Nottingham City Council

NOTTINGHAM CITY COUNCIL
HEALTH SCRUTINY COMMITTEE

Date: Wednesday, 27 May 2015

Time: 10.00 am

Place: LB31 - Loxley House, Station Street, Nottingham, NG2 3NG

Councillors are requested to attend the above meeting to transact the following business

Acting Corporate Director for Resources

Governance Officer: Clare Routledge **Direct Dial:** 0115 8763514

AGENDA **Pages**

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1	**APPOINTMENT OF VICE CHAIR**	
2	**APPOINTMENT OF LEAD HEALTH SCRUTINY COUNCILLOR**	
3	**APOLOGIES FOR ABSENCE**	
4	**DECLARATION OF INTERESTS**	
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9 **EXTENDED WORK PROGRAMME PLANNING 2015/16** 97 - 156
Report of the Head of Democratic Services

10 **2015/15 HEALTH SCRUTINY COMMITTEE MEETING DATES**
To consider meeting at 1.30 pm on the following dates:
18/06/15
23/07/15
24/09/15
22/10/15
19/11/15
1712/15
21/01/16
18/02/16
24/03/16
21/04/16

IF YOU NEED ANY ADVICE ON DECLARING AN INTEREST IN ANY ITEM ON THE AGENDA, PLEASE CONTACT THE GOVERNANCE OFFICER SHOWN ABOVE, IF POSSIBLE BEFORE THE DAY OF THE MEETING

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

CITIZENS ARE ADVISED THAT THIS MEETING MAY BE RECORDED BY MEMBERS OF THE PUBLIC. ANY RECORDING OR REPORTING ON THIS MEETING SHOULD TAKE PLACE IN ACCORDANCE WITH THE COUNCIL'S POLICY ON RECORDING AND REPORTING ON PUBLIC MEETINGS, WHICH IS AVAILABLE AT WWW.NOTTINGHAMCITY.GOV.UK. INDIVIDUALS INTENDING TO RECORD THE MEETING ARE ASKED TO NOTIFY THE GOVERNANCE OFFICER SHOWN ABOVE IN ADVANCE.

NOTTINGHAM CITY COUNCIL

HEALTH SCRUTINY PANEL

MINUTES of the meeting held at LB31-32 - Loxley House, Station Street, Nottingham, NG2 3NG on 25 March 2015 from 1.30pm – 3.31pm

Membership

Present
Councillor Ginny Klein (Chair)
Councillor Thulani Molife (Vice Chair)
Councillor Merlita Bryan
Councillor Azad Choudhry
Councillor Brian Parbutt
Councillor Anne Peach

Absent
Councillor Mohammad Aslam
Councillor Eileen Morley
Councillor Timothy Spencer
Councillor Emma Dewinton

Colleagues, partners and others in attendance:

Voluntary and Community Sector
Jenny Billings - MESH Nottingham
Anne Darby - Disability Involvement Group
Craig Galpin - OSCAR Nottingham
Maxine Robinson - Support for Survivors
Barbara Venes - Patient representative
Chrissie Wells - OSCAR Nottingham

Nottingham City Clinical Commissioning Group
Dr Manik Arora
Russell Pitchford
Naomi Robinson
Hazel Wigginton

Nottingham City Council
Noel McMenamin - Governance Officer
Annette Molyneux - Project Officer, Equalities and Community Relations
Louise Noon - Public Health Manager
Kim Pocock - Constitutional Services Manager
Clare Routledge - Senior Governance Officer

49 APOLOGIES FOR ABSENCE

Councillor Emma Dewinton (other Council business)
Councillor Eileen Morley (leave)

50 DECLARATION OF INTERESTS

Councillor Merlita Bryan declared a personal interest in agenda item 6 (minute 54 below) – 'Overview of the work of OSCAR Nottingham' – as a patron of the organisation, which did not preclude her from speaking or voting.

51 MINUTES

The Panel confirmed the minutes of the meeting held on 27 January 2015 as a true record and they were signed by the Chair.

52 URGENT CARE SERVICES

Naomi Robinson, Commissioning Manager – Primary Care, Nottingham City Clinical Commissioning Group, introduced a report and presentation, updating the Panel on the preferred provider for urgent care services, providing further detail on plans for interim and future service provision.

Ms Robinson made the following points in her presentation:

(a) a review of both walk-in service contracts had previously taken place. While a service data and patient survey review in 2011/12 indicated a duplication of services and variances in delivery between both services. Patient feedback indicated high levels of satisfaction with the services, but also highlighted problems in accessing primary care. GP commissioners used these findings to inform a remodelling of walk-in services committing the same level of funding but develop a service model that treats an extended range of urgent health problem; the remodelling approach presented to key stakeholders in 2013/14 was broadly welcomed. There was specific support for a more seamless 'see and treat' approach, for greater clarity between the roles of walk-in and primary care services, and for greater equity of access through having a city centre location;

(b) there followed intensive clinical and patient engagement, involving the Patient Engagement Team and Healthwatch Nottingham and including 'roadshows' and 2 significant engagement events. The engagement findings confirmed support for a city centre location, increased diagnostics (particularly x-Ray), co-location with urgent dental services, consistent 7-day opening times and public transport and parking access;

(c) a further period of engagement focused on 'seldom heard' groups. Feedback included the need for a welcoming and non-judgmental approach, maintaining current links between services and substance misuse and homelessness organisations and access to repeat prescriptions;

(d) the key features of the final urgent care specification included high quality assessment, diagnosis and treatment of urgent health conditions, urgent diagnostic x-Ray without attending Accident and Emergency, year-round opening hours of 7am-9pm, short waiting times for initial assessment and treatment and continued access for vulnerable patient groups with close links to specialist services;

(e) the procurement process attracted 13 expressions of interest, and, following a market management-bidder event in September 2014, 3 organisations submitted a bid. The procurement process was supported by a Patient Procurement Panel, providing a 'patient voice' throughout;

(f) Nottingham CityCare Partnership was announced as the preferred bidder in February 2015, and an Implementation Group is to be established to oversee the development of the Urgent Care Centre;

(g) The Centre is to be sited at Seaton House, London Road and the CityCare Partnership is working to a commencement date of 1 October 2015. There will be a managed transition of the Urgent Care Centre and the closure of the 8-8 Health Centre and Clifton Nurse Access Point; .

The Panel commended the process for its high levels of transparency and stakeholder engagement. During discussion, the following points were made:

(h) Ms Robinson confirmed that there will be consistent ongoing communication with citizens and GP practices on transition arrangements. While it would be for the preferred bidder to clarify what was meant by 'urgent' care, communications leads from all relevant organisations involved in interim arrangements needed to liaise to ensure a seamless transition;

(i) Ms Rigby confirmed that Healthwatch's close involvement with the Urgent Care Services development was as a direct result of the Health Scrutiny Panel commencing the scrutinising of the remodelling process in March 2014;

(j) Ms Robinson confirmed that TUPE arrangements will apply for affected staff and a programme of upskilling staff will take place. A Provider Event and Roadshow Events for staff had also taken place.

(k) There was consensus that Seaton House on London Road, while not ideal, was the best available option, being relatively central, on an arterial route and having parking available;

(l) A Panel member suggested that a 'Hopper' bus service would make the Centre more accessible;

(m) Ms Robinson welcomed a Healthwatch suggestion to locate a Healthwatch 'Talk to Us' information and feedback point at Seaton House;

(n) The Panel welcomed the Urgent Care Centre alleviating pressure on the A&E Department and shorter waiting times for patients;

(o) The Panel requested an update once the Seaton House facility was fully established, and welcomed the opportunity to visit the Seaton House site in the future.

RESOLVED to

(1) thank Ms Robinson for her informative presentation;

(2) consider a further update once the Seaton House Walk-In Centre was fully operational, and to organise a Panel visit to the Centre.

53 ACCESS TO SERVICES FOR PEOPLE WITH ME (MYALGIC ENCEPHALOPATHY/ENCEPHALOMYELITIS)

The Chair introduced a report of the Head of Democratic Services on the services provided for and issues faced by people with Myalgic Encephalopathy (ME) and related diagnoses, to determine whether further scrutiny is required. The issue had been brought to the Panel's attention by members of the public, and public concerns had been expressed about gaps in and consistency of service provision.

The Panel received a presentation by Russell Pitchford, Commissioning Manager – Community Services and Integration at NHS Nottingham City Clinical Commissioning Group (CCG), who highlighted the following points:

(a) ME and related conditions, including Chronic Fatigue Syndrome (CFS), Post-Viral Fatigue Syndrome (PVFS) and Chronic Fatigue Immune Dysfunction Syndrome (CFIDS) were prevalent in 0.2 to 0.4% of the population. The National Institute for Clinical Excellence classifies ME/CFS into 3 categories: mild, moderate and severe, but definitive figures for each category are not known;
(b) It is acknowledged that there is a considerable variation in current practice by service providers;
(c) Diagnosis is by exclusion of other possible diagnoses, with symptoms persisting for 4 months in adults and 3 months in children and young people, and may present with other conditions, making diagnosis complex;
(d) It is acknowledged that the conditions have a significant impact on patients and families;
(e) There is a specialist Nottinghamshire Adult CFS/ME Clinic based at the City Hospital, providing services to those with mild to moderate diagnoses. The programme offered seeks to sustain and/or extend the person's physical, emotional and cognitive capacity, to manage the physical and emotional impact of their symptoms and to provide cognitive behaviour therapy and/or graded exercise therapy;
(f) The nearest facility for treating severe ME is in Leeds, but there are no current patients from Nottingham referred to the facility;
(g) Services should be needs-based and delivered under local integrated services, with support from specialist services;
(h) The CCG has identified training and education and continuity of care and access to services as the key development areas going forward. The CCG will look to offer education and awareness raising among non-specialists on the symptoms, diagnosis and management of the ME, will look to make local clinicians aware of the specialist services available, and seek to ensure that specialist services consider providing education and awareness training to non-health professionals;
(i) The CCG will also establish agreed pathways to ensure timely diagnosis, consider local referral protocols so people are treated in the right setting, include guidance in protocols so that care is consistent across services.

The Chair then invited Jenny Billings of the ME Self Help Nottingham Group (MESH) to address the Panel, who made a number of points, summarised below:

(j) sufferers of ME/CSF in Nottingham City have experienced delays in diagnosis, have been misdiagnosed and have not been taken seriously by GPs when presenting with ME/CSF symptoms. Sufferers of Fibromyalgia have had similar experiences;
(k) there is a need for a training refresh for GPs in Nottingham to address attitudes to ME/CSF, and to ensure consistency of diagnosis and treatment. In particular, there has been inconsistency in carrying out blood tests and in referring patients to specialists to rule out other illnesses at an early stage;
(l) it is regrettable that Nottingham City CCG did not circulate to GPs for information a report produced by Carruthers and Van de Sande on ME/CSF, as

it purportedly failed to meet NICE Guidelines. This was at odds with NHS Services elsewhere in England, which have based information given to patients on this report;

(m) it is unacceptable that the nearest service for those with severe ME/CSF is in Leeds, while patients with moderate ME/CSF find it difficult to access the service at the City Hospital because of its remote location;

(n) MESH Nottingham has experienced poor levels of communication and consultation with Nottingham City CCG, particularly about progression and outcomes of a personalised health budget pilot, and proposed service provision for those with severe ME/CSF. Better working relations between MESH Nottingham and Nottingham City CCG are needed to achieve better outcomes for Nottingham citizens;

(o) It is unacceptable to have local diagnosis figures based on national percentages rather than on local NHS medical records, and this is down to a failure to diagnose and refer appropriately;

(p) There is a sense that there has been little positive action to improve the situation for patients 'on the ground'. Without the CCG being held to account through a timetable for action this situation is likely to continue, and MESH Nottingham wanted the Panel's help in continuing to monitor the service provided to ME/CSF sufferers in Nottingham;

(q) A service user endorsed Ms Billings' comments about diagnosis difficulties, and advised that a majority of survivors of child sexual exploitation suffered from CFS;

(r) In response to points (j) to (p) above, Mr Pitchford advised that patient feedback for the ME/CSF clinic for mild to moderate sufferers was very positive. He acknowledged that there were gaps in provision for those with severe ME/CSF, but that commissioning a service was difficult given low numbers, and options for a joint Nottingham/Derby service were being explored.

Dr Manik Arora of Nottingham City CCG provided a GP/clinician perspective, making the following points:

(s) GPs need to diagnose by exclusion and, while frustrating for both patients and clinicians, taking time to eliminate non-ME/CSF conditions such as anaemia and Multiple Sclerosis is vital if very serious alternative conditions are to be identified and treated. An added complication was that diagnosing other conditions did not mean that ME/CSF was not also present;

(t) Clinicians are happy to take on board learning but are also frustrated by the conflicting guidance, advice and evidence available;

(u) Accurately recording numbers is challenging and this makes the task of commissioning a service very difficult. Addressing the lack of information through the Joint Strategic Needs Assessment (JSNA) would be helpful;

(v) Fragmented commissioning is an issue, but can only be improved through all stakeholders working together non-confrontationally. Ultimately, clinicians want to address patient needs.

Ruth Rigby, Managing Director, Healthwatch Nottingham, appealed to all stakeholders, but especially to patients groups, to share information with Healthwatch. This will build an evidence base to help inform the Joint Strategic Needs Assessment (JSNA) and commissioning decisions going forward. As an

independent body, Healthwatch Nottingham is in a position to help facilitate information-sharing among stakeholders.

RESOLVED to note the presentations and very valuable, open discussion and to endorse Healthwatch Nottingham's offer to facilitate information gathering and exchange.

54 OVERVIEW OF THE WORK OF OSCAR NOTTINGHAM

Craig Galpin and Chrissie Wells of OSCAR Nottingham (Organisation for Sickle Cell Anaemia Relief) gave a presentation on the disorder and the organisation's work in Nottingham, addressing the following points:

(a) Both Sickle Cell Disorder (SCD) and Thalassaemia Major (TM) are related inherited blood conditions affecting red blood cells, primarily affecting people with family backgrounds in in areas where malaria is or was prevalent;
(b) It is estimated that there are 250,000 SCD carriers and 214,000 TM carriers in the UK. There is no current information on prevalence in the East Midlands, but in 2009 there were 320 SCD and 35 TM sufferers diagnosed in the region;
(c) In Nottingham, OSCAR provides non-medical support to SCD and MT sufferers and their families. It also runs the WHY (Health and Wellbeing for You) Project to help address wider Black and Minority Ethnic health inequalities, and engages in education and awareness raising activities;
(d) OSCAR has trained 120 Police custody officers from across Nottinghamshire on the care of people with SCD and TM, and it is hoped this service will be rolled out nationally. It also works closely with health and housing partners to improve outcomes and opportunities for sufferers;
(e) The organisation gave a presentation to the All Party Parliamentary Group for Sickle Cell and Thalassaemia, informing it of a pilot screening project commissioned by Nottingham Clinical Commissioning Group Norcomm Cluster Group;
(f) OSCAR Nottingham's main challenges going forward include helping secure sustainable social and welfare support for people with blood disorders, and to identify further funding streams and efficiencies for general health and wellbeing through bringing together health and social care.

The Panel thanked Mr Galpin and Ms Wells for their informative presentation, and made the following points:

(g) In response to a Panel member's query, Ms Wells explained that the symptoms include chronic pain, fatigue, dehydration, shortness of breath and palpitations. Because symptoms can be episodic, it can be difficult to maintain jobs or education opportunities, or find appropriate housing that does not exacerbate symptoms;
(h) It was suggested that OSCAR Nottingham should inform the review of Nottingham's Joint Strategic Needs Assessment to help identify prevalence and gaps in provision;
(i) It was suggested that GPs sometimes misdiagnose the conditions. While babies and pregnant women are screened, being diagnosed as a carrier of the conditions is not considered a major medical issue by some doctors. Ruth Rigby

of Healthwatch Nottingham advised that issues about specific GPs should be referred to them to help ensure a consistent approach;

(j) The Chair advised that there is a specialist team of NHS nurses doing outreach work in Nottingham to address blood disorders, including SCD and TM;

(k) OSCAR Nottingham is involved with the social element of a medical research project on SCD and TM being conducted by De Montfort University;

(l) A Panel member undertook to raise awareness of the conditions' symptoms among Trade Union colleagues;

(m) City Council actions to license the private rental housing sector will help improve housing conditions in Nottingham, alleviating SCD and TM sufferers' symptoms.

RESOLVED to note the presentation and Panel members' comments.

55 WORK PROGRAMME

The Panel considered a report of the Head of Democratic Services relating to the work programme for the Health Scrutiny Panel's first meeting in 2015/16. The Panel noted that there will be an extended work programme planning session at the May 2015 meeting.

RESOLVED to note the Panel's work programme.

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HEALTH SCRUTINY COMMITTEE
27 MAY 2015
HEALTH SCRUTINY COMMITTEE TERMS OF REFERENCE AND JOINT AGREEMENT
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To ensure all members of the Health Scrutiny Committee are aware of the Committee's terms of reference and joint agreement between the Health and Wellbeing Board, Healthwatch Nottingham and Health Scrutiny and the implications for the operation of the Committee during the year.

2. Action required

2.1 The Committee is asked to note the terms of reference for the Health Scrutiny Committee and the joint agreement between the Health and Wellbeing Board, Healthwatch Nottingham and Health Scrutiny.

3. Background information

3.1 On 18 May 2015 Council is due to agree its terms of reference.

3.2 The Nottingham City Health and Wellbeing Board, Health Watch Nottingham and Health Scrutiny Ways of Working Agreement was agreed at the Health Scrutiny Panel on 28th May 2014.

4. List of attached information

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

Appendix 1 – Health Scrutiny Committee Terms of Reference
Appendix 2 - Nottingham City Health and Wellbeing Board, Health Watch Nottingham and Health Scrutiny Ways of Working Agreement

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 18 May 2015
Health Scrutiny Panel - Nottingham City Health and Wellbeing Board, Health Watch Nottingham and Health Scrutiny Ways of Working Agreement Report and Minutes held on 28 May 2014.

7. Wards affected

All

8. Contact information

Clare Routledge, Senior Governance Officer (Health Scrutiny)
Tel: 0115 8763514
Email: clare.routledge@nottinghamcity.gov.uk

Health Scrutiny Committee

(a) To set and manage its work programme to fulfil the overview and scrutiny roles and responsibilities for health and social care matters, including, 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 policies and strategies of the Council and other local decision-makers where they impact on Nottingham residents;
   iii. explore any matters affecting Nottingham and/ or its residents;
   iv. make reports and recommendations to relevant local agencies in relation 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 Nottingham City in accordance with the 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 panels (no more than 1 panel at any one time) to carry out a review of a matter within its remit. Commissioning includes setting the remit, initial timescale and size of membership to meet the needs of the review to be carried out. Such review panels will be chaired by the Chair of the Health Scrutiny Committee;

(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 Committee or any review panels it commissions to support effective delivery of the overview and scrutiny work programme.

Membership

The Health Scrutiny Committee comprises 10 members.

Labour Group:	8
Conservative Group:	2

Quorum

The quorum for a meeting of the Health Scrutiny Committee is three members.

Chairing

The Chair will be a member of the pool of five overview and scrutiny chairs and is appointed by Full Council. The Vice-Chair will be appointed at the first meeting of the Health Scrutiny Committee from the membership of the Committee.

Appendix 2

Nottingham City Health and Wellbeing Board, Healthwatch Nottingham and Health Scrutiny Ways of Working Agreement

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1. Purpose of the Agreement

This Ways of Working agreement sets out the relationship between the Nottingham City Health and Wellbeing Board, Healthwatch Nottingham and Nottingham City Council's Health Scrutiny function.

Health and Wellbeing Boards and Local Healthwatch were formed as a result of the 2012 Health and Social Care Act, which also expanded the role of Health Scrutiny. Whilst these bodies have specific distinct functions, there is potential for overlap in their work and opportunities for them to work in a complementary fashion whilst maintaining their independence.

The Agreement clarifies the key roles of the 3 bodies, their legal obligations to each other and how they will work together to improve the health and social care services for people in Nottingham.

2. Role of Nottingham City Health and Wellbeing Board

The Nottingham City Health and Wellbeing Board is the city's lead multiagency partnership for improving health and wellbeing and reducing health inequalities of the citizens of Nottingham City. Functions of the Health and Wellbeing Board include:

- Supporting the development of improved and joined up health and social care services.
- Overseeing, where appropriate, the use of relevant public sector resources across a wide spectrum of services and interventions to ensure outcomes from health care, social care and public health interventions.
- Developing and overseeing the implementation of the Joint Health and Wellbeing Strategy.
- Developing and overseeing the implementation of the Joint Strategic Needs Assessment and the Pharmaceutical Needs Assessment.
- Overseeing joint commissioning and joined up provision for citizens, patients, social care service users and carers, including social care, public health and NHS services with aspects of the wider local authority agenda that also impact on health and wellbeing, such as housing, education and the environment.
- Considering local commissioning plans to ensure that they are in line with the Joint Health and Wellbeing Strategy.
- Promoting public involvement in the development of the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.
- Being one of the theme partnerships within the One Nottingham partnership family to lead on the Nottingham Plan to 2020 Healthy Nottingham priority.

3. Role of Healthwatch Nottingham

Healthwatch Nottingham will:

- Use its seat on the Health and Wellbeing Board to ensure that the views and experiences of patients, carers and other service users are taken into account when local needs assessments and strategies are prepared, such as the Joint Strategic Needs Assessment.
- Enable people to share their views and concerns about their local health and social care services and understand that their contribution will help build a picture of where services are doing well and where they can be improved.
- Give authoritative, evidence-based feedback in relation to the commissioning and delivery of local health and social care services.
- Help and support the Board to make sure that services really are designed to meet citizens' needs.
- Be inclusive and reflect the diversity of the community it serves.

4. Role of Health Scrutiny

Overview and scrutiny helps to provide accountability and transparency in local public services. It is an opportunity for non-executive councillors to review policies, decisions and services of the City Council and other organisations operating in Nottingham to ensure they meet the needs of the community and, where necessary, makes recommendations for improvement.

Health Scrutiny not only holds Council decision makers to account but also reviews and scrutinises commissioning and delivery across the health and social care system to ensure reduced health inequalities, access to services and the best outcomes for local people. Scrutiny can make reports and recommendations to NHS bodies and providers of NHS funded services. When a substantial change to a local health service is proposed, Health Scrutiny should be consulted and has a statutory role to ensure that the public interest has been taken into account and the proposed change is in the best interests of local health services.

There are two Health Scrutiny Committees:

- Health Scrutiny Committee (for health and adult social care matters in Nottingham City)
- Nottingham City and Nottinghamshire County Joint Health Scrutiny Committee (for health matters across the Greater Nottingham area)

For the purpose of this Agreement the term 'Health Scrutiny' refers to both of these Committees.

5. Legal Obligations between the 3 Bodies

All three bodies have a legal basis and within their statutory functions there are specific legal obligations that exist between them.

- The Health and Wellbeing Board has a duty to involve Healthwatch. Nottingham in the preparation of the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment.
- The Health and Wellbeing Board has a duty to have a voting representative from Healthwatch Nottingham.
- Healthwatch Nottingham must appoint one person to represent it on the Health and Wellbeing Board.
- Healthwatch Nottingham must provide a copy of its annual report to Health Scrutiny.
- Health Scrutiny has a responsibility to review and scrutinise matters relating to the planning, provision and operation of health services in Nottingham and make reports and recommendations to relevant decision makers, including the Health and Wellbeing Board.
- Health Scrutiny must acknowledge and respond to referrals from Healthwatch Nottingham.

6. Local Commitments between the 3 Bodies

The Health and Wellbeing Board, Healthwatch Nottingham and Health Scrutiny will:

a) have a shared understanding of each other's roles, responsibilities and priorities
b) work in an open and constructive way
c) work in a climate of mutual respect and courtesy
d) respect each other's independence and autonomy.

Each body will produce and maintain an up-to-date work programme that is shared with each other to enable issues of mutual concern to be identified at an early stage and dealt with in a way that makes best use of respective roles, responsibilities and resources and avoids duplication. On major pieces of work requiring engagement, involvement or consultation of services users, carers and the public, the bodies will work collaboratively to agree roles and responsibilities. Where possible, the three bodies will seek to agree joint responses to consultation.

In working together recognition will be given to Healthwatch Nottingham's position as a member of the Health and Wellbeing Board; and the impact that this might have on its contribution to the work of Health Scrutiny, when that work relates to the Health and Wellbeing Board and its decisions and activities.

The successful application of the principles and commitments set out in this Agreement will depend on effective communication between the three bodies.

Every effort will be made to ensure ongoing open communication and regular informal meetings will be arranged to facilitate this.

The Health and Wellbeing Board will:

- Share the Board and Commissioning Executive Group's work plan with Health Scrutiny and Healthwatch Nottingham.
- Update Health Scrutiny on its progress with the Joint Strategic Needs Assessment and the Joint Health and Wellbeing Strategy.
- Take account of and respond to the opinions of Healthwatch Nottingham.
- Be subject to scrutiny by the Council's Health Scrutiny Committees and provide information[1] and attend meetings as requested to assist in their scrutiny work.
- Take account of and respond to comments, reports and recommendations submitted by Health Scrutiny.
- Request Health Scrutiny (subject to available resource) to undertake a particular piece of work within its remit. (Health Scrutiny may choose not to do so).
- Request (subject to available resource) Healthwatch Nottingham to undertake a particular piece of work in order to inform the Board of public opinion and experience of services where there are particular concerns and enable the public to influence decisions. (Healthwatch Nottingham may choose not to do so).

Meetings of the Health and Wellbeing Board which includes Healthwatch Nottingham, are held in public and representatives of Health Scrutiny Committee and Joint City and County Health Scrutiny Committee will be welcome to attend.

Healthwatch Nottingham will:

- Share its work programme with the Health and Wellbeing Board and Health Scrutiny.
- Provide relevant public opinions/experiences about services to support the development of JSNA chapters.
- Highlight concerns about services to Health Scrutiny and, where appropriate, make referrals in line with the process set out in Section 7 of this agreement.
- As a member of the Health and Wellbeing Board, provide information and challenge from the perspective of the public, service users and carers as well as appropriate intelligence on any strategic and/or commissioning concerns.

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[1]The Board and its partners will not be required to provide:

- Confidential information which relates to and identifies an individual unless the information is disclosed in a form ensuring that individuals' identities cannot be ascertained, or an individual consents to disclosure.
- Any information, the disclosure of which is prohibited by or under any enactment.
- Any information, the disclosure of which would breach commercial confidentiality.
-

- Work with the Health and Wellbeing Board and Health Scrutiny to provide information and comments as the public champion.
- Regularly inform Health Scrutiny of current issues and, in exceptional circumstances, request Health Scrutiny to consider whether a formal referral to the Secretary of State for Health is required.
- Provide Health Scrutiny with information as requested for specific topics and issues regarding patient and user experiences and access to services (subject to available resource).
- Acknowledge and respond to referrals from Health Scrutiny in line with the process set out in Section 7 of this agreement.

Health Scrutiny will:

- Share the Health Scrutiny Committee and Joint City and County Health Scrutiny Committee work programmes with Healthwatch Nottingham and the Health and Wellbeing Board.
- Seek views of Healthwatch Nottingham and the Health and Wellbeing Board when formulating Health Scrutiny work programmes.
- 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, including its responsibilities in relation to the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment.
- Make reports and recommendations to the Health and Wellbeing Board as a result of scrutiny activity, including any concerns identified regarding the commissioning and/or delivery of local health and care services with a view to influencing future commissioning plans.
- Request Healthwatch Nottingham (subject to available resource) to submit relevant intelligence and information to support scrutiny work.
- Invite representatives of Healthwatch Nottingham to attend and, at the Chair's discretion, speak at Health Scrutiny meetings.
- Request Healthwatch Nottingham (subject to available resource) to undertake a particular piece of work in order to inform Health Scrutiny activity. In exceptional circumstances, this may include requesting that Healthwatch Nottingham use its 'Enter and View' powers where there is an issue of particular concern. (Healthwatch Nottingham may choose not to do so).
- Take account of and respond to the views and recommendations of Healthwatch Nottingham and the Health and Wellbeing Board.
- Acknowledge and respond to referrals from Healthwatch Nottingham in line with the process set out in Section 7.
- Refer relevant issues to Healthwatch Nottingham in line with the process set out in Section 7.
- Consider Healthwatch Nottingham's annual report.

Meetings of the Health Scrutiny Committee and Joint City and County Health Scrutiny Committee are held in public and representatives of Healthwatch Nottingham and the Health and Wellbeing Board will be welcome to attend.

7. Referrals between Healthwatch Nottingham and Health Scrutiny

Referrals from Healthwatch Nottingham to Health Scrutiny

If, during the course of its work, Healthwatch Nottingham identifies an issue that it feels warrants exploration by Health Scrutiny it can make a referral. Referrals should be made in writing to the lead health scrutiny councillor via the Council's Overview and Scrutiny Team. Referrals should set out:

- the nature of the referral
- the reason why the referral is being made
- any evidence about the issue
- what action it is proposed should be taken

Referrals will be acknowledged and considered at the next available meeting of the appropriate Health Scrutiny Committee. Healthwatch Nottingham will be informed of the outcome of this consideration and if the request is supported, any actions planned and progress then made in investigating the issue. If Health Scrutiny decides not to act on a referral it will provide reasons for not doing so.

Referrals from Health Scrutiny to Healthwatch Nottingham

If, during the course of its work, Health Scrutiny identifies an issue that it feels warrants exploration by Healthwatch Nottingham it can make a referral. Referrals should be made in writing to the Healthwatch Nottingham Managing Director. Referrals should set out:

- the nature of the referral
- the reason why the referral is being made
- any evidence about the issue
- what action it is proposed should be taken

Referrals will be acknowledged and considered. Health Scrutiny will be informed of the outcome of this consideration and if the request is supported, any actions planned and progress then made in investigating the issue, if. Healthwatch Nottingham decides not to act on a referral it will provide reasons for not doing so.

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HEALTH SCRUTINY COMMITTEE
27 MAY 2015
FLU IMMUNISATION
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To provide the Committee with information on commissioning arrangements for flu immunisation, the progress of the children's flu immunisation programme, targeting of flu immunisations to children and adults and the relationship between flu in adults and flu in children.

2. Action required

2.1 The Committee is asked to use the information provided to inform scrutiny of flu immunisation in Nottingham.

3. Background information

3.1 NHS England and Public Health England (PHE) have specific roles in the commissioning and system leadership of the national flu immunisation programme. NHS England has responsibility for commissioning the programme and GPs, midwives, other healthcare professionals and immunisation system leaders, managers and co-ordinators all play a role in delivery. NHS England has to ensure that robust plans are in place locally to identify all eligible patients, that sufficient vaccine has been ordered by practices to meet their needs, and that high vaccination uptake levels are reached in all the eligible groups. Local authorities, through the Director of Public Health (DPH), provide scrutiny and challenge of the arrangements of NHS England, PHE and providers.[1] More detail on the responsibilities of each of the partner can be found at Appendix 1.

3.2 An annual Flu Plan sets out a co-ordinated and evidence-based approach to planning for and responding to the demands of flu across England, taking account of lessons learnt during previous flu seasons.

3.3 Flu is a key factor in NHS winter pressures. It impacts on both those who fall ill and the NHS services that provide direct care, and on the wider health and social care system that supports people in at-risk groups. The annual immunisation programme is a critical element of the system-wide approach for delivering robust and resilient health and care services throughout the year, helping to reduce unplanned hospital admissions and pressure on A&E.

3.4 The plan promotes increased uptake of vaccination, especially among those in clinical risk groups and health and social care workers with direct patient contact, to improve the prevention and management of flu. Clinical risk groups include older people, pregnant women and those with underlying disease, particularly chronic respiratory or cardiac disease, children with severe neurological disease or learning disability, and those who are immunosuppressed.

[1] Flu Plan Winter 2014/15, Department of Health, NHS England, Public Health England

3.5 In 2014/15 the following people were identified as eligible for flu vaccination:
- those aged 65 years and over;
- those aged six months to under 65 in clinical risk groups;
- pregnant women;
- all two, three and four year olds;
- school-aged children in pilot areas;
- those in long-stay residential care homes;
- carers;
- health and social care workers who are in direct contact with patients or service users.

3.6 Flu vaccination to children has been extended in 2014/15 to reduce the impact of flu by directly averting cases in children. The Joint Committee on Vaccination and Immunisation (JCVI) concluded that, by reducing flu transmission in the community, it will avert many cases of severe flu and flu-related deaths in older adults and people with clinical risk factors.[2]

3.7 The programme for children in 2013/14 covered the following:
- a routine offer of vaccination to all those aged two and three year old (but not four years or older) on 1 September 2013;
- all primary school aged children in seven geographical pilot areas.

3.8 The programme for 2014/15 expanded 2013/14 delivery as follows:
- a routine offer of vaccination to all those aged two, three and four years old (but not five years or older) on 1 September 2014 (ie date of birth on or after 2 September 2009 and on or before 1 September 2012);
- seven geographical pilots of primary school aged children started in 2013/14 continued;
- a minimum of 12 geographical pilots in secondary school aged children in Years 7 and 8 in 2014/15 .

Children in clinical risk groups who are not in locations covered by pilot areas continue to be vaccinated in general practice.

3.9 Representatives of NHS England, Public Health England and Nottingham City Council's Public Health team will attend today's meeting to provide information and answer councillors' questions in relation to the vaccination programme in Nottingham.

4. List of attached information

4.1 Appendix 1 - Flu Immunisation - Partner Responsibilities

Appendix 2 – North Midlands (Derbyshire, Nottinghamshire, Shropshire and Staffordshire) Screening and Immunisation Team , NHS England - Seasonal Influenza (Flu) Programme 2015/16 Report

[2] JCVI statement on the annual influenza vaccination programme – extension of the programme to children, 25 July 2012

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

None

6. Published documents referred to in compiling this report

Flu Plan Winter 2014/15, Department of Health, NHS England, Public Health England

JCVI statement on the annual influenza vaccination programme – extension of the programme to children, 25 July 2012

7. Wards affected

All

8. Contact information

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APPENDIX 1

Flu Immunisation - Partner Responsibilities

The **Department of Health** (DH) is responsible for:

- policy decisions on the response to the flu season
- holding NHS England and PHE to account
- oversight of the supply of antiviral medicines

NHS England is responsible for:

- commissioning the flu vaccination programme
- assuring that the NHS is prepared for the forthcoming flu season
- building close working relationships with Directors of Public Health to ensure that local population needs are understood and addressed by providers of flu vaccination services.

Public Health England is responsible for:

- planning and implementation of the national approach
- monitoring and reporting of key indicators related to flu, including flu activity and vaccine uptake
- procurement and distribution of flu vaccine for children
- oversight of vaccine supply and the strategic reserve
- advising NHS England on the commissioning of the flu vaccination programme
- supporting Directors of Public Health in local authorities in their role as local leaders of health and ensuring that they have all relevant expert input, surveillance and population data needed to carry out this role effectively

Local authorities, through their Director of Public Health, have responsibility for:

- providing appropriate challenge to local arrangements and advocacy with key stakeholders to ensure access to flu vaccination and to improve its uptake by eligible populations
- providing independent scrutiny and challenge to the arrangements of NHS England, PHE and local authority employers of frontline social care staff and other providers of health and social care
- providing leadership, together with local resilience partners to respond appropriately to local incidents and outbreaks of flu infection

Clinical commissioning groups (CCGs) are responsible for:

- a duty of quality assurance and improvement which extends to primary medical care services delivered by GP practices including flu vaccination and antiviral medicines

GP practices and other providers are responsible for:

- ordering the correct amount and type of vaccine for their eligible patients, taking into account new groups identified for vaccination and the ambition for uptake
- ordering vaccine for children from PHE
- ensuring that all those eligible for the flu vaccine are invited personally to receive their vaccine
- encouraging and facilitating flu vaccination of their own staff
- ensuring that antiviral medicines are prescribed for appropriate patients

All employers of individuals working as providers of NHS services are responsible for:

- management and oversight of the flu vaccination campaign for their frontline staff
- support to providers to ensure access to flu vaccination and to maximise uptake amongst those eligible to receive it

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Public Health England

NHS England

Nottingham City Health Scrutiny Panel

27 May 2015

North Midlands (Derbyshire Nottinghamshire, Shropshire & Staffordshire) Screening and Immunisation Team, NHS England.

Seasonal Influenza (Flu) Immunisation Programme 2015-2016

1. Introduction

This paper describes the commissioning arrangements and key public health issues in relation to the seasonal flu vaccination programme commissioned by NHS England North Midlands (Derbyshire and Nottinghamshire) for the Nottingham city population. The paper outlines the strategies implemented to improve quality and performance.

2. Commissioning Arrangements and Responsibilities

NHS England is responsible for commissioning all of the national immunisation programmes. Details of the national commissioning arrangements for immunisation programmes are described in *Public Health Commissioning in the NHS 2015-2016*[1]

3. Background

Flu is an unpredictable annually recurring pressure that the NHS faces during the winter.

Increasing flu vaccine uptake in clinical risk groups is important because of the increased risk of serious illness should people in these groups catch flu.

Healthy children have the highest influenza-attributable hospital admission rates, over 5 fold higher than 65+ year olds[2]

A Flu Plan[3] is developed each year which sets out a coordinated and evidence-based approach to planning for, and responding to, the demands of influenza across England.

Vaccination is the best possible protection against flu. Washing your hands and using disposable tissues for coughs and sneezes helps reduce transmission, but the vaccination will help your body to fight flu viruses.

4. National Extension of Flu Programme to Children

The routine annual flu vaccination programme is being extended to include children in England. This extension is being phased in over a number of years.

This programme will lower the potentially serious impact of influenza on those children but should also have a more profound effect on influenza transmission. Children are the main source of transmission in the population, and this programme will therefore reduce the spread of infection from children to other children, to adults and to those in clinical risk groups of any age.

Extension of the programme this year will be to children of school years 1 and 2 and delivered Predominately in primary school settings.

GP Surgeries will vaccinate children aged 2, 3 and 4 years.

5. Vaccinating children in Nottinghamshire

NHS England North Midlands has commissioned School Aged Immunisation Services to deliver all school age immunisations via the school setting in Derbyshire and Nottinghamshire. The vision for this service is to increase the uptake of immunisations in children, provide a high quality equitable service and reduce health inequalities.

Children not in school attendance will be offered the flu vaccination via outreach clinics, home visits and primary care services.

Nationally, uptake of school age vaccinations is higher in school based programmes. They allow for increased access to immunisations, reduce the risk of children being missed due to being a dedicated service, vaccinating ‘on mass’ and reduce border issues.

Delivery across Nottingham City & County will be provided by Nottinghamshire Healthcare Partnership. With service commencing 1st September 2015

The Screening and Immunisation Team will work closely with the new providers to ensure a smooth mobilisation and continued support will be provided with the aim to enable the teams to achieve national targets across all children’s immunisation programmes.

6. Targeting flu

The aim of the routine influenza immunisation programme is to protect those who are most at risk of serious illness or death should they develop influenza.

GP practices in Nottingham play an essential role in the delivery of flu vaccinations. The Screening and Immunisation Team monitor uptake data for the flu programme and inform poor performing practices of their low uptake and seek assurances that

issues will be addressed, working in partnership with the local CCG's (Clinical Commissioning Groups).
In order to increase flu vaccination uptake NHS England North Midlands has commissioned a second wave of the pharmacy flu pilot for 15/16.

The pilot will offer flu vaccinations to anyone in an at risk category over the age of 18 and pregnant women via their local pharmacy. The aim of the pilot is to improve choice and access for patients and the public and to capture a cohort of the population that would not usually access primary care services. The local flu pilot from 14/15 presented evidence that 37% of the population that were vaccinated in pharmacies had never previously attended for their flu vaccination. It is hoped that extending the flu pilot to pregnant women will enable a higher uptake rate of flu vaccinations for this particularly vulnerable cohort.

Negotiations are currently taking place with local maternity units around the possibility of midwives delivering the seasonal flu programme in antenatal clinics. Chesterfield Royal Hospital ran a successful programme last year and it is hoped this can be replicated across Derbyshire and Nottinghamshire this year.

7. The benefits of vaccinating against flu

Children

Vaccinating children each year will provide a number of benefits:
• providing direct protection thus preventing a large number of cases of flu in children
• providing indirect protection by lowering flu transmission from children:
  - to other children
  - to adults
  - to those in the clinical risk groups of any age

Thus averting many cases of severe flu and flu-related deaths in older adults and people with clinical risk factors
• reducing absence from work or school which would otherwise result because people are ill or need to remain home to care for someone else who is ill

Adults

In the wider context of health outcomes, the influenza vaccine programme aims to:
• protect the health of individuals and the wider population
• protect those who are most at risk of serious infection or death should they develop influenza
• reduce the transmission of infection, and thereby contribute to the protection of vulnerable individuals who may have suboptimal response to their own immunisation
• achieve high coverage across all groups identified
• minimise adverse physical/psychological/clinical aspects of immunisation (e.g. anxiety, adverse reactions).

7. Uptake in Nottingham City

See appendix 1

Nottingham City Council can help to improve uptake in vulnerable cohorts by assisting NHS England to promote effective communications around the flu vaccination programme to their population, especially to vulnerable cohorts. Communication materials can be shared closer to the flu season. We would wish Nottingham City Council also be involved with the promotion of flu vaccinations within care homes and schools to staff and patients and also to offer vaccination to their front-line care workers.

7. Conclusion

Extending flu vaccination to healthy children will reduce the impact of flu by directly averting many cases in children. Reducing flu transmission in the community will avert many cases of severe flu and flu-related deaths in older adults and people with clinical risk factors. This in turn will aid the NHS to reduce its winter pressures.

The annual flu immunisation programme helps to reduce unplanned hospital admissions and pressure on A&E and is therefore a critical element of the system-wide approach for delivering robust and resilient health and care services during winter.

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References:

1. Public Health Commissioning in the NHS 2015-16 https://www.gov.uk/government/publications/public-health-commissioning-in-the-nhs-2015-to-2016

2. Cromer et al. The burden of influenza in England by age and clinical risk group: A statistical analysis to inform vaccine policy. J Infect (2013) http://dx.doi.org/10.1016/j.jinf.2013.11.013

3. The Flu Plan: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418038/Flu_Plan_Winter_2015_to_2016.pdf

Appendix

Appendix 1: Nottingham City CCG

Eligible group	2014-2015 target	2014-2015 performance	2013-2014 performance	2012-2013 performance
Age 65yrs	75%	71.9%	72.3%	72.6%
Age 6mths-<65yrs in a clinical at risk group	75%	47.2%	49.3%	49.8%
All pregnant women	75%	37.4%	32.5%	36.3%
All age 2 years	No target	35.4%	39.4%	NA
All age 3 years	No target	39.4%	33.9%	NA
All age 4 years	No target	30.0%		

Derbyshire and Nottinghamshire (national uptake in brackets)

Eligible group	2014-2015 target	2014-2015 performance	2013-2014 performance
Age 65yrs	75%	74.7% (72.8)	75.4%
Age 6mths-<65yrs in a clinical at risk group	75%	49.5%(50.3)	52.3%
All pregnant women	75%	44.7%(44.1)	42.9%
All aged 2 years	No target	45.4%(38.5)	50.6%
All aged 3 years	No target	48.5%(41.3)	46.6%
All age 4 years	No target	38.6%(32.9)	

HEALTH SCRUTINY COMMITTEE
27 MAY 2015
NOTTINGHAM CITYCARE PARTNERSHIP QUALITY ACCOUNT 2014/15
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 Nottingham CityCare Partnership will present its draft Quality Account 2014/15 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 Committee is asked to consider the Nottingham CityCare Partnership draft Quality Account 2014/15 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 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.

3.3 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.

3.4 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;
- 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 England 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.

3.5 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.

3.6 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. This includes sharing with:

- The appropriate NHS England 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

3.7 The NHS England Area Team/ 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.

3.8 In January 2015, Nottingham CityCare Partnership informed the Panel of its proposals for its Quality Account 2014/15. Key issues raised and discussed by the Health Scrutiny Panel were:
   a) Phlebotomy Services
   b) Dementia Services
   c) Connect House
   d) An evaluation of instances of falls in Care Homes

The 2015/16 priorities were noted as follows:
   a) Pressure Ulcers
   b) Duty of Candor
   c) Development of wider scrutiny
   d) Carer support

3.9 At this meeting, it will present its draft Quality Account 2014/15 for consideration. The Committee will have opportunity to decide whether to put forward any comments for inclusion. Please note that the document is still in draft form.

3.10 The Quality Account exercise mirrors that undertaken by the Joint City and County Health Scrutiny Committee for organisations delivering services across Nottingham City, Nottingham County, and, in some instances, further afield. Nottingham CityCare Partnership operates exclusively within the City, hence its consideration by this Committee.

4. List of attached information

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

Appendix 1 – Nottingham CityCare Partnership Quality Account 2014/15

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 2015

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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Nottingham CityCare Partnership

Annual Quality Account – 2014/15

Inside front cover

If you would like this information in another language or format such as large print, please contact:

0115 883 9678

About Annual Quality Accounts

Quality Accounts are produced by providers of NHS funded healthcare, and focus on the quality of the services they provide.

They look at:

- Where an organisation is performing well and where they need to make improvements
- Progress against quality priorities set previously and new priorities for the following year
- How the public, patients, carers and staff were involved in decisions on these priorities.

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Part 1

Introduction from the Director of Quality and Safety and board statement on quality

Welcome to Nottingham CityCare Partnership's Annual Quality Account for 2014/15.

I am delighted to bring you our Annual Quality Account as this is one of our most important publications, providing us with an opportunity to celebrate our care delivery and demonstrate our commitment to high quality care and receive feedback from our partners and stakeholders.

As a dynamic social enterprise, we are dedicated to supporting the health and wellbeing of all local people, working with other health and care partners across the Nottinghamshire community and sharing and spreading our best practice across the country.

We are answerable to the local communities that we serve, and are committed to service user engagement and ensuring the patient voice is heard throughout our organisation. We firmly believe that care is improved when we listen to our patients. This report offers another opportunity for local people to find out more about the quality of our services, and to let us know what they think.

Our aim is to ensure that quality is at the heart of all we do as an organisation; that our care delivery is safe and clinically effective, and that care is compassionate and centred around the individual's needs. We need to listen to our patients' experience of their care delivery, maximise opportunities for integration and innovation to deliver high quality care, and ensure we deliver this through a skilled and competent workforce.

We have joined the Signed up to Safety campaign, and are now building on this commitment through working on new safety priorities. Our Sign up to Safety pledges will be published on our website.

I am very proud to present to you some of our achievements from the last year and to lay out our ambitions for the next year and into the future.

Board statement

We are presenting our quality account for 2014/15 as an accurate and honest representation of the quality of care we are delivering across all parts of our organisation. We have continually improved the quality in care and are fully committed to ensuring our patients receive the best care at all times. We have continued to build on the great work that we have achieved year on year and we want to continue to improve in the next year. We continue to be registered with the Care Quality Commission without any conditions. We understand fully the importance of listening to our patients and to ensure we act on both positive and negative feedback to ensure we can drive forward the continual service improvements and share best practice. We also monitor our performance from our patients' point of view, and have been delighted by the feedback we have received. We have encouraged openness and honesty from all of our staff to ensure that when things go wrong we can learn from these and reduce the risk of avoidable harm in the future.

Our approach to research and innovation, service transformation and further improvements to quality are, and will always be, a key priority for us as an organisation and we believe passionately that this will drive forward and ensure high quality patient care at the heart of all we do and offer. We continue to develop innovative creative services that are fit for the future and enable us to keep people in their homes, and cared for in the community by embracing technology and working closely with our partners to bring about real change. We hope you find this document useful, and please do offer us your feedback to help us develop or report for next year.

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

Tracy Tyrrell, Director of Quality and Safety and Executive Nurse/AHP, on behalf of the board

Developing this report

We have spoken to a number of different groups and organisations to help us develop this report and set new priorities for 2015/16. We have also made use of information gained throughout the year from patient and service user experience and feedback.

We have received feedback from:

- The Patient Experience Group
- The Health Group (learning disabilities)
- The Nottingham Health Scrutiny Committee
- People attending the Indian Community Centre
- The Acorn Day Service (physical disabilities)
- Healthwatch Nottingham

- The East Midlands Academic Health Science Network Patient and Public Involvement Senate.

The draft priorities were widely circulated for information and comment amongst community groups and organisations.

About CityCare

CityCare is a trusted provider of community health services, and we are dedicated to working in partnership to build healthy, sustainable futures for local people.

Previously a provider arm of an NHS organisation, we 'spun out' of the NHS, launching as a social enterprise in April 2011. Our vision is to build healthier communities, by working together with local people, each other and with other health and social care organisations, to improve long-term health and wellbeing.

As an award winning provider in service design and delivery, our expertise is founded upon our NHS heritage and a legacy of professionalism and excellence of care.

Our community ethos shapes everything we do. We honour our responsibility to generate value and invest in social return, for the wider benefit of the community.

Our services

Adult Services

Care homes, Community Diabetes, Community Matron, Community Neurology, Community Nursing and Rehabilitation, Continence, Continuing Care, Urgent Care Service, End of Life Care, Macmillan nurses, Falls Prevention and Bone Health, free nursing care, Homeless Health, Integrated Diabetes Service, Integrated Respiratory Service, Reablement services, Learning Disability Health Facilitators, New Leaf smoking cessation and Smoke Free Homes, Nutrition and Dietetics, Physiotherapy, Podiatry, Primary Care Cardiac Rehabilitation, Speech and Language Therapy, Stroke Services, Juggle diabetes structured education, Tissue Viability

Children's services

Continence, Family Nurse Partnership, Health Visiting, Nutrition and Dietetics, School Nursing and Immunisation, Youth Offending Team

Health and wellbeing

Breastfeeding Peer Support, Go4it weight management, Health Promotion, Healthy Change, Infection Prevention and Control, Interpreting Service, Walk-in Centre, Phlebotomy, Safeguarding.

Our brand and values

CityCare is a values-driven, people business, with a passion for excellence in care. Our values of Integrity, Expertise, Unity and Enterprise lie at the heart of what we do, guiding how we work together with partners and each other, to consistently deliver high quality, compassionate care.

We are committed to listening and responding to all service users and provides a translation and interpreting service that is available to all patients who need it, along with communications materials in a range of community languages.

We are also available to patients through new electronic channels including a corporate Twitter feed and online feedback forms, which patients can access for immediate and paperless feedback.

We work in partnership with patients, staff and partners to build a healthier, more sustainable future, for all.

Building community capacity and social return on investment

As a community interest company (a type of social enterprise) we exist for the benefit of the community and specifically to benefit the health and wellbeing of people as well as reducing health inequalities.

We must remain financially sustainable and deliver year-on-year surpluses for reinvestment through the enhancement of existing services or the creation of new services, investment in partnerships or donations to charities or other organisations that are supporting our objectives.

Since becoming a social enterprise, we have reinvested into a wide variety of projects to benefit local people, including extra community and school nurses; extra clinic capacity and new locations such as Boots and the Indian Community Centre, Radford Care Group and the Carers Federation, allowing us to offer around an extra 500 clinic appointments a week; the Hospital Discharge Service (see part two of this report); an Admiral Nurse service (see part two); and a Nottingham University Social Business Award.

To ensure we offer the greatest benefit we:

- Engage with staff to scope the potential for service investment and new services based on their knowledge of the services and the communities in which they work
- Involve the local community through established engagement groups, local partnerships and discussion with other third sector organisations.

We are also setting up an independent charity, named the CityCare Community Foundation by our staff. Through this charity we will be able to streamline the social return work we

have been doing, be able to offer charitable donations to voluntary organisations in the health sector, and work together with others to achieve our aims.

We already sponsor LD Sports, an organisation for young people with learning disabilities, Nottingham Forest FC Champions' Centre, and a breakfast club for schools, and this move will give an independent route to channel that funding.

Another aim of the charity will be to support training and education within healthcare. Offering training and opportunities for personal growth beyond those usually funded within the NHS will potentially offer massive benefits to patients, as our staff remain highly motivated, highly skilled and at the cutting edge of care. Through the charity, our teams will also be able to offer targeted support in areas where they have specific expertise to other local voluntary healthcare organisations.

Sustainability

Our work on sustainability has been recognised with a silver award from Investors in the Environment for our Sustainable Development Management Plan (SDMP) for 2015-2018.

We are supporting the NHS to achieve its carbon reduction target and as well demonstrating best practice in sustainable health and care system. Our SDMP has been developed to set out our vision for becoming a leading green and sustainable organisation, and our key drivers for implementing this vision.

It is the framework on which we will effectively respond to the current and emerging environmental, social and economic challenges and risks posed by climate change. The key areas of focus include:

- Governance
- Organisational and workforce development
- Community engagement
- Partnerships and networks
- Adaptation
- Designing the built environment
- Sustainable models of care
- Procurement and supply chain
- Commissioning
- Low carbon travel
- Water
- Waste
- Energy and carbon management.

Our strategic objectives for 2014/17

- Provide high quality, accessible and equitable services
- To grow a successful, sustainable organisation that creates social value and invests in the wider community
- Prevent ill health, improve well-being and provide services that improve local health outcomes
- Deliver services that are responsive to the needs of our local communities and commissioners
- Deliver financial duties and ensure the efficient use of resources
- Be an employer of choice and an organisation that supports local employment

Listening to patient voices

We are committed to listening to the views of people who use our services and making continual improvements based on what they have said. We value their views, and consider collecting them as an integral part of service delivery.

Patient satisfaction

We ask people about their experience of our services on a regular basis. We are pleased that in 2014/15 we have either matched or bettered the levels of satisfaction in the previous year, and that through a successful drive to listen to more of our patients, the number of patient survey responses increased to 5,709 from 4,861.

- 96% said our services were excellent or good
- 98% of the 3,862 people who answered agreed that they were involved in decisions
- 98% of the 4,154 people who responded said ‘excellent’ or ‘good’ about whether they were treated with dignity and respect
- 96% of the 4,075 respondents who answered said ‘excellent’ or ‘good’ about how we met their particular needs
- **Family and Friends Test -** 97% of 4,417 respondents said they were likely or extremely like to recommend CityCare service that they had received to their family or friends.

The Patient Experience Group

Our Patient Experience Group continues to meet six weekly, and we’re grateful to them for giving us their valuable time. Over the year, the group has continued to offer insights into their own experience of CityCare services as well as their feedback on new initiatives and developments. These have included:

- Giving feedback on the new clinic at Boots in the Victoria Centre and Connect House
- Early discussion regarding the development of CityCare’s independent charity
- Increased links with Healthwatch
- Taking part in the CityCare student nurse induction programme

- Helping develop a DVD aimed at preventing pressure ulcers
- Contributing to the development of a leaflet within End of Life services, ensuring information is shared appropriately between services
- Helping to judge the CityCare 'Valuing You' staff awards
- Attending the staff Summer Celebration.

There is more information on the work of the PEG and its developing role in part two of this report.

The Health Group

The Learning Disability Health Group, supported by the CityCare Learning Disability Health Facilitator Team, ensures that the voice of people with learning disabilities is fed into service planning and developments. This is an important group for CityCare and other local services. We very much appreciate their input, which is key to us continually learning how best to support this community.

Key activities this year have included:

- Contributing to the consultation around the 'Self-Assessment Framework' led by the Learning Disability Partnership Board
- Talking to phlebotomists, and hearing about how they are working to make taking blood a more relaxed experience for people with learning disabilities.
- Discussing the management of complaints and how we can develop clearer information for people with learning disabilities, their families and carers
- Discussing diet and the different food groups with the Nutrition and Dietetics Service
- Participating in a first aid session
- Taking part in a DVD to support learning disability awareness training, as well as enhanced service training for GP practices
- Supporting the national 'Seeability' initiative to deliver an event in Nottingham focused on supporting people with learning disabilities to look after their eyes
- A 'learning how to look after feet' session delivered by the Podiatry Service.

What did people say about our services?

- *"Better job of my feet than when I paid private." (Social Nail Care)*
- *"Very friendly, excellent at what they do." (Integrated Diabetes Team)*
- *"Keep me informed of any new services/products, prepare prescriptions straight away." (Continence Prescription Service)*
- *"Very professional speedy treatment, in which I had every confidence." (Treatment Rooms)*

- *"Help when you need, help for me and my kids, I don't know what we would do without the Walk-in Centre." (Walk-In Centre)*
- *"Communicating info/exercises in a detailed way. The physiotherapist explained this very well. Very helpful and respectful too." (Musculoskeletal Physiotherapy Clinic)*
- *"I feel very safe and get support. I can tell all my problems through the interpreter and understand what doctor says." (Interpreting and Translation Service)*
- *"Support me to enable me to feel better about myself and my ability to look after my baby." (Health Visiting)*
- *"Gives time to discuss problems describes next steps and provides written back up information." (Continence Advisory Service)*
- *"The Service was excellent." (Community Stroke Discharge and Rehabilitation Service)*
- *"I find that personally the care and attention I receive is very good and the Podiatrist very friendly to talk to and explains things too." (Community Podiatry – core)*
- *"Wide range of services in one team. Much more knowledge re my condition and therefore able to give individual/specialised advice." (Community Neurology Service)*
- *"It is a personal touch, feeling comfortable and approachable and willingness to help." (Community Macmillan Team)*
- *"Provides support and advice on healthcare issues, healthy eating and points you in the right direction for other support, such as equipment in the home and financial. My heart nurse was brilliant. Professional, understanding, helpful and informative. I used to look forward to their visits and looked on them as a friend." (Primary Care Cardiac Service)*
- *"The service was excellent and all the staff good and friendly. Could not have done better." (Community Stroke Team)*
- *"The nurse was very supportive in helping me with my medicines and my return to good health. She helped me understand what I needed and gain confidence. I have returned to work, which I thought was not possible at that time." (Primary Care Cardiac Service)*
- *"They talk to you how you want to be spoken to and they listen to any problems." (Health Visiting)*
- *"It's amazing support to have." (Family Nurse Partnership)*
- *"It makes you feel at ease with the person you're talking to and decisions are made jointly not without your input in everything that is discussed. The staff are very warm and friendly and they don't prejudge you on things you do but they do advise you of what will happen if you're not willing to work with them to help yourself." (Integrated Diabetes Service)*
- *"Help get you mixing with other people out of the house. Also get you moving more. Help at the end of the phone makes you feel safe." (Integrated Respiratory Service)*
- *"The nurse that treated my wife was exceptional. We have used this service a few times and find it great." (Treatment Rooms)*

- *"I have been having treatment from the nurses at Clifton for years. They are always caring, I think I am very lucky to have them looking after me." (Tissue Viability Service).*
- *"Our school nurse is lovely; gave me help with my feelings and lots of leaflets, and told me about groups that I can go to on-line." (School Nursing)*

What do people feel that we can improve?

We continually listen to peoples' concerns and complaints and to improve services based on what they have told us. Find out more in part two of this report about how we are working to improve even further the ways we listen and respond to complaints.

Service	Issue raised	The changes we made	Protected Characteristic (see part seven for more on our work to promote equality and diversity)
Continence Prescription Service	Some people having difficulty obtaining prescriptions as they were unable to get through on the phone, and answerphone messages not responded to.	We introduced an optional e-mail ordering system for prescriptions. We removed the answerphone and improved the telephone system.	None specific
Stroke Team	Patient raised issue of lack of clarity in terms of how long the period of rehabilitation would be	We reviewed the service leaflet to ensure clarity of information.	Disability
Podiatry	The PEG raised the importance of support with nail cutting to address the needs of elderly people who may not meet the criteria for podiatry	We introduced a new Social Nail Cutting Service and are promoting it to local people.	Age/Disability
Learning Disability Health Facilitator Team	The Health Group told us that people with learning disabilities would like to receive information directly from the health services available to them.	Services now deliver presentations regularly to the Learning Disability Health Group, for example Phlebotomy, Podiatry and Continence.	Disability
Infection Prevention and Control	We canvassed opinions on the standard and quality of services received in baby clinics, with a particular emphasis on cleanliness, hand washing and cleanliness of equipment. 61 people responded to our survey.	We will ensure that: • Staff are bare below the elbows when working in baby clinics • Staff remember to make their hand washing visible to	Pregnancy and Maternity

		- service users whenever possible - Staff remind service users of the need to clean their hands when changing babies' nappies.	
Juggle – our Structured Diabetes Service	Service users requested sessions delivered in different languages. Deaf Society requested sessions with use of a signer.	We now deliver sessions in the main languages spoken in Nottingham. The service has developed dedicated sessions at the Deaf Society with the use of a signer.	Race & Disability
Walk-in Centre	Uncomfortable chairs, and no play area for young children.	We bought new chairs and are developing a dedicated area with children's toys.	All people with young children
Musculoskeletal	A number of patients who attend the pilates classes ask to continue attending when they reach the end of their allotted sessions, but the service does not have capacity to offer further sessions.	We created a leaflet signposting all the pilates groups and classes in the area. This is given to patients when their sessions come to an end.	All
Boots Clinic	PEG members visited the clinic to give us early feedback on any potential issues.	A water machine is now available for all users of the clinic. We ordered a clinic bed with sides, for people who feel unsupported on original type of bed. We are working to improve opportunities for people to give feedback while in the clinic.	All

As a pull out section

Listening to local families

During September and October 2014 we surveyed 326 parents of children aged under five who had been supported by our Health Visiting service. We wanted to see if the changes we initiated in response to feedback in an earlier survey in 2012 have resulted in improved practice. These are just a few of the highlights.

Where we have made a difference since 2012

10% increase in parents knowing who their health visitor is. In 2014:

- 86.5% knew their Health Visitor's name
- 96% knew how to contact them

In 2012 we received comments that it was difficult to get through to the service and that calls weren't returned. In 2014:

- 81% had made contact with their Health Visitor over the phone. 99% got through to the service quickly. 93% of those who didn't get straight through said someone called them back.

In 2014 nearly 92% said the Health Visitor talked to them about their emotional health and wellbeing and how they may feel after the birth of their infant, compared to 53% in 2012. We introduced training in February 2014 to support this.

A 33% improvement in the number of parents reporting that they had received a developmental review.

In 2012, 41% of parents did not comment on whether they had had a discussion about ***infant mental health,*** suggesting that they felt this topic was not covered by the health visiting team. Some comments indicated that 'this area needs more development as it is not discussed'.

In 2014 the response rate had significantly improved, with over 61% saying that infant mental health was discussed with their health visitor and of those 100% understood the information presented to them and 98% felt fully involved in the discussion and felt able to say what they wanted.

Find out more in part two of this report on our Unicef Baby Friendly accreditation, our award winning Breastfeeding Peer Support Service and our Small Steps, Big Changes programme.

Part 2

Review of Quality Performance

2.1 Patient safety

Our pioneering work in Integrated Care, together with other local health and care providers and commissioners, took centre stage in the priorities we set last year in relation to patient safety.

The workstreams that we highlighted for the Annual Quality Account included Care Delivery Groups, mobile working and assistive technology, and workforce development in integrated care.

In a pull out section:

Sharing information across teams and organisations

Integrated working means that it is essential for us to share patient records with other health and social care providers – and for them to share the information that they hold about their service users with us. The purpose of sharing this information is to improve the quality of care provided. CityCare

has invested a lot of time in training to ensure that our staff understand when it's appropriate to directly share records for care, how to inform patients about this, and obtain consent.

In another pull out section:

National pioneer for integrated care

Nottingham City has become a Wave Two Pioneer site for integrated care, placing our programme among the most trailblazing initiatives in the country.

Lyn Bacon said: "We're delighted that Nottingham City has been chosen as one of ten wave two pioneers from across the country, as recognition of the groundbreaking work that partners across the city have been delivering.

"As a pioneer we will be supported to drive the integration programme forward even faster and really make a difference to the lives of our most vulnerable local people."

The Integrated Care programme is run by NHS Nottingham City Clinical Commissioning Group (CCG) and Nottingham City Council, working alongside CityCare and other partner organisations. It aims to provide seamless care by integrating health and social care and help keep more people healthier in the community and out of hospital.

2.1.1 Care delivery groups

We have been delighted with the progress made by the newly introduced care delivery groups (CDGs) over the last year.

CDGs are teams of key professionals (neighbourhood teams) working together in a specific geographical area. By bringing together health and social care workers into one team we are better able to work together around a citizen's needs, share information and combine experience to shape continuous improvement.

CityCare employs care co-ordinators who take referrals from GPs and the neighbourhood teams, provide an information gathering service, and support successful navigation of citizens who previously may have 'fallen in between' specialist service criteria.

What we said we would do	What we achieved
Explore the expansion of the care co-ordinator role to support citizens with complex needs throughout their whole pathway of care. Explore the diversification of the	We now have 15.8 whole time equivalent care co-ordinators (CCs) in post, based within allocated Care Delivery Groups (CDHs). This number will be increased to 19.2 with additional funding to pilot new ways of working in this role, making it more patient facing and offering more assistance to primary care to improve patient outcomes The CC service now operates Monday to Friday, 8.30am-6.00pm, including co-ordination of the Acute Visiting Service.

role by taking non-clinical tasks from clinicians to release time to care.	Our CCs now have access to several IT systems across CityCare and Nottingham City Council (NCC). They increasingly attend multidisciplinary team meetings (MDTs) and are allocated actions A roll out to all CDGs of Joint Case Reviews has assisted in reducing duplication and increased sharing between members of the neighbourhood teams. Referrals being processed CCs are increasing. The team pass social care referrals from GPs to the Nottingham Health and Care Point (NHCP), saving significant time for GPs. In a further expansion of their role, CCs are also now: • Co-ordinating the Housebound Project • Promoting third sector organisations, including supporting Nottingham Energy Partnership by identifying citizens who would benefit from assistance towards reducing fuel poverty • Supporting the 'swap shop' of wound care dressings for the Community Nursing teams (six month period) • Using e-healthscope to identify high risk citizens for discussion at MDTs • Supporting the link social worker role by providing access to health information and coordinating attendance at MDTs.

Patient comment: 'Treat me with dignity & respect, respect confidentiality, kind/friendly, helpful, skilled, well presented.' (Health Reablement at Home Service)

Patient comment: 'They provide the help that is required really quickly such as equipment and the staff are really friendly.' (Urgent Care Service)

Patient comment: "The service is regular, the staff are friendly, very happy and polite. They offer helpful advice and address all the important queries. They provide detailed explanations as required. They are always around and are able to listen to any queries and they deal with every issue in a fantastic way. I am really pleased with the service, thank you. There is nothing more we could ask for from the service as members of staff provide fabulous support, care and management." (Community Matrons)

Carer comment: 'The Urgent Care Team was fantastic and District Nurses. Without them I wouldn't have been able to get my mum into her bed, move or handle her and she was cleaned up lovely after the ambulance left her home alone after discharge from hospital with no care or anyone to look after her. She was left 23 hours wet through. I'm so grateful for Urgent Care Team.'

Patient comment: 'Staff encouraged me to do as much as possible myself. Built up my confidence. Treated me with respect and dignity at all times. All staff have been professional at all times.'

Patient comment: 'Pleased that the services were able to advise me of the current and future needs by carrying out a full assessment'.

Patient comment: 'Communication between Reablement Team and Community Matron was very good. Everyone listened to all of my needs and did all they could for me.'

***The Patient Experience Group said:** We would like to be involved in the continued planning and development of the Integrated Care programme, and to be able to influence at a 'grass roots' level.*

How we responded: CityCare is actively discussing developments in this programme with the PEG on a regular basis. The CCG has also delivered some citizen engagements events. The CC role so far has been commissioned to support professionals within the CDG's. However, as part of the on-going development of the role, it will become citizen facing in 2015 and citizen engagement around what will be meaningful to them will take place.

As a pull out stat:

91% of the 240 questionnaire respondents between October 2014 to April 2015 said they would recommend the Integrated Care services to their friends and family.

2.1.2 Assistive technology and mobile working

The assistive technology project aims to increase the use of Telecare and Telehealth across social care and health, improving patient safety and experience.

What we said we would do	What we achieved
Increase the awareness among health professionals and patients of the benefits of and barriers to Telehealth	Telehealth equipment training has been delivered to all relevant CityCare staff groups. Patient and staff leaflets approved by CityCare's Quality Assurance Forum, have been distributed and are available on the intranet. Targets within service specifications have been agreed across adult care, and case study examples are supporting uptake. Further engagement work is planned with specialist nurse teams such as cardiac care, respiratory, community diabetes and stroke teams. As at 20 April 2015, there were 179 patients with Telehealth in their home or about to be installed.

'The team were friendly and explained the benefits of the equipment before fitting it.' (Community Rehabilitation)

Mobile working

We are implementing a mobile working project to enable nurses to access the information they need whilst with the patient in their home or any other community setting, such as medication, care and treatment plans, hospital letters and test results.

This will help them make better informed decisions, and free up time for patient care. More integration of care also means organisations need clear plans and protocols for sharing information to ensure that care is delivered appropriately, as and when needed.

What we said we would do	**What we achieved**
Implement the mobile working project across four key service areas: • Community nursing • Care Delivery Groups • Intermediate care • Evening and night nursing	A project manager has been recruited, and pilots completed across Rehab North and South, Family Nurses, CDG 3 and more than 20 Health Visitors. Stage one of the organisation-wide roll out is now complete across community nursing, care delivery groups, intermediate care and evening and night nursing. The champions from each area will cascade training to their respective teams during the second phase of delivery. Over 280 staff now have tablet devices to use while working in the community, and more than 500 remaining staff will receive tablet devices from March/April onwards. Staff have been involved in testing the equipment to be used, and in developing new ways of working to maximise the benefits of mobile technology. Feedback has included that the benefits of mobile working and the new technology include "a better work life balance" and "greater/easier productivity."

Looking to the future for mobile working

Technical details are being addressed as the programme rolls out, and the main challenge now is to truly realise the optimal benefits of mobile working through continual organisation-wide change, management support and guidance.

From March 2015, the PC replacement programme will start removing old computers and updating or replacing them where necessary. Stage two of the roll out of the tablet devices will coincide with this programme, and we hope the changes and investment in our IT will encourage users to use their tablet device.

2.1.3 Workforce development in integrated care

In last year's report, we highlighted that workforce planning for people working with citizens who have complex long term conditions had identified that a joint health and social care competency framework was needed to ensure that we have an equitable and skilled workforce to meet citizens' needs and to make every contact count.

Over the last year, we have reviewed our existing holistic worker model, which provides an opportunity for clinical staff to be skilled up in other professions and a new framework has been developed. This is currently being internally ratified and processes are underway to achieve accreditation for the model. The model includes competencies around mental health incorporating dementia awareness and interventions.

In addition a dementia awareness training package has been delivered to all staff in Reablement and urgent care (see section 2.2.2 for more information on dementia training).

In a pull out section

The holistic worker role

Qualified nurses, social care staff, occupational therapists and physiotherapists in the Urgent Care service are all trained in each other's disciplines up to the level of a band 4 assistant practitioner.

In practice it means, for example, a nurse can undertake a full nursing assessment during a visit and, while there, sort out basic occupational therapy issues such as equipment to get in and out of bed or to cook safely in the kitchen. Similarly, a physiotherapist could teach an exercise programme and do a basic tissue viability assessment at the same time.

CityCare won the Value and Improvement in Training and Development award in the Workforce Development category at the 2014 HSJ Value in Healthcare Awards for its work on the holistic worker role.

Natasha Austen was one of the first Assistant Practitioners to join the Crisis Response Team (later becoming the Urgent Care Service).

She said: "It quickly became clear to me and my colleagues that to fulfil the role of completing a comprehensive, holistic patient assessment within two hours of referral, we would need a wider set of skills.

"As a holistic worker, I have now been trained in competencies covering occupational therapy, physiotherapy, nursing and social care, which have given me the knowledge and skills to carry out a thorough assessment and identify a patient's immediate needs in all those areas. I can now refer people to other services and order equipment with confidence, and support all the different clinicians in the team.

"As a service we aim to have all the necessary support and equipment needed to keep someone safely at home within 48 hours, and to avoid unnecessary hospital admissions. Having one team member able to work with a person holistically rather than having to call on colleagues from various areas is the only real way to deliver on this.

"This is also a benefit to our patients, who don't need to repeat themselves over and again to different teams – not only for assessment, but also for ongoing care, as I am able to pass the information needed to all the services we refer to.

"I feel this new role not only supports me to do a better job for my patients, offering more value and an improved experience of care, it also offers the team more job satisfaction, as we know we can make a real difference."

2.2 Clinical effectiveness

Our quality priorities related to clinical effectiveness for 2014/15 focused on further development of the Hospital Discharge project, dementia training and care, and research into falls and older people.

We have been very pleased with the progress made and some excellent service user feedback, while also recognising the need for further work, some of which is outlined below.

2.2.1 Hospital Discharge Service

The Hospital Discharge service launched in 2013 to help reduce readmissions and to support rehabilitation for older patients. The team telephones elderly patients who have been discharged from Nottingham University Hospitals to check for medication issues or unmet health and social care needs such as a need for mobility aids or assistance with daily activities.

What we said we would do	What we achieved
Evaluate the service Provision and pilot a three telephone call model Audit project data Audit and analyse patient feedback	An evaluation has been carried out and has shown good outcomes have been achieved with regard to the resolution of medication issues and with referrals to other health, voluntary and social care agencies. We have changed the service from a single follow up call to three follow up calls: the first within 72 hours of discharge followed by two further calls at seven day intervals. Audit data shows that this development has been successful in enabling us to help more people, with approximately 52%, 28% and 20% of our referral and signposting activity coming from our 72 hour, 7 day and 14 day calls respectively. Some other key figures include: • NUH notifies the team of 580 elderly patients discharged after

	emergency admission per month. • Each month, 45 patients receive care referrals and 68 patients receive signposting. • This equates to 540 patients receiving care referrals and 816 being signposted over the year. The project has led to increased efficiency by changing our use of SystmOne, and weekly team meetings have been introduced to enable education and sharing of good practice. We have obtained feedback from service users and the CityCare patient experience group. Figures from our patient satisfaction surveys: • 28% response rate. • 93% would recommend the service to friends and family (one patient commented that she wouldn't have any need to recommend our service, since it was automatic and she didn't have to call us). • 94% rate the service as good or excellent. The team has set up a telephone-based patient satisfaction survey process, the first of its kind in CityCare.

The team met with the Patient Experience Group in October 2014, and these are some excerpts from an update provided to them in March 2015:

- You advised that we shouldn't ask different medicines questions to over 70s and under 70s.
    - W*e've changed our protocol so everyone we call is now asked the same medicines questions.*
- You suggested that patients should be asked whether they are a carer for someone else during our first contact.
    - *This is now in the protocol for our first call.*
- You suggested that 72 hours was too long to wait for our first contact and that we should be making contact within 24 hours.
    - *We've discussed this with the information team at QMC. At the moment they are unable to give us data over the weekend, so we would not be able to deliver a 24 hour contact time. They are changing their systems this year, which should facilitate a shorter first contact time. We will follow this up later in the year.*

Looking to the future

During 2015/16, the team plans to:

- Work to a 48 hour timescale for the first call.
- Work with the business unit to provide more detailed analysis of activity arising from the calls.

- Implement more of the suggestions from the CityCare PEG e.g. provision of written information: using letters and leaflets to improve the level of information provided to patients about our service and other local healthcare services.
- Maintain (as a minimum) the current levels of patient satisfaction of the service
- Increase the overall proportion of patients helped by the service, by:
  - Looking at alternative methods of targeting the service to those likely to derive most benefit from it.
  - Case finding for other CityCare teams working with patients at high risk of readmission.

What team members say about their role

Andrew (Pharmacist) said: "I've been with the team for just over two years and have seen big changes, including improving the way we work with SystmOne and streamlining our work by reducing the paperwork."

"Making three calls rather than one now allows us to build up a better rapport with people, and they open up a bit more."

"The patients value the fact that someone is checking up on them after a stressful time. With an emergency hospital admission they hadn't a chance to prepare themselves for what was happening. We're proactive, rather than waiting for someone to ask for help. We also support them with what they actually want support with - giving them more control."

John (Administrator) said: "We often make referrals as a result of our third call, so making that extra call is definitely worthwhile."

Shailesh (Head of Medicines Management) said: "This has been a very beneficial service to rehabilitate older patients by addressing their medicines and social care needs. The service has improved the safety of medicines use which could in turn prevent readmissions."

Patient comments

David, 83, said: "Being called three times is most reassuring – you're not just dumped out and left to your normal routine. Although you've left hospital there's still contact."

William, 89, said: "I couldn't have wished for a better service, very good indeed."

Other comments received through feedback questionnaire

"Very grateful for phone calls and the things they have been able to support us with."

"It's nice to have someone follow up on my progress after a traumatising experience."

"I thought that they were very helpful and they point you in the right direction. They provided me with contact numbers for other support I needed."

“It is great to be able to talk to someone about things, if there are any worries or doubts in your mind they reassure you about them and put you at ease. The aftercare was fantastic, felt like people wanted to genuinely help you.”

“I was unsure with the medication and was referred to a pharmacist who then contacted me and put me at ease.”

“Stays in contact with you over a few weeks and isn’t just a one off call.”

“They offer good support not just to the patient but to the carer/family as well.”

”They have enlightened me on the different services that are available to me.”

2.2.2 Dementia training and care

Our Admiral Nurse, Justine – appointed in May 2014 as one of our dementia quality priorities for 2014/15 – has made an incredible impact on our dementia training, and subsequently our staff are even more dedicated to making a big difference to the experiences of those patients and carers who are living with dementia.

The Admiral Nurse post, hosted by Dementia UK, has been commissioned directly by CityCare, initially to provide other staff in the organisation with the support they need to provide the best possible care to dementia patients and their carers. This is delivered through improved access to dementia training, and the ability to refer patients and their carers for support from the service.

Priority: We will raise levels of early diagnosis and support staff to provide an improved standard of care

Being diagnosed early with dementia supports people to get the right treatment, find the best sources of support and make decisions about the future.

Our Admiral Nurse has delivered early diagnosis training to clinicians as part of the Mental Capacity Act training included in the Mentorship programme. More than 50 senior clinicians have attended a two-day ‘level 2’ training course provided by Dementia Pathfinders CIC. We plan to roll this training out to clinicians at band 5 and above to enhance their knowledge and practice.

A second Admiral Nurse has been appointed, to come into post in May 2015.

What the Admiral Nurse says about her role supporting early diagnosis and service improvements

“My role is to advocate for Admiral Nursing and the needs of dementia patients and their carers, and my time is divided between training staff and supporting my caseload of patients and carers.

“I deliver dementia training at CityCare staff inductions, and to student nurses who are being hosted by CityCare, giving essential education, facts and training that some have never received throughout

their nursing education to date. This is a unique opportunity to introduce dementia awareness to a cross section of all staff, regardless of their band or role.

“As part of my work to support CityCare staff, I am also working to link our services with other providers of dementia support locally.

“I am actively involved with the Alzheimer’s society and attend their monthly meetings. I also belong to the Diversity In Dementia group, which works closely with carers and professionals from Nottingham University Hospitals, the City Council and CityCare, discussing initiatives and sharing knowledge and news.

“I also speak at various venues and forums, most recently at the Institute Of Mental Health at The University of Nottingham.”

Priority: We will improve the emotional support available to those who care for people with dementia

Our Admiral Nurse both supports families directly and has delivered Dementia Friends training to over 180 staff in eight months.

Dementia Friends is all about giving more people an understanding of dementia. It makes a difference to people with dementia if those around them know what dementia is and how it might affect them.

The Dementia Friends training has been very highly rated by all the delegates, and they regularly requested more information or training in this area.

As well as helping colleagues to work with patients and carers themselves, the training has also made the Admiral Nurse service more visible across CityCare, supporting referrals.

There are now more than 55 families on the Admiral Nurse’s caseload, most of whom have been referred by other health professionals, but some have also been self-referrals from carers.

The role of the Admiral Nurse when working with families is to support them as appropriate to their personal circumstances, signposting to available services; advocating for them, for example when applying for continuing care funding; and helping them develop coping strategies. Following a diagnosis the Nurse will also ensure they are given the right ongoing support from community services, and that GPs review medications.

Justine says: “I also help people with the social care referral process, and look at the family holistically – the mental and physical health and wellbeing of both the person with the dementia diagnosis and their carers, to keep them as supported and well as possible.

“I can also be there for people when their loved one dies – this is not an urgent care or one-off service, it represents a long and rewarding relationship with both myself and colleagues.”

Comments from staff on the Dementia Friends training:

"Brought it (dementia) to my attention and how it affects other people and their loved ones."

"The course explained a lot of things I never knew about dementia."

"The whole content of the training was interesting. It made my perception of dementia positive rather than negative."

"Thought provoking. I will use this knowledge when I come into contact with anyone with dementia."

"I thought I knew and understood a lot already but it was a great course and told me a lot more."

"Definitely opened my eyes regarding dementia."

"I found it helpful to learn about the behaviour of someone with dementia so that I am able to identify it in the future and to learn about the different types of dementia."

Comments from people who have received support from our Admiral Nurse:

"The Admiral Nurse has been terrific from the very first phone call. She has listened and understood what I am saying; she has contacted relevant people on my behalf; she has given me excellent help and advice and explained how things work. Above all, she has been totally supportive to me – returning all calls and talking through problems. She has given me encouragement when I have felt completely inadequate in the face of the many challenges. She was the only person who could do this and she was the only person who seemed to be in contact with the whole range of people, services and the medical team."

"Very happy to know that someone is at hand for help and support."

"There should be more Admiral Nurses as they are so much support to dementia families and there are lots of people who need help like me. We had many bad times with my husband. She gave me really good advice and didn't hide things for me and said what was really going on. I had to make the decision to place my husband of 59 years into a care home and I am trying to cope with that, but my thanks for what she has done, she is such a lovely lady."

"I have had an assessment by a social worker to support me in my caring role thanks to my Admiral Nurse. We feel reassured and happier knowing there is help out there for us."

"She communicates with us; caring, compassionate, realistic lady."

"I feel I can call any time for help and support, if and when I need it. The Admiral Nurse explained the stages and signs to look for which has helped me a lot."

“I feel far more confident and well informed. After just one visit the Admiral Nurse provided us with lots of information on services available and how to access them. I also know I can contact her at any time for support. Excellent service!”

“We would not have made such progress without you.”

Looking to the future

The Admiral Nurse will lead on the following plans for 2015/16:

- Delivering Barbra’s story (an award winning dementia training package from Guy’s and St Thomas Hospital) to band 2, 3 and 4 staff and their equivalent in Nottingham City Council
- Working with all CityCare’s Registered Mental Nurses (RMNs) to take the Dementia Pathfinders Tier 2/3 training forward for clinicians at band 5 and above to deliver the 11 elements of the Dementia Framework, for continued professional development and education. Dementia Pathfinders are developing a dedicated website resource for CityCare to take this training forward.
- Building on the strong alliance formed with the third sector Radford Care Group, there are plans for the Admiral Nurse to work with carers at the centre by offering one-to-one support in the podiatry room funded by CityCare. Our Admiral Nurse is actively involved in the carer’s forums and attends Radford Care Group at least once a week.

Our progress against other specific dementia-related actions planned for 2014/15:

What we planned to achieve	What we achieved
We will improve our compliance with the Mental Capacity Act by carrying out a clinical audit of our compliance. We will use the clinical audit to identify any specific training needs.	It was decided that a clinical audit of the Community Nursing service would be undertaken, and an audit tool was been designed and data collection is about to commence. Data collection began in February 2015 and is due for completion in April 2015.
We will review the recently restructured Older Persons Mental Health Team.	There is no longer a separate Older Persons Mental Health Team within Reablement. Instead, there are a number of mental health nurses working proactively within the wider Reablement services, supporting discharges from the acute hospitals and reducing the risk of admission. This is improving the way in which mental health needs of patients are being seen within wider teams and accessing support to meet these needs is more streamlined. Where a citizen is identified as having a mental health need, assessment and intervention can be accessed without the need for referrals to secondary care services. We have completed a series of dementia awareness training across our Urgent Care and Reablement teams.

	We have embedded a set of dementia competencies within our holistic worker model which are being rolled out to teams from April 2015.

2.2.3 Research into falls and older people

Reducing falls is an important priority, as the effect of a fall can have a major impact on the quality of life and health for an older person.

Research into falls, stroke and older people currently accounts for a quarter of the total research activity being undertaken in CityCare. As a quality priority, we will continue to work in partnership with researchers at the University of Nottingham and Nottingham Trent University to develop new studies in these important areas.

The studies that have recently finished, are currently taking place or in set up include:

Falls In Care Homes (FICH)

Assessing whether falls intervention guidance (Guide to Action for Care Homes) developed by the researchers reduces falls in care homes; collecting data to inform a larger trial.

- A follow on research grant application to conduct the larger trial is being prepared for submission to National Institute for Health Research (NIHR) in May 2015 by Professor Pip Logan, University of Nottingham.
- In October 2014 Professor Pip Logan in collaboration with colleagues from Nottingham CityCare Partnership and Nottinghamshire County Health Partnerships was awarded the Patient Dignity and Experience Innovation Award by the East Midlands Academic Health Science Network for the Guide to Action Care Home (GtACH) tool for fall prevention.

Care and Communication

Investigating patient, carer and professional perceptions and experiences of initiating and subsequently reviewing Advance Care Planning (ACP) discussions and decisions throughout the last six months of life.

This NIHR funded study led by Dr Kristian Pollock from the University of Nottingham has now finished and the final report is awaiting publication by the NIHR.

Balance and the Mind Programme

Ways to reduce the risk of falling; in particular to find out if memory or other aspects of thinking affect why people fall. The treatment is likely to include things like exercises and memory training.

The NIHR programme development grant has been completed and has provided preliminary data. A full NIHR Programme Grant for Applied Research funding application was submitted in March 2015 by Professor Rowan Harwood at NUH for the following research programme: Balance and the Mind: maintaining physical and mental activity whilst reducing risk of falls for people with memory problems.

Community In-reach Rehabilitation and Care Transition clinical and cost effectiveness study

Assessing whether the Community In-reach and Rehabilitation service reduces the length of hospital stay compared to the usual rehabilitation service for unplanned hospital admission of people 70 years or older. This is ongoing until May 2015.

Evaluation of the 'Regaining Confidence after Stroke' course for Stroke Survivors and their Carers: A Feasibility Trial

Comparing the 'regaining confidence after stroke' (RCAS) group for stroke survivors and their carers, with usual treatment for this patient group.

The study collected data to inform a larger trial. Professor Pip Logan is reviewing opportunities for future research grant funding to conduct a larger trial.

Reducing Falls in People with Stroke

Professor Pip Logan will commence development work in April 2015 with the stroke rehabilitation and falls prevention teams at CityCare, to lead to another NIHR research grant application in September 2015 in relation to reducing falls in people who have had a stroke.

Dignity Care intervention for use by community nurses with older patients nearing end of life

Professor Bridget Johnston, University of Nottingham will commence development work in April 2015 with the community nursing and end of life teams at CityCare to lead to an NIHR research grant application in relation to a Dignity Care intervention for use by community nurses with older patients nearing the end of life.

2.3 Patient experience

Delivering a great patient experience is a top priority for everyone at CityCare, and we are very pleased with the levels of patient satisfaction that we have maintained over the year.

Our patient experience quality priorities for 2014/15 related to improving our response to complaints and concerns, a review of the complaints process, the work of the Patient Experience Group and the development of Patient Stories for the board.

2.3.1 Improving our response to complaints and concerns

In 2014/15, we have had a strong focus on improving our response to complaints and concerns. This work has been informed by feedback from complainants, all of whom are now sent a survey once their complaint has been closed. In addition, we have been involved in an external, independent review of our complaints management process led by the Patients' Association, a national independent organisation supporting the 'patient voice'. We were pleased that they identified some good practice in relation to our complaints management and assessed our processes as generally clear, thorough, open and fair.

Some of the improvements we have achieved in 2014/15 include:

- Ensuring all staff respond quickly and appropriately to complaints: There has been a gradual increase in the percentage of complaints resolved within 25 days throughout the year, with 100% resolved within this timeframe from January to March 2015.
- Improving our information to the public: We have revised our complaints leaflet and are working to ensure that people are made aware at every opportunity of their right to raise concerns.
- Ensuring that the person making a complaint is at the heart of the process.
- A review of our training materials.
- Making use of the 'Datix' web system to improve information sharing between complaints officers and team managers when resolving complaints.

We will continue to build on this work in 2015/16 by embedding the recommendations of the Patients' Association and:

- Continuing to focus on our communication with complainants, encouraging early telephone or face-to- face contact whenever possible and appropriate, to ensure their wishes and specific needs are met.

- Increasing awareness of complaints processes amongst seldom heard and vulnerable groups.

- Ensuring we continue to improve our services based on lessons learned from patient experience.

- Ensuring rigour in maintaining accurate and complete complaint files.

- Continuing to share learning and best practice in complaint handling with partner organisations.

- Continuing to gather regular feedback from patients and complainants, and developing action plans based on the information received.

Our progress against other specific actions planned for 2014/15:

What we planned to achieve	What we achieved
Deliver regular training workshops for staff who are likely to be involved in investigating complaints.	We have delivered quarterly training sessions to staff regarding managing complaints and concerns. We will continue to support quarterly learning networks in 2015/16.
Provide clear examples of changes and improvements in services as a result of patient feedback, including complaints or concerns. We will do this by: • Using Patient Stories for the board • Working with teams to identify examples of service changes based on patient feedback.	All quarterly patient and public engagement reports to commissioners and the board contain examples of service change and improvements in response to patient feedback. The board receives patient stories on a regular basis (see section 2.3.3).

2.3.2 The Patient Experience Group

The Patient Experience Group (PEG) remains a valuable forum to ensure that patients, carers and members of the public have a voice and are involved in the development, scrutiny and improvement of our services.

What we planned to achieve	What we achieved
Formalise the feedback loop between PEG and the board by: • Developing an update in the form of a 'Board communique' from the PEG • Inviting board members to attend PEG.	Board members and directors regularly attend PEG. A productive 'Board and PEG' meeting was held in October 2014, to discuss how to strengthen this link. Some key recommendations have been agreed for 2015/16. These are: • Formalising the role of non-executive directors in representing the patient voice at the board. • Ensure all PEG meetings have a formal agenda slot for board feedback and to view the board forward agenda so that PEG members are able to be involved in early discussions regarding service developments. • Hold joint board and PEG meetings twice yearly. • Incorporate 'the patient voice' into all sub-groups of the board.
Provide training and development for PEG members through: • A patient leadership programme • In-house training regarding specific	Internal training is being developed, for example supporting CityCare staff in assurance processes.

issues, e.g. involvement in staff recruitment/training.	CityCare will liaise with Healthwatch and other organisations to provide appropriate training opportunities for PEG members.
We will involve the PEG in staff recruitment and training by: • Including a PEG member in induction training for all staff • Supporting PEG members to deliver this induction training	PEG members are now supported in providing input to the induction programme for all students undertaking placements in CityCare. This model will be taken forward to engage PEG members in staff inductions in 2015. PEG members have been involved in staff recruitment, including for the post of Director of Quality and Safety/Executive Nurse/Allied Health Professionals.

2.3.3 Patient stories

Listening to stories and personal accounts can be powerful incentives for change. Patient stories enable us to learn about what works well and what doesn't work so well, based on actual experience.

What we planned to achieve	What we achieved
We will capture and record individual Patient Stories. We will capture and record information from people accessing our services in community settings.	Patient stories are recorded and presented regularly to the board. The 'Family and Friends Test' question is now asked within all CityCare services.

Excerpts from two Patient Stories shared with our board

Healthy Change

A service user was referred to the Healthy Change Service by her GP as she had high cholesterol and her doctor felt that she was dangerously close to having a stroke.

The service offered a large variety of initiatives that are run in the city to try and lose weight and lower her cholesterol. They also let the service user make the decisions about what to try which she found empowering.

She said: "The Healthy Change Service is not a one size fits all package – they have options that people can tailor to themselves depending on circumstances and what people feel comfortable trying."

She says she gained so much from using the service, including attending a slimming club and joining a local gym to exercise regularly.

She said: "I have so much more energy since I have made these changes to my life, and I am sleeping better as a result. I am so grateful to the Healthy Change Service for everything they have done for me."

Healthy Change supports people over an initial 12 week programme, depending on their individual needs. The service never closes the door on people, with service users being given the Healthy Change number to call if they need any help or advice from the team either during the programme or when they have completed it.

Sarah, Health Visiting

Sarah gave birth to a healthy boy weighing 7lb 14oz in August 2014. She had some concerns about his feeding from a very early stage when he was not stopping his feeds to pull away satisfied as expected.

Over the next couple of months she received ongoing support and advice from the Health Visiting service, her midwife, and CityCare's Specialist Health Visitor – infant nutrition. After consultations at the Infant Feeding Clinic at City Hospital, then with a consultant at the QMC, a tongue-tie procedure resolved her baby's feeding problems in October 2014.

Sarah said "While we had excellent access to the Health Visiting team, the advice we received was inconsistent. In hindsight if you look at all of the issues put together the tongue tie becomes more of an obvious diagnosis. A referral to the Infant Feeding Clinic could have been done much earlier and the possibility of a tongue tie may have been detected sooner. This may have prevented quite a lot of stress and upset."

Sarah would like there to be an increased awareness of tongue ties and other conditions affecting breastfeeding.

Thanks to the learning from our involvement with Sarah and her baby, the following changes to practice have been made:

- *Revision of the breastfeeding pathway, which is to be re-launched after ratification.*
- *A plan has been made to develop strategies city-wide for dealing with slow weight gain in breastfed babies.*
- *Revision of workbook that accompanies breastfeeding training to include a case study for discussion where feeding is not progressing well and it is not clear why.*
- *Additional information added to training regarding tongue tie and other complex conditions (including when and where to signpost in the City).*

In a pull out section:

The 'thumbs up' from mums helps CityCare gain Baby Friendly award

Feedback from mums on CityCare's health visiting service has helped us achieve the prestigious Baby Friendly Award from Unicef – a benchmark which recognises outstanding care for babies and mothers.

Pippa Atkinson, Specialist Health Visitor for Infant Nutrition said: "Breastfeeding protects babies against a wide range of serious illnesses including gastroenteritis and respiratory infections in infancy as well as asthma, cardiovascular disease and diabetes in later life. We also know that breastfeeding reduces the mother's risk of some cancers.

"But however a mother chooses to feed her baby, she can be sure that she will be supported to form a strong loving relationship with her newborn – through having maximum skin to skin contact and understanding how her baby communicates with her and needs her to respond.

"We're delighted that all the hard work that health visiting teams, the breastfeeding peer support service, Family Nurse Partnership and children's centre staff have put in over the last few years is clearly making a difference to the health and wellbeing of local mums and babies."

What the report said

The report said it was clear to the assessment team that pregnant women and new mothers receive a very high standard of care:

"Throughout the assessment there was consistent positive feedback from all the mothers interviewed, who expressed how much they valued the services provided. The clinics, groups and peer support services were highly praised by all mothers not only for the quality of the service provided but also because the mothers felt welcomed and listened to. A number of mothers commented on how they had noticed an improvement in services, since they had last accessed them."

What the mums told the assessors

Ninety six per cent of the fifty mums interviewed said they were very happy with their overall care from the health visiting service, and no one said they were unhappy.

"The drop in is very accessible and helpful. I love the group now it has been rebranded. You can have breakfast too"

"If ever I have any questions they answer them. Everyone is lovely. It feels very different to last time"

"I just ring if I have any issues and they come around really quickly. I'd like to say thank you"

Separate article but in the same area:

Breastfeeding Peer Support Service wins regional award

The CityCare Breastfeeding Peer Support Service won the Reducing Health Inequalities category at a Public Health in the East Midlands: Celebration & Recognition Event.

The service provides targeted one-to-one peer support for pregnant and breastfeeding women aged under 25, and aims to increase the number of women who breastfeed, and how long they breastfeed for.

The service delivers mother-to-mother support from trained staff. It's targeted at new mothers aged under 25 as research shows that younger mothers are less likely to initiate breastfeeding and are also likely to stop breastfeeding within the first two weeks after delivery.

Since the service started in 2012, 98 per cent of mothers who responded to feedback surveys said that they were well supported and 98 per cent said they were well informed.

Separate article but in the same area:

Small Steps, Big Changes

The Big Lottery Fund's A Better Start programme has allocated a total of £215 million to five areas to fund work to improve children's health and wellbeing, including Nottingham's Small Steps Big Changes (SSBC) programme.

Small Steps Big Changes is a parent-led programme of children's services that will scale what works to improve the lives of young children aged nought to three. It brings together partner organisations from across the city and will see strong community bonds and parent-child focused programmes developed in four Nottingham wards – Aspley, Arboretum, St Ann's and Bulwell – over the next 10 years.

SSBC will build on the Healthy Child Programme, delivering activities and interventions that are designed to improve the lives and life-chances of children. It will start with the target wards, then scale new elements of the programme across the city over the next ten years and beyond to maximise the impact.

Part 3

Priorities for quality improvement 2015/16

In previous reports our quality priorities have been segmented into those addressing patient safety, those supporting patient experience, and those delivering clinical effectiveness.

This year, we are recognising that all those aims are interlinked, and each of the areas we have chosen to prioritise will address all of those aspects of care.

3.1 Pressure ulcers

Pressure ulcers are considered to be a harm to a patient that should not occur whilst they are receiving care. This has raised their profile to become part of the overall patient safety plan which also includes falls, medicine safety and infections from catheters. These 'harms' can be linked, for example catheter infections can cause falls or immobility leading to pressure ulcers; pressure ulcers lead to immobility increasing risks of urinary tract infection and falls; mismanagement of medicines can lead to confusion, increasing instability and falls and fear of falling can lead to immobility.

The prevention of pressure ulcers in the first place can therefore lead to a reduction in other harms and reduction of the other harms can lead to a reduction in pressure ulcers. CityCare will be leading its patient safety campaign by reducing all these issues and will result in a reduction in all harm to patients. This is measured by a tool called safety thermometer which is a quality measure reported monthly.

We are delighted that as a result of actions taken by our dedicated Tissue Viability team and the work of our wider staff groups, the numbers of pressure ulcers have reduced by 31% from 168 to 116.

Over the last year the Tissue Viability Service has continued to roll out the STOP THE PRESSURE – CARING FOR YOUR SKIN MATTERS initiative, focusing on two areas - staff education and information for patients and carers.

Staff competencies have been introduced to accurately assess pressure ulcer risk and to accurately identify different stages of pressure damage. Both of these involve an assessment for the staff to demonstrate their learning. A competency for developing an individualised SSKIN bundle is currently in development.

A public information film has been developed in consultation with patients' groups, staff and information from investigations into why pressure damage has developed. Patient information leaflets have also been redesigned. The film was awarded third prize in the Journal of Wound Care Awards and second prize in the British Journal of Nursing awards. It was launched to the public in April 2015.

The Tissue Viability team is also in the process of reviewing clinical care in Leg Ulcer Clinics. New guidelines for leg ulcer management will be designed together with the vascular services in hospital and all the information for patients is being updated.

The Tissue Viability Nurses are working more closely with the teams in the Care Delivery Groups (CDGs) to see patients, so that practical skills and knowledge are disseminated to colleagues, ensuring quality care for patients with wounds is maintained.

We recognise however that much work remains to be done, and we will build upon our achievements and continue to strive to reach our aim of a further reduction in pressure ulcers of 25%.

Reducing pressure damage will increase quality, patient experience and clinical effectiveness. We need to improve understanding and awareness in the wider community, and our new priorities for 2015/16 focus on this area.

Our new quality priorities for 2015/16:

What do we plan to achieve?	**How do we plan to achieve it?**	**How will we measure/evaluate our progress and success?**
Continue to reduce the	A public information	Evaluate individual events to

occurrence of pressure ulcers and their severity across the City of Nottingham by 25%. To increase the awareness of pressure damage and its prevention.	campaign to raise the profile of pressure ulcers within the wider population. Inform patients, carers, staff (including care home staff) and the public using our new information film.	assess increased awareness. Pressure damage will be seen to be reported earlier. The number of pressure ulcers developing into a serious incident (stage 3 or 4 ulcer) will reduce. There will be a reduction in communication issues and lack of awareness identified in pressure ulcer investigations.
If pressure damage does occur it is acted upon quickly and appropriately. Pressure damage will be treated according to best practice and will not undergo protracted healing.	Introduce competency training for staff in aspects of pressure ulcer treatment and further prevention. Monitor the healing rates of full thickness pressure damage.	Monitor healing rates as a CQUIN target. Reduction in the amount of superficial pressure ulcers deteriorating to severe pressure ulcers.
Improve the identification of pressure damage in dark skin.	Conduct a search of literature and learning in this subject. Develop a research proposal to investigate how we can improve the identification of pressure damage in more darkly pigmented skin.	We will have guidance on the identification of pressure ulcer damage for patients with darkly pigmented skin. Patients and their families will be better informed of what skin changes to look for.

3.2 Duty of Candour

The detrimental effect of an incident on a patient can result in emotional and physical consequences and we take our responsibility to be open, honest and transparent with our patients very seriously. We are committed to acknowledging, apologising and explaining when things go wrong. We have a Being Open process which is part of our incident reporting policy and procedures, and this is included in our training (see Board Assurance section of this report).

We recognise that there are occasions when care falls short of some patients' expectations and as a learning organisation we very much welcome and promote feedback from those who have had experiences of our services. This allows us to make any changes necessary and is part of the continuous cycle of improvement.

The Care Act 2014 places a specific duty on the Government to include a statutory 'Duty of Candour' on providers registered with the CQC. Candour is defined in Robert Francis' report as: *'The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.'*

The Duty of Candour requirement applies to any unintended or unexpected patient safety incident that occurs in respect of a service user during the provision of services, or is suspected to have occurred, resulting in moderate or severe harm or death (i.e. notifiable safety incidents as per the National Reporting and Learning System/ National Patient Safety Agency definitions).

As part of our corporate induction we talk to new staff about Being Open and the Duty of Candour, and we are working to fully embed the principles across our services and within our training and learning events. We will use the lessons learned from our incidents in the learning network events planned for 2015/16.

We have integrated the Duty of Candour reporting requirements into the Datix web system and staff now have to document whether or not a patient has been made aware of an incident affecting them which has moderate or serious implications. This will allow us to monitor our compliance with the Duty of Candour and ensure that we are being open and transparent with our patients when things go wrong.

Our Patient Experience Group have also told us that they feel it is important for us to ensure that vulnerable people and their carers (particularly in care homes) are able to raise a concern.

Further improvements planned for 2015/16

What do we plan to achieve?	**How do we plan to achieve it?**	**How will we measure/evaluate our progress and success?**
Compliance with the Duty of Candour.	Audit of all moderate and severe harm incidents.	Audit report will be presented to the Quality and Safety Group.
Improve our staff understanding of the Duty of Candour.	Integrating Duty of Candour within our training programmes. To be included in the training needs analysis for 2015/16.	By evaluating the training and addressing any inconsistencies that have been identified.
Improve the timeliness of our investigations.	Monitoring the length of time investigations are open on the Datix (incident monitoring) system.	Quarterly audit report to the Quality and Safety Group.

Ensure patients in our reablement beds are able to raise any concerns directly to CityCare	Quality Monitoring visits by our patient safety and quality assessment analyst will include this within visits	Quality reports

3.3 Development of a scrutiny/consultation framework for Patient Experience Group members (PEG)

Within CityCare, we believe that the voice of patients and service users is paramount and should influence our planning and delivery of services at all levels. Patient and public engagement is fundamental to helping us assess the quality of our services, ensuring that they are caring and responsive to peoples' needs.

In October 2014 a meeting was held with the PEG and the CityCare board members, reviewing the work that was undertaken by the PEG in 2014, looking at CityCare priorities and discussing the PEG's developing role within the organisation.

One of the key emerging themes was that PEG members would like a greater role in the scrutiny of CityCare services, and would like to be involved in consultation processes at an earlier stage. This approach will ensure that the lay perspective is fully embedded in CityCare's planning, development and delivery of services, and supports the CityCare values of listening to patients, pioneering improvement and supporting customers.

What do we plan to achieve?	**How do we plan to achieve it?**	**How will we measure/evaluate our progress and success?**
Involve PEG members in the internal quality assurance 'peer review' process.	Deliver training for PEG members - April 2015. Include PEG members in a quality assurance peer review - by end June 2015. Evaluate and roll out the model - by end September 2015.	Peer review findings will be summarised and reported to the Quality and Safety group.
Ensure that the PEG is involved in the early stages of service development.	Bi-annual meetings with PEG and CityCare Board members to agree areas that PEG can influence - two meetings to be held by end of March 2016. CityCare Board forward plan to be shared at PEG as part	Progress to be measured through PEG meetings/Board meetings and by Non-Executive Director and Director of Quality and Safety/Executive Nurse.

	of regular ‘Board up-date’ slot Agree priority areas for PEG involvement - ongoing.	
PEG involvement in the early implementation of services.	Identify opportunities for PEG involvement, for example in the project groups for ‘Connect’ and for the Urgent Care Centre - ongoing.	Progress to be measured through PEG meetings/Board meetings and by Non Executive Director and Director of Quality and Safety/Executive Nurse.

3.4 Carer support

CityCare recognises the essential role that carers undertake in supporting individuals with health conditions. Caring can be very rewarding and also very challenging. We recognise the impact that caring for someone can have, and the need to support carers to address their own health needs and develop a life of their own alongside their caring role. We want carers to feel recognised and valued for the job they do.

CityCare values opportunities to work with carers as experts in care to shape and inform service delivery. To ensure that this happens, we will listen to the experience of carers accessing our services, for themselves or their loved ones, and ensure that we take action in response to their views. This includes responding to and learning from complaints and concerns.

CityCare will support carers by adopting the “Think Family, Think Carer” approach. Building on national and local drivers, and in consultation with carer support services and carer representatives, we have identified the following priority areas

- Identification and involvement of carers (including young carers)
- Recognition of carer needs
- Information, advice and signposting.

This work embeds the CityCare values of listening to patients, supporting customers, empowering choice and putting customers and patients first.

What do we plan to achieve?	**How do we plan to achieve it?**	**How will we measure/evaluate our progress and success?**
Support staff to identify carers and provide them with information/guidance.	Develop a ‘factsheet’ and signposting information - by end of September 2015.	Monitored by the Senior Management Team.

	Ensure information is disseminated to staff through inductions, on the intranet, and in team briefings etc - roll out by end of March 2016.	
Develop and maintain feedback processes to ensure that we address the needs of carers.	Analyse outcomes of carer/service user surveys and identify any trends - quarterly summary in patient and public engagement reports. Analyse outcomes of complaints/concerns and identify any trends - quarterly summary in patient and public engagement reports.	Presented to Quality and Safety meetings in patient and public engagement reports.
Ensure that feedback from carers influences CityCare service planning and delivery.	Ensure carers are aware of opportunities to offer feedback, for example through the Patient Experience Group/on the feedback section of the CityCare website - ongoing. Work with partners to increase carers' awareness of support available - attend Carer Roadshows and other events planned throughout 2015-16.	Presented to Quality and Safety meetings in patient and public engagement reports.

As a pull out quote:

The East Midlands Academic Health Science Network Patient and Public Involvement Senate said it was great to note that CityCare would be identifying and supporting carers, including young carers.

Part 4

Board Assurance

The Board is accountable for our Quality Account and has assured itself that the information presented in this report is accurate.

4.1 Review of services

During 2014/15 CityCare provided 56 NHS services and sub-contracted 25 NHS services or elements of NHS services to permitted material sub-contractors.

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

The income generated by the NHS services reviewed in 2014/15 represents 89.84% of the total income generated from the provision of NHS services by CityCare for 2014/15.

4.2 Participation in clinical audits

During 2014/15, three national clinical audits and no national confidential enquiries covered NHS services that CityCare provides.

During that period CityCare participated in 66% of those national clinical audits and 100% of those national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that CityCare participated in during 2014/15 were:

- National Intermediate Care Audit
- National Chronic Obstructive Pulmonary Disease Audit.

Sentinel Stroke National Audit Programme - Access and information governance issues preventing participation in in 2014/15 have now been resolved and data collection will begin on 1 April 2015.

The national clinical audits and national confidential enquiries that CityCare participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

- National Intermediate Care Audit 100%
- National Chronic Obstructive Pulmonary Disease Audit In progress

The reports of 21 local clinical audits were reviewed in 2014/15 and CityCare intends to take the following actions to improve the quality of healthcare provided:

Clinical audit project	Outcomes/actions/learning
End of Life Care Pathway Re-audit 2013	Identified training and education needs leading to improvements to Syringe Pump and Anticipatory Prescribing policies.

Paediatric Constipation and Night Wetting Re-audit 2013	Templates for assessments and care plans being changed. Advice sheets to be updated.
MRSA Re-audit 2013/14	Infection Prevention and Control Team now add alerts on patients with MRSA. Use of MRSA Care plan reiterated amongst clinicians and included in training for community nurses. Review and improve system documentation for MRSA management.
Essential Steps Re-audit 2013/14	Raising awareness on single use items by cascade and Infection Control Training, and inclusion of sharps bin safety on cleaning audits, pocket guides now given to staff on induction and training. Services also had individual action plans.
Community Rehabilitation Falls Audit 2013	Ensure referrals to Community Nursing and Rehab Team have primary reason for referral amended to 'Falls Risk Assessment' in order to accurately monitor the number of falls referrals received. Ensuring Guide to Action is completed for all Falls assessments. Reviewing falls templates and if appropriate all clinicians to complete these on initial assessment.
Exercise Continuation Re-audit 2014	Local 'Physical Activity Guide' sent to patients on original list and now given out as people complete final Postural Stability Class. Results shared with within Public Health, Councillors and Local Authority to support discussions on local service provision around physical activity aimed at older people.
Housebound Patients at Risk of Pressure Ulcers Audit 2013/14	Disseminating findings to teams and discussion with Head of Tissue Viability. Discuss getting SSKIN bundle on clinical decision tree.
School Nursing Practice Audit 2013/14	Service working towards all nurses at Band 6 having Specialist Public Health Practice qualification as a minimum, all vacancies filled will have this. Development of pathways of care through the school health service. Training matrix to be developed with timescales to ensure staff receive appropriate training.
Health Action Plans Re-audit 2013/14	Areas for improvement discussed with the carers involved.
Hand Hygiene Re-audit 2013/14	Business case for a hand hygiene assessment unit and changes to the Essential Steps Audit to incorporate observations of Hand

	Hygiene. Services also had individual action plans
Community Heart Failure IV Diuretics Audit 2012-14	Audit results shared with the team and the audit tool to be changed to reflect that some patients are accepted despite not meeting the inclusion criteria.
Domestic Abuse Referral Team (DART) Pathway Audit 2013/14	Re-write pathways for School Nursing and Health Visiting. A DART template for SystmOne agreed.
Baby Friendly Initiative Audit 2013/14	Provision of more information to bottle-feeding women on how to sterilise feeding equipment and how to make up bottles of formula. Training for student health visitors on formula feeding planned and if it evaluates well will be made available for all Health Visiting staff. A resource for staff to use with pregnant, bottle feeding and breast feeding mothers is being developed. A feeding contact (a telephone call to mothers by a nominated person within the team to provide further information/support about feeding) was delivered by four teams in the run up to Stage 3 Baby Friendly assessment and is currently being evaluated.
Sharps Practice Audit 2014	Training and information is being provided by the Infection Prevention and Control Team.
Sexual Health Clinic in a Box Audit 2014	Results shared with Locality Manager recommending Health Visitors attend full-day training on 'clinic in a box' and have annual updates. Results also shared with the lead who is updating the guideline.
Clinic Rooms Infection Prevention & Control Audit 2014	Health Centre Managers to address issues identified in sites they cover and feedback through Quality and Safety Group.
Falls and Bone Health Service Audit 2014	New initial comprehensive Falls and Bone Health assessment developed.
Healthy Child Programme Audit 2013/14	Results shared at the Health Visiting Transformation Day, and then with other staff groups.
Health Visitor – Client Communication Audit 2014	Most clients attempted to contact the health visiting service on a Thursday when most GP practices close for training. This requires further consideration to ensure the service is responsive. A

	dedicated phone line to enable clients to contact a Health Visitor is to be considered.
Breastfeeding Support Equipment Cleaning Audit 2014	Results shared with Infant Feeding Specialist, who is the author of the guidance on cleaning the equipment. Health Visiting Team Leaders to communicate findings to staff.

Section 4.3 Participation in clinical research

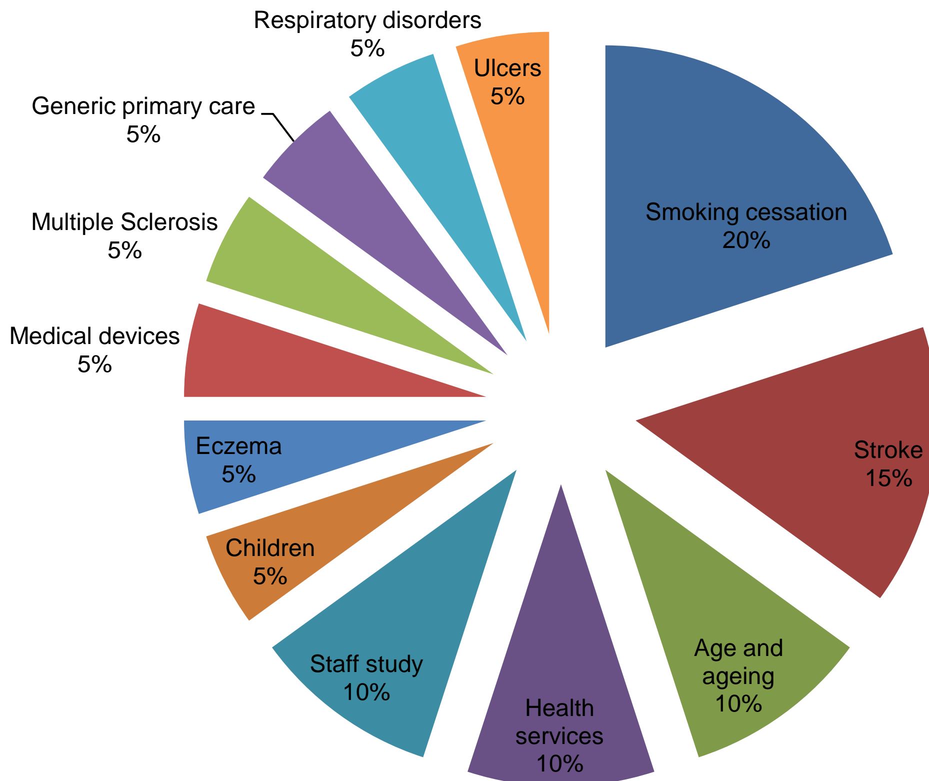
We continue to undertake a wide range of research studies and this year CityCare was involved in conducting 20 clinical research studies relating to smoking cessation, stroke rehabilitation, age and ageing, use of assistive devices, Multiple Sclerosis and children's health including the Family Nurse Partnership, amongst others.

The number of patients receiving NHS services provided or sub-contracted by CityCare in 2014/15 that were recruited during that period to participate in research approved by a National Research Ethics Committee was 78.

Forty six CityCare clinical staff participated in research approved by a research ethics committee during 2014/15. These staff participated in research relating to smoking cessation and stroke rehabilitation.

We are committed to working with our partners to build and maintain strong research links, and collaborate in projects that promote our research priorities. We will continue to ensure research is embedded across the organisation and is an integral part of everyday service.

Active participation in research promotes opportunities for patients to take part in research of relevance to them. Research is essential for the continual improvement of patient care and experience, health outcomes and effectiveness of health services. (See part five for more on how we are increasing our research capacity.)



4.4 Goals agreed with commissioners – use of the CQUIN payment framework

CQUIN Reference	Measure	Q1	Q2	Q3	Q4
1a - Friends and Family Test - Staff	Implementation of staff FFT				
1b - Friends and Family Test - Early	Full delivery of FFT across all services				
1c - Friends and Family Test - Phased	Phased expansion				
2 - Safety Thermometer	Reduction of 50% by the end of Q4 from baseline pressure ulcer prevalence				
3a - Overarching sharing protocol	Approved information sharing agreements in place with all listed providers				
3b - Sharing Arrangements	Development of cross organisational sharing arrangements				
3.c - Implementation of best practice	Implementation of Caldicott 2 NICE Guidance				
3.d - Information sharing and consent	Patients have a decision about their consent choices recorded				
3.e - Approved plans for data sharing	Plans in place to deliver technical connectivity and information messaging				
3.f - Technical readiness	Data sets available for all patients using services				
4 - Complaints management	Complaints process reviewed internally and externally				
5.a - Number of fallers 65 years and over	The number of fallers in the age group 65 years and over				
5.b - 'Guide to Action' tool completed	Completion of the 'Guide to Action' tool for those who are known to have fallen				
6.a - Improving patient safety - Transfers	Plans in place within 24 hours of admission				
6.b - Improving patient safety	Number of meetings attended by Trust's named lead in 2014/15				
7.a - Dementia Training – Level 1	Number of eligible staff receiving level 1 Dementia Training				
7.b - Dementia Training – Level 2	Number of eligible staff receiving level 2 Dementia Training				
7.c - Dementia Friends Training	Number of eligible staff receiving Dementia Friends Training				
8 - Hospital Avoidance (Care Homes)	Evidence the work taking place around the plan to reduce admissions				
9 - Urinary Catheter Competency	Community Nurses who have received training and completed self-assessment				
10.a - MECC - Questions	Number of people asked Making Every Contact Count questions				
10.b - MECC - Referrals	Referrals by CityCare health professionals to the Healthy Change programme				
	Key				
	Achieved target				
	Not achieved target				
	Awaiting results				
	No target to achieve				

*2 – We reached a 31% reduction on the baseline pressure ulcer prevalence. This figure was partly affected by issues with data recording relating to the staging of ulcers. The Tissue Viability service now checks the data for accuracy, and a competency for staging pressure ulcers has been introduced for all nursing staff.

*9 – Urinary Catheter competence – this CQUIN continues into 2015/16 with the Continence Advisory Service continuing to support teams in supervision of competencies and embedding within practice

4.5 Statement on Care Quality Commission (CQC) registration

CityCare is required to register with the Care Quality Commission and is currently registered with no conditions on its registration.

In June 2014 the CQC conducted an inspection to check progress relating to action required following their earlier review of our Walk-in Centre location, that had taken place in August 2013. We are pleased that we were found to be meeting the standard checked which related to cleanliness and infection prevention and control.

We received no other scheduled or unannounced inspections during this year, and the CQC has not taken any enforcement action against CityCare as of 31 March 2015.

4.6 Data quality

CityCare is taking the following actions to improve data quality:

- We have been working towards the reporting of data against the National Community Information Dataset (CIDs), and are now awaiting further national guidance
- We have been able to realign data reporting for all the community services that now form part of Integrated Neighbourhood Teams
- We have worked closely with commissioners to ensure data quality reporting is accurate for any measures reported through the Quality Schedule such as Serious Incidents and Clinical Incidents
- We are working hard to ensure systems and processes are more user-friendly for our staff to be able to input and analyse accurate data
- We are working to produce a clinical dashboard report that will incorporate all our organisations reporting streams. This will enable managers, Directors and the Board to analyse integrated corporate information such as activity performance, HR and workforce information, finance, clinical incidents and risks in a much more meaningful way
- We have used the findings of the 360 Assurance review of CQUIN to ensure robust processes and data quality reporting is established for the 2015/16

4.7 NHS Number and General Medical Practice Code Validity

CityCare has submitted one test extraction to the Secondary Uses Service which is still being validated. The extract contained 28,146 records which was for six months of the 2014/15 year (Aug 2014 – Jan 2015). 98.5% of the records for the A&E dataset had a valid NHS number

CityCare does not submit inpatient or outpatient datasets as this is not applicable to us as a community service.

4.8 Information Governance Toolkit attainment levels

The Information Governance Toolkit measures CityCare's performance against 39 requirements. CityCare’s Information Governance assessment report overall score for 2014/15 was 67% and was graded green (satisfactory). 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 achievement of level 3.

4.9 Clinical coding error rate

As a community service CityCare is not subject to clinical coding for Payment by Results and therefore will not be involved in the audit for either 2013/14 or 2014/15.

4.10 Incident reporting

Improving patient safety is central to our approach to delivering high quality and safe care for our patients. We recognise the value and importance of an open reporting culture when reporting incidents and actively encourage staff to speak out safely on all patient safety incidents.

In 2014/15 there were 3,497 patient safety incidents reported, of which 2,836 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 3,015 incidents were reported.

Because of our commitment to learning and an open reporting culture, CityCare staff report all patient safety incidents including those not attributable to our services e.g. transfer of care from a different provider to CityCare. This means that approximately 1,800 patient safety incidents within this figure are not attributable to CityCare. This commitment to reporting demonstrates a commitment to patients and their safety by promoting the ability to learn from each patient safety incident that is reported.

Incidents are easy for staff to report, with web-reporting and a 'See it! Report it! Stop it!' button prominent on the intranet homepage. Of the incidents reported over the last year approximately 10% of the incidents directly related to patient safety regarding vulnerable adults. We know this because our staff document on the incident form when a safeguarding concern has been identified relating to a vulnerable adult. All safeguarding incidents are reported to the local authority and the commissioners so that required action can be taken or further investigations commenced.

Despite our best efforts, we know that sometimes we unintentionally harm patients whilst they are in our care. Harm is described as suboptimal care which reaches the patient either because of something we shouldn't have done or something we didn't do that we should have done. In addition to Being Open we now have a Duty of Candour policy in place and will be training staff in how to follow the duty of candour (see part three of this report).

The following are updates on our specific quality improvement areas:

1. Continue to improve the way information is made available to teams so that they are able to see trends to be addressed. The Datix administrator provides training to staff on incident reporting and how to code incidents by adverse event so that the manager can identify any trends. One area of focus remains stage 3 and 4 pressure ulcers, all of which are investigated to check how they developed, the care provided and to see whether there was anything that could have been done to prevent their development. The numbers of avoidable stage 3 and 4 pressure ulcers reduced from x in the first quarter of 2014/15 to x in the last quarter, which is a reduction of x%. (Numbers will be available late May)

Our clinical risk training has also been revised to include information on trends of incidents within services, so that they can identify potential risks and ensure action plans are implemented to reduce or mitigate those risks. We use a quality and safety dashboard to

identify any initial early warning signs to triangulate with other quality information so that actions can be taken early on. We will continue to develop the dashboard.

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. The Quality and Safety team developed a template to share key learning from the Patient Safety and Infection Prevention and Control Group. This was cascaded via members who act as patient safety champions. Over 2015/16 we will be running learning networks for our staff to attend where they will have the opportunity to share best practice as well as sharing learning.

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. We have listened to our staff who want to learn more about how to undertake detailed investigations and we are working with the workforce team to develop a new training package.

4. Senior managers will be trained in Being Open. Being Open is included in all patient safety training and we have introduced combined incident and complaints investigation training for managers.

Serious Incidents (SIs)

Within the open reporting culture of the organisation, staff are encouraged to identify and escalate any Serious Incidents (SIs) and, as with any other incident, the organisation reviews SIs for trends and themes to look for opportunities for to improve care to patients.

In 2014/15 the organisation reported 211 SIs, none of which have been categorised as Never Events. This is a decrease of 41 incidents reported in 2013/14.

The organisation investigates every SI through a Root Cause Analysis (RCA) and an action plan for improvement is developed. Action plans are implemented by the appropriate service and monitored for completion within identified time frames. Organisation-wide learning will be shared through the learning networks planned for 2015/16.

Our incidents are graded by the degree of harm following National Patient Safety Agency definitions of harm.

‘Moderate harm’ means harm that requires a moderate increase in treatment, and significant, but not permanent, harm, for example a ‘moderate increase in treatment’ means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

‘Severe harm’ means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is

related directly to the incident and not related to the natural course of the service user's illness or underlying condition.

We take all our incidents seriously and fully investigate any moderate or severe harm incidents. The department of health has classified certain incident in specific categories as serious incidents. These include

- Patient fall resulting in fracture or significant head injury
- Stage three or four pressure ulcers.

Reducing harm from falls is a national issue; as well as being a CQUIN target it is one of the NHS Institute's High Impact Actions for Nursing and Midwifery. Fortunately, relatively few falls result in serious harm such as fractured wrist, but all falls can be distressing for patients and their families even where no physical harm is caused; confidence can be adversely affected and recovery delayed. In the last year six incidents were reported where a patient had sustained a fracture following a fall. One area of learning is that all patients must have a falls risk assessment on admission to a care home. Our Falls and Bone Health service offers specialist multi-disciplinary assessment and treatment to those people with complex multifactorial falls. We aim to reduce the numbers of falls and injuries caused by falls in older people through a range of multi-disciplinary interventions including specialist physiotherapy, occupational therapy and nursing assessment – which includes medical assessment, medication review, continence assessment, postural blood pressure assessment, bone health assessment and addressing home hazards.

Our work regarding reducing the number of stage 3 and 4 community acquired pressure ulcers is discussed in detail in section 3.1.

Part 5

Other quality measures

In addition to the new priorities set in last year's report, this section covers our other ongoing quality priorities.

Support for care homes

Our Reablement service provides specialist short term care and reablement including nursing and therapy within the community to prevent inappropriate admissions into hospital or long term care and enable people to recover from an acute illness and regain their independence.

We have commissioned 95 care home beds in Nottingham City and Nottingham County, and provide a reablement package for up to four weeks to support citizens to develop the confidence and skills needed to continue to live at home. In August 2014 we recruited a Patient Safety and Quality Assessment Analyst and part of the role is to monitor the quality of care provided in those beds. The analyst supports and provides assurance to CityCare and our commissioners on the quality of care delivery in these care homes through completing quarterly visits to the homes, including responsive review visits, providing support and guidance around best practice and escalating any concerns. Information is gathered and shared via a monthly information sharing meeting with CityCare team management. The new role provides assurances of quality and safety of residents to CityCare and CityCare commissioners.

Medicines management

Some priorities around medicines safety were carried over from 2013/14:

- We said that we will provide tailored medicines training for CityCare staff. Roll out of bespoke training programme on controlled drugs for district nurse teams, to be completed by December 2014. This training is now due to start in April 2015.
- We also said that we would roll out specialist modules on medicines administration developed for the intermediate care teams by December 2014. This training is also now due to start in April 2015.
- We have re-commissioned the Derby University two-day course for non-medical prescribers.

Quality of non-medical prescribing

Nurses and some allied healthcare professionals are allowed to prescribe drugs either from a limited formulary or from the whole of the British National Formulary, with certain caveats depending on the drugs and the nature of the qualification of the prescriber. As an organisation we are committed to raising the quality of non medical prescribing for this group of staff. This can be done through providing training and supervision and through our nurse prescribing forums, newsletters and one to one clinical supervision meetings.

Increasing our research capacity

We have continued our commitment to undertaking high quality research in collaboration with our research partners, to improve health outcomes for patients and the effectiveness of our services. We continue to increase the research capacity of the organisation by encouraging clinical staff to develop their research awareness, knowledge and skills, which in turn enables patients to have the opportunity to take part in research which is relevant to them.

In November 2014 we held a half-day research conference for staff, celebrating CityCare's research journey so far; to share, learn and network with colleagues and other stakeholders and to look ahead to future research opportunities and developments. The successful conference was attended by 75 delegates and demonstrated the clear interest and enthusiasm for research within CityCare.

We have continued to support health professionals on the clinical academic pathway. This year two staff were awarded a Health Education East Midlands Clinical Scholar Bronze Award; one staff member took part in a three day clinical academic mentorship programme organised by Nottingham University Hospitals and the University of Nottingham; one staff member is currently on the NIHR (National Institute for Health Research) funded Masters in Research Methods (MARM) course at University of Nottingham; and CityCare jointly funded a PhD opportunity for a member of staff with NIHR CLAHRC East Midlands (National Institute for Health Research, Collaboration for Leadership in Applied Health Research and Care) and Health Education East Midlands.

The PhD fellowship was awarded to a Senior Physiotherapist in the Falls and Bone Health Team, following an open competition. The physiotherapist started his PhD on adherence to exercise and rehabilitation programmes for older people, in October 2014 at the University of Nottingham, whilst also maintaining a clinical role in CityCare.

A task and finish group has been set up to refresh CityCare's research strategy. The Patient Experience Group has been invited to join this group, which will meet in May and July 2015.

Clinical training, supervision and ongoing training

We have reviewed the lessons from the Francis Report into care at the Mid Staffordshire Hospital Trust. We are embedding the learning by introducing a new appraisal programme supported by a Performance Management and Development Programme, currently being rolled out across the organisation.

E-Appraisal was launched in November 2014 and it is being rolled out using a 'top down' approach, from the directors through the senior teams, line managers and then to staff across all services. The roll out should be complete by June 2015.

Our Multi-rater and 360 degree peer feedback review has been well received, providing information to inform the Talent Management Pool and provide management information around internal succession planning.

Recruitment and retention of clinical staff

As an organisation we are proactively managing the recruitment and retention of our clinical workforce. Our Executive Nurse/AHP will be launching a nursing and AHP strategy in the next few months after undertaking a series of engagement workshops to identify the key

issues we are facing and identifying a series of actions we want to take to make a difference and impact to improve the recruitment of skilled staff into our organisation and to retain these staff.

The Cavendish Report

The national Cavendish Report was commissioned following the Francis Report and the failings at Winterbourne View. It looked at the recruitment, training, supervision and support of health care assistants and support workers. In response, in 2013 we launched an annual HCA Conference for all healthcare assistants.

We have now also introduced values-based recruitment with complementary management training.

In April 2015 we introduced the Care Certificate for all new Bands 2-4 employees entering Health and Social Care, following its national launch in February 2015. This consists of a 12-week defined programme of Best Practice formulated within the care industry. We aim to put all band 2-4 employees through this programme.

Community Nursing Preceptorship programme

All new band 5 community nurses have been working within the newly designed Preceptorship programme bringing a “supportive and engaged” group of individuals through from newly qualified to experienced nurse. This programme continues to be developed as both the Code and Revalidation come into place during 2015.

Customer care training

We have revised our induction programme to replicate CityCare’s values which complement the 6C’s (**competence, communication, courage** and **commitment** to create a culture of **compassion** and **care**), the NHS Constitution and the Revised NMC Nursing and Midwifery Code.

Customer care training now forms a fundamental part of the induction programme.

Safeguarding

We have achieved the following during the last year:

<u>Safeguarding Adults</u>

- We prepared for the implementation of the Care Act (2014), including reviewing and re-writing the safeguarding adults policy and procedures to ensure we meet its requirements. The CityCare Lead Practitioner for Safeguarding Adults is also an active participant of the NCSAPB Care Act task and finish group.

- A Care Act briefing including new roles and responsibilities has been cascaded to staff, including face to face sessions with clinical teams, as part of a targeted roll out plan which will continue in 2015/16.
- We developed a Vulnerable Adults Risk Management (VARM) tool to support staff with decision making and recording concerns in a consistent and robust way.
- We completed a comprehensive review of Safeguarding Adults activity within CityCare, informing capacity mapping and shaping a proposal for a new service. A decision on the proposal is expected from the CCG shortly.
- We completed Individual Management Reviews for a substantial Serious Case Review.
- We developed an internal information sharing meeting to capture and analyse the data and soft intelligence regarding concerns raised by staff in relation to Care Homes (QUIF).
- We had significant involvement in the Care Home closure process to ensure that the safety, dignity and wellbeing of residents remains paramount, once a decision to close a home has been made.
- Our Lead Practitioner for Safeguarding Adults reviewed the internal process for CityCare attendance at multi-agency safeguarding adults meetings to provide clarity both internally and to external organisations regarding roles and responsibilities.
- We developed specific advice recording sheets for Care Homes:
    - Care Home Equipment Prescription Process
    - Care Home Concern Sheet

PREVENT

- Following the completion of the PREVENT 'Train the Trainer' course, accredited trainers delivered PREVENT training to more than 300 staff since July 2014. A rolling programme of PREVENT training is in place as part of the safeguarding 'Think Family' training matrix.
- The PREVENT lead has supported practitioners with managing a number of PREVENT concerns that have been raised by frontline staff, liaising with statutory organisations to ensure a co-ordinated multi-agency response is in place.

Mental Capacity Act

- We achieved 91% compliance with Mental Capacity Act training.
- Two further staff have been supported to undertake 'Best Interest' assessors training.
- We developed an MCA / Best interests aide memoire card for clinical staff which will be provided to staff at induction and training.
- We reviewed and updated the CityCare Mental Capacity Act Policy and Consent to Treatment Policy.
- We carried out an audit to inform practice and demonstrate compliance with MCA legislation, with findings due in spring 2015.

Safeguarding Children

- The roll out of the 'Think Family' safeguarding group supervision model commenced in summer 2014. It has been positively received by staff.

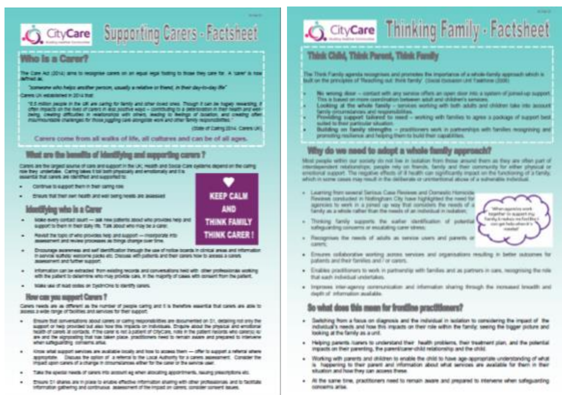
- We completed an audit of the one-to-one supervision model via focus groups and a questionnaire for both supervisors and supervisees. A report of the findings is being compiled.
- We have rewritten the Safeguarding Children policy to provide staff with practice guidance on dealing with safeguarding concerns and to ensure that internal procedures are compliant with Working Together to Safeguard Children (2015) and Care Act requirements, specifically in relation to transition to adult services.
- We completed Individual Management Reviews for several Serious Case Reviews (SCR) / Serious Incident Learning Process (SILP).
- We developed and rolled out a training programme on child sexual exploitation.
- We completed the Section 11 Self-Assessment Framework.
- We developed an organisational process and pathways to respond to the 'Children Missing from Home' and 'Home Educated Children' agenda.
- We targeted awareness raising within CityCare Children's services of the updated Local Authority Family Support Pathway.

Domestic Abuse

- We reviewed Domestic Abuse Referral Team pathways and procedures.
- We implemented the Domestic Violence Disclosure process (DVDS – previously referred to as Claire's Law)
- Our Domestic Abuse Nurse Specialist gained accreditation as a trainer for Honour-based Violence and Forced Marriage.

Strategic work

- We introduced a Serious Incident Review Group (a sub group to the Safeguarding Group), tasked with reviewing and implementing recommendations from serious safeguarding incidents.
- We further developed our safeguarding intranet pages to support staff.
- We developed a Carers strategy and 'Supporting Carers' factsheet, and a 'Think Family' factsheet for frontline staff.



Key priorities for 2015/16 include:

- Development of level 2 Safeguarding Adults and Safeguarding Children training for identified Adult Services staff
- A Safeguarding Conference for CityCare staff
- A Safeguarding Champions Network
- Completion of the Safeguarding Adults Self-Assessment Framework
- Appointment to a designated MCA Lead Practitioner role
- Development and Implementation of new Safeguarding Adults service
- Audit of 'Think Family' group supervision model.

Infection prevention and control - zero tolerance to avoidable infections

During 2014/15 we have continued to prioritise Infection Prevention and Control.

- 95% of staff members have had their clinical practice observed and results indicate that they are adhering to the correct infection prevention and control practice.
- More staff members were vaccinated against influenza this year than in previous campaigns. Over 50 CityCare staff volunteered to be flu fighters and vaccinate their colleagues.
- Infection Prevention and Control training specific to each clinical service is delivered on a two year rolling programme. 82% of all staff members working clinically have received training.
- Policies for infection prevention and control have been reviewed within timescales and are available for the staff to access.
- Audits of all health centre environments in which CityCare deliver services have been undertaken and where improvements are required these have been communicated to the organisation responsible for the upkeep of buildings.

Patients receive care in a number of different settings e.g. GP practice, the hospital, health clinics in primary care, so it is vital that all these organisations work together. Monthly meetings are held to review all infection prevention and control related incidents and ensure that any actions for the health economy are progressed. This year CityCare has worked with other providers of healthcare across Nottingham and Nottinghamshire to develop an MRSA strategy. This will help to standardise and improve the quality of care patients receive in relation to this infection.

CityCare also has a shared responsibility with Nottingham University Hospitals and Nottingham City Clinical Commissioning Group to endeavour to meet the locally agreed health care associated infection targets. The targets are based on the population numbers within Nottingham City and for 2014/15 were as follows:

Infection	Target for City of Nottingham	Actual numbers

Clostridium difficile	No more than 60 cases	60	
MRSA blood stream infection	Zero cases of infection that are deemed to be avoidable	3	1 pre 48 hour community acquired case
			2 post 48 hour hospital acquired cases

The three MRSA cases occurred while the patients were under the care of another provider, and so were reviewed and investigated by them.

Staff survey

We value our staff and understand that engaged staff are essential for delivery of top quality services. We carried out a staff survey during 2014/15, receiving 769 responses.

We understand how important are staff are to us and are working hard with our Staff Voice and our workforce to ensure we provide support to our staff and actively manage any issues that are identified and ensure a positive culture across our organisation.

The above text to be supported by the following in a graphic format:

The Friends and Family Test:

"How likely are you to recommend CityCare if friends or family needed treatment?"

Extremely Likely = 29.41%

Likely = 50.35%

Neither = 13.49%

Unlikely = 3.46%

Extremely Unlikely = 1.38%

Don't Know = 1.90%

Over the next year the majority of respondents believe that CityCare will change for the better (42.05%) with 13.5% believing CityCare will change for the worse.

41.81% of respondents believe that CityCare is currently managing change well whilst 20.99% believe that CityCare is not managing change well.

"CityCare has a clear vision for the future" – 52.69% positive, 10.78% negative

"Morale in my team is generally high" – 53.52% positive, 10.78% negative

"I am often affected by excessive pressure" – 45.16% agree, 41.93% disagree

"How likely are you to recommend CityCare to friends and family as a place to work?"

Extremely Likely = 20.32%

Likely = 39.40%

Neither = 22.07%

Unlikely = 11.21%

Extremely unlikely = 3.85%

Don't Know = 3.15%

"Overall, how satisfied are you with CityCare as a place to work?" – 65.17% positive, 15.08% negative

Part 6

What other people think of our Quality Accounts

NHS Nottingham City CCG

Healthwatch

Nottingham City Health Scrutiny Panel

Part 7

Our commitments to you

East Midlands Academic Health Science Network Patient Safety Collaborative

EMAHSN has established a local Patient Safety Collaborative whose role is to offer staff, service users, carers and patients the opportunity to work together to tackle specific patient safety problems, improve the safety of systems of care, build patient safety improvement capability and focus on actions that make the biggest difference using evidence based improvement methodologies.

Nottingham CityCare Partnership CIC is committed to working with the EMPSC and has pledged to contribute to the emergent safety priories below:

- Discharge, transfers and transitions

- Suicide, delirium and restraint
- The deteriorating patient
- The older person: focussing on what ‘good safety’ looks like in the care home setting.

In addition we pledge to support the core priorities identified below:

- Developing a safety culture/leadership
- Measurement for improvement
- Capability building

Equality and Diversity

We are committed to embracing diversity and embedding inclusion in all aspects of our business, in relation to the communities that we serve and staff at all levels within the organisation.

We aim to eliminate discrimination, promote equality of opportunity and develop a culture of inclusion in relation to people from diverse communities. We want everyone to be able to benefit from our services, and we are working to improve our data collection in relation to the nine protected characteristics (age, disability, race, religion, sex, gender reassignment, marriage and civil partnership, sexual orientation, pregnancy and maternity) as defined in the Equality Act 2010. This will include ensuring that staff have the right support and guidance to collect information sensitively and effectively and improving the way we record and reflect on data. CityCare will review its progress regularly in workshops hosted by the Equality and Diversity Group, and ensure that information gathered from a range a sources informs the Equality and Diversity Action Plan.

We have already introduced monitoring regarding all nine protected groups within the Integrated Care patient survey and within complaints monitoring, and are gradually introducing it into all of our service satisfaction surveys. This will be fully in place by the end of September 2015.This will help us plan and inform our service development and delivery more effectively. Data collected within surveys and through complaints is reflected in regular reports to commissioners as part of the contract monitoring process, demonstrating any trends in relation to information gathered regarding protected characteristics and changes made as a result of feedback.

Our Equality and Diversity action plan has been developed using the Equality Delivery System (EDS2) that has now become part of the NHS standard contract. This will support us in delivering our Equality Objectives and will be reported upon regularly to the Equality and Diversity Group, Governance and Risk Committee and CityCare Board as well as to commissioners. Some key actions for 2015/16 are:

- Updating Equality Impact Assessments within services, ensuring that action plans are in place addressing the needs of people with protected characteristics .
- Ensuring we have good communication standards embedded across the organisation addressing, for example, the needs of people with learning disabilities, speech and language problems, hearing and visual impairment.
- Ensuring that we have a range of training/development opportunities and resources/materials in place for staff to enable them to address discrimination and promote equality, diversity and inclusion in all aspects of their work.
- Embedding the national Workforce Race Equality Standard (WRES) within CityCare, demonstrating progress against a number of indicators of workforce equality.
- Delivering a workshop focusing on the 'patient and staff voice' in relation to equality and diversity issues.
- Engaging stakeholders in reviewing and grading our work in relation to EDS2.

We monitor and analyse patient experience data from patient surveys and complaints on a regular basis to identify any issues or trends. We will continue to encourage all users of our services to provide feedback, ensuring that we have clear mechanisms in place to enable people to do this. We will work closely with community groups and organisations to ensure that we listen to the views of vulnerable groups and people that are seldom heard.

Listening to feedback on this report

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

We will listen to their feedback on this report and use their feedback when developing quality improvement priorities for 2016/17. We welcome feedback from all readers 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 the Patient and Public Involvement team on 0115 883 9678, email tracy.tyrrell@nottinghamcitycare.nhs.uk or write to Freepost RSSJ-YBZS-EXZT, Patient and Public Engagement, New Brook House, 385 Alfreton Road, Nottingham, NG7 5LR.

HEALTH SCRUTINY COMMITTEE
27 MAY 2015
WORK PROGRAMME 2015/16
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To consider the Committee's work programme for 2015/16, based on areas of work identified by the Committee at previous meetings and any further suggestions or priorities raised at this meeting.

2. Action required

2.1 The Committee is asked to note the work that is currently planned for municipal year 2015/16 and make amendments to this programme if considered appropriate.

3. Background information

3.1 The Health Scrutiny Committee 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 Committee are included elsewhere on this agenda.

3.2 The Committee is responsible for determining its own work programme to fulfil its terms of reference. The potential returning items and potential further items for inclusion in 2015/16 work programme are attached at Appendix 3.

3.3 To support the discussion and development of the 2015/16 work programme the Committee will hold its annual discussion with updates from the Portfolio Holder for Adults, Commissioning and Health and a short presentation from the Acting Director of Public Health regarding 2015/16 priorities. A copy of Nottingham City's Clinical Commissioning Group's (CCG) 2015/16 Operational Plan is also attached for information.

3.4 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 Committee has statutory responsibilities in relation to.

3.5 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.

3.6 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 Committee 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.

3.7 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. <u>List of attached information</u>

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

Appendix 1 – Discussion with the Portfolio Holder for Adults Commissioning and Health - Report 27th May 2015
Appendix 2 – Nottingham City Clinical Commissioning Group 2015/16 Operational Plan
Appendix 3 – Health Scrutiny Committee potential returning items and potential further items for inclusion in 2015/16 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

None

7. Wards affected

All

8. Contact information

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APPENDIX 1

HEALTH SCRUTINY COMMITTEE
27 MAY 2015
DISCUSSION WITH PORTFOLIO HOLDER FOR ADULTS, COMMISSIONING AND HEALTH
REPORT OF HEAD OF DEMOCRATIC SERVICES

1. Purpose

1.1 To hear from the Portfolio Holder for Adults, Commissioning and Health about progress in delivery of objectives relating to health and adult social care; current areas of work and priorities for the year ahead; and future challenges and plans for addressing them.

2. Action required

2.1 The Committee is asked to use the information received at the meeting from the Portfolio Holder for Adults, Commissioning and Health to inform questioning as part of scrutiny's role in holding the Executive to account and to identify where scrutiny can most usefully support the achievement of Council priorities relating to health and adult social care.

3. Background information

3.1 As part of scrutiny's role in holding the Executive to account, every year the Committee invites the Portfolio Holder with responsibility for health and adult social care issues to attend a meeting to discuss:

a) progress of delivery of objectives relating to health and adult social care over the last year;
b) current areas of work and priorities for the year ahead; and
c) future challenges and plans for addressing them.

3.2 The Portfolio Holder for Adults, Commissioning and Health for 2015/16 will be attending the meeting.

3.3 The remit of this Portfolio has expanded since 2013/14 with the addition of commissioning responsibilities.

3.4 When the Panel spoke to Councillor Norris (the previous Portfolio Holder) in July 2014 he identified the following as key priorities for 2014/15:

<u>Health</u>

1. Creating stability during a period of significant change in the NHS.

Adults

1. Supporting the continued existence of the Council as a direct provider of care.

2. Ensuring that personalisation is appropriately applied and supported.

3.5 The Portfolio Holder for Adults, Commissioning and Health is always a member of the Health and Wellbeing Board. The Board has been in operation since April 2013 and is responsible for the delivery of Nottingham City Joint Health and Wellbeing Strategy 2013 – 2016. The Committee may wish to explore the Portfolio Holder's assessment of the development and progress of the Board and its Strategy.

The 2014/15 challenges were outlined as follows:

1. Further work on the Health and Wellbeing Strategy.

2. The integration of health and social care and implications of The Better Care Fund.

3. The prevention of alcohol misuse to reduce the number of citizens who develop alcohol related diseases.

4. Earlier intervention to increase the number of citizens with good mental health.

5. The support of priority families into work, improving school attendance and reducing levels of anti-social behaviour and youth offending.

6. New responsibilities under the Care Act 2014.

7. Looking after each other – empowering communities to look out for one another and greater use of the voluntary sector.

8. Both the Health Scrutiny Panel and Joint Health Scrutiny Committee scrutinised a number of items relating to the above during 2014/15.

   The Health Scrutiny Panel considered:

   - The Adult Integrated Care Programme
   - Implications and progress of the Care Act 2014 within Nottingham City Council
   - Child Adolescent Mental Health Services
   - An overview of the work of OSCAR Nottingham

   The Joint Health Scrutiny Committee considered:

   - Intoxicated Patients Review
   - Transformation plans relating to Child and Adult Mental Health Services and Perinatal Psychiatric Services on to a single site

- Developments in Adult Mental Health
- Developments in Mental Health Services for Older People
- Third Sector Organisations briefing

3.6 Following the 2015 General Election, Jeremy Hunt MP, has again been appointed as the Secretary of State for Health and Alistair Burt MP, as Minister of State for Care and Support.

3.7 The Committee may wish to take this opportunity to discuss with the Portfolio Holder how scrutiny can support achievement of the Council's priorities relating to health and adult social care and/ or address the challenges that it faces. This can be used to inform the Committee's work programme.

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

Report to and Minutes of the meeting of the Health Scrutiny Panel held on 30 July 2014.

7. Wards affected

All

8. Contact information

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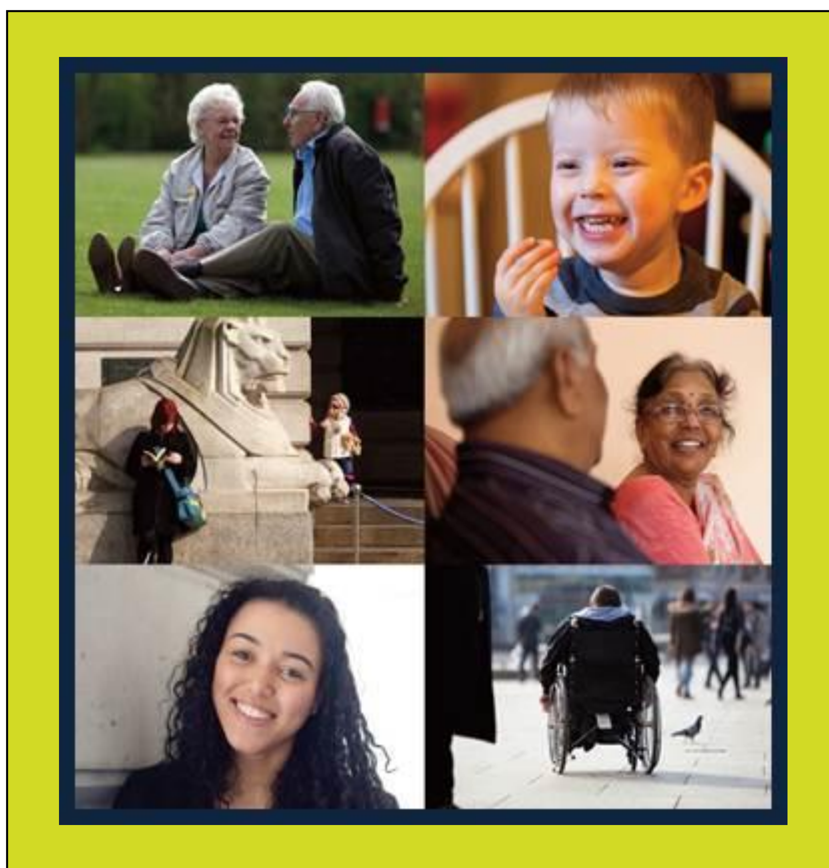
NHS
Nottingham City
Clinical Commissioning Group

2015/16 Operational Plan



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Introduction

We are pleased to present NHS Nottingham City CCG's Operational Plan for 2015/16. This sets out how we will continue to deliver the vision we described in our commissioning strategy for 2013-2016 in line with the intentions defined within NHS England's Five Year Forward View, which was published in October 2014.

As set out within our commissioning strategy, our priorities are, as follows:

- Improving mental health outcomes
- Early detection and improved outcomes for people with cancer
- Enhancing the quality of life for people with long term conditions (with a focus on diabetes and respiratory conditions)
- Improving the health and wellbeing of the frail and elderly
- Improving the health and wellbeing of children, young adults and students
- Developing an effective and efficient urgent care system

Two years on, these priorities remain relevant, and our programmes and activities centre on delivering improved outcomes and services for patients in each of these areas. We also remain committed to delivering the various obligations we have as an NHS commissioning organisation, including delivery of NHS Constitution standards and other key outcome and performance measures, many of which are addressed within this plan.

In addition to our commissioning strategy, our Operational Plan for 2015/16 should also be read in conjunction with a number of other interrelated plans:

- **Five Year Transformation Plan** – Overall, the citizens of South Nottinghamshire receive safe health and social care, however, it has been recognised that services are not consistently coming together to provide joined up, quality and sustainable systems of service provision for the population served. Furthermore, by 2018/19, a £100-140 million financial gap is forecast based on current models of health and social care service provision.

  In response to this, a South Nottinghamshire Transformation Partnership has been formed to reshape the health and social care system and develop a collective work-plan of transformational change. In the short to medium term, the Partnership, which includes members from all key health and social care commissioning and provider organisations, aims to optimise the current health and care system, ensuring improvement interventions are both aligned to, and support, the incremental building of the new system of care. The Partnership has described outcomes for the desired future state as presented below:

  - Care organised around individuals, not institutions.
  - The removal of organisational barriers, enabling teams to work together.
  - Resources shifted to preventive, proactive and care based closer to people's homes.
  - Hospitals, residential and nursing homes only for people who need to be in these care settings.

- High quality, accessible, sustainable services based on real needs of the population.

The Transformation Plan includes a workforce specific workstream, which is being mobilised with an initial focus on urgent care and the modelling of the future workforce for this service area. The Nottinghamshire Local Education and Training Council (LETC) and Health Education East Midlands (HEEM) are aligning their support to the Partnership's needs and providing learning from across the region through implementation of the Strategic Workforce Development Plan for Nottinghamshire 2014/17.

- **Integrated Care Programme and Better Care Fund** – There is a strong national driver to improve services through better integration. Integrated care is seen as being essential to meeting the needs of the ageing population by transforming the way that care is provided for people with long term conditions, enabling people with complex needs to live healthy, fulfilling, independent lives.

  Nottingham City has a good range of community services with skilled clinicians and carers supporting an increasing number of people with complex needs. However, it has been recognised that the system is often confusing and difficult for patients and citizens and carers to understand and navigate. In response to this, we have established an Integrated Care Programme in partnership with Nottingham City Council to deliver improved outcomes and ensure maximum benefit for patients and citizens. The objectives of the Programme are to:

  - Empower people with long term conditions including the frail and elderly to feel supported to manage their own health and care needs and live independently in their own homes for longer with less reliance on intensive care packages.
  - Engage and enable primary care clinicians and health and social care professionals to deliver the right care at the right time using a joined up approach, improving the citizen experience of health and social care.
  - Develop integrated and sustainable health and social care services.

  The Better Care Fund will support the delivery of the Nottingham City Integrated Care Programme, and as such, will be spent on health and social care services to drive closer integration and improve outcomes for patients and citizens. The fund equates to £23.3 million in 2015/16 for Nottingham City and will operate as a pooled budget arrangement under a Section 75 Agreement.

- **Primary Care Co-Commissioning Plan** – 2015/16 will be the first year that the CCG has taken on delegated responsibility for co-commissioning primary medical services. This is one of a series of changes set out in the Five Year Forward View, which emphasises the need to increase the provision of out-of-hospital care and to break down barriers in how care is delivered. We see co-commissioning as a key enabler to developing seamless, integrated out-of-hospital services, based around the diverse needs of our local population. During early 2015/16, we will prepare a three-year plan that sets out how we propose to exercise the functions delegated to us by NHS England to enable and support a more responsive primary care system for the City.

We welcome any comments that people may have about our operational plan, and look forward to delivering it in collaboration with providers and other partners across the local health and care system.

Dawn Smith
Chief Officer

Dr Hugh Porter
Clinical Chair

1. Our performance against outcomes

The NHS Outcomes Framework sets out the high-level national outcomes that the NHS should be aiming to improve. The outcomes indicators are grouped around five domains and seven outcome ambitions:

NHS Outcome Framework Domains	Outcome ambitions
Domain 1: Preventing people from dying prematurely	1: Securing additional years of life for the people of England with treatable mental and physical health conditions
Domain 2: Enhancing quality of life for people with long term conditions	2: Improving the health related quality of life of the 15 million+ people with one or more long term condition, including mental health conditions
Domain 3: Helping people to recover from episodes of ill health or following injury	3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.
	4: Increasing the proportion of older people living independently at home following discharge from hospital.
Domain 4: Ensuring that people have a positive experience of care	5: Increasing the number of people having a positive experience of hospital care
	6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	7: Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

The table at Appendix 1 shows how we benchmark against others in England for key outcome indicators across the five health domains. It also indicates the changes in outcome performance since the previous year. It should be noted that the data relates to the year ending March 2014, and many new initiatives and measures have been introduced since this dataset was released. We therefore expect to see a related improvement in performance against a number of outcomes for the year ending March 2015, although that is not to underestimate the extent of health inequalities in Nottingham City and our ambition to work with partners to address them.

1.1 Outcome 1 - Securing additional years of life for the people of England with treatable mental and physical health conditions

Across all domains, long term conditions and cancer remain the two principal areas where Nottingham City benchmarks poorly against other areas in England and this contributes to the poor outcomes relating to the potential years of life lost amenable to healthcare. As a key driver of health inequalities in our City, our plans to secure better outcomes in these areas are set out in section 3.

1.2 Outcomes 2 and 3 - Improving the health related quality of life of people with one or more long term condition, including mental health conditions & reducing the time people spend avoidably in hospital through better and more integrated care in the community

Community Type 1 Diabetes Service – Enhancing the quality of life for people with diabetes is one of our strategic priorities. In addition to commissioning services for patients with Type 2 diabetes, we are now piloting a service to provide care in the community for patients with Type 1 diabetes. Our aim for 2015/16 is to target patients who do not attend their follow-up appointments at hospital. The service is presently provided through a variety of clinics spread out across the City. A whole system approach to diabetes care will be procured in 2016 following a review. This will enable us to commission a more integrated service for patients.

Hypoglycaemia pathway – A hypoglycaemia pathway for patients with diabetes was launched in February 2015. It aims to ensure that patients presenting as an emergency are triaged and managed in the community, without having to attend hospital as an emergency admission. This pathway will be incorporated into the review and redesign of diabetes services that will take place in 2015/16.

Increased availability of structured education programmes – We have commissioned a structured education programme for patients with Type 2 diabetes (not treated on insulin). Known as 'Juggle', this consists of four weekly sessions during which patients explore and learn about different aspects of diabetes. The programme helps people to understand their diabetes, and supports them in choosing to make the lifestyle changes that will benefit their health. Juggle has also been developed so that it can be delivered in other languages to target groups for whom diabetes is more prevalent. At present, this includes groups who speak Polish, Urdu or Punjabi. Furthermore, a signed programme targets people who are deaf, and we also run a course tailored to those with disabilities. We have also commissioned two further structured education programmes, with similar aims, to support patients with Type 1 diabetes (DAFNE), and patients with Type 2 diabetes who are on Insulin (2TONIC). The availability of structured education sessions will continue to play an important part in supporting patients to manage their own condition and to avoid hospital admissions throughout 2015/16

Improving services in the community through GP education – The CCG has implemented a successful programme of education and training for General Practice through the Practice Learning Time initiative. This aims to update healthcare professionals on the latest clinical guidance and best practice on a regular, planned basis. There is a strong focus on using these sessions to support practices to manage patients with long term conditions in the community, including diagnosis and management of chronic obstructive pulmonary disease (COPD), diagnosis and management of asthma, chronic kidney disease, hypertension, and atrial fibrillation. During 2015/16 this focus will be continued and sessions will include community teams as well as GPs and practice staff.

Cancer – With cancer increasingly being considered as a long term condition, improving the experience of people living with cancer and reducing the time that they spend in hospital is a key way in which the CCG will improve on this outcome during 2015/16. Through our benchmarking, we discovered that chemotherapy patients were being admitted for one to

two days on average, simply because they needed a change of prescription. We have since implemented a process whereby prescription requests are sent by the hospital to community prescribing teams, thereby reducing the need for patients to go into hospital. In addition, a 24/7 helpline allows patients to contact clinicians directly about their ongoing care as well as any complications from chemotherapy. These arrangements were piloted with breast cancer patients, and as a result of their success they will be rolled out in 2015/16 for patients with other cancers, including gynaelogical and colorectal. One of the complexities resulting from the fact that people with cancer are now living longer is that many patients experience complications following their treatment. This can sometimes escalate, causing the patient to be readmitted to hospital. We are commissioning a community cancer service to offer ongoing medical and psychological support, care and advice to these patients. Funded by Macmillan, our pilot will start in October 2015 and run for a year.

End of Life care – We have commissioned an Electronic Palliative Care Co-ordination System (ePACCS). This will record the latest information relating to patients who are either approaching, or experiencing the end of their life. This system will be accessible across ambulance, community and acute services so that clinicians are able to respond quickly to the patient's needs, regardless of where they are being cared for. It will also help to prevent actions and treatments from being administered (and an associated admission to hospital in some cases) if they are unwanted by the patient. Currently, End of Life Services are provided by a number of providers. We are retendering the service in 2015/16 to appoint a single provider who will co-ordinate all local services, eliminate duplication, and improve patient experience. We expect to award the new contract in June 2015.

Improving the experience of carers – There are 27,000 carers resident in Nottingham City (1:11 of the population) and of these, 28% provide in excess of 50 hours of care per week. Our Joint Carers Strategy 2012-17 sets out our commitment, along with Nottingham City Council, of improving the experience of carers in order to support better health and wellbeing outcomes. We will continue our work to ensure that vulnerable older people and those with long term conditions are able to live as independently as possible in their own homes through effective support of their carers. We aim to do this through the delivery of a range of integrated and comprehensive services that meet the needs of carers resident in the City in accordance with the requirements of the Care Act 2014. We will work to ensure that carers are able to access the appropriate support services at the appropriate time to enable them to continue to care for family members in an independent setting. A holistic offer of provision is planned ranging from universal advice and support to end of life respite with all Nottingham carers targeted. Referral into provision will be dependent on the nature of service provided but the Community Carers Hub will be the first port of call for City carers in relation to understanding what services are available to meet their needs and how to access these. In addition, our Primary Care Support Service aims to raise awareness of carer support provision among primary care staff and carers accessing primary care.

Working with our local hospital to prevent admissions and readmissions to hospital – Working with the hospital to prevent admissions to hospital, particularly for people with a long term condition is an ongoing piece of work, which will continue in 2015/16. Plans have been developed with partners across the health and social care community in Nottingham through the System Resilience Group. As part of this work, we will ensure that clinicians working in the Emergency Department have access to services that can support them to

avoid admitting someone with a long term condition (including people with a mental health condition) to hospital. We will do this by enabling better access both urgent outpatient slots within the hospital and alternative services in the community. This will include extending the provision of the Rapid Response Liaison Psychiatry Service. All specialities within the hospital will develop plans for reducing readmissions to hospital and we will carry out regular audits to monitor how well this is working.

1.3 Outcome 4: Increasing the proportion of older people living independently at home following discharge from hospital.

The Care and Support Minister, Norman Lamb, announced in January 2015 that Nottingham City has become a Wave Two Pioneer site for Integrated Care. As a pioneer, we are showcasing innovative ways of creating change in the health service, which the Government and national partners want to see spread across the country.

Our Integrated Care Programme is run in partnership with Nottingham City Council and Nottingham CityCare Partnership. The Programme includes the improvement of reablement and rehabilitation services, and aims to keep more people healthier in the community, preventing admissions and readmissions. Reablement services are currently offered by both health and social care. These services vary accordingly, and patients or carers are required to refer themselves to the services they need through two different routes. From the summer of 2015, we will be implementing the 'independence pathway' model, which will enable a single, integrated approach. In future, patients requiring reablement services will be able to call a single telephone number, and will undergo an assessment to determine the various packages of care that are right for them. Hospital staff will also be able to refer patients on discharge. This will improve patient experience, ensure that over 65s have access to the health and care services they need, and ultimately help people to realise the maximum level of independence possible.

Work is also underway to improve the transfer of care process from our acute provider. The aim is to assess and review all patients with complex needs within the community, and to ensure that the appropriate support is put into place as quickly as possible. This will mean that patients can be discharged as soon as they are medically stable, rather than having to wait for arrangements to be made.

Addressing social isolation is a key priority for improving the health and wellbeing of vulnerable citizens in the City, including older people and those with long term conditions. Evidence indicates that those who are socially isolated often access mainstream primary health provision as a means of addressing isolation, thus stimulating demand and capacity pressures. Social isolation is a contributing factor to a more rapid deterioration in physical and mental functionality and, therefore, a need for more intensive provision. During 2015, we will commission a single co-ordinated service to help prolific users of health and social care to become better socially connected to other people and to their local community. Each of the eight recently established Care Delivery Groups within the City will be assigned a Community Pioneer who will be the designated key worker responsible for working with individuals using a person-centred approach to understand and overcome barriers to becoming socially active. They will encourage individuals to become volunteers and arrange their own social activities. Community Pioneers will also be looking to identify carers who

may not have identified themselves as carers and will signpost them to the appropriate advice and support to enable them to continue with their caring role in a supported way.

1.4 Outcome 5 – Increasing the number of people having a positive experience of hospital care

Effective hip replacement case-mix – The indicator for hip replacement case-mix suggests that Nottingham City has some of the poorest outcomes in the country. However, there have been concerns expressed nationally about the validity of this outcome measure, not least because patient numbers are so small. We know that there is a national issue with clinicians failing to submit the three forms required to measure this outcome, and so we are working with our local hospital to make improvements. However we have not been complacent and through our community-based Integrated Clinical Assessment and Treatment (ICAT) Service all patients identified as possibly needing a hip replacement are assessed to establish their suitability. This triage process has been proven to improve the effectiveness and quality of care. We undertake a local assessment with independent clinicians and have found outcomes to be good. For this reason, we will continue with local arrangements and reassess the position as methods of assessing this outcome improve.

Responsiveness to inpatients personal needs – The data on which these scores are based relate to care delivered in 2013 and we expect that the work that has been ongoing by our acute provider will have improved these scores as they have continued to implement a range of measures and initiatives to improve patient experiences. Scores across the relevant areas in the annual inpatient survey have shown an improvement year on year. We will continue to check progress during 2015/16. Further information on how the CCG will set measurable ambitions to reduce poor experience of inpatient care is set out in section 7.1.

1.5 Outcome 6 – Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community

This outcome relates to access to and experience of GP services. Whilst the CCG is not an outlier on these measures, we continue to respond to falling levels of satisfaction. We have a number of activities already underway, and others planned for 2015/16 which will be supported by the CCG having been granted delegated authority to commission primary care services from April 2015. Details of our plans in relation to improving access to GP services are described in section 5.

1.6 Outcome 7 - Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

The CCG performs well on this outcome and in 2015/16 we will continue to ensure that this performance is maintained through a variety of robust arrangements designed to ensure that we can understand and measure any harm that may occur in healthcare services. These are set out in detail in section 6.2.

2. Improving health in partnership

Developed and led by the local Health and Wellbeing Board, the Nottingham City Joint Health and Wellbeing Strategy runs from 2013 to 2016. It has four priorities, identified using a process which reflects that set out in Public Health England's *Commissioning for Prevention Report*, published in November 2013. Key health problems and principal gaps were identified utilising the Joint Strategic Needs Assessment. Partners and stakeholder then came together to prioritise, based on assessing where the greatest additional impact could be made to improve health and wellbeing through joint working between local agencies and joint commissioning. This enabled a small set of priorities to be established which build on and complement the City's existing partnership working towards the Nottingham Plan to 2020. The four priority programmes are listed below:

- Prevention of alcohol misuse - to reduce the number of people who drink at levels harmful to their health and to prevent alcohol-related disease.
- Provision of more integrated primary and secondary health and social care services that will ensure a better experience of care is offered to older people and those with long term conditions.
- Earlier intervention to increase the number of local people with good mental health, including improving early years experiences to prevent mental health problems in adulthood, and enabling people to begin working or remain in work where previously their health (especially mental health problems) has been a barrier.
- Support for priority families to get into work, improve school attendance and to reduce levels of anti-social behaviour and youth offending, and improve health outcomes.

The strategy is delivered by the partnership through a range of evidenced-based and innovative interventions. Progress is monitored and evaluated by the Health and Wellbeing Board on a regular basis, with additional input and governance through the Board's Commissioning Executive Group. During 2015/16 the Commissioning Executive Group will lead the development of a timetable and process for reviewing the strategy and the development of a new Health and Wellbeing Strategy from 2016.

3. Reducing health inequalities

3.1 Key Facts

- Life expectancy in Nottingham City is significantly lower than the England average, with three years less for men and two years less for women (Nottingham: 75.7 men; 80.7 women. England: 78.6 men; 82.6 female).
- In several wards (St Ann's, Bulwell, Bridge, Arboretum and Radford & Park), people are living on average ten years less than those in more affluent wards (Wollaton West).
- The largest contributors to the difference between Nottingham City's life expectancy and England's life expectancy are cardiovascular disease, cancer and respiratory disease.

- Smoking is the biggest preventable cause of premature death, and most cancers in Nottingham City are due to smoking; 50% of the gap in life expectancy is due to smoking.
- People with poor mental health experience poor physical health and reduced life expectancy. Data that is currently available, together with national models of need suggest that Nottingham City has worse mental health than nationally.
- One in 20 deaths in the City is alcohol-related and there are rising numbers of alcohol-related hospital admissions.

3.2 Our Approach

We have a clear vision that is built around our ambition to end health inequalities in Nottingham City. The following paragraphs set out how we will continue to close the gap in life expectancy through the development of services to support the delivery of our strategic objectives; by implementing the cost-effective high impact interventions recommended by the NAO report on health inequalities; by implementing the revised Equality Delivery System and making progress against the first NHS Workforce Race Equality Standard.

3.3 Reducing health inequalities through our strategic objectives

Three of our strategic objectives have particular relevance here as they were derived from detailed analysis of what health conditions contribute to the life expectancy gap. They are:

- Improving mental health outcomes.
- Early detection and improved outcomes for people with cancer.
- Enhancing the quality of life for people with long term conditions (with a focus on diabetes and respiratory).

During 2015/16, we will further develop our understanding of which groups in our City experience the worst outcomes, which will inform the development of our new commissioning strategy from 2016/17.

Improving Mental Health Outcomes

In Nottingham City, around 46,000 people have a commonly occurring mental health problem. Adults diagnosed with mental ill-health are more likely to make unhealthy lifestyle choices and suffer a greater burden of disease and premature mortality. Mental health is a priority for all partners across Nottingham City. In collaboration with Nottingham City Council, we have a joint mental health and wellbeing strategy called *Wellness in Mind*. The Health and Wellbeing Board agreed the strategy in August 2014. Key elements include:

- Promoting mental resilience and preventing mental health problems.
- Identifying problems early and delivering improved outcomes through effective treatment and relapse prevention.

- Ensuring adequate support for those with mental health problems.
- Improving the wellbeing and physical health of those with mental health problems through delivering effective interventions.

Our various programmes of work over the next year include:

- Piloting a children and young people's behavioural, emotional or mental health needs pathway. This was launched in December 2014 (see section 4).
- The introduction of a self-harm pathway for young people by October 2015.
- Further development of Nottingham City's *Fit for Work* service, which supported 700 people in 2014/15 of whom just over half had mental ill-health.
- The promotion of smoke free environments and smoking cessation support for people with mental health problems. A number of these services are detailed below as part of our strategic objective to improve outcomes for people with cancer.
- Continuing to ensure that there is parity of esteem between mental and physical health conditions (see section 4 for more information on this item).
- During 2015/16, we will implement a new Black and Minority Ethnic (BME) community mental health service (see section 5).

People with Cancer

The prevalence of, and mortality from, most cancers for people of all ages is significantly higher in Nottingham City than in the East Midlands. Cancer is the joint largest contributor to the life expectancy gap for women in Nottingham City, and the second biggest contributor for men. We are tackling the following key considerations:

- Smoking is the largest preventable risk factor for cancer in the City.
- Most modifiable lifestyle risk factors are higher in areas of deprivation, and we need to help reduce the known risk factors, such as smoking and obesity.
- People are presenting late with symptoms of cancer, particularly those living in areas with higher levels of deprivation, and those from certain BME communities. We need to increase community awareness of symptoms and encourage people to seek the appropriate medical advice to help increase early presentation and detection of cancers.
- Supporting *Change Makers for Cancer Awareness* and delivering any service changes that are recommended.
- Screening uptake needs to be higher to enable earlier detection of cancers, particularly those of the breast, cervical and bowel. Along with lack of awareness, there are particular barriers that are preventing people, particularly those from BME communities, from accessing these services.

We have around twenty programmes or activities underway to make improvements across the entire cancer pathway, from awareness and prevention, through to survivorship and end of life. These include:

In-reach smoking cessation services – We are funding a specialist smoking cessation service, which will be delivered by two advisers based at Nottingham University Hospitals from September 2015. While patients are in hospital and unable to smoke, it is an opportune time to encourage them to stay smoke-free through prescribing nicotine replacement products, offering support, and following up with them once they are back home. This will increase both the number of referrals to the *New Leaf* services - which are already established in the community - and the number of quitters across Nottingham City. We are also planning to roll the service out to Nottinghamshire Healthcare NHS Trust within the same timescale.

Addressing wider issues relating to smoking – We will continue to work with partners on the Health and Wellbeing Board to develop tobacco interventions on a wider scale. The Board has just signed up to a single declaration on tobacco, which is a milestone achievement. This will help to define future areas of work, including the development of programmes and policies to improve education, de-normalise smoking for young people, reduce the illicit trade, introduce more smoke-free zones, and increase advocacy.

Macmillan Early Diagnosis of Cancer Programme – We are recruiting a *Macmillan Early Diagnosis of Cancer* Project Manager, who will develop a volunteer workforce to promote screening and early diagnosis, and help to raise awareness. This programme will target areas of deprivation in the City and areas with a high ethnicity mix, working in the centre and the north of the City in particular.

Research into bowel screening take-up – We have commissioned a bowel screening research programme to help us understand the barriers that prevent people from BME communities accessing screening. The findings will inform appropriate interventions for us to commission in future, and will feed into the early diagnosis project mentioned above. Led by Nottingham Trent University and supported by 12 community researchers, the study is due to conclude in March 2015 and actions to address its findings will be developed and agreed by the Bowel Cancer Screening Group during 2015/16.

Addressing low uptake in GP Practices – We are working with GP practices where there is a low uptake by their patients to access bowel cancer screening services. We have identified priority practices and will continue to support them directly in encouraging patients to undergo screening tests.

Over 55s bowel screening programme – We are implementing the new national bowel screening programme for over 55s.

Raising awareness of prostate cancer – A joint pilot service with Nottingham City Council called '*Hear Me Now'* will promote awareness of prostate cancer to Black African and Black Caribbean men, with the aim of increasing the number of those who undergo screening. This group is currently three times more likely to die from prostate cancer.

Community-based screening for chest cancers – Lung cancer is the most significant reason for poor outcomes in cancer across Nottingham City, linked directly to a high prevalence of smokers. Our local population experiences comparatively high numbers of lung cancer cases with high levels of mortality, and issues relating to late presentation and diagnosis. The main symptoms of lung cancer include a persistent cough, which most smokers have in any case. Consequently, cancers are often detected very late in their development. In 2015/16, we will pilot lung cancer screening in those parts of the City with high numbers of smokers, with the use of mobile CT scanners based in the community.

Direct GP access to CT scans for suspected chest cancers – We will continue with our new programme to enable GPs to make direct bookings for CT scans, where they suspect that a patient may have chest cancer following a normal chest x-ray. This addresses the issue that chest x-rays can sometimes be a poor way of identifying certain lung cancers. Our pilot in this area has shown that this step accelerates the diagnostics pathway by eliminating the need for a consultant referral and outpatient appointment. It enables the earlier diagnosis of cancer and also better patient experience.

Identifying high-risk patients from practice lists – A cancer audit was completed in 2014/15, and findings will be shared and applied in 2015/16. This will include the implementation of the cancer decision toolkit. This is an automated software tool, which works with GP computer systems to identify patients who have a high risk of cancer. It notifies GPs of the need to make appropriate referrals and undertake diagnostics, therefore facilitating the earlier diagnosis of cancers.

Further education for GPs – We will undertake a series of webinars for secondary care clinicians to meet with GPs and discuss appropriate referrals for cancer patients. This is an educational approach to help clarify the latest NICE guidelines, including how GPs might interpret them, and when patients should be referred to ensure the best care and outcomes.

Enhancing the quality of life for people with long term conditions

Diabetes – More than 15,000 local people have diabetes, and the number of people developing diabetes is rising continually, linked to both an ageing population and to rising levels of obesity. We know that diabetes is particularly common amongst people with South Asian and Black African and Black Caribbean backgrounds, with an earlier age of onset in the former group. Diabetes reduces life expectancy, and outcomes for people with diabetes are a major health inequality issue within Nottingham City. This is therefore a key group for us to target to support improved outcomes. In June 2014, we commissioned a BME outreach worker through *Self Help Nottingham* to work directly with communities to address greater prevalence of diabetes, lower levels of recommended physical activity levels, and a higher likelihood of obesity. Patients and carers from BME communities can now become engaged in activities that will help to enhance their health and wellbeing. We have recently commissioned an 18-month long exploratory research study to inform how we can best work in partnership with local BME communities to increase the uptake of long term conditions primary and community services in Nottingham City. Focusing on diabetes and respiratory services, the findings will help us to have a better understanding of the issues and barriers preventing people from accessing these services. In turn, this will help us to tailor our commissioning approaches accordingly. The study is expected to conclude in September 2016.

Respiratory – Following an extensive audit of respiratory services, we will commission a respiratory rehabilitation and transition service that will create capacity on wards and reduce the number of patients readmitting with respiratory conditions. Current readmission data demonstrates that patients may be being discharged too quickly, therefore, we will work with our acute trust to understand the reasons for readmissions in a bid to better understand patients’ needs. This assessment will include advanced care planning to ensure

patients are ready to go home with all relevant social networks in place, with assistive technology now being offered to every patient. In addition, a virtual COPD clinic will start in April 2015 so patients at 'high risk' of readmission will have direct access to a hospital consultant.

3.4 Implementing the five high impact interventions

In December 2013, the National Audit Office made recommendations on the five most cost-effective, high impact interventions to address health inequalities.

Most of these areas are covered across Nottingham City by Quality and Outcomes Framework (QoF) targets at practice level, which are aimed at improving the identification of health concerns, as well as the monitoring and management of patients, and ensuring follow up. Performance is monitored through a variety of indicators and data from practices. These are then discussed in more detail with individual practices during their annual peer support visits. Pathways are in place and are regularly reviewed to ensure smooth transition for patients between primary, community, and secondary care specialist services.

Delivery of a number of the high impact interventions is also supported through NHS Health Checks, which is a vascular assessment and management programme commissioned by Nottingham City Council. The programme is aimed at helping to improve life expectancy and reduce health inequalities. In Nottingham City, health checks are largely undertaken by GP practices, with a smaller number carried out by pharmacists and outreach services.

Those assessed at higher risk are then offered a range of interventions, including lifestyle change counselling, stop smoking services, and programmes for weight management, physical activity, and alcohol harm reduction.

Increased prescribing of drugs to control blood pressure – NICE guidance addresses the various causes of blood pressure. The majority of cases within Nottingham City are managed in primary care, and medicine management support is available to promote and encourage appropriate prescribing. Support services are also available in secondary care to enable urgent access to specialist support if needed. We will remain focused on increasing awareness of guidelines and promoting the importance of patient assessment to identify those with high blood pressure. We will also continue to highlight the need for regular monitoring and medication reviews to ensure that each patient’s treatment is tailored to their needs.

Increased prescribing of drugs to reduce cholesterol – We are working with public health colleagues to support implementation of this high impact intervention within GP practices. We have developed guidance and supporting resources to help front-line clinicians in targeting their efforts to those patients who will benefit most from cholesterol-reducing drugs, in terms of improving both the length and quality of their lives. Patients are both assessed against, and advised on, the benefits and risks of the treatment. Involving patients in prescribing decisions helps to ensure that they are fully informed and committed to their treatment.

Increase smoking cessation services – The New Leaf NHS Stop Smoking Service has been operating in Nottingham City since its establishment in 2000, and we plan to expand the service in 2015/16 to enable in-reach services (see section 3.3). Health Equity Audits

demonstrate that the service is typically accessed by smokers on lower incomes and from the more disadvantaged areas of the City. They also show that the four-week and twelve-month quit rates are better than many other areas with similar levels of deprivation outside of Nottingham City. Services have evolved to respond to a range of preferences indicated by local smokers, and offer individual and group support on a face-to-face basis, as well as drop-ins and access to services and support via the telephone, email and texts.

Increased anticoagulant therapy in atrial fibrillation – National NICE guidance has directly informed local clinical guidelines relating to anticoagulant therapy in atrial fibrillation. These have been developed in collaboration with secondary care through the Nottinghamshire Area Prescribing Committee, and are presented in a user-friendly format to help front-line clinicians apply them in everyday practice. This measure will help to ensure consistency of approach and treatment choices, as well as enable clinicians to direct patients to appropriate medicines support services if needed. Educational events are underway for GP prescribers, pharmacists and community services to increase awareness of both the various options for drug treatment, and the facilities available to support patient decision-making. An education event for GPs will reinforce new NICE guidelines relating to the prescribing of anticoagulant medication. We will also introduce a tool, known as 'GRASP-AF', to GP practices. This is used to help GPs assess the risk of atrial fibrillation related stroke across their patient registers, and to support the effective management of these patients. A review of the findings will help us to identify any commissioning gaps that we still need to address.

Improved blood sugar control in diabetes – The Community Diabetes Specialist Nurse Service provides teaching clinics for Type 2 diabetes patients, with the aim of managing and monitoring their blood sugar levels. Since January 2014, Type 1 patients are managed through the Integrated Diabetes Service, which also measures blood sugar levels and monitors the nine 'care processes' relating to diabetes. We also provide structured education programmes for all diabetes patients, and more about these can be found in section 1.2. A new hypoglycaemia pathway was introduced in February 2015. We are working with ambulance crew staff to ensure that patients experiencing hypos receive advice together with a leaflet on the risks of these and how to prevent them. At the same time, ambulance staff refer the patient to the relevant community service for follow-up and ongoing management and support. During 2015/16, we will undertake a tender exercise to remodel existing services to enable a whole-system approach to diabetes. This will provide a simple triage process for patients, with one referral point for GPs. We also plan to bring together structured education, podiatry, dietetics, and counselling clinics as a 'one stop shop'. Our vision is to improve self-management for patients so that they remain independent and feel empowered.

3.5 Implementing the Revised Equality Delivery System (EDS2)

We have already adopted the revised Equality Delivery System (EDS2) as the framework through which we assess our equality performance. The system is built around eighteen outcomes, grouped under four overarching goals, and it is against these that organisational performance is required to be analysed and graded, and appropriate action determined. The four EDS Goals are listed below:

Goal 1: Better health outcomes

Goal 2: Improved patient access and experience

Goal 3: A represented and supported workforce

Goal 4: Inclusive leadership

Meeting once a year, we have established Grading Panels to consider and grade our equality performance, taking into account supporting evidence and feedback from patients and staff. One panel focuses on Goals 1 and 2 and membership is drawn from our People's Council, which is an advisory group comprising key representatives from the local population. The other panel focuses on Goals 3 and 4, and includes members of our Staff Reference Group. Both panels include appropriate independent membership from our Governing Body and committees. CCG officers are invited, as needed, to provide both panels with advice and information. Both panels met in January 2015 and noted that we take the requirements of all the EDS2 outcomes very seriously. However, they also recognised that the CCG is a lean organisation with limited capacity that needs to balance the demands of completing a robust annual EDS2 evidence-gathering assessment process, with delivering priority equality actions. Referring to EDS2 guidance to help make the process more manageable, the panels supported a proposal to assess our equality performance from 2015 onwards by reviewing outcomes over a three-year cycle. Our Equality, Diversity and Inclusion Framework, Annual Equality Assurance Report, and a paper on the outcome of the grading process for 2014/15 are all available on our public website.

The NHS Standard Contract for 2015/16 includes a requirement for all providers to implement EDS2, and to meet the requirements of the national Workforce Race Equality Standard (see section 3.6 below). We will be looking at how we can determine our overall grade for the EDS2 outcomes that are more relevant to provider organisations, based on the aggregate grades of our main providers. Further key areas of focus for 2015/16 have been agreed as follows:

- The enhancement of patient engagement arrangements and feedback mechanisms.
- Continuation of embedding equality requirements within provider Quality Schedules and service review processes and the provision of comprehensive training to relevant staff to ensure that they have the knowledge and skills required.
- Completion of a more detailed analysis of our recruitment process.
- Provision of specific training for each of the newly nominated GP Equality Champions, in accordance with the specific focus of their roles.
- Review of the process for reporting equality performance to the Quality Improvement and Risk and Performance Committees, both of which have responsibility for the ongoing monitoring of our equality performance.

3.6 Workplace Race Equality Standard (WRES)

This national standard will, for the first time, require all NHS organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of Black and Minority Ethnic (BME) Board representation.

Detailed guidance has been published in March 2015, which will enable us to compare our performance against the nine metrics defined within the standard. These include ensuring fair opportunities and representation for BME staff, discrimination, bullying and harassment, equal access to career promotions or progression, and ensuring that our Governing Body is broadly representative of the population we serve. Once current levels of performance have been identified, plans will be prepared to enable us to demonstrate sustained progress against the standard.

From April 2015 onwards, we will also work with our providers to agree action plans with clear milestones against the standard, with progress monitored as part of our existing contractual management arrangements.

4. Achieving parity of esteem

We are committed to achieving parity of esteem for those with mental health problems in the communities that we serve. In 2015/16, we will increase funding of mental health-related services by £1.38m to enable us to achieve parity of esteem. This represents an increase of 2.8% on last year's budget, and will mean a total investment this year of just over £50.5m in mental health contracts and continuing healthcare packages across Nottingham City.

Following a review of Children and Adolescent Mental Health Services (CAMHS) in December 2014, we launched a Children's and Young People's Behavioural, Emotional or Mental Health Needs Pathway. This is a two-year pilot, delivered in conjunction with a number of health and care partners, including Nottingham City Council, Nottinghamshire Healthcare NHS Trust, CityCare Partnership CIC, and Nottingham University Hospitals NHS Trust. The new pathway aims to respond to the findings of the CAMHS review as well as to patient feedback received. It will improve access as a result of having an integrated single point of access, provide online information for parents, and deliver co-ordinated, evidence-based care which ensures that no child or family is left unsupported. This will improve outcomes for children, young people and their families who are affected by behavioural, emotional or mental health problems. A performance management framework has been developed to assess the success of the pilot pathway against our objectives.

With the support of colleagues at Nottingham City Council and within healthcare services, we will continue to raise the priority of a joint approach to addressing the physical and mental health needs of local adults and children. Owned by the Health and Wellbeing Board, a partnership mental health strategy – *Health in Mind* – has been agreed, and a steering group has been established to oversee its implementation. Furthermore, a development session on mental health was held for members of the Health and Wellbeing Board in July 2014. This has enabled a better understanding of the issues by all parties, and will help to support the effective roll out of plans in 2015/16 to improve mental health, which is one of our four shared priorities. All reports presented to Health and Wellbeing Board meetings are now required to include an introduction which describes how both mental and physical health have been considered.

We remain focused on reducing the 20-year life expectancy gap for people with severe mental illness. We will continue to focus on improving the physical health of patients with serious mental illness, through a partnership approach between primary and secondary

care. For more than two years the CCG has had in place a 'physform', which is a physical health checklist to support the assessment of patients with serious mental illness. In 2015/16, this will also include bowel cancer screening and targeted smoking cessation support where appropriate. Undertaken within secondary care, this is an annual screening test covering indicators such as blood pressure, smoking, Body Mass Index, lipids and alcohol intake. The resulting summary is sent to primary care for action, where the patient is supported to improve their physical health. We have also implemented the national CQUIN, which focuses on improving the physical healthcare of patients with serious mental illness. Patients with mental ill-health can also refer to our Wellbeing+ Service, which offers a range of support, including physical health assessments and advice.

5. Enabling convenient access

We have a range of initiatives underway to improve access to all local services, including GPs, community and mental health services.

Primary Care

Results from last year's outcome measures (see section 1) showed that Nottingham City's performance had deteriorated significantly in relation to the number of patients able to access GP services. We have responded, and will continue to respond to this in 2015/16 supported by the CCG having delegated authority to commission primary care services from April 2015. Over the next year we will work directly with practices to deliver the following measures, which respond to insight from the national *Better Together* patient experience programme, a survey of more than 700 Nottingham City patients, and feedback from our local population.

We will encourage practices to review their booking systems, and look at innovative ways in which we can improve access to primary care, one of these may be to consider introducing a form of clinical triage before appointments are offered. This approach has been tried and tested in other areas and has had a direct result of freeing up capacity, so that patients with more pressing needs will be able to gain faster access to a primary care clinician. It will also ensure that all patients receive the appropriate levels of care to meet their needs. This work will help us to respond to the increasing number of appointments requested as well as mitigating a recognised shortage of General Practitioners in the primary care workforce.

In accordance with the GP contract, all practices must ensure electronic access to appointments. This facility will be promoted to patients, and we will support practices in taking a consistent approach to the marketing and management of these appointments. We will also provide technical support to ensure that mobile phone appointment bookings, reminders and cancellations are also available.

The role of medical receptionist is a core function within any GP practice. Over the years, it is clear that many Nottingham patients perceive the receptionist as the 'gate keeper' to the GP's time. This was substantiated by our recent patient survey, and we are now keen to address this. We will provide intensive training to *all* receptionists and front-line staff, helping to develop them into healthcare guides. Receptionists will learn more about how the healthcare system works, the importance of their role, and how they can help patients by

steering, guiding and supporting them through complex, confusing and sometimes frustrating situations. This training package will be bespoke to Nottingham City, and all practices will send their receptionists and other relevant staff to at least one of the four courses available.

The *Home Visiting Service* will support GP practices by providing rapid access to acute care at home, so reducing the need to attend hospital for urgent treatment. Operating from 9am to 1pm Monday to Friday, the service aims to reduce inappropriate emergency attendances and admissions as a result of better access management. It will make better use of existing services and help to achieve better patient satisfaction. Visiting clinicians are all local and therefore familiar with local services and care pathways. They will aim to visit patients within 60 minutes, supported by a basic clinical history provided by the patient's GP, to include practice and named contact details, information relating to the presenting complaint and relevant history, and a list of any repeat medication. Where a GP is required to attend, they will carry out a full appraisal within the patient's own home, supported by mobile technology to access notes and enable the documenting of vital information.

We will review and realign *Local Enhanced Services* (now known as *Primary Care Contracts*), aiming to ensure that they are fit for purpose and commissioned in as transparent and simple a way as possible. We will do this through continued engagement with all interested parties. By Spring 2015, we will be in a position to ensure that all patients have better access to, and a choice of local primary care services, such as wound care and phlebotomy.

Having agreed care pathways in place is proven to help healthcare staff to deliver and patients to access care which is safe, person-centred, and both clinically and cost-effective. It is well documented that the combination of targeted action within primary care, as well as informing and empowering individuals with certain conditions, can also help to improve the patient's sense of wellbeing and control over their condition. In turn, this helps to avoid repeat admissions to hospital. In the first instance, we will focus on pathways where the behaviour of primary care has the greatest impact on both secondary care, and on the health service as a whole.

Whilst we are committed to delivering the improvements outlined above for the benefit of patients, we also acknowledge that the pace of change will be dependent on the ability of practices to adopt new approaches. We will therefore develop a one year 'responsiveness contract' to encourage practices to adopt and migrate to the change programmes described within this plan. An incentive payment will enable practices to use funds to backfill GPs, or for engagement and training, so that they can make the leap to new ways of working.

Service redesign to improve access

Enabling convenient access for patients now forms a key requirement of our service improvement programmes. Here are some examples of how we have improved, or are improving access to community services:

- The Integrated Diabetes Service, currently being piloted, is looking at how to improve access for patients. The service is available through a variety of clinics across the City, and patients can choose which clinic is most convenient for them.

- We are also redesigning the reablement service. One of the measures to improve access will see the hours of operation change from 8am to 10pm, to 7am to 11pm.
- Following service redesign, our Integrated Respiratory Service now offers a service from 8am to 10pm, 7 days a week.

Mental Health

From the 1 April 2015, a 24/7 enhanced crisis and home treatment service will be in operation. The service will ensure that patients in crisis receive an assessment, and ongoing support if required. The aim is to treat people in the community, and to minimise the number of transfers to hospital as well as inpatient admissions.

We have commissioned a new BME community mental health service, which will be in place by the end of June 2015. The service will provide one-to-one support, including care plans that focus on a patient's recovery, in addition to training and educational opportunities. It will also offer group activities, including training on mental health issues, support sessions, and peer support. Access to the new service and performance targets will be monitored and evaluated to ensure that the intended improvements are delivered.

A new personality disorder service will increase access for patients, provide targeted interventions, prevent emergency attendances, reduce in-patient admissions and increase community-based support. Based on the 'developmental model of personality' this integrated service will offer a range of treatments and interventions tailored to each individual's stage of personality development. Services include Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT) and Mentalisation Based Therapy (MBT).

All these services will improve access to mental health and other services, and will complement the services already in place, including the *Rapid Response Liaison Psychiatry Service*.

We also commission third sector services to increase access for people with mental ill health, for example, Wellbeing+ Service. Based in primary care, this is a non-statutory service which enables individuals, including carers, to refer themselves to mental health support services. These include one-to-one support sessions, counselling, stress management, developing assertiveness skills, training, employment, physical health assessments, and self-care to promote recovery by helping people to thrive physically, mentally, socially and spiritually.

Our two-year, award winning pilot street triage project will continue in partnership with Nottingham Police and mental health nurses. This helps people with mental health and learning disabilities to gain immediate access to the right care and treatment in an emergency situation, rather than being arrested or taken to a place of safety under section 136 of the *Mental Health Act*.

5.1 Improving access to services for minority groups

This plan sets out many initiatives to help improve access to services from those within minority groups. Here is a summary of just some of these, together with section references where readers can find further information.

- Delivering structured education programmes for patients with diabetes who speak Polish, Urdu or Punjabi, as well as for those who are deaf or have disabilities (section 1.2).
- Commissioning of a BME outreach worker who will work within the community to improve and wellbeing (section 3.3).
- Our *New Leaf* stop smoking service caters directly for cultural differences, and programmes have been tailored to address the various methods for chewing or smoking tobacco (sections 3.3 and 3.4).
- Introducing the 'Hear Me Now' service to raise awareness of prostate cancer awareness and screening for Black African and Black Caribbean men (section 3.3).
- Researching lower rates of bowel cancer screening take-up by BME groups (sections 3.3 and 4).
- Commissioning of the Wellbeing+ Service, which engages directly with minority communities and homeless people (sections 4 and 5).
- Undertaking a research study to improve uptake in services, particularly respiratory and diabetes, by BME communities (section 3.3).
- Introducing of a new BME community mental health service (section 5).

5.2 Plans to improve early diagnosis for cancer

Improving the overall cancer pathway is one of our key strategic priorities, and many of the measures we are taking are outlined in sections 1.2 and 3.3 above. Of the various activities described above, the following are key to enabling earlier diagnosis for cancer:

- Various initiatives to increase awareness will encourage people with symptoms of cancer to seek medical advice earlier. These include the New Leaf smoking cessation services to be delivered within Nottingham Hospitals and Nottingham Healthcare Trust, and the 'Hear me Now' project to promote awareness of prostate cancer to Black African and Black Caribbean men.
- The Early Diagnosis of Cancer Project, to include a dedicated project manager funded by Macmillan and backfill payments for GPs so that they are able to participate.
- Enabling better access to, and availability of, screening services, including the initiative to provide mobile CT scans to communities with high levels of smoking, the in-reach programme to support GP practices with low uptake rates, and implementing the national screening programme for over 55s.
- Direct access to CT scans for GPs who still suspect a patient may have lung cancer after receiving a 'normal' chest x-ray result.
- Education for GPs to improve diagnosis and referral in partnership with secondary care.

5.3 Tracking one year cancer survival rates

Across healthcare in England, national statistics currently establish overall measures of survival for local populations. As these are tracked annually, it is not possible to monitor progress throughout the year and so we have recently developed a local cancer dashboard, which is updated monthly and helps to provide evidence of change and improvement across all of our cancer initiatives. The dashboard itself is also reviewed each month for its effectiveness, and it continues to evolve so that it can reliably inform the commissioning process. The responsibility of reviewing the dashboard and its indicators falls to our Internal Cancer Programme Group. This brings together project leads and GPs with special interest in cancer who discuss the metrics and assess whether projects are making the desired difference. From March 2015, progress will be reported through to our Governing Body.

5.4 Meeting the NHS Constitution Standards

We are currently meeting most of the NHS Constitution Standards, and progress is well underway to address those where improvement is needed. The following describes our performance against each standard, and the action planned for 2015/16 and beyond.

18 week referral to treat – Our performance continues to be strong, and we have commissioned various activities with NHS Trusts to ensure that current performance is maintained.

Diagnostics – We continue to meet our obligations for diagnostics. However, we are conscious that demand continues to increase, particularly for MRI and CT scans, and so we have commissioned additional activity in 2015/16 to ensure that our strong performance is maintained. This will be provided by existing hospitals as well as by independent providers.

Increasing Access to Psychological Therapies – Actions are underway to improve access to services and enhance recovery rates. A new provider was recently commissioned to increase access and choice for patients and ultimately to reduce waiting times. We are confident that we will meet the quarter 4 2014/15 target of 15% of the eligible population accessing treatment.

Dementia – We are hitting all our targets for dementia and do not foresee any issues.

A&E / Winter resilience – The System Resilience Implementation Group brings together partners from across the Urgent Care Pathway to identify and agree the priority issues, as well as the actions required to address them. Meeting every week, its members are all, without exception, very senior representatives of local organisations. This group has signed up to a system-wide action plan, which considers changes that need to be made across the entire pathway, including prevention and demand management, management of Emergency Department attendances, bed management, accelerating the flow of patients leaving hospital, and supporting them to stay in their permanent residence. The plan is reviewed weekly to ensure delivery and to assess the impact of the various activities underway. Members of the group discuss which interventions are working, and whether any further actions are required to deliver the desired result. There is significant scrutiny of this plan across all agencies, and it has high-level visibility across the entire health and care system.

Cancer – The number of GP referrals to cancer services increases by 10% each year. We are developing plans to ensure that we meet and sustain both the two-week wait, and the 62

day standards. These will be implemented this year, and will help to improve the management of demand, and the flow of patients coming through the system. GP webinars with secondary care clinicians and decision toolkits will help to ensure that GP referrals are undertaken in accordance with best practice. We are also addressing the common issue of delays for tertiary patients in relation to cases where they are diagnosed at cancer units and then visit hospital for specialist treatment. We are working with Nottingham University Hospitals to manage the flow of patients better, with a particular emphasis on those with suspected or confirmed lung cancers. Activities will help to improve capacity and minimise delays.

Early intervention – Infant mortality is line with national expectations, and we have in place proven, effective processes to review all child mortality. However, we do have challenges relating to higher levels of smoking during pregnancy and lower rates of breastfeeding, when compared with elsewhere. We are working with other partners – public health, local authority, community and acute hospitals – to deliver improvements in these areas. Some of the actions include:

- Joint working with public health to ensure pregnant women have easy access to stop smoking services throughout their pregnancy. This includes an 'opt out' referral system where all women with high CO2 readings are automatically referred to services.
- Provide intervention training for midwives, and other training to key staff to raise their awareness of the dangers of smoking in pregnancy.
- Implement stop smoking services within antenatal clinics.
- Provide a targeted one-to-one breastfeeding service for women aged less than 25 years.
- Provide extra support to breastfeeding women in commercial and community settings, and when returning to work.
- Offer a breastfeeding support and guidance service in line with UNICEF Baby Friendly Standards and NICE guidance.

5.5 Preparing for the new mental health access standards

We are assessing current performance against the four new mental health access standards, which are described in more detail below. A Service Development Improvement Plan will be agreed with each provider by the end of March 2015, and will detail key milestones to ensure achievement of all standards by the 1 April 2016.

Standard 1: Early intervention in psychosis *– More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved package within two weeks of referral –* We already commission an *Early Intervention in Psychosis Service*, and a preliminary review indicates that this waiting time standard is not being met. We continue to work with the principal provider to agree actions to improve performance. Due for sign off in April 2015, this plan will ensure the standard is met by April 2016. Additional funding will be made available to increase capacity, if required.

Standard 2: Improving access to psychological therapies (IAPT) *– 75% of people referred to the IAPT programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral –* Work is being undertaken to assess performance against this

standard across the three current providers. We will then agree measures to ensure delivery of the access targets. Plans will be in place by December 2015. In the meantime, we continue to monitor actions to improve waiting times for IAPT, including increasing the provision of on-line resources, e.g. *SilverCloud,* an online application that helps individuals to learn techniques to overcome symptoms of low mood and anxiety. Additionally, we are increasing the number of providers who deliver services. Each provider is responsible for the systematic review and sharing of exception reports relating to long waits for psychological therapies. In addition, we regularly review a plan that sets out the specific actions being taken by providers to improve access to these services. This includes the assessment of staff productivity levels and recruitment plans, increasing awareness of services in primary care, and the promotion of self-referral.

***Standard 3: Liaison Psychiatry** – By 2020 all acute trusts will have in place liaison psychiatry services for all ages appropriate to the size, acuity and speciality of the hospital –* An acute liaison service - *Rapid Response Liaison Psychiatry* - is already in place at Nottingham University Hospitals. This service will be reviewed by the end of September 2015 to ensure that it meets the required standards. We will also assess whether it is operating in the most effective way, diverting patients away from the acute trust and into mental health services where appropriate.

***Standard 4: Eating Disorders** – A national access and waiting time target will be developed for eating disorders during 2015/16 –* We have funded a community eating disorder service for children and young people, which will be evaluated by the end of September 2015.

6. Improving quality

6.1 Responses to the findings of national reviews and reports

We have ensured that our plans reflect the key findings of all national reports published, including Francis, Berwick and Winterbourne View. This has helped us to ensure that high quality, compassionate, safe and clinically effective care is delivered to residents living within Nottingham City.

All reports identified that the NHS needs to be open and transparent, and more focused on both patient needs, and improving individual patient outcomes. They advocated continuous learning, effective leadership and fundamental standards and measures of quality, and emphasised the importance of listening to patients and staff and acting on feedback received.

Francis and Berwick Reports

The report of the *Mid Staffordshire NHS Foundation Trust Public Inquiry*, known as the 'Francis Report', was published in February 2013. Following its publication, six further independent reviews were commissioned by the Government to consider some of the key issues identified by the Inquiry. These include the *Cavendish Review of Healthcare Assistants and Support Workers in the NHS and Social Care Settings*; *A Promise to Learn – A Commitment to Act: Improving the Safety of Patients in England* by Professor Don Berwick;

and a *Review of the NHS Hospitals Complaints System: Putting Patients Back in the Picture* by Rt Hon Ann Clwyd MP and Professor Tricia Hart.

We created an action plan to address the recommendations made by all reports, and these actions are at the heart of our commissioning decisions. They underpin our plans and contracts with providers, and have informed the nature of information that we request from them. We have specified the standards and improvements that we expect from providers, and how we will measure achievement against them to assess the quality of care being delivered. Providers are also required to update us every six months regarding both compliance against the recommendations of the national reports, and the steps they will take to continue to meet standards. The action plan has also helped to determine behaviour and competency frameworks for CCG staff.

We have now developed a comprehensive framework of indicators to serve as an 'early warning system'. This allows us to monitor performance and identify if further action or investigation is required. It is split into five key areas listed below:

- Preventing problems
- Detecting problems quickly
- Taking prompt action
- Ensuring robust accountability
- Ensuring staff are trained and motivated

During 2015/16, reports detailing performance against the early warning system indicators will be presented to our Quality Improvement Committee on a quarterly basis. This will enable us to demonstrate ongoing compliance with the recommendations made and to take early action to address any concerns identified.

Winterbourne View

We remain focused on reducing the number of people with learning disabilities or autism staying in hospital or residential homes where it is inappropriate, and we are committed to ensuring the safe care of all our vulnerable patients who do reside in these settings, whether temporarily or permanently.

In conjunction with NHS England, the Local Authority and healthcare providers, Care and Treatment Reviews were undertaken on an individual basis to ascertain whether people were in the most appropriate setting, receiving safe and high quality care, and that they had proper future plans tailored to their needs. These were completed in December 2014 for all appropriate individuals, and a number of changes to care and settings were recommended a result. Any changes will be completed by June 2015.

Our review programme will continue during 2015/16 and beyond, and will involve service users, advocates and family members in ensuring that these vulnerable people are cared for in the best environment available to meet their needs.

The Governing Body regularly receives progress reports to ensure that recommendations and actions are delivered, and to ensure an appreciation of the latest requirements to undertake care and treatment reviews for eligible individuals, both nationally and locally.

6.2 Patient Safety

We have in place a variety of robust arrangements to ensure that we can understand and measure any harm that may occur in healthcare services. We use the quality, information and CQUIN (Commissioning for Quality and Innovation) schedules of the NHS Standard Contract to gain the information that we need in relation to quality, including metrics and indicators for patient safety and harm. This enables us both to share and to act on the information we receive to increase awareness and to drive further improvements. This section sets out some of the arrangements either already in place or underway, together with details of how we will increase the reporting of harm to patients.

We will continue to expect providers to report promptly and investigate all incidents robustly, including serious incidents and never events. They must have in place systems to identify themes and trends and to facilitate the sharing of learning from incidents. We regularly scrutinise incidents and discuss them with providers, including how learning might be expected to impact on future practice. As a CCG, we review the themes and trends from reported incidents and use them to inform decisions relating to service provision. One such example is the identification of suicide and self-harm as a key area of focus, which led to a transformation of crisis services. Learning also informs CQUINs, for example, where we developed an indicator to ensure that patients have comprehensive crisis plans in place so it is clear what should happen if individuals need to access services.

We also use information reported via the NHS Safety Thermometer to measure harm and to assess the number of patients who have harm-free care. The Safety Thermometer is a point-of-care survey that is carried out on patients on one day each month only. In October 2014, we rolled out the latest versions, which cover areas of care other than acute, including mental health and maternity services. We have collected information from the Safety Thermometer and have already targeted our intervention to those areas where data showed that harm was occurring. One such example relates to pressure ulcers, where we have focused on ways to reduce avoidable pressure ulcers through training, education, different ways of working for staff, and robust performance management with provider organisations. We will continue with this programme in 2015/16, and this will include a piece of work to measure healing rates and sizes of pressure ulcers to improve patient safety and experience.

Reducing the rates of suicide and self-harm amongst adults and children within Nottingham City has been a focus for us. Self harm is one of the indicators included within the new safety thermometer for mental health services and we will use this data, together with that gained from implementing the actions required within the *2014-2016 Suicide Prevention Strategy for Nottingham City*, to identify groups at high risk of suicide and self-harm and improve timely data capture.

In addition to requiring information from organisations, we will also continue to undertake annual quality visits to all commissioned services, linking in with the regular service reviews that already take place. We have a schedule of visits and set criteria are used to measure standards of care provision, which include listening to the views of staff and patients during the visit. All information gathered is used to inform future commissioning decisions or to target areas requiring further exploration; for example, improving the understanding of confidentiality in relation to safeguarding children. In addition, to our own programmes of audit and visits to services, we work cooperatively with the Care Quality Commission (CQC) to provide relevant information and intelligence prior to inspection. Following inspection,

providers are expected to supply an early summary of areas requiring improvement to commissioners and produce actions plans for CQC demonstrating how they intend to achieve compliance against standards, which are also shared with us and monitored through to completion.

The Patient Safety Collaborative has a key role in understanding and measuring harm across the local health and social care economy. We will continue to work with them on a number of projects, including reducing harm from pressure ulcers, reducing healthcare associated infections, and improving safety in care homes. The data gathered, together with evidence of what works in practice, enables us to identify the actions required to make further improvements to patient safety.

National and local CQUIN indicators, which are set to incentivise improvements in quality, also enable us to identify and measure harm that may occur. For example, we developed a scheme to provide us with benchmarking data relating to individuals who had fallen, or were at are at risk of falling, and targeted assessments and interventions to help reduce the resulting harm. This work will continue in 2015/16, and we will monitor and evaluate the impact that it has had on patient outcomes.

We will continue to work in partnership with Nottingham City Council to understand and measure harm within care homes. We have established a dashboard of metrics to identify homes that are at risk of failing, and we will use this information to ensure that support is available to them through an Early Intervention Team. This new approach is a joint venture with the local authority, and will be piloted in 2015/16.

6.3 Increasing the reporting of harm to patients

We recognise that improvements can always be made as a result of increasing the reporting of patient harm. We have a number of mechanisms and tools to allow us to improve reporting on a continual basis. Working with the Patient Safety Collaborative, we intend to review whether there are any further areas where we might benefit from collaboration. This might include the delivery of root cause analysis training for clinicians to improve the identification of learning from incidents, as well as solutions for reducing harm. We also want to identify the support that clinicians need to encourage them to report incidents, as well as to explore the barriers that may prevent them from doing so.

To help promote the benefits of incident reporting, we will continue to share case studies taken from incident reporting, investigation and lessons learned in our quarterly newsletter *Quality Matters*. This includes examples from all sectors, and is distributed to providers across primary, secondary and community care, and care homes.

Primary Care – We undertake annual practice visits, during which we review a range of indicators linked to performance and quality, to support practices in improving their standards. We consider findings at our Primary Care Quality Steering Group, and we share examples of good practice identified with other practices. As we have not been responsible previously for commissioning general practice, we have focused on sharing learning, following incident investigation to facilitate improvement, rather than on the rates and numbers of incidents (which cause harm to patients) being reported. However, now that we have been granted delegated authority, during 2015/16 we will work with practices to

increase incident reporting and demonstrate the value of a positive safety culture with regard to patient care. We will do this by using established tools, for example, Seven Steps to Patient Safety in General Practice (National Patient Safety Agency) to benchmark current practice, identify areas for improvement and generate actions plans to support the changes required at a CCG level. We will work with practices to understand what would support an increase in reporting within primary care as well as exploring barriers to reporting so that we can understand how reporting rates could be improved on a sustainable basis. This can be fed into the wider piece of work with the Patient Safety Collaborative. At individual practice level, we will identify current rates of reporting, benchmark these appropriately and target practices with lower than expected level of reporting.

Secondary and Community Care – During 2014/15, we set trajectories for an increase in the reporting of medication-related safety incidents along with a number of other areas, including falls. These are in line with national quality premium guidance for all providers of community and secondary care. We will continue to include these targets in 2015/16 contracts, and have set clear expectations that there will be an increase in the proportion of incidents reported that result in 'no or low harm', and a decrease in the number causing 'moderate or severe harm'. We will continue to monitor the uploading of incidents onto the *National Reporting and Learning System.* Providers will be expected to detail the actions they are taking to address any areas identified within their organisational reports, and to provide evidence to show that these have been implemented.

Care homes – New contracts are being issued to care homes with effect from 1 April 2015. These include a contractual requirement to report incidents directly to the CCG. During the consultation and engagement period, we have highlighted this requirement to care homes. At the same time, we have promoted the new CQC regulations, which set out fundamental standards of care that come into force on 1 April 2015. These include regulation 20 (the duty of candour) which will require incidents to be reported and investigated appropriately.

6.4 Tackling sepsis and acute kidney injury

For our acute provider, we are developing CQUIN schemes which relate to two areas: to ensure that staff are able to recognise acute kidney injury and sepsis at an early stage; and that there is consistent assessment and treatment, both of which are evidence-based, to ensure prompt rescue and improved outcomes for patients. We will measure outcome data, e.g. mortality and unexpected admissions to intensive care, and triangulate findings with compliance against the sepsis care bundle, early warning score monitoring, and the national acute kidney injury algorithm.

Within community and mental health settings, we are also exploring how staff should be both trained to recognise acute kidney injury and sepsis at an early stage, and able to maintain their competence. We are also reviewing pathways for care and referral to ensure that they are clear, provide sufficient information, and support staff in dealing with what may be infrequent events within their sphere of clinical practice.

For primary care, again we will focus on recognition, diagnosis and treatment, and targeted education and training for sepsis in both adults and children. This also responds to the failings in care highlighted by a recent case in Nottinghamshire.

We will review these plans when the new nationally mandated CQUIN schemes for 2015/16 are published, to ensure that we are doing everything required.

6.5 Improving antibiotic prescribing in primary and secondary care

Updated, antimicrobial guidelines for the health community have been developed in collaboration with primary and secondary care. These will be signed off formally at the Nottinghamshire Area Prescribing Committee, and will ensure consistency in antibiotic prescribing recommendations across the Nottinghamshire health community. They will also help to ensure the appropriate use of antibiotics.

Antibiotic prescribing indicators are in place within GP practices, and are monitored quarterly. The findings are discussed at annual prescribing visits, or more frequently should a practice become an outlier. In this instance, outlying practices receive individual practice support, and are audited regularly to monitor progress and ensure that changes are implemented effectively.

Antibiotic prescribing across primary and secondary care is further strengthened through links to district-wide Health Community Acquired Infection groups. This helps to facilitate a collaborative approach across the health community. We also work closely with the Infection Prevention and Control Teams from community health providers to share results and learning from audits, incidents and root cause analysis. Key messages are then identified and disseminated to prescribers within primary care.

7. Improving patient experience

7.1 Setting measurable ambitions to reduce poor experience of inpatient care

We have access to a wealth of data and information relating to experiences of local healthcare services. Sources include complaints, patient feedback, CQC and provider survey findings, comments left on websites - for example, *NHS Choices* and *Patient Opinion*, Friends and Family Test results, targeted engagement work, and quality visits. We will continue to monitor and triangulate this data to identify areas of concern and to set improvement targets. So that we can make further improvements in how we use data, we will review how we categorise the complaints and enquiries we receive and manage. We will consider changing our coding system to reflect NICE quality standards 14 and 15, so that we can monitor this against information received from providers. These standards relate to patient experience in adult NHS or adult mental health services. We will also review how information about patient experience is triangulated with other data sources, for example patient safety, staffing levels and service performance indicators, to provide a more representative picture of how patients truly experience the care and services they receive.

Providers are required to monitor and triangulate their own patient survey data, and demonstrate to commissioners how this has improved or impacted on both practice and service delivery. We request that a minimum of four examples are identified and shared with us each quarter, so that we can track the effect of patient feedback received.

Based on the information we have to date, the following ambitions have been set for 2015/16. Each of these will have measurable targets for achievement, appropriate to each organisation:

- Increased numbers of complaints received from seldom-heard and vulnerable populations.
- Reduced numbers of complaints relating to the attitude of carers or staff (nursing, allied health professionals and medical), dignity and respect, and care and treatment.
- Reduced number of complaints accepted for investigation by the Parliamentary and Health Service Ombudsman.
- Reduced number of complaints upheld by the Parliamentary and Health Service Ombudsman.
- Reduced percentage of patients who would not recommend services to others.
- Increased response rates to all forms of patient survey.
- Increased numbers of patient survey respondents from seldom-heard and vulnerable populations (providers' own surveys).
- Increased number of complaints acknowledged and responded to within timeframes agreed with the complainant.
- Increased numbers of patients who agree that their experiences of care align with the statements within NICE Quality Standard 14 or 15.

7.2 Assessing and improving the quality of care for vulnerable patients

The methods of evaluating the quality of care as set out within section 7.1 above apply equally to the care provided to vulnerable people.

Equality Delivery System – We have continued, and will continue to assess our performance against the Equality Delivery System (EDS2) outcomes for both goals one (better health outcomes) and two (improved patient access and experience). These relate to the nine protected characteristics and inclusion health groups within Nottingham City, whom we know to be vulnerable for a number of reasons. This assessment allows us to establish how vulnerable groups fare compared with the general population, and to determine where further focus is required. As set out within their contracts, in 2015/16 we will continue to require providers to report information on patient experience measures and complaints by protected characteristics. We then review information received, and work with providers both to target areas where experiences vary between different groups, and to agree improvement objectives.

Care homes vanguard – We know that some of our most vulnerable patients are in care homes, are elderly, or may have mental health conditions, learning, or physical disabilities. We have recently submitted an application to NHS England's *New Models of Care* programme to become a vanguard site. This has been developed in conjunction with a number of our partners, including Nottingham City Council, acute and mental health providers, and Age UK. With support from the structured national programme, we would

like to commission a care home model that is seen as a beacon of best practice and fit for the future. Over the course of the next year we plan to review the effectiveness of our current arrangements in meeting the needs of care home residents. Findings will inform improvements and the development of new services, and we would look to start introducing new ways of working from October 2015.

Clinical accountability – We will continue to work towards embedding the practice of clear clinical accountability, with a named doctor responsible for each individual patient's care, within and across different care settings. In 2014/15, as part of the commitment to more personalised care for patients with long term conditions, all patients aged 75 and over were assigned a named accountable GP. During 2015/16, we will continue to focus on vulnerable adults through implementation of a local and a national Enhanced Service to reduce unnecessary emergency admissions to secondary care. This will require proactive case management of at-risk patients using a risk stratification tool to identify vulnerable older people, high risk patients, patients needing end of life care and patients who are at risk of unplanned admission to hospital. Personalised care plans will be developed for patients on the case management register by a named accountable GP within their practice.

7.3 Demonstrating improvements from complaints and feedback

Complaints and other sources of feedback, including comments, concerns and survey data help commissioners to identify problem areas by giving an insight into the services that we commission and provide a barometer of quality and standards of care. Above all, they help us to take action to prevent similar problems occurring in the future and to allow services to continually improve.

As outlined in previous sections, we already expect our providers to monitor and triangulate their own patient survey data and demonstrate to commissioners how this has improved or impacted on practice and service delivery and to ensure that this can be linked to vulnerable groups via analysis by protected characteristic and this will continue in 2015/16. We will also monitor progress against the patient and staff experience ambitions identified to ensure that improvements are being seen.

7.4 Meeting NHS Constitution patient rights and commitments

All providers are required to supply an annual declaration to commissioners that they are i) compliant with the rights and commitments of the NHS Constitution with respect to patients and staff; and ii) have plans in place to address any areas of concern identified. This declaration is scrutinised and reviewed against patient feedback and other information received during the year.

7.5 Ensuring that Caldicott Review recommendations are relevant to patient experience

We will use the general condition, included within the NHS Standard Contract, to ensure that our providers adopt and implement all recommendations from the Caldicott review (including those relevant to the patient experience) and conduct an annual audit of their

practices against the quality statements relating to data sharing, as set out in NICE Clinical Guideline 138.

In 2014/15, we implemented a CQUIN relating to information sharing. This targeted a number of areas for improvement, including information sharing protocols and preparing technical solutions for sharing data appropriately. There was also a requirement for providers to improve information sharing and as part of this a survey was conducted to ascertain patient views on how information is handled. Providers will need to present the results of this survey to commissioners, together with an action plan to address any gaps or weaknesses identified. We will require providers to repeat this survey in 2015/16 to ensure that actions implemented have been effective. We expect patients to report better experiences and greater confidence in the way in which their data is managed and handled. In addition, the CQUIN scheme has been developed to focus on implementing the technical solutions created in 2014/15 to improve handovers between professionals during episodes of clinical care.

8. Compassion in Practice

Compassion in Practice, the national strategy for nurses, midwives and care staff, was launched in December 2012. Since that time, a significant programme of work through six action areas, known as the '6 Cs', has gained a momentum across the country which has recognised the very crucial role that organisational culture plays in determining the experience of patients and users of our services. Our role as a commissioner is to assure that providers are delivering against the 6Cs, which are: care; compassion; competence; communication; courage; and commitment.

We have recently completed a review of the assessments undertaken by providers of how well *Commission in Practice* has been implemented within their organisations. As a result, we are assured that provider plans are delivering against the 6 Cs, and no concerns have been identified. This review has highlighted examples of good practice and has demonstrated the extent to which activities to date have directly benefited patients and staff. The 6Cs are being rolled out to all staff in a number of ways, including incorporating them in recruitment approaches, induction programmes, and ongoing training, appraisal and supervision. We will continue to monitor progress against these implementation plans via existing contractual mechanisms.

9. Improving staff satisfaction

We have access to a range of information available to provide us with an insight into staff satisfaction locally, and how sentiment compares with similar organisations. This includes findings from the annual staff surveys, *Friends and Family* tests and quality visits; staff sickness and absence rates, staff appraisals, safe staffing returns and other workforce indicators; complaints; patient surveys; and feedback from student placements. The following provides an overview of satisfaction for staff working at each of our key providers.

Nottinghamshire Healthcare NHS Trust – Generally staff are satisfied with the organisation and would recommend it as a place to work or receive treatment. In the 2013 staff survey

published in February 2014, the overall score for staff engagement relating to their work, their team and the Trust, was amongst the top 20% of similar Trusts across England. The Trust scored well on issues relating to work pressure, although many staff reported that they had felt pressure in the last three months to attend work when feeling unwell, and this was in the worst 20%. The percentage of staff appraised in the last twelve month was also in the worst 20%, although the Trust scored 86% against a national average of 87%.

Nottingham University Hospitals NHS Trust – Generally, staff are satisfied with the organisation and would recommend it as a place to work or to receive treatment. In the most recent survey, published in February 2014, the Trust scored better than average for the percentage of staff appraised in the last twelve months. It was also in the top 20% for those considered to have well-structured appraisal systems. The Trust was in the worst 20% both for access to training, and for the number of errors, near misses or incidents witnessed in the last month. The results from the 2014 staff survey are due to be published in early 2015. We will review these to establish how performance has changed over the past year. Providers will be required to share their action plans with us, and we will monitor these as part of our contractual performance management process. We will also work directly with Health Education East Midlands to ensure that we can recruit and retain a motivated and skilled workforce. Furthermore, this workforce will need to meet the needs of both changing populations and the NHS landscape, as well as respond to the new models of care and working required for successful transformation.

9.1 Delivering improvements in staff experience to improve patient experience

We will continue to monitor and triangulate all the data and information we hold about experiences of health care and services from staff and patient perspectives. This will to identify areas of concern and set targets for improvements. The following ambitions have been set for 2015/16, against which we will develop measurable targets appropriate to each organisation:

- Increase general response rates to staff surveys
- Increase or maintain the position on overall staff engagement
- Increase or maintain the position relating to recommending the organisation as a place to work or to receive treatment
- Reduce sickness and absence rates
- Increase staff retention and reduce turnover

Once the results of the 2014 survey are known, we will set objectives to address areas where performance is worse than average, or where performance has deteriorated since the previous year.

10. Achieving seven day services

There is clear evidence that patients admitted to hospital as an emergency at the weekend have an increased risk of dying compared to those admitted on a weekday. Because of this,

the planning guidance for the NHS for 2013/14 expressed a clear commitment to move towards making routine services available seven days a week, with an initial focus on hospital care. This included a clear recommendation that the NHS should adopt the following ten evidence-based clinical standards for urgent and emergency care.

- Standard 1 – Patient experience: health professionals and social workers actively involve patients, real time data collection and feedback.
- Standard 2 – Time to first consultant review: clinical assessment by consultant within 14 hours of arrival.
- Standard 3 – Multidisciplinary team review: MDT review within 14 hours of emergency inpatient and establish management plan and estimated date of discharge within 24 hours.
- Standard 4 – Shift handover: handovers between incoming and outgoing and led by a key decision-maker.
- Standard 5 – Diagnostics: seven day access to consultant diagnostic tests and reporting within 1 for critical, 12 for urgent and 24 hours for non-urgent.
- Standard 6 – Interventions/key services: timely 24/7 access to consultant led interventions.
- Standard 7 – Mental health: acute admission patients assessed by psychiatric liaison 24/7.
- Standard 8 – On-going review: High dependency area patients to be seen by consultant twice daily, and once moved onto general wards at least once daily.
- Standard 9 – Transfer to primary, community and social care: support services onsite and offsite to be available seven days a week to ensure next steps in pathway can be taken.
- Standard 10 – Quality improvement: review of patient outcomes to drive care and quality improvement.

We are working with our partners, particularly Nottingham University Hospitals NHS Trust to ensure that as a minimum, by 2016/17 the hospital will comply with five of the ten standards, with compliance against the remaining five standards from April 2017 onwards. During 2014/15, Nottingham University Hospitals NHS Trust was required to assess its current compliance and agree an action plan for implementing the standards. This has involved working with individual wards to determine their baseline positions against the national standards and all Directorates identifying how they are moving to seven day working as part of the annual planning process. For 2015/16, we will agree an updated Seven Day Plan with the Trust to ensure that significant progress is made towards implementation of the standards. Key priorities have been identified as Standards 2, 5 and 9, with plans in place to make progress on Standards 6 and 8.

In support of the work taking place in the hospital, particular focus will be paid over the next two years on developing seven-day community and mental health services where appropriate. For example, Standard 9 (transfer to primary, community and social care) is already the focus of local improvement efforts through the Better Care Fund plans. For Standard 7 (psychiatric liaison), the Clinical Commissioning Groups in South Nottinghamshire

will invest recurrent resources to further support capacity into the existing 24/7 Rapid Response Liaison Psychiatry Service and will review the use of the £30 million targeted investment announced nationally as soon as further information on this becomes available.

11. Safeguarding

11.1 Meeting our requirements to protect vulnerable people

We have robust arrangements in place to meet the requirements for CCGs within the NHS Commissioning Board's accountability and assurance framework: Safeguarding Vulnerable People in the Reformed NHS (March 2013). These include the following:

- Maintaining clear lines of accountability through both the Director of Quality and Delivery, and the GP Executive Lead for Safeguarding.
- Coordinating and overseeing all safeguarding activities through our Safeguarding Steering Group, with assurance being provided to the Quality Improvement Committee and the Governing Body.
- Actively participating in all sub-groups (both statutory and non-statutory) in addition to chairing a number of local Safeguarding Boards for both adults and children.
- Continuing to be a funding partner and vice chair of Local Safeguarding Boards for adults and children.
- Working in partnership with statutory agencies to Identify emerging areas of concern and work together to deliver improvements, for example historic abuse, child sexual exploitation and modern slavery.
- Maintaining ongoing membership of the Nottinghamshire/Derbyshire Safeguarding Forum.
- Ensuring that we have a designated doctor and nurse for children and looked-after children and a lead practitioner for safeguarding adults and the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).
- Undertaking an annual assessment of safeguarding capacity requirements for both adults and children, to ensure that staffing levels and arrangements for safeguarding purposes remain appropriate and effective.
- Undertaking Section 11 audits and Markers of Good Practice (MOGP) and Safeguarding Adults Assessment Framework audits with all providers and for the CCG.
- Implementing all the actions required to complete the action plan following the Child Safeguarding and Looked After Children inspection undertaken by the CQC in June 2014.
- Operating appropriate policies and procedures to safeguard adults and children.
- Providing an annual report on safeguarding performance to both the Quality Improvement Committee and the Governing Body for assurance.
- Delivering a training programme for general practice and care homes in relation to safeguarding; to include adults, children, MCA, DoLS and the Prevent strategy.

- Developing and delivering training, as described above, to all members of the Governing Body to ensure ongoing compliance with any national requirements, including the intercollegiate guidance for children.
- Delivering training for all CCG staff for all areas described above.
- Learning from, and monitoring the impact on practice following Serious Case Reviews and other types of learning reviews.

The Care Act 2014 has been introduced since the publication of the Accountability and Assurance Framework. We will therefore work with Nottingham City Council and other partners to ensure that the requirements of phase 1 of this Act are introduced and implemented with effect from April 2015. This includes introducing the role of the Senior Manager and Designated Safeguarding Adults Manager (DSAM) within our CCG. We will also continue to support Nottingham City Council with implementation plans required for phase 2, which takes effect from April 2016.

11.2 Delivering improvements in the application of the Mental Capacity Act

The work to introduce the Care Act 2014 will support improvements in safeguarding adults and the MCA by ensuring that statutory processes are fully operational. We have already undertaken work to ensure that staff are adequately trained in relation to the MCA and DoLS. Following the receipt of funding from NHS England, we have also developed a suite of tools to support primary care clinicians with complying with the MCA and DoLS. This has involved the development of an 'App', an e-learning package and a number of workshops to improve education and understanding. We will continue to promote and embed these tools into practice and will provide one-to-one support and advice on individual cases as required.

We have reviewed our practices following the Cheshire West judgment and are reviewing all individuals funded by Continuing Healthcare Funding to ensure that they are not deprived of their liberty in care homes, supportive living or domiciliary settings. A number of these are being referred to the Court of Protection for a decision on their circumstances.

We will provide regular progress reports on all of these areas to the Safeguarding Steering Group, so that progress and quality improvement can be monitored.

11.3 Meeting the standards in the *Prevent* agenda

The *Prevent* strategy is one element of the government's anti-terrorism strategy with the aim of preventing people from being drawn into extremism or extremist activities. Although Nottingham is not deemed to be a high-risk area, we will ensure that these standards are met. In light of the latest guidance relating to the training and awareness required for this agenda, we will ensure that there is an increase in the number of accredited *Prevent* trainers across the health community. This will allow training to be delivered within the required timescales, whereby 90% of all staff requiring such training will have completed it within 12 months of starting in a role. The training will be supplemented with a communications strategy, together with policies and procedures to ensure that all staff are aware of how referrals should be made in the event of any concerns.

We will measure compliance with the requirements to have an executive and operational lead, access to accredited trainers, a *Prevent* policy, clear referral processes and completion of awareness-raising and the training requirements listed above. This will be measured using the Safeguarding Adults Assessment Framework for both the CCG and our provider organisations, and we will provide reports to the Safeguarding Steering Group. We will address any areas of risk, or non-compliance by providers using existing contractual mechanisms.

Providers will be required, through quality schedules, to provide information relating to the *Prevent agenda*. This will include regular returns, compliance against the training and competencies framework, and performance against the duties in the Counter-Terrorism and Security Bill (which are currently subject to consultation).

12. Research and innovation

12.1 Fulfilling our statutory responsibilities to support research

We remain committed to promoting and supporting research and innovation across local healthcare. This includes fulfilling three related statutory duties, which are described in the following sections.

Duty to promote research – We have a dedicated Research Strategy Group to oversee our statutory duty to promote research. The Group is chaired by Dr Alastair McLachlan, GP Executive lead for Research, and meets quarterly. Group membership includes representatives from research-active GP member practices, commissioning managers, the Head of Quality Governance, a Public Health Consultant and the Deputy Director of the National Institute for Health Research (NIHR) Research Design Service East Midlands. We have in place well-established research partnerships with:

- University of Nottingham
- Nottingham Trent University
- NIHR Clinical Research Network East Midlands (NIHR CRN EM)
- NIHR Collaboration for Applied Leadership Health Research and Care East Midlands (NIHR CLAHRC EM), where Lucy Branson, Associate Director for Corporate Development, is a member of the Governance Board

We will continue to utilise NIHR Research Capability Funding, which is awarded to research-active organisations. This will provide ongoing support for the strategic development of high quality primary care research and research capacity, delivered in partnership with our GP member practices and local academics. We have commissioned two exploratory research studies with a view to increasing the uptake of Long Term Conditions and cancer services within primary and community care for Black and Minority Ethnic (BME) groups within Nottingham City. More about these can be found in section 3.3, and findings will inform the future commissioning and provision of services in 2015/16. We will also commission another research study this year to support the ongoing development and delivery of our commissioning strategy. We will work with our People's Council, GP leads and commissioning managers to determine the focus of the new study. We will continue to include research indicators within our provider contract quality schedules, where we are the

lead commissioner. Furthermore, we will develop and approve an Intellectual Property Policy within 2015/16.

Duty to promote the use of research evidence – Our Clinical Effectiveness Forum is the mechanism through which the CCG receives assurance of our statutory duty to promote the use of research evidence. This forum advocates and encourages clinical effectiveness and quality throughout all our activities. One of its duties is to review reports from local research studies and service evaluations, share learning, and make recommendations on the appropriate action to take. We are developing an *Integrated Impact Assessment Toolkit* to help us determine whether any new or changed activity will impact adversely or positively on service users, CCG staff or other organisations in relation to equality, quality and privacy. It will also assess whether planned activities are based on the best available evidence. To support the effective roll-out of the toolkit to staff, the Nottingham City Knowledge Resources Team will develop and deliver training to CCG staff, focusing on accessing and utilising evidence to support the commissioning process.

Duty to follow the Department of Health's policy on excess treatment costs for research – The matter of excess treatment costs for research is included within our detailed financial policies. We have an agreed a process for considering applications for excess treatment costs, which includes a dedicated budget. Our Head of Research and Evaluation has led a process to standardise the information required to support an application to commissioners for excess treatment costs. The resulting new form is now widely accepted by CCGs across the East Midlands and further afield.

12.2 Using Academic Health Science Networks (AHSNs) to promote research

Together with our health community, we are both actively engaged in, and benefitting from, the work of the East Midlands Academic Health Science Network (AHSN). This activity includes the development of evidence-based early supported discharge for stroke patients, community rehabilitation teams, and the Patient Safety Collaborative.

The *PINCER* initiative is a pharmacist-led intervention that will use information technology to address clinically important errors in the management of medications within primary care. The initiative will reduce prescribing errors, improve patient safety and reduce the number of unnecessary admissions to hospital. We are one of 17 CCGs in the East Midlands to take part in the PINCER initiative in collaboration with the East Midlands Academic Health Science Network (EM AHSN), Lincolnshire Community Health Services NHS Trust and the Universities of Lincoln and Nottingham. The initiative will be rolled out over the next two years to 150 GP practices across the East Midlands. Funding from both the EM AHSN, and a Health Foundation *Scaling Up Improvement Award* will enable partners to implement and evaluate the initiative.

The CCG is also in discussion with the EM AHSN regarding the commissioning of a SPARKLER (Spreading Applied Research and Knowledge – Longer Evidence Review) to support the transformation of urgent care. The SPARKLER is a pioneering service to help health organisations within the East Midlands to synthesise research from multiple sources. The evidence gathered provides the base on which to build rapid service improvements. During 2014, the South Nottinghamshire Unit of Planning asked the East Midlands AHSN to produce

a SPARKLER to identify the characteristics of three internationally renowned systems of care in Jonkoping, Sweden; Canterbury, New Zealand; and Alzira/Valencia, Spain. The findings will help to inform the development of new models of care for Nottingham City over the course of 2015/16.

12.3 Delivering Health and Wealth: accelerating adoption and diffusion in the NHS

The Department of Health's report, *Innovation Health and Wealth,* sets out a delivery agenda for spreading innovation at pace and scale throughout the NHS. We will continue to meet the requirements of this report with respect to our role and responsibilities as a commissioner. Here, we set out how we will do this.

Reducing variation and strengthening compliance – NICE Technology Appraisal – Where we are the lead commissioner, our Quality and Contract Review meetings will continue to monitor the quality reporting requirements compliance against NICE Technology Appraisals for providers. Our CCG has delegated authority, through the Medicines Management Team, to the Nottinghamshire Area Prescribing Committee to ensure the appropriate implementation of NICE Technology Appraisals and clinical guidelines relating to medicines used within primary care.

Leadership for Innovation – We are aware of our duty to seek out and adopt best practice, and to promote innovation. In 2015/16, we will hold a session on innovation as part of our Governing Body development programme. This will be based on NHS England's 2013 guidance: *Strengthening Leadership and Accountability for Innovation. A practical guide for Governing Bodies and Provider Boards.*

High Impact Innovations – Assistive Technology Programme – The Assistive Technology (AT) Strategy within the Adult Integrated Care Programme aims to secure increasing and more effective use of AT across health and social care. It also seeks to integrate the two separate services - Telehealth and Telecare - into one service. We will focus on key priority groups, such as adults with long term conditions, adults with learning disabilities and disabled children, with a view to preventing hospital admissions, supporting discharges, and preventing or delaying care home admission. Included within the Better Care Fund Plan, the AT programme has an overall target to support up to 10,000 local people by 2018. This incorporates an increase from 4,800 to 6,000 people within 2015/16. Feedback from both users and carers is very positive. 96% of users report that they feel safer at home with the equipment, and 75% of carers say they feel less stressed than before. Patients using Telehealth have told us that the technology has helped them to manage their condition, so reducing hospital attendances and admissions, as well as visits to their GP. Feedback forms part of the formal evaluation of the programme, and in 2015/16 we will also conduct a cost-effectiveness study to demonstrate the impact that using AT has had on the cost of providing services. Following the accolade of 'Highly Commended' at the 2014 Government Opportunities Award, there are also further initiatives planned for 2015/16. We aim to introduce Telehealth and video conferencing to support patients in care homes, together with virtual clinics to support respiratory patients to manage their condition and avoid hospital admissions through their Telehealth device. This will also provide more help to GP Practices in supporting their high-risk patients and in managing frequent attenders.

13. Delivering value

13.1 Meeting the business rules on financial plans

The CCG has a duty to deliver against a set of business rules for financial plans. For 2015/16, these are as follows:

- To deliver a minimum of 1% surplus on our total allocation (resource limit). This equates to a surplus of just over £4,230k.
- To ensure that at least 0.5% contingency is held by the CCG for in-year risk. This equates to £2,116k.
- To ensure that at least 1% of our programme resources are funded non-recurrently during the year. This equates to £4,230k.

Our 2015/16 plans successfully deliver against *all* of these metrics.

13.2 Developing credible, evidence-based QIPP plans

QIPP plans have been identified for 2015/16 to deliver efficiency savings of £6.5m in line with our targets.

In developing our specific QIPP priorities and initiatives, we have benchmarked our performance, data, services and activities with evidence gained from a number of sources and approaches, including *Commissioning for Value*, *Dr Foster*, deep dives and programme budgeting. Our *Better Care Fund* team has also met with a number of peer CCGs and other organisations to compare activity and to explore best practice. These include NHS Wolverhampton CCG (long term conditions); Leicester and Lincoln CCGs (smoking cessation); Torbay Care Trust (older people's services); and Manchester and Liverpool CCGs (cancer pathways and QIPP programmes in general).

Benchmarking has shown that the main opportunities for efficiency improvement across Nottingham City healthcare lie within urgent care, long term conditions, mental health, and emergency admissions. Prescribing also has a national focus, and whilst we perform well in terms of prescribing spend, there are still savings to be made. In accordance with these findings, our QIPP programme is divided into five core programme areas to align with specific pathways of care:

- Urgent care
- Planned care
- Long Term Conditions
- Mental health
- Prescribing

Representatives from our CCG have also attended national QIPP redesign conferences and workshops to gain best practice, develop further skills, and share learning in relation to various areas of care.

In many areas we are leading the agenda for service improvement; for example, giving GPs direct access to CT scans for suspected lung cancer patients, our orthopaedic community ICAT service, and our community diabetes service. Many of these initiatives are a direct benefit of the clinical commissioning approach, whereby GPs developed the ideas to respond directly to local challenges, and simply made it happen through the CCG. Thanks to this local innovation, a number of the QIPP arrangements we are implementing in full this year are as a result of successful local pilots.

We have worked, and will continue to work in collaboration with our providers to develop and to deliver QIPP plans across the local system. This ensures ownership of organisational plans, as well as commitment to their delivery. The process has involved 'confirm and challenge' sessions with finance, commissioning and clinical leads across the CCG, as well as the relevant leads from provider organisations. In turn, each provider has taken proposals through their own organisational governance processes.

All QIPP plans have an integrated impact assessment undertaken before being shared with GP Leads and signed off by the Risk and Performance Committee, and on to our Governing Body. Other partners, such as the local authority, are involved in this process where a scheme either involves, or impacts on them. Any initiatives requiring investment are referred to the Resource Allocation and Prioritisation Panel, and undergo a process of further assessment and scrutiny before funding is committed.

Our QIPP plans for 2015/16 will be available on our public website once they have been signed off by the Governing Body.

14. System Resilience

System Resilience Groups (SRGs) are the forum where all the partners across the health and social care system come together to undertake the regular planning of service delivery. Nottingham City CCG is part of the Greater Nottingham SRG.

In the second and third quarter of 2014/15 Nottingham City CCG and its partner CCGs in Greater Nottingham received two separate allocations of non-recurrent money (totalling £9.2m) which was used to support 22 separate resilience and service improvement schemes across three key areas:

- Avoiding Hospital Admission.
- Internal Capacity and Flow with Nottingham University Hospitals (NUH).
- Effective Discharge and Rehabilitation.

With the increasing understanding that system resilience is not just an issue in the winter there has been a national decision to move away from ad-hoc funding and in 2015/16 every CCG in England has received a system resilience allocation on a recurrent basis. Whilst this allocation is considerably reduced from that received in 2014/15 (£4.2m across Greater Nottingham CCGs) the certainty of recurrent funding is hugely beneficial. However for 2015/16 it will require the system to reduce the number of resilience schemes that were in operation at the end of 2014/15.

The Greater Nottingham system has undertaken a detailed 'stock take' exercise to review all of the schemes put in place during 2014/15, understand their impact on system resilience and understand the risk should those schemes be reduced or stopped. Recommendations from the 'Stock Take' meetings were presented to the SRG meeting in March 2015 and the following investments confirmed utilising both System Resilience and alternative sources of funding.

- Additional clinical staff in the Liaison Psychiatry Service to support the Emergency Department at Queens Medical Centre.
- Additional diagnostics imaging capacity to support the Emergency Department at Queens Medical Centre.
- Additional Emergency Department Consultant cover to increase the number of consultants on duty during the evening and overnight period.
- Nottingham Care Navigator Service (a range of initiatives which enable doctors at the hospital to access alternative services for patients to prevent them from having to admit someone to a hospital bed).
- Additional nurses at Ling Bar Community Hospital to support the rehabilitation of patients and a reduced length of stay to improve flow through hospital.
- Discharge Coordinator for community facilities to improve flow through community in-patient facilities and eliminate delayed transfers of care and additional staff to coordinate discharges from hospital.
- Additional social worker capacity to achieve timely assessment and discharge of patients from hospital who require ongoing support at home or in the community.
- Resilience capacity for East Midlands Ambulance Service.
- GPs working in the Emergency Department (this will be trialled over the Easter holiday bank holiday weekend).

In addition to this all of the other resilience schemes that were in place as at the end of 2014/15 will continue to be supported during April 2015. This will provide additional resilience over Easter and will allow further work to take place to assess a safe way to withdraw from these schemes (which includes additional beds in the hospital) or alternatively to look at how they can be continued if this is deemed to be necessary.

Appendix 1 – NHS Outcomes Framework Performance

Domain	IndicatorName	Range	Increase / Decrease
Preventing people from dying prematurely	1.1 Potential Years of Life Lost amenable to healthcare - female	IQ Range	Sig Decrease
	1.1 Potential Years of Life Lost amenable to healthcare - male	Worst	Non-sig Decrease
	1.2 Under 75 Mortality from CVD	Worst	Non-sig Decrease
	1.6 Under 75 Mortality from respiratory disease	Worst	Non-sig Increase
	1.8 Emergency admissions for alcohol released liver disease	Worst	Non-sig Decrease
	1.9 Under 75 Mortality from cancer	IQ Range	Non-sig Decrease
	1.10 One year survival from all cancers combined	Worst	Non-sig Increase
	1.7 Under 75 Mortality from liver disease	Worst	Non-sig Decrease
	1.4 Myocardial infarction, stroke and stage 5 kidney disease in people with diabetes	Worst	N/A
	1.11 One year survival from breast, lung and colorectal cancers	Worst	Non-sig Increase
	1.17 Record of stage of cancer at diagnosis	IQ Range	
Enhancing quality of life for people with LTC	2.2 % of patients with long term conditions who feel supported to manage their condition	IQ Range	Non-sig Decrease
	2.6 Unplanned admissions chronic ACS conditions	Worst	Non-sig Decrease
	2.7 Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s	IQ Range	Non-sig Decrease
	2.15 Health-related quality of life for carers	IQ Range	Non-sig Increase
	2 Health-related quality of life for people with long-term conditions	Worst	Non-sig Increase
Helping people to recover from episodes of ill health or following injury	3.1 Emergency admissions for acute conditions that should not usually require hospital admission	IQ Range	Non-sig Increase
	3.2 Emergency readmissions within 30 days of discharge from hospital	Worst	N/A
	3.3 Hip replacement casemix adjusted health gain	Worst	Non-sig Increase
	3.3 Knee replacement casemix adjusted health gain	IQ Range	Non-sig Increase
	3.3 Groin hernia casemix adjusted health gain	IQ Range	Non-sig Decrease
	3.4 Emergency admissions for children with lower respiratory tract infections	IQ Range	Non-sig Increase
	3.3 Varicose veins casemix adjusted health gain	N/A	Non-sig Decrease
	3.6.i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Worst	Non-sig Decrease
	3.6.ii Proportion of older people (65 and over) who were offered rehabilitation following discharge from acute or community hospital.	Best	Sig Increase
Ensuring that people have a positive experience of care	4.1 Patient experience of GP out-of-hours services	IQ Range	Non-sig Decrease
	4.2 Patient experience of hospital care	IQ Range	N/A
	4.5 Responsiveness to Inpatients' personal needs	Worst	
	4.4.i Access to GP services	IQ Range	Sig Decrease
	4.4.ii Access to NHS dental services	Best	Non-sig Increase
	4a.i Patient experience of GP services	IQ Range	Sig Decrease
	4a.ii Patient experience of GP out-of-hours services	Best	Non-sig Decrease
	4a.iii Patient experience of dental services	IQ Range	Non-sig Increase
Treating and caring for people in a safe environment and protecting them from avoidable harm.	5.4 Incidence of healthcare-associated infection - C.Difficile	Best	N/A
	5.3 Incidence of healthcare-associated infection - MRSA	Best	N/A

Key	Meaning
	Overarching indicator
Worst	Worst quartile nationally
IQ Range	Within interquartile range nationally
Best	Best quartile nationally

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APPENDIX 3

Health Scrutiny Committee 2015/16 Work Programme

27 May 2015	• **Flu Immunisation** To consider the progress of the children's flu immunisation programme, targeting of flu immunisations to children and adults, the relationship between flu in adults and flu in children; and the benefits and potential disadvantages of vaccination in children. (NHS England/ Public Health England/ NCC) • **Nottingham CityCare Partnership Quality Account 2014/15** To consider the draft Quality Account 2014/15 and decide if the Panel wishes to submit a comment for inclusion in the Account (Nottingham CityCare Partnership) • **Extended work programme planning session to include:** 1. **Discussion with the Portfolio Holder for Adults, Commissioning and Health** 2. **A presentation of 2015/16 Public Health Priorities** 3. **Consider the Nottingham City Clinical Commissioning Group 2015/16 Operating Plan** 4. **Potential returning agenda items from 2014/15** 5. **Potential future agenda items for 2015/16** To agree a draft work programme for 2015/16 and agenda items for June and July meetings
18 June 2015	
23 July 2015	
24 September 2015	
22 October 2015	

19 November 2015	
17 December 2015	
21 January 2016	
18 February 2016	
17 March 2016	
21 April 2016	

Potential returning items to the Health Scrutiny Committee during 2015/16

- Progress in transition of children's public health commissioning for 0-5 year olds to Nottingham City Council
- Progress in implementation of the Care Act
- Healthwatch Nottingham Annual Report
- Review of school nursing services
- Implementation of the Better Care Fund
- Update on bowel cancer screening uptake
- Update on NHS Health Check Programme performance
- Nottingham CityCare Partnership Quality Account 2015/16
- Child and Adolescent Mental Health Services

Potential further items that the Committee 2015/16 might want to consider for work programme

- Community end of life services - new contract from April 2015
- Phlebotomy – change to services
- Review of residential care homes quality bandings/ quality dashboard/ number of concerns raised to assess effectiveness of actions identified from Strategic Review of Care Home sector.
- Issues raised by Catherine Cook at Joint (10/02/15) re HWB3 and joint working - could be useful to get all round the table - HWB3, Nottingham City CCG, Healthwatch, Health and Wellbeing Board reps to discuss issues
- Informal meeting with Lyn Bacon (CityCare Partnership)
- The strategic response to health inequalities/ to what extent is the JHWS supporting a reduction in health equalities?
- Sex and Relationships Education in schools
- Quality of GP practices - To consider the implications that quality of GP provision has for future GP provision in the City
- Healthwatch Nottingham's contract due to end March 2016 – review of 3 year performance and re-procurement
- Implementation of Strategy to Reduce Avoidable Injuries in Children and Young People
- Implementation of Mental Health Strategy and performance against associated JHWS targets
- Smoking cessation – new approaches
- Childhood obesity
- Telecare/ Telehealth – how they are working together
- Transition between CAMHS and adult mental health services

Scrutiny Review Committee (or Study Group)

- Service user experience of care at home services
- Review of End of Life Services

Items to be scheduled for 2016/17

- Nottingham CityCare Partnership Quality Account 2015/16 (May 2016)

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