Nottingham CityCare Partnership
Quality Account 2011/12

30 June 2012

Please note that prior to publishing this document will be professionally designed and will include further graphics and photographs. The patient case studies and patient comments will be highlighted.

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Part 1 – Board Statement on Quality

Welcome to the Annual Quality Account for Nottingham CityCare Partnership CIC covering 2011/12.

Nottingham CityCare Partnership (CityCare) was formed on 1 April 2011, meaning this report covers our first full year as a social enterprise organisation delivering NHS community health services.

In it we look back on the progress made against the quality priorities we set in last year's report, and lay out our quality ambitions for next year.

During the year our staff have worked hard to ensure quality remains high while the transformation into a new organisation continued.

Key to improving our services is encouraging, listening to, and acting on patient and public feedback. Threaded throughout this report we look at the feedback we have received, focusing in on where we have made positive changes in response to that feedback.

Patient safety is a top priority for CityCare we will look back at our achievements over the year in safeguarding children and vulnerable adults, serious incident reporting, infection prevention and control, and Medicines Management. In our priorities for 2012/13 we will outline how we will work to improve Medicines Management across the organisation as our quality priority.

In last year's report we looked at how we could improve our clinical effectiveness through the Department of Health's High Impact Actions, covering the issues of pressure ulcers, falls prevention, nutrition, promoting normal birth, end of life care, reducing sickness and absence among staff, improving discharge processes and reducing urinary tract infections in the patient population. This report will highlight achievements in these areas, and we will also look forward at how we can further increase clinical effectiveness through improved training and supervision.

Our staff are the best ambassadors for CityCare and our services, and later in the report we outline how we will develop customer care training as one of our quality priorities for 2012/13. Through this we aim to improve our patients' experiences and remain the provider of choice for NHS community services in Nottingham.

In the 2011 national NHS staff survey, our staff were asked to score from 1-5 (with 5 as the highest score), whether they would recommend CityCare as a place to work, or to receive treatment. CityCare scored 3.7 – above the

national average for other social enterprises, community trusts and acute (hospital) trusts.

The Board continues to closely monitor the quality of our services and receives regular reports to outline performance against objectives, and monitor patient safety, quality and patient experience. A non-executive director, Paul Grant, chairs our Patient Experience Group to get face-to-face input from local people, and reports back from that group to the Board.

We are continuing to build closer relationships with partners across the city, to develop ways in which we can work together to improve the overall quality of services offered to the people in Nottingham. We are also a member of the Health and Wellbeing Board and the Health and Wellbeing Board Third Sector Forum. This reflects our core value of offering better health and complete care, owned and delivered locally.

I hope you find this report helpful, and ask that you give us your feedback on the report and our work, to help us shape our future quality priorities.

To the best of my knowledge, the information in this document is accurate, and a true account of our quality of services.

Lyn Bacon
Chief Executive

Patient Case Study
Improving access to Podiatry

Helen Thomson is happy with improved access to our podiatry services since we opened a new clinic in Boots in the Victoria Centre, a shopping centre in the heart of the city centre.

Helen said: "I had previously attended appointments at the St Ann's Health Centre, some distance away from my home in the city centre. I heard about the new clinic at the Patient Experience group, and as soon as it opened I asked to move my appointments to the Boots health clinic. It was really easy, and I got an appointment within two days.

"The clinic is so much easier to get to, and the podiatrist I saw is the same one I've always seen, which is a real positive for me.

"The clinic room is very well laid out, it is a good quality service, and I was seen on time – I can't speak highly enough of the service I received."

Part 2 – Review of Quality Performance

This section includes nationally mandated statements of assurance by the Board (sections 2.1, 2.5-2.9) in addition to updates on local quality priorities, which were included in last year's Annual Quality Account following consultation with patients and the public, and with other external organisations.

In Section 2.2 we chart our progress against the quality priorities set out in our Annual Quality Account for 2010/11. The priorities were grouped under the three headings of Patient Safety, Clinical Effectiveness, and Patient Experience. Together these groups address whether our patients feel '*cared for, safe and confident in their treatment'.*

2.1 REVIEW OF SERVICES

During 2011/12 CityCare provided 60 services to the specifications required by the commissioners and issued eight material sub-contracts for services received from NHS services, and subcontracted elements of NHS services to 13 other NHS organisations or other local partners.

CityCare has reviewed all the data available to it on the quality of care in the 60 NHS service specifications in line with the reporting and monitoring requirements of those commissioning these services.

The income generated by the NHS community contract in 2011/12 had a contract value of approximately £36 million, which represents more than 99% of the total income, generated from the provision of NHS services by CityCare for 2011/12.

2.2 PATIENT SAFETY

We recognise the importance of ensuring systems and processes are in place to record, monitor, report and analyse any concerns relating to patient safety.

Last year's quality priorities for patient safety included Safeguarding Children and Vulnerable Adults, Serious Incident Reporting, Infection Prevention and Control, and Medicines Management.

Safeguarding Adults

We have introduced two great innovations to support staff in adult safeguarding this year.

The first has been to recruit a number of staff from a variety of disciplines from across CityCare to act as Special Interests Practitioners (SIPs) in adult safeguarding. The SIPs will support the Lead Practitioner for Adult Safeguarding in providing advice and support to staff.

The second initiative has been in response to an increasing need expressed by staff for more knowledge and guidance in the application of the Mental

Capacity Act (MCA) for service users who may lack capacity to make treatment decisions. A number of staff have been trained as MCA Champions and will link in with services across the organisation to increase awareness, and support staff to become experts in their own right.

The Adult Safeguarding Committee has continued to lead on further developing our safeguarding processes. In last year's report we outlined five aims:

1. We intend to carry out an evaluation of service user satisfaction.

We have worked very closely with our Patient Experience Group and our Health Group for service users with a learning disability in this aim. We asked for their opinions on the adult safeguarding pathway and the support we offer to vulnerable adults. We also asked them for feedback on the information leaflets we have been developing for service users, which explain how to recognise adult abuse, and the response that service users can expect from us when abuse is suspected or reported to us.

We have used their comments to help develop the final version of our leaflets, and will also use their feedback to further improve how we safeguard vulnerable adults.

We also strengthened our links with the Nottingham Elders Forum, and attended a forum meeting in May where we received positive and constructive feedback on service user satisfaction.

Work on this aim will continue into 2012/13.

2. We will carry out an assessment against the Adult Safeguarding Assessment Framework which was developed by the Department of Health as part of the earlier pilot.

CityCare took part in the East Midlands 2010 pilot of the Region Self Assessment and Assurance Framework. The pilot aimed to refine a set of standards that NHS Boards can use to check that their adult safeguarding measures meet nationally agreed standards.

As part of the pilot our self assessment was peer reviewed by a representative from Lincolnshire who ranked us at a higher standard than we had ranked ourselves. This was a great achievement which gives us confidence in our ability to improve services further.

We have now formally adopted the framework and are using it to assess all our services against national standards. It has helped us identify where services can be improved and the Adult Safeguarding Committee has used it to develop an action plan, monitored by the Governance Committee, to ensure that services meet the required standards.

Standards

Excelling				
Effective				
Working towards effective				
Not effective				
	Systems	Strategy	Workforce	Partnership

Measures that support good safeguarding

Table 1 – CityCare's rankings in the assurance framework

3. We intend to deliver essential training to all relevant staff.

We have robust systems in place to ensure that all staff receive training as appropriate, and this is monitored by the Workforce Development Team. In 2011/12, more than 400 staff received essential adult safeguarding training and a further 60 staff received referrer training.

Our induction programme for all new staff includes training on safeguarding children and safeguarding vulnerable adults.

We also provide alerter level training to all clinical staff with face-to-face contact with service users, and to non-clinical staff whose role brings them in contact with potentially vulnerable adults. Alerter level training is provided on-line through an e-learning programme, and is designed to raise awareness of what to do if you suspect abuse is taking place. Managers need a higher level of adult safeguarding training to prepare them for the decision making role they have when alerted to a safeguarding concern. They receive face-to-face referrer training.

The number of staff requiring training has been considerable and staff working patterns and access to computers has presented challenges for some staff. We have therefore provided additional face-to-face training to meet the needs of staff who have difficulties accessing the on-line training.

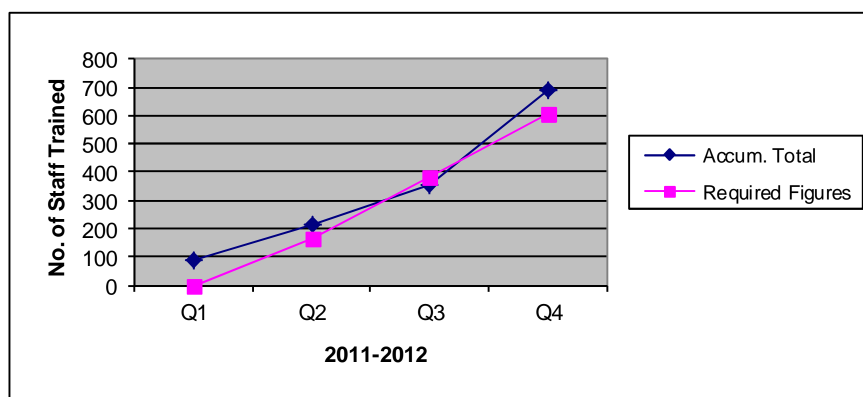
4. As part of our CQUIN (Commissioning for Quality and Innovation) we intend to deliver basic dementia care training to staff with face to face patient contact including administrative staff – this will comply with Quality Standard 1 in the Dementia Quality Standard (NICE June 2010).

To deliver our basic dementia care training (Level1) we have introduced the nationally acclaimed e-learning programme, *The Open Dementia Programme*,

developed by the Social Care Institute for Excellence (SCIE). Completing the first two modules gives staff Level One training, and those who wish to develop their knowledge in dementia care further can access Level Two Dementia Training. This can be completed either through e-learning or by attending a one-day face-to-face in-house training course.

Over the year, 63% of staff have received training, exceeding our CQUIN target of 55% and more than 140 staff went further to complete level 2. Work will continue in 2012/13 to increase the number of staff completing this training to 95%.

Table 2 Numbers of staff trained in dementia care



5. We will collaborate with the Walk in Centre and Nottingham Emergency Medical Services (NEMS) to further the work of the Adult Safeguarding Steering Group

Representatives from CityCare's Walk-in Centre and NEMS, who provide urgent medical care and advice whenever people's own General Practitioner's (GP) surgery is closed, and joined the Adult Safeguarding Steering Group in May 2011 and January 2012 respectively.

The Adult Safeguarding Steering Group has subsequently been renamed the Adult Safeguarding Committee and these additional members have greatly increased the specialist input available to it, and the ability to look at a whole pathway of care, putting people at the heart of what we do and keeping people safe.

Safeguarding children

In last year's report we outlined the results of the City's Safeguarding and Looked After Children Inspection which took place in 2011, in which services were rated as 'good'. All the findings and recommendations of the report have been implemented, helping us improve our partnership working with other local organisations.

Our other aims and progress against them include:

1. **We will implement the recommendations from the Markers of Good Practice Assessment and continue to take part in our annual assessments.**

We have successfully implemented all recommendations from the 2010/11 report, and the 2011/12 assessment took place in April 2012. Recommendations from that assessment will also be implemented.

2. **Explore opportunities to work closer with Adults and Children's social care.**

The CityCare Director of Governance, Nursing and Allied Health Professionals sits on both the Adult and Children's Local Safeguarding Boards, alongside representatives from other partner organisations including the local authority. This ensures we have a strong voice, and consistent links between organisations. We are currently investigating the possibility of joint training with social care on domestic violence, supporting vulnerable adults with learning disabilities and learning from Serious Case Reviews.

3. **Continue to make a tangible shift to early intervention through use of the Common Assessment Framework, leading to improved identification of need and integrated delivery of health and social services.**

The Health Visitor Implementation Plan 'A Call to Action' aims to increase the number of Health Visitors to deliver a new model of support to families and improve preventative and early intervention services. The almost doubling in the numbers of Health Visitors in Nottingham by 2015 will enable a tangible to shift in early intervention.

In addition, NHS Nottingham City has provided additional funding to expand the Family Nurse Partnership, increasing the programme's reach to 25% of the eligible population.

Common Assessment Framework (CAF) initiation rates continue to improve and reflect a shift to early intervention. The Common Assessment Framework provides a simple process for a holistic assessment of children's needs and strengths taking account of the role of parents, carers and environmental factors on their development. In 2011/12 the number of CAFs initiated were:

- Health Visiting - 113
- School Nursing - 20
- Family Nurse Partnership - 13

4. **Review the current model of Safeguarding Supervision.**

The review is underway and will be completed in 2012/13.

5. **Increase closer partnership working with Nottingham Emergency Medical Services (NEMS) and Local Authority.**

The in-hours CityCare Children's Safeguarding Team is co-located with the social care Duty Team, and the out-of-hours social care Duty Team is based at NEMS. We are ensuring we make the most of the opportunities this gives

us, such as working more closely together in response to safeguarding referrals.

6. **Ensure the views of children and young people are recorded in a way that provides assurance that they have been heard and their wishes and feelings are being taken appropriately into account in planning.**

We have a range of approaches in place, both formal and informal, that encourage and enable the part of children and young people on their own terms and in a way they feel comfortable.

Children and Young people are invited to feed back their views on their satisfaction of services they use and suggestions inform improvements.

The Family Nurse Partnership has designed a user friendly version of the satisfaction survey for young people and is also establishing a young people's forum where ideas will inform planning.

A focus group with Young Carers has informed our Annual Quality Account.

7. **Ensure unconditional registration with CQC for the new organisation April 2012.**

CityCare continues to be registered unconditionally with the CQC.

8. **HR department to establish a robust Electronic Staff Record (ESR) system for collection of safeguarding training records for staff and CRB checks.**

CityCare are now registered for the provision of CRB checks and have put in place a rechecking programme.

Professional Registrations are monitored through the Electronic Staff Record on a monthly basis with information being provided to line managers. Safeguarding training records are also monitored.

Incident Reporting

Serious incidents can include death, fire, a significant disruption to a service, sexual assault, sudden unexpected death, attempted suicide, significant safeguarding concerns or incident, serious self-harm, serious accident or injury, unexplained serious injury, security breach, confidentiality breach, serious allegation against staff, serious medication errors, stage three and four pressure ulcers and loss of patient data.

We emphasize an open learning culture where incidents and complaints are investigated thoroughly to determine the root causes and action is taken, where appropriate, to improve services as a result.

We recognise the importance of continuing to promote a culture of openness within a learning environment where risk management is everyone's business. It is the responsibility of all staff to practice safely and to participate in the assessment, reporting and management of risk.

All incidents are investigated by the Line Manager to ensure that root causes have been identified and that learning has been documented and shared within the whole of the team. The Head of Patient Safety analyses clinical incidents. Reports are then prepared which identify trends in reported incidents, detailing cause groups and the nature of incidents by services. These are reflected in the quarterly patient safety trend analysis reports which are received by the Governance Committee for scrutiny.

In 2011/12, 1842 patient safety incidents were reported, of which the vast majority were graded as 'no or low harm' and were not serious incidents. There has been an increase in reporting from within some of the adult services. For example, in the Crisis Response Team there was an increase in reporting this year to 53 from 9 in the previous year, and in the District Nursing and rehabilitation teams there was an increase from 398 to 431. The most frequent types of clinical incidents reported by these services are;

- Pressure ulcers
- Lack of availability of a device
- Discharge from hospital

We encourage our staff to report all pressure ulcer incident reports whether acquired or inherited and at all stages from one to four. All stage three and four pressure ulcers are reported on STEIS (Strategic Executive Information System) and a root cause analysis investigation conducted.

The incidents relating to a lack of availability of a device resulted partly from the change in service provider for obtaining community equipment for patients from the Integrated Equipment Stores (ICES). Staff reported problems which generally reflected within one of the following categories

- Delivery timescales
- Availability of stock
- The newly introduced online equipment ordering service

Reporting incidents ensured that managers were able to work with ICES to resolve the problems and this resulted in a reduction of incidents reported on a month by month basis. Staff also access up to date information on ICES including the regular ICES bulletins, policies and guidance so that they are notified of any changes in process to ensure that there is no disruption to ordering equipment for patients.

In relation to discharges from hospital there is a Transfer of Care group where any incidents relating to discharge are discussed so that action can be taken to reduce the number of incidents.

Any significant risks identified through incident reporting are added on to the service risk register. All entries within the register must have identified controls in place, actions and a review date. The risk register remains a dynamic document, continually evolving, and is updated monthly. The

corporate risk register is also reviewed by the Governance Committee and Board.

Safeguarding serious incidents
In 2011/12 CityCare undertook two Serious Case Reviews in relation to child safeguarding. One of the recommendations was to review and improve the existing escalation process for dealing with child protection cases of immediate concern. The escalation process will be implemented in early 2012.

Pressure ulcers
Work began in 2011/12 to ensure that all stage 3 and 4 pressure ulcers that were community acquired were reported as incidents. All of the incidents were also reported directly to our Tissue Viability team who undertook the root cause analysis investigation and then met with the manager of the team to formulate the action plan to ensure that learning from the incident would be embedded into practice. Actions taken included; improved assessment of patient's skin on discharge from hospital, better documentation so that the condition of the patient's skin is reviewed regularly and work with care homes regarding compliance with advice regarding pressure area care.

In 2011/12, staff reported 52 pressure ulcer incidents, which are regarded as serious incidents. This needs to remain a high priority for CityCare until all corrective action has been taken. We have set up an embedding learning into practice group to which managers are invited to demonstrate how the learning has been embedded into practice. The Director of Governance, Nursing and Allied Health Professionals is provided with monthly reports on progress.

Other quality priorities for incident reporting
In last year's report we set the following quality priorities for 2011/12, and the following progress has been made:

1 Continue to improve the way information is made available to teams so that they are able to see trends to be addressed.
In this aim we have focused on Root Cause Analysis investigations (RCAs) into pressure ulcers, and how the learning is shared. We will then be able to embed the systems developed across the organisation for all serious incident investigations.

Root Cause Analysis allows us to look deep into an incident or issue, see why it is happening and how we can solve the problem.

Over the last year we have developed our process further so that Team managers now undertake RCAs with a Tissue Viability nurse, so that the team can take ownership of the investigation and the action plan. Key learning from RCAs is communicated to teams through line managers, and the team manager is responsible for embedding changes that are needed into practice. The embedding and learning will be monitored through the monthly meeting of the learning and embedding group which will report into the Patient Safety and Infection Prevention and Control Committee.

The Patient Safety and Infection Prevention and Control Committees have joined to become one committee to streamline governance around patient safety, to assist us in ensuring issues and trends are identified and actions implemented and monitored

This committee reviews all RCAs, and additional learning from stage 3 and 4 pressure ulcers is cascaded through teams by the Adult Locality Lead via manager meetings.

Learning from all RCAs is cascaded through the quarterly management forum, and team meetings, however more work will take place during 2012/13 to ensure this process of information sharing is truly embedded.

2 Continue to build a Safety Culture by encouraging reporting of incidents and supporting the recognition of lessons that can be learned from incidents and ensuring that lessons are shared and implemented to improve safety for all patients, and cascade web reporting so that staff can report incidents directly on line.

We actively encourage the reporting of incidents by our staff. We remain a high reporter through comparison of NRLS (National reporting and learning system) data which is provided quarterly by the NPSA (National Patient Safety Agency).

The majority of our services can now report incidents on-line using the electronic system rolled out from April 2011, and managers are automatically notified of incidents. All patient safety incidents are also automatically reported to the Head of Patient Safety and reviewed. Specialists are immediately notified for certain incident types to offer specialist advice and support. The improved system enables the manager to undertake their investigation and feed back to the staff in a timely manner.

As a result of introducing on-line reporting we have seen a general increase in reporting, particularly across adult services. The vast majority of our incidents remain no harm incidents.

3 Four training sessions on Root Cause Analysis tools will be delivered to staff Team Leaders and clinical managers and the Head of Patient Safety will continue to support managers in more complex investigations.

A general RCA training package has been developed by the commissioners and includes input from Tissue Viability specialists and the Infection Prevention and Control team. Two sessions have taken place so far, with attendance predominantly by managers, and work will continue on delivering this training to frontline staff.

A separate distinct training session on pressure ulcer RCAs has also been provided to team managers by the Head of Tissue Viability and Head of Patient Safety.

4 Senior managers will be provided with training in Being Open

This aim has been superseded by the work on providing training on RCAs, and a session is planned for senior managers on RCAs and their responsibilities. The Head of Patient Safety is trained on Being Open and supports senior managers where needed.

5 Produce 'spotlights' to highlight areas of good practice and lessons learned to share across all services
The template for sharing information from monthly incident reports has been reviewed and updated so that members of the Patient Safety Committee can use this to cascade out to teams.

We have launched a newly-reinvigorated Safety First newsletter for staff, which highlights patient safety and issues from other areas of governance such as Health, Safety and Security, Medicines Management, and Information Governance.

Infection Prevention and Control
During 2011/12 we met the two nationally-set targets in relation to health care associated infections. The target is based on the population of Nottingham City and must be met by the whole of the local health community.

The targets were as follows:

To not exceed 116 cases of Clostridium difficile infection
Patients are attributed to the target if:

- They reside in Nottingham and are registered with an NHS Nottingham City GP
- They are registered with an NHS Nottingham City GP but an inpatient for over 72 hours anywhere in the country
- They are identified with Clostridium difficile in the first 72 hours of admission to hospital and are registered with an NHS Nottingham City GP

To not exceed 10 MRSA bacteraemia
Patients are attributed to the target if:

- They reside in Nottingham and are registered with an NHS Nottingham City GP
- They are registered with an NHS Nottingham City GP but an inpatient for over 48 hours anywhere in the country
- They are identified with Clostridium difficile in the first 48 hours of admission to hospital and are registered with an NHS Nottingham City GP

Clostridium difficile
During 2011/12 the total number of Clostridium difficile cases was 86 which is within the trajectory of 116 set by the Department of Health. A number of initiatives have helped the organisation to meet the trajectory:

- The new antibiotic guidelines were launched in May 2011 at a training event for both medical and nurse prescribers
- The laboratory instituted a three stage technique to test stool samples which allowed a more accurate diagnosis to occur in relation to Clostridium difficile infection
- A review of the four serious incidents relating to Clostridium difficile this year has enabled some common themes to be highlighted which have been shared with clinicians across the health economy.

MRSA
During 2011/12 there were four MRSA bacteraemia. This is within the trajectory of 10 set for 2011/12 by the Department of Health. Diabetic foot ulcers remained a common theme and the diabetic foot clinic has revised the processes within the clinic. Work is now underway to review the interface between the diabetic foot clinic and primary care because patients are often cared for by both providers. The aim will be to:

- Have clearer processes for the treatment of diabetic foot ulcers
- Ensure all infections are identified promptly and treated in accordance with local antimicrobial prescribing guidelines.

Themes are shared with independent contractors via a twice yearly report and to CityCare via the quarterly health care associated infection report. The Health Economy Committee continues to meet monthly to progress this work.

Medicines Management
The Medicines Management Team has undergone significant organisational change on migration to CityCare from NHS Nottingham City during 2011/12. The team has recently expanded and aims to promote high levels of Medicines Management across the organisation.

These key actions have occurred to progress the key quality priorities from last year's report:

These key actions have occurred to progress the key quality priorities from last year's report:

- All medication related incidents are notified to the Head of Medicines Management, and where appropriate significant medication incidents are now being reviewed within five working days.

- All incidents are discussed at the Patient Safety Committee, and appropriate action plans are developed. The Head of Medicines Management is working with the Head of Patient Safety to ensure appropriate action is taken following medication incidents. Any incidents with actual harm greater than the category of 'low harm' will be investigated. A written action plan will be produced where appropriate, and approved by the Head of Medicines Management.

- The Head of Medicines Management has produced and disseminated a Non-Medical Prescriber Policy. The team has also had input into

innovative new services to deliver medicines in the community, such as cytotoxics or intravenous diuretics.

- The pharmacy technician-led training service has been training Care Home staff since November 2011. All Care Homes within the Nottingham City boundaries will receive a visit at least annually, to train staff on General Medicines (administration, safety and handling) and Controlled Drugs regulations. In addition, nurses in Nursing Homes receive further training, tailored to their role.

- In November 2011, the pharmacy technicians also launched the Compliance Review Service to help patients get the most from their medicines. Any member of health and social care staff can refer any adult patient who is struggling with their medicines. The technicians support patients by, for example, explaining their medication regime to them; providing information on medicines; counselling on complex medicines; providing written lists of medicines; or exploring solutions for patients with swallowing, memory or dexterity problems.

For both the technician-led services, the Medicines Management pharmacists are available for support and advice.

2.3 CLINICAL EFFECTIVENESS

In last year's report this section looked at what work was being done on the NHS High Impact Actions, and progress against each is highlighted below.

High impact action number 1: Your skin matters. No avoidable pressure ulcers in NHS provided care.

This initiative has been taken forward in the following areas, with some actions underway due to be completed in 2012/13:

- All full thickness pressure ulceration that occurs has an in depth investigation known as Root Cause Analysis. These investigations generate changes that need to be made in practice and learning points. These will now be formally introduced across all of the organisation by April 2012 to help further reduce the occurrence of pressure ulcers.

- New documentation will be introduced by July 2012 which will include a screening tool for patients at risk of pressure ulceration and a SKIN bundle (Surface, Keep Moving, Incontinence, Nutrition) to ensure that appropriate pressure relief and skin care is given.

- New competency assessments for staff will be introduced by October 2012 to ensure they are appropriately trained to do pressure ulcer risk assessment and skin assessments.

- New training packages have been developed so that more staff can access training in pressure ulcer prevention. This is currently being implemented by the Tissue Viability Team who are recruiting further trainers to be able to access more staff.

- Pressure ulcer champions are being identified who can promote pressure ulcer prevention throughout the organisation and lead an awareness campaign in this will be launched at the summer CityCare live event in June 2012 for staff, carers, and community and voluntary organisations.

- The experience of patients who have had pressure ulceration has been researched by the Tissue Viability Team and this will be used to ensure that the effects on patients' quality of life is highlighted during training.

- A new pressure ulcer prevention and treatment policy and guidance will be produced by July 2012.

High impact action number 2: Staying safe – preventing falls. Demonstrate a year on year reduction in the number of falls sustained by older people in NHS provided care.

We now have a referral system that passes patient information on a daily basis to the Falls and Bone Health administration team from the Emergency Department. Access to their assessment means better clinical information can be accessed by the Falls and Bone Health Team, supporting better care.

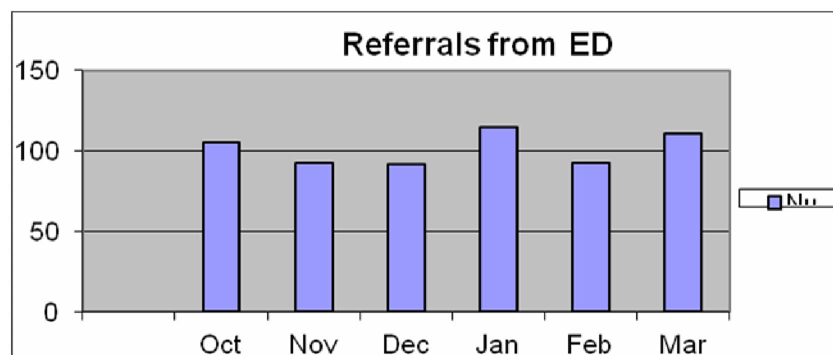


Table 3. This shows the number of referrals from the Emergency Department since October 2011. This represents double the amount of previous referrals to the team per month.

Working with commissioners and secondary care, we have streamlined the pathway for falls services. The appointment of three extra nurses to CityCare's Falls and Bone Health Team means clinics can be run in GP surgeries, enabling people to be assessed and treated closer to home.

The nurses running these Falls and Bone Health Clinics in GP practices will offer screening and advice about falls as well as referring patients into CityCare for rehabilitation and postural stability classes.

The nurse-led clinics will roll out across all City GPs from April 2012.

A new CityCare administration post has been created, working within Nottingham University Hospitals' Fracture Liaison and Emergency Departments. This will allow a referral to the Falls and Bone Health Team for a falls assessment to be included in the Fracture Liaison Service pathway.

High impact action number 3: Keeping nourished – getting better. Stop inappropriate weight loss and dehydration in NHS provided care.

Our aims for this high impact action centre on the Nottinghamshire Oral Nutritional Supplement (Sip Feed) Guidelines for Adults. Sip feeds are prescribable drinks that provide a range of nutrients, and are generally taken by mouth to supplement a patient's dietary intake.

The Sip Feed Guidelines, which incorporated the MUST tool (Malnutrition Universal Screening Tool), were developed by the group following discussions with a range of other health professionals. These were then circulated to the Area Prescribing Committee (APC) for comments, following which amendments were made and a two page quick reference guide and patient information leaflets were produced.

The amended guidelines were accepted by APC and the majority of feedback received has been very positive. The community and hospital-based Dietetic Services have had an initial joint meeting to discuss implementation across the teams, and it is expected that within the Community Dietetic Service the guidelines will be implemented by the end of 2012/13.

A multidisciplinary group will be set up to facilitate implementation of the Sip Feed Guidelines across Nottinghamshire; the group will develop a full implementation plan.

Prescribing costs are currently being monitored by the Medicines Management team, and discussions are underway to look at how the teams can work together with areas with a high spend on sip feeds, to ensure they are being used appropriately.

The number of referrals for patients requiring nutritional support has greatly increased over the past year, which has resulted in a long waiting list. A significant proportion of these referrals have been for patients who may be able to be managed instead by the Primary Health Care teams, following the approval of the Sip Feed Guidelines.

By enabling the Primary Health Care teams to manage less complex referrals, the Community Dietetic Service will be able to provide better input and on-going support to more complex patients, once implementation of the guidance is complete.

High impact action number 4: Promoting normal birth. Increase normal birth rate and eliminate unnecessary caesarean sections.

The Family Nurse Partnership is an intensive home visiting programme working with teenage parents to improve pregnancy outcomes, child health and development, and parents aspirations for themselves and their baby. The guidelines for Family Nurses are used in a structured way to support the clients and promote normal birth. These include checklists to identify any cause for concern, and topics such as healthy eating, smoking and exercise.

A recent survey of 60 clients on the programme found that 92% had normal births, which compares very favourably with the rate for the whole of the UK in 2011, which was 41.8% (www.birthchoiceuk.com).

High impact action number 5: Important Choices; Where to die when the time comes. Avoid inappropriate admissions to hospital and increase the number of people who are able to die in the place of their choice.

The Nottingham End of Life Care team have successfully implemented the Gold Standards Framework and Best Practice Principles across all care settings, including all GP practices, all Community Nursing teams, Care Homes and specialist services.

The team offer teaching, advice and support to health and social care professionals to empower staff to take end of life care forward with a positive, supportive approach.

The number of patients identified on GP palliative care registers has increased to 989 patients from 798 in April 2011; this is 93.74% against the anticipated number of expected deaths in Nottingham City. Recognising when a patient has end of life care needs is key to delivering on people's wishes. Using the principles agreed in the Nottinghamshire End of Life Care Pathway the team will continue to educate teams in end of life care.

The end of life care team will continue to support the audit of the Nottinghamshire end of life care pathway. This is an audit of community nursing and rehabilitation notes by the team using SystmOne.

A Virtual Hospice Service was launched in May 2011. In March 2012 the service had successfully cared for 48 patients, offering respite and terminal care. Patients have been admitted from GP services, Community Nursing and specialist nursing services and Acute care.

High impact action number 6: Fit and well to care. Reduce sickness and absence in nursing and midwifery to no more than 3%

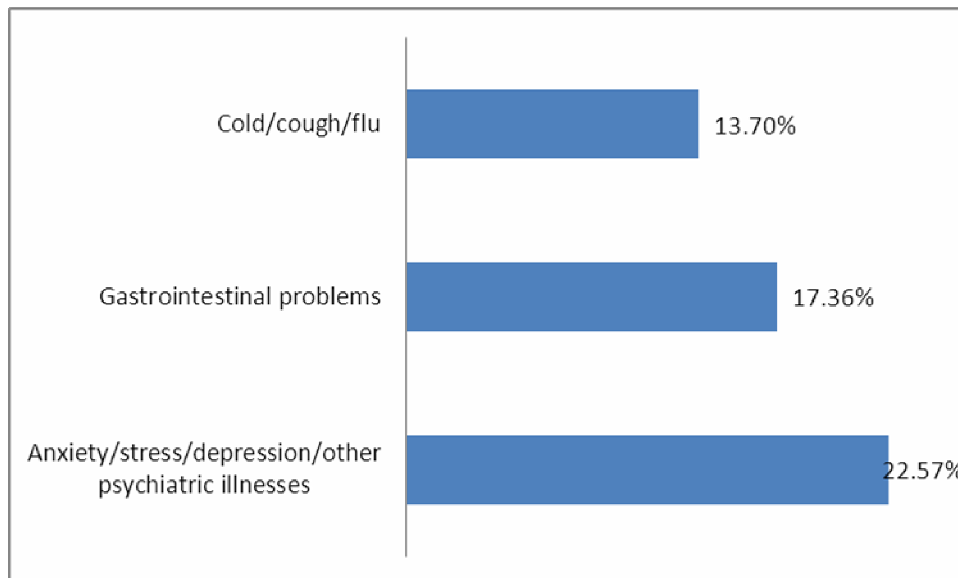
During 2011/2012 we began work to reduce sickness absence down to 3% across all services. We achieved an average rate of 4% across the organisation, and reducing this further remains an important focus for us and is also important for our staff.

To support managers and staff in managing sickness absence, the Human Resources department has developed a range of tools.

During the year we introduced weekly sickness absence reporting and we will now be improving that further by moving to electronic notification of absence. This will mean managers have real time access to information, which should help them monitor and reduce sickness absence.

During 2012/13 the newly appointed HR Business Partners will work with the service managers they support and Occupational Health to identify causes of sickness absence in areas where there are high levels, so that those causes can be addressed. Learning will be shared across the organisation.

Table 4. Sample top three reasons for sickness absence – figures for January 2012



In addition to electronic absence notification we are introducing electronic forms into other areas of HR, replacing the Electronic Staff Record. During 2012/13 we will continuously review the electronic integration of data and information.

High impact action number 7: Ready to go – no delays. Increase the number of patients in NHS care who have their discharge managed and led by a nurse or midwife where appropriate.

Our focus in this area over 2011/12 was to increase the number of patients who have their discharge facilitated by through CityCare's In-reach service and Crisis Response Team, and a pilot to enable specialist information to be available at Nottingham University Hospitals to help decision making for discharge of Chronic Obstructive Pulmonary Disease (COPD) patients.

Crisis Response Team

The Crisis Response Team was mainstreamed in June 2011, offering support in the community to help patients stay out of hospital and avoid unnecessary admissions. They offer out of hours and weekend cover, and are currently seeing an average of 130 patients per month.

Following a consultation the Crisis Response Team clinicians now work within Intermediate care to 10pm, seven days a week, to facilitate increased discharges from Nottingham University Hospitals (NUH), especially at weekends. The team's work means that patients discharged at a weekend or in the evening have their needs safely supported in their home environment.

Community In-reach pilot

The Community In-reach pilot is an arm of the Crisis Response Team. Its aim is to reduce the number of patients with a 14-day length of stay or more, and it has first focused on an ortho-geriatric ward at Nottingham University Hospitals. As of April 2012, 257 patients had been seen by the service and 250 of those have been discharged. Their average length of stay was eight days, and 85% were home within 14 days. The pilot will continue for another

year and will be rolled out to eight Health Care of the Elderly Wards if Transformation funding is received.

Patient feedback has been sought on the In-reach pilot, and comments have included:
"This is a very valuable service and I am very impressed. It was essential in getting my husband the correct treatment"

"In reach follow up was crucial in addressing mums missed fracture in hospital and ensuring that she had further rehabilitation and equipment to be managed at home"

"Really useful, service seeing us home and follow up was brilliant"

COPD discharge pilot
The Chronic Obstructive Pulmonary Disease (COPD) team have been working together with Nottingham University Hospitals (NUH) in a pilot to help ensure patients receive the appropriate care and are supported on discharge.

The team case manages up to 90 patients at one time, and systems have been put in place to automatically alert them if one of those patients is admitted to Nottingham University Hospitals. The team are then able to plan for and facilitate their discharge as soon as appropriate. A COPD Nurse Specialist attends the weekly round at the City Hospital campus, and at this they discuss these patients and their discharge.

All of these patients are seen by the COPD Team within five days of discharge, although if the Respiratory Nurse Specialists at NUH advise a visit the following day, this will take place.

Work is now underway to look at the discharge of patients who are known to and supported by the COPD team, but not actively case managed, and those who are coded as having a COPD issue but not under the care of a specialist team. We will look at ways such patients can be identified and reviewed to see what support, if any, they require from specialist services, and whether the COPD coding is accurate.

High impact action number 8: Protection from infection – Demonstrate a dramatic reduction in the rate of Urinary Tract Infections (UTIs) for patients in NHS provided care.
During 2011/12 the major priorities were as follows:
- Implement the pathway and troubleshooting guide for catheter care further to ensure it is embedded within care delivery. This will require an audit of practice to be undertaken and further work around implementation of findings.
- To implement and embed within practice the recurrent UTI management pathway.
- To start to review the hospital admissions as a result of UTIs particularly from care home environments to try and reduce the number to admissions and ensure the incidence of infections is reduced.

During 2011/12 a discharge pathway for patients from Nottingham University Hospitals (NUH) has been developed and approved by both NUH and the CityCare Infection Prevention and Control Committee.

This was launched in early 2012 within the Urology wards at Nottingham University Hospitals and with clinical staff working within CityCare. The trouble shooting guide for clinical staff to use when caring for patients with catheters has also been approved and is currently being disseminated to clinical staff.

Nottingham University Hospitals have continued to progress with the development of their Health Innovation Education Cluster funding to develop a training package for clinical staff. This has had input from CityCare's Continence Advisory and Infection Prevention and Control Services. The training package should be completed by June 2012. By standardising the general principles relating to catheter care across the health economy, patients can expect a high quality seamless service in which avoidable infections are prevented.

The recurrent UTI management pathway was agreed by the Urologists and Continence Team specialists in December and will be disseminated to all the relevant clinical teams throughout May 2012.

The approach to the third priority has been amended to a proactive approach involving a Clinical Nurse Specialist working with all the care homes in Nottingham to reduce admissions. The nurse works with the care homes on a rolling programme to undertake clinical management planning. This concentrates on staff observation, reporting and early detection of illness and infection. By training staff to use this daily documentation it will enable residents in care homes to be treated earlier and more effectively with the aim of preventing a need for hospital admission.

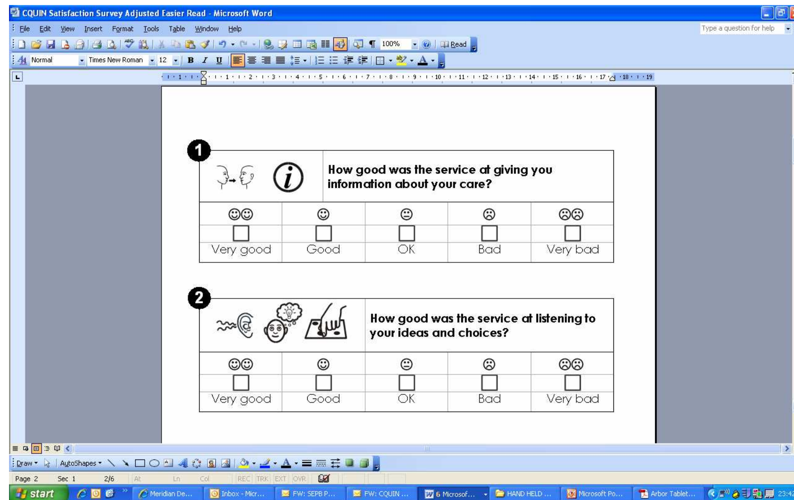
2.4 PATIENT EXPERIENCE

CityCare is committed to continued improvements in the experience of people using our services. This section highlights our progress on the key areas we felt would improve patient experience.

Patient Satisfaction Surveys and Service Improvement Action Plans

- Thirty nine of our services now regularly conduct satisfaction surveys - an increase of 12 additional services since last year
- As well as paper versions, surveys and feedback forms are also available on our website and hand held devices - increasing patient choice and real time feedback.

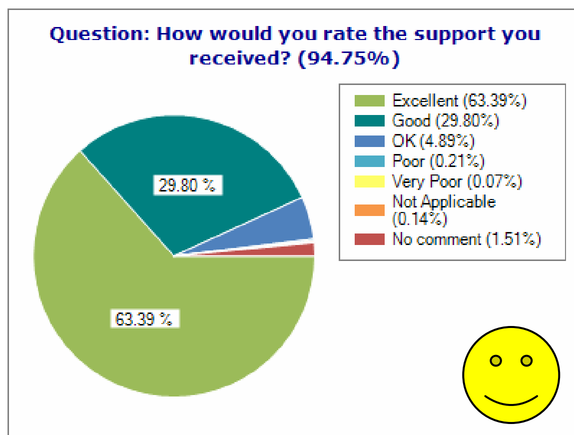
- To meet diverse needs and improve access, surveys are also available in large print, 42 languages and formats suitable for young people and people with learning disabilities (Easy Read)



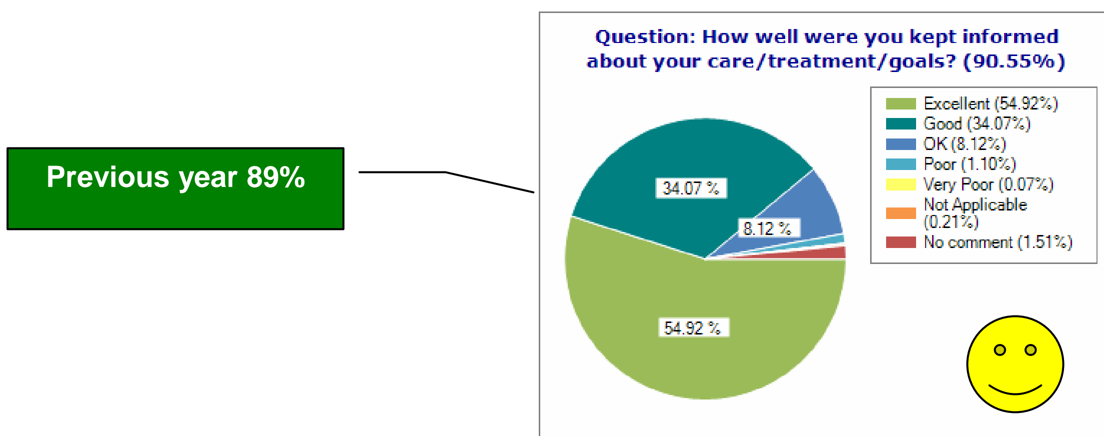
- Where satisfaction levels are lower than our 85% positive response target and/or patients suggest improvements, services use Service Improvement Action Plans.

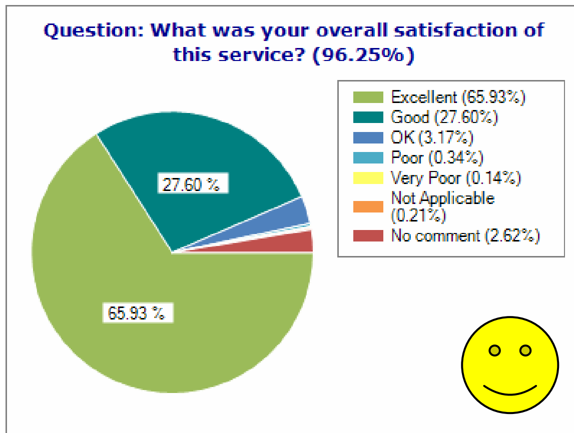
Patient Satisfaction Survey results:

	2011/12	Previous year 2010/11
Surveys completed	**1440**	**1475**



Previous year 92%





Previous year 91%

Additional questions asked: How well…	Target	Satisfaction Achieved 2011/12	Satisfaction Achieved 2010/11
Were you involved in decisions about your care?	85%	90%	88%
Were you treated with dignity and respect?		96%	92%
Were your particular needs met?		93%	92%
Was confidentiality respected?		96%	88%

What our patients tell us.

We are always pleased to hear about people's good experiences, but we also encourage and welcome suggestion for improvements. When asked, ***"What can we do to improve our service?"*** patients said….

"Nothing. The service we received was marvellous and made a real difference to our lives. Keep up the good work"

"More clinics and staff to do the job please. Staff seem to be rushed off their feet"

"Staff need to spend more time with patients"

"Nice, clean health centre, friendly, helpful staff and overall excellent service"

"A service leaflet with your contact number including who to contact in an emergency would have been useful"

"Improve signage in health centres instructing people where to collect a ticket for the service"

"I can't think of anything you could do better. The care I received was second to none. The staff were caring and helpful and went beyond the call of duty. I don't know what I would do without them"

"Improve parking and more magazines in the waiting area please"

"Excellent communication. I am so pleased an interpreter was booked. Staff were very friendly and showed respect. They explained what they were doing and why, involved my mum and listened to her"

"I wish she had called to let me know she was running late"

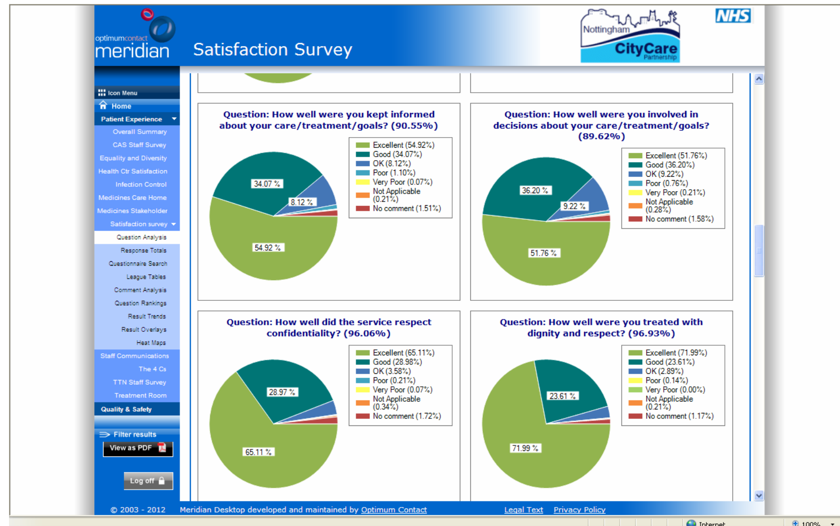
"On behalf of me and my family, we would like express our heartfelt thanks. We will never forget the quality of care and compassion you provided and would recommend the service to anyone"

Here are some of our actions we have taken following feedback:

- **Improved communication** in health centres with signs informing patients where to obtain a ticket.
- Putting on **additional clinics** responding to concerns about long waits for podiatry service.
- Delivering Podiatry, Physiotherapy and Continence clinics from Boots in the City Centre – responding to **easier access and improved choice** requests.
- Individual **service leaflets** including contact details.
- Staff encouraged divert calls to another response line when unavailable, to **improve patient access.**
- Developing **Customer Care training for staff** including measurable behavioural standards. This will be informed by patients and staff, and underpinned by organisational values, equality and diversity, and dignity and respect principles.
- Delivering a Productive Community Services Programme across all CityCare services, reducing wastage, increasing efficiencies and releasing **more time for patient care.**
- Equality Objectives including improving data collection and **staff training on equality and diversity, disability awareness and cultural competency/awareness.**

Improving Processes for Collating and Reporting Patient Experience

- Meridian Patient Feedback System and Hand Held Devices.



The switch to the Meridian Patient Feedback System has improved the performance, access, quality and reporting of patient experience data right down to individual services. Meridian is an integrated web based data system, which collates paper surveys and feedback using hand held devices and/or our website in one central data repository.

- Reporting Patient Experience
  Analysis of data from patient surveys, complaints, comments, concerns, compliments and incidents, has enhanced our understanding of the issues, themes and trends experienced by our patients and the actions we need to take.

  Patient Experience reports are fed back to services, managers, our commissioners, and our Patient Safety and Governance Committee for review and action.

- Patient Experience Groups (PEG), Members Panel and Strengthening Partnerships
  Our PEG is supported by a Non-Executive Director and feeds directly into the Board. We have also established a Members Panel and in line with our Equality Objectives we strive to recruit membership from diverse and seldom heard groups to both these forums. We have also established The Health Group, where people with learning disabilities meet to feed back views.

"I enjoy coming. I meet other people, learn about CityCare services and feel that people are listening.
I am benefiting from CityCare services. One of the clinics I attend is running from Boots in the City Centre - right on my doorstep."
PEG Member

Patient Experience Group

"It is very good, I like talking about health issues in general and I think you listen to me. It is a good way of us being able to make comments."
Roger

The Health Group

We continue to strengthen our relationships with patient/carer groups, LINks and Voluntary and Community groups. We have undertaken a series of Listening Events, targeting the above groups including Black and Minority Ethnic groups, people with learning disabilities, and carers, including Young Carers. Views have informed our Quality and Equality priorities.

Nottingham CityCare Partnership

NHS

Help us to set our Quality Priorities

Here at Nottingham CityCare Partnership, our top priority is the quality of care we provide. To help us provide even better care, we would like to understand what 'quality' means to people who use our services.

From November we will be listening to patients and carers from diverse communities about their experience of our services. These views will inform our quality priorities for the coming year, and will be reflected in our Annual Quality Account.

We would like to invite patients to our listening event where you can:

- Share your experiences of our services with members of CityCare staff
- Give your views about what quality means and what the focus should be
- Discuss your quality priorities with other patients

Our Quality Priorities Listening Event will take place in the CityCare Headquarters Boardroom on Monday 28 November 10am-12.30pm, 1 Standard Court, Park Row, Nottingham NG1 6GN

If you would like to attend this event, please contact Jonathan Wright by Wednesday 16 November on 0115 883 9603 or via email Jonathan.wright@nottinghamcitycare.nhs.uk You can also contact Jonathan to register an interest in any further events we arrange, or to be contacted via another means.

We look forward to meeting you there.

Sarah Kirkwood
Director of Governance, Nursing and Allied Health Professionals

Health at the heart of the city

"Thank you for asking us to share our views about CityCare Services. On behalf of the other carers we were pleased that you acknowledge the vital role carers play in the care of the most ill and most vulnerable. I do hope our suggestions will be used to help make improvements and do keep us informed."
Carers Federation Carer

Patient Public Engagement (PPI) Strategy

Throughout the year the views and ideas of patients, carers and communities have been collated and used to inform our PPI Strategy. This document explains what and how CityCare will engage and involve patients, the public and communities.

Mystery Shopper Patient Safety/Experience Walkabouts

To ensure the business of the organisation is informed by the experience and views of people using our services and staff, a programme of activities involving Board Members and the Senior Management Team is being developed. This will involve taking part in 'mystery

shopper' and 'walk and talk' events with services, where senior staff talk with staff and patients, and plan where improvements can be made.

2.5 PARTICIPATION IN CLINICAL AUDIT

Clinical audit is a quality improvement process. It aims to improve patient care and outcomes through a review of care against clear criteria and making changes in light of this.

During 2011/12, no national clinical audits or national confidential enquiries covered NHS services that CityCare provides, so we were not eligible to take part in any.

The reports of two national clinical audits were reviewed by CityCare in 2011/12 and we intend to take the following actions to improve the quality of healthcare provided

National Audit of Continence Care 2010/11
• Promote documenting of duration of symptoms, nocturnal symptoms, and faecal incontinence frequency through training sessions.
• Research potential standardised measures to record functional ability and cognition.
• Promote increase in rectal examinations through training and through dissemination of new clinical guidelines for Manual Removal of Faeces and Digital Rectal Examinations.
• Improve links to geriatric medicine though Geriatrician who now attends Multidisciplinary Team meetings and invite to Link Nurse Day.
• Promote assessments of Quality of Life using a validated symptom score/ standardised assessment scale by discussing use of ICIQ (currently used by the Continence Advisory Service but not District Nurses).
• Promote documenting type and cause of incontinence through training sessions.
• Practice Pharmacists to raise awareness with GPs (as part of prescribing audit of continence products) of minimising medicines which may exacerbate urinary incontinence.
• Discuss ways of recording/collating patient suggestions with District Nursing, potentially using PALS.
• Explore re-establishing user group.
• Discuss whether patient satisfaction survey used by Continence Advisory Service could be used within District Nursing.
• Promote discussions with patients/ cares on type and cause of continence through training sessions.
• Promote provision of copies of treatment plans to patients and carers through training sessions.
• Obtain details from PALS of relevant support groups and psychological/ emotional support available as part of long-term faecal incontinence management.

National Audit of Falls and Bone Health 2010/11
• To increase administration support to the existing FLS to ensure all patients referred to their service also receive a multifactorial falls

assessment through onward referral for community falls assessment
• Emergency Department to receive commissioning support to enable them to identify all patients over the age of 65 years who have had a fall and are seen at ED. These patients will be referred to the city single point of access for further community falls and bone health assessment
• Nottingham CityCare Partnership Falls and Bone Health Service will receive commissioned support to employ nurses to work within both the service and GP practices to identify those patients who are at risk of falls and fracture. This will build on the work from the primary care initiative Better Bones Better Balance project which identifies and supports management of people at risk of falls and osteoporosis.

The reports of 12 local clinical audits were reviewed by CityCare in 2011/12 and we intend to take the following actions to improve the quality of healthcare provided:

Local Falls Service Audit 2010/11	• (Joint report with National Audit of Falls and Bone Health therefore same actions as above)
Record Keeping Audit 2010/11	• Chase outstanding reports and outcomes forms through Assistant Directors. • Set up a time-limited group to discuss and action findings of the audit, including reviewing trends from action plans to identify any action required at organisational level, and identifying changes needed to the audit tool/ guidance to ensure clarity and consistency of results. • Sub-group to report to Governance Compliance Group.
Resuscitation Audit 2010/11	• Report to be presented to the Governance Committee. • Audit information for incidents during 2011/12 to be presented as they occur and in an annual report.
Leg Ulcer Clinics Infection Prevention and Control Audit 2010/11	• To discuss with Estates the need to move the hopper into a dirty utility that can be easily accessed by the clinic. To discuss recommendations in the interim regarding use of the hopper to reduce the risk of infection. • Rooms to have the clutter removed prior to clinics starting and liaise with Health Centre Managers for ongoing issues. More appropriate rooms identified as a long term plan • To highlight how the patient trolleys are to be used and decontaminated after each patient by discussing in locality feedbacks and Team Leads meeting. • Task group already in place reviewing all equipment including that in the clinics • Ensure all staff have completed the hand hygiene audit tool. Highlight good hand hygiene principles at locality meeting. • Ensure wound care packs and sterile gloves are available in the clinic. Aseptic Non- touch technique to be applied when performing wound care. • Ensure couch roll is on a dispenser.

	• Date all creams and ointments once opened and discard after one month. • Ensure all equipment stored on the larger trolley and individual patient equipment stored on the small trolley when required to be at the point of care. • Task group in place reviewing documentation and record Keeping. • Ensure adherence to the Waste policy and liaise with Health Centre Manager for larger bins or more frequent bin emptying. • To ensure all sealed bags to be stored in the waste compound and not in the corridors. • Ensure core care plans have infection control principles included. Ensure patients with known infections have a care plan identifying the infection and proposed treatment plan. Ensure the alert facility on SystmOne is used effectively to identify patient has a known infection. • To establish a workable process to record samples taken and follow up of results
Health Visitors Supervision Audit 2010/11	• Administration staff to liaise with Business Team in order to consider revising database to incorporate alert system for files breaching timescales. • Safeguarding Children Nurse Specialists to ensure that database reviewed prior to supervision sessions in order that files are supervised within timescales. • Address at Team Meeting and at individual supervision sessions to increase awareness that information needs to be recorded. • Documentation revised to incorporate staff identification information. • Address at Team Meeting and at individual supervision sessions to increase awareness that information needs to be recorded. • Address at Team Meeting and at individual supervision sessions to increase awareness of correct documentation. • Safeguarding Children Nurse Specialists to ensure that High Support Files taken to supervision sessions in order that all files reviewed within timescales. • Address at Team Meeting and at individual supervision sessions to ensure that photocopying completed and documentation attached to High Support Files for administration staff to file.
Hand Hygiene Audit 2010/11	• Results to be shared at the following committees: Infection Prevention & Control, Patient Safety, Clinical Governance. • All staff who have direct contact with patients/clients to complete the hand hygiene session on an annual basis.
Crisis Response Team Stakeholder Audit 2011/12	• Changes to the existing Single Point of Access have been agreed for implementation early 2012. This will include an automated facility within SPA which will allow referrers to press 1 to go straight through to the Crisis Response Team will be implemented from 16 January.

	• A voicemail service on all of the co-ordinators' phones is now active. This will ensure any referrers can leave a message which coordinators can then access and follow up.
Medicines Management of Controlled Drugs Audit 2011/12	• Review and update current CD policy. • Redesign audit to more accurately reflect CD use by CityCare services. • Carry out site visits to service locations to investigate the use of CDs. • Obtain SOPs from services who claim to have them. • Devise SOP templates for use by services to cover the common processes like destruction, transport etc. • Find out the details of what restrictions services place on who is allowed to order, receive, and access CDs. • Ensure CD incidents are investigated by MMT. • Devise a rolling programme of CD training for the services that do handle CDs.
MRSA Audit 2011/12	• Alert to be set up on patient records that easily informs health professionals if a patient has an infection eg MRSA/ C Diff. • More detailed documentation is required of screening carried out, including which sites are screened each time, results from these screens and the outcome of these. Whether it be treatment required or more screens, staff need to be informed through training/ feedback. • Patients' knowledge of diagnosis, consent to treatment and treatment outcomes is rarely documented within the patient records. Possible templates to be set up so staff have a prompt of what is expected in the documentation. • It is not being documented in the patients records what stage of the MRSA process the patient is at, be it initial MRSA screen, decolonisation treatment or, post treatment screens. • Patients are not being informed how to use the decolonisation treatment. Template to be set up to prompt staff what to tell patients to do in regard to their treatment. Staff will have to sign to say that they have given the patient the correct information. • Health professionals are not documenting that post treatment screens have to be taken 48 hours after the last day of treatment. This again could be on a template that is signed when the information is given. • Health professionals are not documenting when decolonisation treatment has been repeated. This can also be put on a template to prompt staff. • Patients are not receiving information about MRSA when they remain colonised. Infection Control Team to ensure that leaflets are available for all health professionals. These can be translated into different languages as required. • When antibiotics are prescribed, it is not documented in

	the patient records - Record keeping training
Environmental Infection Control Audit 2011/12	• Blinds have looped cords and chains and are not secured out of the reach of children and vulnerable adults - Fittings to be applied to walls to allow for this and a reminder to all staff to ensure they are used. Health Centre Managers to clarify that issue has been resolved. • Other areas of concern were that health centres did not have proper sluices and those that did have only partial compliance. This is being reviewed by Estates and Facilities. • Concerns raised with the cleanliness of kitchen areas, and the refrigerators not being cleaned properly, Head of Infection Prevention and Control to look at creating a cleaning checklist for kitchen areas.
School Nurse Child Protection Audit 2011/12	• Reports to be written for all initial and review case conferences • Home visits to be encouraged particularly in school holidays as children not seen daily by school • Children on a Child Protection Plan should be seen a minimum of termly unless otherwise stated in the plan
Vaccine Storage Audit 2011/12	• For the audit tool to be reviewed and to be targeted to Adults and Children's Services clinical leads. The responsibility for ensuring vaccines are stored at the correct temperature is the responsibility of nurses within the services where vaccines are administered. • Health Centre Managers to ensure there are staff trained and deputies in place for checking vaccine fridge temperatures daily. • Team Managers to ensure that staff have access to a cool box. • Any problems identified with vaccine fridges should be reported as incidents – reminders to go out to staff. • Review current location of vaccine fridges and provide updated list to estates. • Review role of community pharmacy in relation to vaccine fridge storage

Patient Case Study
Responding to complaints

Claire Gardner uses the Phlebotomy service at The Mary Potter Centre in Hyson Green. In September 2011 she went to have a fasting blood test. Upon arrival Claire was given ticket number 3 and the receptionist said that the number went up to 35. What the receptionist did not say was that the current number was 19, so there were some 18 or so people before her in the queue. There was no mention of delays at reception.

Claire said: "If I had realised I would have to wait for two hours, I would have gone somewhere else like the City Hospital.

"There was around 15 minutes to wait between patients. When I was finally called I found it very difficult to walk as I suffer from arthritis and had been sitting for a very long time. I then saw a notice on the clinic door stating that there was only one phlebotomist, and delays should be expected – but it was too late to go elsewhere by then."

Claire raised this as a complaint with CityCare, and we carried out a full investigation.

Since then Claire has been for another appointment at The Mary Potter Centre and was happy to report that there is now a sign you can see when you arrive, that clearly states the ticket information and waiting times.

Claire added: "Waiting times have also been improved since I raised the issue. I'm happy to go back to the clinic, and I'm pleased with the way CityCare responded to my complaint."

2.6 PARTICIPATION IN CLINICAL RESEARCH

Clinical Research influences the safety and effectiveness of medications, devices/equipment, diagnostic products, treatments and interventions intended for patients. These may be used for prevention, treatment, diagnosis or for relief of symptoms in a disease.

The number of patients receiving NHS services provided or sub-contracted by CityCare in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 70.

Participation in clinical research demonstrates CityCare's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

2.7 GOALS AGREED WITH COMMISSIONERS

Commissioning for Quality and Innovation (CQUIN)

CQUIN is a payment framework which enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals.

Use of the CQUIN payment framework
Commissioning for Quality and Innovation (CQUIN)
CQUIN is a payment framework which enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals.

Use of the CQUIN payment framework
During 2011/12 1.5% of Nottingham CityCare Partnership's income was conditional on achieving optional quality improvement and innovation goals agreed between CityCare and NHS Nottingham City, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The table below (see pdf document) describes the detail of the targets set by our commissioners NHS Nottingham City Primary Care Trust (the local targets) and also those set by NHS East Midlands (the regional targets). In order to achieve the targets we set up a robust process with a task and finish team consisting of the CQUIN leads in each area, and staff from the Business Unit. Most importantly the frontline staff embraced the work involved and this resulted in an excellent outcome with most goals set achieved. We are pleased with the overall achievement and will be looking to improve even further next year.

2.8 STATEMENT ON DATA QUALITY

The main focus for Data Quality Improvement Plans (DQUIP) in 2011/2012 has been to increase the detail of activity broken down by Lead commissioner/Associate commissioner and by GP Cluster and Practice. The main focus in quarters 2-4 has been to provide the information in a pivot table so that commissioners and GP Clusters can interrogate the data and filter the data flexibly to answer any queries, and can tailor the data in the way they need by service, by Practice, by Cluster and over time.

With the introduction on the Community Information Data Set (CIDS) the main driver for the DQUIP will now be the capability to meet the CIDS requirements, while responding to any further flexibility and additional functionality requested in the way that activity can be presented to commissioners.

NHS Number and General Medical Practice Code Validity

Nottingham CityCare Partnership did not submit records during 2011/12 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data, as this is not applicable to us as a community service.

Information Governance Toolkit attainment levels

The Nottingham CityCare Partnership Information Governance Toolkit Assessment Report for 2010/2011 scored 74% overall and was graded Green 'Satisfactory'.

The Information Governance Toolkit Assessment was audited by East Midlands Internal Audit Service and received xxxxxx Assurance. Updated by LW, remaining info tbc

Patient Case Study
Responding to patient consultations

A consultation into a move of a Continence Advisory Clinic resulted in extra benefits for patients.

The move was proposed following a review of the premises used at Ropewalk House near the city centre and patient feedback through satisfaction surveys which included comments like "the worst part is ringing the bell and standing at the door marked Continence". A risk assessment also showed uneven floor surfaces, which would have meant the service having to relocate for up to 6 months whilst repairs where undertaken.

Taking into account access, public transport, parking, signage and the clinic space required, it was proposed that the present department and clinics move to Sherwood Rise Health Centre. All other clinics remained at their current venues.

The consultation with patients showed that the move to Sherwood Rise was supported for reasons such as "It will be easier to get to and the buses stop outside", but it also raised calls for a city centre clinic location: "The central location is the key – central Nottingham, and "City Centre location, easy to access".

This feedback was key in the decision to run Continence Clinics from Boots in the Victoria Centre once the agreement was in place for CityCare to use the clinic rooms. This means we can offer clinics in the heart of the city centre, and importantly, dignity and respect have been improved as there is no signage indicating to general shoppers what clinic is being attended.

Since moving, both Sherwood Rise and Boots clinics have been busy and feedback has been positive overall. A feedback survey will be carried out in the near future to gauge views on the moves.

2.9 WHAT OTHERS SAY ABOUT THE PROVIDER

Statement on Care Quality Commission (CQC) registration

The CQC is the independent inspector and regulator for health and social care organisations, ensuring we meet essential standards in quality and patient safety.

Nottingham CityCare Partnership is required to register with the Care Quality Commission and its registration status for the year 2011/12 was Registered. Nottingham CityCare Partnership registered without condition to provide its regulated activities across its registered locations.

The Care Quality Commission has not taken enforcement action against Nottingham CityCare Partnership during April 2011 - March 2012.

Full details of our registration can be found on the Care Quality Commission on line directory here

Clinical coding error rate

Nottingham CityCare Partnership was not subject to the Payment by Results clinical coding audit during April 2011/March 2012 by the Audit Commission.

Part 3 – Priorities for Quality Improvement 2011/2012

This year we have again grouped our quality priorities under the three headings of Patient Safety, Clinical Effectiveness, and Patient Experience. Together these groups address whether our patients feel '*cared for, safe and confident in their treatment'.*

To put together our priorities we engaged with staff, NHS Nottingham City, the Local Authority Health Scrutiny Committee, the Nottingham Local Improvement Network (LINk), our Patient Experience Group, our Health Group for adults with learning disabilities, the Carers Federation, attended a Community in Unity consultation event, and held a listening event for young carers. We also looked at themes emerging from patient satisfaction surveys.

3.1 PATIENT SAFETY

Medicines Management and medication safety was highlighted as a quality priority in most of the listening events we held when developing this report.

The Medicines Management team has been developed over the last year, and now includes Pharmacists and Pharmacy technicians.

In order to improve Medicines Management across CityCare, the team's main priority for 2012/13 is to identify and address any staff medication training needs.

Training will be introduced for new staff, as part of the staff induction programme. General medication training will be targeted to teams with high proportions of staff providing care in people's own homes, for example on managing medicines safely, documentation and dangerous medicines.

Tailored training will be developed to promote best practice with medicines within specialist clinical teams. Uptake of training will be monitored through the Workforce Development Team and reported to the Health and Safety Committee.

Managers will be advised on how they can meet the Care Quality Commission Essential Standard on Medicines Management. This will be measured through evidence placed on the 'Health Assure' monitoring tool.

The Medicines Management team will ensure all staff have access to information on medicines via the intranet, and know how to contact them for advice.

The team will also review the medication-related policies and procedures.

Another priority is to adapt and develop the newly-introduced technician-led services to improve medicines management quality and safety in care homes and people's own homes:

- Training of care home staff - All Care Home staff attending training will be invited evaluate the training sessions. Care Home managers will also be invited to feed back. The team will respond to constructive staff comments to adapt training packages where appropriate. They will aim to tailor the more general training to the type of Care Home (for example dementia or learning difficulties).
- Providing Medication Compliance Reviews for patients in their own home - We will ensure that patients, carers, referring staff and GPs are invited to feed back on the service offered, and any constructive ideas and comments will be acted on. The service will be extensively marketed to ensure all appropriate patients are referred.

Progress on the two above initiatives will be monitored and reported to the Governance Committee quarterly.

3.2 CLINICAL EFFECTIVENESS

Following feedback from our various listening events, we have set a priority for 2012/13 of **i**mproving clinical training, supervision and on-going training, including disability, cultural and dementia awareness training.

We will:

- Review our current essential and statutory training provision to ensure staff are offered training that is appropriate for their roles.
- Review the induction workbook for new staff to include disability, cultural and dementia awareness training.
- Plan and develop new starter induction days that cover clinical training to ensure new staff receive basic training, including Basic Life Support, Conflict Resolution, and Equality & Diversity. New staff will receive their induction within eight weeks of starting in their role.

- Plan, develop and deliver clinical supervision training, aimed at individuals within teams wishing to become supervisors or facilitators, to ensure that staff have access to group supervision.
- Review and refresh Equality and Diversity training to include disability, cultural, and dignity and respect awareness.
- Plan and provide dementia training at a basic and more advanced level using varied teaching methods.
- Review on-going training methods and offer alternative learning opportunities to staff.
- Scope the opportunities to use action learning sets to discuss current training provision and how staff would like to receive training.

Progress will be monitored and be measured through:

- An annual review of training matrix and essential and statutory training.
- Regular reports on essential and statutory training to ensure compliance
- Evaluation of training sessions and methods including the induction workbook.
- Monitoring attendance on the Oracle Learning Management (OLM) system and feeding back to managers.

Progress will be reported regularly to the Board as part of the Workforce Report.

3.3 PATIENT EXPERIENCE

In our look back section we have outlined many ways in which we respond to patient feedback on their experience of our care.

As a priority for 2012/13 we have identified the need to develop customer care training for all CityCare staff. Our customer care is a topic often referred to in comments, compliments, concerns and complaints.

Customer care also covers many areas raised in our listening events when planning our quality account for this year, such as listening and understanding, dignity and respect, involving people in their care and care plans, and supporting people including young carers.

A working group has been brought together to develop the training, and we are looking at good practice by other organisations to learn from them. We will also collate patient experience feedback and views through our Patient Experience Groups, patient surveys and other routes to inform the training development. We will also use the NHS Constitution and any other national guidance available.

The working group will develop the behaviours linked to our values that we and our patients expect from CityCare, and these will be incorporated into the training.

In addition to delivering face-to-face training to all staff, the values and behaviours will be an ongoing theme in our internal communications, keeping staff awareness of them high at all times, across the whole organisation.

We will monitor the uptake of the training and staff will be asked to evaluate the training, and suggest ways we can improve and follow up on the training.

We will also monitor the number of concerns and complaints relating to dignity and respect and not being involved, and hope to see a reduction.

We will monitor patient survey comments indicating satisfaction levels in terms of being involved in patients and carers in care plans, dignity and respect.

We will also look for ongoing feedback on our services from our Patient Experience Groups.

Part 4 – What other people think of our Quality Accounts

4.1 Commissioning Primary Care Trust – NHS Nottingham City
4.2 Local Involvement Network (LINk)
4.3 Local Authority Overview and Scrutiny Committee
(Text to be inserted once the document has been seen by the above for assurance)

Part 5 – Our commitment to you

This Annual Quality Account has featured a review of 2011/12 and a look forward to 2012/13. It gives not only an overview of some of our quality achievements but also highlight the areas where we know we need to improve.

Quality, measured through patient safety, clinical effectiveness and patient experience (or patients feeling cared for, safe, and confident in their treatment), remains the cornerstone of our services.

Throughout the year, across CityCare we will encourage patient feedback, and act on that feedback to improve our services.

We would like to thank all the stakeholders, patient and community groups who gave their feedback and suggestions for the content of this report (see page xx), and thanks also to all the staff involved in producing this document.

We welcome feedback on this report and our work on our quality priorities. If you would like to give us your thoughts on this report, or get involved in the development of next year's report, please contact Head of patient and Public Involvement Shahnaz Aziz on 0115 883 9678 or email shahnaz.aziz@nottinghamcitycare.nhs.uk or write to PALS at Freepost RSSJ-YBZS-EXZT, Patient Advice and Liaison Service, Nottingham CityCare Partnership CIC, 1 Standard Court, Park Row, Nottingham, NG1 6GN.

Responding to patient consultations

A consultation into a move of a Continence Advisory Clinic resulted in extra benefits for patients.

The move was proposed following a review of the premises used at Ropewalk House near the city centre and patient feedback through satisfaction surveys which included comments like “the worst part is ringing the bell and standing at the door marked Continence”. A risk assessment also showed uneven floor surfaces, which would have meant the service having to relocate for up to 6 months whilst repairs where undertaken.

Taking into account access, public transport, parking, signage and the clinic space required, it was proposed that the present department and clinics move to Sherwood Rise Health Centre. All other clinics remained at their current venues.

The consultation with patients showed that the move to Sherwood Rise was supported for reasons such as “It will be easier to get to and the buses stop outside”, but it also raised calls for a city centre clinic location: “The central location is the key – central Nottingham, and “City Centre location, easy to access”.

This feedback was key in the decision to run Continence Clinics from Boots in the Victoria Centre once the agreement was in place for CityCare to use the clinic rooms. This means we can offer clinics in the heart of the city centre, and importantly, dignity and respect have been improved as there is no signage indicating to general shoppers what clinic is being attended.

Since moving, both Sherwood Rise and Boots clinics have been busy and feedback has been positive overall. A feedback survey will be carried out in the near future to gauge views on the moves.