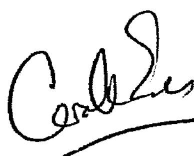
NOTTINGHAM CITY COUNCIL
HEALTH SCRUTINY PANEL

Date: Wednesday 29 May 2013

Time: 1.30pm (1pm pre-meeting for all Panel members)

Place: LB 31 at Loxley House, Station Street

Councillors are requested to attend the above meeting on the date and at the time and place stated to transact the following business.



Deputy Chief Executive/Corporate Director for Resources

Overview and Scrutiny Co-ordinator: Jane Garrard direct dial – 0115 8764315

AGENDA

1	**APPOINTMENT OF VICE CHAIR**	
2	**APPOINTMENT OF LEAD HEALTH SCRUTINY COUNCILLOR**	
3	**APOLOGIES FOR ABSENCE**	
4	**DECLARATIONS OF INTERESTS**	
5	**MINUTES** To confirm the minutes of the last meeting held on 28 March 2013	Attached
6	**HEALTH SCRUTINY PANEL TERMS OF REFERENCE** Report of Head of Democratic Services	Attached
7	**'COMMUNITY CASE FINDERS' HOSPITAL DISCHARGE** Report of Head of Democratic Services	Attached
8	**ADULT INTEGRATED CARE** Report of Head of Democratic Services	Attached

9	**CITYCARE PARTNERSHIP QUALITY ACCOUNT 2012/13** Report of Head of Democratic Services	Attached
10	**WORK PROGRAMME** Report of Head of Democratic Services	Attached
11	**DATES OF FUTURE MEETINGS** The Panel to consider meeting on the following Wednesdays at 1:30pm 2013 - 24 July, 25 September, 27 November 2014 - 29 January, 26 March	

CITIZENS ATTENDING MEETINGS ARE ASKED TO ARRIVE AT LEAST 15 MINUTES BEFORE THE START OF THE MEETING TO BE ISSUED WITH VISITOR BADGES.

IF YOU ARE UNSURE WHETHER OR NOT YOU SHOULD DECLARE AN INTEREST IN A PARTICULAR MATTER, PLEASE CONTACT THE OVERVIEW AND SCRUTINY CO-ORDINATOR SHOWN ON THIS AGENDA, IF POSSIBLE BEFORE THE DAY OF THE MEETING, WHO WILL PROVIDE ADVICE IN THE FIRST INSTANCE.

THERE WILL BE A PRE-MEETING FOR ALL PANEL MEMBERS IMMEDIATELY PRIOR TO THE MEETING AT 1PM

Agenda, reports and minutes for all public meetings can be viewed online at:-
http://open.nottinghamcity.gov.uk/comm/default.asp

NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY PANEL

MINUTES

of the meeting held on **28 MARCH 2013** at Loxley House from 11.00 am to 12.25 pm

✓	Councillor G Klein	(Chair)
	Councillor T Molife	(Vice Chair)
✓	Councillor M Aslam	
✓	Councillor M Bryan	
	Councillor E Campbell	
	Councillor A Choudhry	
✓	Councillor E Dewinton	
✓	Councillor B Ottewell	
✓	Councillor S Parton	
	Councillor T Spencer	

✓ indicates present at meeting

Also in attendance

Andrew Hall	-	Acting Director of Health and Wellbeing Transition	- NHS Nottingham City/ Nottingham City Council
Jane Garrard	-	Overview and Scrutiny Co-ordinator	) Nottingham City Council
Mark Leavesley	-	Constitutional Services Officer	)
Matthew Mitchell	-	East Midlands Area Manager	- Nottinghamshire Healthcare NHS Trust

44 APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors Campbell, Choudhry, Molife and Spencer.

45 DECLARATIONS OF INTERESTS

No declarations of interests were made.

46 MINUTES

RESOLVED that the minutes of the last meeting held on 29 January 2013 be confirmed and signed by the Chair.

47 NHS TRANSITION ARRANGEMENTS

(a) Report of Head of Democratic Services

Consideration was given to a report of the Head of Democratic Services, briefly summarising the transition to date.

RESOLVED that the report be noted.

(b) Update by Andrew Hall, Acting Director of Health and Wellbeing Transition

(i) Transfer of public health functions to the local authority

- o the necessary arrangements were in place for the local authority to take on its public health responsibilities from 1 April 2013;

- o the majority of public health contracts had been agreed by the Leader / Executive Board Commissioning Sub-Committee and transferred to the local authority. Subject to agreement regarding its urgent nature from the Chair of Overview and Scrutiny, the contract with Nottingham CityCare Partnership would be signed that day and there was ongoing discussion around the final Nottingham University Hospitals Trust contracts (hopefully to be finalised within the next week or so);

- o the Leader had signed-off all spend as appropriate;

- o Appointments and Conditions of Service Committee had agreed the appointment of Dr Chris Kenny as Director of Public Health, for a period of 12 months from April 2013, which would be a joint post with the County Council;

- o the Secretary of State had now issued guidance on the transfer of public health staff to the local authority. Staff consultation had been underway since January 2013 and where appropriate staff were transferring into existing Council departments, for example procurement.

(ii) The establishment of HealthWatch

- o a Chair (Martin Gawith) and Vice-Chair (Adele Cresswell) had now been appointed, and other positions on the Board were being recruited to;

- o the Board would be appointed for an interim period, with a view to holding elections for a permanent Board, to be in place for the 2013/14 financial year. The constituency for elections would be members of HealthWatch and interested individuals engaged with the Health and Social Care Network.

- o HealthWatch Engagement and Liaison Partnership (HELP) had been appointed to support HealthWatch Nottingham;

RESOLVED that

(1) information regarding the Healthwatch election process be forwarded to Panel members; and

(2) the Chair and Vice-Chair (HealthWatch) be invited to attend the May 2013 meeting.

(iii) NHS Nottingham City Clinical Commissioning Group (CCG)

- o the CCG had been authorised and was on track to go live from 1 April 2013.

(iv) Health and Wellbeing Strategy

- consultation on the Strategy closes in May, and it would be submitted for approval to the June 2013 Health and Wellbeing Board meeting.

48 EX-SERVICE PERSONNEL – MENTAL HEALTH ISSUES

(a) Report of Head of Democratic Services

Consideration was given to a report of the Head of Democratic Services briefly summarising the mental health issues affecting ex-service personnel, and including a leaflet entitled 'Nottinghamshire Ex-Armed Forces and Families Partnership'.

RESOLVED that the report and leaflet be noted.

(b) Discussion with Matthew Mitchell, Nottinghamshire Healthcare Trust regarding Nottinghamshire Veterans Partnership

From a presentation by Matthew Mitchell and subsequent questions and discussion, the following evidence was gathered:

- the Veterans Partnership was set up 2 years ago following recognition by Nottinghamshire Healthcare Trust that ex-service personnel were a particular group with issues around accessing mental health trauma services. Working with partners it was then recognised that there were also issues in accessing other services, such as housing and social care. While most ex-service personnel transfer to civilian life without any problems and support services are available if needed, there were issues around access and engagement;

- there were currently over 20 partner organisations involved with the Partnership, including the City and County Councils, Framework, Royal British Legion and Rethink. Ex-service personnel were involved in providing support to service users and Chetwynd Barracks were informing returning personnel of the services available (and assessing prior to discharge if any problem was evident);

- it was often the families of ex-service personnel, rather than they themselves, that contacted the Partnership regarding issues, the majority of which were about substance misuse, finance, mental health or housing;

- when an organisation in the Partnership was contacted by an individual, an initial assessment was completed and information was passed to other relevant partners, ensuring a 'joined-up' provision of services;

- across Nottinghamshire the Partnership dealt with approximately 3000 cases per year, mostly referred from the Royal British Legion;

- most cases dealt with were relatively straight forward but figures for the first quarter of 2013 showed 16 particularly complex cases relating to mental health issues. 50% were diagnosed with PTSD, 90% had a history of substance misuse and over 75% had housing problems. Of these 16 cases,

14 were not already known to Nottinghamshire Healthcare Trust. All 16 cases were stabilised and transferred to mainstream services;

- a large proportion of problems stem from the fact that people joined the Forces at 16/17 years of age and stayed in for 20/30 years, therefore not having any real knowledge of how to access services, such as banking or housing, when they left the Forces. Also, when in Service, if personnel became unwell they would go directly to the Medical Officer, whereas when they had left the Service, it could take weeks to get an appointment with NHS health services, assuming they had organised registering with a surgery/health centre;

- sometimes ex-service personnel were reluctant to access support services because of a sense of mistrust and feeling that the impact of their military experience would not be understood. One way of addressing this had been to involve ex-service personnel in delivering support and one of the mental health nurses is a veteran themselves;

- Chetwynd Barracks does provide information about available support when Service personnel leave but this can get lost within the vast amounts of information provided and often issues do not arise until 10-15 years later in response to a specific trigger incident. If individuals leave with a medical discharge then a pre-release assessment was completed and jointly managed;

- GPs should be aware of the Partnership and support available but more publicly needed to be done. This would take place during the coming year;

- although it could be difficult to assess the level of need, there was capacity within the system to cope with current understanding of need within Nottinghamshire. There was likely to be a rise in Service leavers due to impending redundancies (as part of the proposed Armed Forces restructure), but the rise in mental health issues may not happen for up to 10 years (dependent on how those leavers coped with civilian life);

- there was no extra funding available to support the work of the Partnership;

- there were still some gaps which had been identified and plans were in place to address these. Areas for improvement included developing specialised trauma services for veterans; support for those with a criminal justice history and whether, in some cases, offenders could be referred to support services rather than being imprisoned; further development of peer support and advocacy as a more effective referral route; and scoping the potential to utilise inpatient substance misuse services. Consideration was also being given to whether the model could be transferred to other locations.

RESOLVED

(1) that the thanks of the Panel to Mr Mitchell for his attendance be recorded;

(2) that as the Nottingham Veterans Partnership was providing a comprehensive service in signposting to support available and plans were in place to address identified gaps, the Panel agreed that no further

scrutiny, in regard to mental health issues of ex-service personnel and their families, was required at the present time.

49 FRANCIS ENQUIRY: ISSUES ARISING FOR HEALTH SCRUTINY

Consideration was given to a report of the Head of Democratic Services briefly summarising the implications for health scrutiny arising from the findings of the Mid-Staffordshire NHS Foundation Trust Public Inquiry (the Francis Inquiry) into care at the Stafford Hospital during 2005 and 2008.

It was stated that in light of recommendations contained in the report regarding scrutiny (numbers 47, 119, 147, 149 and 150), this Panel needed to ensure that it was more challenging and proactive and that this was evidenced through clear and comprehensive minutes.

RESOLVED

(1) that the Panel supported the creation of a training programme for all City Councillors dealing with scrutiny of health issues (Health Scrutiny Panel and Joint City/County Health Scrutiny Committee members);

(2) that the Panel agreed that a more focussed and in-depth scrutiny of issues would ensure more robust outcomes.

50 WORK PROGRAMME 2013/14 (DRAFT)

Consideration was given to a report of the Head of Democratic Services, copies of which had been circulated.

RESOLVED that

(1) subject to the following, the draft work programme for the municipal year 2013/14, be approved:

(i) removal of 'Any Qualified Provider' from May 2013;
(ii) inclusion of Nottingham CityCare Partnership Quality Account 2012/13 (May 2013);
(iii) inclusion of Nottingham CityCare Partnership Quality Account 2013/14 (January and May 2014);
(iv) inclusion of HealthWatch Nottingham (May 2013);
(v) inclusion of Integration of Health and Adult Social Care (May 2013);

(2) the Chair of Health Scrutiny Panel contact the Nottingham City Clinical Commissioning Group regarding concern about GP waiting times with a view to potentially including an item on the future work programme.

HEALTH SCRUTINY PANEL
29 MAY 2013
HEALTH SCRUTINY PANEL TERMS OF REFERENCE
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To make sure all members of the Health Scrutiny Panel are aware of the terms of reference for the Panel and its implications for the operation of the Panel during the year.

2. Action required

2.1 The Panel is asked to note the terms of reference for the Health Scrutiny Panel.

3. Background information

3.1 On 20 May 2013 Council is due to establish the Health Scrutiny Panel and agree its terms of reference. The terms of reference (pending agreement by Council) is attached at Appendix 1.

3.2 The main changes to the terms of reference from 2012/13 are:

a) The Panel is a scrutiny committee in its own right (not a sub-committee of Overview and Scrutiny Committee as previously) and holds all the overview and scrutiny roles and responsibilities for matters within its remit.

b) The Panel's remit has been expanded to include social care matters. This reflects increasing integration of health and social care, feedback from colleagues and councillors and learning from other local authorities.

c) To reflect the enhanced statutory health scrutiny powers as set out in the Health and Social Care Act 2012, expanding the scope of health scrutiny to include all 'relevant health service organisations', including providers of NHS and public health services commissioned by clinical commissioning groups, local authorities and the NHS Commissioning Board, including providers in the independent and third sectors.

d) To reflect the changes arising from the Health and Social Care Act 2012, in particular the establishment of the Health and Wellbeing Board and Healthwatch.

4. List of attached information

4.1 The following information can be found in the appendices to this report:

Appendix 1 – Health Scrutiny Panel Terms of Reference

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Report to Full Council meeting held on 20 May 2013

7. Wards affected

All

8. Contact information

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Health Scrutiny Panel Terms of Reference

(a) To set and manage its work programme to fulfil the overview and scrutiny roles and responsibilities in relation to health and social care matters, including, for matters within its remit, the ability to:

   i. hold local decision-makers, including the Council's Executive, to account for their decisions, action and performance;
   ii. review policy and contribute to the development of new policy and the strategy of the Council and other local decision-makers where it impacts on Nottingham residents;
   iii. explore any matters affecting Nottingham and/ or its residents;
   iv. make reports and recommendations to relevant local agencies with respect to the delivery of their functions, including the Council and its Executive;

(b) To exercise the Council's statutory role in scrutinising health services for the City in accordance with National Health Service Act 2006 as amended and associated regulations and guidance;

(c) To engage with and respond to formal and informal consultations from local health service commissioners and providers;

(d) To scrutinise the commissioning and delivery of local health and social care services to ensure reduced health inequalities, access to services and the best outcomes for citizens;

(e) To hold the Health and Wellbeing Board to account for its work to improve the health and wellbeing of the population of Nottingham City and to reduce health inequalities;

(f) To work with, and consider referrals from the Overview and Scrutiny Committee, to support effective delivery of a co-ordinated overview and scrutiny work programme;

(g) To respond to referrals from, and make referrals to, Healthwatch Nottingham as appropriate;

(h) In consultation with the Chair of Overview and Scrutiny, to commission time-limited review panels (no more than 1 major review at any one time) to carry out a review of a matter within its remit. This commissioning includes setting the remit, initial timescale and size of membership to meet the needs of the review being undertaken. Review Panels will be chaired by the Chair of the Health Scrutiny Panel;

(i) To monitor the effectiveness of its work programme and the impact of outcomes from its scrutiny activity;

(j) To appoint a lead health scrutiny councillor for the purposes of liaising with stakeholders on behalf of the health scrutiny function, including the Health and Wellbeing Board, Healthwatch Nottingham and the Portfolio Holder with responsibility for health and social care issues;

(k) To co-opt people from outside the Council to sit on the Panel or any review panels it commissions as relevant to support effective delivery of the overview and scrutiny work programme.

HEALTH SCRUTINY PANEL
29 MAY 2013
'COMMUNITY CASE FINDERS' HOSPITAL DISCHARGE
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider the implementation of the 'community case finders' model for facilitating timely discharge of patients from hospital to home.

2. Action required

2.1 The Panel is asked to use the information provided at the meeting to inform questioning and discussion to ensure the 'community case finders' model for hospital discharge is achieving the best outcomes for patients and their carers.

3. Background information

3.1 The Joint Health Scrutiny Committee has been considering the reconfiguration of services offered at Lings Bar Hospital in Gamston. An aspect of the changes was a City-based pilot to redirect resources through avoiding unnecessary admissions to Lings Bar Hospital.

3.2 In December 2012, the Committee heard that the Enhanced Community Support Pilot has ended. An independent evaluation of the pilot by Nottingham University found that while 100% of patients surveyed indicated their preference to return home directly from hospital, referrals had been low. The evaluation identified the importance of integration to the success of services working across organisations.

3.3 In March 2013 councillors heard that, in response to the evaluation findings, an alternative model 'community case finders' was launched in February 2013. The approach was part of community support provision and work was taking place to integrate it within the Integrated Discharge Team at Nottingham University Hospitals.

3.4 Councillors felt that there was need for a specific focus on how the model was developing and the outcomes for patients and therefore it was referred to this Panel for further more in-depth consideration.

3.5 The Locality Manager for the Service will be attending the meeting to outline how the model is developing, the number of referrals to the service and patient feedback.

4. List of attached information

None

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Reports to and minutes of Joint Health Scrutiny Committee meetings held on 11 December 2012 and 12 March 2013.

7. Wards affected

All

8. Contact information

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HEALTH SCRUTINY PANEL
29 MAY 2013
ADULT INTEGRATED CARE PROGRAMME
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To hear about work taking place to integrate health and social care services in Nottingham through the Adult Integrated Care Programme.

2. Action required

2.1 The Panel is asked to use the information provided at the meeting to inform questioning and discussion about the Adult Integrated Care Programme.

3. Background information

3.1 There are strong national and local drivers for increasing integration of health and social care. Commentators argue that fragmented services fail to meet the needs of the population and that greater integration can improve the patient experience and health and social care outcomes, and increase efficiency in care provision. There are increasing pressures from an ageing population and increases in numbers of people with multiple long-term conditions.

3.2 On 14 May 2013 the Care and Support Minister launched a commitment to co-ordinating health and care. Plans, to be delivered by national and local partners include:

a) An ambition to make joined up and co-ordinated health and care the norm by 2018 – with projects in every part of the country by 2015;
b) An agreed definition of what people say good integrated care and support looks and feels like (see paragraph 3.3);
c) 'Pioneer' areas around the country appointed by September 2013; and
d) New measures of people's experience of joined up care and support by the end of this year.

3.3 Commissioned by NHS England, National Voices (national coalition of health and social care charities) has developed a definition and narrative for integrated care. This is attached at Appendix 1.

3.4 The Adult Integrated Care Programme was established in July 2012 to change the way health and social care is commissioned and provided for older people and those with long term conditions. It is supported by

Nottingham City Clinical Commissioning Group and the City Council. In a report to the Health and Wellbeing Board in December 2012 it was stated that the vision was that "through integrated strategies, within 3-5 years, citizens will see a transformed health and social care system where there is:

a) Early identification and intervention of on-going health and social care needs.
b) Support to ensure that citizens are empowered to manage their own condition/s.
c) A proactive approach to identify citizens at risk of needing an increased level of care to ensure appropriate support is in place before a crisis situation occurs.
d) The right care delivered at the right time through primary care, community services and social care working together in localities; accessing secondary care appropriately.
e) Coordinated care through services being delivered by multi-disciplinary teams holding regular MDT meetings.
f) Personalised care planning with access to appropriate specialist support in the community.
g) Improved transition of care between community and hospital setting."

3.5 The Programme comprises four projects:

a) Co-ordinate care – a new model changing how primary care, community health services and social care services are commissioned and delivered, emphasising joined-up care and proactive support.
b) Independence pathway – a new model of assessment and rehabilitation, enabling people to remain as independent as possible.
c) Single front door – building on existing work in Nottingham CityCare to deliver a joint, single point of access to health and social care services.
d) Assistive technology – supporting the early intervention and prevention approach will be integrated assistive technology, harnessing products and services designed to enable independent living.

3.6 The Programme Manager for Adult Integrated Care will be attending the meeting to provide information on the aims and directions of the Programme and how it will be supporting priorities contained within the Joint Health and Wellbeing Strategy, an overview of the work streams and the intended outcomes for citizens.

4. List of attached information

4.1 The following information can be found in the appendices to this report:

Appendix 1 – National Voices 'A Narrative for Person Centred Co-ordinated Care

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Report to Health and Wellbeing Board meeting held on 19 December 2012

'Connecting Care' Newsletter January 17 2013

7. Wards affected

All

8. Contact information

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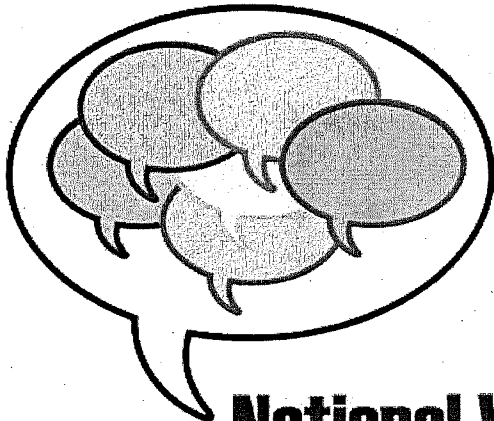
think local
act personal



National Voices
People shaping health
and social care

A Narrative for Person-Centred Coordinated Care

www.nationalvoices.org.uk
www.thinklocalactpersonal.org.uk

@NVTweeting
@TLAP1

NHS England Publication Gateway Reference Number: 00076

About this Narrative

- Commissioned by NHS England on behalf of the National Collaboration for Integrated Care and Support
- Co-developed with the health and care system by National Voices, a grouping of 130 health and social care charities
- Draft based on: research on what matters most to patients and service users; on survey questions that were fully tested with patients; and on consultations with National Voices members
- Refined at a workshop in September 2012, with service users, charity representatives and NHS and social care leaders
- Second draft published for two months feedback in January 2013
- Feedback from commissioners and providers of care, service user organisations and others was analysed and discussed at a workshop in March 2013, and a final version produced
- This final version aligns with TLAP's 'Making it Real' initiative

Overarching summary – service user perspective

Summary

Care planning

My goals/outcomes

Person centred coordinated care

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."

Information

Transitions

Communication

Decision making

Subject

('Integrated care' means...)

person centred coordinated care

Definition - service user perspective

I can plan my care
with people who work together
to understand me and my carer(s),
allow me control,
and bring together services
to achieve the outcomes important to me.

Generic 'I' statements

My goals/outcomes

All my needs as a person are assessed.

My carer/family have their needs recognised and are given support to care for me.

I am supported to understand my choices and to set and achieve my goals.

Taken together, my care and support help me live the life I want to the best of my ability.

Care planning

I work with my team to agree a care and support plan.

I know what is in my care and support plan. I know what to do if things change or go wrong.

I have as much control of planning my care and support as I want.

I can decide the kind of support I need and how to receive it.

My care plan is clearly entered on my record.

I have regular reviews of my care and treatment, and of my care and support plan.

I have regular, comprehensive reviews of my medicines.

When something is planned, it happens.

I can plan ahead and stay in control in emergencies.

I have systems in place to get help at an early stage to avoid a crisis.

Communication

I tell my story once.

I am listened to about what works for me, in my life.

I am always kept informed about what the next steps will be.

The professionals involved with my care talk to each other. We all work as a team.

I always know who is coordinating my care.

I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time.

Information

I have the information, and support to use it, that I need to make decisions and choices about my care and support.

I have information, and support to use it, that helps me manage my condition(s).

I can see my health and care records at any time. I can decide who to share them with. I can correct any mistakes in the information.

Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand.

I am told about the other services that are available to someone in my circumstances, including support organisations.

I am not left alone to make sense of information. I can meet/phone/email a professional when I need to ask more questions or discuss the options.

Generic 'I' statements

Decision making including budgets

I am as involved in discussions and decisions about my care, support and treatment as I want to be.

My family or carer is also involved in these decisions as much as I want them to be.

I have help to make informed choices if I need and want it.

I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment, or a 'personal budget' from the council or NHS).

I am able to get skilled advice to understand costs and make the best use of my budget.

I can get access to the money quickly without over-complicated procedures.

Generic 'I' statements

Transitions

When I use a new service, my care plan is known in advance and respected.

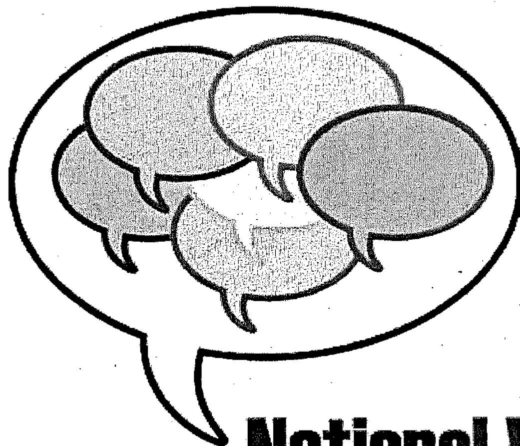
When I move between services or settings, there is a plan in place for what happens next.

I know in advance where I am going, what I will be provided with, and who will be my main point of professional contact.

I am given information about any medicines I take with me – their purpose, how to take them, potential side effects.

If I still need contact with previous services/professionals, this is made possible.

If I move across geographical boundaries I do not lose me entitlements to care and support.



A Narrative for Person-Centred Coordinated Care

NHS England Publication Gateway Reference Number: 00076

9

HEALTH SCRUTINY PANEL
29 MAY 2013
CITYCARE PARTNERSHIP QUALITY ACCOUNT 2012/13
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 CityCare Partnership will present its draft Quality Account 2012/13 and the Panel will have opportunity to decide if it would like to submit a comment for inclusion in the Account.

2. Action required

2.1 The Panel is asked to consider the CityCare Partnership draft Quality Account 2012/13 and decide whether it would like to provide a comment for inclusion.

3. Background information

3.1 A Quality Account is an annual report to the public from providers of NHS healthcare services about the quality of their services. It aims to enhance accountability to the public and engage the organisation in its quality improvement agenda, reflecting the three domains of quality: patient safety, clinical effectiveness and patient experience.

3.2 Since April 2010, all providers of acute, mental health, learning disability and ambulance services have been required to produce an annual Quality Account. Community providers were asked to develop Quality Accounts from 2011 and the provision of Quality Accounts by primary care providers is being evaluated.

3.3 A Quality Account should:

- improve organisational accountability to the public and engage boards (or their equivalents) in the quality improvement agenda for the organisation;
- enable the provider to review its services, show where it is doing well, but also where improvement is required;
- demonstrate what improvements are planned;
- provide information on the quality of services to patients and the public;
- demonstrate how the organisation involves, and responds to feedback from patients and the public, as well as other stakeholders.

3.4 Quality Accounts are both retrospective and forward looking. They look back on the previous year's information regarding quality of services, explaining what is being done well and where improvement is needed. But, they also look forward, explaining what has been identified as priorities for improvement.

3.5 Guidance from the Department of Health requires that a Quality Account should include:

- priorities for improvement – clearly showing plans for quality improvement within the organisation and why those priorities for improvement have been chosen; and demonstrating how the organisation is developing quality improvement capacity and capability to deliver these priorities;
- a review of quality performance – reporting on the previous year's quality performance offering the reader the opportunity to understand the quality of services in areas specific to the organisation. From 2012/13 this should include reporting on a core set of quality indicators as relevant to the services provided;
- an explanation of who has been involved and engaged with to determine the content and priorities contained in the Quality Account; and
- any statements provided from either the NHS Commissioning Board or Clinical Commissioning Group as appropriate; Local Healthwatch; and Overview and Scrutiny Committees including an explanation of any changes made to the final version of the Quality Account after receiving these statements.

3.6 Quality Accounts are public documents, and while their audience is wide ranging (clinicians, staff, commissioners, patients and their carers, academics, regulators etc), Quality Accounts should present information in a way that is accessible for all. For example, data presentation should be simple and in a consistent format; information should provide a balance between positive information and acknowledgement of areas that need improvement. Use of both qualitative and quantitative data will help to present a rounded picture and the use of data, information or case studies relevant to the local community will help make the Quality Account meaningful to its reader.

3.7 As a first step towards ensuring that the information contained in Quality Accounts is accurate (the data used is of a high standard), fair (the interpretation of the information provided is reasonable) and gives a representative and balanced overview, providers have to share their Quality Accounts prior to publication. From 2012/13 this includes sharing with:

- The appropriate NHS Commissioning Board area team where 50% or more of the provider's health services are provided under contract, agreement or arrangement with the Board or the clinical commissioning group which has the responsibility for the largest number of persons to whom the provider has provided relevant health services during the reporting period;

- The appropriate Local Healthwatch organisation; and
- The appropriate local authority overview and scrutiny committee

3.8 The NHS Commissioning Board/ clinical commissioning group has a legal obligation to review and comment on a provider's Quality Account, while Local Healthwatch and Overview and Scrutiny Committees are offered the opportunity to comment on a voluntary basis. Any statement provided should indicate whether the Committee believes, based on the knowledge they have of the provider that the report is a fair reflection of the healthcare services provided. The organisation then has to include these comments in the published Quality Account.

3.9 In January, CityCare Partnership informed the Panel of its proposals for its Quality Account 2012/13. At this meeting, it will present its draft Quality Account 2012/13 for consideration. The Panel will have opportunity to decide whether to put forward any comments for inclusion. Please note that the draft document is a plain Word version only and the final version will be professionally designed to be user friendly.

4. List of attached information

4.1 The following information can be found in the appendices to this report:

Appendix 1 – CityCare Partnership Draft Quality Account 2012/13

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Report to and minutes of Health Scrutiny Panel meeting held on 29 January 2013

Department of Health Quality Accounts Toolkit
http://www.dh.gov.uk/health/2012/02/quality-accounts-toolkit

7. Wards affected

All

8. Contact information

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Annual Quality Account 2012/13

Part one – introduction from the chief executive and Board statement on quality

Nottingham CityCare Partnership's express vision is to offer 'better health and complete care, owned and delivered locally.

This Annual Quality Account is one way in which we are held to account on that promise; another is by Care Quality Commission (CQC) monitoring.

Care Quality - Checked

We are pleased to announce that we were inspected by the CQC in March 2013, and were found to be meeting all the Essential Standards checked. The full report can be found at http://www.cqc.org.uk/directory/1-298791257

This is great news for our organisation, our partners, patients and service users, and testament to CityCare colleagues' dedication and professionalism.

The standards we were judged against were:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Supporting workers
- Assessing and monitoring the quality of service provision

Chief executive Lyn Bacon said: "This is great news for everyone at CityCare, and testament to everyone's dedication and professionalism."

As part of the inspection, the CQC spoke to 18 patients about CityCare services. Patients said:

- "I am very happy with my care, I get what I ask for"
- "The care has been very good and it has made a real difference to me"
- "I'm confident about the skills staff have" and
- "The service seems to run smoothly, but if there was ever a problem I'd speak to a manager about it. I'm sure they'd listen."

The inspectors also spoke to 15 staff, observed practice, and highlighted areas of good practice. Staff said:

- "It's marvellous working here. I really enjoy it and they are very supportive with their training."
- "They have been a very supportive employer and provided training for specialist areas," and

- "I feel that my opinions are listened to by my managers and I've been involved in making decisions about how the service is run."

The report says:

- Patients' privacy, dignity and independence were respected. Patients' diversity, values and human rights were respected
- Patients experienced care, treatment and support that met their needs and protected their rights
- Patients were protected from the risk of abuse, because CityCare had taken all reasonable steps to identify the possibility of abuse and prevent abuse from happening
- Patients were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard
- CityCare had an effective system to regularly assess and monitor the quality of service that patients receive.

Our staff are committed to the excellent standards that our patients and the public have a right to expect.But this report doesn't mean we will become complacent.

We will learn from the feedback, continue to listen to patients, and focus on quality, safety and experience to drive up standards.

This Annual Quality Account outlines the progress we have made against the quality priorities set in 2012, as well as progress made against work begun in the previous year, where there was more still to do.

The Francis Report

The independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust January 2005 to March 2009, published in February 2013, has a series of key lessons learned and recommendations for all NHS care providers. Our response to the report is included in Part XX, our look forward to next year's quality priorities.

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.

<u>Listening</u>

Paul Grant – Non executive director chairs our Patient Experience Group. The groups mandate is to get face-to-face feedback from local people, and report back to the Board. A Patient Experience Group member said; "It is imperative that the patient voiceis heard at the very beginning oftraining and service planning, notpart-way through or at the end".

<u>Social Return</u>

As a Social Enterprise CityCare are committed to ensuring the quality of its offer is maintained and improved upon by the reinvestment of any surplus to improve the outcomes and experiences of its patients and users.

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

Lyn Bacon Chief Executive

Part two – review of quality performance

Parts 2.1 and 2.5-2.9 of this section are nationally mandated statements of assurance.

In parts 2.2-2.4 we chart our progress against the quality priorities we set out in 2012. These 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 OFSERVICES

During 2012/13 CityCare provided 61 and sub-contracted 22 NHS services or elements of NHS services.

CityCare has reviewed all the data available to it on the quality of care in line with the requirements of those commissioning these services.

Where these contracts for NHS services had a fixed contract value this amounted to £331,802, which represents 1% of the total income, generated from the provision of NHS services by CityCare under the standard NHS contract for 2012/13.

2.2 PATIENT SAFETY

Last year's patient safety quality priorities, and below is an update on our current position..

2.2.1 Medicines Management

In last year's report, we set out various priorities. Some were achieved and are detailed below. Some have yet to be achieved and have been carried over to next year (see section 3.1).Last year, we said we would:

- **Introduce training for new staff as part of the induction programme:** Anew training module for new starters covers topics includes medication policies, information on medicines, and medication processes. Take up is monitored by the workforce development team.

- **Advise managers on how they can meet the CQC Essential Standard on Medicines Management:** The quantity and quality of evidence being collected for the CQC essential standard has been improved.

- **Ensure all staff have access to information on medicines via the intranet, and know how to contact the Medicines Management team for advice:** The amount of information distributed through Cascade (an all-staff weekly email) has increased dramatically. Topics like local prescribing, advice on drug administration, drug information, and information on drug safety have featured.

- **Adapt and develop the newly-introduced technician-led services to improve medicines management quality and safety in care homes and people'sown homes:** Our technician-led medicines compliance review has improved through better use of technology, and through streamlining and improving the internal processes. The care homes training packages have also been revised and improved.

2.2.2 Safeguarding Adults

In last year's report we looked at our progress on five key quality improvements from the previous year. Below we highlight the further progress we have made this year.

- Using views gathered from our Patient Experience Group and the Health Group on our safeguarding procedures, we have now produced information leaflets on adult safeguarding and making decisions under the Mental Capacity Act in Plain Language and Easy Read format.
- We have continued to review our adult safeguarding standards. An area highlighted for development isPREVENT, part of the government's counter terrorism strategy, which aims to reduce the risk of radicalisation of vulnerable people who may be at risk of exploitation.
- We have continued to deliver adult safeguarding awareness training to new employees, combining adult and child safeguarding awareness to recognise that abuse can occur in any family and community situations. Uptake of alerter level training is increasing, with a target of a 5% increase per quarter.
- Last year we exceeded our Commissioning for Quality and Innovation (CQUIN) target of 55% of staff receiving basic dementia care training and we stated that we would continue in 2012/13 to increase the number of staff completing this training to 95%.
- This year an additional element to the CQUIN has been introduced to assist GPs in identifying adults aged 70 years or over who would benefit from being referred to a memory clinic. Community Matrons and Community Nurses have been identifying patients, completing memory tests and informing their GPs when memory difficulties have recently occurred. We have continued to raise the importance of this work with our community nursing staff with the ambition of helping more patients benefit from early detection and intervention in dementia.
- We intend to merge the Adults and Children's Safeguarding Committees in progression to a 'Think Family' approach to safeguarding which will be in line with the Nottingham City Adults and Children's Safeguarding Boards..

2.2.3 Safeguarding Children

The information below is an update in the work continuing on priorities originally identified in 2011.

1. Implement recommendations from the Markers of Good Practice Assessment and continue to take part in annual self-assessments: An annual review took place in April 2013. The organisation continues to further strengthen areas assessed as compliant with full assurance and make progress towards those with partial compliance. In particular:

- **Serious Case Review:** Additional training in investigation skills for the safeguarding team to further enhance the reviews submitted for serious case reviews, Domestic Homicide reviews and Serious Incident Learning Processes.
- **Safeguarding Supervision** : Implementing a new safeguarding supervision model allowing for greater depth of discussion and opportunities for reflection to explore the emotional impact of this work, with experienced qualified staff adopting a practitioner led approach and newly qualified staff receiving more intensive safeguarding supervision for a specified period of time post qualification.A focus on learning and reflection following series case reviews will be prioritised.
- **Inclusion of young people in the planning, delivery and evaluation of services:** TheFamily Nurse Partnership has created a Young People's forum which actively engages with service development.
- **Nottingham City Family Support Strategy:** A safeguarding pathway is being developed as part of the Health Visitor Implementation Plan to work in partnership with the family support pathway and ensure that staff access services at the appropriate level of need.

2. Explore opportunities to workcloser with Adults and Children'ssocial care: CityCare is represented on both the Adult and Children's Safeguarding boards. We have recently reviewed both the Safeguarding Adults and Children's services and agreed to integrate the services for a combined safeguarding service that practices a 'Think Family' approach. The Safeguarding Adults and Children steering groups have also been combined.

CityCare are also currently working with Local Authority children's services to implement the 'signs of safety' approach to working with families.

3. Continue early intervention through use ofthe Common Assessment Framework(CAF): Interactive CAF training and a CAF tracking system have been introduced.

CityCare have recently reviewed CAF processes and training has been developed that supports the use of IT systems to streamline the process. In addition, as part of the Safeguarding review that CityCare began in October 2012 following a request by NHS Nottingham City, additional resources have been requested to facilitate the development of a CAF service. The service will maintain a database of CAF's, provide support to health practitioners.

If a CAF is recommended during supervision, consultation call or Domestic Abuse Referral Team (DART)referral, this information is logged and an expiry date applied.

Other developments in Safeguarding Children
The CQC recently visited CityCare to inspect our performance on a number of standards, including Safeguarding people who use services from abuse.

*People are safeguarded from abuse, or the risk of abuse, and their human rights are respected and **upheld**.*

Information on each outcome is available in the 'What the CQC Quality and Safety Outcomes mean for you' booklet which is available on the CityCare website.

. The inspectors confirmedthis standard had been met and the report highlighted that service users felt safe, and staff knew about safeguarding processes and what to do should they be concerned. Staff files reviewed demonstrated that staff had received safeguarding training. Patient journeys where safeguarding concerns existed were followed and deemed to have the appropriate action in a timely manner.

Serious incidents

In 2012/13 CityCare participated in the completion of one Serious Case Review and one Serious Incident Learning Process. Recommendations included:

- The development of a Mental Health Screening tool for the Health Visiting Service
- The inclusion of training on risk assessment tools as part of the Health Visitor role specific training
- School health staff are fully conversant with the Information sharing protocol relating to domestic abuse incidents
- Revised escalation pathway for reporting serious incidents.

Domestic Abuse Referral Team (DART)

Since June 2012, the safeguarding team have been an integral part of the DART – andare co-located with police, health and social care team that respond to incidents and disclosures relating to domestic abuse. The team are tasked with reviewing the information as a joint team to establish the required response according to the level of assessed risk – the introduction of the DART has significantly improved the timeliness of information sharing and resource planning with agencies.

This is strengthening working and ensuring domestic violence is a priority safeguarding concern.

This is reflected in the team structure to ensure a 'Think Family' approach.

2.2.4 Incident reporting

In 2012/13 there were **2,207** incidents reported, of which **2,054** resulted in no harm or were categorised as minor injury requiring first aid. This is an increase in the number of patient safety incidents from last year when 1,842 incidents were reported.

There have been no *never events* reported this year. *Never events* are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Last year we reported that there had been an increase in the numbers of incidents reported relating to the lack of availability of a device for a patient. Managers have worked with provider Integrate Equipment Stores (ICES) to resolve issues reported by staff and there has been a significant reduction in the number of incidents reported.

Other updates include:

1. Continue to improve the way information is made available to teams so that they are able to see trends to be addressed: The focus is root cause analysis investigations (RCA) of which the majority are for stage 3 and 4 pressure ulcers. This year the tissue viability team have introduced a 'newsflash' alert that goes out to all relevant staff each week so that one key area of learning is cascaded through the relevant services on a regular basis. The learning and embedding group continues to meet monthly but the number of stage 3 and 4 pressure ulcers reported has increased this year. Part of the reason is increased staff vigilance in reporting and education of staff remains key to this work. Pressure ulcers will remain a high priority until all remedial action has been taken to prevent harm to patients in our care.

Further support from the tissue viability team is being provided to teams. The Head of Tissue Viability has developed an action plan which will be reviewed monthly and regular updates will be provided to the Board.

2. Continue to build a safety culture by encouraging the reporting of incidents and supporting the recognition and sharing of lessons that can be learned: We have continued to see an increase in incident reporting and all services are now reporting on-line. Feedback following an incident remains an issue and we are reviewing ways to improve this. We have revised the template for managers to report back to the Patient Safety and Infection Prevention and Control Committee regarding the incidents in their services, any risks and action being taken including how that learning is being shared within the teams.

The Safety First newsletter is being revised to ensure all staff receive feedback about learning from incidents.

We will continue to monitor trends in incidents and key areas are being taken forward into the annual patient safety programme for the next 12 months.

3. Training in Root Cause Analysis: A half-day course for all senior managers on serious incident investigations provided additional skills for serious incident investigations and report writing. This year we will be focusing on a half-day course for the safeguarding team.

4. Senior managers will be trained in *Being Open:* *Being open* is included in all patient safety training and this year we plan to introduce combined incident and complaints investigation training for managers based on a three-hour workshop.

2.2.5 Infection Prevention and Control

During 2012/13 we continued to work towards national targets in relation to healthcare associated infections. The target is set according to the size of the population of Nottingham City and must be met by the whole of the local health community, which includes Nottingham University Hospitals.

The targets for 2012/13 were:

- To not exceed 106 cases of Clostridium difficile infection

- To not exceed 3 cases of MRSA bacteraemia infection. During 2011-12 the target was to not exceed 10 cases; this equates to a 70% reduction.

Clostridium difficile

During 2012/13 the total number of Clostridium difficile cases was 79, of which 36 were pre-72 hour and 43 were post-72 hours after admission to hospital. The target for 2013/14 has been reduced still further to no more than 66 cases. In order to work towards meeting the target CityCare will be involved in the following initiatives:

- Re-launch of the antibiotic guidelines for primary care in March 2013
- Review antibiotic prescribing data quarterly at the joint Infection Prevention & Control Committee and address any areas of concern promptly
- Review all positive sample results of patient with Clostridium difficile to ensure prompt treatment
- Continue to share lessons learnt from reviews into serious incidents across the local health economy. These are shared with independent contractors where appropriate in the form of newsletters.

MRSA

During 2012/13 the MRSA target was breached. The target was three, and the actual outcome at the end of March 2013 was nine. Threewere attributed to primary care because they occurred in the first 48 hours of admission to hospital and the other six were classified as post-48 hours.

The outcomes of the root cause analysis highlighted:

- The management of diabetic foot wound pathways needed to be reviewed – an ongoing item that CityCare has been working on with Nottingham University Hospitals (NUH). Patient information has been developed by the NUH Diabetic Foot Clinic for patients who choose to manage their own wounds between hospital appointments. It details the importance of good hand hygiene and how to reduce the risk of infection.
- The second bacteraemia occurred when the patient had only been discharged from hospital two days previously and all screening and treatment protocols within primary care had been followed
- The third bacteraemia patient, a care home resident, had no health needs and did not require care from CityCare prior to being admitted to hospital and found to be MRSA positive.

These initiatives will continue to help reduce the number of MRSA bacteraemias:

- Monitor the number of patients positive for MRSA on admission to NUH from care home environments. Consider further proactive treatment and screening in care home environments where clusters of cases are appearing.
- Review all MRSA positive swabs and samples and ensure the patients are on the correct treatment and management plans to try to reduce the risk of more serious infections developing.
- Continue to share the lessons learnt from reviews across the health economy.

The Infection Prevention and Control team are commissioned to undertake an annual audit of all the buildings owned or leased by NHSNottinghamCity. These audits are necessary to ensure that care is being provided in an environment which meets the Essential Standards of Quality and Safety, which is monitored by the Care Quality Commission.These buildings are audited to look not only at environmental factors but also cleanliness standards which enable the Organisation to benchmark against national standards for clinical environments.
The overall level of compliance achieved across all the sites was 87%, which has increased from the 81% achieved in 2011.

Since the audits began in 2010, a great deal of work has been undertaken in consulting rooms with vinyl flooring being replaced and hand hygiene sinks being updated to incorporate sensor operated taps and integrated plumbing. This has led to significant improvements in the scores in these areas. Following the 2011 audits nine sites have had sluices incorporated into the centre which has facilitated the correct disposal of body fluids and waste materials.

Areas of Good Practice identified from the audits were as follows:

- Items of equipment were visibly clean
- Waste bins were not overfull
- Sterile procedure packs were available
- Examination lights were visibly clean
- Sharps containers were assembled correctly and were not overfull
- Needles and syringes were discarded as a single unit
- Single use items were not being reused
- Vaccines were stored in their original packaging, in a fridge intended for this purpose and daily temperatures were within range.

The environmental audit is undertaken on a yearly basis and will be repeated by the team again in April 2013.

2.3 CLINICAL EFFECTIVENESS

The priorities identified in last year's report looked at the work underway to improve clinical training, supervision and on-going training, including disability, cultural and dementia awareness training.

Here we also look back on other on-going priorities from the previous year's report based on High Impact Actions.

2.3.1 Clinical training, supervision and on-going training

A new essential and statutory training matrix has been developed and launched in March 2013, with regular reports on compliance now available.

The corporate induction and new starter training programme has also been reviewed and revised to ensure timely access to quality and effective new starter training. The new starter workbook has been updated and is now an information booklet, as more face-to-face sessions have been introduced.

The clinical supervision policy has been reviewed and a new *Restorative Supervision* model for nursing has been adopted, to be launched in 2013/14.

The Equality and Diversity training has been reviewed and is now available as either face-to-face or e-learning. Individual managers in all services have also been trained in carrying out Equality Impact Assessments.

Dementia training has been delivered at levels 1, 2 and 3. All staff have had access to level 1(basic awareness) training. As appropriate,staff have been able to access level 2 training, and clinical staff working in specialist older person's services have been able to access an accredited specialist dementia module.

All training and training methods are continually reviewed as part of the workforce development quality processes.

2.3.2 Updates on High Impact Actions

High Impact Action 1 – Your skin matters

Pressure Ulcer Prevention:

A new 'Stop the Pressure' campaign has been launched with a dedicated conference, and a new logo for CityCare has been developed. A new training package has been developed which will be implemented across all services by the Tissue Viability Team and Pressure Ulcer Champions, including:

- A new staff handbook for Pressure Ulcer prevention
- SSkin bundle documentation
- Pressure ulcer prevention leaflets
- Information Plans for patients
- Guide to reporting pressure ulcer incidents.

As part of this campaign every patient at risk of pressure ulcers will have a sticker with the logo on it on the front of their patient record folder.

CityCare has actively participated in the Pressure Ulcer Change Champion and Pressure Ulcer Collaborative Programmes implemented by NHS Midlands and East. A patient experience DVD made by CityCare'sTissue Viability team has been shown at regional events.

The pressure ulcer prevention policy is in its final draft for consultation, and the competencies for pressure risk assessment and skin assessment are being developed by the clinical nurse specialists in Tissue Viability.

High Impact Action 2 – Staying safe, preventing falls

- A new referral system passes patient information on a daily basis to the CityCare administration team. A staff member working at NUH allows us to have access to ED assessmentsand better clinical information for assessment.(see table)

- Referrals for falls assessment are now included in the Fracture Liaison Service pathway
- We have worked across the pathway with commissioners and secondary care, to streamline the service. Clinics are now run in GP surgeries, allowing people to be assessed and treated closer to home.

A new Falls Rapid Response Team pilot was launched in April 2013, in partnership with East Midlands Ambulance Service.

High Impact Action 3 – Keeping nourished

- **The MUST screening tool:** The roll out of the training sessions to CityCare staff has started and it is hoped that many teams will have been trained by the end of April 2013. The next stage will be to identify those who have not been trained as part of the SSKIN Bundle roll out and provide them with training.Further work needs to be done within care homes and GP practices in order to promote and support their use of the MUST tool and implementation of all aspects of the Sip Feed Guidelines.The number of referrals for patients requiring nutritional support has continued to increase over the past year regardless of the complexity of their needs. Some of referrals have been for patients who may now be able to be managed by CityCare staff or Primary health Care teams following the rollout of the MUST tool training linked in the increased use of the Sip Feed Guidelines.
- **Prescribing cost of SIP feeds:**Discussions have held with regard to possible joint working between Dietetics and the Medicines Management team. This would involve working with areas that have been identified as having a high spend on sip feeds, in order to promote correct usage.

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 priority identified last year of developing Customer Care training for staff, and other key areas we felt would improve patient experience.

2.4.1 Customer Care Training

Excellent customer care is a key priority for CityCare. In an effort to embed customer care across the organisation we facilitated a development session in April 2012. Drawing on the experience and views of patients, carers and staff and CityCare's Vision and Values, we developed a set of behavioural standards from which to develop our Customer Care training.

Working with the Derbyshire and Nottinghamshire Chamber of Commerce (DNCC), we were able to source a training provider and jointly developa training programme of Customer Experience. The programme was innovative and fun, moving away from the traditional customer care approach to the whole customer experience concept. The new programme gives staff the principles and skills to enhance the customer experience and incorporates the NHS Six C's principles to develop the culture of compassionate care.

The new programme was piloted with three service areas: Podiatry, the Nottingham Health and Care Point, and Resources with positive outcomes.

A podiatry manager said: "One of the podiatrists felt really inspired by the training and had really taken on board everything that was said. She said she had her smile on and had made sure that her patients were given everything they need."

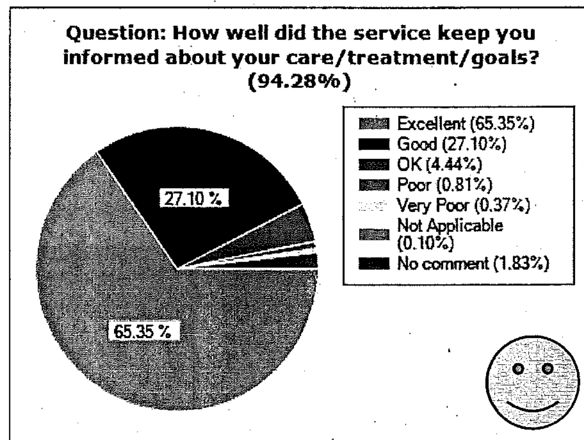
2.4.2 Improving outcomes for patients and carers through satisfactions surveys, complaints and concerns and feedback.

Patient Satisfaction

	2012/13	Previous year 2011/12
Number of questionnaires completed July 2012 to March 2013	3,830	1,400

Questionnaire responses have increased by 2,430 this year. This is because more services are routinely carrying out surveys, and service users tell us they feel they are being listened to.

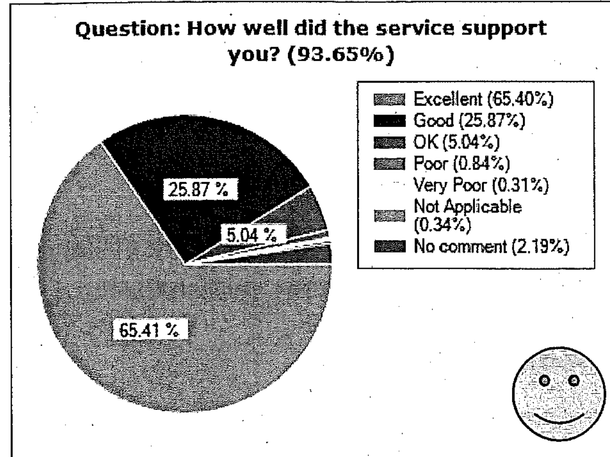
How well did the service keep you informed about your care?



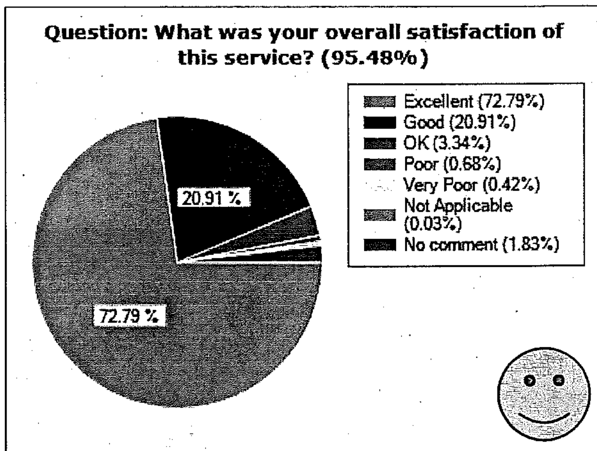
Previous year 91%

How well did the service support you?

Previous year 95%



What was your overall satisfaction?



Previous year 96%

N.B The % is calculated by adding excellent and good responses, divided by all responsive, excluding not applicable and no comment

How well...	Target	Previous year 2011/12	This year 2012/13
Were you involved in decisions about your care?	85%	90%	97%
Were you treated with dignity and respect?		96%	97%
Were your particular needs met?		93%	94%

How likely is it that you would recommend this service to friends and family?

From July 2012 – March 2013, ten CityCare services asked patients if they would recommend their service to friends and family. 779 people fed back their views and...

94 % said they would recommend our services to friends and family

What we have done as a result of complaints and concerns

From July 2012 – March 2013 CityCare recorded 117 concerns and 26 formal complaints. Actions we took as a result of feedback include:

You said...	We listened and acted...
The wait for blood testat some of the drop in clinics areway too long	Additional staff are provided at peak time and we will improve our booking system to ensure patients are not missed
Signage to services in certain health centres and the Walk In Centre is unclear	Signage has improved
Staff do not always use interpreters where people do not speak English as a first language	We have developed guidance on the use of interpreters and are developing a system to monitor usage by service
Staff should always be mindful when discussing patient-sensitive information in public	We will continue to remind all staff to maintain the privacy of patient information and data at all times and ensure all staff have regular Information Governance training
They would like to access CityCare services more easily and not have to give their information several times	In partnership with the Local Authority we have launched Nottingham Health and Care Point as a single point of access for some CityCare services and adult social care assessment
Staff need to listen, smile more and show compassion and care	We aim to develop a culture of compassion and will embed the 6 C's into our customer care training
Staff need to ensure infection control procedures are carried out at all times	We reminded all staff carrying out treatment of our Bare Below the Elbow policy, the need to wash hands pre and post treatment in front of patients and the need to wear gloves and aprons
They wanted services in more accessible locations	In addition to people's home, health centres, and community centres we are also running services from Boots in the Victoria Centre, Kiddicare and the Carers Federation
Carers are not always fully involved in the care of their loved ones	We will remind staff to involve family carers in our aim to provide holistic, sustainable community support
New parents want more support with breast feeding and coping with children with behavioural difficulties. Easier access to Health Visitors	An increase in staff will ensure there are more, trained staff to support parents with feeding and how to manage behavioural difficulties. We are developing ways to improve contact with staff.

What people say about our services

"My Health Visitor sent texts to remind me, gave me leaflets, listened to me and gave me good advice."

"They kept me updated throughout, gave me information and involved me in what would happen and my views and wishes about it. They understood what you are going through and listened. They were non-judgemental and very supportive."About the community nursing service.

"My New Leaf Advisor supported me at my pace, did not rush me and got to know what I needed. I felt I was in control and that felt good.

"Thank you to the District Nurses for your kindness and hard work during this difficult time. The team showed true professionalism and compassion. You have always made me feel I am in safe hands and reassured me and my wife. We could not have got through these tough times without your support."

"The assistance provided by the Occupational Therapist and Assistant Practitioner provided the support needed to avoid an unnecessary hospital discharge". GP feedback about the Crisis Intervention Service

"The Podiatrist helped get me on my feet. I am dancing on air!"

"The staff have been excellent in their care. They always come as arranged or call to let me know. They always do what they have agreed to do and have gone beyond the call of duty."

"Go4It are fab. I enjoy coming and meeting my friends. My family eat better and I am exercising more and don't feel so bad!"

"Physio was great. I feel I can now get on with my life.

2.5 PARTICIPATION IN CLINICAL AUDIT

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

During 2012/13, one national clinical audit but no national confidential enquiries covered the NHS services that CityCare provides.

During that period CityCare participated in 100% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audit that CityCare participated in during 2012/13 was the Sentinel Stroke National Audit Programme (SSNAP).

CityCare's Environmental Infection Control Audit was shortlistedin the 2013 Clinical Audit Awards Patient Safety Category. It wasfantastic be one of only 3 shortlisted from 33 entries.

The reports of 23 local clinical audits were reviewed by CityCare 2012/13 and the organisation intends to take the following actions to improve the quality of healthcare provided:

Essential Steps Audit 2011/12	**Sharps Handling** • clinical staff to receive training in the use of the new sharps bin • clinical staff complete infection prevention and control training every two years which includes an update on sharps management. • To ensure the sharps report completed in March 2012 is disseminated to all clinical teams. **Stocks of Wipes and Alcohol Gel** • All clinical staff to have access to wipes and alcohol gel. **Re-audit** • The Head Infection Prevention and Control and our Clinical Audit Specialist will meet to finalise the tool for 2012-13. • The head of Infection Prevention and Control will launch the new tool and audit process at the joint Infection Prevention and Control and Patient Safety Committee. • Clinical Governance Committee to agree the audit process and to ensure dissemination through the services. • The Head Infection Prevention and Control and our Clinical Audit Specialistto provide updates to the Clinical Governance Committee of compliance with the audit process.
Hand Hygiene Audit 2011/12	• The joint Patient Safety and Infection Prevention and Control Committee will receive regular feedback on the audit. • Provide key points to clinical staff in relation to the hand hygiene audit process. The key points are:

	• Staff must be bare below the elbows when providing clinical care • Staff need access to alcohol gel for use at domiciliary visits • Staff need to ensure that all areas of the hand are included within their hand hygiene technique including cuticle areas and tips of fingers. • The Service Leads will be responsible for disseminating the key points. • The Clinical Audit Specialist and the Infection Prevention and Control Team to ensure the audit tool for 2012-13 is always completed correctly.
Record Keeping Audit 2011/12	• Ethnic origin – The head of Clinical Audit will analyse any differences between paper and electronic records, Managers to ensure the field is included in their templates. • Occupation/ employment status – Query about SystmOne templates allowing 'retired' status to be recorded. Managers to ensure the field is included in their templates. • Pre-registered student entries countersigned – Explanation added to the audit guide for 2012/13, and is to be added to the Health Records Policy. • To ensure that 24hr clocks active on all SystmOne entries, services using paper records to be reminded to use 24 hour clock for entries. • Alerts – Explanation to be added to audit guide that for some modules on SystmOne the allergy node is greyed-out where 'no known allergies' is selected so should be checked, also to remind staff to use the 'Not relevant to care provided' option if applicable. • Consent – The question has been changed for 2012/13 to reflect the new policy. Explanation to be added to the audit re: patients at end of life • Infection control questions – Changes have been made to the wording of questions for 2012/13. • Ensure that all records have the current organisational address. • Patient Group Directions (PGD) – This section of the audit form has changed for 2012/13, PGD Policy to be rewritten • Transfer of Care – This section of the audit tool has been rewritten to reflect the new Clinical Handover and Discharge of Patient Care Policy.
Health Visitors Supervision Audit 2011/12	• Ensure compliance with 3 monthly timescales for supervision.
Cardiac Rehab and Heart Failure Physiotherapy Audit 2011/12	• Ensure SMARTER goals are set with all patients • Modify method of identifying and referring suitable patients • Continue to target patients from BME groups
Resuscitation Audit	• Reminders sent to all managers that facemasks or face shields

2011/12	• Reminder re face shields/face masks to be sent via Cascade twice yearly • Added into local induction – provision of facemask/face shield to new clinical staff • Clinical staff should attend annual resuscitation training – Patient Safety and Infection Prevention and Control meeting to review training figures regularly. • Business case for AED's has been sent to commissioners.
Continuing Care Records Storage Audit 2011/12	• To write procedures for storage of records in line with the corporate record keeping policy. • To ensure all records have a tracking forms
Continuing Care Checklist Audit 2011/12	• To request that all referrers send a copy of the MCA attached to the checklist
Adult Safeguarding Audit 2011/12	• A copy of the completed adult safeguarding proforma to be sent to the Head of Patient Safety and Medical Devices. • Strategy for adult safeguarding training to be reviewed and a model to be recommended to the Governance Committee • Assurance to be gained that staff managers/supervisors acting in the role of referrer have completed alerter level training as well as referrer training • Staff to be reminded that an adult safeguarding referral to Adult Social Care must be followed up by faxing a completed adult safeguarding referral proforma
Domestic Abuse Incidents Audit 2012	• Support the implementation of the Domestic Abuse Referral Team (DART) and embed this into daily practice. • Promote the use of the CAF, where safe and appropriate, through DART and work with Family and Community Teams
Podiatry Decontamination Audit 2012	• Steps are being taken to remove bench top autoclaves and ultrasonics,
Social Care Referral Form Audit 2012	• There are a number of different referral forms in circulation. Remind all staff to use the current referral form. • Re-audit
MRSA Audit 2012/13	• Infection Prevention and Control Team to discuss with District Nurse Team Managers responsibility and pathway for putting alerts on patient records. From October 2012 the Infection Prevention and Control Team now have access to SystmOne to undertake this. • MRSA Care Plan to be uploaded to SystmOne to aid recording of MRSA care. • Audit results to be fed back to the District Nurse Teams.
Environmental Infection Control Audit 2012/13	**Infection Control Principles** • Estates informed as part of the Environmental audit report. • Waste segregation work in CityCare is ongoing.

	• For managers to feedback to clinical staff. Health Centre Managers to monitor. • Audit visit highlighted the need to remove soft toys. Cleaning schedules for toys should be in place. **Cleaning** • Cleaning schedules and frequencies need reviewing and in house monitoring is needed. • Ensure regular replenishment of soap and hand towels • An assessment needs to be made of mechanical extraction and air vents re: cleaning frequencies. • Cleaning staff need to be reminded about storage of mops and buckets after use **Estates** • We will work with estates to ensure there is a robust maintenance and replacement program in place to include items such as taps/sinks, blinds and easy to clean light fittings in addition to all hard surfaces. • Wall mounted dispensers including those for gloves, apron and liquid soap in areas that do not have them. • The sites that are not currently flushing the shower need to be given guidance re: flushing regimes required. • Cleaning of showers was identified as the problem rather than the state of the equipment which will be included in the cleaning report. • Coved skirting needs to be in place. • Foot operated bins need to be purchased for rooms that need them.
Self Care of Dressings Audit 2012/13	• To develop a guideline and written information for staff to use when patients or carers request to do a dressing themselves. • To ensure there is a section within the care plan to indicate when patients and carers are undertaking wound dressings and the frequency of those changes.
Crisis Response Team Stakeholders Audit 2012/13	• Review format and method of obtaining stakeholder feedback
Paediatric Constipation/ Soiling and Night Wetting Audit 2012/13	• Adapt the paediatric bowel assessment template to include abdominal distension and when first passed meconium • To create an advice sheet on faecal impaction, treatment and symptoms that may indicate a serious condition • To continue to ensure that all aspects of the assessment are completed, a care plan developed and families receive verbal and written information on their condition with planned follow up

Vaccine Storage Audit 2012/13	• To have Data Loggers for all vaccine fridges. • To ensure staff are aware of reading the vaccine fridges. • All vaccine fridges to have data sheets attached escalate any non-compliance to Balfour Beatty. • Need to establish how long data from the fridge temperatures are kept for audit purposes • Folders for each vaccine fridge will be created. All servicing/instructions to the fridge/manuals/contact names and numbers in the event of a fridge failure. • Identify fridges used by School health and other services.
Paediatric Continence Stakeholders Audit 2012/13	• Increase the number of continence link nurses to include a representative from each area of the city. The link nurse will then be responsible for attending link nurse days and then ensuring information about the service/continence is disseminated to the nurse in their area. • Circulate results of the audit to Community Paediatricians, GPs, Health Visitors and School Nurses. • Continue to work on development of a pathway of care for children with continence issues in the community in conjunction with medical staff.
Community Nursing Standards (Minimum Dataset) Audit 2012/13	• To share the results of the audit with all managers and frontline staff who input into the district nursing unit on SystmOne • To remind staff when auditing notes that we only go back in time since the last audit we do not expect sections of notes to be audited that are over a year old, this does not include demographic and general information. • To send out a reminder to all staff inputting in the district nursing unit the importance of recording next of kin and emergency contact details, • Draw up a chart to show what assessments should be done and when within the patients journey • To look at the efficacy of completing the data set audit alongside the main audit or undertaking it separately.
Clinical Diagnostics and Screening Audit 2012/13	• Where clinical diagnostic and/ or screening procedures take place and there is currently no Standard Operating Procedure in place steps will be taken to ensure that they are developed and are in line with the requirements of the Clinical Diagnostic Testing and Screening Policy. • Those responsible for communicating test results to the patient and relevant health care professionals involved in the care will ensure that they do so and that this is documented in the clinical record in line with the requirements of the Clinical Diagnostic Testing and Screening Policy. • All clinicians should be aware of the Clinical Diagnostic Testing and Screening Policy and their responsibilities in relation to it.
Splinting Guidelines	• Musculoskeletal Service (MSK) Occupational Therapist (OT) to share results with all OTs in the organisation and highlight the

Audit 2012/13	• MSK OT to feedback to MSK Team Leader
Exercise Continuation Audit 2012/13	• This audit is to be shared with various audiences: Nottingham City Council (in a forthcoming seminar); University of Nottingham (School of Physiotherapy); Nottingham CityCare Physiotherapists and Occupational Therapists (Professional Lead meeting); Nottingham CityCare Falls & Bone Health Service (team meeting) • Work is already underway to improve the links between the public sector and the private sector in the provision of accessible and appropriate exercise programmes • As a result of this dissemination phase, increased access to appropriate low cost, easily accessible venues will be investigated.

2.6 PARTICIPATION IN CLINICAL RESEARCH

We continue to undertake a wide range of research studies that aim to reduce hospital stays, prevent unnecessary admissions, reduce falls, increase smoking cessation and improve mobility. CityCare was involved in conducting 21 clinical research studies in Age & Ageing; Depressive Disorders; Neurological Disorders – Stroke; Paediatrics – ADHD; Paediatrics – Other; Palliative & Support Care; Reproductive Health; Respiratory Disorders; Service Delivery; and Smoking Cessation during 2012/2013.

Clinical Research influencesthe safety and effectiveness ofmedications, devices/equipment, diagnostic products, treatments andinterventions intended for patients.

These may be used for prevention,treatment, diagnosis or for relief ofsymptoms in a disease.

The number of patients receiving NHS services provided or sub-contracted by CityCare in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 57.

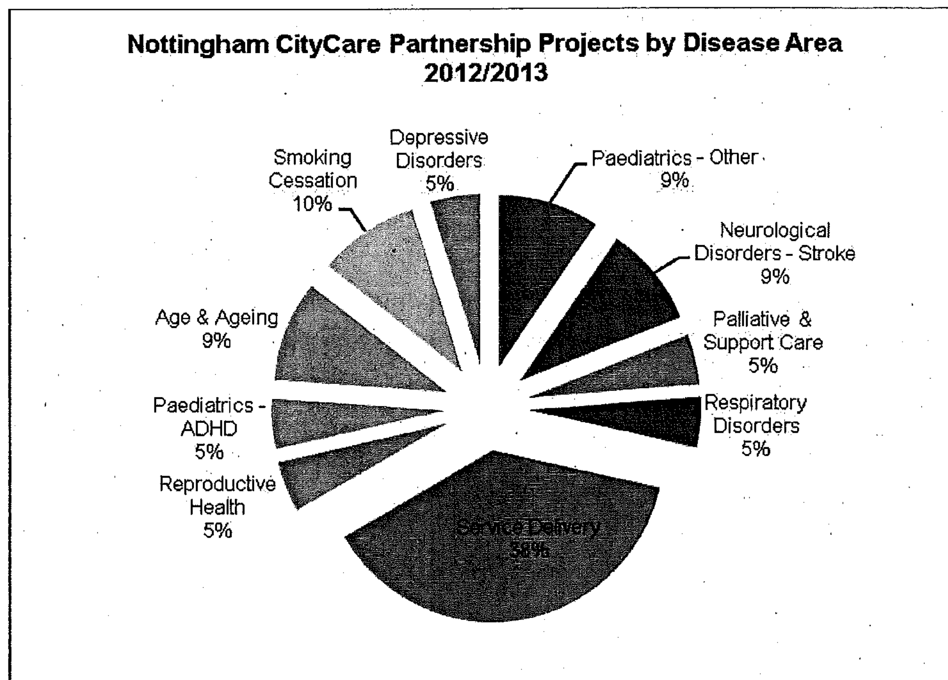
Fifty-two CityCare clinical staff participated in research approved by a research ethics committee during 2012/2013. These staff participated in research covering two medical specialties - Palliative and Support Care and Service Delivery.

We are committed to working with our partners to build and maintain stronger research links, and fund projects that promote the research interests of our company.

We will ensure research is embedded across the organisation and is an integral part of every service by ensuring appropriate levels of research activity is integrated into service plans, building clinical research support and training for staff.

Total CityCare Projects by Disease Area 2012/2013	
Disease Area	Count

Age & Ageing	2
Depressive Disorders	1
Neurological Disorders - Stroke	2
Paediatrics – ADHD	1
Paediatrics – Other	2
Palliative & Support Care	1
Reproductive Health	1
Respiratory Disorders	1
Service Delivery	8
Smoking Cessation	2
Total Number of Studies	21



2.7 GOALS AGREED WITH COMMISSIONERS

Commissioning for Qualityand Innovation (CQUIN)
CQUIN is a payment framework whichenables commissioners to rewardexcellence by linking a proportion ofproviders' income to the achievementof local quality improvement goals.

Use of the CQUIN paymentframework
During 2012/132.5% of CityCare's income wasconditional on achieving optionalquality improvement and innovationgoals agreed between CityCare andNHS Nottingham City, through theCommissioning for Quality and Innovation(CQUIN) payment framework.

2.8 STATEMENT ONDATA QUALITY

CityCare will be taking the following actions to improve data quality.

- Complete actions identified following East Midlands Internal Audit Service(EMIAS) review of Health Visiting.
- Provide information on data quality performance to community nursing services to support the improvement of data quality.

NHS Number and General Medical Practice Code Validity

CityCare did not submit records during 2012/13 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 Information Governance toolkit measures CityCares performance against 39 requirements. The Information Governance assessment report score

CityCare strives to continually improve quality and therefore, as a minimum, will seek to maintain level 2 compliance in all the requirements and work progressively towards level 3.

2.9 WHAT OTHERS SAY ABOUT THE PROVIDER

Statement on Care Quality Commission (CQC) registration
CityCare is required to register with the Care Quality Commission and itscurrentlyregistered withno conditions on its registration.

CityCare has been subject to two routine inspections.The CQC has not taken enforcement action against CityCare as of 31 March 2013.

CityCare intends to take the following action to address the conclusions or requirements reported by the CQC:

- Completion of a compliance action in relation to an inspection of our Walk-in Centre location on 12 February 2013; this relates to outcome 14 supporting workers 'There was insufficient evidence to demonstrate that all staff had received induction, supervision, appraisal and training. Regulation 23(1)(a)'.

CityCare had made the following progress by 31 March 2013 in taking such action:

- Defined and communicated its current standards for the delivery of induction, essential training, and appraisal, defined and communicated the standard for staff files, and also has begun a revision of our management supervision policy, the organisation will continue to quickly progress this work.

Full details of our registrationcan be found on the Care QualityCommission online directory at www.cqc.org.uk.

CityCare was not subject to the Payment by Results clinical coding audit during 2012/13 by the Audit Commission.

Part 3 - Priorities for Quality Improvement 2013/2014

This year we have againgrouped our quality prioritiesunder the three headings ofPatient Safety, ClinicalEffectiveness, and PatientExperience. **Together these groups address whether our patients feel *'cared for, safe and confident in their treatment'.***

To put together our prioritieswe engaged with staff, NHSNottingham City, the LocalAuthority Health ScrutinyCommittee, the NottinghamLocal Improvement Network(LINk), our Patient ExperienceGroup, our Health Group foradults with learning disabilities,the Carers Federation,

We attended a Community inUnity consultation event,and held a listening event foryoung carers. We have also sought feedback from Age UK, BECONN,Pakistan and Indian community centre, the Clifton health and wellbeing group, and the Refuge Forum.

We also lookedat themes emerging frompatient satisfaction surveysand the feedback from complaints and PALS queries.

3.1 PATIENT SAFETY

Medicines Management andmedication safety was once again highlighted as a quality priority, with some priorities carried over from last year's report.

The Head of Medicines Management provides regular updates summarising key safety messages.

The tailored medicines training for CityCare staff will be carried forward to 2013/14. The aim is to provide specific training to specialist teams. For example, the Diabetes Specialist Nurses will receive training on new diabetes drugs. The Crisis Response Team and the Intermediate Care teams will receive training on medicines management. The delivery of these training sessions will be fully evaluated

Our medicines administration processes are of a high standard, there is always scope to improve them. For example, we will instigate a new system of competency assessments for all nurses involved in insulin administration.

We will aim to improve the quality of our non-medical prescribers (NMPs) by improving education and training support.

3.2 CLINICAL EFFECTIVENESS

In this section we also look at both new priorities and those carried over from last year's report on improving clinicaltraining, supervision and on-goingtraining, including disability, culturaland dementia awareness training.

3.2.1 Increasing our research capacity

CityCare is committed to undertaking effective research that informs the development and delivery of high quality patient-centred healthcare. Nottingham City is a leading centre of early intervention to improve health inequalities. CityCare has a strong commitment to building research capacity. We will produce and deliver a co-ordinated plan for research training for staff, and set up a research web page which will inform the workforce about research projects, training, research outcomes and funding opportunities.

We will continue to work in partnership with our local universities and support research activity to improve outcomes for patients.

3.2.2Clinical training, supervision and on-going training

Clinical Supervision will be delivered using a new *restorative supervision*model. It will be introduced initially to Health Visitors and Community Nursing services. *Restorative supervision* is an evidence-based programme that has proven outcomes to increase resilience and job satisfaction. A robust training programme will be put in place to ensure supervisors have the skills to deliver effective restorative supervision. A plan will be produced as to how the supervision will be cascaded through the identified services.

We will work closely with the Children's Partnership in the implementation of the cross-partnership Supervision Framework.

<u>Leadership</u>

Leadership development is paramount to the success of the organisation. The organisation will review its Organisational Development (OD) Strategy during 2013. As part of this review leadership will be explored to ensure our current leadership offer is fit for purpose for our future leaders, both clinical and non-clinical.

As part of the East Midlands Leadership Academy we will continue to support our leaders and managers in accessing resources and we will explore the new National NHS Leadership programme being launched later in 2013. We will continue to support our managers on the Liberating Social Enterprise Leadership programme where they can explore leadership in the context of social enterprises and social return on investment.

3.2.3 Staff Survey

This process offers a unique insight into the experiences and perceptions of staff across all levels and roles. It provides the organisation with clear evidence about the impact of corporate policies, practices and strategies on our workforce.

The Survey was developed as a bespoke on-line survey, sponsored by the Staff Working group. The themes of the survey were:

- Strategy and vision
- Culture and governance
- Leadership and management
- Support and wellbeing
- Working with a team
- Assessment and review
- Development
- Respect and dignity.

An action plan has been developed jointly by the Staff Working Group and the Executive Team to focus on the elements within the survey results requiring improvements and further developments. The plan will be owned by the Staff Working Group and the outcomes will be reported directly to the Board via the Staff Member's Board Report.

As part of the action plan consideration is being made on how the 2013 Staff Survey will be best delivered.

In the last financial year CityCare's statistics in sickness absence and turnover of staff were:

Sickness Absence = 4.15%

Turnover % Headcount = 12.04% & % FTE 11.89%

3.2.4 The Francis Report

Robert Francis' second report on the failings of Mid Staffordshire NHS Foundation Trust was published on 6 February 2013. The report focuses upon the response of the wider system to concerns about quality at the Foundation Trust.The overarching theme was of a negative NHS culture and not putting the safety of patients first:

- The Francis Report reminds all organisations providing NHS services that patient care and the quality is at the heart of our organisation, whatever role we play.
- The report also makes a number of recommendations around training, compassion, performance management and accountability for everyone providing NHS services to patients.

As a key provider we take a proactive stance in monitoring the safety and quality of our services. We are externally scrutinised by our commissioners, our Patient Experience Group and Members Panel. We also undergo organised external inspections as part of our monitoring programme. Patient surveys have demonstrated a high level of satisfaction with all our services (currently with a mean average 96% satisfaction rate).

We will review the Francis Report in detail to identify areas where we could benefit from making changes as the result of any recommendations that emerge.

We are committed to reviewing and embedding the lessons learnt from this report. We are focusing on the standards of quality care to ensure people are put first. This work will be supported by the board and senior leaders in embedding a culture of Being Open that supports staff to ensure that care and compassionis at the forefront of our service provision.

This will underpin all of our transformation work acrossadult services, working with our partners including social care,stakeholders and the public to deliver fully integrated care and continue delivering service improvement.

Central to our values and principles are:

- An improved patient focus with the patient at the heart of working together for service users, carers and families and other staff in everything we do! And the overriding value that patients are put first
- Integrating our Patient and Public Involvement (PPI) reporting into our early warning systems to ensure that emerging themes are identified early
- Embedding the learning from compliments and complaints.

We will:

- Demonstrate a shared culture in which the patient is the priority in everything CityCare does
- Review our common set of core values and standards to be shared throughout the organisation- values expressed in the NHS Constitution
- Ensure leadership at all levels
- Review systems for risk management to including openness and transparency in everything we do.

3.3 PATIENT EXPERIENCE

In our look back section we outlined our work to develop Customer Care training, and this section looks at any further outstanding actions needed.
We listen carefully to patients comments, concerns, complaints and compliments – and respond to them.

We also ask for local people's views when we're developing new services or making changes to existing ones, so that we always offer the services patients need, where, when and how they want them.
Patients can feedback form if they want to send us an idea or suggestion, can fill in satisfaction surveys when they have received our care, or there are different advisory groups they can join.

The Patient Experience Group feeds directly into the CityCare Board. It meets every 6 weeks, and staff, patients, service users, carers and the public discuss health and service issues. This includes ideas and suggestions for service improvements and new developments.Individual patients and carers using our services, members of the public, voluntary and community groups are welcome to join us.

CityCare Members panel: The panel is open to patients, carers, members of the public and organisations. Although there are no regular meetings, panel members will be invited to take part in surveys, consultations and meetings to help develop services.

As a priority for 2013/14 we haveidentified improving patient experience through the delivery customer care training and embedding the 6 C's across the organisation:

3.3.1 Customer care training and the 6 C's

Building on from the development of the new customer experience training programme, during 2013/14 the programme will be opened up to all staff.

We will add customer care training to our new essential and statutory training matrix. We will deliver a series of 'train the trainer' programmes to ensure there is adequate expertise within the services to understand and deliver excellence in customer care.

We will also offer opportunities for staff to develop higher level customer care skills through the delivery of customer care apprenticeship frameworks and accredited modules. In light of the Francis Report recommendations we will ensure our customer experience training programme includes the six C's - competence, communication, courage and commitmentto create a culture of compassionand care.

We will improve how we respond to service users after receiving their feedback.

The way we act has a significant impact on the quality of care that we deliver to people. Implementing the 6C's and creating an environment where we model the right behaviours and demonstrate them to users of our services will be critical to achieving the aim of having high quality, compassionate care and excellent health and well-being outcomes for all people.

We have identified six areas for action:

- Working with people to provide a positive experience of care
- Building and strengthening leadership
- Ensuring that we have the right staff, with the right skills in the right place
- Supporting positive experience
- PPI, communications and every contact counts.

3.3.2 Quality and Innovation

We have adopted a systematic approach to drive innovation through both clinical research and service delivery to make innovation everybody's job and bring about lasting change in culture and behaviour in our leaders and workforce as a whole.

Innovation is the priority- consistently breaking the mould and challenging current working practice, through developing evidence-based care and extend evidence through research, making 'every contact count' to promote health and wellbeing at individual, family and community levels.

New technologies are viewed as key enablers to operational delivery and a high level of investment has been made in new technology that has been the catalysis for change.

We have a history of high Impact Innovations working with, Crisis Response, and the integrated transformation programme across adults and social care, including productive community services where there is a focus on working in an efficient and cost effective way.

Clinical audit is an invaluable tool for quality assurance and improving outcomes for patients, and CityCare has an extensive programme. Projects undertaken during 2012-13 are driving improvements in areas such as infection control, paediatric continence, pressure ulcers, and rehabilitation after falls. For example the Continence service identified a real need for change based

on users and audit feedback a review of service provision was undertaken and a new model of care implemented.

Part 4 -What other people thinkof our Quality Accounts

Text to come when relevant groups have seen draft report

4.1 Commissioning Primary Care Trust - NHS Nottingham City

4.2 Local Involvement Network (LINk) or HealthWatch

4.3 Nottingham City Health Scrutiny Panel

Part 5 -Our commitment to you

This Annual Quality Account has featured a review of 2012/13 and a look forward to 2013/14. It gives not only an overview of some of our quality achievements but also highlights the areas where we know we need to further improve.

We will ensure there is a further focus on quality and a culture of continuous improvement , embedding values in everything we do. We will need to look underneath our quality measures through patient safety, clinical effectiveness and patient experienceto ensure patients are at the heart of everything we do.

We will drive our standards in putting people first,supporting our patients in feeling cared for, safe, and confident in their treatment, with services delivered by a caring and compassionate workforce.

We will build and learn from our internal governance review and implement the recommendations developing an integratedmodel of governance for better outcomes, bringing about organisational change to improve patient outcomes by ensuring that there are risk management processes in place.

Throughout the year, across CityCare we will encourage patient feedback, and act on that feedback to improve our servicesthrough systems and processes that bring about organisation change to improve patient outcomes. This will be delivered through a model of change with a comprehensive approach to actions that support each other with engagement with through the whole organisation to embed the values of quality and innovation across the whole organisation.

We will strengthen a high performing organisation that is well run and well led, with an open culture that supports staff and is focused on delivering its purpose through strong leadership, increased openness and a culture of transparency.

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.

Patient Quotes to go in the document spread around – if longer quotes required we can change this:

“The level of professionalism, care and support provided during the very traumatic and difficult time really made a difference”

“All staff were very professional, and highly considerate”

“They made the family feel at ease and provided much needed reassurance.”

“They always follow up what they have agreed and go over and above their expected duties to provide care. They are both a credit to their profession.”

“The staff are efficient and supportive”

“We could not have got through this tough time without their help and support. The staff are a credit to the health service.”

“They are a credit to their profession.”

“Feels like I am walking on air. Podiatrist has done a brilliant job”.

“Straight forward, hassle free and professional.”

"Very good.Very prompt and helpful service. Seen and sorted in 20 minutes".

"Excellent service with very good staff".

HEALTH SCRUTINY PANEL
29 MAY 2013
WORK PROGRAMME 2013/14
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider the Panel's work programme for 2013/14, based on areas of work identified by the Panel at previous meetings and any further suggestions raised at this meeting.

2. Action required

2.1 The Panel is asked to note the work that is currently planned for municipal year 2013/14 and make amendments to this programme if considered appropriate.

3. Background information

3.1 The Health Scrutiny Panel is responsible for carrying out the overview and scrutiny role and responsibilities for health and social care matters and for exercising the Council's statutory role in scrutinising health services for the City. The terms of reference for the Panel is included elsewhere on this agenda.

3.2 The Panel is responsible for determining its own work programme to fulfil its terms of reference. The work programme is attached at Appendix 1. This is based on the provisional draft work programme that was considered by the Panel at its last meeting of 2012/13 municipal year in March.

3.3 The work programme is intended to be flexible so that issues which arise as the year progresses can be considered appropriately. This is likely to include consultations from health service providers about substantial variations and developments in health services that the Panel has statutory responsibilities in relation to.

3.4 Where there are a number of potential items that could be scrutinised in a given year, consideration of what represents the highest priority or area of risk will assist with work programme planning. Changes and/or additions to the work programme will need to take account of the resources available to the Committee.

3.5 Councillors are reminded of their statutory responsibilities as follows:

While a 'substantial variation or development' of health services is not defined in Regulations, a key feature is that there is a major change to services experienced by patients and future patients. Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area.

This Panel has statutory responsibilities in relation to substantial variations and developments in health services set out in legislation and associated regulations and guidance. These are to consider the following matters in relation to any substantial variations or developments that impact upon those in receipt of services:

(a) Whether, as a statutory body, the relevant Overview and Scrutiny Committee has been properly consulted within the consultation process;

(b) Whether, in developing the proposals for service changes, the health body concerned has taken into account the public interest through appropriate patient and public involvement and consultation;

(c) Whether a proposal for changes is in the interests of the local health service.

Councillors should bear these matters in mind when considering proposals.

3.6 Nottingham City and Nottinghamshire County Councils have established a Joint Health Scrutiny Committee which is responsible for scrutinising decisions made by NHS organisations, together with reviewing other health issues that impact on services accessed by both City and County residents.

4. List of attached information

4.1 The following information can be found in the appendix to this report:

Appendix 1 – Health Scrutiny Panel 2013/14 Work Programme

5. Background papers, other than published works or those disclosing exempt or confidential information

None

6. Published documents referred to in compiling this report

Report to and minutes of Health Scrutiny Panel meeting held on 28 March 2013

7. Wards affected

All

8. Contact information

Jane Garrard, Overview and Scrutiny Review Co-ordinator
Tel: 0115 8764315
Email: jane.garrard@nottinghamcity.gov.uk

APPENDIX 1

Health Scrutiny Panel 2013/14 Work Programme

Date	Items
29 May 2013	• **CityCare Partnership Quality Account 2012/13** To consider CityCare Partnership's Quality Account 2012/13 and whether to make a statement for inclusion • **Adult integrated care** To consider the adult integrated care programme • **'Community case finders' hospital discharge** To consider work to facilitate timely hospital discharge and prevent unnecessary hospital admissions through the 'community case finders' model
24 July 2013	• **Healthwatch Protocol** To agree a protocol for the working relationship between health scrutiny and Healthwatch Nottingham • **Public health** To take an overview of the Council's public health responsibilities and key priorities and challenges
25 September 2013	• **Quality of care in care homes (tbc)** *focus to be determined* • **CityCare Partnership complaints** To review how CityCare Partnership responds to patient comments and complaints
27 November 2013	• **Care at home (tbc)** *focus to be determined*

29 January 2014	• **CityCare Partnership Quality Account 2013/14** Preliminary consideration of priorities for CityCare Partnership's Quality Account 2013/14
26 March 2014	• **Healthwatch Nottingham** To review the first year since the establishment of Healthwatch Nottingham • **Health and Wellbeing Board and Joint Health and Wellbeing Strategy** To review the first year of Health and Wellbeing Board and progress in implementing the Joint Health and Wellbeing Strategy

To schedule:

- Nottingham Local Account