Worcestershire County Council

Agenda

Health Overview and Scrutiny Committee

Monday, 18 October 2021, 2.00 pm
County Hall, Worcester

All County Councillors are invited to attend and participate

This document can be provided in alternative formats such as Large Print, an audio recording or Braille; it can also be emailed as a Microsoft Word attachment. Please contact Scrutiny on telephone number 01905 844965 or by emailing scrutiny@worcestershire.gov.uk

DISCLOSING INTERESTS

There are now 2 types of interests:
'Disclosable pecuniary interests' and 'other disclosable interests'

WHAT IS A 'DISCLOSABLE PECUNIARY INTEREST' (DPI)?

- Any **employment**, office, trade or vocation carried on for profit or gain
- **Sponsorship** by a 3rd party of your member or election expenses
- Any **contract** for goods, services or works between the Council and you, a firm where you are a partner/director, or company in which you hold shares
- Interests in **land** in Worcestershire (including licence to occupy for a month or longer)
- **Shares** etc (with either a total nominal value above £25,000 or 1% of the total issued share capital) in companies with a place of business or land in Worcestershire.

NB Your DPIs include the interests of your spouse/partner as well as you

WHAT MUST I DO WITH A DPI?

- **Register** it within 28 days and
- **Declare** it where you have a DPI in a matter at a particular meeting
  - you must **not participate** and you **must withdraw**.

NB It is a criminal offence to participate in matters in which you have a DPI

WHAT ABOUT 'OTHER DISCLOSABLE INTERESTS'?

- No need to register them but
- You must **declare** them at a particular meeting where:
  You/your family/person or body with whom you are associated have a **pecuniary interest** in or **close connection** with the matter under discussion.

WHAT ABOUT MEMBERSHIP OF ANOTHER AUTHORITY OR PUBLIC BODY?

You will not normally even need to declare this as an interest. The only exception is where the conflict of interest is so significant it is seen as likely to prejudice your judgement of the public interest.

DO I HAVE TO WITHDRAW IF I HAVE A DISCLOSABLE INTEREST WHICH ISN'T A DPI?

Not normally. You must withdraw only if it:

- affects your **pecuniary interests OR**
  relates to a **planning or regulatory** matter
- **AND** it is seen as likely to **prejudice your judgement** of the public interest.

DON'T FORGET

- If you have a disclosable interest at a meeting you must **disclose both its existence and nature** – 'as noted/recorded' is insufficient
- **Declarations must relate to specific business** on the agenda
  - General scattergun declarations are not needed and achieve little
- Breaches of most of the **DPI provisions** are now **criminal offences** which may be referred to the police which can on conviction by a court lead to fines up to £5,000 and disqualification up to 5 years
- Formal **dispensation** in respect of interests can be sought in appropriate cases.

Simon Mallinson Head of Legal and Democratic Services July 2012 WCC/SPM summary/f

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Health Overview and Scrutiny Committee
Monday, 18 October 2021, 2.00 pm, Council Chamber

Membership

Worcestershire County Council	Cllr Brandon Clayton (Chairman), Cllr Salman Akbar, Cllr David Chambers, Cllr Lynn Denham, Cllr Adrian Kriss, Cllr Natalie McVey, Cllr Jo Monk, Cllr Chris Rogers and Cllr Kit Taylor
District Councils	Baxter, Bromsgrove District Council Cllr Mike Chalk, Redditch District Council Cllr Calne Edginton-White, Wyre Forest District Council Cllr Mike Johnson, Worcester City Council Cllr John Gallagher, Malvern Hills District Council Cllr Frances Smith, Wychavon District Council (Vice Chairman)

Agenda

Item No	Subject	Page No
1	**Apologies and Welcome**	
2	**Declarations of Interest and of any Party Whip**	
3	**Public Participation** Members of the public wishing to take part should notify the Assistant Director for Legal and Governance in writing or by email indicating the nature and content of their proposed participation no later than 9.00am on the working day before the meeting (in this case 15 October 2021). Enquiries can be made through the telephone number/email address below.	
4	**Confirmation of the Minutes of the Previous Meeting** Previously circulated	
5	**Community Ambulance Stations** (indicative timing: 2.05-2.50pm)	1 - 12
6	**Primary Care (GP) Access** (indicative timing: 2.50-4.00pm)	13 - 28

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All the above reports and supporting information can be accessed via the Council's website websitehttp://www.worcestershire.gov.uk/info/20013/councillors_and_committees

Date of Issue: Friday, 8 October 2021

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE
18 OCTOBER 2021

COMMUNITY AMBULANCE STATIONS

Summary

1. The Health Overview and Scrutiny Committee (HOSC) has requested a report on West Midlands Ambulance Service's (WMAS) Strategy in relation to community ambulance stations (CAS) as part of a review by the Service.

2. Senior representatives will be present from NHS West Midlands Ambulance Service University Foundation Trust (the Trust).

Background

3. The Committee would like to gain an understanding of the rationale behind the plans, which will see a number of changes to provision of CAS, and to seek reassurances about any impact on services in Worcestershire, including response times to rural areas.

4. Of the ten community ambulance stations due to close, two are in Worcestershire (Malvern and Evesham) and the others are in Shropshire, Warwickshire and Staffordshire.

Context of the Review

5. Currently, it is recognised that WMAS response times are not good enough but having Community Ambulance Stations (CAS) makes that worse than it needs to be. A Briefing regarding the review of ambulance CAS points in Worcestershire and current operating models is attached at Appendix 1**.**

6. Under the changes, the same number of ambulance staff and the same number of ambulances will continue to operate in the area; the only change is where two of the circa 35 ambulances that operate in the County start and finish their shifts. Closing the CAS sites will increase the amount of ambulance time available to respond to patients.

7. If a crew starts at a hub, such as Bromsgrove, they do so with an ambulance that is cleaned, fuelled and has a standard load list that should last the full 12 hour shift. Whereas if a crew starts at a CAS site, the crew start with an ambulance that has been used for around half a shift and they then have to return to the hub to swap over to a new vehicle every shift (twice a day). The additional time spent travelling back to the CAS point for meal breaks and at the end of a shift means that the crew are not available to respond to patients.

8. On average, crews that operated at-CAS sites lost in order of 2½ to 3 hours of ambulance time at each CAS site, over each 24 hour period.

9. In addition, if the ambulance is delayed at for example Worcestershire Royal Hospital (WRH) at the end of the shift and is an hour late getting back to the CAS, then the on-coming crew have no vehicle to respond in and effectively another hour of ambulance time is lost due to the situation – a 'double whammy'.

10. Closing the remaining 10 CAS sites will enable the Trust to get to an additional 5,000 to 6,000 cases every year with no additional resource.

11. The biggest single thing that impacts the Trust's ability to get to patients in a timely way is hospital handover delays. In August, three crews waited over 11 hours to hand over their patient at Worcestershire Royal - the national target is 15 minutes! Supporting data is attached at Appendix 2 to this report.

12. It is acknowledged that hospitals have seen large increases in people attending, are working to catch up with elective work cancelled during the pandemic and continue to have to abide by COVID-19 restrictions which reduce capacity, however the handover delays to have a disproportionately large impact on the Trust's ability to get to patients.

13. Prior to their closure, the ambulance at each CAS site only visited it four times a day: twice for meal breaks and twice for shift changes. The idea that crews regularly sit on them awaiting cases is a thing of the past since crews go from case to case all day, only stopping for meal breaks and shift handovers.

Issues Raised

14. The types of Issues raised with the Trust regarding the CAS closures are set out below.

15. A common message has been for example that all of the ambulances in say Evesham will have to come from Worcester, Hereford or even Bromsgrove. It must be clarified that where an ambulance starts or finishes its shift often has little to do with here it ends up, as in the recent case of an ambulance from Dudley that ended up doing cases in Malvern.

16. While some ambulances may have to come from those hubs, it is just as likely, if not more so that they will come from the local area, particularly as the Trust now takes fewer than 50% of patients to A&E. Appendix 1 shows that for the first six months of the year, there were 22,801 cases in the Malvern area (not the town). In over 10,000 of those cases, the ambulance crew discharged the patient and were then available to respond to other cases in the area.

17. Regarding staff welfare, there were only seven permanent staff based at Malvern so three staff are already regularly travelling for shifts and they have reported no issues with this arrangement. In addition, when talking to staff at other CAS sites, many have said that they actually foresee the change reducing their day, not lengthening it. Additionally, staff are able to choose which hub they moved to, and also had the opportunity to stay on the shift pattern they were on, if they wanted to. Travelling expenses are paid as per national conditions.

18. Regarding concerns that the changes will lead to people in cardiac arrest not being saved, there is no question that a fast response is required for a cardiac arrest. The survival rate in the UK for an out of hospital cardiac arrest is just 7%. This is put into stark contrast by the same figure in Denmark being around 25%. The difference: everyone in Denmark has been taught CPR and they are prepared to do it. Thankfully learning CPR is now part of the national curriculum but we need many more adults to learn as well as many more public access defibrillators.

19. While it is true that around 70% of the demand that WMAS is called to comes within the Birmingham and the Black Country area, the Trust is committed to equity of service. However, there is no question that getting to cases in more rural areas will inevitably be more difficult to achieve response times simply because they are rural. The Trust is currently in the middle of a programme of bolstering the frontline workforce in areas such as Worcestershire because it is recognised that additional resources are needed to meet response times.

20. Another suggestion raised was to move the CAS sites into fire stations, or other NHS premises to save money, but that does not solve the problem of their inherent inefficiencies. Looking at the cost savings, the rent paid is only part of the cost of having the CAS sites; they also include the rates, maintenance, but also things such as the need for one of our Operational Managers to visit every day to carry out mandatory checks on the stores such as the controlled drugs kept at the site.

21. Apart from the efficiencies of the hub system known as Make Ready, the Trust is also able to have crews starting at a range of times. This means that at changeover, rural areas continue to have cover rather than the ambulances all returning to base at the same time, as used to happen before the introduction of the system.

22. In summary, while saving money is not the driving factor behind the closures, the decision to close the CAS sites will also free up around £750,000 which will be reinvested in frontline patient care through additional staff hours and ambulance shifts for Worcestershire. These changes will help to save lives; unlike spending money on seldom used buildings, which will not.

Purpose of the Meeting

23. Members are invited to consider and comment on the information discussed and agree:

- whether any further information is required
- whether any further scrutiny work is required at this stage.

Supporting Information

- Appendix 1 - Briefing Document
- Appendix 2 - Data Submission to Worcestershire HOSC

Contact Points

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West Midlands Ambulance Service

Background Papers

In the opinion of the proper officer (in this case the Assistant Director for Legal and Governance), the following are the background papers relating to the subject matter of this report:

- Agenda and minutes of the Health Overview and Scrutiny Committee on 27 June 2019

Briefing Regarding Review of Ambulance CAS Points in Worcestershire

The following document sets out the reasons why West Midlands Ambulance Service has been reviewing the provision of Community Ambulance Stations (CAS) in Worcestershire, which we hope will be useful background reading.

The Trust was formed in June 2006 and many of you will be aware that we initially had circa 70 ambulance stations across the region. Over the last decade we moved to a new model of operation which sees us use 15 large Make Ready Hubs; in Worcestershire these are based in Worcester, down the road from County Hall and Bromsgrove. When the move was made, we initially created a network of rapid response vehicles (RRV), usually 4x4 cars, that worked from strategic locations known as Community Ambulance Stations (CAS), very often in market towns across the West Midlands. This was largely due to the call categorisation system that we were obliged to use at that time that concentrated on getting to calls very quickly, but not necessarily with the right resource.

A good example of this would be a stroke patient; an RRV would get there in under eight minutes but, if the patient was FAST positive, what they actually needed was an ambulance to take them to a hyper-acute stroke unit for immediate care – we aren't able to transport patients by car. Doing so can make a huge difference to the life of the patient going forward. What happened in the West Midlands to some extent, but much more so in other areas of the UK, was that the car would wait sometimes for hours for an ambulance to arrive to take the patient to hospital. This severely limited the ability of the hospital to provide the necessary care. While we hit the statutory target, the patient didn't get the care they needed, which clearly was not appropriate.

With the introduction of the Ambulance Response Programme in 2018, WMAS firstly reduced and then got rid of entirely, it's fleet of cars – at one point we had over 100 operating each day! These were all replaced by ambulances. As that move took place, we reduced the number of CAS points as they were simply not being used. By 2020, we were down to just 13 sites. The money saved from not having the CAS sites was invested in additional staff and ambulances.

As you will be aware, the last few months have been extremely challenging; in July, we saw demand at levels that we could not possibly have envisaged. We set a new record for 999 calls on 19th July when we received and answered 6,418 calls in a 24-hour period! When you consider a busy day at the moment should see us receive circa 4,000 calls, you can see the level of challenge we face.

Another factor that has badly affected us over recent months have been the delays handing patients over at hospital. As you will be aware, we are supposed to do so within 15 minutes of arriving at an A&E Department. Unfortunately, many of the hospitals in our region are extremely challenged and this has led to some very long delays. Indeed, in recent weeks, we have had crews wait over 11 hours to hand their patient over. During July, there were many days when we were losing over 1,000 hours of ambulance time while crews waited to hand over patients – that is the equivalent of taking 85 ambulances off the road and putting them in a car park and deciding not to use them that day. You can only imagine the challenges this brought us. To put it into context, in July 2019 (pre pandemic) we lost 4,818 hours during the month of July due to handover delays. In July 2021, we lost 14,866 hours and in August that deteriorated further with us losing 15,651 hours! Almost 7,000 patients waited over an hour to be handed over in July and 6,500 in August, with many of them having to be kept in the back of the ambulance for hours. Not only was this poor for patients it put an intolerable strain on our staff with many regularly finishing their shift late, often to the tune of three hours on top of a 12 hour shift. No other NHS staff face such situations.

The Trust moved to REAP 4 (the highest level of concern) for the first time in its history. At one point, all ten English ambulance services were at REAP 4. Currently, only WMAS and one other Service have de-escalated to REAP 3. You may also have seen in the news that three services in other parts of the country are now receiving military assistance due to the level of challenge they face. Thankfully demand has calmed down a bit since the latter half of July, though it remains at about 10% above contract.

As a result of the above, we have implemented a number of changes to protect patients and our staff. One of the biggest changes has been the introduction of the Clinical Validation Desk. Calls continue to be triaged by our call assessors in the normal way: they are divided into four categories – Cat 1 is the most serious and includes a patient in cardiac arrest. Category 2 included heart attacks and strokes while Category 3 are classed as 'urgent' and Category 4 as 'non-urgent' by NHS England. Under the new scheme, a number of Category 3 and 4 calls are further examined by a team of advanced paramedics in our control rooms. The aim is to take these lower category calls and make better use of the alternative pathways that are available in the NHS.

This could be through directing occupational therapy teams, fall co-ordination services or advanced nurse practitioners working in the community to visit the patient instead of an ambulance. Many other calls are being resolved with advice only. The work of the team is expected to reduce the number of ambulance dispatches by several hundred each day purely by arranging for more appropriate healthcare staff to visit the patients. Our 'Hear and Treat' rate has risen from around 5% to 15% each day and may go higher still. This allows us to focus our ambulances on the calls that really need our help and will allow us to respond more quickly.

This brings me on to the next significant area of work, a review of the Trust's CAS sites. Two have already closed – Leominster after it was flooded 18 months ago, and Uttoxeter which suffered a leak. Stourport is due to close in early September. The Operations team have been examining the other ten sites (Evesham, Malvern, Craven Arms, Oswestry, Market Drayton, Bridgnorth, Biddulph, Leek, Rugby and Stratfor upon Avon) for the last few weeks.

There is a common misconception that where an ambulance starts or finishes a shift will have a substantial impact on the area that it is based in. What must be remembered is that as soon as an ambulance is available it will be sent to the nearest available case so that we can minimise the time a patient waits to be seen, something I am sure you would support. This means that vehicles can often end up in rather odd places. Recently, we had a Dudley ambulance in Malvern and a Hereford vehicle that had gone to Birmingham Children's Hospital then getting a case in Birmingham itself as it was the nearest ambulance available.

If you look at the data from the first six months of the year, for the three CAS sites in Worcestershire, you find the following:

Evesham
Total cases: 29,222
Cases attended by Evesham ambulance: 1,015
Percentage: 3.5%

Malvern
Total cases: 22,801
Cases attended by Malvern ambulance: 1,113
Percentage: 4.9%

Stourport
Total cases: 39,177
Cases attended by Stourport ambulance: 1,161
Percentage: 3.0%

Given what I have already outlined in regard to demand, it is now rare, if ever, that the crews who work at the CAS points ever get back to the site other than for their meal break or at the end of their shift. Like the crews based at the Hubs, they literally go from one emergency to the next, 24 hours a day; they are no longer sat on a station anywhere in the region waiting for a call. Therefore, one of the questions we are duty bound to consider is whether it is appropriate for the Trust to spend precious funds on a building that is rarely used when these could instead be spent on additional staff and vehicles; the things that save lives?

One of the questions we have been asked is whether a closure would mean that ambulances have to come from one of the hubs each time a call comes in and the answer is no. Currently, less than 50% of patients seen by our emergency crews are taken to hospital. This means that, for example in Stourport, in roughly 20,000 occasions for the time period above, an ambulance was in the area available to respond, even though it wasn't the ambulance that is based in the town.

In cases where a patient needs to be taken to hospital, they will inevitably end up in Worcestershire Royal, the Alexandra or potentially the Queen Elizabeth in Birmingham depending on the patient's condition and location. If we assume that it was the Stourport ambulance that took them there, then clearly it would not be in the town ready to respond to another call. Quite rightly you would not expect us to wait for the ambulance based in the town to finish with its current patient before we responded to any subsequent call that is waiting in the area. You can therefore see how the above figures come about.

Any changes made will not see a decrease in the number of staff or ambulances in the area, just change where they start or finish a shift. In fact, removing the CAS sites actually increases the amount of time ambulances are available to respond to patients.

When a crew come on shift at one of our Hubs they will get into an ambulance that is fully fuelled, clean, stocked and ready for the full shift. In contrast, when crews start at a CAS site, they are in a vehicle that has already been used for half a shift. The crew coming on will have to check over wat stock they have on board before they start responding, reducing the amount of time they are available. We will then lose further time because twice a day the crew have to go to a Hub to exchange their vehicle for a newly stocked vehicle.

We lose further time still because we have an agreement that crews will always return to their bases station for a meal break. This means a crew in say Evesham have to drive from Worcester back to the town before they can start their break. All of these issues reduce the amount of time that the ambulance is available to respond to incidents, often to the tune of 90 minutes in every 12 hour shift.

As we have already mentioned, hospital handovers cause us significant issues. This has a particular knock on affect for crews at CAS points. If a crew is late back at the end of their shift at a hub, the on-coming crew simply use another vehicle. At a CAS point, there is no other vehicle, so the on-coming crew have to wait for the previous shift to return before they can start responding. If a crew are two hours late, which is far from uncommon, we have lost the on-coming CAS based crew for two hours on top of the 90 minutes already lost due to the way the system operates. This is both

inefficient and cannot be right in this day and age when we need to maximise the amount of time that crews are available to respond.

The welfare of staff is clearly one of our highest priorities, particularly when they are under so much pressure at the moment. By having the ambulance based in Stafford, we will be better able to support the 10 staff previously based in Uttoxeter. A manager is available at the Hub 24/7, whereas the staff in Uttoxeter would only have seen one when they went to the hub to change vehicle.

The Trust has discussed the review with staffside colleagues and wrote to all of the staff affected and will talk to individuals about what might happen. What we have said to both staff and their representatives is that should a CAS site close we will do what we have in Leominster, Uttoxeter and Stourport and work with the staff so that they can choose which Hub they move to and if they wish to stay on a current roster, then that will also be accommodated.

I am sorry that the briefing is anything but brief, but I hope it provides a useful update about the current challenges and context about the review currently being undertaken. If I can finish by assuring you that we will only make a change if we are convinced that it will benefit patients. WMAS continues to be the highest performing ambulance service in the country and we aim to ensure that that position continues to be the case.

Yours sincerely,

Murray MacGregor
Communications Director

CC. Anthony Marsh, Chief Executive
Mark Docherty, Director of Clinical Commissioning / Executive Nurse
Vivek Khashu, Strategy and Engagement Director

Submission of Data to Worcestershire HOSC

Breakdown of Patient Types

September 2021	Incidents	%
Hear and Treat	1,353	15.6%
See and Treat	2,374	27.4%
See and Convey	4,932	57.0%
Total	8,659	100%

Where Do Patients Go

Of the 4,932 taken to hospital, 4,687 were conveyed to The Alex and Worcestershire Royal Hospitals giving a conveyance rate to A&E of 54%.

Of the remaining 245, some will be taken to Cheltenham, Gloucester, Hereford. Some patients will require specialist care that is only available at the likes of Major Trauma Centres at Queen Elizabeth Hospital Birmingham or Birmingham Children's Hospital. A few will also be taken to the Kidderminster, Malvern and Evesham minor injuries units, but the numbers they accept is low.

Substantive Staff at each CAS Site

Data as at 30-06-2021	Permanent Staff	% Permanent Crews
Evesham CAS	10	100%
Malvern CAS	7	60%

Support from Other Areas

June
Jobs that Worcestershire vehicles have done out of the county: 838
Jobs that other hubs have done in Worcestershire: 525
Plus 313 into Worcestershire (10 a day)

July
Jobs that Worcestershire vehicles have done out of the county: 421
Jobs that other hubs have done in Worcestershire:829
Plus 408 into Worcestershire (13 a day)

August 2021
Jobs that Worcestershire vehicles have done out of the county: 525
Jobs that other hubs have done in Worcestershire: 1171
Plus 632 into Worcestershire (20 a day)

September 2021
Jobs that Worcestershire vehicles have done out of the county:488
Jobs that other hubs have done in Worcestershire: 886
Plus 398 into Worcestershire (13 a day)

Hospital Data – September

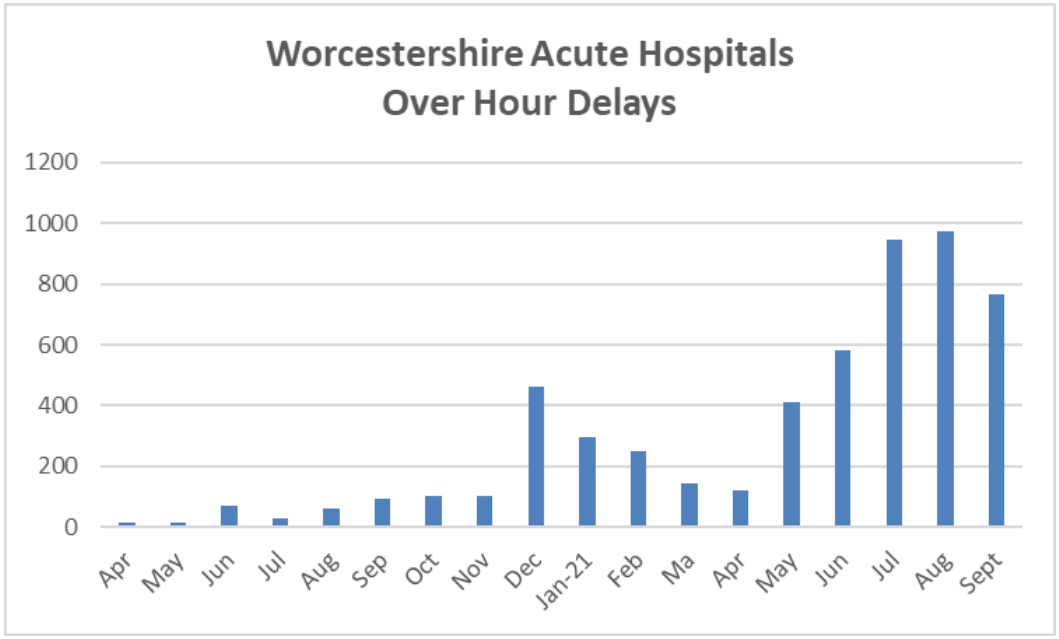
Patients taken in
Alex – 1,833
WRH – 2,854

Average handover (Target is 15 mins)
Alex – 20:38
WRH – 52:17

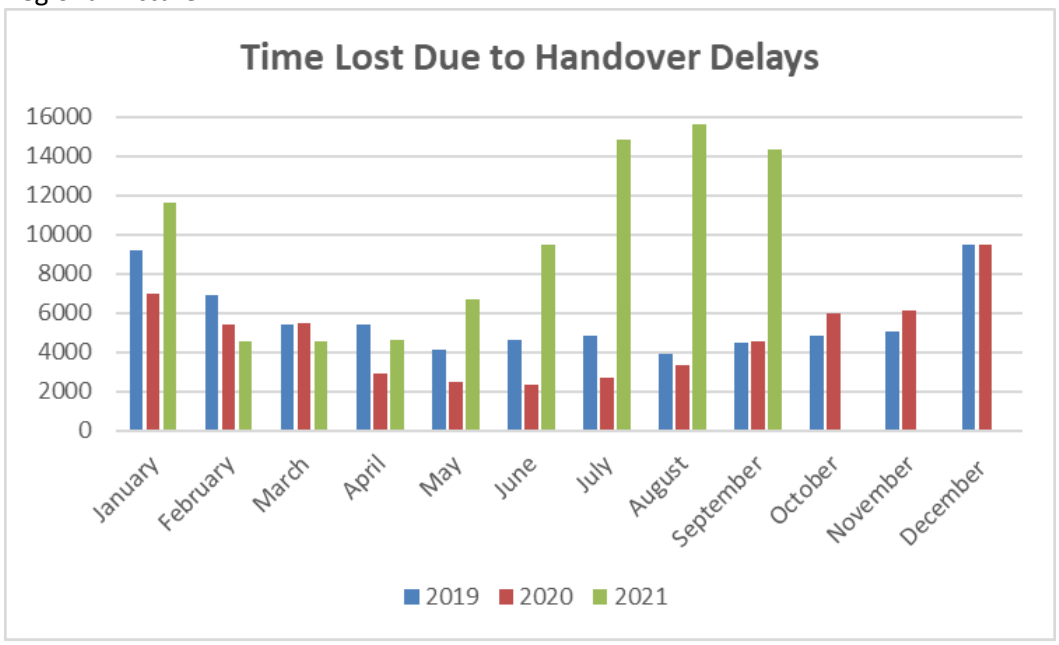
Percentage of crews who breached the 15min target
Alex – 30.9%
WRH – 62.6%

Over hours
Alex – 155 (8.6%)
WRH – 735 (25.8%)

Longest delays
Alex – 5:09:35
WRH – 7:24:47 (this doesn't reflect cohorting of patients)



Regional Picture



Performance By Former CCG Area

1st October – 31st December 2020

	Category 1			Category 2			Category 3			Category 4	
	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	90th centile (mm:ss)	Inc Count
Red & Broms	7:14	12:01	575	13:54	25:16	3,712	36:41	80:57	2,782	127:53	165
South Worcs	8:39	16:06	879	15:03	27:52	5,994	37:57	89:29	4,637	107:14	292
Wyre Forest	9:43	17:47	295	19:04	32:40	2,261	47:38	108:39	1,511	164:32	69

1st January – 31st March 2021

	Category 1			Category 2			Category 3			Category 4	
	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	90th centile (mm:ss)	Inc Count
Red & Broms	6:56	11:50	524	13:05	24:06	3,713	30:32	63:04	2,716	79:24	155
South Worcs	8:21	15:17	832	14:18	26:47	5,952	31:16	68:08	4,491	81:58	296
Wyre Forest	8:34	15:42	301	17:47	30:47	2,094	40:07	78:31	1,421	113:00	100

1st April – 30th June 2021

	Category 1			Category 2			Category 3			Category 4	
	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	90th centile (mm:ss)	Inc Count
Red & Broms	6:50	11:23	528	15:23	28:58	3,821	52:30	124:11	2,431	179:01	144
South Worcs	9:01	16:53	998	17:39	33:48	6,683	54:32	127:32	4,490	155:11	262
Wyre Forest	9:34	17:02	349	21:50	38:50	2,366	64:44	144:52	1,497	213:10	72

1st July – 30th September 2021

	Category 1			Category 2			Category 3			Category 4	
	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	Mean (mm:ss)	90th centile (mm:ss)	Inc Count	90th centile (mm:ss)	Inc Count
Red & Broms	7:45	13:08	679	29:48	61:01	4,088	135:50	340:43	1,693	282:02	108
South Worcs	9:38	17:54	1,168	32:14	64:40	6,914	137:40	339:25	2,917	306:25	173
Wyre Forest	11:25	19:54	410	38:12	75:32	2,489	168:49	402:30	876	340:21	48

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HEALTH OVERVIEW AND SCRUTINY COMMITTEE
18 OCTOBER 2021

PRIMARY CARE (GP) ACCESS

Summary

1. The Health Overview and Scrutiny Committee (HOSC) has requested a report on how the residents of Worcestershire are able to access appointments with GPs following the COVID-19 pandemic including how services are monitored to ensure equity of access across the County.

2. The Committee would like to gain an understanding of how access to GP appointments has changed following the Pandemic (including the timeliness, availability, and types of appointments), the success of changes made/new ways of working, the challenges faced by GPs and residents and how residents' views are being considered.

3. Senior representatives will be present from NHS Herefordshire and Worcestershire Clinical Commissioning Group (CCG), which commissions primary care.

Background

4. The HOSC has maintained regular oversight of access to Primary Care, particularly as services recover from the COVID-19 pandemic. An initial overview of how GP services were being restored and accessed was provided on 20 July 2020 weblink to agenda and minutes and this was followed by further updates which are detailed in the background papers of this report.

Current GP operating model

5. The way in which General Practice (GP) must operate during 2020/21 has been determined by NHS England / Improvement (NHSE/I). At the start of the COVID-19 Pandemic NHSE/I mandated a Standard Operating Procedure (SOP) for General Practice (in the context of Covid-19) which was a total triage model with minimal onsite access for patients, to comply with pre-determined infection control procedures. In addition, Primary Care Networks (PCNs) came together to operate as hubs according to the clinical need of patients requiring face-to-face appointments and their infection status. Practices have been operating in accordance with this SOP to protect both patients and staff.

6. The SOP has continued to be reviewed throughout the pandemic with the most recent directive published on 19 July 2021 which requires practices to 'offer a blend of remote and face-to-face appointments with digital triage where possible'. In addition, it is a contractual requirement that all practices offer a range of digital appointment types including video consultations. For example, practices are required to offer 5 per 1,000 patient's online consultations each week from 1 October 2021.

7. The digitalisation of General Practice to enable remote working and a move to a hub model, shared with the Committee in July 2020, ensured that all practices in Worcestershire remained open during waves 1, 2 and to the current date. This did not happen universally throughout the country.

8. Until further notice, the existing COVID-19 Infection Protection and Control (IPC) guidance continues to apply in healthcare settings. In a COVID-19 Response on 19 July 2021, the Cabinet Office confirmed that: "Health and care settings will continue to maintain appropriate infection prevention and control processes as necessary, and this will be continually reviewed…". All primary care contractors have therefore been mandated to follow this guidance, including the use of face coverings in NHS settings. This includes suggested ways to minimise contact in waiting areas.

9. Since July 2021, the number of competing priorities which practices are responding to is creating pressure and challenges for many of them. This is no different to any other part of the NHS at the current time.

10. The nationally agreed priorities for General Practice in 2021/22 include:

- Delivery of the national COVID-19 Vaccination Programme
- Restoration of long-term condition management, focussing on high-risk patients and tackling health inequalities
- Delivery of the Flu Immunisation Programme
- Preparing for two major new services to be delivered from 1 April 2022, namely Cardiovascular Disease Prevention and Diagnosis, and Tackling Neighbourhood Health Inequalities.

COVID-19 Vaccination Programme

11. In Worcestershire, 87.5% of the adult population has been vaccinated, with the Herefordshire and Worcestershire system being the highest in the West Midlands for overall uptake. In total 620,000 patients have received their first dose and 580,000 their second dose. NHS Herefordshire and Worcestershire CCG has been highlighted as a top achiever in the country, often achieving the highest or in the top 3 in the country for delivering targets against cohort patient groups. This trajectory is illustrated in Appendix 1, Graph 1f.

12. The vaccination programme has recently been expanded to include the 12 to 17-year old cohort (40,100 population size).

National and local monitoring of access

13. General Practice Appointment Data (GPAD) has been collated nationally since December 2018. This is published monthly by NHS Digital. This is the main indicator used by NHSE/I to monitor activity. NHS Herefordshire and Worcestershire CCG analyses this data to benchmark local appointment data against national / neighbouring CCGs levels, and to review trends month-on-month. Data is reported to and monitored by the Primary Care Quality and Risk Sub-Committee which reports to the Primary Care Commissioning Committee.

14. The latest data available (August 2021) is available in Appendix 1, Graph 1a. The headlines are:

- 406,961 appointments - 28% more appointments than August 2020. This figure excludes 62,000 appointments used to administer the COVID-19 vaccine (see Appendix 1, Graph 1f). If included, activity is 33% above 2020 levels and 20% above 2019 levels
- Primary Care General Practice is working at higher than pre-pandemic levels - currently 7% up on August 2019. Comparing 2019 to 2021 for the months January to August, the appointment levels are up 2.3%, excluding Covid-19 immunisation numbers
- Primary Care appointment recovery rates compared to last year have been the highest in the region for the past six months compared to 2020 activity (see Appendix 1, Graph 1b)
- Average daily appointment numbers are 17,117. This averages out to 214 per day per practice, higher than the national rate of 167 (note that practice list sizes vary considerably but the figure is used to compare to national rates)
- As a comparative measure, the number of appointments is equivalent to 0.46 per head of population per month, which is consistently the highest in the Region and compares well to a national rate of 0.39
- 54% of primary care appointments were with a GP, compared to the national rate of 52% (see Appendix 1, Graph 1c)
- 53.9% of appointments were face to face, a similar but slight increase on the previous month which was 53.5%. This is generally about 5% lower than national levels, however this is equivalent to 0.25 face to face appointments per head of population, compared to the national average of 0.22 (see Appendix 1, Graph 1d)
- 57.3% of patients booking an appointment are seen within 1 day, compared to the national rate of 54.8% (see Appendix 1, Graph 1e)
- Online and video appointments account for 21,258 (local data sources used as national reporting is vastly underestimated). This is now just under 6% of all appointments, from a baseline of 0% in January 2020
- By 30 July, all practices nationally were required to undertake a data mapping exercise to improve the quality of appointment data, in line with contractual requirements. This has been completed.
- NHS 111 direct booking has been increasing over the past year and most of our practices have been configured to enable direct booking. There have been issues with NHS 111 direct booking with three practices. This is not atypical with 50 practices in the Region having technical difficulties; these have been escalated to EMIS for resolution. Our conversation rates are 25%, just under the Regional average of 27%. However, 111 requests only represent <1% of appointments.

GP Contract Changes October 2021

15. NHSE/I recently published an update to the GP Contract on 23 August 2021, setting out a plan for the gradual introduction of new service requirements for PCNs. Funding through voluntary incentives such as the Investment and Impact Fund (IIF) is the principal way in which NHS England will be promoting PCN service improvement goals from the NHS Long Term Plan. This includes contractual requirements to support improved patient access to primary care services. The PCNs' IIF objectives are:

- Improved patient experience of accessing general practice
- Reduction in the proportion of patients waiting longer than 2 weeks for a routine general practice appointment
- Improved provision of online consultations
- Increased utilisation of specialist advice services, and community pharmacist consultations.

Public feedback and engagement including National Patient Survey findings

16. The CCG is aware of some issues or perception with access, particularly from complaints or local feedback during COVID-19. The pandemic has highlighted inequalities that may/may not have already existed and has increased some barriers faced by marginalised groups. There may be disproportionate numbers of cohorts that are prone to face inequalities e.g. the elderly or those on lower income/rural poverty which may compound access issues.

17. As a result, the CCG has reviewed several reports by organisations such as Healthwatch and The Patients Association, together with a recent NHSE/I Midlands Access Survey report. During 2020 the CCG undertook further engagement exercises (sometimes with other organisations such as Healthwatch) to confirm any findings identified in national reports and highlight areas for improvement or where our patients could be supported. This included a number of local patient feedback exercises where we focused on patient groups, such as those with Cancer or Learning Disabilities and Autism, or where patients were digitally excluded.

18. These information sources were also correlated with the National Patient Survey findings. We continue to achieve highly on the National Patient Survey in all the key areas. The findings compared to the previous year, and national comparisons are noted in Appendix 3.

19. This has given us over 13 sources of information to take account of patients' views, ensure accessibility is not compromised at practice level and to help some marginalised groups who have been disproportionately affected. As a result, we have undertaken the following actions:

- A website audit to ensure consistency of message and that practices advertise they are open as usual and describe a range of access options
- Telephone audits have resulted in a number of practices that have been contacted following the audit and placed on the NHSE/I Improving Access Programme. Further practices are receiving new telephone systems in line with a planned digital update programme
- All survey results have been triangulated to give a clear steer on areas of concern, particularly inequalities. Improvements will be directed through the Digital Group.
- A Digital Inclusion Advisory Group (DIAG) has been set up with key stakeholders and patient advocates to look at practical initiatives to reduce

inequalities because of digital exclusion. Initial meetings have commenced with a further meeting planned for 14 October 2021
- The CCG has carried out further feedback initiatives; digital live events and feedback sought from hard-to-reach groups e.g. LD and autism
- There have been further meetings with Patient Participation Groups (PPGs) and outreach events are planned to educate about online and video consultations
- A video has been developed for Herefordshire, and similar is in production for Worcestershire, for patients to understand the roles that each profession undertakes in GP practice, and who may be more appropriate to care for various patient conditions (instead of resorting to a GP appointment as first line)

Workforce capacity

20. A focus for the CCG over the past 5 years has been a recognition of the need to increase the Primary Care workforce to meet the demand and long-term challenges facing General Practice. Despite the challenges we continue to meet current capacity demands and are working towards managing future demand.

21. Overall GP numbers were increasing slightly until August with a reduction of 8 GPs (7 FTE) in the last quarter. Overall, the number of GPs has increased by 21 since 2015, but FTE has reduced by 28, from 456 in 2015 (see Appendix 2, tables 2a and 2b).

22. However, in anticipation of the age profile of the GPs working in Herefordshire and Worcestershire, the programme for training and then retaining GP Registrars has increased (see Appendix 2 table 2c and 2d). Since 2015, numbers of Registrars have increased by 23, and more of these are full-time at 83 FTE.

- Since General Practice workforce data records began in 2015, we have seen the age profiles of GPs slightly change
- During 2015, 50% of the GP workforce were over 45 years of age
- At July 2021, 57.7% of GPs were under 45 years of age, with 18.7% over 55
- There have been a number of GP retirements, but with the initiatives we have developed to support recruitment and retention, we have seen growth in the workforce and retention of the future workforce pipeline
- With a view to this we have a comprehensive range of packages and support to improve recruitment, but more importantly aid retention of our current workforce (See Appendix 2, Table a).

23. It should be recognised that the workforce profile is changing in General Practice and that the GP workforce initiatives are run in parallel to the recruitment of alternative clinicians and health professionals to increase appointment options.

General Practice Communications Plan

24. As with much of the NHS, General Practice across the country is facing huge demand for its services, with even more pressure because of the COVID-19 Pandemic.

25. Public perception is that GP practices are not open, that GPs themselves are not seeing patients, and that GPs and practices should be 'returning' to pre-pandemic way of working. This has resulted in frustration and a negative narrative often resulting in hostility and abuse of practice staff.

26. In addition, a Digital Access survey conducted by the CCG in October 2021 shows a low level of understanding of how people can get help through different ways, for example 55% of respondents said they would access their practice online but hadn't seen it promoted.

27. A communication campaign has been developed to support patient education. It aims to raise awareness and educate patients and public on how they can access the care needed through General Practice and how they can use these services to support them in managing their health and the health of those they care for better.

28. The campaign will have three main aims:

- Raising awareness of the multidisciplinary teams that now make up General Practice (the different roles and what each does)
- Informing people about how to access help in different ways without having to ring their practice, e.g. GP online, NHS 111 appointments, pharmacy, and the NHS App
- Encouraging and supporting people to take ownership and make decisions about the care they need (personalised care/self-referral), i.e. seeing a GP may not always be the best option, and sometimes First Contact Physiotherapy, Improving Access to Psychology Therapy (IAPT), Social Prescribers and Pharmacists can be appropriate alternatives.

29. The campaign's key messages are:

- General Practice or Primary Care has changed and is working differently
- The NHS Long Term Plan outlined these changes in 2019 as it was recognised that General Practice was not sustainable in its current form
- These changes were accelerated due to COVID-19 and the need to rapidly adapt to the pandemic
- There are new ways to access the help you need.
- Many of your health needs can be supported by professionals other than a GP
- Your healthcare can be supported through remote methods including online, video, and telephone appointments
- Face-to-face appointments are available if clinically required.

30. The campaign's tactics will be supplemented with a mix of regular online, digital, and public relations, including:

- Cascading through health and care staff, patient groups, PPGs, voluntary sector, local authority distribution lists and newsletters
- Publicity through press releases and local spokespeople
- Development of GP toolkits (assets for practices and guidance on communicating with patients)
- System-wide social media channel promotion
- Digital screens and websites.

31. We know from increasing patient and practice concerns that more can be done to help patients understand the changes in general practice and how, for example, they can get the most out of a remote consultation. Healthwatch and Patient Groups across the country are also producing videos to support this aim.

Resilience

32. The CCG has designed a 'real time' workforce reporting tool, which allows the CCG to understand the scale of problems and report capacity issues to the system along with other providers. Practices reporting difficulties are contacted and supported to ensure patient access is not adversely affected and practices are not at risk of closure. This includes them utilising mutual aid, and to offer support to the practice during the period until the workforce has returned to normal levels. This is monitored daily.

Challenges

33. The current challenges are:
    - Current appointment activity continues to increase
    - Restoration backlog activity being undertaken, alongside the national COVID-19 vaccination and Influenza Programmes, noting we only have the same skills and workforce available to deliver both
    - Maintaining a total triage model, while enabling more face-to-face appointments
    - Maintaining / increasing online and digital appointments in line with national direction, balanced with patient choice (particularly with regards to face-to-face appointments).

Moving forward / opportunities

34. Access to GP surgeries has changed since March 2020. While reverting to pre-COVID-19 levels, the opportunities of working in a COVID-19 environment has fast tracked many developments that were planned that should now be capitalised on. While the infection control procedures will remain for the medium-term, we will continue to maintain a range of access methods that support us working towards the priorities of the NHS Long Term Plan, namely:

- Sustainable General Practice, working collectively within PCNs and through them with partners across health and care and the voluntary and community sector
- Ensure consistent, equitable, high-quality services to patients and the public

- Continued investment in General Practice through local and national funding streams aligned to PCNs
- Digital solutions to support the future model of care.

35. By working in this way, we will continue to deliver the NHS Oversight Framework metrics for patient access and outcomes which are:

- All general practices to be delivering at, or above, pre-pandemic appointment levels, including through consolidating and maximising the use of digital consultation methods and technology
- Delivering safe, high-quality care.

Conclusion

36. 90% of all contact with the NHS is with General Practice. Given the backlogs created by COVID-19 plus the national mandate on delivering the flu and COVID-19 vaccination programme, work has exponentially increased leading to stress, illness, and resignations from General Practice. The quality of General Practice in Worcestershire has always been high as evidenced by national metrics. Public dissatisfaction has never been so high and there is no one solution to address these concerns voiced by practices or patients. The CCG is committed to working with partners, practices, and patients to ensure that there are no practice closures, quality patient services are sustained, and the General Practice workforce is increased.

Purpose of the Meeting

37. Members are invited to consider and comment on the information discussed and agree:

- whether any further information is required
- whether any further scrutiny work is required at this stage.

Supporting Information

Appendix 1 – GP Appointment Data
Appendix 2 – Workforce Data
Appendix 2 – Recruitment and Retention
Appendix 3 – H&W CCG Achievement in the National Patient Survey 2021

Contact Points

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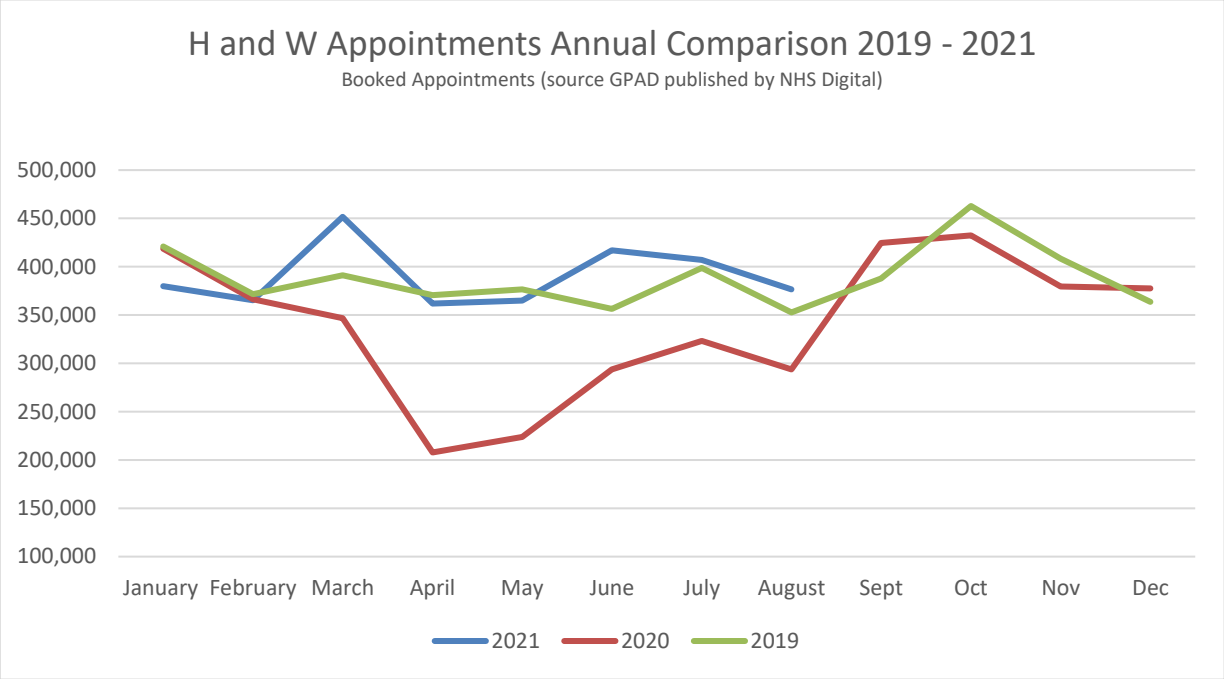
Background Papers

In the opinion of the proper officer (in this case the Assistant Director for Legal and Governance), the following are the background papers relating to the subject matter of this report:

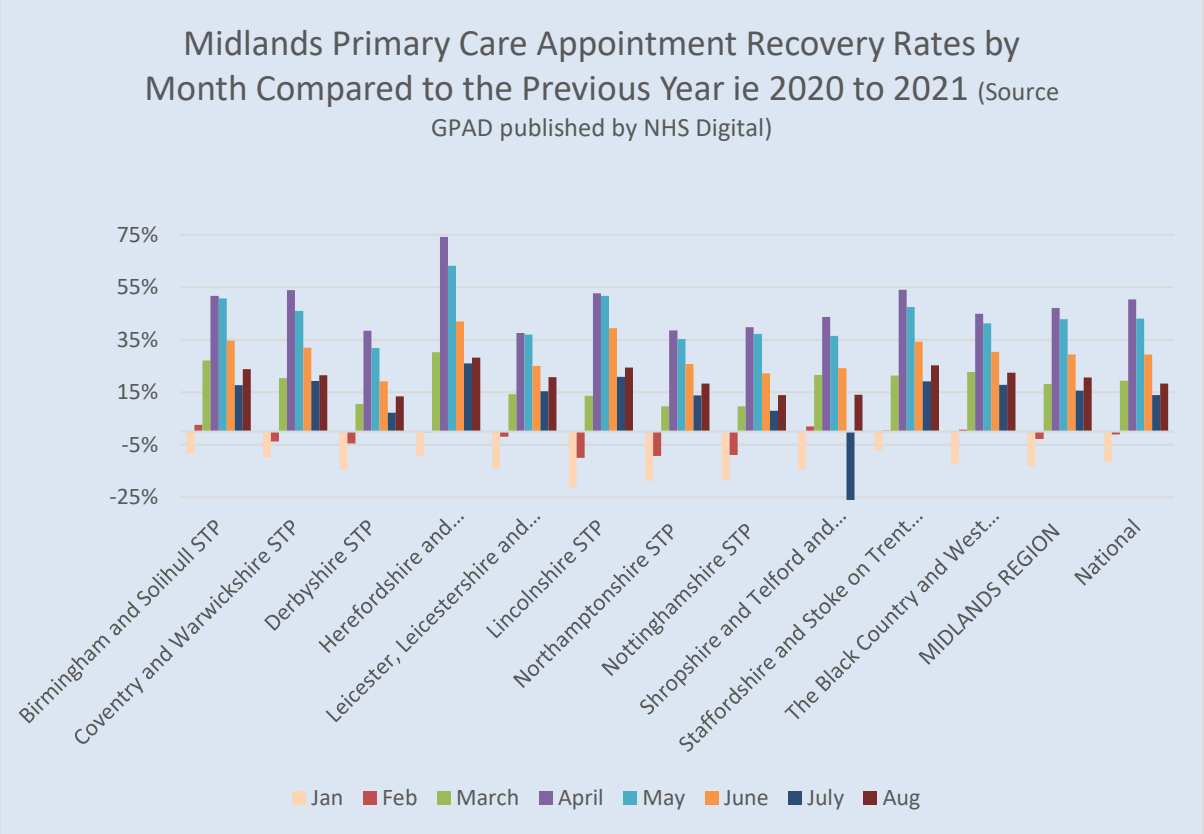
- Agenda and minutes of the Health Overview and Scrutiny Committee on 19 July and 10 March 2021, 16 November, 30 September, 20 July 2020 Browse meetings - Health Overview and Scrutiny Committee - Worcestershire County Council (moderngov.co.uk)

Appendix 1 – GP Appointment Data

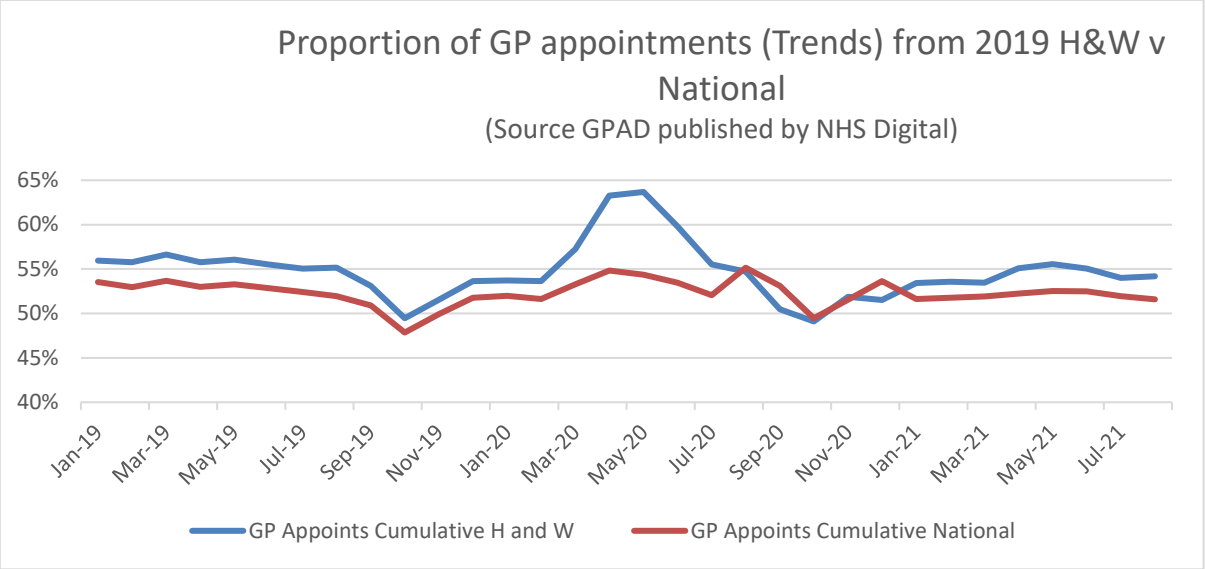
Graph 1a Appointment Numbers and Trends



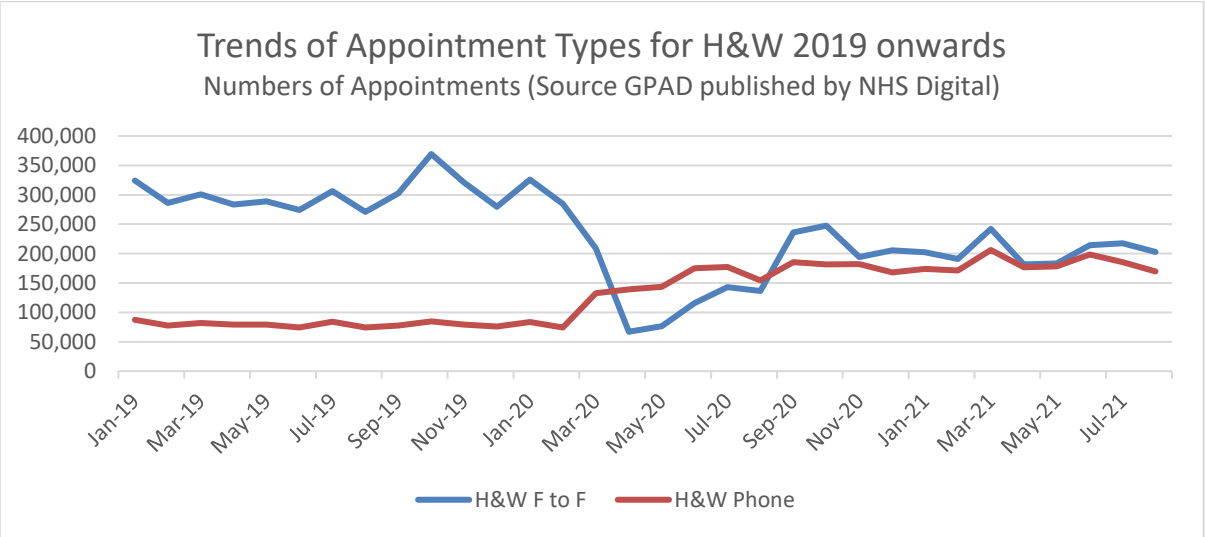
Graph 1b – H&W High Recovery Rates Compared to other CCGs



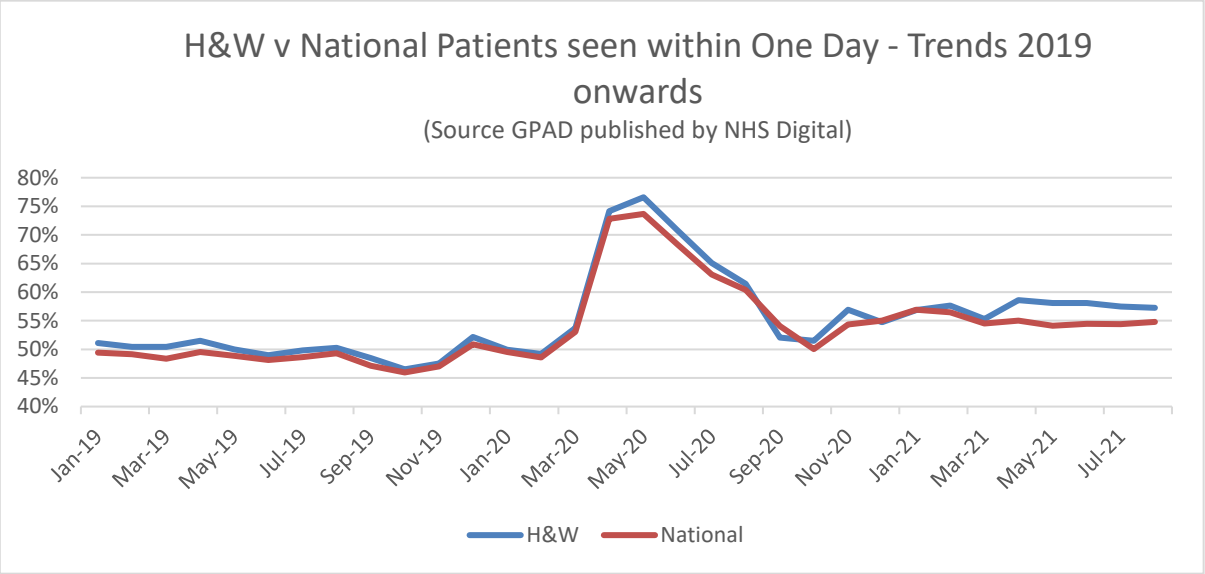
Graph 1c – GP Appointment Rates



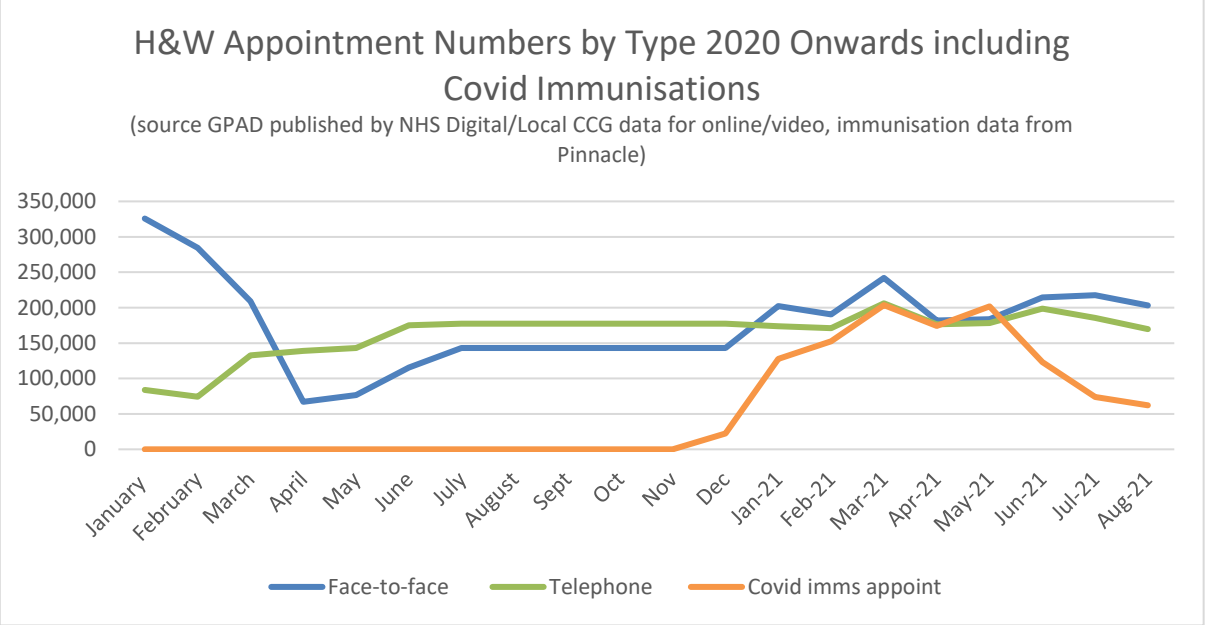
Graph 1d – Face to Face and Telephone Appointments



Graph 1e – Patients Seen with 1 day

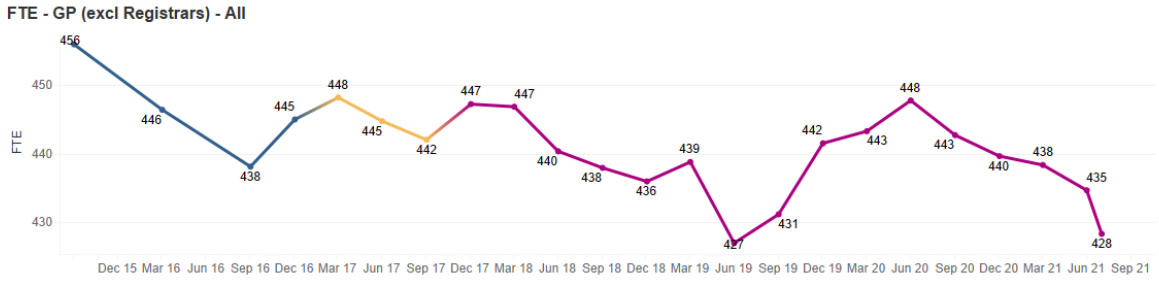


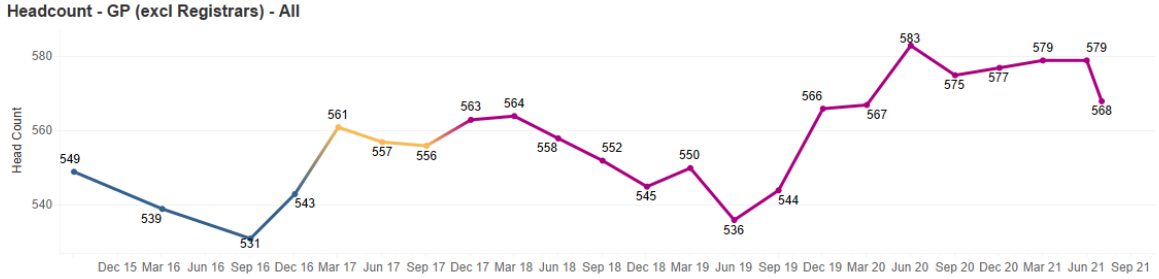
Graph 1f – Main Appointment Types Including Covid Immunisations



Graph 2a and 2b – GP Workforce

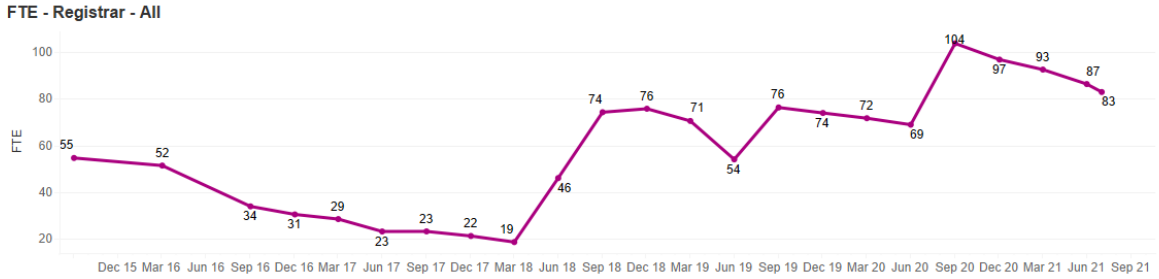
Region Name	STP Name	CCG Name	Staff Group	Staff Role
Midlands	Herefordshire and Worcestershire	All	GP (excl Registrars)	All

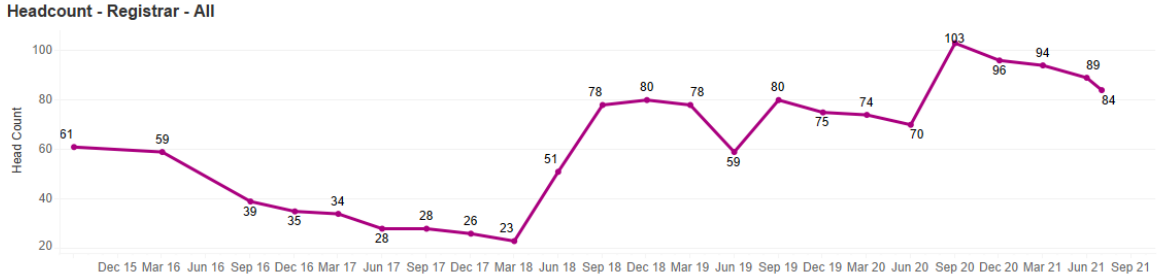




Different colours denote changes in the data collection methodology. This affects only GP Locums and GP Registrars.

Graph 2c and 2d – Registrar Workforce





Different colours denote changes in the data collection methodology. This affects only GP Locums and GP Registrars.

Table a - Support for Recruitment and Retention

Available to all GPs (including locums) GP Workforce Clinical Lead – Single Point of Access for GP Retention/GP Mentoring/Portfolio Role Grants/GP Medical Education Academy/Training Hub for Education – Events and Jobs/Supported Welcome Back to Work/Flexible GP Pools/GP Workforce.

Early Career GPs ST1 to 5 years post CCT	**Mid-career GPs** >5 years post CCT	**Late Career GPs** within 10 years of retirement
• Fellowships programme for newly qualified GPs • Next Generation GP programme • Mentoring • Virtual Peer Support • Quality Improvement training • Partnership development • Clinician Welcome Pack • First 5 network – on various channels	• Phoenix GP programme • Balint Groups/Networking/Air and Share/Virtual Peer Support • Quality Improvement training • Mentoring and Mentor opportunities • Partnership development and Leadership Opportunities • GP trainer • GP appraiser • Join GP Support Team	• Mentor opportunities • GP appreciation events • Late Career options sessions • Teaching opportunities • National GP retainer scheme • Retirement options discussion • GP appraiser • Join GP Support Team

Appendix 3 – H&W CCG Achievement in the National Patient Survey 2021

2021 Patient Survey % Good	2020 Result for H&W	H&W 2021	National	2021 v 2020 H&W
Overall experience	87%	87%	83%	
Getting through on the phone	70%	75%	68%	
Ease of online services	80%	78%	75%	
Choice of appointment	62%	70%	69%	
Satisfaction with appointment offered (type)	77%	84%	82%	
Overall experience of making an appointment	71%	75%	71%	
Given time for appointment	90%	93%	91%	
Satisfaction with appointment (times)	67%	70%	67%	
In hours (when they are not happy with the appointment and do not take it) do they go to A&E	*9%*	*3%*	*8%*	
When the GP is closed do, they go to A&E	*35%*	*26%*	*26%*	

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