals NHS Foundation Trust)	0.9203	0.9153	0.9216	0.9220
SWFT (South Warwickshire NHS Foundation Trust)	1.0024	0.9878	0.9978	0.9741
UHCW (University Hospital Coventry and Warwickshire NHS Trust)	1.0863	1.0973	1.1384	1.0998
WHAT (Worcestershire Acute Hospitals NHS Trust)	1.1152	1.1440	1.1384	1.1414

2.7 As can be seen, SHMI rates at OUH and SWFT are stable and within the anticipated range with SWFT demonstrating a further reduction. Rates at UHCW have been fluctauating slightly but the latest report for May 2019 shows a slight decrease. Rates at WHAT have increased marginally since April 2019. Host commissioners (Coventry and Rugby CCG and Worcestershire CCGs) take a lead in working with the Trusts to address mortality rates, as required. There is a system wide Coventry and Warwickshire Mortality meeting that takes place with all providers to look at mortality trends and share good practice. Feedback is also given to the NHSE Mortality Meeting that take place quarterly.

2.8 LeDeR steering group meetings continue on a regular basis in 2019/20. At the last meeting the steering group agreed proposals to re-structure the steering group and associated meetings to ensure efficiency and effectiveness in delivering the objectives of the programme. To date, there have been 107 notifications across the Arden Transforming Care Partnership (TCP) footprint since the LeDeR programme commenced on 1 October 2017. South Warwickshire CCG have had 36 notifications of deaths of people with a learning disability and out of the 36 reviews: 28 (78%) have been completed and signed off by Bristol University, 4 reviews (11%) are with allocated reviewers but remain incomplete, four (12%) LeDeR notifications werer noted as child deaths and will be managed by the child death process and there are no cases unassigned. Through the LeDeR steering group, numbers will continue to be monitored against the trajectory submitted to NHSE.

2.9 The first LeDeR annual report has been produced and is included as a separate item on the agenda. Learning from LeDeR reviews has been incorporated into the Health Inequalities Priorities for Action for people with a Learning Disability as an appendix to the LeDeR annual report.

Safeguarding

2.10 The first formal meeting of the Warwickshire Safeguarding Executive Board took place on 1 October 2019. In line with a revised approach for the safeguarding of adults and children in Warwickshire, the first quality assurance audit cycle has commenced, focused on the topic of 'Exploitation'. Supported by the new Quality Assurance leads for Safeguarding, these regular audits aim to assess the effectiveness of partner organisations in their day to day safeguarding practice, as well as understanding the extent to which learning from serious case reviews is being and has been embedded in practice.

Continuing Healthcare

3.1 The CCG has recently received feedback from NHS West Midlands regarding its most recent review of eligibility per 50,000 population. The review concluded the CCG has robust processes for implementing the national framework fairly and consistently and the higher rate of eligibility is most likely a result of demographics and the volume of nursing homes in the locality. NHS West Midlands commended the CCG on its analytical work to understand the issue and on its action plan to address areas for improvement. NHS West Midlands considers the CCG implements 'best practice' in a number of areas and is an exemplar organisation that other CCGs could learn from.

3.2 The integrated management structure for CHC is embedding well but the CHC team continues to struggle with high sickness rates. Agency staff have been appointed to fill critical gaps whilst recruitment continues however, on a positive note, we have had the highest application rates for new posts since the CCG created an embedded service two years ago.

3.3 The development of an action plan to progress appeals' and retrospectives' work is well advanced with the plan due to be presented to Performance Committee in December.

Personal Health Budgets

4.1 As at the end of September, the CCG had a cumulative position of 110 Personal Health Budgets (PHB) meeting the Quarter 2 trajectory of 110. The current PHBs are held by 109 adults who are eligible for Continuing Healthcare and 1 child within the Transforming Care programme, 92 of whom have a notional budget and 18 a direct payment/third party budget. Work is progressing alongside CR/WNCCG to implement Personal Wheelchair Budgets and PHBs for individuals entitled to S117 aftercare.

Transforming Care

5.1 The Transforming Care programme includes individuals who have a Learning Disability and/or Autism with behaviour that challenges who are at risk of admission or are admitted to learning disability/mental health inpatient beds.

5.2 As at the end of October the CCG had 10 adults in hospital in CCG commissioned beds. There were also 4 south Warwickshire residents meeting Transforming Care criteria in beds within services commissioned by NHS England, including 2 individuals who were admitted recently through the justice system. With the implementation of the Children's Intensive Support Team the sustained improvement in the number of children and young people in the Transforming Care cohort in CAMHS tier 4 beds continues.

	Low secure	Medium secure	High secure	CAMHS Tier 4
Adult	2	1	0	0
Child	0	0	0	1

5.3 The table below details performance against the CCG trajectory for adult inpatient admissions by March 2020 and against the TCP trajectory for children's admissions, which has been set regionally and is considered too small to split by CCG.

People in SWCCG beds as at 31/10/19	Target March 2020	SWCCG Adults in NHSE beds as at 31/10/19	Target March 2020	Children in NHSE beds as at 31/10/19	TCP Target March 2020
10	4	3	3	1	6

Governance

6.1 EU Exit preparations had been undertaken, in earnest, during October in readiness for a potential 'no-deal' scenario. This included establishing additional rotas of support staff to manage information cascades, sitrep reporting and issues' resolution on a 7 day per week basis, if required.

6.2 Work has been done to update the CCG's Conflicts of Interest records, prepare its mid-year Data Security and Protection Toolkit baseline submission, and temperature check the organisation against Thrive at Work measures.

Recommendation

7.1 That Governing Body members note the content of this report.

NHS South Warwickshire Clinical Commissioning Group

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Contractual Quality Dashboard, SWFT – Q2 2019/20

Appendix 1

						Trend / Graph / Comments
Data as of 29.10.19	**Organisation**	***Data Source***	**Jul-19**	**Aug-19**	**Sep-19**	Trend from Aug 2018 -Aug 2019 position
Patient Safety						
Serious Incidents at local providers relating to SWCCG patients:	**SWFT**	*SWCCG Patient Safety Team*	*4*	*4*	*3*	
	UHCW		*2*	*2*	*1*	
	CWPT		*0*	*1*	*0*	
Serious Incidents- overall number per month at **local providers** relating to SWCCG patients	**SWCCG Total**		*6*	*7*	*4*	
Serious Incidents other contracted services relating to SWCCG patients:	**NHS111**		*0*	*0*	*0*	
	BPAS		*0*	*0*	*0*	
Serious Incidents- overall number per month at **other contracted providers** relating to SWCCG patients	**SWCCG Total**		*0*	*0*	*0*	
Serious Incidents at out of area providers relating to SWCCG patients:			*0*	*2*	*0*	
Never Events	**SWFT**		*0*	*0*	*0*	
Infection Control			**Jul-19**	**Aug-19**	**Sep-19**	
C Difficile - Total monthly number reported by SWFT	**SWFT**		*2*	*1*	*2*	
C Difficile - Total number reported by SWFT YTD 2019/20 (Nb: tolerance = total of 24 lapses of cases for the year)		*Rolling number YTD*	*4*	*5*	*7*	
MRSA	**SWFT**		*0*	*0*	*0*	
Patient Experience			**Jun-19**	**Jul-19**	**Aug-19**	
Friends & Family Test (FFT) at SWFT						
Inpatient Areas Threshold =>25%						
SWFT Response Rates			*25.5%*	*22.6%*	*29.1%*	
NHSE Average Response Rates	NHSE	*NHSE*	*24.6%*	*25.4%*	*24.9%*	
SWFT % patients recommending the service	SWFT	*NHSE*	*95.0%*	*95.0%*	*94.0%*	
NHSE Average % patients recommending the service	NHSE	NHSE	*96.0%*	*96.0%*	*96.0%*	
A&E Department Response Rate Threshold =>12.8%						
SWFT Response Rates	SWFT	*NHSE*	*14.7%*	*7.7%*	*5.9%*	
NHSE Average Response Rates	NHSE	*NHSE*	*12.4%*	*12.4%*	*13.2%*	
SWFT % patients recommending the service	SWFT	*NHSE*	*95.0%*	*96.0%*	*94.0%*	
NHSE Average % patients recommending the service	NHSE	*NHSE*	*86.0%*	*85.0%*	*86.0%*	
Maternity Services (Response Rate Trajectory Threshold =>23.3%)						
Birth Question 2 SWFT Response Rate %			*28.0%*	*30.0%*	*24.0%*	
Birth Question 2 NHSE Average Response Rate %	NHSE	*NHSE*	*20.5%*	*21.3%*	*21.1%*	
SWFT % patients recommending the service	SWFT	*NHSE*	*93.0%*	*93.0%*	*97.0%*	
NHSE Average % patients recommending the service	NHSE	*NHSE*	*97.0%*	*97.0%*	*96.0%*	
All Community Health Areas (Threshold =>97 %)						
SWFT % patients recommending the service	SWFT	*NHSE*	*97%*	*91%*	*97%*	
NHSE Average % patients recommending the service	NHSE	*NHSE*	*96%*	*96%*	*96%*	
All Outpatient Areas (Threshold => 95%)						
SWFT % patients recommending the service	SWFT	*NHSE*	*95%*	*93%*	*93%*	
NHSE Average % patients recommending the service	NHSE	*NHSE*	*93%*	*94%*	*94%*	
Complaints	SWFT		*13*	*TBC*	*TBC*	
Clinical Outcomes at SWFT			**Jun-19**	**Jul-19**	**Aug-19**	
SHMI (rolling 12 months Apr 18 to Mar 19)	SWFT	*SWFT*	0.99	0.99	0.99	
RAMI (rolling 12 months Aug 18 to July 19)	SWFT	*SWFT*	98.6	75.6	76.3	