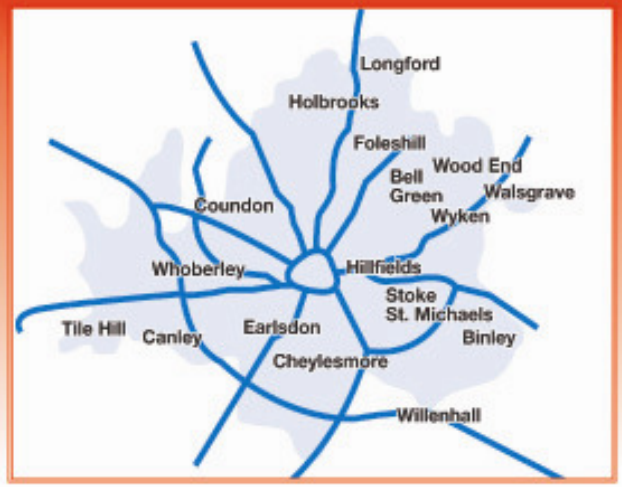
NHS
Coventry

Legacy Document



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SECTION 1: INTRODUCTION AND PURPOSE OF THIS DOCUMENT

1.1 The National Quality Board document "Maintaining and improving quality during the transition : safety, effectiveness, experience" Part One, published in March 2011, set out the requirement for effective handovers, in particular, capturing the organisational memory. In order to do this, each outgoing organisation (PCT and SHA) is required to provide a "legacy document" to feed into a Cluster - wide legacy document.

1.2 As part of the process of Consortia and Cluster development and the decommissioning of Coventry PCT, the PCT therefore has a responsibility to ensure that in a period of considerable change it does not lose information that is important to the future commissioning of health and which has been accumulated through managerial and clinical interactions over the years.

1.3 It is intended that the legacy document will be reviewed at updated at quarterly intervals until the abolition of the organisation, thus ensuring the most relevant and up to date information is available for incoming teams and new organisations.

SECTION 2 – COVENTRY BACKGROUND AND OVERVIEW

Geography

2.1 Coventry is a city in the West Midlands comprising 18 wards under one metropolitan Council. The city has a rich and varied history and has developed multicultural links making it a vibrant conurbation. Over the years strong links have been fostered with the local authority and voluntary agencies and there are a number of projects and services run through joint agreements.

FIGURE 1 Coventry in relation to surrounding areas	***FIG 2 Coventry City wards and boundaries***
	

2.2 For example, during 2010 NHS Coventry started a pilot programme working with colleagues in the Local Authority, Chamber of Commerce and Job Centre Plus focused on work and health. The programme has three work streams:

- Working Well in Coventry (WWiC)
- Fit for Work (FFW)
- Health Checks for the Unemployed (HCU)

Consortia

2.3 There are 2 GP consortia wit hin the city, and all GP practices are aligned with one or the other Consortium, thus the whole city is covered through the Consortia network. The Godiva Consortia is Chaired by Dr T Feltbower and covers 41GP practices, and a population of 183,464. The In Spires Consortia is co-chaired by Dr S Allen and Dr P O'Brien and covers 24 GP practices and a population of 183,640. Both Consortia were part of the 4th wave announced in April 2011.

2.4 Consortia are being encouraged to develop Strategic Plans to confirm their priorities and set timescales and to work with the cluster around aligning staff and services. A Training Needs Analysis is being undertaken to determine their readiness for commissioning and development needs which will inform what support they need. The Listening Exercise and subsequent changes to the White Paper will be incorporated into any future plans.

Table 1: Consortia Profile

	Godiva	Inspires
Population	183,464	183,640
Number of GP Practices	41	24
Consortia Lead	Dr T. Feltblower	Dr. S Allen DR. P. O'Brien
Chief Operating Officer	Peter Hodder	Juliet Hancox

Population demographics, socio-demographic considerations

2.5 The current registered population of Coventry is 359,230 and the resident population is 312,800. There is significant growth in the population of Coventry and this is greater in the registered population than the resident population. The numbers of elderly and children are increasing steadily following a dip in 2006/7.

2.6 The term 'Health Inequalities' refers to the fact that significant outcomes in health, such as life expectancy, and disability-free life expectancy, show a gradient with socioeconomic class, with those living in the poorest circumstances likely to become ill and disabled at an earlier age and to die sooner than those who are wealthy. Health inequalities are known to result from a complex array of interdependent factors, and there are few straightforward evidence-based solutions.

2.7 The local review illustrates the extent to which Health Inequalities are evident in Coventry; life expectancy for a resident born in Coventry is lower (76.5 years for males; 81.8 females) than for England as a whole (77.9 years for males; 82.01 females). Data for 2006/08 shows that within Coventry, the mean age of death for men resident in Foleshill is 13.5 years earlier than for those living in Earlsdon. Over the past decade or so, NHS policy has been focused on this issue. Coventry, as a Spearhead Trust, has specific targets to reduce the gap between the average life expectancy for Coventry.

2.8 Life expectancy has increased in Coventry during this period; however it has also increased for England as a whole. The local review details how the infant mortality and life expectancy for women targets are likely to be met (by 2011 – allowing for 3 year average), but that it is unlikely that the relative reduction in male deaths will be sufficient for the male life expectancy target to be met.

2.9 Coventry has statistically significantly high death rates from parasitic and infectious disease. Rates of death are decreasing in recent years though they are still higher than national, regional and peer rates.

2.10 Though no specific gaps were identified in Coventry's plans to tackle health inequalities, when they were reviewed by the National Support Team, further work is required because there has been no narrowing of health inequalities in the City.

2.11 A new strategic target has been agreed to ensure a continued focus on reducing health inequalities in Coventry. The target is to:

Reduce the gap between the average all-age all-cause mortality rate for Coventry and for England by at least 10% and reduce the gradient within Coventry, by 2026[1]

2.12 The Acting Director of Public Health in the most recent Public Health Annual Report has recommended that:

- Health inequalities should be explicitly considered within all health and social care strategies as these are developed and / or reviewed.
- There should be a focus on the development of community engagement mechanisms particularly in the most deprived communities

Health Issues

2.13 In Coventry, 72% of those diagnosed with HIV are Black-African and 17% are White. In the West Midlands, this demographic differs considerably with 42% of those affected being Black African and 43% White. Interestingly, in the West Midlands, 87% of White people affected are male and 12% female; however of the Black-African people affected, 65% are female and 35% male.

2.14 66% of those affected in Coventry stated that their probable source of infection was men having sex with women. 26% stated that the probable source of infection was 'other/unknown' and just 8% was likely to be via men having sex with men (Figure 3.7). In the West Midlands, 57% of those affected stated that their probable source of infection was men having sex with women and 32% was likely to be via men having sex with men. Reasons for the remaining sources of infection were mother-child transmission, blood/ blood product recipient and injecting drug use which each contributed 8% or more.

2.15 In terms of screening programmes, the Coventry population has met the national uptake target of 60%. The screening uptake is lower in men than women and uptake varies greatly by GP practice, ranging from 10 – 80% uptake.

2.16 With regard to cancer, efforts need to be directed at early diagnosis for the large number (over 90%) of cancer patients who are diagnosed as a result of symptoms rather than national screening programmes. This principle was being supported through the Arden Local Awareness and Early Detection Initiative (LAEDI) with a particular focus on areas of high deprivation.

2.17 A recent equity audit of the uptake of screening for diabetic retinopathy cross Coventry has shown how uptake varies according to age, gender, deprivation, ward of residence, GP practice and ethnicity in the city. The group with the lowest percentage uptake, in terms of ethnicity, is within the South Asian 'Other' group.

2.18 Smoking claims the lives of 1 in 6 of all Coventry residents and still remains the single greatest cause of preventable death in the city. It has been identified as the major force behind the health inequalities which exist between the poorest and most affluent wards.

2.19 The 2011 survey suggested that 24% of the Coventry population smoke and reducing smoking is a strategic priority with a local target to reduce smoking prevalence to 22% by 2012. In terms of smoking during pregnancy, there is a prevalence of 15% at delivery with a target to reduce this to 11% or less by 2015.

2.20 With regard to obesity, the data shows that 25% of adults, 10% of Reception class children and 20% of Year 6 in Coventry are obese. A Healthy Weight Strategy has been agreed

between the PCT and Local Authority to address this major issue. As Coventry has higher levels of obesity during pregnancy than either England or the West Midlands, women in Coventry were more likely to have complications in pregnancy or childbirth and that their babies were more likely to suffer with health problems.

2.21 NHS Coventry continues to work with other partners in the city, including the Community Safety Partnership, to ensure that health remains a key focus in the multi-agency work to reduce alcohol related harm. Specific work streams include a pilot to offer Identification and Brief Advice on alcohol in pharmacies, increasing uptake of the Alcohol DES in primary care, and a social marketing campaign to communicate the dangers of drinking whilst pregnant.

2.22 In 2010/11, alcohol services funded by the Coventry Health Improvement Programme (CHIP) have provided interventions for more than 800 of some of the city's most problematic drinkers. Overall, CHIP funded projects have helped to extend provision for alcohol-using clients in Coventry, with the number of alcoholics receiving treatment in the city increasing by more than 20% on the previous 12 months.

2.23 All drug and alcohol treatment services in the city are currently being re-tendered, with new provision due to come into place in December 2011. The new provision will secure a long term future for the projects funded through CHIP and aims to get 15% of the City's estimated alcohol-using population in treatment, in line with recent DH Guidance.

Projections around Population Changes

2.24 The total number of births in Coventry has increased from 3,634 in 2001 to 4,678 in 2009: an increase of 29%. Almost all of the increase is due to births among mothers who have recently immigrated to the UK.

2.25 In his recent Annual Report the Acting Director of Public Health recommended that Commissioners need to take into account the impact of the numbers of births on antenatal/midwifery, paediatric and translation services, and to work with the Local Authority and the voluntary sector to promote access to health care for new communities (recently immigrated to the UK).

Current demand for services and projected changes

2.26 73% of TB cases in the city are non UK born and that is similar to the national picture where 75% of all notifications for TB are in individuals from countries with a high burden of disease. Coventry does not undertake the Universal BCG vaccination for babies as it has not reached the threshold but this would be kept under review. In order to address this issue it is suggested that Coventry TB Service need to prioritise screening of new entrants and refugees and asylum seekers to identify cases of tuberculosis and latent disease. Additionally, a repeat audit of the uptake of BCG vaccination is required in neonates to make sure that the eligible population is receiving it appropriately.

2.27 As the prevalence of HIV has now risen above 2 per 1000 people in the general population of Coventry, BHIVA and NICE guidelines recommend an increased level of HIV testing. These recommendations include the following changes to services:

- Offering and recommending an HIV test for all men and women registering at a GP practice.
- Offering and recommending an HIV test to all medical patients admitted at hospital
- Offering and recommending an HIV test to anyone who has a blood test, regardless of the reason.

2.28 Despite levels of public and media concern, overall levels of consultation for flu-like illness, and mortality from respiratory causes, were within usual limits for seasonal flu during 2010/11.

However, the distribution of cases was different to the pattern seen in most seasonal flu seasons, with a larger number of younger people aged 15-44 affected and fewer older people aged 65 or above. This is similar to the pattern seen during the last pandemic and reflects the patterns of morbidity for the H1N1 strain which caused the pandemic.

2.29 To combat this NHS Coventry aims increase uptake of seasonal flu vaccination, to decrease the variation in vaccination levels by GP Practice, and to prioritise the vaccination of front line workers in health and social care and achieve the :

- 75% target for over 65s (2010/11 value 69%)
- 60% target for those in the clinical risk groups (2010/11 value 52%)
- 60% target for pregnant women (2010/11 value 38%)

2.30 The dental health of 5 year old children in fluoridated Coventry has been improving and is better than other health areas with similar levels of deprivation. However, further work is required to reduce the inequalities by improving access to dental services and developing an oral health improvement programme targeted at children in the affected areas. The changes suggested include:

- Developing an oral health improvement programme targeted at pre-school children in the risk areas as part of the Healthy Child Programme.
- Promoting interagency partnership working aimed at ensuring the healthy growth and development of children.
- Improving access to dental services by working with Primary Care to develop and commission appropriate dental services in Coventry.

2.31 Teenage conception rates in Coventry are the 10th highest in the country and have remained unchanged and higher than peer PCTs, the West Midlands and England, since 1998. The promotion of Long Acting Reversible Contraception to develop a hub and spoke model for sexual health services delivery will increase demand for this service and impact on the numbers of young people who are at risk of teenage pregnancy.

SECTION 3 – OVERVIEW OF SERVICES

Primary Care Services

General Practitioners

3.1 Coventry has a total of 65 GP practices which are divided between 2 Consortia, Godiva and In Spires. Godiva covers 41GP practices and In Spires Consortia 24 GP practices. GPs are experts in family medicine, preventative care, health education and treating people with multiple and long-term conditions.

3.2 All GP Practices are contracted to a Medical Contract including General Medical Services, Personal Medical Services and Alternate Personal Medical Services. Most practices are also signed up to a wide range of Direct and Local Enhanced Services. All patients have a choice to register with a practice in Coventry as long as they reside within its boundaries.

Community Pharmacies

3.3 There are currently 85 community pharmacies in Coventry who deal with approximately 40,000 each day. Coventry community pharmacies dispense approximately 5 million items per year and there are community pharmacies situated in high street locations, in neighbourhood centres, in out-of-town developments, in supermarkets and some in GP practices in the heart of the most deprived communities.

3.4 Community Pharmacy provide a range of services as well as dispensing prescriptions and these may include some or all of the following:

- Emergency contraception
- Incontinence supplies
- Needle exchange
- Pregnancy testing
- Taking Blood samples

Optometrists

3.5 Optometrists are trained to examine the eyes to detect signs of injury, disease, abnormality and defects in vision. They provide a range of services including advice on visual problems, perform eyesight tests and examinations, prescribe corrective lenses or spectacles to those who need them and fit spectacles or contact lenses. There are 29 optometrist practices across Coventry whose services are commissioned under two main contract types (Mandatory GOS) and Additional Services (GOS) .

Community Dentistry

3.6 Across Coventry there are 36 Dental practices. Dentists are commissioned under a number of contract forms including (Personal Dental Services, Personal Dental Services Plus and General Dental Services)

3.7 Information on primary care providers can be found via the following link
http://www.coventrypct.nhs.uk

Acute Providers

3.8 The majority of acute services are commissioned from University Hospitals Coventry and Warwickshire (UHCW), which provides a wide selection of both general and specialised acute specialities. A number of other acute hospitals also provide services to the population of Coventry.

3.9 The contracts held with each of these providers reflect the requirements of the PCT to meet national acute access targets (e.g. 18 week waiting times from referral to treatment) and activity levels are modelled to ensure their achievement. The Commissioning Development Directorate is responsible for monitoring all acute targets and their achievement. The contracts also support the delivery of the PCT's health strategy and QIPP (Quality, Innovation, Productivity and Prevention) plans in ensuring that the most cost-effective and high quality care possible is delivered by the hospitals we contract with.

3.10 The Directorate also leads programmes of work in unscheduled and scheduled care which support the health strategy and delivery of our QIPP initiatives.

University Hospitals Coventry and Warwickshire NHS Trust

3.11 University Hospitals Coventry and Warwickshire NHS Trust (UHCW) was founded in 1992. The Trust is responsible for managing two major hospitals, these are the University Hospital Coventry and Warwickshire and the Hospital of St Cross Rugby. These hospitals provide a wide range of district general hospital services to around 500,000 people and tertiary services to over 1 million. It is also a specialist centre for cardiology, neurology, strokes, joint replacements, IVF, diabetes, cancer care and kidney transplants. The Trust serves as the principal teaching hospital for Warwick Medical School with whom it works in close partnership to develop innovative medical education programmes and clinical research.

3.12 The Trust employs approximately 6,400 staff. In 2009/10 the Trust's revenue expenditure amounted to £465m with a further £9.3m on capital

Table2 : Services provided by UHCW

University Hospital	
General Acute Services Accident and Emergency. Acute Medicine. Age Related Medicine and Rehabilitation. Anaesthetics. Assisted Conception. Audiology. Cardiology Critical Care. Dermatology. Diabetes and Endocrinology. Ear, Nose and Throat. Gastroenterology. General Medicine. General Surgery. Breast Surgery. Upper Gastrointestinal Surgery. Hepatobiliary and Pancreatic Surgery. Colorectal Surgery. Gynaecology. Haematology. Maxillo Facial Surgery. Neurology and Neurophysiology. Obstetrics. Ophthalmology. Optometry. Orthodontics. Orthoptics. Paediatrics. Pain Management.	**Specialised Services** Bone Marrow Transplantation. Invasive Cardiology. Cardiothoracic Surgery. Clinical Physics. Haemophilia. Neonatal Intensive Care and Special Care. Neuro Imaging. Neurosurgery. Oncology and Radiotherapy. Renal Dialysis and Transplantation. Plastic Surgery. **Diagnostic and Clinical Support Services** Biochemistry. Dietetics. Echo Cardiography. Endoscopy. Haematology. Histopathology. Medical Physics/Nuclear. Medicine. Microbiology. Occupational Therapy. Pharmacy. Physiotherapy. Respiratory Function Testing. Ultrasound. Vascular Investigation. **Other services based on site but provided**

Plastic Surgery. Renal Medicine. Reproductive Medicine. Respiratory Medicine. Rheumatology. Orthopaedics Trauma. Urology. Vascular Surgery.	**by other organisations:** Myton Hospice, BMI Meriden, Caludon Centre
Hospital of St Cross	
Ambulatory Care Day Surgery, Overnight Stay / 23 hour Surgery. Outpatients Services. Magnetic Resonance Imaging (MRI) Scanning. X-ray including Ultrasound Scanning, Bone Density. Laboratory Services. Endoscopy. Satellite Renal Dialysis Unit. Macular Unit **Screening** Retinal Screening Centre. Colorectal Cancer Screening Centre. Breast Screening. **Urgent Care Centre** A&E Department.	**Acute Medicine** Inpatient Medical Services. Intermediate Care. Inpatient Rehabilitation Service Acute Surgery. Inpatient Elective Surgery. **Other services provided on site:** Services based on the Hospital of St Cross site, but provided by other organisations: Myton Hospice, Mental Health Unit, Social Services, Recompression Chamber. GP (Out of hours service). Walk In Centre.

3.13 Following the award of a PFI contract the University Hospital Coventry site was substantially redeveloped over a period of three years. These new buildings and new facilities became operational in July 2006 and have helped ensure that the population of Coventry/ Warwickshire has access to modern buildings and a facilities that are capable of providing excellent healthcare. The contract also has a significant financial legacy that has implications for the local health economy.

3.14 Click here to visit University Hospitals Coventry and Warwickshire's website **http://www.uhcw.nhs.uk/**

Tertiary Services

3.15 The West Midlands Strategic Commissioning Group (WMSCG) commissions specialised services on behalf of all PCTs in the West Midlands. These are low volume/high cost services which would present a potential significant financial risk if commissioned by individual PCTs

3.16 Specialised services are commissioned at 2 levels within the : Tier 2 services are commissioned at a regional level by the Specialised Commissioning Group (SCG) and Tier 1 services are commissioned by Local Collaborative Commissioning Boards (LCCBs) which cover a smaller number of PCTs. The local LCCB includes NHS Coventry and NHS Warwickshire.

Mental Health Providers

3.17 Mental health, learning disability and substance misuse services are procured by NHS Coventry via a number of providers which include Coventry and Warwickshire Partnership Trust, independent hospitals, third sector providers, private sector health and social care agencies, West Midlands Specialised Commissioning Team and other NHS organisations.

3.18 There is significant partnership working within mental health, learning disabilities and substance misuse. NHS Coventry is a member of the Coventry COMPACT which involves partnership working between the voluntary, community and statutory sectors to improve the quality of life for people. NHS Coventry also works closely with NHS Warwickshire, Coventry City Council, Warwickshire County Council, West Midlands Specialised Commissioning, West Midlands Strategic Health Authority and local user and carer forums.

3.19 As Commissioners, NHS Coventry strives to ensure that contracts reflect the PCT vision, strategies and pathways and that through ongoing monitoring, contracts will be used to support the delivery of necessary improvements in quality, health and outcomes to clients. The table below details budgets for mental health services in Coventry.

Table 3 Mental Health Contracts

Contract	Duration		Value	Current Status
Coventry & Warwickshire Partnership Trust	1st April 2011	31st March 2012	£49,423,764	
Birmingham & Solihull Mental Health Trust	1st April 2011	31st March 2012	£180,936	
Care UK - Maplewood	1st April 2010	31st March 2011	£817,888	Contract extension applied until 30th September 2011.
Swanswell	1st April 2010	31st March 2011	£478,060: £385,563 - PCT £92,497 - LA	Contract extension requested until 30th November 2011.
Trust the Process	1st June 2009	31st May 2012	£846,000	Contract termination letter issued, service to terminate 30th November 2011.
West Midlands Police	1st April 2009	31st March 2010 - service variation extended to 30th June 2011	£75,000	Contract extension requested until 30th November 2011.

Community Services

3.20 Improving health and reducing health inequalities is made possible through greater partnership working across primary and community health services. NHS Coventry's supportive approach to effective partnership working has been beneficial to both service users and service providers in Coventry. For service users, it allows for the provision of more consistent, co-ordinated and comprehensive care and removes barriers to progressing towards stabilisation / rehabilitation. Benefits for service providers include developing a better understanding of local needs, managing a broader range of services that address individual needs, and the sharing and development of skills and resources.

3.21 Services which support delivery of care within a community setting are procured by NHS Coventry via a number of Providers which include Coventry Community Health Services (CCHS) and a wide variety of third party suppliers including organisations from the voluntary and community sector.

3.22 Prior to 31st March 2011 responsibility for the bulk of community services rested with Coventry PCT. However following the DH requirement for PCTS to divest themselves of all clinical services provision these services were transferred to the Coventry and Warwickshire Partnership Trust. The specific services transferred included

- Community Mental Health

- Interpreting Services
- Learn Disabilities
- Mental Health
- Psychology
- Clinical Assessment Service
- Chaat
- Child & Family
- Community Dental
- Community Nursing
- Continence
- Children & Young People's Occ Ther
- Foot Health
- Intermediate Care
- Learning Disability
- Out Of Hours
- Palliative Care
- Physiotherapy
- Speech & Language
- Tb
- Tissue Viability Department
- Wheelchair Services

3.23 As Commissioners we will ensure our contracts reflect these visions, strategies and pathways and that through ongoing monitoring, contracts will be used to support the delivery of necessary improvements in quality, health and outcomes to clients.

Voluntary Sector Services

3.24 NHS Coventry engages with the third sector through voluntary provider contracts and provide funding where appropriate to meet community needs. The main contracts let by the PCT cover services in the areas of mental health, older people, palliative care, sexual health, carers and public health. These contracts amount to in 2011/122. Details of the organisations and associated budget values are set out in the table below

Table 4: Voluntary Sector Contracts

Provider	2011/12 Contract Value £	2011/12 Value £ from finance	Contract Type	Length of Agreement	Expiry Date
Actively Influencing Mental Health Services (AIMHS) - service user involvement project	69,848	69,848	PCT Compact	3 years + one year extension	31/03/2012
Alzheimer's Society x3 elements (see details below)	100,567	100,567	PCT Compact	3 years	31/03/2012
Arty Folks	2,020	2,000	PCT Grant	3 years	31/03/2012
Citee Ltd x 2 elements - 1. Steps (training)	12,450	12,450	PCT Compact	3 years	31/03/2012
Citee Ltd (church initiative in training, employment) 2. Foot in the Door	33,720	33,720	PCT Compact	3 years	31/03/2012

Provider	2011/12 Contract Value £	2011/12 Value £ from finance	Contract Type	Length of Agreement	Expiry Date
Coventry Carer's Centre x 2 elements 1. Core	52,679	52,679	PCT Compact	3 years	31/03/2012
Coventry Carer's Centre 2. Mental Health Specific	40,060	40,060	PCT Compact	3 years	31/03/2012
Coventry Cynerians Drop In Centre (Norton House for Homeless)	57,054	57,054	Joint Contract	3 years	31/03/2012
Coventry Mind - Befriending Services	60,301	60,301	PCT Compact	3 years	31/03/2012
Coventry Mind - Coopers Lodge Day Centre	47,843	47,843	Joint Compact	3 years	31/03/2012
Coventry Mind - Drop in Centre	77,051	77,152	Joint Compact	3 years	31/03/2012
Coventry Mind - SHARE (group therapy sessions)	37,306	37,306	PCT Compact	3 years	31/03/2012
Coventry Mind - VIBES (young persons project)	18,221	20,850	(being developed)	1 year	31/03/2012
Crossroads (caring for carers)	31,478	31,478	PCT Compact	3 years	31/03/2012
Grapevine	68,971	68,911	Joint Compact	2 years	30/03/2012
Independent Advocacy x 3 elements: 1. IMHA Statutory Responsibility;2. Inpatient Advocacy; 3. Community Advocacy	114,450	115,850	PCT Compact	3 years	31/03/2012
Krysalis - drop in centre	37,965	37,965	PCT Compact	3 years	31/03/2012
Manic Depression Fellowship	1,010	1,000	PCT Grant	3 years	31/03/2012
Relate and GP Counselling	52,734	80,508	PCT Compact	3 years	31/03/2012
Sahara - asian elders support	29,394	32,503	Joint Contract (rolled over)	3 years	31/03/2012
Sahil - asian womens support	36,063	36,063	Joint Compact	3 years	31/03/2012
Samaritians - helpline	4,442	4,399	PCT Grant	3 years	31/03/2012
The Lighthouse Christian Care Ministry	15,029	14,882	PCT Grant	3 years	31/03/2012
Older People					
Age Concern - Contact & Connect	77,038	77,038	Joint Compact	3 years	31/03/2012
Age Concern - Hospital Advocacy	14,476	14,476	Joint Compact	1 year	31/03/2012

Provider	2011/12 Contract Value £	2011/12 Value £ from finance	Contract Type	Length of Agreement	Expiry Date
Age Concern - Orbit Care & Repair (home safety/hospital discharge element)	104,483	104,484	Joint Compact	2 years	30/09/2012
Coventry & District Multiple Sclerosis Society	5,223	5,223	PCT Grant	1 year	31/03/2012
Coventry & Warwickshire Sign Language Interpreting Service	34,667	34,667	PCT Grant	1 year	31/03/2012
Coventry Voluntary Service Council (VAC)	49,575	50,065	Joint Compact	3 years	31/03/2012
Headway Coventry & Warwickshire	17,382	17,210	PCT Grant	1 year	31/03/2012
Substance Misuse					
Compass - childrens Substance Misuse (services to tackle problem drug use)	118,175	275,235	Joint Commercial Contract	1 year	30/06/2010
Sexual Health					
Longer Term Grant Investments (Second Year)					
Age Concern - Dementia Project	37,500	50,000	PCT Compact	3 years	31/02/2012
Alzheimer's Society - Dementia Project	38,750	51,667	Joint Compact	3 years	31/02/2012
Coventry Mind - IAPT Low Intensity Service (inc CCBT)	223,216	223,216	In progress	1 year	31/03/2012
Citizens Advice Bureau	150,000	150,000	PCT Grant	3 years	31/03/2012
Community Transport	26,666	26,667	Joint Compact	3 years	31/03/2012
Crossroads - Carers Emergency Support Service	25,000	25,000	Joint Compact	2 years	31/03/2012
Crossroads - End of Life	175,000	175,000	PCT Compact (being developed)	2 years	31/03/2012
Crossroads - Stroke Survivor Enablement Carer Support Service	7,130	71,030	Joint Compact	2 years	25/01/2012
Crossroads - Dementia Project	75,000	75,000	PCT Compact	2 years	31/03/2012
The Stroke Association (family carer support service)	45,750	45,750	PCT Compact	2 years	31/03/2012
Voluntary Action Coventry - Innovations	187,938	125,351	PCT Compact	3 years	31/03/2012
Acorns Childrens Hospice	67,086	59,136	Grant Agreement	1 year	31/03/2012

Provider	2011/12 Contract Value £	2011/12 Value £ from finance	Contract Type	Length of Agreement	Expiry Date
Atrium Healthcare	93,000	93,000	PCT Compact	2 years	31/03/2012
AGE UK		91,514			
Mary Annes Hospice		6,620			
Helen Ley Hospice		24,480			
The Bridge		Included within CHIP programme with LA			
Apnee Sehat	53,291	8,882			
Meridan - CRC	73,542.00	24,514	Grant Agreement	1 year	30/07/2012
Swanswell Trust - Community Alcohol Service		385,563	Council Contract		
Myton Hospice		705,180	Grant Agreement	3 years	31.03.12

Other Services

West Midlands Ambulance Service

3.25 The West Midlands Ambulance Service (WMAS) was formed in 2006. The Trust serves a population of 5.36 million and covers an area of over 5,000 square miles including Coventry and Warwickshire as well as Shropshire, Herefordshire, Worcestershire, Staffordshire and the Birmingham, Solihull and Black Country conurbation

3.26 The WMAS has been one of the top performing ambulance Trusts in the country, being recognised as Ambulance Service of the Year on four occasions. In 2010-11 it was the only Ambulance Trust in the country to achieve all four of the national performance standards.

3.27 The WMAS has a budget of over £180 million per annum. It employs approximately 4,000 staff and operates from over 50 ambulance stations and other bases across the region. It has over 800 vehicles ambulances, response cars, non-emergency ambulances and specialist vehicles.

3.28 There are two Emergency Operations Centres taking around 2,700 emergency 999 calls each day. In 2010/11 the Trust responded to 805,000 emergency and urgent incidents and completed 850,000 non-emergency patient journeys. It also provides emergency preparedness services, special operations and some primary care services. These core services are supported through a range of clinical and corporate functions.

3.29 Detailed information on the Trust finances, governance, performance and other matters are contained in its annual report located at:
http://www.coventrypct.nhs.uk

3.30 More information on the West Midlands Ambulance is available via their website at **http://www.wmas.nhs.uk/**

Table 5: WMAS Budgets

	Budget 2010-11
West Midlands Ambulance Service - Passenger Transport - Emergency	 £1.4m £9.8 m

SECTION 4 - QUALITY

Effectiveness

Patient Safety

4.1 The Patient safety agenda at NHSC is delivered through a series of structures and processes including:

- The establishment and monitoring of CQUIN schedules for all key NHS providers (eg SWFT, CWPT)
- The development of dashboards to track Clinical Quality reviews (CQR) along with joint Clinical review meetings with providers
- The tracking and management of responses to Serious Incidents (SI)s for commissioned services

4.2 Oversight of the Patient Safety agenda is conducted through the Patient Safety and Quality Group which is a reports to the Integrated Governance Committee of the PCT Board . The terms of reference of the Patient Safety Group are available Committee along with sample agendas are available at http://www.coventrypct.nhs.uk

Recent Key Issues

4.3 Some of the key issues addressed in relation to patient safety over the past twelve months have included:

Stroke

4.4 Significant work has taken place in 2010/11 to ensure NHS Coventry met its stroke targets. The PCT is measured on the percentage of stroke patients spending at least 90% of their time on a Stroke Unit and performance at the end of 2010/11 was 83.67%, ahead of the end of year target of 80%. This is a significant improvement on 2009/10 end of year performance of 65.57%.

4.5 In 2010/11 NHS Coventry was also measured on the proportion of people who have a Transient Ischaemic Attack (TIA) who are scanned and treated within 24 hours. At the end of 2010/11 performance was measured at 96.88%, ahead of the annual target of 60%.

Pressure ulcers

4.6 To the end of August 2011, 72 pressure ulcers have been reported. It is a requirement of the NPSA that all Grade 3 and 4 pressure ulcers are reported as SI's. The SHA have produced new guidance – Tissue Viability for Reporting and Safeguarding.

Serious Incidents

4.7 To the end of August 2011, 8 Serious Incidents **(**SI) incidents were reported by the PCT via STEIS to the SHA, 4 of which have been reported since the last meeting (3 Pressure Ulcers and 1 Child Death).

Safeguarding

4.8 There is a statutory duty on Trust Boards to receive, as a minimum, an annual child protection report, acknowledging that ensuring children are safeguarded is an integral part of its responsibilities.

4.9 Implementation of Coventry Health Economy Safeguarding Children Training strategy across NHS Coventry has increased staff awareness of their roles and responsibilities in safeguarding children. A review is currently under way following the publication of updated guidance, one of several key national drivers which influence safeguarding children; their effect on the local

context is outlined. Work is currently being undertaken to measure the impact of training on practice.

4.10 Safeguarding supervision, cited as a requirement to enhance critical thinking for practitioners and also for their own wellbeing, in this complex area, is currently under development

4.11 An audit of safeguarding practice in primary care is underway, this is aimed at identifying support requirements which can be offered by the PCT in enabling GPs to meet safeguarding children requirements. This is in response to the letter from DH to PCT CEO's 'Safeguarding Children and Primary Medical Care' (gateway reference 13083). Details of training support offered to other independent contractors in meeting their requirements is outlined.

4.12 Significant factors for child protection interventions remain the level of domestic violence alcohol and drug misuse within the city. Professionals who work with adults in this area are critical to supporting vulnerable children and families to reduce risk. The risks to current domestic violence information systems, within the city are also identified.

4.13 Assurance is provided on the health economy safeguarding performance, health engagement with specific reviews is outlined including the findings of the Themed Safeguarding Children Reviews of Provider Trusts. This includes the issue relating to current Child Sexual Abuse and other child protection medical service provision.

4.14 There has been progress within the Looked After Children health requirements, systems and processes, and implementation of recommendations and actions from local Serious Case Reviews and Case Reviews is also progressing well. The Child Death Review Process is now firmly embedded locally along with the multi-agency Sudden Unexpected Death of a Child (SUDC) West Midlands protocol.

Healthcare Acquired infection

4.15 The Infection Control Annual Programme for 2010/11 was successfully implemented as planned with the exception of one sub element intended to formalise the current informal Microbiology arrangements accessed via University Hospitals Coventry and Warwickshire Hospital. This was in part due to local health economy restructuring and staffing issues across the Microbiology network. Work to address this issue across the health economy will continue in 2011/12.

Description of infection control arrangements.

4.16 The Infection Control Team (ICT) based within CCHS, provided Infection Control expertise to NHS Coventry (Commissioners) during 2010/11 (3 sessions per week) via a service level agreement (SLA). The Audit and Surveillance Nurse post (1.0 WTE band 6) remained vacant from February to June 2010. The post was filled in July 2010 and provided the ICT with the resources necessary to successfully complete the a programme of Infection Control audit and develop local alert organism surveillance within CCHS.

Infection Control Committee

4.17 The Infection Control Committee (ICC) chaired by the DIPC (Commissioning) met quarterly last year. In January 2011 the committee was stood down in preparation for the Commissioner – Provider separation. Infection Control reporting was maintained through NHS Coventry and CCHS respective Integrated Governance Committee's by continued monthly meetings between the DIPC and Infection Control Lead Nurse and continuous verbal and electronic communication across the organisation.

Infection Control Reporting Pathway

4.18 Progress with the delivery of the Infection Control Annual Programme for 2009/10 was reported via the agreed Infection Control reporting line on a quarterly basis. Each element of the Work Programme was rated as either red amber or green and an action plan outlined within the report for any element rated red.

4.19 All action plans were reviewed monthly by the Infection Control Lead Nurse and DIPC. Identical copies of the report were submitted to both Commissioning and Provider functions of the organisation via Corporate and CCHS Integrated Governance Committee's as demonstrated in the reporting framework in Appendix B.

Links to Clinical Governance and Risk Management.

4.20 The Infection Control Committee and subsequently the Integrated Governance Committee's provided Infection Control links to both Clinical Governance and Risk Management functions on both the Commissioning and Provider arms of the organisation. These links were further embedded by the DIPC (Commissioning and Provider) membership within their respective Integrated Governance Committees.

Links to Medicines Management Team.

4.21 The Head of Medicines Management has supported the ICT and the *Clostridium difficile* root cause analysis (RCA) process undertaken for every reported community associated case of Clostridium difficile.

Reported Outbreaks/Increased Incidence in 2010/11

*Independent Contractors***. -** None reported.

Care Homes (Nursing and Residential) - Outbreaks of infection within Care Homes in Coventry are managed by the local Health Protection Unit (HPU). The Health Protection Agency maintained communication via outbreak reporting across the health economy. This has enabled the ICT to target Care Homes who have experienced an outbreak, in order to offer Infection Control basic training.

CCHS - None reported.

HCAI Mandatory Reporting - Targets for the reduction of infections in the community, including Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia and Clostridium *difficile* Infections for 2010/11 were apportioned locally based on the Strategic Health Authority (SHA) stretch targets set for Primary Care Organisation's (PCO).

Meticillin Resistant Staphylococcus Aureus (MRSA) bacteraemia. - The target for community associated MRSA bacteraemia was no more than 2 cases for the period April 1st 2010 to March 31st 2011. The target was achieved this year with nil cases reported.

Clostridium difficile Infection (CDI).- The PCO target for community associated Clostridium difficile infections (CDI's) was no more than 14 cases for the period April 1st 2010 to March 31st 2011. However by July this year the target was exceeded as demonstrated below (Graph A).

4.22 Information on healthcare acquired infections and infection prevention can be found on the NHS Coventry website **http://www.coventrypct.nhs.uk/**

Innovation

Referral Support Service

4.23 Experience from other areas such as Kingston, Epsom and Nottingham in using primary care-led referral triage schemes suggested improvements in the quality of referrals, the completeness of patient work-up and the control of referral growth rates. Such services can

also enable service redesign and referral guidance development by capturing patient information that is much more clinically focused than acute contract outpatient data returns.

4.24 The implementation of a RSS and its ability to help control elective expenditure in the local health economy falls within the objectives of the Scheduled Care QIPP Programme, as well as effective implementation of Choice and Choose and Book initiatives.

4.25 In the future GP Commissioners will need to have a robust understanding and control over elective expenditure, starting with new referral flows. New and follow-up outpatient attendances currently account for nearly 20% of the total value of NHS Coventry's contract with UHCW. While approximately half of new referrals do not originate from GPs, these are the referrals that GPs have greatest direct control over.

4.26 RSS also enables support other workstreams related to the Scheduled Care QIPP programme:

- Enforcement of the Low Priority Treatment and Aesthetic Policies
- Support data collection for future service redesign inc setting thresholds
- Act as a potential mechanism to review/audit new referrals from other sources
- Act as a potential mechanism to review/audit follow-up referrals

Patient Experience

Overview

4.27 The PCT has a number of ways of communicating with the public to seek and receive their views on services provided. NHS Coventry listens to feedback from local people and uses what they said to ensure that all of the decisions made about healthcare in the city are underpinned by a clear understanding of public views, concerns and aspirations. In addition, knowing what people think about health services in Coventry is central to the goal of improving patient experience. Public, carer and patient views and feedback from across the city were collected and analysed to pick up emerging trends. It also acted as an early warning system for issues or concerns that local people were commenting on, so that appropriate action could be taken an at early stage.

PALS

4.28 The Patient Advice & Liaison Service (PALS) enables service users, carers, relatives and members of the public to comment on health services in Coventry. PALS work to resolve concerns, issues and informal complaints at a local level, as well as recording compliments and ideas about service improvements.

4.29 During 2010/11 the NHS Coventry service has dealt with 1015 cases. The breakdown of queries is as follows:

Table 6 Source of PALS Enquiries

Organisation	Nos.	%
GP	218	21%
Dental	168	17%
Commissioning / funding treatment	103	10%
Pharmacy	11	1%
CCHS*	100	10%
Other org*.	88	9%
Opticians	16	2%
General information	311	30%

***CCHS:** examples of enquiries and concerns have included *The Out Of Hours Services, the Walk in centre, Physiotherapy, Podiatry, District Nursing, Children's Occupational Therapy, Wound Care Clinics, Pain Clinic and CAS*

4.30 Examples of enquiries and concerns have included *University Hospitals Coventry & Warwickshire (UHCW), West Midlands Ambulance Service (WMAS), George Eliot Hospital, Social Services Departments, Voluntary services/agencies and housing.*

4.31 The cases and trends highlighted contributes to improving the patient experience by ensuring timely resolution of queries or issues, and feeding insight back to commissioners and service providers.

Patient and Public Engagement

4.32 The Patient & Public Engagement (PPE) team employ a wide range of activities to capture public opinion of health services e.g. surveys', focus groups, forums and meetings etc. These include utilising ongoing engagement activities within partner agencies and colleagues from other sectors, including the voluntary and community sector to engage with members of the public to capture views, experiences and aspirations of health services. PPE also supports the development of 'Patient Representative Panels' to ensure that the patient's views and opinions are integrated within GP practices.

4.33 NHS Coventry works closely with the relevant Health Oversight and Scrutiny Committee, Local Involvement Network (LINK) and voluntary groups, actively encouraging members of the public to help us plan and buy the best quality high services possible. This year, individual patients and carers have met with the NHS Board members and shared their stories before every public meeting. Feedback from the Board has been extremely positive, with non executives stating that this direct feedback from patients and carers using services in Coventry gives them a better understanding of current patient experience and how this can be improved in the future.

4.34 NHS Coventry's Public and Patient Engagement (PPE) Team hold regular city wide events for local people and have talked to different communities to support the organisation's role as a commissioner of high quality health services, e.g. in Children's and Sure Start Centres work has been done around immunisation and vaccination and how to keep babies safe at home.

4.35 A campaign for people in Coventry to have their say on healthcare reached a new milestone at the end of 2010, with more than 2,000 volunteers signed up to the scheme. In total 2,372 NHS

Coventry Champions have been recruited so far as part of a drive to keep residents informed and involved in shaping health services in their local area.

4.36 Patients and members of the public volunteered to be a Champion after talking to staff at a range of community meetings and events, including the Godiva Festival and hubs in the town centre, hospitals, universities and colleges. Champions are invited to have their say on health service issues that interest them, in a way that fits their lifestyle. Options include e-mail consultations, events and meetings designed to share experiences and ideas of how services could be improved.

4.37 Key documents relating to the PCT's approach to communications can be found via the following web link on http://www.coventrypct.nhs.uk

Other Methods of Feedback

4.38 A range of other methods are also used to elicit feedback from patients and the public, for example , 'Have your say…' comment cards are used to seek the views and comments that relate to the how "patients experience" NHS Coventry service provision. These are simple free text cards that can be returned by Freepost to the PALS team. The comments (both positive and negative) are used as feed back to the relevant service leads / departments.

4.39 'Contact Us' – is an email address set up specifically to enable the public to contact NHS Coventry with any specific questions, views, compliments or comments relating to service provision. Any issues and/or questions surrounding patient concerns or problems etc. are dealt with and responded to directly by the PALS team.

4.40 The Patient Opinion & NHS Choices are Internet feedback platforms that are devised to encourage public and patients alike to share their views and comments about NHS experiences and/or healthcare provisions etc. The PALS team routinely review these sites to glean any comments/appraisals etc. pertaining to NHS Coventry, and feedback to the Patient & Public Engagement (PPE) team on a quarterly basis.

Complaints

4.41 In terms of complaints, comments and suggestions about NHS Coventry as both the provider and commissioner of services are welcomed and complaints are viewed as providing a learning opportunity for the organisation and individuals concerned to improve services. The PCT believes that a consistent and responsive complaints system will lead to improved relations with patients, their relatives and carers and confidence of staff and patients that NHS Coventry is committed to reviewing and improving services.

4.42 The main issues raised by complainants were clinical treatment, communication and attitude with patients and PCT commissioning including waiting lists. As a result of complaints being made and subsequent investigations, a number of service improvements have been introduced In 20010/11 NHS Coventry received 93 formal complaints about the services we directly provide and commission.

Table7 Number of Complaints Received by Organisation

Organisation	Number of Complaints
Community Services (including GP Out of Hours Service)	53
Walk-in Centre	14
Commissioning	26
Total	**93**

4.43 In 2010/2011, across the city GPs received 345 complaints, which is a considerable decrease compared to 419 in 2009/2010 and 2 conciliation meetings, were held to try and resolve the concerns raised both with successful outcomes. In respect of dentists, there were 94 complaints compared to 99 in 2009/2010.

The GP and dental complaints have been broken down into the following categories:

Table8 Source of Complaints Issues

Subject of Complaint	GP	Dentist
Communication/Attitude	128	34
Premises	7	1
Practice Management	24	3
Practice Administration	65	11
Clinical Matters/Treatment	95	38
Other	26	7
Total	**345**	**94**

SECTION 5 - PERFORMANCE

Summary of performance against national core standards

5.1 Detailed spreadsheets outlining the current performance against key targets is available through viewing the Performance Reports which are scrutinised by the Finance and Performance Committee on a monthly basis and by the Board on a bimonthly basis. The Board reports are available via the hyperlink opposite and this link also enables readers to peruse the historical data available.

5.2 Current performance analysis indicates issues with the following areas within Coventry, and outlines the actions being taken to address the situation:

Stroke Care

5.3 Quarter 3 2010/11 data against the proportion of people who spend at least 90% of their time on a stroke unit shows performance of 79.81%, against a quarterly target of 70%. Performance was just below the annual target of 80% by quarter 4.

5.4 Performance against the second national stroke target, for the proportion of people who have a TIA who are scanned and treated within 24 hours was 95.24% in quarter 3 2010/11, ahead of both the quarter 3 and 4 targets of 50% and 60% respectively. A stroke remedial action plan is in place at UHCW and work to improve performance continues against this action plan.

Chlamydia Screening

5.5 Quarter 3 2010/11 performance against the percentage of the 15-24 population to be screened or tested for Chlamydia continued to improve with performance of 21.3% (cumulative) in comparison to performance of 11.8% in quarter 3 2009/10. Quarter 3 2010/11 was below the quarterly target of 26% (annual target of 35%). Work is continuing in ensuring the individuals most at risk are screened and CCHS are to focus on promoting the programme in core services.

CAMHS

5.6 A full range of CAMH services for children and young people with learning disabilities have been commissioned for the council area and performance against the effectiveness of CAMHS has improved in quarter 3 2010/11 to a rating of 4 from a rating of 3 in quarter 2 2010/11. Coventry PCT has an overall CAMHS performance at quarter 3 of 16, from an available rating of 16.

Childhood Obesity

5.7 Results of 2009/10 performance against the childhood obesity targets show an improvement against the reception obesity target with performance of 10.50% against 2008/09 performance of 10.59%. Performance was ahead of the 11% target.

5.8 Results have show a decline in performance against the year 6 target in 2009/10 with 20.30% reported, against 2008/09 performance of 19.45%. Performance did not meet the target of 19%.

5.9 Participation targets were met in 2009/10 for both reception and year 6, with improvements seen on 2008/09 performance.

Category A and B Ambulance Calls

5.10 Performance dropped significantly in December 2010 against the Category A and B calls. In December 2010 performance against the target for 75% of Category A calls to be responded

to within 8 minutes was 64.3%, a significant drop, given that this target had been met in all other months in 2010/11

5.11 Performance against the 95% target for category B calls to be responded to within 19 minutes was 88.9% in December 2010. January performance was ahead of target and year to date performance slipped slightly below the 95% target to 94.8%.

Cervical Screening – 14 Day Turnaround

5.12 The target against the cervical screening performance indicator is, 100% of women should be receiving their cervical screening results in 14 days, from December 2010. Whilst performance improved from the poor performance seen in September 2010 of 34.2%, in December 2010 and January 2011 NHS Coventry did not meet the 100% target with performance of 97.3% and 98.80% respectively. Plans and monitoring are in place to address the underperformance.

Track record in delivering choice

5.13 From April 2008, all patients registered with an English GP had the right to choose from any NHS funded provider following a referral to a hospital consultant. The only exceptions were cases requiring speed of access, such as suspected cancer and chest pains, in addition to maternity and mental health services.

5.14 To assist the process a Generic Electronic referral templates was developed which combined the vast majority of Specialties/Services into one template. In January 2010, the Choose and Book service was expanded to include the continence service, the tissue viability clinic and surgery for prolapsed intravertebral discs.

5.15 The PCT's Patient Choice and Resource allocation Policy was been developed as part of the work being undertaken by CHC commissioners and Deloitte on the Collaborative Commissioning Programme for NHS Continuing Healthcare. The Policy is to assist PCTs to make decisions about the most clinically appropriate care packages for individuals, thus improving financial management by

- Informing robust and consistent care package decisions for each PCT in the West Midlands using a regionally developed policy;
- Ensure that there is consistency across the region over the services that individuals are offered;
- Ensure each PCT achieves value for money in its purchasing of services for NHS Continuing Healthcare ("CHC") individuals;
- Help health care providers understand how they can most effectively work with NHS bodies in this region.

5.16 Information on Choose and Book, Patient Choice and RSS are available via the following link: http://www.coventrypct.nhs.uk

SECTION 6 – FINANCIAL HISTORY

Overview

6.1 Echoing the global economic downturn, the 2010 Comprehensive Spending Review confirmed a period of public sector spending constraint. Having addressed the financial deficit incurred in 2006/7, NHS Coventry was fortunate to enter this challenging period with a strong and improving record of financial stewardship:

Table 9 Financial Performance

	2006/7	2007/8	2008/9	2009/10	2010/11
Financial Out-turn	£6.8m deficit	£3.89m surplus	£4.98m surplus	£4.64m surplus	£6.25m surplus
Use of Resources rating	Weak	Weak	Fair	Fair	n/k
Value for Money opinion	Unqualified UoR opinion VfM – Adequate per UoR	Unqualified UoR opinion VfM – Adequate per UoR	Qualified (commissioning and procurement of services)	Qualified (use of natural resources)	Unqualified

NHSC demonstrates a similarly strong performance in relation to statutory financial duties:

Table 10 Achievement of statutory duties

	2006/7	2007/8	2008/9	2009/10	2010/11
Net Expenditure not to exceed Revenue Resource Limit	Not Achieved	Achieved	Achieved	Achieved	Achieved
Expenditure not to exceed Capital Resource Limit	Achieved	Achieved	Achieved	Achieved	Achieved (£59k surplus)
To remain within Cash Limit	Achieved	Achieved	Achieved	Achieved	Achieved
To achieve full cost recovery on Provider Services	Not Achieved (£1.72m deficit)	Achieved (£0.5m surplus)	Achieved (£91k surplus)	Achieved (breakeven)	Achieved (£309k surplus)

This performance is set against a context of reducing revenue growth:

Table 11 Financial Limits and RRL Growth

	2007/8	2008/9	2009/10	2010/11	2011/12
Revenue Resource Limit (recurrent – as per Exposition book)	£469.4m	£502.0m	£529.6m	£558.7m	£557.4m*
RRL growth received	10.4%	5.46%	5.50%	5.50%	1.95%
Distance from Target - %	3.5% under	3.5% under	0.6% under	0.3% under	3.6% over
Distance from Target - £m	£17.0m under	£18.2m under	£3.2m under	£1.5m under	£19.2m over

**Adjusted for transfer of funding for Adult LD social care to LA*

6.2 Following the voluntary 'Financial Turnaround' plan, initiated in 2006/7 and which released recurrent revenue savings of circa £7.0m in 2007/8, NHS Coventry did not set an internal cost improvement programme in either 2008/09 nor 2009/10. A modest CIP target of £4.04m was set in 2010/11. Whilst the PCT achieved this net target, this masked a number of variances at individual project level – see table below.

Table 12 QIPP Schemes Financial targets

2010/11 QIPP Cost Reduction Schemes	**Revised Annual Target (net) £000s**	**2010-11 Savings Actual (net) £000s**	**Variance Over/ (Under) Recovery £000s**
Outpatients	240	(8)	(248)
Unscheduled Care	(130)	(130)	0
Transforming Mental Health	75	260	185
Prescribing	1,353	1,598	245
Continuing Healthcare	451	886	435
Integrated Pathway	(30)	0	30
UHCW Block Contract	312	420	108
Stroke	500	500	0
Low Priority Treatments	1,140	461	(679)
Lifestyle Risk Management	125	125	0
Total Investment	**4,036**	**4,112**	**76**

6.3 Within NHSC, 2010/11 was acknowledged as a preparatory year in terms of QIPP delivery, with schemes needing to be implemented by March 2011 in order to meet the much more significant 2011/12 savings target

Summary of current organisational budgets

6.4 NHSC's revenue budget for the 2011/12 financial year may be summarised as follows:

Table 13 2011/12 Budget

Income:- Resource Limit	Approved 1st April 2011 £000s 609,369	Updated as at 30th June 2011 £000s 609,858
Acute & Specialised services	282,232	283,332
Non Acute services	147,640	147,750
Prescribing	51,893	52,073
General Practitioner services	44,768	44,557
Primary Care Dental services	13,459	13,459
Community Pharmacy	12,134	12,134
Community Opthalmics	2,999	2,999
Corporate Functions	15,390	15,186
Capital Charges (inc. Impairments)	7,410	7,626
Sub Total	**577,925**	**579,116**
Earmarked Provisions	11,861	11,399
Health Strategy Initiatives	2,847	2,607
Social Care Fund & Re-ablement	5,236	5,236
General Contingency	5,700	5,700
Total Planned Expenditure	**603,569**	**604,058**
2011/12 Control Total Surplus	**5,800**	**5,800**

6.5 For further detail, please refer to the Board approved 2011/12 Financial Plan (March 2011) and subsequent update (May 2011). These are available via the following link http://www.coventrypct.nhs.uk

6.6 Revenue budgets for 2011/12 are underpinned by a QIPP/cost improvement requirement of £16.25m gross (£13.4m net ie. if associated investment is included). The detail of the 2011/12 QIPP programme is detailed in both the Arden System Plan and the NHSC Financial Plan (attached above).

6.7 As at 30th June, NHS Coventry is forecasting that it will achieve its planned 2011/12 surplus of £5.8m despite some slippage against QIPP plans and an anticipated over-performance against its main Acute contract. See the Finance report to the July Board meeting for more detail.

6.8 Details of the PCT's 2011/12 Capital Programme are also included in this Board report.

6.9 The Revenue budgets for 2011/12 are further underpinned by the application of the 2% of PCT revenue resource that can only be committed non-recurrently ie. to support strategic Change. For NHSC this figure is £11.366m in 2011/12. The application of this funding in 2011/12 is detailed on pages 53-55 of the Arden System Plan

Financial Risks

6.10 The 2010 Comprehensive Spending Review protected the NHS from budget cuts, with a settlement that provides for an annual inflation uplift on existing budgets for the next three years (in line with national whole economy inflation assumptions). In the current climate that is a comparatively good settlement for the NHS. However, demand for services is expected to outstrip funding growth and nationally, it has been recognised that there is a a potential gap

between resources required and resources available of £15-20 billion cumulative by 2014/15- if the NHS carries on as it does now.

6.11 The Arden System Plan (pages 3-12) describes how this national challenge applies to the local health economy. NHS Coventry recognises that the next three years will be financially challenging. This is reflected in our medium term financial plan, which is summarised below:

Table 14: QIPP Financial Impact

	2011/12	2012/13	2013/14	2014/15
	£m	£m	£m	£m
Total Income	**622.169**	**627.550**	**638.185**	**646.388**
Acute & Specilaised	285.275	282.627	278.987	281.621
Mental Health & LD	68.588	69.808	70.657	71.655
Community Services	62.228	66.374	67.675	68.562
Continuing Care	20.292	21.073	22.442	23.934
Primary Care	136.123	140.295	144.907	148.281
Other Commissioning Spend	32.927	26.134	27.808	26.221
Social Care	5.236	5.037	5.037	5.037
Strategic Change Fund (2%)	0.000	5.907	11.814	12.044
General Contingency	5.700	5.794	5.906	6.022
Total Expenditure	**616.369**	**623.049**	**635.233**	**643.377**
Planned Surplus	**5.800**	**4.501**	**2.952**	**3.011**
QIPP challenge in above figures	**13.117**	**8.539**	**9.667**	**1.649**

These projections are based upon the following planning assumptions:

Table 15 QIPP Financial Planning Assumptions

	2011/12	2012/13	2013/14	2014/15
Recurrent RRL growth	2.00%	2.00%	2.00%	2.00%
Tariff - Gross uplift	2.50%	2.50%	2.50%	2.50%
Tariff - Efficiency	-4.00%	-4.00%	-4.00%	-4.00%
CQUIN addition	0.00%	0.00%	0.00%	0.00%
Acute growth	3.00%	2.00%	2.00%	2.00%
Non Acute growth	2.00%	1.00%	1.00%	1.00%
IPP growth	8.00%	8.00%	8.00%	8.00%
Prescribing volume	4.50%	4.50%	4.50%	4.50%

6.12 For full details, please refer to NHS Coventry's Long Term Sustainability Model (last updated May 2011).

6.13 The LTSM will updated over the summer and then again after publication of 2012/13 NHS Operating Framework, PCT allocations and Tariff uplifts.

High Risk Financial Issues

6.14 The Arden System Plan recognises financial sustainability as a fundamental issue for the Coventry & Warwickshire health and social care economy. NHS Coventry faces the same generic in-year financial risks/challenges as other Commissioners

- Failure to deliver QIPP initiatives and associated cost efficiency savings.
- Unplanned variations in Acute & Specialised activity that may result in contracts over-performing in-year
- The potential for other volume–related costs, particularly Prescribing and Continuing Healthcare/Individual Packages, to be higher than anticipated

6.15 Delivery of stable financial balanced across the health economy remains perhaps the greatest challenge for the organisation in this and coming years. Table highlights the scale of financial challenge facing Warwickshire

Table 16: QIPP cumulative savings

	2010/11 £000s	**2011/12 £000s**	**2012/13 £000s**	**2013/14 £000s**	**2014/15 £000s**	**Cumulative Total over 5 years £000s**
NHS Coventry	(2,817)	(23,516)	(29,673)	(33,435)	(35,128)	(127,386

6.16 Internal performance management processes and the PCT's general contingency provision will be key tools in managing these risks.

6.17 The following issues are identified in the System Plan as risks to QIPP delivery and hence the delivery of PCT financial plans:

- Changing population behaviour (including where/how they access services). For example, there are still considerable numbers of patients who attend A&E as an alternative to their GP practice – in some instances because they have been unable to make appointments with their GP or the practice nurse, in others because they don't fully understand how to access services appropriately.
- Changing clinical behaviour. For example, whilst the PCTs have agreed lists of Low Priority Procedures, a number of GP referrals are still being made for these procedures and operations undertaken.
- Robust capacity planning across all sectors and planning and implementing bed reductions in hospital
- Reductions in social care funding and transparency of capacity within social care.
- Enhancing the skill set in the community workforce to facilitate the anticipated shift in care from hospital to community setting and to support the self-care agenda
- Securing clinical sign up across primary and secondary care to agree clinical thresholds and shared care arrangements.

6.18 A summary of the mitigation plans for these generic risks is available within the Arden System Plan, pages 177-181.

6.19 NHSC (and its constituent clinical commissioning groups) is seeking to develop contingency plans should any QIPP scheme(s) fail to deliver, or the financial challenge grow as the result of other factors. The areas identified are:

- Cutting the cost of Frailty
- Childrens Continuing Healthcare

- Mental Health High Cost Drugs
- Development of additional commissioning policies, particularly in high cost areas
- Decommissioning of services that do not deliver desired health outcomes

6.20 The work to scope these schemes will be undertaken as part of the 2012/13 commissioning cycle.

Pooled Budget Arrangements

6.21 For the financial year 2011/12, NHSC has two pooled budget arrangements with Coventry City Council:

- Integrated Community Equipment Store: NHSC budget contribution = £ 269,355. Total budget = £1,125,203. Any under/over-spend to be shared pro-rate to initial budget contribution.
- Learning Disabilities Development Fund: NHSC budget contribution = £NIL. Total budget = £269,766.

Both budgets are monitored via the Adult Joint Commissioning Board

6.22 Budgetary reductions being implemented by Warwickshire County Council are compounding the NHS financial savings requirements. This will have a significant impact on social care provision across all client groups within the county.

6.23 There will be a transfer of funding from the NHS to the Local Authority to invest in meeting increasing demand, maintaining levels of service and investing in service transformation. This equates to circa £5.2M for Coventry City Council recurrently from 2011/12. Given this is less than the levels of funding being lost from Adults and Children's Services within our local authorities we will need to work even more closely together to commission effective and efficient services across health and social care that aim to reduce duplication and increase integration, thus improving overall patient experience and achieving best use of the reduced funding available.

SECTION 7 – PROVIDER CAPACITY

Market Management Initiatives

7.1 A number of market management initiatives have been put in place by NHSC these include a procurement process under the Any Willing Provider (AWP) approach

- Lifestyle Services (Smoking Cessation, Smoking in Pregnancy and Chronic Disease Self Management). This contract covers the period 1/4/10 to 31/3/13.
- Extended Choice Network (as part of the West Midlands Regional Choice Network). The contract covers the period 1/7/11 to 31/3/14.

Procurements

7.2 Procurements undertaken in the last three years for Patient Services in addition to the above:-

- Continuing Health Care NHS Coventry
- Continuing Health Care Deloitte Framework as part of the West Midlands Regional procurement
- Beds and mattresses

7.3 Planned procurements exercises include the following

- Lets Get Moving Tender (in hand)
- Further rounds of the AWP as above (in hand)
- Diabetic Retinal Screening across the Arden Cluster
- PTS across the Arden Cluster
- Domiciliary Care Services for the Arden Cluster and Warwickshire County Council (in hand) led by WCC
- Dexa Scanning
- Specialised Orthodontics across the Arden Cluster
- Document Storage
- GP Registration Services for Homeless and Refuge Clients (in hand)
- Database for Individual Funded packages across the Arden Cluster
- Home Oxygen (in hand)

SECTION 8 – WORKFORCE

Snapshot of the NHS Coventry Workforce

8.1 NHS Coventry has a 279 head count and this equates to 244.83 FTE (taken from latest LTSM submission). This number also includes the Arden Cancer Network (9.6 FTE).

Table17 The breakdown of the staff groups is shown

Staff Group	% of workforce
Admin and Clerical	76%
Nursing and Midwifery	15%
Scientific and Technical	6%
Medical and Dental	2%
Estates	1%

8.2 Agency and bank have been used in a responsible way to maintain current levels of service whilst the government plans are being finalised and we will be reviewing this on a constant basis.

Workforce Challenges

8.3 The Demand on the workforce is coming from 3 key areas:

- Setting up of the Arden Cluster
- Alignment and Assignment to GP Consortia, Local Councils and other Providers
- Delivery of QIPP

8.4 There are no plans to increase the level of workforce and therefore the demands on our workforce are causing some pressures, due to natural wastage and not being replaced, maintaining PCT services whilst moving to a new structure within the Cluster and undertaking Alignment.

8.5 There is a plan in place to reduce the number of FTE staff down to 214 by the end of March 2014, and this is encompassed in the Arden Cluster Workforce Planning document.

Agenda for Change

8.6 Agenda for Change is the single pay system in operation in the NHS. It applies to all directly employed NHS staff with the exception of doctors, dentists and some very senior managers. The three core elements that make up Agenda for Change are:

- Job evaluation,
- Harmonised terms and conditions
- The knowledge and skills framework

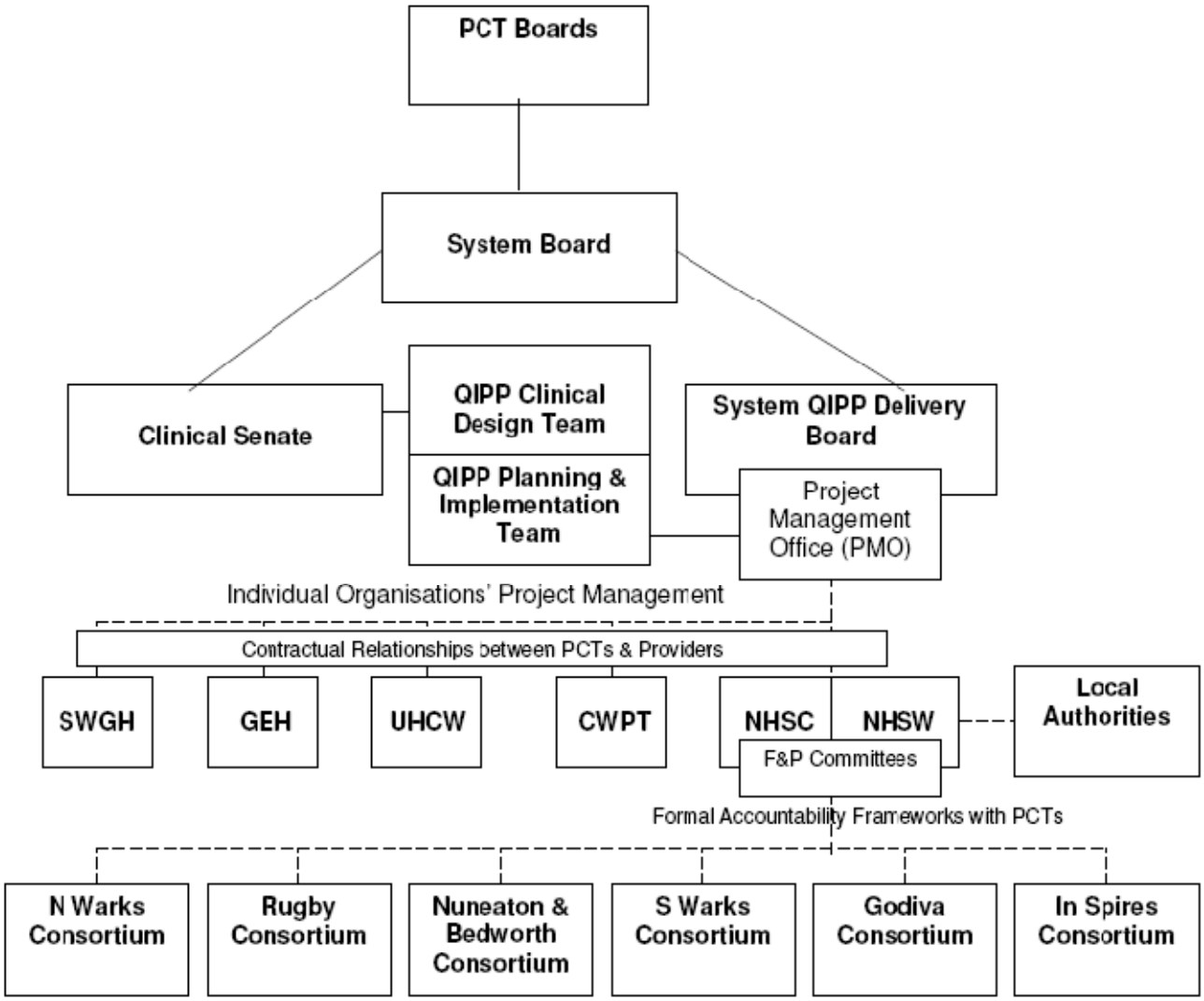
A key requirement of Agenda for Change has been the need to ensure all jobs are assessed against the NHS job evaluation criteria to identify appropriate pay and banding

SECTION 9 - SUMMARY OF PLANNED KEY CHANGES

9.1 NHSC has a well developed strategy for change in the guise of the Quality, Innovation, Productivity and Prevention (QIPP) programme. The aim of this programme is to

- help secure improvements in the quality of health services
- rationalise service pathways to secure improved efficiency and greater economies in delivery
- help forestall health problems through more effective and coordinated action to prevent disease and ill health

Figure 3: QIPP Governance



9.2 The System Plan for Coventry and Warwickshire sets out the context, challenge and response of key agencies in the health economy in delivering the QIPP agenda. In particular it describes our local assessment of the size of the QIPP challenge, for commissioners and providers the changes required and how they will be delivered change agenda will be delivered

9.3 This Plan identifies a series of key strategic challenges that NHSC in conjunction with partners within the health economy needs to address. These crystallise around the following issues and areas

- Ensuring the best quality of care for patients, including fair and timely access to a choice of services which are safe, clinically effective and patient-centred;
- Ensuring high levels of engagement and partnership working with patients, the public, clinicians, providers and partners;
- Ensuring clinical and financial sustainability through effective use of resources;
- Ensuring true transformation of clinical services in response to the needs of the populations.

9.4 In delivering its QIPP schemes each PCT has committed to achieving improvements in health outcomes for its population, as originally identified within World Class Commissioning Strategic Plans. For NHS Coventry these outcomes are:

- To reduce the prevalence of smoking amongst people aged 16 or over to achieve top quartile performance in respect of prevalence by 2014/15.
- To reduce the prevalence of obesity in children in Year 6 by 2014/15.
- To reduce teenage conception rates per 1000 females aged 15-17 by 20% by 2014/15.
- To reduce COPD mortality rates per 100,000 to below the national median by 2014/15.
- To reduce diabetes mortality to below the national median by 2014/15.
- To reduce the CVD mortality rate per 100,000 (under 75s) to achieve a prevalence lower than the growth associated with an ageing population, a reduction in mortality rates of 15% by 2014/15 and a 10% reduction in premature mortality by 2014/15.
- To increase the proportion of women aged 25-49 who have received cervical screening and the proportion of 2 year olds who have completed their MMR vaccinations by ensuring <10% of Coventry practices fall within the bottom quartile of all practices nationally by 2014/15.

9.5 To secure delivery against the key strategic challenges presented by the QIPP agenda NHSW (in conjunction with Coventry PCT and the other stakeholders within the health economy) has undertaken a strategic assessment to determine its on-going strategic priorities within QIPP programme. This has led to a focus on the following key areas

- Unscheduled Care
- Long Term Conditions
- Elective Care – including procedures of limited clinical value
- Outpatient Referrals and Follow-ups
- Prescribing

The essential characteristics of our future Care Delivery System

9.6 The essential characteristics of our future care delivery system envisaged in the System Plan includes the following principles:

- The right capacity, in the right place (including an appropriate balance between hospital and community-based care).
- The right care delivered by the right individual at the right time.
- The health care delivery system is the right size – reflecting the extent of funding available.

- Pathways are clinically-driven, ensuring that the best care is provided in line with evidence of effectiveness and delivered in a patientcentred way.

9.7 Ultimately, we expect shifts in activity from tertiary services to secondary services - e.g. through reduced lengths of stay in forensic secure units; and in secondary services to community services – through reduced attendances, admissions and lengths of stay in hospital. In the community setting we aim to achieve a reduced volume of long-term residential placements (whether in nursing or residential care homes) through enhanced re-ablement services and better provision of care to people in their own home or supported housing. The latter should deliver cost efficiencies to both Health and Social Care whilst also improving the quality of life for individuals in their older years.

9.8 Across the Cluster there is a strategic intention to work towards a joint intermediate care service and care pathways which reduce admissions to residential care placements direct from hospital. In addition, the intention will be to grow the Extra Care Housing economy and the use of specialist residential care placements where appropriate, reducing utilisation of nursing homes for Social Care funded clients, wherever appropriate and feasible.

9.9 Traditional care models (and providers of services) will be challenged as we implement our plans. We are likely to see secondary care providers increasingly partaking in activities previously associated with community providers, e.g. smoking cessation services, more secondary care consultant-led provision of specialist community services through integrated teams; with community providers increasingly delivering more complex care through 'virtual ward' type arrangements. As a result of this, the need for enhanced integration and partnership working across the Health and Social Care system has never been greater. We also anticipate there may be a requirement to re-align services across the Cluster as a result of the impact of existing and additional QIPP schemes to ensure future clinical and financial sustainability, particularly beyond 2011/12. As previously stated, the Clinical Senate will play a key role in this but it will need to be supported by robust activity modelling and capacity planning across the Health and Social Care system.

9.10 Within Coventry we expect there to be a small amount of growth in primary care consultations (GPs and Dental UDAs) as a result of growth in the population over the next four years. During this time, items prescribed will increase to a much greater extent, in line with recent trends, and the on-going focus on early identification and treatment of under-lying health conditions.

9.11 Through our work on unscheduled care we anticipate a continued growth in ambulance journeys to A&E but less than previous levels of growth as a result of more patients appropriately accessing primary care and the walk in centre. We anticipate a higher percentage of patient calls resolved through telephone advice (and possible re-direction to primary care or the walk-in centre) with those patients that are taken to A&E being of a higher level of complexity.

9.12 Within Mental Health Services we believe growth in out of area placements (i.e. beddays) will continue, albeit at a lower level than in previous years due to better gate-keeping processes and earlier repatriation through creation of enhanced out of area case management teams and risk-sharing arrangements with CWPT. To accommodate a greater volume of patients locally, we anticipate increasing volumes of outpatient attendances and community contacts as higher volumes of clients are effectively cared for in the community.

9.13 In line with our QIPP plans we expect to see reductions in hospital outpatient appointments (firsts and follow-ups); reductions in elective procedures due to ceasing funding for procedures of limited clinical value and thresholds for elective access in a number of other specialities. Our QIPP schemes on unscheduled care and long-term condition management should result in a reduction in non-elective spells in hospital. A&E attendances are planned to remain stable over

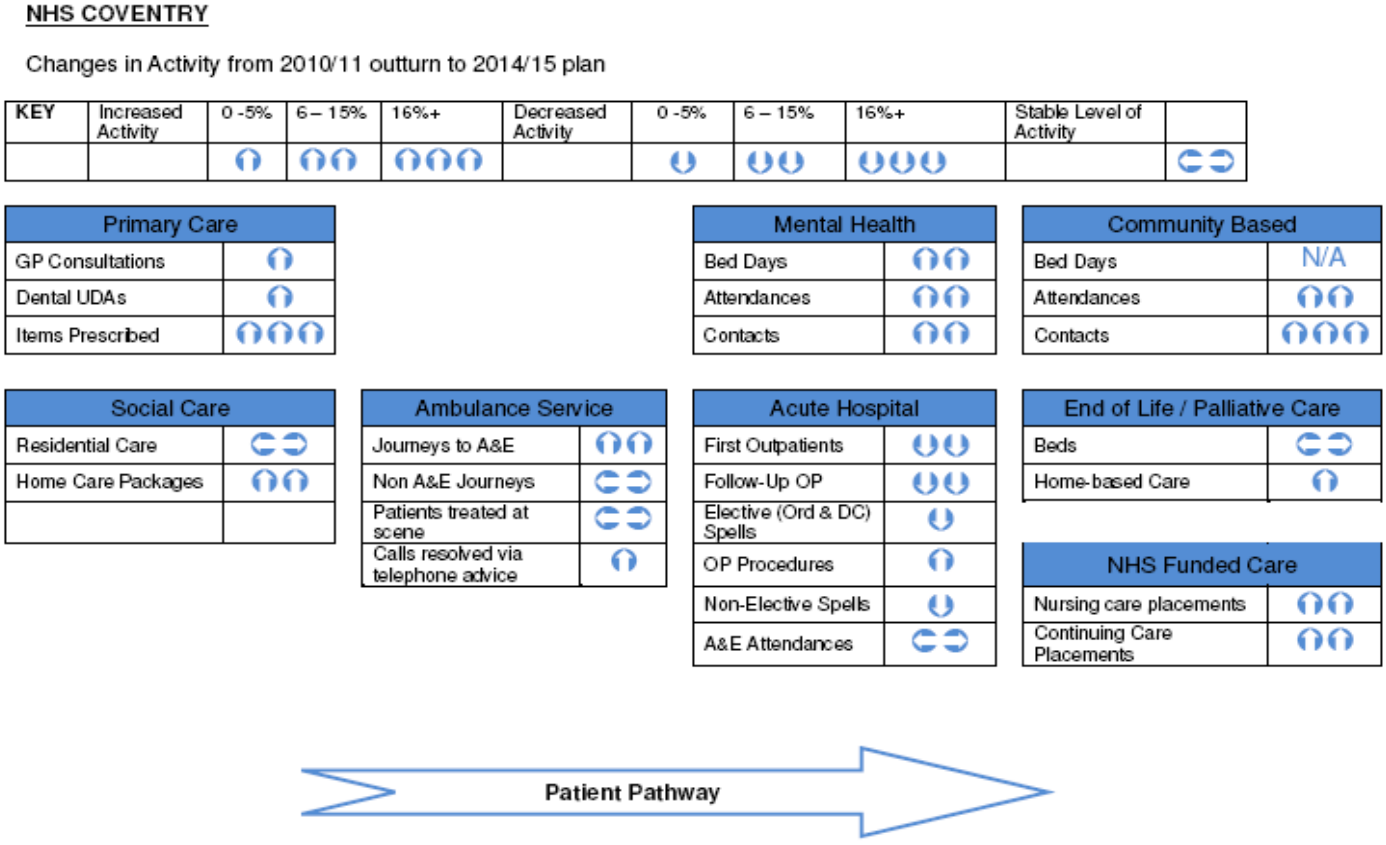
the period (through better utilisation of primary care and the walk-in centre) albeit, complexity of patients is likely to increase.

9.14 A focus on community provision in support of secondary care activity reductions will result in increases in community attendances and contacts – across general and end of life services. Our plans see the number of end of life beds remaining stable over the period but with an increase level of home-based care.

9.15 Across Health and Social Care we expect to see continued increase in bed days for Continuing Healthcare and Nursing Home Care as the population becomes increasingly elderly, however this is less than previous levels of growth. A focus on greater levels of reablement should stabilise residential home placements and enable a greater volume of patients to be effectively managed in their own homes.

9.16 The diagram below helps illustrate the expected alteration in activity and patient flows that will occur as a result of the changes engineered through the implementation of the QIPP programme.

Fig 4: Expected Changes to Activity and Patient Flows



Procurements

9.17 Please see section 7.2/7.3

Consultations

9.18 Two key consultations are planned by NHSC these are

- IV Therapy at Home
- 111 Out of Hours

SECTION 10: ORGANISATIONAL ASSETS AND LIABILITIES

Estate

10.1 Primary care and community services are provided from a variety of locations across Coventry. These include facilities owned or leased directly by us or facilities owned and leased by our service providers. These include service providers such as GP's, pharmacies, dentists and opticians.

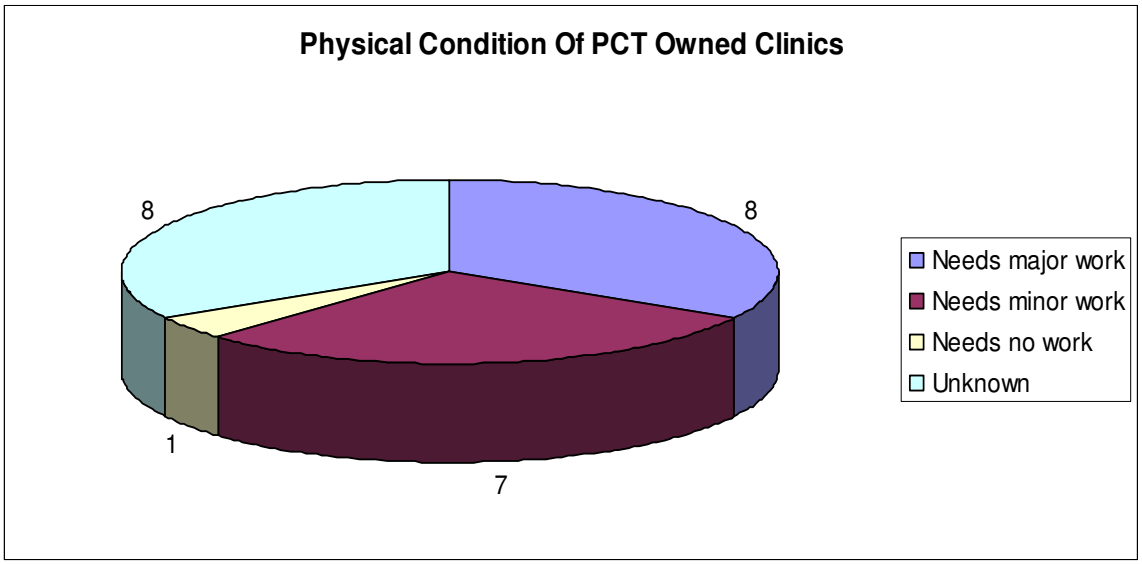
NHS Coventry Owned Premises

10.2 NHSC has a range of primary care facilities that are used by providers. As part of the recent CIAMS process, NHSC recently reviewed the whole of its estate and made the following observations:

10.3 We have 26 properties across Coventry; as part of the CIAMS review[2] (Tartan Rug), all facilities had their physical condition reviewed. The assessment looked at any required work in addition to planned routine maintenance. All facilities required some form of works.

10.4 The chart below highlights that of the 26 clinics surveyed only 1 building required no work, nearly two thirds of the buildings required some attention and for the 8 buildings that are highlighted as 'Unknown' this signifies that there was no six facet survey result available.

Fig 5: PCT Condition of PCT Clinics

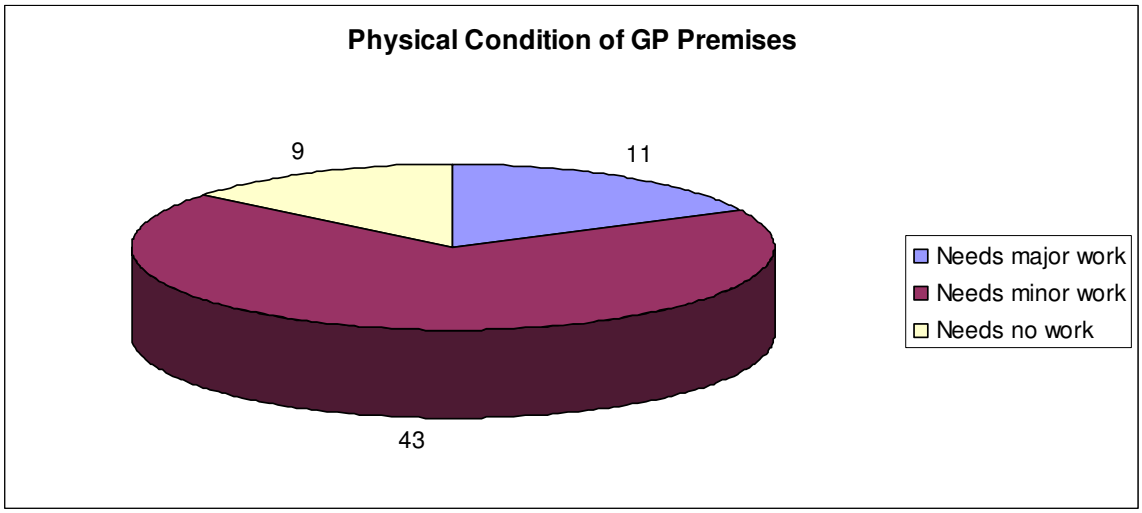


GP Practice Premises

10.5 There is a broad spectrum of quality, age range, physical condition, functionality and environmental status amongst GP practices in Coventry. As part of future planning processes it is important to understand the condition and availability of clinical spaces across Coventry. NHSC is committed to working with GP practices to improve the quality of the primary care estate and together agreeing the minimum accommodation standards required to deliver quality patient services.

[2] NHS Coventry CIAMS Return March 2010

Fig 6 GP Premises Physical Condition



10.6 The outcome of the physical condition of all GP buildings highlights that 9 require no work with the remaining buildings equating to 86% requiring some form of attention

NHSC Service Delivery Model

10.7 Key to our vision for the future of primary care and community services is the integration of Community Nursing services with General Practice. This integration will be achieved through working closely with GPs and Community staff to agree a Service Delivery Model that reflects health needs at a locality level and adheres to locally agreed pathways.

10.8 The model envisages care beginning in the home with the potential of extending to the next level which is contact with the GP who is the 'gate keeper' to primary care services located within a **Primary Care Spoke** setting, and possible access to a pharmacy, optician and dentist. Services may include community nursing, phlebotomy, life style risk services, midwifery and psychological services.

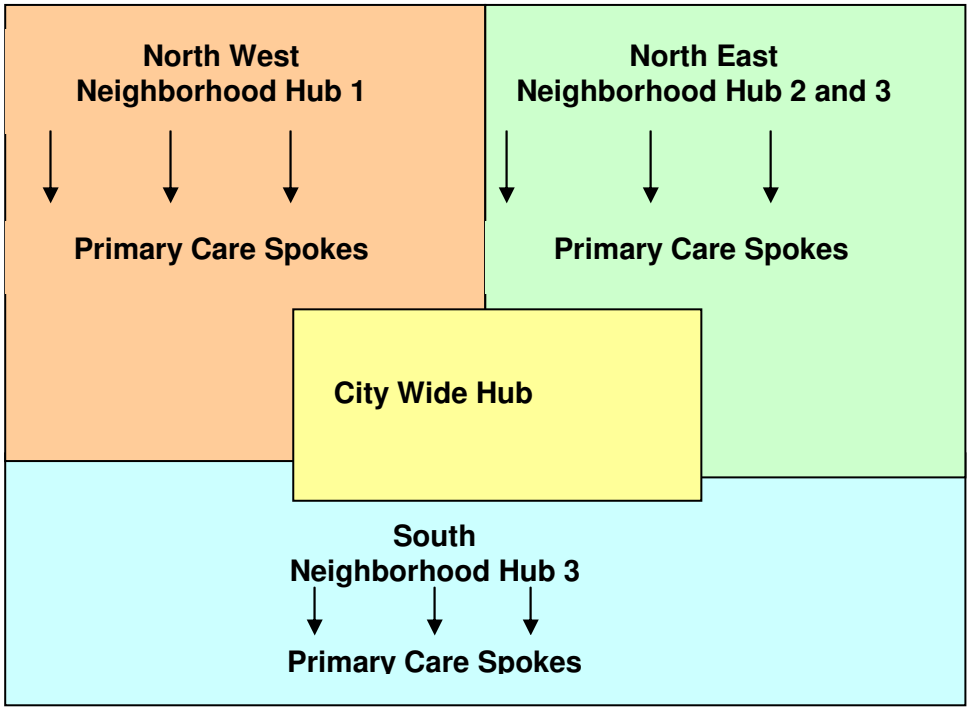
10.9 It is envisaged that a flexible infrastructure will be developed that will enable us to realise and implement our vision. In addition it is important to be mindful that fundamental changes in working practices may need to be addressed to ensure continuity of care and services to patients.

10.10 Alternatively care may be provided from within a **Neighbourhood Hub**, which would include all the aforementioned services within the spokes and in addition community therapy services and possibly appointments with some clinical assessment services, i.e. diabetes, physiotherapy etc.

10.11 For specialist services and outpatient appointments rather than attend an acute environment, care closer to home will be available in a centralized location within the proposed **City Wide Hub.** Here you would have access to diagnostic imaging services, walk-in centre and minor procedures.

10.12 The services to be delivered from these facilities can be seen illustrated in the diagram below:

Fig 7 Service Delivery Model



City Wide Hub

10.13 The City wide Hub will provide specialist and outpatient services, including diagnostics.

• GP Lead Health Centre • Diagnostics - Ultrasound • Dental Health Services (including Orthodontics) • Unscheduled Care (Walk in Centre and Out of Hours) • Adult Physiotherapy • Podiatry • Sexual Health Services - Tier 3, Complicated sexual health services (nurse and consultant led), e.g. contraception, GUM and HIV	• Adult Speech and Language Therapy • Phlebotomy • Psychological Services • Clinical Assessment Services (outpatient services) • Pharmacy • Café area • Specialist Children's Services plus including CAMHS

10.14 In addition to the aforementioned services the City Centre Health Facility will also accommodate GP practices and community services for the local community

Services to be provided from the four (4) Neighbourhood Hubs

10.15 The Neighbourhood Hubs will provide integrated services provided by GP's and community services,

• Adult Physiotherapy • Clinical Assessment Services • Sexual Health – Tier 2, More complex work that requires use of clinical accommodation to undertake procedures, e.g. contraceptive insertion of coils, access to health advisors • Podiatry	• Primary Care Services • Phlebotomy • General Community Services; i.e. wound care • [Hearing Aid Services] • Some Mental Health Services i.e. Improving Access to Psychological Therapies (IAPT)

Primary Care Spokes

10.16 'Integrated Community Services' will be located within Primary Care Spokes (PCS), provided within GP or PCT owned premises, enabling flexible use of space to be booked on a sessional basis by visiting professionals. Primary Care Spokes may be GP owned or GP leased premises, or PCT owned or leased premises. Where required, funding mechanisms will be developed to reflect ownership and room usage.

• Consultations • Retinopathy screening • Phlebotomy service which will also be available at some named Pharmacies • Improving Access to Psychological Therapies (IAPT's)	• Midwifery • Community Services which may include district nursing, (health visiting maybe aligned with Children Centres') • Life Style Services – weight management, smoking cessation etc, • Sexual Health – Tier 3, Non complex work that is undertaken in the community, e.g. contraception, Chlamydia and health promotion

Community Hub

- This hub will provide specialist Community based services such as:
- All of the clinical services will be outpatient orientated and no beds are planned as part of the project proposal.

1. Specialist Nurses - including COPD, Diabetes, Parkinson's team, Macmillan Nurses, Control of Infection and Heart Failure nurses 2. Community Rehabilitation Team - including staff attached to the Stoke Association, Neuro-psychologist and management/A&C support.	3. Community Physiotherapy 4. Wheelchair assessment services

10.17 The service delivery model has been developed to embrace Coventry's vision for the future. All levels of care can be provided in a primary and community care setting, with services only provided in hospital where their level of complexity, or the ability to achieve economies of scale, means that a hospital setting is the most effective place for provision of that care.

10.18 Key estates documents including the Estates Strategy, CIAMS Report Risk Profiles and Statutory returns are available at http://www.coventrypct.nhs.uk

Information Management and Technology Services

10.19 Information management and technology services are provided through a shared service arrangement hosted by the South Warwickshire NHS Foundation Trust. This consists of three core service areas:

- PCT information / intelligence service
- PCT IT services
- Leadership of whole LHE IM&T Programme

10.20 History and current position for each of above services described in table below with key documents attached.

Table 18 IMT Service

	Information / intelligence	PCT IT service	Leadership of C&W IM&T Programme
Key functions	Documents show structure and key functions in each area as at end 2010 These are available via the following link : http://www.coventrypct.nhs.uk		
History and key events	The Coventry Information Department has undergone many changes in responsibility in the last 5 years. In 2007, it was responsible for information for mental health, community (both commissioner and provider), acute and non-acute, PAS / Lorenzo and Child Health System management and development, Referral Management Centre, corporate, LAA and statutory returns, support to planning, finance and public health and many additional 'ad hoc' information requests which did not fit neatly into a particular category. Also, since 2007, the department has been responsible to 7 directors and as many directorates. Despite this, however, in 2007, the Information Team became focused on the organisation and standardisation of data flows into a data	Shared IT service established Summer 07 to cover NHS Coventry (inc Community services) and Coventry and Warwickshire Partnership Trust – each organisation employs approx 50% of staff; pooled pay budget, separate non-pay budgets Collaborative Agreement and Service Level Operational Policy agreed. Regular SLA review through Stakeholder Executive Board NHSC-employed IT resources transferred to CWPT April 2011 as part of TCS transfer arrangements As of April 2011, NHSC are buying an IT support service from CWPT to cover commissioning and primary care – latest SLA below is available on the PCT website at	C&W IM&T Programme established Spring 2007, with representatives of all local NHS organisations; chaird by Chief Exec of NHS Warwickshire; led by Director of Intelligence, NHS Warks (latterly CIO, NHSC &NHSW) Plans agreed annually by Programme Board. Board 're-launched' November 2010 to change focus away from implementing the National Programme for IT locally – to using IM&T locally to support Arden System Plan and QIPP. Senior non-IT involvement in Board increased

	warehouse and, for analyses, it focused on teams to support contracting, performance and service re-design. All teams participated in supporting a new process for ad hoc requests. This process has been valuable in tracking the changing information needs of the organisation and in focusing developments accordingly. The staff/resources for mental health and community (provider) were transferred out in 2007, with acute contracting (to the CBSA), Lorenzo and Child health (to the arms length community service) following in 2008. The RMC was also disbanded in this period.	http://www.coventrypct.nhs.uk/ourwork/documentlibrary/legacydocument	
Key Developments / Achievements	• Dedicated support to service re-design and contribution to non standard analyses and research (Best Practice findings, interpreting national findings for local circumstances) • Joint work with Local Authority in providing ESRs for 'Instant Atlas Application' Standardisation of data flows and analytical tools to support dissemination of information	• Rationalised core infrastructure of merging organisations, rationalised email, departmental systems etc • Installed new C&W-wide Child Health systems • Development of Public websites, Intranets, Supported managerial remote and hot desk working, blackberry service etc	• Range of NPfIT implementations in C&W providers including PAS, PACS, Choose and Book, Electronic Prescription Service, GP Systems of Choice, Summary Care Record • Deployed local health record sharing pilots, telehealth pilots • Selected as national demonstrator site for Common Assessment Framework (CAF) for adults in partnership with Warwickshire County Council
Current position end August 2011	• Most Information resources moved to Delivery Systems Directorate May 11. Increasing joint working with NHS Warwickshire information team	• CIO (within Delivery Systems Directorate) managing SLAs with SWFT to cover NHS Warks and with CWPT to cover NHS Coventry • Incremental work wth 2 IT services to provide integrated IT support for Cluster and consortia working • SLA monitoring arrangements fully	• Draft C&W Collaborative IM&T plan under discussion by member organisations http://www.coventrypct.nhs.uk

		implemented • NHS Warks and NHS Coventry IMT Plans for 2011/12 agreed as per link below http://www.coventrypct.nhs.uk	
Key challenges and risks going forwards	• Establishing effective information service within Commissioning Support Unit • Further development of commissioning information systems • Cost reduction targets	• Creating effective IT support for Cluster and Consortia from 2 existing IT services and different core technologies employed • Effective support for increased mobile and multi-site working, hot desks etc	• Establishing effective collaborative working • Agreeing effective solutions to information sharing requirements across providers and care settings • Agreeing medium term ownership of collaborative plans and solutions

SECTION 11 – STAKEHOLDER MAP

List of stakeholders & partners

11.1 NHS Coventry is committed to meaningful Patient and Public Engagement (PPE): actively engaging with communities, patients, service users and carers to develop a full understanding of needs and commissioning services that meet those needs.

11.2 Equally, engagement with stakeholders, is pivotal to NHS Coventry's developing role as local leader of the NHS, ensuring that the strategic partners – such as elected councillors and primary care clinicians – are informed and engaged in a two-way dialogue on the priorities and vision for local health services and health improvements.

11.3 There is a renewed focus on both primary care trusts and partnership working, this has helped drive change in organisational culture and boost the status of patient and public engagement (PPE). This cultural shift has been felt in Coventry and as an organisation we are now working towards much earlier, more systematic and more strategic engagement & communication.

11.4 The work which has been done locally has helped to shape the national PPE agenda, with best practice examples used in high profile reports produced by the Government's Central Office of Information and the Picker Institute, as well a featuring in the Health Service Journal (a respected publication for NHS Managers) and referenced at national conferences. A Department of Health National Support Team visit has also praised partnership approach to community engagement and NHS Coventry scored highly on community consultation.

11.5 Engagement and communication makes a crucial contribution to commissioning assurance and NHS Coventry has previously worked with the Department of Health as one of three pilot to develop a practical model, the Engagement Cycle, that will ensure PPE is embedded into all stages of the commissioning cycle, namely:

Strategic planning:

- Engaging communities to identify health needs and aspirations;
- Engaging public in decisions about priorities;

Specifying outcomes and procuring services:

- Engaging patients in service design and improvement;
- Patient-centred procurement and contracting;

Managing demand and performance management:

- Capture/use of patient experience data;
- Patient-centred monitoring and performance management.

A copy of the stakeholder map and communications strategy is available through the following link http://www.coventrypct.nhs.uk

Local Authority

11.6 Health and Social Care in both Coventry and Warwickshire are working together to meet their respective and joint challenges in a number of ways. All organisations understand that commitment to collaboration and partnership working is essential to ensure delivery of our joint challenges without de-stabilising individual organisations. These 'concordats' will be translated through to formal decisions by the respective organisations to support joint commissioning arrangements to enable delivery of our joint transformation agendas.

11.7 Within **Coventry** the core elements of the Concordat include:

- The Long Term Vision for Joint Commissioning in Coventry of a single integrated commissioning function where this is possible and practicable and in the best interests of Health and Local Authority commissioners, as well as the population of Coventry, comprising a team of joint commissioning managers who would commission services across Health and Social Care from a joint budget with the explicit aim of redesigning services to deliver the best outcomes for individuals in the most cost-effective way. With the advent of GP commissioning we need to be very clear at the outset which services will be subject to integrated commissioning and which will be subject to GP-led commissioning, recognising that the balance is likely to change over time, particularly if integrated commissioning becomes very effective at utilising financial resources to best effect.

- Our Joint Strategic Vision - for adults and children our joint strategic vision is one of achieving enhanced service integration, where Health and Social care staff work more effectively together to deliver improved outcomes for individuals through:
  - Single assessment processes;
  - Joint care planning processes;
  - Improved communication and information sharing;
  - Reduced duplication in the delivery of services (skill-mixing and creation of generic workers).
  - Within Adult and Children's services we will identify key client groups or areas within client group services where enhanced integration would be beneficial in maximising outcomes and improving cost effectiveness. Early wins are likely to include:
  - In adults: learning disabilities, intermediate care, falls prevention and care, and dementia;
  - In children: speech and language therapy and CAMHS.

- Commissioning Principles - Jointly owned commissioning principles are essential in under-pinning an integrated commissioning function and will include:
  - The requirement to drive cost efficiencies through reduced duplication and more stream-lined services;
  - The requirement to improve quality of experience and user outcomes;
  - A focus on proactive and early intervention as well as on quality of service delivery;
  - Fair and timely access to a choice of services which are safe, effective and patient-centred;
  - Services being provided as locally as possible;
  - Services being joined up and easy to use, requiring individuals to tell their story only once to an integrated team of professionals through a Single Assessment Process;
  - Building and maintaining mature partnerships to enhance delivery.

- Principles of Partnership Working - In order to maximise the success of working in partnership it is important that all partners agree fundamental principles. These have been agreed as:
  - Transparency (of information relating to services, activity, budgets);
  - Objectivity and Fairness (e.g. doing what is best for the population, rather than doing what is best for the individual organisation, ensuring any proposals or decisions are fair to individual organisations and that it's not 'all one way');
  - Maximising Value for Money (e.g. making sure that the use of joint resources delivers additional cost benefit, whether this is funding or staffing);
  - Development of a common language (at present even words such as 'commissioning' have a different interpretation in the two organisations);
  - Ensuring clarity of risk and risk mitigation – to individual organisations;

- Ensuring clarity of benefits to be accrued – and monitoring whether this is achieved.
- Being explicit about agreements to re-invest efficiency savings in particular areas/client groups (or not). Ultimately, we need to be clear that in any particular scenario the benefits accruing to our population and our individualorganisations from working in partnership are greater than those that would accrue from working as individual organisations.

- Governance Arrangements - Robust governance arrangements should include the production of a Governance document outlining:
  - Our vision, including how joint working contributes to our respective strategies;
  - Our partnership principles – underpinning how we work together;
  - Clarity of purpose with respect to partnership working for specific client groups – what are we are trying to achieve (core objectives);
  - Formal governance arrangements – meeting structures, including administrative arrangements;
  - Partnership post protocols – what they are, what they do, how they are managed, how they support core objectives, what happens when someone leaves etc;
  - Risk sharing arrangements – specific to individual areas.

11.8 Existing arrangements include formal Section 75 agreements for Integrated Community Teams (CWPT and CCC) and the Integrated Community Equipment Store (NHSC and CCC). In addition there is a 'lead provider' arrangement in place in respect of Intermediate Care provision (CCHS and CCC) which will need to be reviewed in light of changes to funding flows for this type of provision over the coming years.

11.8 Joint commissioning/partnership commissioning arrangements are in place in Coventry for Mental Health, Learning Disabilities, Drugs and Alcohol, Sexual Health and Children's Services.

11.9 A copy of the concordat and other documents is available at : http://www.coventrypct.nhs.uk

SECTION 12 – GOVERNANCE

The Board

12.1 In accordance with the Membership, Procedure and Administration Arrangements regulations, the make up of the PCT Board comprises:

- The Chairman of the PCT (*appointed by the NHS Appointments Commission)*
- Up to 7 Non-officer members (appointed by the *NHS* Appointments Commission)
- Up to 7 Officer members (but not exceeding the number of non-officer members) including:
  - Chief Executive
  - Director of Finance
  - Chairman of the Professional Executive Committee
  - Director of Public Health
  - Director of Nursing

  Officers of the PCT, other than the Chief Executive and Director of Finance appointed by the Chairman and non officers members of the PCT.

12.2 Under the NHS Act 2006 engagement with stakeholders including LINKs is a required element of the Board responsibilities.

12.3 The Board functions as a corporate decision-making body, Officer and Non-Officer Members are full and equal members. Their role as members of the Board of Directors is to consider the key strategic and managerial issues facing the PCT in carrying out its statutory and other functions. The specific roles and responsibilities of each of the Board members is outlined in the Corporate Governance Framework.

12.4 Ordinary Board meetings take place on a bi-monthly basis, with extraordinary Board meetings and Board development sessions being called and arranged as necessary.

Subcommittees

12.5 In order to discharge its duties effectively, the Board has a number of sub committees which take decisions and receive and ratify reports on behalf of the Board as delegated responsibilities. The sub committees of NHS Coventry are as follows:

- Finance and Performance Committee
- Integrated Governance Committee
- Audit committee
- Personnel Appeals committee (ad hoc)
- Appeals committee (against decisions of Officers)
- Reference committee (ad hoc)
- Oral Hearing Panel (ad hoc)
- Remuneration committee (ad hoc)
- Reference committee (ad hoc)
- Poor Professional Performance Working Group (ad hoc)
- Individual Funding Appeals Panel (ad hoc)
- Godiva Consortium sub committee
- In Spires Consortium sub committee

12.6 Terms of reference for all the above committees are found within the Corporate Governance Framework.

Summary of key policy documents

12.7 Key documents supporting the NHS Coventry Governance agenda include the following:

- Corporate Governance Framework
- Board reports and papers
- Complaints Policy
- FOI policy
- Health and Safety Policy
- All Information Governance policies and Strategy

12.8 All of these and numerous additional polices can be accessed through the link opposite.

Risk and Assurance

12.9 The current Corporate Risk Register for NHS Coventry is available via the link below
http://www.coventrypct .nhs.uk/ourwork/documentlibrary/legacydocument

12.10 Currently, there are 4 risks which have been on the Register for over 6 months. These risks are reviewed quarterly and updated as appropriate.

- Public Health Directorate x **2**
- Nursing, Quality & Engagement Directorate x **1**
- Finance x **1**

12.11 The risks related to:

- **Public Health** – (No 168). Patients referred to Retinopathy Screening Unit are lost to follow-up in the UHCW Ophthalmology Dept. Following the appointment of the Medical Retina locum consultant the action plan which has been developed with Public Health is being implemented and monitored through CQR meetings.
- **Public Health** – (No 173). Smoking - Risk of not meeting national Stop Smoking Targets. Provisional 4 week quitter figures for 2010/11 are 2212 compared to 1983 for 2009/10. Estimates suggest that this could reach 2606 when final year end figures have been received. This is very close to the 2866 target. The Big Pledge campaign has been running March to May 11 and has produced around 1200 referrals. These will impact on 2010/11 and 2011/12 figures. A couple of new providers are beginning to deliver quitters and another is due to start shortly. This will increase quitters for 2011/12.
- **Nursing Quality and Engagement** - (No 149) Uptake of statutory and mandatory training. Commissioning uptake at statutory & mandatory training for April 2010 – March 2011

Table 20: Mandatory Training Scores

Training	TakeUp
Fire Safety –	58.82%
Annual Update	58.23%
Trust Induction	68.0%

12.12 Although attendance has improved compared to the last quarter, it still falls below the target and so will remain as a RED risk.

Finance –

- (No 174) Ability to maintain Financial Balance over the medium term. Current LTSM identifies a need for net QIPP savings of £15.8m in 2011/12 rising to £34.5m by 2014/15. Plans have been developed which will potentially achieve the majority of this level of

saving but there are significant delivery risks. Plans now embedded in Provider contract but not to the extent originally envisaged. Clinical leadership and an agreed Cluster-level capacity plan remain key to sustainable & successful delivery.

Information Governance

12.13 Information Governance (IG) in NHS Coventry encompasses responsibility for ensuring that all information, for which the PCT is responsible, is handled in accordance with legal and professional requirements.

IG brings together all of the legislation, guidance and best practice that apply to the handling of information. The requirements are complex and numerous. For example, the key legal obligations are contained within 18 separate pieces of legislation, the most common being The Data Protection Act 1998. The requirements can limit, prohibit or set conditions in respect of the management, use and disclosure of information. They require efficient, effective and secure processes across the PCT. IG plays a key part in supporting clinical governance, service planning and performance management.

12.14 Appropriate policies and procedures have been developed, which set out the approach to meeting these obligations and are a reference source for staff. They enable consistent working practices across all Directorates. The policies are as follows:

- Information Governance Policy
- Confidentiality and Data Protection Policy
- Information Security Policy
- Information Risk Policy
- Email Policy
- Laptop and Mobile Computer Policy
- Secure Use of Removable Media Policy
- Records Management Policy
- Disposal of Redundant Information (electronic and paper) Policy
- Access to Personal Information Policy
- Registration Authority Policy

12.15 A comprehensive IG training programme has been established for the entire workforce. A range of quick reference guidance documents have been created for staff and a specialist advisory service is available.

12.16 A high level of importance is placed upon minimising information risk and safeguarding information. A programme is in place to identify, prioritise and manage information risk. This encourages a proactive, rather than a reactive approach.

12.17 NHS Coventry uses the Department of Health Information Governance Toolkit (IGT) to assess and monitor compliance against a range of IG requirements. This enables the PCT to identify areas for improvement. The scores achieved over the last 4 years are contained in the table below. However, it should be borne in mind that the standards do not cross-match exactly from one year to the next, as the standards are frequently revised and strengthened. In addition the number of standards often changes from year to year; some standards may be amalgamated whilst new ones are added.

Table21 Information Governance Toolkit Scores

Assessment	Overall Score	Grade
Version 8 (2010-2011)	68%	Satisfactory
Version 7 (2009-2010)	72%	GREEN
Version 6 (2008-2009)	74%	GREEN
Version 5 (2007-2008)	58%	AMBER

12.18 NHS Coventry supports independent contractors in meeting their IG obligations and seeks assurances from all third party providers that they are compliant with IG standards.

12.19 NHSC has put in place a range of policies along with training for all staff to help ensure it meets both its statutory responsibilities and the wider DH requirements for Information. These policies are available at http://www.coventrypct.nhs.uk

Freedom of Information

12.20 Freedom of Information (FOI) is part of the government's commitment to greater openness. The Freedom of Information Act 2000 gives individuals the right to request information held by a public authority. The Trust can refuse to release information if it is covered under the Data Protection Act 1998; for example, if the information requested contains personal/sensitive data or breaches confidentiality.

12.21 The Trust responds to FOI requests within 20 working days. Information will usually be sent free of charge; however, if a significant amount of additional work is required we can apply a charge to cover expenses (you will be informed if a charge is incurred). For requests involving environmental information, the Trust must respond within 40 days, under the Environmental Information Act 2004.

12.22 Sometimes the information requested contains details identifying people with whom the Trust has had contact. During the course of answering a request the Trust will therefore decide whether you are required to supply specific authorization before information can be released to you. This usually only applies where the information requested contains information that could be used to identify individuals. It could help to shorten the time it takes to process your request if you supply any relevant authorisation at the time you make your request.

12.23 In 2010/11 the PCT received 329 information requests 97% of these were responded to within the required timescale under the FOI Act 2000 and were relating to the areas outlined below:

Table 22 Number of FoI requests Received

Area/Department	Number of Enquiries
Primary Care	84
Commissioning	81
Corporate	50
Finance	37
Medicines Management	31
Human Resources	15

Area/Department	Number of Enquiries
Public Health	13
Information Technology	10
Estates	8

Equality and Diversity

12.24 NHS Coventry is committed to promoting equality, valuing diversity and eliminating discrimination against individuals or communities in all that it does.

12.25 NHS Coventry promotes good relations with the many communities it serves and seeks to ensure that the workforce reflects those communities in line with the Equality Act 2010.

12.26 NHS Coventry has recently been awarded NHS Employers' Equality and Diversity Partner status. And will continue to implement the agreed strategy on equality and diversity which is a publicly available document and which sets out an action plan. In implementing this strategy partners in the city will be involved and service users and staff and will monitor progress through the equality and diversity group which reports to the PCT's Board.

12.27 Equality Impact Assessments (EIAs) of strategic priorities ensure that the services commissioned are targeted and appropriate to the populations at greatest need. During 2011 NHS Coventry will be working with NHS Warwickshire and other NHS and third sector partners to develop the Equality Delivery System plan.

12.28 NHS Coventry is committed to meeting the general duty under the Equality Act 2010, of encouraging participation by disabled persons, eliminating unlawful disability discrimination and promoting equality ofopportunity. The PCT is accredited to display the "Disability 2-Ticks' symbol and complies with the related standards on advertising and recruitment. In 2010 we audited our 2-Ticks process to reassure ourselves of our compliance with the standards.

12.29 In 2010, NHS Coventry became a Stonewall Equality Champion as part of our commitment to supporting our LGB staff.

Emergency Preparedness

12.30 The Civil Contingencies Act, which came into force in 2004, sets out a single framework for civil protection in the United Kingdom. Organisations at the core of emergency response, such as emergency services, local authorities and PCTs, are classified as Category 1 responders.

12.31 As a Category 1 responder, NHS Coventry is required to:

- Assess the risk of emergencies occurring and use this information to inform contingency
- planning.
- Put in place emergency plans and business continuity management arrangements.
- Establish systems to make information available to the public about civil protection matters and to warn, inform and advise the public in the event of an emergency.
- Share information and co-operate with other local responders to enhance coordination and efficiency.

12.32 NHS Coventry continually ensures that there is compliance with these requirements, as well as with specific NHS Guidance, so that the PCT can both continue to provide existing services and offer any additional services required in the event of a major incident. The emergency plans are continually reviewed, developed and tested to ensure that an effective and efficient response to existing and potential new risks can be provided.

12.33 NHS Coventry strives to embed emergency planning into all of its work and ensure staff are aware of, trained and practiced in their roles and responsibilities. NHS Coventry also works closely with multi-agency partners, such as the police, fire, council, Ambulance service, acute hospitals and voluntary organisations, to ensure responses are well co-ordinated and effective.

12.34 With the transfer of the provider arm to CWPT (Coventry and Warwickshire Partnership Trust) under TCS (Transforming Community Services from 1st April 2011), NHS Coventry still remains responsible for setting up the services required during an emergency, such as vaccination centres, but will no longer have the resources to run them. Contracts have been set up with CWPT to ensure that they have appropriate emergency plans in place and that these services will be available when needed.

Sustainability

12.35 In January 2009, the NHS published 'Saving Carbon Improving Health', the NHS Carbon Reduction Strategy for England. One of the key requirements of the CRS is to include sustainability in annual reports.

12.36 The NHS Coventry Board has received a report on the development and delivery of an Environmental Sustainability and Carbon Reduction Plan. The plan included key areas for Measurement and Targeting. The Trust actively pursued a programme to reduce energy consumption during the year and its commitment to at least a 10% reduction of energy used as a minimum of the 2007 levels by 2015. As part of the Trust's capital programme, replacement energy efficient lighting systems were installed at Willenhall Health Centre, Wood End Health Centre, Tile Hill Health Centre and Newfield House.

12.37 Replacement Building Management Systems (BMS) have been installed at Newfield House, Willenhall Health Centre, Tile Hill Health Centre, Christchurch House and Broad Street Health Centre. These systems are connected across the Trust's network which will allow remote access to control and target and monitoring of energy consumption.

12.38 The Trust continues to report energy usage and waste disposed as part of the ERIC (Estate Returns Information Collection) returns. The Trust has started to roll out recycling programmes for waste collected at Trust buildings. While in the early stages of implementation, it is believed 15% of all waste disposed of, including clinical waste, was recycled. The Trust reported for the first time the total business miles travelled by employees, which was 1,200,906 miles. In order to reduce this, the Trust will be adopting agile working practices, which will include greater use of IT and telephone conferencing and video conferencing.

Cardiovascular and Stroke Network

12.39 The Cardiovascular and Stroke Network was established in 2000 to deliver the National Service Framework for CHD, and then additionally the National Strategy for Stroke in 2007. The network is currently funded from DoH monies until 2012 and is hosted by NHS Warwickshire.

12.40 The purpose of the network is to work with stakeholders across the health and social economy in the development of Cardiac and Stroke services.

12.41 The network is able to boast a number of key successes including the implementation of a single centre model for thrombolysis for Hyper Acute Stroke patients with a repatriation agreement (this is now one of the best performing services in England) and the successful implementation of a Network of support groups for stroke survivors and their carers – Life after Stroke – including a HIEC funded programme for self help groups.

12.42 In terms of success with the cardiac agenda, the network has introduced a successful programme of work with GPs on delivering support to reduce the number of strokes through the management of Atrial Fibrillation (AF) in General Practice. It has also published a series of patient centred information cardiac booklets. The cardioversion service at UHCW has also been redesigned through the network. For further information, please see the attached presentation

Emergency Care Network

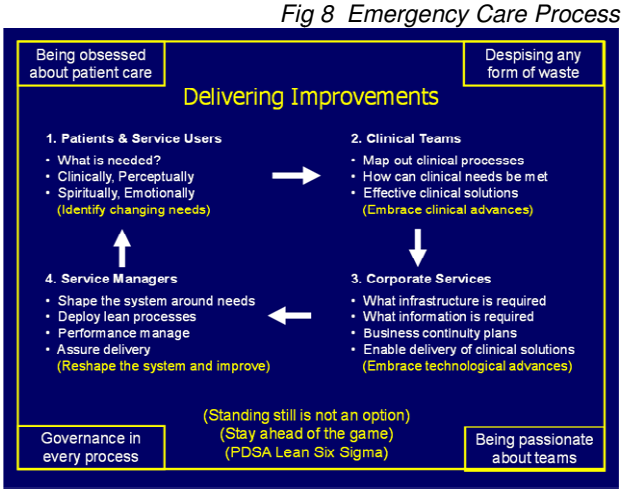
12.43 The Emergency Care Network provides a forum for individual healthcare organisations; commissioners and providers; to come together as a team and take coordinated action to improve the quality and effectiveness of clinical services to patients.

12.44 It is a forum wherein Health and Social Care teams work alongside independent and voluntary services to ensure that we make the best use of available resources to treat patients requiring emergency or urgent care.

12.45 The role of the network is to ensure that care is delivered around patients needs as never before and cross boundary working is evident at all levels. This will be achieved by integrated working between the Ambulance Service, Primary Care Trusts (PCT's), the Partnership Trust, Acute Trusts, Social Services, the voluntary sector, charitable organisations, Strategic Health Authority, NHS Direct, out of hours providers and all those who provide aspects of emergency and urgent care.

12.46 The model below displays the factors that have been found to be most effective in bringing about improvements in services. It is designed to help colleagues to remove waste from care processes and ensure that patients receive the right service first time.

Fig 8 Emergency Care Process



Arden Cancer Network

12.47 The Arden Cancer Strategic Plan is attached opposite and provides a full overview of the service, its' roles and responsibilities and plans to 2015. The following provides a flavour of the work which is undertaken.

12.48 The Arden Cancer Network's ambition is to increase uptake of screening rates, reduce late presentation, achieve higher survival rates, and actively engage with patients and users to enhance pathways. These will all be undertaken through targeted interventions to specifically impact on existing cancer inequalities.

12.49 Cancer Networks were originally set up as the organisational model to implement the National Cancer Plan, and to bring together all stakeholders to develop strategic service delivery plans to develop all aspects of a cancer programme; Prevention, Screening, Diagnosis, Treatment, Supportive and Palliative Care and Research. The Arden Cancer Network has engaged users, commissioners, clinicians and providers, as well as gaining other expert contributions from networks, clinicians in related fields, GPs and Oncologists across the UK. Arden Cancer Network also has strong working relationships with independent and third sector organisations which provide a range of services from early detection and prevention, to end of life care. The network has strong links with local Hospices and voluntary sector agencies such as Macmillan Cancer Support, Marie Curie, and the Citizens Advice Bureau and is developing stronger links with local authorities.

12.50 The role of the Cancer Network is:

- To be an expert commissioning resource to work with local stakeholders to secure agreement of localised value for money (QIPP) pathways benchmarked to National Standards and informed by local proirities
- To work with PCTs to translate these pathways into contractural specifications
- Monitor implementation of pathways through agreed metrics and other performance standards and outcome measures
- Inform PCT strategies for cancer care including horizon scanning