APPENDIX 1 -
Extract from Nottingham CityCare Partnership Quality Account 2013/14

3

Priorities for quality improvement 2014/15

3.1 Patient safety

Our patient safety quality priorities will be delivered through work within Care Delivery Groups, mobile working and assistive technology, and workforce development in integrated care.

3.1.1 Care Delivery Groups

We employ care co-ordinators to work within the Care Delivery Groups (see page 22).

Currently care co-ordinators 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 plan to achieve	How we plan to achieve it	How we will monitor and report on our progress
• We will explore the expansion of the care co-ordinator role to support citizens with complex needs throughout their whole pathway of care • We will explore the diversification of the role by taking non-clinical tasks from clinicians to release time to care	We will develop and test processes and protocols for information sharing	The development of processes and protocols, plus the evaluation of their implementation will be monitored through the Task and Finish Group of the Integrated Care Programme and reported to the Programme Board

"The Patient Experience Group said:
A joined up approach across health and social care is required for people with long term conditions, of all ages."

3.1.2 Assistive technology and mobile working

We are embracing the effective use of new technologies as a major strategic priority to improve the safety of care and patient experience. Two important developments are assistive technology and mobile technology.

Assistive technology

The assistive technology project is looking at increasing the use of Telecare and Telehealth across social care and health in the next five years.

What we plan to achieve	How we plan to achieve it	How we will monitor and report on our progress
We will increase the awareness among health professionals and patients of the benefits of and barriers to Telehealth	• Training package on new Telehealth system delivered to relevant CityCare staff • Clinicians directed to training resources within the new system • Patient information leaflet distributed	The effectiveness of the Telehealth deployment is part of OPM's evaluation of the whole integration programme. This is also supported by a Nottingham University research project which is providing qualitative evidence of the effectiveness

Mobile technology

Our clinical staff need to have the right resources to ensure they can meet the needs of those who use our services, and we are driving towards the provision of community services seven days a week, 24 hours a day. More integration of care means organisations need clear plans and protocols for sharing information to ensure that care is delivered appropriately, as and when needed.

We were part of a successful bid with Nottinghamshire Healthcare NHS Trust and County Health Partnerships to secure funding from the 'Nursing Technology fund'. We will now implement 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 by reducing the need to duplicate entries to paper and computer records and cutting the number of phone calls to check records. It will also enable flexible working in line with our patients' choices.

What we plan to achieve	How we plan to achieve it	How we will monitor and report on our progress
We will implement the mobile working project across four key service areas: • Community nursing • Care Delivery Groups • Intermediate care • Evening and night nursing	Employ a project manager to develop a project plan and begin to implement the plan in a staged approach	The Project Implementation Group will monitor progress and report to the CityCare Senior Management Team

Case study – Hospital Discharge project

An 83 year old lady with heart failure and atrial fibrillation had been admitted to hospital with shortness of breath due to worsening fluid retention. She was treated and discharged home with a higher dose of diuretics (water tablets).

Several days later, the Hospital Discharge team telephoned to ask how she was getting on. She said she was confused about the changes to her medicines, so the pharmacist in the Hospital Discharge project team visited her at home. The pharmacist:

- Clinically reviewed the medications the patient was taking and liaised with the GP to update her repeat prescription
- Found out that she had only been taking her water tablets once a day, rather than twice a day as prescribed. They explained this to the patient to enable her to take the medication properly in future
- Liaised with the anticoagulant clinic to advise the patient on taking her warfarin and the need for further blood tests
- Reminded the patient about taking potassium supplements as prescribed by the hospital, and having follow-up blood tests.

The pharmacist also arranged for the medicines to be dispensed into a weekly blister pack and for the community pharmacist to become involved in making sure she continued taking them correctly.

Several of the issues identified in this case could have led to the patient being re-admitted to hospital if left to continue.

What we plan to achieve	How we plan to achieve it	How we will monitor and report on our progress
We will improve the emotional support available to those who care for people with dementia *(Providing emotional support to carers will reduce stress and promote health and well-being. This improves the health and welfare of the person with dementia.)*	Recruit two Admiral Nurses to help provide this support *(Admiral Nurses support families throughout the dementia journey. They provide family carers with the tools and skills to best understand the condition, as well as emotional and psychological support through periods of transition.)*	Processes for monitoring and evaluating the work of the Admiral Nurses will be developed and agreed with the post holders once appointed
We will review the recently restructured Older Persons Mental Health Team *(The Older Persons Mental Health Team has been restructured to act a peripatetic service (based in various places) and work with a wider range of health professionals across the city.)*	• Audit referrals into the team from primary care • Audit discharges into the team from acute care • Complete a clinical audit of patient outcomes	The audit results will be reported to the CityCare Senior Management Team by the end of 2014/15

"Councillors on the Health Scrutiny Committee agreed that dementia care training should remain a priority for 2014/15."

Case Study

A 79 year old lady had broken both her wrists and one of her ankles over a period of five years, as she lost her balance and fell to the ground.

But she hasn't lost her confidence or ended up having to use a walking frame, thanks to our community Falls and Bone Health Service.

The service gave her advice and support, and installed balancing aids in her house, a step up to her bath, handles around her bathroom and handrails up her staircase to help make sure she doesn't fall at home.

She said: *"Falling over really ruins your confidence and makes you feel like you can't care for yourself.*

"The CityCare team visit me to check that I'm getting on all right. And they arranged for me to go to a special exercise class at the Lark Hill older people's complex in Clifton. The team has made a massive difference to my life. Just last month I felt confident enough to go to my granddaughter's birthday party.

"If it were not for the help I've been given, and the caring and kind attitude of the staff to let me take my recovery at my own pace, I don't think I'd be where I am today."

What we plan to achieve	How we plan to achieve it	How we will monitor and report on our progress
We will provide clear examples of changes and improvements in services as a result of patient feedback, including complaints or concerns	• Use Patient Stories for the Board (see section below) • Work with teams to identify examples of service changes based on patient feedback	Provide a regular report to commissioners regarding examples of service changes in relation to patient feedback
We will improve patient satisfaction with our complaints process	• Ensure complaints are responded to in a timely and proportionate manner according to the results of the independent review • Send a satisfaction survey to all complainants once their complaint has been responded to	• Complaints responses will be monitored through regular reports to the Governance and Risk Committee and Board • Results of the satisfaction survey will be monitored by the complaints team and reported to commissioners as a CQUIN target for 2014/15

3.3.2 The Patient Experience Group

The Patient Experience Group (PEG) will continue to act as a 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.

We will work with the PEG to implement recommendations for 2014/15 from the recent PEG review.

These include:

What we plan to achieve	How we plan to achieve it	How we will monitor and report on our progress
We will formalise the feedback loop between PEG and the Board *(The PEG is chaired by a non-executive director)*	• An update in the form of a 'Board communique' will be developed by the PEG for the Board • Board members will be invited to attend PEG	• The PEG update will be presented to Board each month by the non-executive director who chairs the PEG • The Board will monitor members' uptake of the invitation to attend PEG
We will provide training and development for PEG members	• Develop and deliver a patient leadership programme • Provide 'in house' training for PEG members regarding specific issues, e.g. involvement in staff recruitment/training	The PEG will report on progress and evaluation through the chair (a non-executive director) to the CityCare Board